| | | |
|---|---|---|
| Tierney | Visclosky | Wise |
| Torres | Waters | Woolsey |
| Towns | Watt (NC) | Wynn |
| Turner | Waxman | Yates |
| Velazquez | Wexler | |
| Vento | Weygand | |

NOT VOTING—11

| | | |
|---|---|---|
| Blagojevich | Forbes | McIntosh |
| Bryant | Gonzalez | Schiff |
| Fattah | Houghton | Young (AK) |
| Foglietta | McCollum | |

So the previous question on the resolution was ordered.

The question being put, viva voce,

Will the House agree to said resolution?

The SPEAKER pro tempore, Mr. BOEHNER, announced that the yeas had it.

So the resolution was agreed to.

A motion to reconsider the vote whereby said resolution was agreed to was, by unanimous consent, laid on the table.

¶90.11 PROVIDING FOR THE CONSIDERATION OF A JOINT RESOLUTION WAIVING ENROLLMENT REQUIREMENTS

Mr. GOSS, by direction of the Committee on Rules, reported (Rept. No. 105–219) the resolution (H. Res. 203) providing for consideration of a joint resolution waiving certain enrollment requirements with respect to two specified bills of the One Hundred Fifth Congress.

When said resolution and report were referred to the House Calendar and ordered printed.

¶90.12 FURTHER MESSAGE FROM THE SENATE

A further message from the Senate by Mr. Lundregan, one of its clerks, announced that the Senate had passed with an amendment in which the concurrence of the House is requested, a bill of the House of the following title:

H.R. 408. An Act to amend the Marine Mammal Protection Act of 1972 to support the International Dolphin Conservation Program in the eastern tropical Pacific Ocean, and for other purposes.

¶90.13 BUDGET RECONCILIATION

Mr. KASICH, pursuant to House Resolution 202, called up the following conference report (Rept. No. 105–217):

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

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

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

**SECTION 1. SHORT TITLE.**

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

**SEC. 2. TABLE OF TITLES.**

This Act is organized into titles as follows:

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

**TITLE I—FOOD STAMP PROVISIONS**

**SEC. 1001. EXEMPTION.**

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

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

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

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

''(6) 15-PERCENT EXEMPTION.—

''(A) DEFINITIONS.—In this paragraph:

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

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

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

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

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

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

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

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

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

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

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

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

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

**SEC. 1002. ADDITIONAL FUNDING FOR EMPLOYMENT AND TRAINING.**

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

''(1) IN GENERAL.—

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

''(i) for fiscal year 1996, $75,000,000;

''(ii) for fiscal year 1997, $79,000,000;

''(iii) for fiscal year 1998—

''(I) $81,000,000; and

''(II) an additional amount of $131,000,000;

''(iv) for fiscal year 1999—

''(I) $84,000,000; and

''(II) an additional amount of $131,000,000;

''(v) for fiscal year 2000—

''(I) $86,000,000; and

''(II) an additional amount of $131,000,000;

''(vi) for fiscal year 2001—

''(I) $88,000,000; and

''(II) an additional amount of $131,000,000; and

''(vii) for fiscal year 2002—

''(I) $90,000,000; and

''(II) an additional amount of $75,000,000.

''(B) ALLOCATION.—

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

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

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

''(III) for each of fiscal years 1999 through 2002, the portion of food stamp recipients who reside in each State who are not eligible for an exception under section 6(o)(3) and who—

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

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

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

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

''(C) REALLOCATION.—If a State agency will not expend all of the funds allocated to the

State agency for a fiscal year under subparagraph (B), the Secretary shall reallocate the unexpended funds to other States (during the fiscal year or the subsequent fiscal year) as the Secretary considers appropriate and equitable.

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

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

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

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

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

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

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

**SEC. 1003. DENIAL OF FOOD STAMPS FOR PRISONERS.**

(a) STATE PLANS.—

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

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

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

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

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

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

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

(3) EFFECTIVE DATE.—

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

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

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

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

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

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

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

**SEC. 1004. NUTRITION EDUCATION.**

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

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

''(f) NUTRITION EDUCATION.—

''(1) IN GENERAL.—To encourage''; and

(2) by adding at the end the following:

''(2) GRANTS.—

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

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

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

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

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

''(D) FEDERAL SHARE.—

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

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

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

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

**SEC. 1005. REGULATIONS; EFFECTIVE DATE.**

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

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

## TITLE II—HOUSING AND RELATED PROVISIONS

**SEC. 2001. TABLE OF CONTENTS.**

The table of contents for this title is as follows:

TITLE II—HOUSING AND RELATED PROVISIONS

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

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

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

(1) in subsection (c)—

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

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

(2) by striking subsection (e).

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

The third sentence of section 8(c)(2)(A) of the United States Housing Act of 1937 (42 U.S.C. 1437f(c)(2)(A)) is amended by inserting

before the period at the end the following: '', and during fiscal year 1999 and thereafter''.

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

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

## TITLE III—COMMUNICATIONS AND SPECTRUM ALLOCATION PROVISIONS

**SEC. 3001. DEFINITIONS.**

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

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

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

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

''(49) TELEVISION SERVICE.—

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

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

**SEC. 3002. SPECTRUM AUCTIONS.**

(a) EXTENSION AND EXPANSION OF AUCTION AUTHORITY.—

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

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

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

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

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

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

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

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

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

(B) in paragraph (3)—

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

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

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

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

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

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

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

(C) in paragraph (4)—

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

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

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

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

(D) in paragraph (8)(B)—

(i) by striking the third sentence; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(B) are located below 3 gigahertz;

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

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

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

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

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

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

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

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

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

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

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

(C) consider the needs of existing public safety radio services (as such services are described in section 309(j)(2)(A) of the Commu-

nications Act of 1934, as amended by this Act);

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

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

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

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

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

(A) specific information on the incumbent licensee;

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

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

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

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

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

(d) IDENTIFICATION AND REALLOCATION OF FREQUENCIES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) IDENTIFICATION AND REALLOCATION OF AUCTIONABLE FREQUENCIES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

such frequencies in accordance with section 309(j) of such Act.

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

**SEC. 3003. AUCTION OF RECAPTURED BROADCAST TELEVISION SPECTRUM.**

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

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

''(A) LIMITATIONS ON TERMS OF TERRESTRIAL TELEVISION BROADCAST LICENSES.—A television broadcast license that authorizes analog television service may not be renewed to authorize such service for a period that extends beyond December 31, 2006.

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

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

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

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

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

''(II) do not have either—

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

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

''(C) SPECTRUM REVERSION AND RESALE.—

''(i) The Commission shall—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(B) that are provided—

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

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

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

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

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

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

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

**SEC. 3005. FLEXIBLE USE OF ELECTROMAGNETIC SPECTRUM.**

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

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

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

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

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

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

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

**SEC. 3006. UNIVERSAL SERVICE FUND PAYMENT SCHEDULE.**

(a) APPROPRIATIONS TO THE UNIVERSAL SERVICE FUND.—

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

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

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

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

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

**SEC. 3007. DEADLINE FOR COLLECTION.**

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

**SEC. 3008. ADMINISTRATIVE PROCEDURES FOR SPECTRUM AUCTIONS.**

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

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

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

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

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

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


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

Subtitle A—Medicare+Choice Program

CHAPTER 1—MEDICARE+CHOICE PROGRAM

SUBCHAPTER A—MEDICARE+CHOICE PROGRAM

Sec. 4001. Establishment of Medicare+Choice Program.

''PART C—MEDICARE+CHOICE PROGRAM

''Sec. 1851. Eligibility, election, and enrollment.

''Sec. 1852. Benefits and beneficiary protections.

''Sec. 1853. Payments to Medicare+Choice organizations.

''Sec. 1854. Premiums.

''Sec. 1855. Organizational and financial requirements for Medicare+Choice organizations; provider-sponsored organizations.

''Sec. 1856. Establishment of standards.

''Sec. 1857. Contracts with Medicare+Choice organizations.

''Sec. 1859. Definitions; miscellaneous provisions.

Sec. 4002. Transitional rules for current medicare HMO program.

Sec. 4003. Conforming changes in medigap program.

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

Sec. 4006. Medicare+Choice MSA.

CHAPTER 2—DEMONSTRATIONS

SUBCHAPTER A—MEDICARE+CHOICE COMPETITIVE PRICING DEMONSTRATION PROJECT

''Sec. 4011. Medicare prepaid competitive pricing demonstration project.

''Sec. 4012. Administration through the Office of Competition; advisory committee.

''Sec. 4013. Project design based on FEHBP competitive bidding model.

SUBCHAPTER B—SOCIAL HEALTH MAINTENANCE ORGANIZATIONS

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

SUBCHAPTER C—MEDICARE SUBDIVISION DEMONSTRATION PROJECT FOR MILITARY RETIREES

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

SUBCHAPTER D—OTHER PROJECTS

''Sec. 4016. Medicare coordinated care demonstration project.

''Sec. 4017. Orderly transition of municipal health service demonstration projects.

''Sec. 4018. Medicare enrollment demonstration project.

''Sec. 4019. Extension of certain medicare community nursing organization demonstration projects.

CHAPTER 3—COMMISSIONS

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

''Sec. 4022. Medicare Payment Advisory Commission.

CHAPTER 4—MEDIGAP PROTECTIONS

''Sec. 4031. Medigap protections.

''Sec. 4032. Addition of high deductible medigap policies.

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

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

Subtitle B—Prevention Initiatives

''Sec. 4101. Screening mammography.

''Sec. 4102. Screening pap smear and pelvic exams.

''Sec. 4103. Prostate cancer screening tests.

''Sec. 4104. Coverage of colorectal screening.

''Sec. 4105. Diabetes self-management benefits.

''Sec. 4106. Standardization of medicare coverage of bone mass measurements.

''Sec. 4107. Vaccines outreach expansion.

''Sec. 4108. Study on preventive and enhanced benefits.

Subtitle C—Rural Initiatives

''Sec. 4201. Medicare rural hospital flexibility program.

''Sec. 4202. Prohibiting denial of request by rural referral centers for reclassification on basis of comparability of wages.

''Sec. 4203. Hospital geographic reclassification permitted for purposes of disproportionate share payment adjustments.

''Sec. 4204. Medicare-dependent, small rural hospital payment extension.

Sec. 4205. Rural health clinic services.

Sec. 4206. Medicare reimbursement for telehealth services.

Sec. 4207. Informatics, telemedicine, and education demonstration project.

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

CHAPTER 1—REVISIONS TO SANCTIONS FOR FRAUD AND ABUSE

Sec. 4301. Permanent exclusion for those convicted of 3 health care related crimes.

Sec. 4302. Authority to refuse to enter into medicare agreements with individuals or entities convicted of felonies.

Sec. 4303. Exclusion of entity controlled by family member of a sanctioned individual.

Sec. 4304. Imposition of civil money penalties.

CHAPTER 2—IMPROVEMENTS IN PROTECTING PROGRAM INTEGRITY

Sec. 4311. Improving information to medicare beneficiaries.

Sec. 4312. Disclosure of information and surety bonds.

Sec. 4313. Provision of certain identification numbers.

Sec. 4314. Advisory opinions regarding certain physician self-referral provisions.

Sec. 4315. Replacement of reasonable charge methodology by fee schedules.

Sec. 4316. Application of inherent reasonableness to all part B services other than physicians' services.

Sec. 4317. Requirement to furnish diagnostic information.

Sec. 4318. Report by GAO on operation of fraud and abuse control program.

Sec. 4319. Competitive bidding demonstration projects.

Sec. 4320. Prohibiting unnecessary and wasteful medicare payments for certain items.

Sec. 4321. Nondiscrimination in post-hospital referral to home health agencies and other entities.

CHAPTER 3—CLARIFICATIONS AND TECHNICAL CHANGES

Sec. 4331. Other fraud and abuse related provisions.

Subtitle E—Provisions Relating to Part A Only

CHAPTER 1—PAYMENT OF PPS HOSPITALS

Sec. 4401. PPS hospital payment update.

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

CHAPTER 2—PAYMENT OF PPS-EXEMPT HOSPITALS

SUBCHAPTER A—GENERAL PAYMENT PROVISIONS

Sec. 4411. Payment update.
Sec. 4412. Reductions to capital payments for certain PPS-exempt hospitals and units.
Sec. 4413. Rebasing.
Sec. 4414. Cap on TEFRA limits.
Sec. 4415. Bonus and relief payments.
Sec. 4416. Change in payment and target amount for new providers.
Sec. 4417. Treatment of certain long-term care hospitals.
Sec. 4418. Treatment of certain cancer hospitals.
Sec. 4419. Elimination of exemptions for certain hospitals.

SUBCHAPTER B—PROSPECTIVE PAYMENT SYSTEM FOR PPS-EXEMPT HOSPITALS

Sec. 4421. Prospective payment for inpatient rehabilitation hospital services.
Sec. 4422. Development of proposal on payments for long-term care hospitals.

CHAPTER 3—PAYMENT FOR SKILLED NURSING FACILITIES

Sec. 4431. Extension of cost limits.
Sec. 4432. Prospective payment for skilled nursing facility services.

CHAPTER 4—PROVISIONS RELATED TO HOSPICE SERVICES

Sec. 4441. Payments for hospice services.
Sec. 4442. Payment for home hospice care based on location where care is furnished.
Sec. 4443. Hospice care benefits periods.
Sec. 4444. Other items and services included in hospice care.
Sec. 4445. Contracting with independent physicians or physician groups for hospice care services permitted.
Sec. 4446. Wavier of certain staffing requirements for hospice care programs in nonurbanized areas.
Sec. 4447. Limitation on liability of beneficiaries for certain hospice coverage denials.
Sec. 4448. Extending the period for physician certification of an individual's terminal illness.
Sec. 4449. Effective date.

CHAPTER 5—OTHER PAYMENT PROVISIONS

Sec. 4451. Reductions in payments for enrollee bad debt.
Sec. 4452. Permanent extension of hemophilia pass-through payment.
Sec. 4453. Reduction in part A medicare premium for certain public retirees.
Sec. 4454. Coverage of services in religious nonmedical health care institutions under the medicare and medicaid programs.

Subtitle F—Provisions Relating to Part B Only

CHAPTER 1—SERVICES OF HEALTH PROFESSIONALS

SUBCHAPTER A—PHYSICIANS' SERVICES

Sec. 4501. Establishment of single conversion factor for 1998.
Sec. 4502. Establishing update to conversion factor to match spending under sustainable growth rate.
Sec. 4503. Replacement of volume performance standard with sustainable growth rate.
Sec. 4504. Payment rules for anesthesia services.
Sec. 4505. Implementation of resource-based methodologies.
Sec. 4506. Dissemination of information on high per discharge relative values for in-hopsital physicians' services.
Sec. 4507. Use of private contracts by medicare beneficiaries.

SUBCHAPTER B—OTHER HEALTH CARE PROFESSIONALS

Sec. 4511. Increased medicare reimbursement For nurse practitioners and clinical nurse specialists.
Sec. 4512. Increase medicare reimbursement for physician assistants.
Sec. 4513. No x-ray required for chiropractic services.

CHAPTER 2—PAYMENT FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

Sec. 4521. Elimination of formula-driven overpayments (FDO) for certain out patient hospital services.
Sec. 4522. Extension of reductions in payments for costs of hospital outpatient services.
Sec. 4523. Prospective payment system for hospital outpatient department services.

CHAPTER 3—AMBULANCE SERVICES

Sec. 4531. Payments for ambulance services.
Sec. 4532. Demonstration of coverage of ambulance services under medicare through contracts with units of local government.

CHAPTER 4—PROSPECTIVE PAYMENT FOR OUTPATIENT REHABILITATION SERVICES

Sec. 4541. Prospective payment for outpatient rehabilitation services.

CHAPTER 5—OTHER PAYMENT PROVISIONS

Sec. 4551. Payments for durable medical equipment.
Sec. 4552. Oxygen and oxygen equipment.
Sec. 4553. Reduction in updates to payment amounts for clinical diagnostic laboratory tests; study on laboratory tests.
Sec. 4554. Improvements in administration of laboratory tests benefit.
Sec. 4555. Updates for ambulatory surgical services.
Sec. 4556. Reimbursement for drugs and biologicals.
Sec. 4557. Coverage of oral anti-nausea drugs under chemotherapeutic regimen.
Sec. 4558. Renal dialysis-related services.
Sec. 4559. Temporary coverage restoration for portable electrocardiogram transportation.

CHAPTER 6—PART B PREMIUM AND RELATED PROVISIONS

SUBCHAPTER A—DETERMINATION OF PART B PREMIUM AMOUNT

Sec. 4571. Part B premium.

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Sec. 4581. Protection under the medicare program for disabled workers who lost benefits under a group health plan.
Sec. 4582. Government entities eligible to elect to pay part B premiums for eligible individuals.

Subtitle G—Provisions Relating to Parts A and B

CHAPTER 1—HOME HEALTH SERVICES AND BENEFITS

SUBCHAPER A—PAYMENTS FOR HOME HEALTH SERVICES

Sec. 4601. Recapturing savings resulting from temporary freeze on payment increases for home health services.
Sec. 4602. Interim payments for home health services.
Sec. 4603. Prospective payment for home health services.
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SUBCHAPTER B—HOME HEALTH BENEFITS

Sec. 4611. Modification of part A home health benefit for individuals enrolled under part B.
Sec. 4612. Clarification of part-time or intermittent nursing care.
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Sec. 4615. No home health benefits based solely on drawing blood.
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CHAPTER 2—GRADUATE MEDICAL EDUCATION

SUBCHAPTER A—INDIRECT MEDICAL EDUCATION

Sec. 4621. Indirect graduate medical education payments.
Sec. 4622. Payment to hospitals of indirect medical education costs for Medicare+Choice enrollees.

SUBCHAPTER B—DIRECT GRADUATE MEDICAL EDUCATION

Sec. 4623. Limitation on number of residents and rolling average FTE count.
Sec. 4624. Payments to hospitals for direct costs of graduate medical education of Medicare+Choice enrollees.
Sec. 4625. Permitting payment to nonhospital providers.
Sec. 4626. Incentive payments under plans for voluntary reduction in number of residents.
Sec. 4627. Medicare special reimbursement rule for primary care combined residency programs.
Sec. 4628. Demonstration project on use of consortia.
Sec. 4629. Recommendations on long-term policies regarding teaching hospitals and graduate medical education.
Sec. 4630. Study of hospital overhead and supervisory physician components of direct medical education costs.

CHAPTER 3—PROVISIONS RELATING TO MEDICARE SECONDARY PAYER

Sec. 4631. Permanent extension and revision of certain secondary payer provisions.
Sec. 4632. Clarification of time and filing limitations.
Sec. 4633. Permitting recovery against third party administrators.

CHAPTER 4—OTHER PROVISIONS

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## Subtitle A—Medicare+Choice Program

## CHAPTER 1—MEDICARE+CHOICE PROGRAM

### Subchapter A—Medicare+ Choice Program

**SEC. 4001. ESTABLISHMENT OF MEDICARE+ CHOICE PROGRAM.**

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

''PART C—MEDICARE+CHOICE PROGRAM

''ELIGIBILITY, ELECTION, AND ENROLLMENT

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

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

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

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

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

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

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

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

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

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

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

''(b) SPECIAL RULES.—

''(1) RESIDENCE REQUIREMENT.—

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

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

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

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

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

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

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

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

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

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

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

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

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

''(c) PROCESS FOR EXERCISING CHOICE.—

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

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

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

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

''(3) DEFAULT.—

''(A) INITIAL ELECTION.—

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

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

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

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

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

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

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

''(2) PROVISION OF NOTICE.—

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

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

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

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

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

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

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

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

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

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

''(i) covered items and services,

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

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

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

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

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

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

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

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

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

''(ii) Any beneficiary cost sharing.

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

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

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

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

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

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

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

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

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

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

''(ii) information on medicare enrollee satisfaction,

''(iii) information on health outcomes, and

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

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

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

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

''(7) PROVISION OF INFORMATION.—A Medicare+Choice organization shall provide

the Secretary with such information on the organization and each Medicare+Choice plan it offers as may be required for the preparation of the information referred to in paragraph (2)(A).

''(e) COVERAGE ELECTION PERIODS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(D) the individual meets such other exceptional conditions as the Secretary may provide.

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

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

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

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

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

''(iii) the month of November 1998;

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

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

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

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

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

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

''(1) DURING INITIAL COVERAGE ELECTION PERIOD.—An election of coverage made during the initial coverage election period under subsection (e)(1)(A) shall take effect upon the date the individual becomes entitled to benefits under part A and enrolled under part B, except as the Secretary may provide (consistent with section 1838) in order to prevent retroactive coverage.

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

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

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

''(g) GUARANTEED ISSUE AND RENEWAL.—

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

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

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

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

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

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

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

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

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

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

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

''(C) CONSEQUENCE OF TERMINATION.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''BENEFITS AND BENEFICIARY PROTECTIONS

''SEC. 1852. (a) BASIC BENEFITS.—

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

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

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

''(2) SATISFACTION OF REQUIREMENT.—

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

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

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

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

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

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

''(3) SUPPLEMENTAL BENEFITS.—

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

''(B) AT ENROLLEES' OPTION.—

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

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

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

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

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

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

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

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

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

''(b) ANTIDISCRIMINATION.—

''(1) BENEFICIARIES.—

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

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

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

tablishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

''(c) DISCLOSURE REQUIREMENTS.—

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

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

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

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

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

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

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

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

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

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

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

''(ii) the supplemental benefits covered, and

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

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

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

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

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

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

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

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

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

''(d) ACCESS TO SERVICES.—

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

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

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

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

''(i) the services were not emergency services (as defined in paragraph (3)), but (I) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition, and (II) it was not reasonable given the circumstances to obtain the services through the organization,

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

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

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

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

''(2) GUIDELINES RESPECTING COORDINATION OF POST-STABILIZATION CARE.—A Medicare+Choice plan shall comply with such guidelines as the Secretary may prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1867.

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

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

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

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

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

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

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

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

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

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

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

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

''(e) QUALITY ASSURANCE PROGRAM.—

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

''(2) ELEMENTS OF PROGRAM.—

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

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

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

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

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

''(v) include measures of consumer satisfaction;

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

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

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

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

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

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

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

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

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

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

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

''(C) DEFINITION OF NON-NETWORK MSA PLAN.—In this subsection, the term 'non-network MSA plan' means an MSA plan offered by a Medicare+Choice organization that does

not provide benefits required to be provided by this part, in whole or in part, through a defined set of providers under contract, or under another arrangement, with the organization.

''(3) EXTERNAL REVIEW.—

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

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

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

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

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

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

''(1) DETERMINATIONS BY ORGANIZATION.—

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

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

''(2) RECONSIDERATIONS.—

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

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

''(3) EXPEDITED DETERMINATIONS AND RECONSIDERATIONS.—

''(A) RECEIPT OF REQUESTS.—

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

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

''(B) ORGANIZATION PROCEDURES.—

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

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

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

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

''(5) APPEALS.—An enrollee with a Medicare+Choice plan of a Medicare+Choice organization under this part who is dissatisfied by reason of the enrollee's failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is $1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the organization shall be entitled to be parties to that judicial review. In applying subsections (b) and (g) of section 205 as provided in this paragraph, and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

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

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

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

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

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

''(j) RULES REGARDING PROVIDER PARTICIPATION.—

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

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

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

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

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

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

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

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

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

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

''(C) CONSTRUCTION.—Nothing in subparagraph (B) shall be construed to affect disclo-

sure requirements under State law or under the Employee Retirement Income Security Act of 1974.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(ii) either—

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

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

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

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

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

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

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

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

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

''(iii) ASSURING ENFORCEMENT.—If the Medicare+Choice organization fails to establish and enforce procedures required under clause (ii), the organization is subject to intermediate sanctions under section 1857(g).

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

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

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

''(C) INFORMATION ON BENEFICIARY LIABILITY.—

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

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

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

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

''PAYMENTS TO MEDICARE+CHOICE ORGANIZATIONS

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

''(1) MONTHLY PAYMENTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(C) MINIMUM PERCENTAGE INCREASE.—

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

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

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

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

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

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

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

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

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

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

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

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

''(ii) for a subsequent year is the annual area-specific Medicare+Choice capitation rate for the previous year determined under this paragraph for the area, increased by the national per capita Medicare+Choice growth percentage for such subsequent year.

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

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

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

''(I) 1998 is 20 percent,

''(II) 1999 is 40 percent,

''(III) 2000 is 60 percent,

''(IV) 2001 is 80 percent, and

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

''(C) PAYMENT ADJUSTMENT.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(iv) for part B services—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(3) GEOGRAPHIC ADJUSTMENT.—

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

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

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

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

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

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

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

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

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

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

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

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

''(2) ESTABLISHMENT AND DESIGNATION OF MEDICARE+CHOICE MEDICAL SAVINGS ACCOUNT AS REQUIREMENT FOR PAYMENT OF CONTRIBUTION.—In the case of an individual who has elected coverage under an MSA plan, no payment shall be made under paragraph (1) on behalf of an individual for a month unless the individual—

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

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

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

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

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

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

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

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

elected before the election with such organization,

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

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

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

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

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

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

''(h) SPECIAL RULE FOR HOSPICE CARE.—

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

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

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

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

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

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

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

''PREMIUMS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(5) REVIEW.—

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

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

''(b) MONTHLY PREMIUM CHARGED.—

''(1) IN GENERAL.—

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

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

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

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

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

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

''(c) UNIFORM PREMIUM.—The Medicare+Choice monthly basic and supplemental beneficiary premium, the Medicare+Choice monthly MSA premium charged under subsection (b) of a Medicare+Choice organization under this part may not vary among individuals enrolled in the plan.

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

''(e) LIMITATION ON ENROLLEE LIABILITY.—

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

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

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

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

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

involved under this part or on the basis of other appropriate data.

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

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

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

''(f) REQUIREMENT FOR ADDITIONAL BENEFITS.—

''(1) REQUIREMENT.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(ii) the State has imposed as a condition of approval of the license documentation or information requirements relating to solvency or other material requirements, procedures, or standards relating to solvency that are different from the requirements, procedures, and standards applied by the Secretary under subsection (d)(2).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(b) ASSUMPTION OF FULL FINANCIAL RISK.—The Medicare+Choice organization shall assume full financial risk on a prospective basis for the provision of the health care services for which benefits are required to be provided under section 1852(a)(1), except that the organization—

''(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which exceeds such aggregate level as the Secretary specifies from time to time,

''(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization,

''(3) may obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and

''(4) may make arrangements with physicians or other health care professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(D) both providers are part of an affiliated service group under section 414 of such Code.

''(4) CONTROL.—For purposes of paragraph (3), control is presumed to exist if one party, directly or indirectly, owns, controls, or holds the power to vote, or proxies for, not less than 51 percent of the voting rights or governance rights of another.

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

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

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

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

''ESTABLISHMENT OF STANDARDS

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

''(1) ESTABLISHMENT.—

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

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

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

''(ii) alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, partnerships with other licensed entities, and valuation attributable to the ability of such an organization to meet its service obligations through direct delivery of care, and

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

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

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

''(3) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under paragraph (2), and for purposes of this subsection, the 'target date for publication' (referred to in section 564(a)(5) of such title) shall be April 1, 1998.

''(4) ABBREVIATED PERIOD FOR SUBMISSION OF COMMENTS.—In applying section 564(c) of such title under this subsection, '15 days' shall be substituted for '30 days'.

''(5) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

''(A) the appointment of a negotiated rulemaking committee under section 565(a) of such title by not later than 30 days after the end of the comment period provided for under section 564(c) of such title (as shortened under paragraph (4)), and

''(B) the nomination of a facilitator under section 566(c) of such title by not later than 10 days after the date of appointment of the committee.

''(6) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under paragraph (5) shall report to the Secretary, by not later than January 1, 1998, regarding the committee's progress on achieving a consensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before 1 month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress towards such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this subsection through such other methods as the Secretary may provide.

''(7) FINAL COMMITTEE REPORT.—If the committee is not terminated under paragraph (6), the rulemaking committee shall submit a report containing a proposed rule by not later than 1 month before the target date of publication.

''(8) INTERIM, FINAL EFFECT.—The Secretary shall publish a rule under this subsection in the Federal Register by not later than the target date of publication. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 60 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications of entities to be certified as provider-sponsored organizations pursuant to such rules and consistent with this subsection.

''(9) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target date of publication.

''(b) ESTABLISHMENT OF OTHER STANDARDS.—

''(1) IN GENERAL.—The Secretary shall establish by regulation other standards (not described in subsection (a)) for Medicare+Choice organizations and plans consistent with, and to carry out, this part. The Secretary shall publish such regulations by June 1, 1998. In order to carry out this requirement in a timely manner, the Secretary may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

''(2) USE OF CURRENT STANDARDS.—Consistent with the requirements of this part, standards established under this subsection shall be based on standards established under section 1876 to carry out analogous provisions of such section.

''(3) RELATION TO STATE LAWS.—

''(A) IN GENERAL.—The standards established under this subsection shall supersede any State law or regulation (including standards described in subparagraph (B)) with respect to Medicare+Choice plans which are offered by Medicare+Choice organizations under this part to the extent such law or regulation is inconsistent with such standards.

''(B) STANDARDS SPECIFICALLY SUPERSEDED.—State standards relating to the following are superseded under this paragraph:

''(i) Benefit requirements.

''(ii) Requirements relating to inclusion or treatment of providers.

''(iii) Coverage determinations (including related appeals and grievance processes).

''CONTRACTS WITH MEDICARE+CHOICE ORGANIZATIONS

''SEC. 1857. (a) IN GENERAL.—The Secretary shall not permit the election under section 1851 of a Medicare+Choice plan offered by a Medicare+Choice organization under this part, and no payment shall be made under section 1853 to an organization, unless the Secretary has entered into a contract under this section with the organization with respect to the offering of such plan. Such a contract with an organization may cover more than 1 Medicare+Choice plan. Such contract shall provide that the organization agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

''(b) MINIMUM ENROLLMENT REQUIREMENTS.—

''(1) IN GENERAL.—Subject to paragraph (2), the Secretary may not enter into a contract under this section with a Medicare+Choice organization unless the organization has—

''(A) at least 5,000 individuals (or 1,500 individuals in the case of an organization that is a provider-sponsored organization) who are receiving health benefits through the organization, or

''(B) at least 1,500 individuals (or 500 individuals in the case of an organization that is a provider-sponsored organization) who are receiving health benefits through the organization if the organization primarily serves individuals residing outside of urbanized areas.

''(2) APPLICATION TO MSA PLANS.—In applying paragraph (1) in the case of a Medicare+Choice organization that is offering an MSA plan, paragraph (1) shall be applied by substituting covered lives for individuals.

''(3) ALLOWING TRANSITION.—The Secretary may waive the requirement of paragraph (1) during the first 3 contract years with respect to an organization.

''(c) CONTRACT PERIOD AND EFFECTIVENESS.—

''(1) PERIOD.—Each contract under this section shall be for a term of at least 1 year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term.

''(2) TERMINATION AUTHORITY.—In accordance with procedures established under subsection (h), the Secretary may at any time terminate any such contract if the Secretary determines that the organization—

''(A) has failed substantially to carry out the contract;

''(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part; or

''(C) no longer substantially meets the applicable conditions of this part.

''(3) EFFECTIVE DATE OF CONTRACTS.—The effective date of any contract executed pursuant to this section shall be specified in the contract, except that in no case shall a contract under this section which provides for coverage under an MSA plan be effective before January 1999 with respect to such coverage.

''(4) PREVIOUS TERMINATIONS.—The Secretary may not enter into a contract with a Medicare+Choice organization if a previous contract with that organization under this section was terminated at the request of the organization within the preceding 5-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

''(5) CONTRACTING AUTHORITY.—The authority vested in the Secretary by this part may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

''(d) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—

''(1) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of the financial records (including data relating to medicare utilization, costs, and computation of the adjusted community rate) of at least one-third of the Medicare+Choice organizations offering Medicare+Choice plans under this part. The Comptroller General shall monitor auditing activities conducted under this subsection.

''(2) INSPECTION AND AUDIT.—Each contract under this section shall provide that the Secretary, or any person or organization designated by the Secretary—

''(A) shall have the right to inspect or otherwise evaluate (i) the quality, appropriateness, and timeliness of services performed under the contract, and (ii) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

''(B) shall have the right to audit and inspect any books and records of the Medicare+Choice organization that pertain (i) to the ability of the organization to bear the risk of potential financial losses, or (ii) to services performed or determinations of amounts payable under the contract.

''(3) ENROLLEE NOTICE AT TIME OF TERMINATION.—Each contract under this section shall require the organization to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled with the organization under this part.

''(4) DISCLOSURE.—

''(A) IN GENERAL.—Each Medicare+Choice organization shall, in accordance with regulations of the Secretary, report to the Secretary financial information which shall include the following:

''(i) Such information as the Secretary may require demonstrating that the organization has a fiscally sound operation.

''(ii) A copy of the report, if any, filed with the Health Care Financing Administration containing the information required to be reported under section 1124 by disclosing entities.

''(iii) A description of transactions, as specified by the Secretary, between the organization and a party in interest. Such transactions shall include—

''(I) any sale or exchange, or leasing of any property between the organization and a party in interest;

''(II) any furnishing for consideration of goods, services (including management services), or facilities between the organization and a party in interest, but not including salaries paid to employees for services provided in the normal course of their employment and health services provided to members by hospitals and other providers and by staff, medical group (or groups), individual practice association (or associations), or any combination thereof; and

''(III) any lending of money or other extension of credit between an organization and a party in interest.

The Secretary may require that information reported respecting an organization which controls, is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

''(B) PARTY IN INTEREST DEFINED.—For the purposes of this paragraph, the term 'party in interest' means—

''(i) any director, officer, partner, or employee responsible for management or administration of a Medicare+Choice organization, any person who is directly or indirectly the beneficial owner of more than 5 percent of the equity of the organization, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5 percent of the organization, and, in the case of a Medicare+Choice organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

''(ii) any entity in which a person described in clause (i)—

''(I) is an officer or director;

''(II) is a partner (if such entity is organized as a partnership);

''(III) has directly or indirectly a beneficial interest of more than 5 percent of the equity; or

''(IV) has a mortgage, deed of trust, note, or other interest valuing more than 5 percent of the assets of such entity;

''(iii) any person directly or indirectly controlling, controlled by, or under common control with an organization; and

''(iv) any spouse, child, or parent of an individual described in clause (i).

''(C) ACCESS TO INFORMATION.—Each Medicare+Choice organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

''(5) LOAN INFORMATION.—The contract shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties.

''(e) ADDITIONAL CONTRACT TERMS.—

''(1) IN GENERAL.—The contract shall contain such other terms and conditions not inconsistent with this part (including requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

''(2) COST-SHARING IN ENROLLMENT-RELATED COSTS.—

''(A) IN GENERAL.—A Medicare+Choice organization shall pay the fee established by the Secretary under subparagraph (B).

''(B) AUTHORIZATION.—The Secretary is authorized to charge a fee to each Medicare+Choice organization with a contract under this part that is equal to the organization's pro rata share (as determined by the Secretary) of the aggregate amount of fees which the Secretary is directed to collect in a fiscal year. Any amounts collected are authorized to be appropriated only for the purpose of carrying out section 1851 (relating to enrollment and dissemination of information) and section 4360 of the Omnibus Budget Reconciliation Act of 1990 (relating to the health insurance counseling and assistance program).

''(C) CONTINGENCY.—For any fiscal year, the fees authorized under subparagraph (B) are contingent upon enactment in an appropriations act of a provision specifying the aggregate amount of fees the Secretary is directed to collect in a fiscal year. Fees collected during any fiscal year under this paragraph shall be deposited and credited as offsetting collections.

''(D) LIMITATION.—In any fiscal year the fees collected by the Secretary under subparagraph (B) shall not exceed the lesser of—

''(i) the estimated costs to be incurred by the Secretary in the fiscal year in carrying out the activities described in section 1851 and section 4360 of the Omnibus Budget Reconciliation Act of 1990; or

''(ii)(I) $200,000,000 in fiscal year 1998;

''(II) $150,000,000 in fiscal year 1999; and

''(III) $100,000,000 in fiscal year 2000 and each subsequent fiscal year.

''(f) PROMPT PAYMENT BY MEDICARE+CHOICE ORGANIZATION.—

''(1) REQUIREMENT.—A contract under this part shall require a Medicare+Choice organization to provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for services and supplies furnished to enrollees pursuant to the contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier (or in the case of a Medicare+Choice private fee-for-service plan, if a claim is submitted to such organization by an enrollee).

''(2) SECRETARY'S OPTION TO BYPASS NONCOMPLYING ORGANIZATION.—In the case of a Medicare+Choice eligible organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with paragraph (1), the Secretary may provide for direct payment of the amounts owed to providers and suppliers (or, in the case of a Medicare+Choice private fee-for-service plan, amounts owed to the enrollees) for covered services and supplies furnished to individuals enrolled under this part under the contract. If the Secretary provides for the direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this part to reflect the amount of the Secretary's payments (and the Secretary's costs in making the payments).

''(g) INTERMEDIATE SANCTIONS.—

''(1) IN GENERAL.—If the Secretary determines that a Medicare+Choice organization with a contract under this section—

''(A) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

''(B) imposes premiums on individuals enrolled under this part in excess of the amount of the Medicare+Choice monthly basic and supplemental beneficiary premiums permitted under section 1854;

''(C) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this part;

''(D) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this part) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

''(E) misrepresents or falsifies information that is furnished—

''(i) to the Secretary under this part, or

''(ii) to an individual or to any other entity under this part;

''(F) fails to comply with the applicable requirements of section 1852(j)(3) or 1852(k)(2)(A)(ii); or

''(G) employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services;

the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2).

''(2) REMEDIES.—The remedies described in this paragraph are—

''(A) civil money penalties of not more than $25,000 for each determination under paragraph (1) or, with respect to a determination under subparagraph (D) or (E)(i) of such paragraph, of not more than $100,000 for each such determination, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(D), $15,000 for each individual not enrolled as a result of the practice involved,

''(B) suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

''(C) suspension of payment to the organization under this part for individuals enrolled after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

''(3) OTHER INTERMEDIATE SANCTIONS.—In the case of a Medicare+Choice organization for which the Secretary makes a determination under subsection (c)(2) the basis of which is not described in paragraph (1), the Secretary may apply the following intermediate sanctions:

''(A) Civil money penalties of not more than $25,000 for each determination under subsection (c)(2) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

''(B) Civil money penalties of not more than $10,000 for each week beginning after the initiation of civil money penalty procedures by the Secretary during which the deficiency that is the basis of a determination under subsection (c)(2) exists.

''(C) Suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under subsection (c)(2) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.

''(4) CIVIL MONEY PENALTIES.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under paragraph (2) or (3) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

''(h) PROCEDURES FOR TERMINATION.—

''(1) IN GENERAL.—The Secretary may terminate a contract with a Medicare+Choice organization under this section in accordance with formal investigation and compliance procedures established by the Secretary under which—

''(A) the Secretary provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under subsection (c)(2); and

''(B) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before terminating the contract.

''(2) EXCEPTION FOR IMMINENT AND SERIOUS RISK TO HEALTH.—Paragraph (1) shall not apply if the Secretary determines that a delay in termination, resulting from compli-

ance with the procedures specified in such paragraph prior to termination, would pose an imminent and serious risk to the health of individuals enrolled under this part with the organization.

''DEFINITIONS; MISCELLANEOUS PROVISIONS

''SEC. 1859. (a) DEFINITIONS RELATING TO MEDICARE+CHOICE ORGANIZATIONS.—In this part—

''(1) MEDICARE+CHOICE ORGANIZATION.—The term 'Medicare+Choice organization' means a public or private entity that is certified under section 1856 as meeting the requirements and standards of this part for such an organization.

''(2) PROVIDER-SPONSORED ORGANIZATION.—The term 'provider-sponsored organization' is defined in section 1855(d)(1).

''(b) DEFINITIONS RELATING TO MEDICARE+CHOICE PLANS.—

''(1) MEDICARE+CHOICE PLAN.—The term 'Medicare+Choice plan' means health benefits coverage offered under a policy, contract, or plan by a Medicare+Choice organization pursuant to and in accordance with a contract under section 1857.

''(2) MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLAN.—The term 'Medicare+Choice private fee-for-service plan' means a Medicare+Choice plan that—

''(A) reimburses hospitals, physicians, and other providers at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk;

''(B) does not vary such rates for such a provider based on utilization relating to such provider; and

''(C) does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established by the plan.

''(3) MSA PLAN.—

''(A) IN GENERAL.—The term 'MSA plan' means a Medicare+Choice plan that—

''(i) provides reimbursement for at least the items and services described in section 1852(a)(1) in a year but only after the enrollee incurs countable expenses (as specified under the plan) equal to the amount of an annual deductible (described in subparagraph (B));

''(ii) counts as such expenses (for purposes of such deductible) at least all amounts that would have been payable under parts A and B, and that would have been payable by the enrollee as deductibles, coinsurance, or copayments, if the enrollee had elected to receive benefits through the provisions of such parts; and

''(iii) provides, after such deductible is met for a year and for all subsequent expenses for items and services referred to in clause (i) in the year, for a level of reimbursement that is not less than—

''(I) 100 percent of such expenses, or

''(II) 100 percent of the amounts that would have been paid (without regard to any deductibles or coinsurance) under parts A and B with respect to such expenses,

whichever is less.

''(B) DEDUCTIBLE.—The amount of annual deductible under an MSA plan—

''(i) for contract year 1999 shall be not more than $6,000; and

''(ii) for a subsequent contract year shall be not more than the maximum amount of such deductible for the previous contract year under this subparagraph increased by the national per capita Medicare+Choice growth percentage under section 1853(c)(6) for the year.

If the amount of the deductible under clause (ii) is not a multiple of $50, the amount shall be rounded to the nearest multiple of $50.

''(c) OTHER REFERENCES TO OTHER TERMS.—

''(1) MEDICARE+CHOICE ELIGIBLE INDIVIDUAL.—The term 'Medicare+Choice eligible individual' is defined in section 1851(a)(3).

''(2) MEDICARE+CHOICE PAYMENT AREA.—The term 'Medicare+Choice payment area' is defined in section 1853(d).

''(3) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE.—The 'national per capita Medicare+Choice growth percentage' is defined in section 1853(c)(6).

''(4) MEDICARE+CHOICE MONTHLY BASIC BENEFICIARY PREMIUM; MEDICARE+CHOICE MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The terms 'Medicare+Choice monthly basic beneficiary premium' and 'Medicare+Choice monthly supplemental beneficiary premium' are defined in section 1854(a)(2).

''(d) COORDINATED ACUTE AND LONG-TERM CARE BENEFITS UNDER A MEDICARE+CHOICE PLAN.—Nothing in this part shall be construed as preventing a State from coordinating benefits under a medicaid plan under title XIX with those provided under a Medicare+Choice plan in a manner that assures continuity of a full-range of acute care and long-term care services to poor elderly or disabled individuals eligible for benefits under this title and under such plan.

''(e) RESTRICTION ON ENROLLMENT FOR CERTAIN MEDICARE+CHOICE PLANS.—

''(1) IN GENERAL.—In the case of a Medicare+Choice religious fraternal benefit society plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the society offering the plan may restrict the enrollment of individuals under this part to individuals who are members of the church, convention, or group described in paragraph (3)(B) with which the society is affiliated.

''(2) MEDICARE+CHOICE RELIGIOUS FRATERNAL BENEFIT SOCIETY PLAN DESCRIBED.—For purposes of this subsection, a Medicare+Choice religious fraternal benefit society plan described in this paragraph is a Medicare+Choice plan described in section 1851(a)(2)(A) that—

''(A) is offered by a religious fraternal benefit society described in paragraph (3) only to members of the church, convention, or group described in paragraph (3)(B); and

''(B) permits all such members to enroll under the plan without regard to health status-related factors.

Nothing in this subsection shall be construed as waiving any plan requirements relating to financial solvency.

''(3) RELIGIOUS FRATERNAL BENEFIT SOCIETY DEFINED.—For purposes of paragraph (2)(A), a 'religious fraternal benefit society' described in this section is an organization that—

''(A) is described in section 501(c)(8) of the Internal Revenue Code of 1986 and is exempt from taxation under section 501(a) of such Act;

''(B) is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches;

''(C) offers, in addition to a Medicare+Choice religious fraternal benefit society plan, health coverage to individuals not entitled to benefits under this title who are members of such church, convention, or group; and

''(D) does not impose any limitation on membership in the society based on any health status-related factor.

''(4) PAYMENT ADJUSTMENT.—Under regulations of the Secretary, in the case of individuals enrolled under this part under a Medicare+Choice religious fraternal benefit society plan described in paragraph (2), the Secretary shall provide for such adjustment to the payment amounts otherwise established under section 1854 as may be appropriate to assure an appropriate payment level, taking into account the actuarial characteristics and experience of such individuals.''.

**SEC. 4002. TRANSITIONAL RULES FOR CURRENT MEDICARE HMO PROGRAM.**

(a) AUTHORIZING TRANSITIONAL WAIVER OF 50:50 RULE.—Section 1876(f) (42 U.S.C. 1395mm(f)) is amended—

(1) in paragraph (1)—

(A) by striking ''Each'' and inserting ''For contract periods beginning before January 1, 1999, each''; and

(B) by striking ''or under a State plan approved under title XIX'';

(2) in paragraph (2), by striking ''The Secretary'' and inserting ''Subject to paragraph (4), the Secretary'', and

(3) by adding at the end the following:

''(4) Effective for contract periods beginning after December 31, 1996, the Secretary may waive or modify the requirement imposed by paragraph (1) to the extent the Secretary finds that it is in the public interest.''.

(b) TRANSITION.—

(1) RISK-SHARING CONTRACTS.—Section 1876 (42 U.S.C. 1395mm) is amended by adding at the end the following new subsections:

''(k)(1) Except as provided in paragraph (2)—

''(A) on or after the date standards for Medicare+Choice organizations and plans are first established under section 1856(b)(1), the Secretary shall not enter into any risk-sharing contract under this section with an eligible organization; and

''(B) for any contract year beginning on or after January 1, 1999, the Secretary shall not renew any such contract.

''(2) An individual who is enrolled in part B only and is enrolled in an eligible organization with a risk-sharing contract under this section on December 31, 1998, may continue enrollment in such organization in accordance with regulations described in section 1856(b)(1).

''(3) Notwithstanding subsection (a), the Secretary shall provide that payment amounts under risk-sharing contracts under this section for months in a year (beginning with January 1998) shall be computed—

''(A) with respect to individuals entitled to benefits under both parts A and B, by substituting payment rates under section 1853(a) for the payment rates otherwise established under section 1876(a), and

''(B) with respect to individuals only entitled to benefits under part B, by substituting an appropriate proportion of such rates (reflecting the relative proportion of payments under this title attributable to such part) for the payment rates otherwise established under subsection (a).

''(4) The following requirements shall apply to eligible organizations with risk-sharing contracts under this section in the same manner as they apply to Medicare+Choice organizations under part C:

''(A) Data collection requirements under section 1853(a)(3)(B).

''(B) Restrictions on imposition of premium taxes under section 1854(g) in relating to payments to such organizations under this section.

''(C) The requirement to accept enrollment of new enrollees during November 1998 under section 1851(e)(6).

''(D) Payments under section 1857(e)(2).''.

(2) REASONABLE COST CONTRACTS.—

(A) PHASE OUT OF CONTRACTS.—Section 1876(h) (42 U.S.C. 1395mm(h)) is amended by adding at the end the following:

''(5)(A) After the date of the enactment of this paragraph, the Secretary may not enter into a reasonable cost reimbursement contract under this subsection (if the contract is not in effect as of such date), except for a contract with an eligible organization which,

immediately previous to entering into such contract, had an agreement in effect under section 1833(a)(1)(A).

''(B) The Secretary may not extend or renew a reasonable cost reimbursement contract under this subsection for any period beyond December 31, 2002.''.

(B) REPORT ON IMPACT.—By not later than January 1, 2001, the Secretary of Health and Human Services shall submit to Congress a report that analyzes the potential impact of termination of reasonable cost reimbursement contracts, pursuant to the amendment made by subparagraph (A), on medicare beneficiaries enrolled under such contracts and on the medicare program. The report shall include such recommendations regarding any extension or transition with respect to such contracts as the Secretary deems appropriate.

(c) ENROLLMENT TRANSITION RULE.—An individual who is enrolled on December 31, 1998, with an eligible organization under section 1876 of the Social Security Act (42 U.S.C. 1395mm) shall be considered to be enrolled with that organization on January 1, 1999, under part C of title XVIII of such Act if that organization has a contract under that part for providing services on January 1, 1999 (unless the individual has disenrolled effective on that date).

(d) ADVANCE DIRECTIVES.—Section 1866(f) (42 U.S.C. 1395cc(f)) is amended—

(1) in paragraph (1)—

(A) by inserting ''1855(i),'' after ''1833(s),'', and

(B) by inserting '', Medicare+Choice organization,'' after ''provider of services''; and

(2) in paragraph (2)(E), by inserting ''or a Medicare+Choice organization'' after ''section 1833(a)(1)(A)''.

(e) EXTENSION OF PROVIDER REQUIREMENT.—Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended—

(1) by striking ''in the case of hospitals and skilled nursing facilities,'';

(2) by striking ''inpatient hospital and extended care'';

(3) by inserting ''with a Medicare+Choice organization under part C or'' after ''any individual enrolled'';

(4) by striking ''(in the case of hospitals) or limits (in the case of skilled nursing facilities)''; and

(5) by inserting ''(less any payments under sections 1886(d)(11) and 1886(h)(3)(D))'' after ''under this title''.

(f) ADDITIONAL CONFORMING CHANGES.—

(1) CONFORMING REFERENCES TO PREVIOUS PART C.—Any reference in law (in effect before the date of the enactment of this Act) to part C of title XVIII of the Social Security Act is deemed a reference to part D of such title (as in effect after such date).

(2) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this chapter.

(g) IMMEDIATE EFFECTIVE DATE FOR CERTAIN REQUIREMENTS FOR DEMONSTRATIONS.—Section 1857(e)(2) of the Social Security Act (requiring contribution to certain costs related to the enrollment process comparative materials) applies to demonstrations with respect to which enrollment is effected or coordinated under section 1851 of such Act.

(h) TRANSITION RULE FOR PSO ENROLLMENT.—In applying subsection (g)(1) of section 1876 of the Social Security Act (42 U.S.C. 1395mm) to a risk-sharing contract entered into with an eligible organization that is a provider-sponsored organization (as defined in section 1855(d)(1) of such Act, as inserted by section 5001) for a contract year beginning on or after January 1, 1998, there shall be substituted for the minimum number of enrollees provided under such section the minimum number of enrollees permitted under section 1857(b)(1) of such Act (as so inserted).

(i) PUBLICATION OF NEW CAPITATION RATES.—Not later than 4 weeks after the date of the enactment of this Act, the Secretary of Health and Human Services shall announce the annual Medicare+Choice capitation rates for 1998 under section 1853(b) of the Social Security Act.

(j) ELIMINATION OF HEALTH CARE PREPAYMENT PLAN OPTION FOR ENTITIES ELIGIBLE TO PARTICIPATE AS MANAGED CARE ORGANIZATION.—

(1) ELIMINATION OF OPTION.—

(A) IN GENERAL.—Section 1833(a)(1)(A) (42 U.S.C. 1395l(a)(1)(A)) is amended by inserting ''(and either is sponsored by a union or employer, or does not provide, or arrange for the provision of, any inpatient hospital services)'' after ''prepayment basis''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) applies to new contracts entered into after the date of enactment of this Act and, with respect to contracts in effect as of such date, shall apply to payment for services furnished after December 31, 1998.

(2) MEDIGAP CONFORMING AMENDMENT.—Effective January 1, 1999, section 1882(g)(1) (42 U.S.C. 1395ss(g)(1)) is amended by striking '', during the period beginning on the date specified in subsection (p)(1)(C) and ending on December 31, 1995,''.

**SEC. 4003. CONFORMING CHANGES IN MEDIGAP PROGRAM.**

(a) CONFORMING AMENDMENTS TO MEDICARE+CHOICE CHANGES.—

(1) IN GENERAL.—Section 1882(d)(3)(A)(i) (42 U.S.C. 1395ss(d)(3)(A)(i)) is amended—

(A) in the matter before subclause (I), by inserting ''(including an individual electing a Medicare+Choice plan under section 1851)'' after ''of this title''; and

(B) in subclause (II)—

(i) by inserting ''in the case of an individual not electing a Medicare+Choice plan'' after ''(II)'', and

(ii) by inserting before the comma at the end the following: ''or in the case of an individual electing a Medicare+Choice plan, a medicare supplemental policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under the Medicare+Choice plan or under another medicare supplemental policy''.

(2) CONFORMING AMENDMENTS.—Section 1882(d)(3)(B)(i)(I) (42 U.S.C. 1395ss(d)(3)(B)(i)(I)) is amended by inserting ''(including any Medicare+Choice plan)'' after ''health insurance policies''.

(3) MEDICARE+CHOICE PLANS NOT TREATED AS MEDICARE SUPPLEMENTARY POLICIES.—Section 1882(g)(1) (42 U.S.C. 1395ss(g)(1)) is amended by inserting ''or a Medicare+Choice plan or'' after ''does not include''.

(b) ADDITIONAL RULES RELATING TO INDIVIDUALS ENROLLED IN MSA PLANS AND PRIVATE FEE-FOR-SERVICE PLANS.—Section 1882 (42 U.S.C. 1395ss) is further amended by adding at the end the following new subsection:

''(u)(1) It is unlawful for a person to sell or issue a policy described in paragraph (2) to an individual with knowledge that the individual has in effect under section 1851 an election of an MSA plan or a Medicare+Choice private fee-for-service plan.

''(2)(A) A policy described in this subparagraph is a health insurance policy (other than a policy described in subparagraph (B)) that provides for coverage of expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under the MSA plan.

''(B) A policy described in this subparagraph is any of the following:

''(i) A policy that provides coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

''(ii) A policy of insurance to which substantially all of the coverage relates to—

''(I) liabilities incurred under workers' compensation laws,

''(II) tort liabilities,

''(III) liabilities relating to ownership or use of property, or

''(IV) such other similar liabilities as the Secretary may specify by regulations.

''(iii) A policy of insurance that provides coverage for a specified disease or illness.

''(iv) A policy of insurance that pays a fixed amount per day (or other period) of hospitalization.''.

**Subchapter B—Special Rules for Medicare+Choice Medical Savings Accounts**

**SEC. 4006. MEDICARE+CHOICE MSA.**

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to amounts specifically excluded from gross income) is amended by redesignating section 138 as section 139 and by inserting after section 137 the following new section:

**''SEC. 138. MEDICARE+CHOICE MSA.**

''(a) EXCLUSION.—Gross income shall not include any payment to the Medicare+Choice MSA of an individual by the Secretary of Health and Human Services under part C of title XVIII of the Social Security Act.

''(b) MEDICARE+CHOICE MSA.—For purposes of this section, the term 'Medicare+Choice MSA' means a medical savings account (as defined in section 220(d))—

''(1) which is designated as a Medicare+Choice MSA,

''(2) with respect to which no contribution may be made other than—

''(A) a contribution made by the Secretary of Health and Human Services pursuant to part C of title XVIII of the Social Security Act, or

''(B) a trustee-to-trustee transfer described in subsection (c)(4),

''(3) the governing instrument of which provides that trustee-to-trustee transfers described in subsection (c)(4) may be made to and from such account, and

''(4) which is established in connection with an MSA plan described in section 1859(b)(3) of the Social Security Act.

''(c) SPECIAL RULES FOR DISTRIBUTIONS.—

''(1) DISTRIBUTIONS FOR QUALIFIED MEDICAL EXPENSES.—In applying section 220 to a Medicare+Choice MSA—

''(A) qualified medical expenses shall not include amounts paid for medical care for any individual other than the account holder, and

''(B) section 220(d)(2)(C) shall not apply.

''(2) PENALTY FOR DISTRIBUTIONS FROM MEDICARE+CHOICE MSA NOT USED FOR QUALIFIED MEDICAL EXPENSES IF MINIMUM BALANCE NOT MAINTAINED.—

''(A) IN GENERAL.—The tax imposed by this chapter for any taxable year in which there is a payment or distribution from a Medicare+Choice MSA which is not used exclusively to pay the qualified medical expenses of the account holder shall be increased by 50 percent of the excess (if any) of—

''(i) the amount of such payment or distribution, over

''(ii) the excess (if any) of—

''(I) the fair market value of the assets in such MSA as of the close of the calendar year preceding the calendar year in which the taxable year begins, over

''(II) an amount equal to 60 percent of the deductible under the Medicare+Choice MSA plan covering the account holder as of Janu-

ary 1 of the calendar year in which the taxable year begins.

Section 220(f)(4) shall not apply to any payment or distribution from a Medicare+Choice MSA.

''(B) EXCEPTIONS.—Subparagraph (A) shall not apply if the payment or distribution is made on or after the date the account holder—

''(i) becomes disabled within the meaning of section 72(m)(7), or

''(ii) dies.

''(C) SPECIAL RULES.—For purposes of subparagraph (A)—

''(i) all Medicare+Choice MSAs of the account holder shall be treated as 1 account,

''(ii) all payments and distributions not used exclusively to pay the qualified medical expenses of the account holder during any taxable year shall be treated as 1 distribution, and

''(iii) any distribution of property shall be taken into account at its fair market value on the date of the distribution.

''(3) WITHDRAWAL OF ERRONEOUS CONTRIBUTIONS.—Section 220(f)(2) and paragraph (2) of this subsection shall not apply to any payment or distribution from a Medicare+Choice MSA to the Secretary of Health and Human Services of an erroneous contribution to such MSA and of the net income attributable to such contribution.

''(4) TRUSTEE-TO-TRUSTEE TRANSFERS.—Section 220(f)(2) and paragraph (2) of this subsection shall not apply to any trustee-to-trustee transfer from a Medicare+Choice MSA of an account holder to another Medicare+Choice MSA of such account holder.

''(d) SPECIAL RULES FOR TREATMENT OF ACCOUNT AFTER DEATH OF ACCOUNT HOLDER.—In applying section 220(f)(8)(A) to an account which was a Medicare+Choice MSA of a decedent, the rules of section 220(f) shall apply in lieu of the rules of subsection (c) of this section with respect to the spouse as the account holder of such Medicare+Choice MSA.

''(e) REPORTS.—In the case of a Medicare+Choice MSA, the report under section 220(h)—

''(1) shall include the fair market value of the assets in such Medicare+Choice MSA as of the close of each calendar year, and

''(2) shall be furnished to the account holder—

''(A) not later than January 31 of the calendar year following the calendar year to which such reports relate, and

''(B) in such manner as the Secretary prescribes in such regulations.

''(f) COORDINATION WITH LIMITATION ON NUMBER OF TAXPAYERS HAVING MEDICAL SAVINGS ACCOUNTS.—Subsection (i) of section 220 shall not apply to an individual with respect to a Medicare+Choice MSA, and Medicare+Choice MSA's shall not be taken into account in determining whether the numerical limitations under section 220(j) are exceeded.''.

(b) TECHNICAL AMENDMENTS.—

(1) The last sentence of section 4973(d) of such Code is amended by inserting ''or section 138(c)(3)'' after ''section 220(f)(3)''.

(2) Subsection (b) of section 220 of such Code is amended by adding at the end the following new paragraph:

''(7) MEDICARE ELIGIBLE INDIVIDUALS.—The limitation under this subsection for any month with respect to an individual shall be zero for the first month such individual is entitled to benefits under title XVIII of the Social Security Act and for each month thereafter.''.

(3) The table of sections for part III of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following:

''Sec. 138. Medicare+Choice MSA.
''Sec. 139. Cross references to other Acts.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1998.

## CHAPTER 2—DEMONSTRATIONS

### Subchapter A—Medicare+Choice Competitive Pricing Demonstration Project

**SEC. 4011. MEDICARE PREPAID COMPETITIVE PRICING DEMONSTRATION PROJECT.**

(a) ESTABLISHMENT OF PROJECT.—The Secretary of Health and Human Services (in this subchapter referred to as the ''Secretary'') shall establish a demonstration project (in this subchapter referred to as the ''project'') under which payments to Medicare+Choice organizations in medicare payment areas in which the project is being conducted are determined in accordance with a competitive pricing methodology established under this subchapter.

(b) DESIGNATION OF 7 MEDICARE PAYMENT AREAS COVERED BY PROJECT.—

(1) IN GENERAL.—The Secretary shall designate, in accordance with the recommendations of the Competitive Pricing Advisory Committee under paragraphs (2) and (3), medicare payment areas as areas in which the project under this subchapter will be conducted. In this section, the term ''Competitive Pricing Advisory Committee'' means the Competitive Pricing Advisory Committee established under section 4012(a).

(2) INITIAL DESIGNATION OF 4 AREAS.—

(A) IN GENERAL.—The Competitive Pricing Advisory Committee shall recommend to the Secretary, consistent with subparagraph (B), the designation of 4 specific areas as medicare payment areas to be included in the project. Such recommendations shall be made in a manner so as to ensure that payments under the project in 2 such areas will begin on January 1, 1999, and in 2 such areas will begin on January 1, 2000.

(B) LOCATION OF DESIGNATION.—Of the 4 areas recommended under subparagraph (A), 3 shall be in urban areas and 1 shall be in a rural area.

(3) DESIGNATION OF ADDITIONAL 3 AREAS.—Not later than December 31, 2001, the Competitive Pricing Advisory Committee may recommend to the Secretary the designation of up to 3 additional, specific medicare payment areas to be included in the project.

(c) PROJECT IMPLEMENTATION.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall for each medicare payment area designated under subsection (b)—

(A) in accordance with the recommendations of the Competitive Pricing Advisory Committee—

(i) establish the benefit design among plans offered in such area, and

(ii) structure the method for selecting plans offered in such area; and

(B) in consultation with such Committee—

(i) establish methods for setting the price to be paid to plans, including, if the Secretaries determines appropriate, the rewarding and penalizing of Medicare+Choice plans in the area on the basis of the attainment of, or failure to attain, applicable quality standards, and

(ii) provide for the collection of plan information (including information concerning quality and access to care), the dissemination of information, and the methods of evaluating the results of the project.

(2) CONSULTATION.—The Secretary shall take into account the recommendations of the area advisory committee established in section 4012(b), in implementing a project design for any area, except that no modifications may be made in the project design without consultation with the Competitive Pricing Advisory Committee. In no case may the Secretary change the designation of an area based on recommendations of any area advisory committee.

(d) MONITORING AND REPORT.—

(1) MONITORING IMPACT.—Taking into consideration the recommendations of the Competitive Pricing Advisory Committee and the area advisory committees, the Secretary shall closely monitor and measure the impact of the project in the different areas on the price and quality of, and access to, medicare covered services, choice of health plans, changes in enrollment, and other relevant factors.

(2) REPORT.—Not later than December 31, 2002, the Secretary shall submit to Congress a report on the progress under the project under this subchapter, including a comparison of the matters monitored under paragraph (1) among the different designated areas. The report may include any legislative recommendations for extending the project to the entire medicare population.

(e) WAIVER AUTHORITY.—The Secretary of Health and Human Services may waive such requirements of title XVIII of the Social Security Act (as amended by this Act) as may be necessary for the purposes of carrying out the project.

(f) RELATIONSHIP TO OTHER AUTHORITY.—Except pursuant to this subchapter, the Secretary of Health and Human Services may not conduct or continue any medicare demonstration project relating to payment of health maintenance organizations, Medicare+Choice organizations, or similar prepaid managed care entities on the basis of a competitive bidding process or pricing system described in subsection (a).

(g) NO ADDITIONAL COSTS TO MEDICARE PROGRAM.—The aggregate payments to Medicare+Choice organizations under the project for any designated area for a fiscal year may not exceed the aggregate payments to such organizations that would have been made under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 4001, if the project had not been conducted.

(h) DEFINITIONS.—Any term used in this subchapter which is also used in part C of title XVIII of the Social Security Act, as amended by section 4001, shall have the same meaning as when used in such part.

**SEC. 4012. ADVISORY COMMITTEES.**

(a) COMPETITIVE PRICING ADVISORY COMMITTEE.—

(1) IN GENERAL.—Before implementing the project under this subchapter, the Secretary shall appoint the Competitive Pricing Advisory Committee, including independent actuaries, individuals with expertise in competitive health plan pricing, and an employee of the Office of Personnel Management with expertise in the administration of the Federal Employees Health Benefit Program, to make recommendations to the Secretary concerning the designation of areas for inclusion in the project and appropriate research design for implementing the project.

(2) INITIAL RECOMMENDATIONS.—The Competitive Pricing Advisory Committee initially shall submit recommendations regarding the area selection, benefit design among plans offered, structuring choice among health plans offered, methods for setting the price to be paid to plans, collection of plan information (including information concerning quality and access to care), information dissemination, and methods of evaluating the results of the project.

(3) QUALITY RECOMMENDATION.—The Competitive Pricing Advisory Committee shall study and make recommendations regarding the feasibility of providing financial incentives and penalties to plans operating under the project that meet, or fail to meet, applicable quality standards.

(4) ADVICE DURING IMPLEMENTATION.—Upon implementation of the project, the Competitive Pricing Advisory Committee shall con-

tinue to advise the Secretary on the application of the design in different areas and changes in the project based on experience with its operations.

(5) SUNSET.—The Competitive Pricing Advisory Committee shall terminate on December 31, 2004.

(b) APPOINTMENT OF AREA ADVISORY COMMITTEE.—Upon the designation of an area for inclusion in the project, the Secretary shall appoint an area advisory committee, composed of representatives of health plans, providers, and medicare beneficiaries in the area, to advise the Secretary concerning how the project will be implemented in the area. Such advice may include advice concerning the marketing and pricing of plans in the area and other salient factors. The duration of such a committee for an area shall be for the duration of the operation of the project in the area.

(c) SPECIAL APPLICATION.—Notwithstanding section 9(c) of the Federal Advisory Committee Act (5 U.S.C. App.), the Competitive Pricing Advisory Commission and any area advisory committee (described in subsection (b)) may meet as soon as the members of the commission or committee, respectively, are appointed.

**Subchapter B—Social Health Maintenance Organizations**

**SEC. 4014. SOCIAL HEALTH MAINTENANCE ORGANIZATIONS (SHMOS).**

(a) EXTENSION OF DEMONSTRATION PROJECT AUTHORITIES.—Section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 is amended—

(1) in paragraph (1), by striking ''1997'' and inserting ''2000'', and

(2) in paragraph (4), by striking ''1998'' and inserting ''2001''.

(b) EXPANSION OF CAP.—Section 13567(c) of the Omnibus Budget Reconciliation Act of 1993 is amended by striking ''12,000'' and inserting ''36,000''.

(c) REPORT ON INTEGRATION AND TRANSITION.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall submit to Congress, by not later than January 1, 1999, a plan for the integration of health plans offered by social health maintenance organizations (including SHMO I and SHMO II sites developed under section 2355 of the Deficit Reduction Act of 1984 and under the amendment made by section 4207(b)(3)(B)(i) of OBRA–1990, respectively) and similar plans as an option under the Medicare+Choice program under part C of title XVIII of the Social Security Act.

(2) PROVISION FOR TRANSITION.—Such plan shall include a transition for social health maintenance organizations operating under demonstration project authority under such section.

(3) PAYMENT POLICY.—The report shall also include recommendations on appropriate payment levels for plans offered by such organizations, including an analysis of the application of risk adjustment factors appropriate to the population served by such organizations.

**Subchapter C—Medicare Subvention Demonstration Project for Military Retirees**

**SEC. 4015. MEDICARE SUBVENTION DEMONSTRATION PROJECT FOR MILITARY RETIREES.**

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.) (as amended by sections 4603 and 4801) is amended by adding at the end the following:

''MEDICARE SUBVENTION DEMONSTRATION PROJECT FOR MILITARY RETIREES

''SEC. 1896. (a) DEFINITIONS.—In this section:

''(1) ADMINISTERING SECRETARIES.—The term 'administering Secretaries' means the Secretary and the Secretary of Defense acting jointly.

''(2) DEMONSTRATION PROJECT; PROJECT.—The terms 'demonstration project' and 'project' mean the demonstration project carried out under this section.

''(3) DESIGNATED PROVIDER.—The term 'designated provider' has the meaning given that term in section 721(5) of the National Defense Authorization Act For Fiscal Year 1997 (Public Law 104–201; 110 Stat. 2593; 10 U.S.C. 1073 note).

''(4) MEDICARE-ELIGIBLE MILITARY RETIREE OR DEPENDENT.—The term 'medicare-eligible military retiree or dependent' means an individual described in section 1074(b) or 1076(b) of title 10, United States Code, who—

''(A) would be eligible for health benefits under section 1086 of such title by reason of subsection (c)(1) of such section 1086 but for the operation of subsection (d) of such section 1086;

''(B)(i) is entitled to benefits under part A of this title; and

''(ii) if the individual was entitled to such benefits before July 1, 1997, received health care items or services from a health care facility of the uniformed services before that date, but after becoming entitled to benefits under part A of this title;

''(C) is enrolled for benefits under part B of this title; and

''(D) has attained age 65.

''(5) MEDICARE HEALTH CARE SERVICES.—The term 'medicare health care services' means items or services covered under part A or B of this title.

''(6) MILITARY TREATMENT FACILITY.—The term 'military treatment facility' means a facility referred to in section 1074(a) of title 10, United States Code.

''(7) TRICARE.—The term 'TRICARE' has the same meaning as the term 'TRICARE program' under section 711 of the National Defense Authorization Act for Fiscal Year 1996 (10 U.S.C. 1073 note).

''(8) TRUST FUNDS.—The term 'trust funds' means the Federal Hospital Insurance Trust Fund established in section 1817 and the Federal Supplementary Medical Insurance Trust Fund established in section 1841.

''(b) DEMONSTRATION PROJECT.—

''(1) IN GENERAL.—

''(A) ESTABLISHMENT.—The administering Secretaries are authorized to establish a demonstration project (under an agreement entered into by the administering Secretaries) under which the Secretary shall reimburse the Secretary of Defense, from the trust funds, for medicare health care services furnished to certain medicare-eligible military retirees or dependents in a military treatment facility or by a designated provider.

''(B) AGREEMENT.—The agreement entered into under subparagraph (A) shall include at a minimum—

''(i) a description of the benefits to be provided to the participants of the demonstration project established under this section;

''(ii) a description of the eligibility rules for participation in the demonstration project, including any cost sharing requirements;

''(iii) a description of how the demonstration project will satisfy the requirements under this title;

''(iv) a description of the sites selected under paragraph (2);

''(v) a description of how reimbursement requirements under subsection (i) and maintenance of effort requirements under subsection (j) will be implemented in the demonstration project;

''(vi) a statement that the Secretary shall have access to all data of the Department of Defense that the Secretary determines is necessary to conduct independent estimates and audits of the maintenance of effort requirement, the annual reconciliation, and related matters required under the demonstration project;

''(vii) a description of any requirement that the Secretary waives pursuant to subsection (d); and

''(viii) a certification, provided after review by the administering Secretaries, that any entity that is receiving payments by reason of the demonstration project has sufficient—

''(I) resources and expertise to provide, consistent with payments under subsection (i), the full range of benefits required to be provided to beneficiaries under the project; and

''(II) information and billing systems in place to ensure the accurate and timely submission of claims for benefits and to ensure that providers of services, physicians, and other health care professionals are reimbursed by the entity in a timely and accurate manner.

''(2) NUMBER OF SITES.—The project established under this section shall be conducted in no more than 6 sites, designated jointly by the administering Secretaries after review of all TRICARE regions.

''(3) RESTRICTION.—No new military treatment facilities will be built or expanded with funds from the demonstration project.

''(4) DURATION.—The administering Secretaries shall conduct the demonstration project during the 3-year period beginning on January 1, 1998.

''(5) REPORT.—At least 60 days prior to the commencement of the demonstration project, the administering Secretaries shall submit a copy of the agreement entered into under paragraph (1) to the committees of jurisdiction under this title.

''(c) CREDITING OF PAYMENTS.—A payment received by the Secretary of Defense under the demonstration project shall be credited to the applicable Department of Defense medical appropriation (and within that appropriation). Any such payment received during a fiscal year for services provided during a prior fiscal year may be obligated by the Secretary of Defense during the fiscal year during which the payment is received.

''(d) WAIVER OF CERTAIN MEDICARE REQUIREMENTS.—

''(1) AUTHORITY.—

''(A) IN GENERAL.—Except as provided under subparagraph (B), the demonstration project shall meet all requirements of Medicare+Choice plans under part C of this title and regulations pertaining thereto, and other requirements for receiving medicare payments, except that the prohibition of payments to Federal providers of services under sections 1814(c) and 1835(d), and paragraphs (2) and (3) of section 1862(a) shall not apply.

''(B) WAIVER.—Except as provided in paragraph (2), the Secretary is authorized to waive any requirement described under subparagraph (A), or approve equivalent or alternative ways of meeting such a requirement, but only if such waiver or approval—

''(i) reflects the unique status of the Department of Defense as an agency of the Federal Government; and

''(ii) is necessary to carry out the demonstration project.

''(2) BENEFICIARY PROTECTIONS AND OTHER MATTERS.—The demonstration project shall comply with the requirements of part C of this title that relate to beneficiary protections and other matters, including such requirements relating to the following areas:

''(A) Enrollment and disenrollment.

''(B) Nondiscrimination.

''(C) Information provided to beneficiaries.

''(D) Cost-sharing limitations.

''(E) Appeal and grievance procedures.

''(F) Provider participation.

''(G) Access to services.

''(H) Quality assurance and external review.

''(I) Advance directives.

''(J) Other areas of beneficiary protections that the Secretary determines are applicable to such project.

''(e) INSPECTOR GENERAL.—Nothing in the agreement entered into under subsection (b) shall limit the Inspector General of the Department of Health and Human Services from investigating any matters regarding the expenditure of funds under this title for the demonstration project, including compliance with the provisions of this title and all other relevant laws.

''(f) VOLUNTARY PARTICIPATION.—Participation of medicare-eligible military retirees or dependents in the demonstration project shall be voluntary.

''(g) TRICARE HEALTH CARE PLANS.—

''(1) MODIFICATION OF TRICARE CONTRACTS.—In carrying out the demonstration project, the Secretary of Defense is authorized to amend existing TRICARE contracts (including contracts with designated providers) in order to provide the medicare health care services to the medicare-eligible military retirees and dependents enrolled in the demonstration project consistent with part C of this title.

''(2) HEALTH CARE BENEFITS.—The administering Secretaries shall prescribe the minimum health care benefits to be provided under such a plan to medicare-eligible military retirees or dependents enrolled in the plan. Those benefits shall include at least all medicare health care services covered under this title.

''(h) ADDITIONAL PLANS.—Notwithstanding any provisions of title 10, United States Code, the administering Secretaries may agree to include in the demonstration project any of the Medicare+Choice plans described in section 1851(a)(2)(A), and such agreement may include an agreement between the Secretary of Defense and the Medicare+Choice organization offering such plan to provide medicare health care services to medicare-eligible military retirees or dependents and for such Secretary to receive payments from such organization for the provision of such services.

''(i) PAYMENTS BASED ON REGULAR MEDICARE PAYMENT RATES.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall reimburse the Secretary of Defense for services provided under the demonstration project at a rate equal to 95 percent of the amount paid to a Medicare+Choice organization under part C of this title with respect to such an enrollee. In cases in which a payment amount may not otherwise be readily computed, the Secretary shall establish rules for computing equivalent or comparable payment amounts.

''(2) EXCLUSION OF CERTAIN AMOUNTS.—In computing the amount of payment under paragraph (1), the following shall be excluded:

''(A) SPECIAL PAYMENTS.—Any amount attributable to an adjustment under subparagraphs (B) and (F) of section 1886(d)(5) and subsection (h) of such section.

''(B) PERCENTAGE OF CAPITAL PAYMENTS.—An amount determined by the administering Secretaries for amounts attributable to payments for capital-related costs under subsection (g) of such section.

''(3) PERIODIC PAYMENTS FROM MEDICARE TRUST FUNDS.—Payments under this subsection shall be made—

''(A) on a periodic basis consistent with the periodicity of payments under this title; and

''(B) in appropriate part, as determined by the Secretary, from the trust funds.

''(4) CAP ON AMOUNT.—The aggregate amount to be reimbursed under this subsection pursuant to the agreement entered into between the administering Secretaries under subsection (b) shall not exceed a total of—

''(A) $50,000,000 for calendar year 1998;

''(B) $60,000,000 for calendar year 1999; and

''(C) $65,000,000 for calendar year 2000.

''(j) MAINTENANCE OF EFFORT.—

''(1) MONITORING EFFECT OF DEMONSTRATION PROGRAM ON COSTS TO MEDICARE PROGRAM.—

''(A) IN GENERAL.—The administering Secretaries, in consultation with the Comptroller General, shall closely monitor the expenditures made under the medicare program for medicare-eligible military retirees or dependents during the period of the demonstration project compared to the expenditures that would have been made for such medicare-eligible military retirees or dependents during that period if the demonstration project had not been conducted. The agreement entered into by the administering Secretaries under subsection (b) shall require any participating military treatment facility to maintain the level of effort for space available care to medicare-eligible military retirees or dependents.

''(B) ANNUAL REPORT BY THE COMPTROLLER GENERAL.—Not later than December 31 of each year during which the demonstration project is conducted, the Comptroller General shall submit to the administering Secretaries and the appropriate committees of Congress a report on the extent, if any, to which the costs of the Secretary under the medicare program under this title increased during the preceding fiscal year as a result of the demonstration project.

''(2) REQUIRED RESPONSE IN CASE OF INCREASE IN COSTS.—

''(A) IN GENERAL.—If the administering Secretaries find, based on paragraph (1), that the expenditures under the medicare program under this title increased (or are expected to increase) during a fiscal year because of the demonstration project, the administering Secretaries shall take such steps as may be needed—

''(i) to recoup for the medicare program the amount of such increase in expenditures; and

''(ii) to prevent any such increase in the future.

''(B) STEPS.—Such steps—

''(i) under subparagraph (A)(i) shall include payment of the amount of such increased expenditures by the Secretary of Defense from the current medical care appropriation of the Department of Defense to the trust funds; and

''(ii) under subparagraph (A)(ii) shall include suspending or terminating the demonstration project (in whole or in part) or lowering the amount of payment under subsection (i)(1).

''(k) EVALUATION AND REPORTS.—

''(1) INDEPENDENT EVALUATION.—The Comptroller General of the United States shall conduct an evaluation of the demonstration project, and shall submit annual reports on the demonstration project to the administering Secretaries and to the committees of jurisdiction in the Congress. The first report shall be submitted not later than 12 months after the date on which the demonstration project begins operation, and the final report not later than 3½ years after that date. The evaluation and reports shall include an assessment, based on the agreement entered into under subsection (b), of the following:

''(A) Any savings or costs to the medicare program under this title resulting from the demonstration project.

''(B) The cost to the Department of Defense of providing care to medicare-eligible military retirees and dependents under the demonstration project.

''(C) A description of the effects of the demonstration project on military treatment facility readiness and training and the probable effects of the project on overall Department of Defense medical readiness and training.

''(D) Any impact of the demonstration project on access to care for active duty military personnel and their dependents.

''(E) An analysis of how the demonstration project affects the overall accessibility of the uniformed services treatment system and the amount of space available for point-of-service care, and a description of the unintended effects (if any) upon the normal treatment priority system.

''(F) Compliance by the Department of Defense with the requirements under this title.

''(G) The number of medicare-eligible military retirees and dependents opting to participate in the demonstration project instead of receiving health benefits through another health insurance plan (including benefits under this title).

''(H) A list of the health insurance plans and programs that were the primary payers for medicare-eligible military retirees and dependents during the year prior to their participation in the demonstration project and the distribution of their previous enrollment in such plans and programs.

''(I) Any impact of the demonstration project on private health care providers and beneficiaries under this title that are not enrolled in the demonstration project.

''(J) An assessment of the access to care and quality of care for medicare-eligible military retirees and dependents under the demonstration project.

''(K) An analysis of whether, and in what manner, easier access to the uniformed services treatment system affects the number of medicare-eligible military retirees and dependents receiving medicare health care services.

''(L) Any impact of the demonstration project on the access to care for medicare-eligible military retirees and dependents who did not enroll in the demonstration project and for other individuals entitled to benefits under this title.

''(M) A description of the difficulties (if any) experienced by the Department of Defense in managing the demonstration project and TRICARE contracts.

''(N) Any additional elements specified in the agreement entered into under subsection (b).

''(O) Any additional elements that the Comptroller General of the United States determines is appropriate to assess regarding the demonstration project.

''(2) REPORT ON EXTENSION AND EXPANSION OF DEMONSTRATION PROJECT.—Not later than 6 months after the date of the submission of the final report by the Comptroller General of the United States under paragraph (1), the administering Secretaries shall submit to Congress a report containing their recommendation as to—

''(A) whether there is a cost to the health care program under this title in conducting the demonstration project, and whether the demonstration project could be expanded without there being a cost to such health care program or to the Federal Government;

''(B) whether to extend the demonstration project or make the project permanent; and

''(C) whether the terms and conditions of the project should be continued (or modified) if the project is extended or expanded.''.

(b) IMPLEMENTATION PLAN FOR VETERANS SUBVENTION.—Not later than 12 months after the start of the demonstration project, the Secretary of Health and Human Services and the Secretary of Veterans Affairs shall jointly submit to Congress a detailed implementation plan for a subvention demonstration project (that follows the model of the demonstration project conducted under section 1896 of the Social Security Act (as added by

subsection (a)) to begin in 1999 for veterans (as defined in section 101 of title 38, United States Code) that are eligible for benefits under title XVIII of the Social Security Act.

**Subchapter D—Other Projects**

**SEC. 4016. MEDICARE COORDINATED CARE DEMONSTRATION PROJECT.**

(a) DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct demonstration projects for the purpose of evaluating methods, such as case management and other models of coordinated care, that—

(A) improve the quality of items and services provided to target individuals; and

(B) reduce expenditures under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for items and services provided to target individuals.

(2) TARGET INDIVIDUAL DEFINED.—In this section, the term ''target individual'' means an individual that has a chronic illness, as defined and identified by the Secretary, and is enrolled under the fee-for-service program under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.; 1395j et seq.).

(b) PROGRAM DESIGN.—

(1) INITIAL DESIGN.—The Secretary shall evaluate best practices in the private sector of methods of coordinated care for a period of 1 year and design the demonstration project based on such evaluation.

(2) NUMBER AND PROJECT AREAS.—Not later than 2 years after the date of enactment of this Act, the Secretary shall implement at least 9 demonstration projects, including—

(A) 5 projects in urban areas;

(B) 3 projects in rural areas; and

(C) 1 project within the District of Columbia which is operated by a nonprofit academic medical center that maintains a National Cancer Institute certified comprehensive cancer center.

(3) EXPANSION OF PROJECTS; IMPLEMENTATION OF DEMONSTRATION PROJECT RESULTS.—

(A) EXPANSION OF PROJECTS.—If the initial report under subsection (c) contains an evaluation that demonstration projects—

(i) reduce expenditures under the medicare program; or

(ii) do not increase expenditures under the medicare program and increase the quality of health care services provided to target individuals and satisfaction of beneficiaries and health care providers;

the Secretary shall continue the existing demonstration projects and may expand the number of demonstration projects.

(B) IMPLEMENTATION OF DEMONSTRATION PROJECT RESULTS.—If a report under subsection (c) contains an evaluation as described in subparagraph (A), the Secretary may issue regulations to implement, on a permanent basis, the components of the demonstration project that are beneficial to the medicare program.

(c) REPORT TO CONGRESS.—

(1) IN GENERAL.—Not later than 2 years after the Secretary implements the initial demonstration projects under this section, and biannually thereafter, the Secretary shall submit to Congress a report regarding the demonstration projects conducted under this section.

(2) CONTENTS OF REPORT.—The report in paragraph (1) shall include the following:

(A) A description of the demonstration projects conducted under this section.

(B) An evaluation of—

(i) the cost-effectiveness of the demonstration projects;

(ii) the quality of the health care services provided to target individuals under the demonstration projects; and

(iii) beneficiary and health care provider satisfaction under the demonstration project.

(C) Any other information regarding the demonstration projects conducted under this section that the Secretary determines to be appropriate.

(d) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(e) FUNDING.—

(1) DEMONSTRATION PROJECTS.—

(A) IN GENERAL.—

(i) STATE PROJECTS.—Except as provided in clause (ii), the Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t), in such proportions as the Secretary determines to be appropriate, of such funds as are necessary for the costs of carrying out the demonstration projects under this section.

(ii) CANCER HOSPITAL.—In the case of the project described in subsection (b)(2)(C), amounts shall be available only as provided in any Federal law making appropriations for the District of Columbia.

(B) LIMITATION.—In conducting the demonstration project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration projects under this section were not implemented.

(2) EVALUATION AND REPORT.—There are authorized to be appropriated such sums as are necessary for the purpose of developing and submitting the report to Congress under subsection (c).

**SEC. 4017. ORDERLY TRANSITION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.**

Section 9215 of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended by section 6135 of OBRA–1989 and section 13557 of OBRA–1993, is further amended—

(1) by inserting ''(a)'' before ''The Secretary'', and

(2) by adding at the end the following: ''Subject to subsection (c), the Secretary may further extend such demonstration projects through December 31, 2000, but only with respect to individuals who received at least one service during the period beginning on January 1, 1996, and ending on the date of the enactment of the Balanced Budget Act of 1997.

''(b) The Secretary shall work with each such demonstration project to develop a plan, to be submitted to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate by March 31, 1998, for the orderly transition of demonstration projects and the project participants to a non-demonstration project health care delivery system, such as through integration with a private or public health plan, including a medicaid managed care or Medicare+Choice plan.

''(c) A demonstration project under subsection (a) which does not develop and submit a transition plan under subsection (b) by March 31, 1998, or, if later, 6 months after the date of the enactment of the Balanced Budget Act of 1997, shall be discontinued as of December 31, 1998. The Secretary shall provide appropriate technical assistance to assist in the transition so that disruption of medical services to project participants may be minimized.''.

**SEC. 4018. MEDICARE ENROLLMENT DEMONSTRATION PROJECT.**

(a) DEMONSTRATION PROJECT.—

(1) ESTABLISHMENT.—The Secretary shall implement a demonstration project (in this section referred to as the ''project'') for the purpose of evaluating the use of a third-party contractor to conduct the Medicare+Choice plan enrollment and disenrollment functions, as described in part C of title XVIII of the Social Security Act (as added by section 4001 of this Act), in an area.

(2) CONSULTATION.—Before implementing the project under this section, the Secretary shall consult with affected parties on—

(A) the design of the project;

(B) the selection criteria for the third-party contractor; and

(C) the establishment of performance standards, as described in paragraph (3).

(3) PERFORMANCE STANDARDS.—

(A) IN GENERAL.—The Secretary shall establish performance standards for the accuracy and timeliness of the Medicare+Choice plan enrollment and disenrollment functions performed by the third-party contractor.

(B) NONCOMPLIANCE.—In the event that the third-party contractor is not in substantial compliance with the performance standards established under subparagraph (A), such enrollment and disenrollment functions shall be performed by the Medicare+Choice plan until the Secretary appoints a new third-party contractor.

(b) REPORT TO CONGRESS.—The Secretary shall periodically report to Congress on the progress of the project conducted pursuant to this section.

(c) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of part C of title XVIII of the Social Security Act (as amended by section 4001 of this Act) to such extent and for such period as the Secretary determines is necessary to conduct the project.

(d) DURATION.—A demonstration project under this section shall be conducted for a 3-year period.

(e) SEPARATE FROM OTHER DEMONSTRATION PROJECTS.—A project implemented by the Secretary under this section shall not be conducted in conjunction with any other demonstration project.

**SEC. 4019. EXTENSION OF CERTAIN MEDICARE COMMUNITY NURSING ORGANIZATION DEMONSTRATION PROJECTS.**

Notwithstanding any other provision of law, demonstration projects conducted under section 4079 of the Omnibus Budget Reconciliation Act of 1987 may be conducted for an additional period of 2 years, and the deadline for any report required relating to the results of such projects shall be not later than 6 months before the end of such additional period.

**CHAPTER 3—COMMISSIONS**

**SEC. 4021. NATIONAL BIPARTISAN COMMISSION ON THE FUTURE OF MEDICARE.**

(a) ESTABLISHMENT.—There is established a commission to be known as the National Bipartisan Commission on the Future of Medicare (in this section referred to as the ''Commission'').

(b) DUTIES OF THE COMMISSION.—The Commission shall—

(1) review and analyze the long-term financial condition of the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.);

(2) identify problems that threaten the financial integrity of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under that title (42 U.S.C. 1395i, 1395t), including—

(A) the financial impact on the medicare program of the significant increase in the

number of medicare eligible individuals which will occur beginning approximately during 2010 and lasting for approximately 25 years, and

(B) the extent to which current medicare update indexes do not accurately reflect inflation;

(3) analyze potential solutions to the problems identified under paragraph (2) that will ensure both the financial integrity of the medicare program and the provision of appropriate benefits under such program, including methods used by other nations to respond to comparable demographic patterns in eligibility for health care benefits for elderly and disabled individuals and trends in employment-related health care for retirees;

(4) make recommendations to restore the solvency of the Federal Hospital Insurance Trust Fund and the financial integrity of the Federal Supplementary Medical Insurance Trust Fund;

(5) make recommendations for establishing the appropriate financial structure of the medicare program as a whole;

(6) make recommendations for establishing the appropriate balance of benefits covered and beneficiary contributions to the medicare program;

(7) make recommendations for the time periods during which the recommendations described in paragraphs (4), (5), and (6) should be implemented;

(8) make recommendations regarding the financing of graduate medical education (GME), including consideration of alternative broad-based sources of funding for such education and funding for institutions not currently eligible for such GME support that conduct approved graduate medical residency programs, such as children's hospitals;

(9) make recommendations on modifying age-based eligibility to correspond to changes in age-based eligibility under the OASDI program and on the feasibility of allowing individuals between the age of 62 and the medicare eligibility age to buy into the medicare program;

(10) make recommendations on the impact of chronic disease and disability trends on future costs and quality of services under the current benefit, financing, and delivery system structure of the medicare program;

(11) make recommendations regarding a comprehensive approach to preserve the program; and

(12) review and analyze such other matters as the Commission deems appropriate.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 17 members, of whom—

(A) four shall be appointed by the President;

(B) six shall be appointed by the Majority Leader of the Senate, in consultation with the Minority Leader of the Senate, of whom not more than 4 shall be of the same political party;

(C) six shall be appointed by the Speaker of the House of Representatives, in consultation with the Minority Leader of the House of Representatives, of whom not more than 4 shall be of the same political party; and

(D) one, who shall serve as Chairman of the Commission, appointed jointly by the President, Majority Leader of the Senate, and the Speaker of the House of Representatives.

(2) DEADLINE FOR APPOINTMENT.—Members of the Commission shall be appointed by not later than December 1, 1997.

(3) TERMS OF APPOINTMENT.—The term of any appointment under paragraph (1) to the Commission shall be for the life of the Commission.

(4) MEETINGS.—The Commission shall meet at the call of its Chairman or a majority of its members.

(5) QUORUM.—A quorum shall consist of 8 members of the Commission, except that 4 members may conduct a hearing under subsection (e).

(6) VACANCIES.—A vacancy on the Commission shall be filled in the same manner in which the original appointment was made not later than 30 days after the Commission is given notice of the vacancy and shall not affect the power of the remaining members to execute the duties of the Commission.

(7) COMPENSATION.—Members of the Commission shall receive no additional pay, allowances, or benefits by reason of their service on the Commission.

(8) EXPENSES.—Each member of the Commission shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

(d) STAFF AND SUPPORT SERVICES.—

(1) EXECUTIVE DIRECTOR.—

(A) APPOINTMENT.—The Chairman shall appoint an executive director of the Commission.

(B) COMPENSATION.—The executive director shall be paid the rate of basic pay for level V of the Executive Schedule.

(2) STAFF.—With the approval of the Commission, the executive director may appoint such personnel as the executive director considers appropriate.

(3) APPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

(4) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(5) PHYSICAL FACILITIES.—The Administrator of the General Services Administration shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals required for the proper functioning of the Commission.

(e) POWERS OF COMMISSION.—

(1) HEARINGS AND OTHER ACTIVITIES.—For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties.

(2) STUDIES BY GAO.—Upon the request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

(3) COST ESTIMATES BY CONGRESSIONAL BUDGET OFFICE AND OFFICE OF THE CHIEF ACTUARY OF HCFA.—

(A) The Director of the Congressional Budget Office or the Chief Actuary of the Health Care Financing Administration, or both, shall provide to the Commission, upon the request of the Commission, such cost estimates as the Commission determines to be necessary to carry out its duties.

(B) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

(4) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

(5) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties.

(6) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(7) OBTAINING INFORMATION.—The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 5, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

(8) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

(9) PRINTING.—For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of the Congress.

(f) REPORT.—Not later than March 1, 1999, the Commission shall submit a report to the President and Congress which shall contain a detailed statement of only those recommendations, findings, and conclusions of the Commission that receive the approval of at least 11 members of the Commission.

(g) TERMINATION.—The Commission shall terminate 30 days after the date of submission of the report required in subsection (f).

(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $1,500,000 to carry out this section. 60 percent of such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and 40 percent of such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t).

**SEC. 4022. MEDICARE PAYMENT ADVISORY COMMISSION.**

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1804 the following new section:

''MEDICARE PAYMENT ADVISORY COMMISSION

''SEC. 1805. (a) ESTABLISHMENT.—There is hereby established the Medicare Payment Advisory Commission (in this section referred to as the 'Commission').

''(b) DUTIES.—

''(1) REVIEW OF PAYMENT POLICIES AND ANNUAL REPORTS.—The Commission shall—

''(A) review payment policies under this title, including the topics described in paragraph (2);

''(B) make recommendations to Congress concerning such payment policies;

''(C) by not later than March 1 of each year (beginning with 1998), submit a report to Congress containing the results of such reviews and its recommendations concerning such policies; and

''(D) by not later than June 1 of each year (beginning with 1998), submit a report to Congress containing an examination of issues affecting the medicare program, including the implications of changes in health care delivery in the United States and in the market for health care services on the medicare program.

''(2) SPECIFIC TOPICS TO BE REVIEWED.—

''(A) MEDICARE+CHOICE PROGRAM.—Specifically, the Commission shall review, with respect to the Medicare+Choice program under part C, the following:

''(i) The methodology for making payment to plans under such program, including the making of differential payments and the distribution of differential updates among different payment areas.

''(ii) The mechanisms used to adjust payments for risk and the need to adjust such mechanisms to take into account health status of beneficiaries.

''(iii) The implications of risk selection both among Medicare+Choice organizations and between the Medicare+Choice option and the original medicare fee-for-service option.

''(iv) The development and implementation of mechanisms to assure the quality of care for those enrolled with Medicare+Choice organizations.

''(v) The impact of the Medicare+Choice program on access to care for medicare beneficiaries.

''(vi) Other major issues in implementation and further development of the Medicare+Choice program.

''(B) ORIGINAL MEDICARE FEE-FOR-SERVICE SYSTEM.—Specifically, the Commission shall review payment policies under parts A and B, including—

''(i) the factors affecting expenditures for services in different sectors, including the process for updating hospital, skilled nursing facility, physician, and other fees,

''(ii) payment methodologies, and

''(iii) their relationship to access and quality of care for medicare beneficiaries.

''(C) INTERACTION OF MEDICARE PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—Specifically, the Commission shall review the effect of payment policies under this title on the delivery of health care services other than under this title and assess the implications of changes in health care delivery in the United States and in the general market for health care services on the medicare program.

''(3) COMMENTS ON CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to payment policies under this title, the Secretary shall transmit a copy of the report to the Commission. The Commission shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as the Commission deems appropriate.

''(4) AGENDA AND ADDITIONAL REVIEWS.—The Commission shall consult periodically with the chairmen and ranking minority members of the appropriate committees of Congress regarding the Commission's agenda and progress towards achieving the agenda. The Commission may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title as may be requested by such chairmen and members and as the Commission deems appropriate.

''(5) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

''(6) APPROPRIATE COMMITTEES OF CONGRESS.—For purposes of this section, the term 'appropriate committees of Congress' means the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate.

''(c) MEMBERSHIP.—

''(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members appointed by the Comptroller General.

''(2) QUALIFICATIONS.—

''(A) IN GENERAL.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, allopathic and osteopathic physicians, and other providers of health services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives.

''(B) INCLUSION.—The membership of the Commission shall include (but not be limited to) physicians and other health professionals, employers, third-party payers, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

''(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under this title shall not constitute a majority of the membership of the Commission.

''(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members.

''(3) TERMS.—

''(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

''(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

''(4) COMPENSATION.—While serving on the business of the Commission (including 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, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General may designate another member for the remainder of that member's term.

''(6) MEETINGS.—The Commission shall meet at the call of the Chairman.

''(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General deems necessary to assure the efficient administration of the Commission, the Commission may—

''(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

''(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(4) make advance, progress, and other payments which relate to the work of the Commission;

''(5) provide transportation and subsistence for persons serving without compensation; and

''(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

''(e) POWERS.—

''(1) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

''(2) DATA COLLECTION.—In order to carry out its functions, the Commission shall—

''(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

''(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate, and

''(C) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

''(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data of the Commission, immediately upon request.

''(4) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the Comptroller General.

''(f) AUTHORIZATION OF APPROPRIATIONS.—

''(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

''(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Sixty percent of such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and 40 percent of such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund.''.

(b) ABOLITION OF PROPAC AND PPRC.—

(1) PROPAC.—

(A) IN GENERAL.—Section 1886(e) (42 U.S.C. 1395ww(e)) is amended—

(i) by striking paragraphs (2) and (6); and

(ii) in paragraph (3), by striking ''(A) The Commission'' and all that follows through ''(B)''.

(B) CONFORMING AMENDMENT.—Section 1862 (42 U.S.C. 1395y) is amended by striking ''Prospective Payment Assessment Commission'' each place it appears in subsection (a)(1)(D) and subsection (i) and inserting ''Medicare Payment Advisory Commission''.

(2) PPRC.—

(A) IN GENERAL.—Title XVIII is amended by striking section 1845 (42 U.S.C. 1395w–1).

(B) ELIMINATION OF CERTAIN REPORTS.—Section 1848 (42 U.S.C. 1395w–4) is amended—

(i) by striking subparagraph (F) of subsection (d)(2),

(ii) by striking subparagraph (B) of subsection (f)(1), and

(iii) in subsection (f)(3), by striking ''Physician Payment Review Commission,''.

(C) CONFORMING AMENDMENTS.—Section 1848 (42 U.S.C. 1395w–4) is amended by striking ''Physician Payment Review Commission'' and inserting ''Medicare Payment Advisory Commission'' each place it appears in subsections (c)(2)(B)(iii), (g)(6)(C), and (g)(7)(C).

(c) EFFECTIVE DATE; TRANSITION.—

(1) IN GENERAL.—The Comptroller General shall first provide for appointment of members to the Medicare Payment Advisory Commission (in this subsection referred to as ''MedPAC'') by not later than September 30, 1997.

(2) TRANSITION.—As quickly as possible after the date a majority of members of MedPAC are first appointed, the Comptroller General, in consultation with the Prospective Payment Assessment Commission (in this subsection referred to as ''ProPAC'') and the Physician Payment Review Commission (in this subsection referred to as ''PPRC''), shall provide for the termination of the ProPAC and the PPRC. As of the date of termination of the respective Commissions, the amendments made by paragraphs (1) and (2), respectively, of subsection (b) become effective. The Comptroller General, to the extent feasible, shall provide for the transfer to the MedPAC of assets and staff of the ProPAC and the PPRC, without any loss of benefits or seniority by virtue of such transfers. Fund balances available to the ProPAC or the PPRC for any period shall be available to the MedPAC for such period for like purposes.

(3) CONTINUING RESPONSIBILITY FOR REPORTS.—The MedPAC shall be responsible for the preparation and submission of reports required by law to be submitted (and which have not been submitted by the date of establishment of the MedPAC) by the ProPAC and the PPRC, and, for this purpose, any reference in law to either such Commission is deemed, after the appointment of the MedPAC, to refer to the MedPAC.

## CHAPTER 4—MEDIGAP PROTECTIONS

### SEC. 4031. MEDIGAP PROTECTIONS.

(a) GUARANTEEING ISSUE WITHOUT PREEXISTING CONDITIONS FOR CONTINUOUSLY COVERED INDIVIDUALS.—Section 1882(s) (42 U.S.C. 1395ss(s)) is amended—

(1) in paragraph (3), by striking ''paragraphs (1) and (2)'' and inserting ''this subsection'',

(2) by redesignating paragraph (3) as paragraph (4), and

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

''(3)(A) The issuer of a medicare supplemental policy—

''(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy described in subparagraph (C) that is offered and is available for issuance to new enrollees by such issuer;

''(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

''(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such subparagraph and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

''(B) An individual described in this subparagraph is an individual described in any of the following clauses:

''(i) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under this title and the plan terminates or ceases to provide all such supplemental health benefits to the individual.

''(ii) The individual is enrolled with a Medicare+Choice organization under a Medicare+Choice plan under part C, and there are circumstances permitting discontinuance of the individual's election of the plan under the first sentence of section 1851(e)(4).

''(iii) The individual is enrolled with an eligible organization under a contract under section 1876, a similar organization operating under demonstration project authority, effective for periods before April 1, 1999, with an organization under an agreement under section 1833(a)(1)(A), or with an organization under a policy described in subsection (t), and such enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under the first sentence of section 1851(e)(4) and, in the case of a policy described in subsection (t), there is no provision under applicable State law for the continuation or conversion of coverage under such policy.

''(iv) The individual is enrolled under a medicare supplemental policy under this section and such enrollment ceases because—

''(I) of the bankruptcy or insolvency of the issuer or because of other involuntary termination of coverage or enrollment under such policy and there is no provision under applicable State law for the continuation or conversion of such coverage;

''(II) the issuer of the policy substantially violated a material provision of the policy; or

''(III) the issuer (or an agent or other entity acting on the issuer's behalf) materially misrepresented the policy's provisions in marketing the policy to the individual.

''(v) The individual—

''(I) was enrolled under a medicare supplemental policy under this section,

''(II) subsequently terminates such enrollment and enrolls, for the first time, with any Medicare+Choice organization under a Medicare+Choice plan under part C, any eligible organization under a contract under section 1876, any similar organization operating under demonstration project authority, or any policy described in subsection (t), and

''(III) the subsequent enrollment under subclause (II) is terminated by the enrollee during any period within the first 12 months of such enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e)).

''(vi) The individual, upon first becoming eligible for benefits under part A at age 65, enrolls in a Medicare+Choice plan under part C, and disenrolls from such plan by not later than 12 months after the effective date of such enrollment.

''(C)(i) Subject to clauses (ii) and (iii), a medicare supplemental policy described in this subparagraph is a medicare supplemental policy which has a benefit package classified as 'A', 'B', 'C', or 'F' under the standards established under subsection (p)(2).

''(ii) Only for purposes of an individual described in subparagraph (B)(v), a medicare supplemental policy described in this subparagraph is the same medicare supplemental policy referred to in such subparagraph in which the individual was most recently previously enrolled, if available from the same issuer, or, if not so available, a policy described in clause (i).

''(iii) Only for purposes of an individual described in subparagraph (B)(vi), a medicare supplemental policy described in this subparagraph shall include any medicare supplemental policy.

''(iv) For purposes of applying this paragraph in the case of a State that provides for offering of benefit packages other than under the classification referred to in clause (i), the references to benefit packages in such clause are deemed references to comparable benefit packages offered in such State.

''(D) At the time of an event described in subparagraph (B) because of which an individual ceases enrollment or loses coverage or benefits under a contract or agreement, policy, or plan, the organization that offers the contract or agreement, the insurer offering the policy, or the administrator of the plan, respectively, shall notify the individual of the rights of the individual under this paragraph, and obligations of issuers of medicare supplemental policies, under subparagraph (A).''.

(b) LIMITATION ON IMPOSITION OF PREEXISTING CONDITION EXCLUSION DURING INITIAL OPEN ENROLLMENT PERIOD.—Section 1882(s)(2) (42 U.S.C. 1395ss(s)(2)) is amended—

(1) in subparagraph (B), by striking ''subparagraph (C)'' and inserting ''subparagraphs (C) and (D)'', and

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

''(D) In the case of a policy issued during the 6-month period described in subparagraph (A) to an individual who is 65 years of age or older as of the date of issuance and who as of the date of the application for enrollment has a continuous period of creditable coverage (as defined in 2701(c) of the Public Health Service Act) of—

''(i) at least 6 months, the policy may not exclude benefits based on a pre-existing condition; or

''(ii) less than 6 months, if the policy excludes benefits based on a preexisting condition, the policy shall reduce the period of any preexisting condition exclusion by the aggregate of the periods of creditable coverage (if any, as so defined) applicable to the individual as of the enrollment date.

The Secretary shall specify the manner of the reduction under clause (ii), based upon the rules used by the Secretary in carrying out section 2701(a)(3) of such Act.''.

(c) CONFORMING AMENDMENT.—Section 1882(d)(3)(A)(vi)(III) (42 U.S.C. 1395ss(d)(2)(A)(vi)(III)) is amended by inserting '', a policy described in clause (v),'' after ''Medicare supplemental policy''.

(d) EFFECTIVE DATES.—

(1) GUARANTEED ISSUE.—The amendment made by subsection (a) shall take effect on July 1, 1998.

(2) LIMIT ON PREEXISTING CONDITION EXCLUSIONS.—The amendment made by subsection (b) shall apply to policies issued on or after July 1, 1998.

(3) CONFORMING AMENDMENT.—The amendment made by subsection (c) shall be effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996.

(e) TRANSITION PROVISIONS.—

(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the changes made by this section, the State

regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act due solely to failure to make such change until the date specified in paragraph (4).

(2) NAIC STANDARDS.—If, within 9 months after the date of the enactment of this Act, the National Association of Insurance Commissioners (in this subsection referred to as the ''NAIC'') modifies its NAIC Model Regulation relating to section 1882 of the Social Security Act (referred to in such section as the 1991 NAIC Model Regulation, as modified pursuant to section 171(m)(2) of the Social Security Act Amendments of 1994 (Public Law 103–432) and as modified pursuant to section 1882(d)(3)(A)(vi)(IV) of the Social Security Act, as added by section 271(a) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191) to conform to the amendments made by this section, such revised regulation incorporating the modifications shall be considered to be the applicable NAIC model regulation (including the revised NAIC model regulation and the 1991 NAIC Model Regulation) for the purposes of such section.

(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the appropriate Regulation for the purposes of such section.

(4) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section, or

(ii) 1 year after the date the NAIC or the Secretary first makes the modifications under paragraph (2) or (3), respectively.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the changes made in this section, but

(ii) having a legislature which is not scheduled to meet in 1999 in a legislative session in which such legislation may be considered,

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after July 1, 1999. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(f) CONFORMING BENEFITS TO CHANGES IN TERMINOLOGY FOR HOSPITAL OUTPATIENT DEPARTMENT COST SHARING.—For purposes of apply section 1882 of the Social Security Act (42 U.S.C. 1395ss) and regulations referred to in subsection (e), copayment amounts provided under section 1833(t)(5) of such Act with respect to hospital outpatient department services shall be treated under medicare supplemental policies in the same manner as coinsurance with respect to such services.

**SEC. 4032. ADDITION OF HIGH DEDUCTIBLE MEDIGAP POLICIES.**

(a) IN GENERAL.—Section 1882(p) (42 U.S.C. 1395ss(p)) is amended—

(1) in paragraph (2)(C), by inserting ''plus the 2 plans described in paragraph (11)(A)'' after ''exceed 10''; and

(2) by adding at the end the following:

''(11)(A) For purposes of paragraph (2), the benefit packages described in this subparagraph are as follows:

''(i) The benefit package classified as 'F' under the standards established by such paragraph, except that it has a high deductible feature.

''(ii) The benefit package classified as 'J' under the standards established by such paragraph, except that it has a high deductible feature.

''(B) For purposes of subparagraph (A), a high deductible feature is one which—

''(i) requires the beneficiary of the policy to pay annual out-of-pocket expenses (other than premiums) in the amount specified in subparagraph (C) before the policy begins payment of benefits, and

''(ii) covers 100 percent of covered out-of-pocket expenses once such deductible has been satisfied in a year.

''(C) The amount specified in this subparagraph—

''(i) for 1998 and 1999 is $1,500, and

''(ii) for a subsequent year, is the amount specified in this subparagraph for the previous year increased by the percentage increase in the Consumer Price Index for all urban consumers (all items; U.S. city average) for the 12-month period ending with August of the preceding year.

If any amount determined under clause (ii) is not a multiple of $10, it shall be rounded to the nearest multiple of $10.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by subsection (a) shall take effect the date of the enactment of this Act.

(2) TRANSITION.—The provisions of section 4031(e) shall apply with respect to this section in the same manner as they apply to section 4031.

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

**SEC. 4041. TAX TREATMENT OF HOSPITALS WHICH PARTICIPATE IN PROVIDER-SPONSORED ORGANIZATIONS.**

(a) IN GENERAL.—Section 501 of the Internal Revenue Code of 1986 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignating subsection (o) as subsection (p) and by inserting after subsection (n) the following new subsection:

''(o) TREATMENT OF HOSPITALS PARTICIPATING IN PROVIDER-SPONSORED ORGANIZATIONS.—An organization shall not fail to be treated as organized and operated exclusively for a charitable purpose for purposes of subsection (c)(3) solely because a hospital which is owned and operated by such organization participates in a provider-sponsored organization (as defined in section 1853(e) of the Social Security Act), whether or not the provider-sponsored organization is exempt from tax. For purposes of subsection (c)(3), any person with a material financial interest in such a provider-sponsored organization shall be treated as a private shareholder or individual with respect to the hospital.''

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

## Subtitle B—Prevention Initiatives

**SEC. 4101. SCREENING MAMMOGRAPHY.**

(a) PROVIDING ANNUAL SCREENING MAMMOGRAPHY FOR WOMEN OVER AGE 39.—Section 1834(c)(2)(A) (42 U.S.C. 1395m(c)(2)(A)) is amended—

(1) in clause (iii), to read as follows:

''(iii) In the case of a woman over 39 years of age, payment may not be made under this part for screening mammography performed within 11 months following the month in which a previous screening mammography was performed.''; and

(2) by striking clauses (iv) and (v).

(b) WAIVER OF DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) is amended—

(1) by striking ''and'' before ''(4)'', and

(2) by inserting before the period at the end the following: '', and (5) such deductible shall not apply with respect to screening mammography (as described in section 1861(jj))''.

(c) CONFORMING AMENDMENT.—Section 1834(c)(1)(C) (42 U.S.C. 1395m(c)(1)(C)) is amended by striking '', subject to the deductible established under section 1833(b),''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

**SEC. 4102. SCREENING PAP SMEAR AND PELVIC EXAMS.**

(a) COVERAGE OF PELVIC EXAM; INCREASING FREQUENCY OF COVERAGE OF PAP SMEAR.—Section 1861(nn) (42 U.S.C. 1395x(nn)) is amended—

(1) in the heading, by striking ''Smear'' and inserting ''Smear; Screening Pelvic Exam'';

(2) by inserting ''or vaginal'' after ''cervical'' each place it appears;

(3) by striking ''(nn)'' and inserting ''(nn)(1)'';

(4) by striking ''3 years'' and all that follows and inserting ''3 years, or during the preceding year in the case of a woman described in paragraph (3).''; and

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

''(2) The term 'screening pelvic exam' means a pelvic examination provided to a woman if the woman involved has not had such an examination during the preceding 3 years, or during the preceding year in the case of a woman described in paragraph (3), and includes a clinical breast examination.

''(3) A woman described in this paragraph is a woman who—

''(A) is of childbearing age and has had a test described in this subsection during any of the preceding 3 years that indicated the presence of cervical or vaginal cancer or other abnormality; or

''(B) is at high risk of developing cervical or vaginal cancer (as determined pursuant to factors identified by the Secretary).''.

(b) WAIVER OF DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)), as amended by section 4101(b), is amended—

(1) by striking ''and'' before ''(5)'', and

(2) by inserting before the period at the end the following: '', and (6) such deductible shall not apply with respect to screening pap smear and screening pelvic exam (as described in section 1861(nn))''.

(c) CONFORMING AMENDMENTS.—Sections 1861(s)(14) and 1862(a)(1)(F) (42 U.S.C. 1395x(s)(14), 1395y(a)(1)(F)) are each amended by inserting ''and screening pelvic exam'' after ''screening pap smear''.

(d) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)) is amended by striking ''and (4)'' and inserting ''(4) and (14) (with respect to services described in section 1861(nn)(2))''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

**SEC. 4103. PROSTATE CANCER SCREENING TESTS.**

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

(1) in subsection (s)(2)—

(A) by striking ''and'' at the end of subparagraphs (N) and (O), and

(B) by inserting after subparagraph (O) the following new subparagraph:

''(P) prostate cancer screening tests (as defined in subsection (oo)); and''; and

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

''Prostate Cancer Screening Tests

''(oo)(1) The term 'prostate cancer screening test' means a test that consists of any (or all) of the procedures described in paragraph (2) provided for the purpose of early detection of prostate cancer to a man over 50 years of age who has not had such a test during the preceding year.

''(2) The procedures described in this paragraph are as follows:

''(A) A digital rectal examination.

''(B) A prostate-specific antigen blood test.

''(C) For years beginning after 2002, such other procedures as the Secretary finds appropriate for the purpose of early detection of prostate cancer, taking into account changes in technology and standards of medical practice, availability, effectiveness, costs, and such other factors as the Secretary considers appropriate.''.

(b) PAYMENT FOR PROSTATE-SPECIFIC ANTIGEN BLOOD TEST UNDER CLINICAL DIAGNOSTIC LABORATORY TEST FEE SCHEDULES.—Section 1833(h)(1)(A) (42 U.S.C. 1395l(h)(1)(A)) is amended by inserting after ''laboratory tests'' the following: ''(including prostate cancer screening tests under section 1861(oo) consisting of prostate-specific antigen blood tests)''.

(c) CONFORMING AMENDMENT.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (E), by striking ''and'' at the end,

(B) in subparagraph (F), by striking the semicolon at the end and inserting '', and'', and

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

''(G) in the case of prostate cancer screening tests (as defined in section 1861(oo)), which are performed more frequently than is covered under such section;''; and

(2) in paragraph (7), by striking ''paragraph (1)(B) or under paragraph (1)(F)'' and inserting ''subparagraphs (B), (F), or (G) of paragraph (1)''.

(d) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)), as amended by section 4102, is amended by inserting '', (2)(P) (with respect to services described in subparagraphs (A) and (C) of section 1861(oo)(2),'' after ''(2)(G)''

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2000.

**SEC. 4104. COVERAGE OF COLORECTAL SCREENING.**

(a) COVERAGE.—

(1) IN GENERAL.—Section 1861 (42 U.S.C. 1395x), as amended by section 4103(a), is amended—

(A) in subsection (s)(2)—

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

(ii) by adding ''and'' at the end of subparagraph (Q); and

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

''(R) colorectal cancer screening tests (as defined in subsection (pp)); and''; and

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

''Colorectal Cancer Screening Tests

''(pp)(1) The term 'colorectal cancer screening test' means any of the following procedures furnished to an individual for the purpose of early detection of colorectal cancer:

''(A) Screening fecal-occult blood test.

''(B) Screening flexible sigmoidoscopy.

''(C) In the case of an individual at high risk for colorectal cancer, screening colonoscopy.

''(D) Such other tests or procedures, and modifications to tests and procedures under this subsection, with such frequency and payment limits, as the Secretary determines appropriate, in consultation with appropriate organizations.

''(2) In paragraph (1)(C), an 'individual at high risk for colorectal cancer' is an individual who, because of family history, prior experience of cancer or precursor neoplastic polyps, a history of chronic digestive disease condition (including inflammatory bowel disease, Crohn's Disease, or ulcerative colitis), the presence of any appropriate recognized gene markers for colorectal cancer, or other predisposing factors, faces a high risk for colorectal cancer.''.

(2) DEADLINE FOR PUBLICATION OF DETERMINATION ON COVERAGE OF SCREENING BARIUM ENEMA.—Not later than the earlier of the date that is January 1, 1998, or 90 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall publish notice in the Federal Register with respect to the determination under paragraph (1)(D) of section 1861(pp) of the Social Security Act (42 U.S.C. 1395x(pp)), as added by paragraph (1), on the coverage of a screening barium enema as a colorectal cancer screening test under such section.

(b) FREQUENCY LIMITS AND PAYMENT.—

(1) IN GENERAL.—Section 1834 (42 U.S.C. 1395m) is amended by inserting after subsection (c) the following new subsection:

''(d) FREQUENCY LIMITS AND PAYMENT FOR COLORECTAL CANCER SCREENING TESTS.—

''(1) SCREENING FECAL-OCCULT BLOOD TESTS.—

''(A) PAYMENT AMOUNT.—The payment amount for colorectal cancer screening tests consisting of screening fecal-occult blood tests is equal to the payment amount established for diagnostic fecal-occult blood tests under section 1833(h).

''(B) FREQUENCY LIMIT.—No payment may be made under this part for a colorectal cancer screening test consisting of a screening fecal-occult blood test—

''(i) if the individual is under 50 years of age; or

''(ii) if the test is performed within the 11 months after a previous screening fecal-occult blood test.

''(2) SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

''(A) FEE SCHEDULE.—With respect to colorectal cancer screening tests consisting of screening flexible sigmoidoscopies, payment under section 1848 shall be consistent with payment under such section for similar or related services.

''(B) PAYMENT LIMIT.—In the case of screening flexible sigmoidoscopy services, payment under this part shall not exceed such amount as the Secretary specifies, based upon the rates recognized for diagnostic flexible sigmoidoscopy services.

''(C) FACILITY PAYMENT LIMIT.—

''(i) IN GENERAL.—Notwithstanding subsections (i)(2)(A) and (t) of section 1833, in the case of screening flexible sigmoidoscopy services furnished on or after January 1, 1999, that—

''(I) in accordance with regulations, may be performed in an ambulatory surgical center and for which the Secretary permits ambulatory surgical center payments under this part, and

''(II) are performed in an ambulatory surgical center or hospital outpatient department,

payment under this part shall be based on the lesser of the amount under the fee schedule that would apply to such services if they were performed in a hospital outpatient department in an area or the amount under the fee schedule that would apply to such services if they were performed in an ambulatory surgical center in the same area.

''(ii) LIMITATION ON DEDUCTIBLE AND COINSURANCE.—Notwithstanding any other provision of this title, in the case of a beneficiary who receives the services described in clause (i)—

''(I) in computing the amount of any applicable deductible or copayment, the computation of such deductible or coinsurance shall be based upon the fee schedule under which payment is made for the services, and

''(II) the amount of such coinsurance is equal to 25 percent of the payment amount under the fee schedule described in subclause (I).

''(D) SPECIAL RULE FOR DETECTED LESIONS.—If during the course of such screening flexible sigmoidoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening flexible sigmoidoscopy but shall be made for the procedure classified as a flexible sigmoidoscopy with such biopsy or removal.

''(E) FREQUENCY LIMIT.—No payment may be made under this part for a colorectal cancer screening test consisting of a screening flexible sigmoidoscopy—

''(i) if the individual is under 50 years of age; or

''(ii) if the procedure is performed within the 47 months after a previous screening flexible sigmoidoscopy.

''(3) SCREENING COLONOSCOPY FOR INDIVIDUALS AT HIGH RISK FOR COLORECTAL CANCER.—

''(A) FEE SCHEDULE.—With respect to colorectal cancer screening test consisting of a screening colonoscopy for individuals at high risk for colorectal cancer (as defined in section 1861(pp)(2)), payment under section 1848 shall be consistent with payment amounts under such section for similar or related services.

''(B) PAYMENT LIMIT.—In the case of screening colonoscopy services, payment under this part shall not exceed such amount as the Secretary specifies, based upon the rates recognized for diagnostic colonoscopy services.

''(C) FACILITY PAYMENT LIMIT.—

''(i) IN GENERAL.—Notwithstanding subsections (i)(2)(A) and (t) of section 1833, in the case of screening colonoscopy services furnished on or after January 1, 1999, that are performed in an ambulatory surgical center or a hospital outpatient department, payment under this part shall be based on the lesser of the amount under the fee schedule that would apply to such services if they were performed in a hospital outpatient department in an area or the amount under the fee schedule that would apply to such services if they were performed in an ambulatory surgical center in the same area.

''(ii) LIMITATION ON DEDUCTIBLE AND COINSURANCE.—Notwithstanding any other provision of this title, in the case of a beneficiary who receives the services described in clause (i)—

''(I) in computing the amount of any applicable deductible or coinsurance, the computation of such deductible or coinsurance shall be based upon the fee schedule under which payment is made for the services, and

''(II) the amount of such coinsurance is equal to 25 percent of the payment amount under the fee schedule described in subclause (I).

''(D) SPECIAL RULE FOR DETECTED LESIONS.—If during the course of such screening colonoscopy, a lesion or growth is detected which results in a biopsy or removal of the lesion or growth, payment under this part shall not be made for the screening colonoscopy but shall be made for the procedure classified as a colonoscopy with such biopsy or removal.

''(E) FREQUENCY LIMIT.—No payment may be made under this part for a colorectal cancer screening test consisting of a screening colonoscopy for individuals at high risk for colorectal cancer if the procedure is per-

formed within the 23 months after a previous screening colonoscopy.''.

(c) CONFORMING AMENDMENTS.—(1) Paragraphs (1)(D) and (2)(D) of section 1833(a) (42 U.S.C. 1395l(a)) are each amended by inserting ''or section 1834(d)(1)'' after ''subsection (h)(1)''.

(2) Section 1833(h)(1)(A) (42 U.S.C. 1395l(h)(1)(A)) is amended by striking ''The Secretary'' and inserting ''Subject to section 1834(d)(1), the Secretary''.

(3) Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 4103(c), is amended—

(A) in paragraph (1)—

(i) in subparagraph (F), by striking ''and'' at the end,

(ii) in subparagraph (G), by striking the semicolon at the end and inserting '', and'', and

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

''(H) in the case of colorectal cancer screening tests, which are performed more frequently than is covered under section 1834(d);''; and

(B) in paragraph (7), by striking ''or (G)'' and inserting ''(G), or (H)''.

(d) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)), as amended by sections 4102 and 4103, is amended by inserting ''(2)(R) (with respect to services described in subparagraphs (B) , (C), and (D) of section 1861(pp)(1)),'' before ''(3)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

**SEC. 4105. DIABETES SELF-MANAGEMENT BENEFITS.**

(a) COVERAGE OF DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES.—

(1) IN GENERAL.—Section 1861 (42 U.S.C. 1395x), as amended by sections 4103(a) and 4104(a), is amended—

(A) in subsection (s)(2)—

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

(ii) by adding ''and'' at the end of subparagraph (R); and

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

''(S) diabetes outpatient self-management training services (as defined in subsection (qq)); and''; and

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

''Diabetes Outpatient Self-Management Training Services

''(qq)(1) The term 'diabetes outpatient self-management training services' means educational and training services furnished (at such times as the Secretary determines appropriate) to an individual with diabetes by a certified provider (as described in paragraph (2)(A)) in an outpatient setting by an individual or entity who meets the quality standards described in paragraph (2)(B), but only if the physician who is managing the individual's diabetic condition certifies that such services are needed under a comprehensive plan of care related to the individual's diabetic condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to participate in the management of the individual's condition.

''(2) In paragraph (1)—

''(A) a 'certified provider' is a physician, or other individual or entity designated by the Secretary, that, in addition to providing diabetes outpatient self-management training services, provides other items or services for which payment may be made under this title; and

''(B) a physician, or such other individual or entity, meets the quality standards described in this paragraph if the physician, or individual or entity, meets quality standards established by the Secretary, except that the physician or other individual or entity shall be deemed to have met such standards if the physician or other individual or entity meets applicable standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations who participated in the establishment of standards by such Board, or is recognized by an organization that represents individuals (including individuals under this title) with diabetes as meeting standards for furnishing the services.''.

(2) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)) as amended in sections 4102, 4103, and 4104, is amended by inserting ''(2)(S),'' before ''(3),''.

(3) CONSULTATION WITH ORGANIZATIONS IN ESTABLISHING PAYMENT AMOUNTS FOR SERVICES PROVIDED BY PHYSICIANS.—In establishing payment amounts under section 1848 of the Social Security Act for physicians' services consisting of diabetes outpatient self-management training services, the Secretary of Health and Human Services shall consult with appropriate organizations, including such organizations representing individuals or medicare beneficiaries with diabetes.

(b) BLOOD-TESTING STRIPS FOR INDIVIDUALS WITH DIABETES.—

(1) INCLUDING STRIPS AND MONITORS AS DURABLE MEDICAL EQUIPMENT.—The first sentence of section 1861(n) (42 U.S.C. 1395x(n)) is amended by inserting before the semicolon the following: '', and includes blood-testing strips and blood glucose monitors for individuals with diabetes without regard to whether the individual has Type I or Type II diabetes or to the individual's use of insulin (as determined under standards established by the Secretary in consultation with the appropriate organizations)''.

(2) 10 PERCENT REDUCTION IN PAYMENTS FOR TESTING STRIPS.—Section 1834(a)(2)(B)(iv) (42 U.S.C. 1395m(a)(2)(B)(iv)) is amended by adding before the period the following: ''(reduced by 10 percent, in the case of a blood glucose testing strip furnished after 1997 for an individual with diabetes)''.

(c) ESTABLISHMENT OF OUTCOME MEASURES FOR BENEFICIARIES WITH DIABETES.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with appropriate organizations, shall establish outcome measures, including glysolated hemoglobin (past 90-day average blood sugar levels), for purposes of evaluating the improvement of the health status of medicare beneficiaries with diabetes mellitus.

(2) RECOMMENDATIONS FOR MODIFICATIONS TO SCREENING BENEFITS.—Taking into account information on the health status of medicare beneficiaries with diabetes mellitus as measured under the outcome measures established under paragraph (1), the Secretary shall from time to time submit recommendations to Congress regarding modifications to the coverage of services for such beneficiaries under the medicare program.

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall apply to items and services furnished on or after July 1, 1998.

(2) TESTING STRIPS.—The amendment made by subsection (b)(2) shall apply with respect to blood glucose testing strips furnished on or after January 1, 1998.

**SEC. 4106. STANDARDIZATION OF MEDICARE COVERAGE OF BONE MASS MEASUREMENTS.**

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x), as amended by sections 4103(a), 4104(a), and 4105(a), is amended—

(1) in subsection (s)—

(A) in paragraph (12)(C), by striking ''and'' at the end,

(B) by striking the period at the end of paragraph (14) and inserting ''; and'',

(C) by redesignating paragraphs (15) and (16) as paragraphs (16) and (17), respectively, and

(D) by inserting after paragraph (14) the following new paragraph:

''(15) bone mass measurement (as defined in subsection (rr)).''; and

(2) by inserting after subsection (qq) the following new subsection:

''Bone Mass Measurement

''(rr)(1) The term 'bone mass measurement' means a radiologic or radioisotopic procedure or other procedure approved by the Food and Drug Administration performed on a qualified individual (as defined in paragraph (2)) for the purpose of identifying bone mass or detecting bone loss or determining bone quality, and includes a physician's interpretation of the results of the procedure.

''(2) For purposes of this subsection, the term 'qualified individual' means an individual who is (in accordance with regulations prescribed by the Secretary)—

''(A) an estrogen-deficient woman at clinical risk for osteoporosis;

''(B) an individual with vertebral abnormalities;

''(C) an individual receiving long-term glucocorticoid steroid therapy;

''(D) an individual with primary hyperparathyroidism; or

''(E) an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

''(3) The Secretary shall establish such standards regarding the frequency with which a qualified individual shall be eligible to be provided benefits for bone mass measurement under this title.''.

(b) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)), as amended by sections 4102, 4103, 4104 and 4105, is amended—

(1) by striking ''(4) and (14)'' and inserting ''(4), (14)'' and

(2) by inserting ''and (15)'' after ''1861(nn)(2))''.

(c) CONFORMING AMENDMENTS.—Sections 1864(a), 1902(a)(9)(C), and 1915(a)(1)(B)(ii)(I) (42 U.S.C. 1395aa(a), 1396a(a)(9)(C), and 1396n(a)(1)(B)(ii)(I)) are amended by striking ''paragraphs (15) and (16)'' each place it appears and inserting ''paragraphs (16) and (17)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to bone mass measurements performed on or after July 1, 1998.

**SEC. 4107. VACCINES OUTREACH EXPANSION.**

(a) EXTENSION OF INFLUENZA AND PNEUMOCOCCAL VACCINATION CAMPAIGN.—In order to increase utilization of pneumococcal and influenza vaccines in medicare beneficiaries, the Influenza and Pneumococcal Vaccination Campaign carried out by the Health Care Financing Administration in conjunction with the Centers for Disease Control and Prevention and the National Coalition for Adult Immunization, is extended until the end of fiscal year 2002.

(b) AUTHORIZATION OF APPROPRIATION.—There are hereby authorized to be appropriated for each of fiscal years 1998 through 2002, $8,000,000 for the Campaign described in subsection (a). Of the amount so authorized to be appropriated in each fiscal year, 60 percent of the amount so appropriated shall be payable from the Federal Hospital Insurance Trust Fund, and 40 percent shall be payable from the Federal Supplementary Medical Insurance Trust Fund.

**SEC. 4108. STUDY ON PREVENTIVE AND ENHANCED BENEFITS.**

(a) STUDY.—The Secretary of Health and Human Services shall request the National Academy of Sciences, and as appropriate in conjunction with the United States Preventive Services Task Force, to analyze the expansion or modification of preventive or other benefits provided to medicare beneficiaries under title XVIII of the Social Security Act. The analysis shall consider both the short term and long term benefits, and costs to the medicare program, of such expansion or modification.

(b) REPORT.—

(1) INITIAL REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit a report on the findings of the analysis conducted under subsection (a) to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate.

(2) CONTENTS.—Such report shall include specific findings with respect to coverage of at least the following benefits:

(A) Nutrition therapy services, including parenteral and enteral nutrition and including the provision of such services by a registered dietitian.

(B) Skin cancer screening.

(C) Medically necessary dental care.

(D) Routine patient care costs for beneficiaries enrolled in approved clinical trial programs.

(E) Elimination of time limitation for coverage of immunosuppressive drugs for transplant patients.

(3) FUNDING.—From funds appropriated to the Department of Health and Human Services for fiscal years 1998 and 1999, the Secretary shall provide for such funding as the Secretary determines necessary for the conduct of the study by the National Academy of Sciences under this section.

**Subtitle C—Rural Initiatives**

**SEC. 4201. MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.**

(a) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.—Section 1820 (42 U.S.C. 1395i–4) is amended to read as follows:

''MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM

''SEC. 1820. (a) ESTABLISHMENT.—Any State that submits an application in accordance with subsection (b) may establish a medicare rural hospital flexibility program described in subsection (c).

''(b) APPLICATION.—A State may establish a medicare rural hospital flexibility program described in subsection (c) if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing—

''(1) assurances that the State—

''(A) has developed, or is in the process of developing, a State rural health care plan that—

''(i) provides for the creation of 1 or more rural health networks (as defined in subsection (d)) in the State;

''(ii) promotes regionalization of rural health services in the State; and

''(iii) improves access to hospital and other health services for rural residents of the State; and

''(B) has developed the rural health care plan described in subparagraph (A) in consultation with the hospital association of the State, rural hospitals located in the State, and the State Office of Rural Health (or, in the case of a State in the process of developing such plan, that assures the Secretary that the State will consult with its State hospital association, rural hospitals located in the State, and the State Office of Rural Health in developing such plan);

''(2) assurances that the State has designated (consistent with the rural health care plan described in paragraph (1)(A)), or is in the process of so designating, rural nonprofit or public hospitals or facilities located in the State as critical access hospitals; and

''(3) such other information and assurances as the Secretary may require.

''(c) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM DESCRIBED.—

''(1) IN GENERAL.—A State that has submitted an application in accordance with subsection (b), may establish a medicare rural hospital flexibility program that provides that—

''(A) the State shall develop at least 1 rural health network (as defined in subsection (d)) in the State; and

''(B) at least 1 facility in the State shall be designated as a critical access hospital in accordance with paragraph (2).

''(2) STATE DESIGNATION OF FACILITIES.—

''(A) IN GENERAL.—A State may designate 1 or more facilities as a critical access hospital in accordance with subparagraph (B).

''(B) CRITERIA FOR DESIGNATION AS CRITICAL ACCESS HOSPITAL.—A State may designate a facility as a critical access hospital if the facility—

''(i) is a nonprofit or public hospital and is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1886(d)(2)(D)) that—

''(I) is located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital, or another facility described in this subsection; or

''(II) is certified by the State as being a necessary provider of health care services to residents in the area;

''(ii) makes available 24-hour emergency care services that a State determines are necessary for ensuring access to emergency care services in each area served by a critical access hospital;

''(iii) provides not more than 15 (or, in the case of a facility under an agreement described in subsection (f), 25) acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period not to exceed 96 hours (unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions), except that a peer review organization or equivalent entity may, on request, waive the 96-hour restriction on a case-by-case basis;

''(iv) meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

''(I) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open and fully staffed, except insofar as the facility is required to make available emergency care services as determined under clause (ii) and must have nursing services available on a 24-hour basis, but need not otherwise staff the facility except when an inpatient is present;

''(II) the facility may provide any services otherwise required to be provided by a full-time, on site dietitian, pharmacist, laboratory technician, medical technologist, and radiological technologist on a part-time, off site basis under arrangements as defined in section 1861(w)(1); and

''(III) the inpatient care described in clause (iii) may be provided by a physician assistant, nurse practitioner, or clinical nurse specialist subject to the oversight of a physician who need not be present in the facility; and

''(v) meets the requirements of section 1861(aa)(2)(I).

''(d) DEFINITION OF RURAL HEALTH NETWORK.—

''(1) IN GENERAL.—In this section, the term 'rural health network' means, with respect to a State, an organization consisting of—

''(A) at least 1 facility that the State has designated or plans to designate as a critical access hospital; and

''(B) at least 1 hospital that furnishes acute care services.

''(2) AGREEMENTS.—

''(A) IN GENERAL.—Each critical access hospital that is a member of a rural health network shall have an agreement with respect to each item described in subparagraph (B) with at least 1 hospital that is a member of the network.

''(B) ITEMS DESCRIBED.—The items described in this subparagraph are the following:

''(i) Patient referral and transfer.

''(ii) The development and use of communications systems including (where feasible)—

''(I) telemetry systems; and

''(II) systems for electronic sharing of patient data.

''(iii) The provision of emergency and nonemergency transportation among the facility and the hospital.

''(C) CREDENTIALING AND QUALITY ASSURANCE.—Each critical access hospital that is a member of a rural health network shall have an agreement with respect to credentialing and quality assurance with at least—

''(i) 1 hospital that is a member of the network;

''(ii) 1 peer review organization or equivalent entity; or

''(iii) 1 other appropriate and qualified entity identified in the State rural health care plan.

''(e) CERTIFICATION BY THE SECRETARY.—The Secretary shall certify a facility as a critical access hospital if the facility—

''(1) is located in a State that has established a medicare rural hospital flexibility program in accordance with subsection (c);

''(2) is designated as a critical access hospital by the State in which it is located; and

''(3) meets such other criteria as the Secretary may require.

''(f) PERMITTING MAINTENANCE OF SWING BEDS.—Nothing in this section shall be construed to prohibit a State from designating or the Secretary from certifying a facility as a critical access hospital solely because, at the time the facility applies to the State for designation as a critical access hospital, there is in effect an agreement between the facility and the Secretary under section 1883 under which the facility's inpatient hospital facilities are used for the provision of extended care services, so long as the total number of beds that may be used at any time for the furnishing of either such services or acute care inpatient services does not exceed 25 beds and the number of beds used at any time for acute care inpatient services does not exceed 15 beds. For purposes of the previous sentence, any bed of a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility applies to the State for designation as a critical access hospital shall not be counted.

''(g) GRANTS.—

''(1) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.—The Secretary may award grants to States that have submitted applications in accordance with subsection (b) for—

''(A) engaging in activities relating to planning and implementing a rural health care plan;

''(B) engaging in activities relating to planning and implementing rural health networks; and

''(C) designating facilities as critical access hospitals.

''(2) RURAL EMERGENCY MEDICAL SERVICES.—

''(A) IN GENERAL.—The Secretary may award grants to States that have submitted applications in accordance with subparagraph (B) for the establishment or expansion

of a program for the provision of rural emergency medical services.

''(B) APPLICATION.—An application is in accordance with this subparagraph if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing the assurances described in subparagraphs (A)(ii), (A)(iii), and (B) of subsection (b)(1) and paragraph (3) of that subsection.

''(h) GRANDFATHERING OF CERTAIN FACILITIES.—

''(1) IN GENERAL.—Any medical assistance facility operating in Montana and any rural primary care hospital designated by the Secretary under this section prior to the date of the enactment of the Balanced Budget Act of 1997 shall be deemed to have been certified by the Secretary under subsection (e) as a critical access hospital if such facility or hospital is otherwise eligible to be designated by the State as a critical access hospital under subsection (c).

''(2) CONTINUATION OF MEDICAL ASSISTANCE FACILITY AND RURAL PRIMARY CARE HOSPITAL TERMS.—Notwithstanding any other provision of this title, with respect to any medical assistance facility or rural primary care hospital described in paragraph (1), any reference in this title to a 'critical access hospital' shall be deemed to be a reference to a 'medical assistance facility' or 'rural primary care hospital'.

''(i) WAIVER OF CONFLICTING PART A PROVISIONS.—The Secretary is authorized to waive such provisions of this part and part D as are necessary to conduct the program established under this section.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for making grants to all States under subsection (g), $25,000,000 in each of the fiscal years 1998 through 2002.''.

(b) REPORT ON ALTERNATIVE TO 96-HOUR RULE.—Not later than June 1, 1998, the Secretary of Health and Human Services shall submit to Congress a report on the feasibility of, and administrative requirements necessary to establish an alternative for certain medical diagnoses (as determined by the Secretary) to the 96-hour limitation for inpatient care in critical access hospitals required by section 1820(c)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395i–4(c)(2)(B)(iii)), as added by subsection (a) of this section.

(c) CONFORMING AMENDMENTS RELATING TO RURAL PRIMARY CARE HOSPITALS AND CRITICAL ACCESS HOSPITALS.—

(1) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) and title XVIII of that Act (42 U.S.C. 1395 et seq.) are each amended by striking ''rural primary care'' each place it appears and inserting ''critical access''.

(2) DEFINITIONS.—Section 1861(mm) of the Social Security Act (42 U.S.C. 1395x(mm)) is amended to read as follows:

''CRITICAL ACCESS HOSPITAL; CRITICAL ACCESS HOSPITAL SERVICES

''(mm)(1) The term 'critical access hospital' means a facility certified by the Secretary as a critical access hospital under section 1820(e).

''(2) The term 'inpatient critical access hospital services' means items and services, furnished to an inpatient of a critical access hospital by such facility, that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.

''(3) The term 'outpatient critical access hospital services' means medical and other health services furnished by a critical access hospital on an outpatient basis.''.

(3) PART A PAYMENT.—Section 1814 of the Social Security Act (42 U.S.C. 1395f) is amended—

(A) in subsection (a)(8), by striking ''72'' and inserting ''96''; and

(B) by amending subsection (l) to read as follows:

''Payment for Inpatient Critical Access Hospital Services

''(l) The amount of payment under this part for inpatient critical access hospital services is the reasonable costs of the critical access hospital in providing such services.''.

(4) PAYMENT CONTINUED TO DESIGNATED EACHS.—Section 1886(d)(5)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(D)) is amended—

(A) in clause (iii)(III), by inserting ''as in effect on September 30, 1997'' before the period at the end; and

(B) in clause (v)—

(i) by inserting ''as in effect on September 30, 1997'' after ''1820(i)(1)''; and

(ii) by striking ''1820(g)'' and inserting ''1820(d)''.

(5) PART B PAYMENT.—Section 1834(g) of the Social Security Act (42 U.S.C. 1395m(g)) is amended to read as follows:

''(g) PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—The amount of payment under this part for outpatient critical access hospital services is the reasonable costs of the critical access hospital in providing such services.''.

(6) TRANSITION FOR MAF.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall provide for an appropriate transition for a facility that, as of the date of the enactment of this Act, operated as a limited service rural hospital under a demonstration described in section 4008(i)(1) of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1395b–1 note) from such demonstration to the program established under subsection (a). At the conclusion of the transition period described in subparagraph (B), the Secretary shall end such demonstration.

(B) TRANSITION PERIOD DESCRIBED.—

(i) INITIAL PERIOD.—Subject to clause (ii), the transition period described in this subparagraph is the period beginning on the date of the enactment of this Act and ending on October 1, 1998.

(ii) EXTENSION.—If the Secretary determines that the transition is not complete as of October 1, 1998, the Secretary shall provide for an appropriate extension of the transition period.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 1997.

**SEC. 4202. PROHIBITING DENIAL OF REQUEST BY RURAL REFERRAL CENTERS FOR RECLASSIFICATION ON BASIS OF COMPARABILITY OF WAGES.**

(a) IN GENERAL.—Section 1886(d)(10)(D) (42 U.S.C. 1395ww(d)(10)(D)) is amended—

(1) by redesignating clause (iii) as clause (iv); and

(2) by inserting after clause (ii) the following new clause:

''(iii) Under the guidelines published by the Secretary under clause (i), in the case of a hospital which has ever been classified by the Secretary as a rural referral center under paragraph (5)(C), the Board may not reject the application of the hospital under this paragraph on the basis of any comparison between the average hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located.''.

(b) CONTINUING TREATMENT OF PREVIOUSLY DESIGNATED CENTERS.—

(1) IN GENERAL.—Any hospital classified as a rural referral center by the Secretary of Health and Human Services under section 1886(d)(5)(C) of the Social Security Act for fiscal year 1991 shall be classified as such a rural referral center for fiscal year 1998 and each subsequent fiscal year.

(2) BUDGET NEUTRALITY.—The provisions of section 1886(d)(8)(D) of the Social Security Act shall apply to reclassifications made pursuant to paragraph (1) in the same manner as such provisions apply to a reclassification under section 1886(d)(10) of such Act.

**SEC. 4203. HOSPITAL GEOGRAPHIC RECLASSIFICATION PERMITTED FOR PURPOSES OF DISPROPORTIONATE SHARE PAYMENT ADJUSTMENTS.**

(a) IN GENERAL.—For the period described in subsection (c), the Medicare Geographic Classification Review Board shall consider the application under section 1886(d)(10)(C)(i) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(C)(i)) of a hospital described in 1886(d)(1)(B) of such Act (42 U.S.C. 1395ww(d)(1)(B)) to change the hospital's geographic classification for purposes of determining for a fiscal year eligibility for and amount of additional payment amounts under section 1886(d)(5)(F) of such Act (42 U.S.C. 1395ww(d)(5)(F)).

(b) APPLICABLE GUIDELINES.—The Medicare Geographic Classification Review Board shall apply the guidelines established for reclassification under subclause (I) of section 1886(d)(10)(C)(i) of such Act to reclassification by reason of subsection (a) until the Secretary of Health and Human Services promulgates separate guidelines for such reclassification.

(c) PERIOD DESCRIBED.—The period described in this subsection is the period beginning on the date of the enactment of this Act and ending 30 months after such date.

**SEC. 4204. MEDICARE-DEPENDENT, SMALL RURAL HOSPITAL PAYMENT EXTENSION.**

(a) SPECIAL TREATMENT EXTENDED.—

(1) PAYMENT METHODOLOGY.—Section 1886(d)(5)(G) (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(A) in clause (i), by striking ''October 1, 1994,'' and inserting ''October 1, 1994, or beginning on or after October 1, 1997, and before October 1, 2001,''; and

(B) in clause (ii)(II), by striking ''October 1, 1994,'' and inserting ''October 1, 1994, or beginning on or after October 1, 1997, and before October 1, 2001,''.

(2) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(A) in the matter preceding clause (i), by striking ''September 30, 1994,'' and inserting ''September 30, 1994, and for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2001,'';

(B) in clause (ii), by striking ''and'' at the end;

(C) in clause (iii), by striking the period at the end and inserting '', and''; and

(D) by adding after clause (iii) the following new clause:

''(iv) with respect to discharges occurring during fiscal year 1998 through fiscal year 2000, the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv).''.

(3) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of OBRA–93 (42 U.S.C. 1395ww note) is amended by striking ''or fiscal year 1994'' and inserting '', fiscal year 1994, fiscal year 1998, fiscal year 1999, or fiscal year 2000''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to discharges occurring on or after October 1, 1997.

**SEC. 4205. RURAL HEALTH CLINIC SERVICES.**

(a) PER-VISIT PAYMENT LIMITS FOR PROVIDER-BASED CLINICS.—

(1) EXTENSION OF LIMIT.—

(A) IN GENERAL.—The matter in section 1833(f) (42 U.S.C. 1395l(f)) preceding paragraph (1) is amended by striking ''independent rural health clinics'' and inserting ''rural health clinics (other than such clinics in rural hospitals with less than 50 beds)''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) applies to services furnished on or after January 1, 1998.

(2) TECHNICAL CLARIFICATION.—Section 1833(f)(1) (42 U.S.C. 1395l(f)(1)) is amended by inserting ''per visit'' after ''$46''.

(b) ASSURANCE OF QUALITY SERVICES.—

(1) IN GENERAL.—Subparagraph (I) of the first sentence of section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended to read as follows:

''(I) has a quality assessment and performance improvement program, and appropriate procedures for review of utilization of clinic services, as the Secretary may specify,''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 1998.

(c) WAIVER OF CERTAIN STAFFING REQUIREMENTS LIMITED TO CLINICS IN PROGRAM.—

(1) IN GENERAL.—Section 1861(aa)(7)(B) (42 U.S.C. 1395x(aa)(7)(B)) is amended by inserting before the period '', or if the facility has not yet been determined to meet the requirements (including subparagraph (J) of the first sentence of paragraph (2)) of a rural health clinic''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) applies to waiver requests made on or after January 1, 1998.

(d) REFINEMENT OF SHORTAGE AREA REQUIREMENTS.—

(1) DESIGNATION REVIEWED TRIENNIALLY.—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)) is amended in the second sentence, in the matter in clause (i) preceding subclause (I)—

(A) by striking ''and that is designated'' and inserting ''and that, within the previous 3-year period, has been designated''; and

(B) by striking ''or that is designated'' and inserting ''or designated''.

(2) AREA MUST HAVE SHORTAGE OF HEALTH CARE PRACTITIONERS.—Section 1861(aa)(2) (42 U.S.C. 1395x(aa)(2)), as amended by paragraph (1), is further amended in the second sentence, in the matter in clause (i) preceding subclause (I)—

(A) by striking the comma after ''personal health services''; and

(B) by inserting ''and in which there are insufficient numbers of needed health care practitioners (as determined by the Secretary),'' after ''Bureau of the Census)''.

(3) PREVIOUSLY QUALIFYING CLINICS GRANDFATHERED ONLY TO PREVENT SHORTAGE.—

(A) IN GENERAL.—Section 1861(aa)(2) of the Social Security Act (42 U.S.C. 1395x(aa)(2)) is amended in the third sentence by inserting before the period ''if it is determined, in accordance with criteria established by the Secretary in regulations, to be essential to the delivery of primary care services that would otherwise be unavailable in the geographic area served by the clinic''.

(B) PAYMENT FOR CERTAIN PHYSICIAN ASSISTANT SERVICES.—Section 1842(b)(6)(C) (42 U.S.C. 1395u(b)(6)(C)) is amended to read as follows: ''(C) in the case of services described in clause (i) of section 1861(s)(2)(K), payment shall be made to either (i) the employer of the physician assistant involved, or (ii) with respect to a physician assistant who was the owner of a rural health clinic (as described in section 1861(aa)(2)) for a continuous period beginning prior to the date of the enactment of the Balanced Budget Act of 1997 and ending on the date that the Secretary determines such rural health clinic no longer meets the requirements of section 1861(aa)(2), for such services provided before January 1, 2003, payment may be made directly to the physician assistant; and''.

(4) EFFECTIVE DATES; IMPLEMENTING REGULATIONS.—

(A) IN GENERAL.—Except as otherwise provided, the amendments made by the preceding paragraphs take effect on the date of the enactment of this Act.

(B) CURRENT RURAL HEALTH CLINICS.—The amendments made by the preceding paragraphs take effect, with respect to entities that are rural health clinics under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) on the date of the enactment of this Act.

(C) GRANDFATHERED CLINICS.—

(i) IN GENERAL.—The amendment made by paragraph (3)(A) shall take effect on the effective date of regulations issued by the Secretary under clause (ii).

(ii) REGULATIONS.—The Secretary shall issue final regulations implementing paragraph (3)(A) that shall take effect no later than January 1, 1999.

**SEC. 4206. MEDICARE REIMBURSEMENT FOR TELEHEALTH SERVICES.**

(a) IN GENERAL.—Not later than January 1, 1999, the Secretary of Health and Human Services shall make payments from the Federal Supplementary Medical Insurance Trust Fund under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) in accordance with the methodology described in subsection (b) for professional consultation via telecommunications systems with a physician (as defined in section 1861(r) of such Act (42 U.S.C. 1395x(r)) or a practitioner (described in section 1842(b)(18)(C) of such Act (42 U.S.C. 1395u(b)(18)(C)) furnishing a service for which payment may be made under such part to a beneficiary under the medicare program residing in a county in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) that is designated as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)), notwithstanding that the individual physician or practitioner providing the professional consultation is not at the same location as the physician or practitioner furnishing the service to that beneficiary.

(b) METHODOLOGY FOR DETERMINING AMOUNT OF PAYMENTS.—Taking into account the findings of the report required under section 192 of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 1988), the findings of the report required under paragraph (c), and any other findings related to the clinical efficacy and cost-effectiveness of telehealth applications, the Secretary shall be establish a methodology for determining the amount of payments made under subsection (a) within the following parameters:

(1) The payment shall be shared between the referring physician or practitioner and the consulting physician or practitioner. The amount of such payment shall not be greater than the current fee schedule of the consulting physician or practitioner for the health care services provided.

(2) The payment shall not include any reimbursement for any telephone line charges or any facility fees, and a beneficiary may not be billed for any such charges or fees.

(3) The payment shall be made subject to the coinsurance and deductible requirements under subsections (a)(1) and (b) of section 1833 of the Social Security Act (42 U.S.C. 1395l).

(4) The payment differential of section 1848(a)(3) of such Act (42 U.S.C. 1395w–4(a)(3)) shall apply to services furnished by non-participating physicians. The provisions of section 1848(g) of such Act (42 U.S.C. 1395w–4(g)) and section 1842(b)(18) of such Act (42 U.S.C. 1395u(b)(18)) shall apply. Payment for such service shall be increased annually by the update factor for physicians' services determined under section 1848(d) of such Act (42 U.S.C. 1395w–4(d)).

(c) SUPPLEMENTAL REPORT.—Not later than January 1, 1999, the Secretary shall submit a report to Congress which shall contain a detailed analysis of—

(1) how telemedicine and telehealth systems are expanding access to health care services;

(2) the clinical efficacy and cost-effectiveness of telemedicine and telehealth applications;

(3) the quality of telemedicine and telehealth services delivered; and

(4) the reasonable cost of telecommunications charges incurred in practicing telemedicine and telehealth in rural, frontier, and underserved areas.

(d) EXPANSION OF TELEHEALTH SERVICES FOR CERTAIN MEDICARE BENEFICIARIES.—

(1) IN GENERAL.—Not later than January 1, 1999, the Secretary shall submit a report to Congress that examines the possibility of making payments from the Federal Supplementary Medical Insurance Trust Fund under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) for professional consultation via telecommunications systems with such a physician or practitioner furnishing a service for which payment may be made under such part to a beneficiary described in paragraph (2), notwithstanding that the individual physician or practitioner providing the professional consultation is not at the same location as the physician or practitioner furnishing the service to that beneficiary.

(2) BENEFICIARY DESCRIBED.—A beneficiary described in this paragraph is a beneficiary under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) who does not reside in a rural area (as so defined) that is designated as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)), who is homebound or nursing homebound, and for whom being transferred for health care services imposes a serious hardship.

(3) REPORT.—The report described in paragraph (1) shall contain a detailed statement of the potential costs and savings to the medicare program of making the payments described in that paragraph using various reimbursement schemes.

**SEC. 4207. INFORMATICS, TELEMEDICINE, AND EDUCATION DEMONSTRATION PROJECT.**

(a) PURPOSE AND AUTHORIZATION.—

(1) IN GENERAL.—Not later than 9 months after the date of enactment of this section, the Secretary of Health and Human Services shall provide for a demonstration project described in paragraph (2).

(2) DESCRIPTION OF PROJECT.—

(A) IN GENERAL.—The demonstration project described in this paragraph is a single demonstration project to use eligible health care provider telemedicine networks to apply high-capacity computing and advanced networks to improve primary care (and prevent health care complications) to medicare beneficiaries with diabetes mellitus who are residents of medically underserved rural areas or residents of medically underserved inner-city areas.

(B) MEDICALLY UNDERSERVED DEFINED.—As used in this paragraph, the term ''medically underserved'' has the meaning given such term in section 330(b)(3) of the Public Health Service Act (42 U.S.C. 254b(b)(3)).

(3) WAIVER.—The Secretary shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (d).

(4) DURATION OF PROJECT.—The project shall be conducted over a 4-year period.

(b) OBJECTIVES OF PROJECT.—The objectives of the project include the following:

(1) Improving patient access to and compliance with appropriate care guidelines for individuals with diabetes mellitus through direct telecommunications link with information networks in order to improve patient

quality-of-life and reduce overall health care costs.

(2) Developing a curriculum to train health professionals (particularly primary care health professionals) in the use of medical informatics and telecommunications.

(3) Demonstrating the application of advanced technologies, such as video-conferencing from a patient's home, remote monitoring of a patient's medical condition, interventional informatics, and applying individualized, automated care guidelines, to assist primary care providers in assisting patients with diabetes in a home setting.

(4) Application of medical informatics to residents with limited English language skills.

(5) Developing standards in the application of telemedicine and medical informatics.

(6) Developing a model for the cost-effective delivery of primary and related care both in a managed care environment and in a fee-for-service environment.

(c) ELIGIBLE HEALTH CARE PROVIDER TELEMEDICINE NETWORK DEFINED.—For purposes of this section, the term ''eligible health care provider telemedicine network'' means a consortium that includes at least one tertiary care hospital (but no more than 2 such hospitals), at least one medical school, no more than 4 facilities in rural or urban areas, and at least one regional telecommunications provider and that meets the following requirements:

(1) The consortium is located in an area with a high concentration of medical schools and tertiary care facilities in the United States and has appropriate arrangements (within or outside the consortium) with such schools and facilities, universities, and telecommunications providers, in order to conduct the project.

(2) The consortium submits to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the use to which the consortium would apply any amounts received under the project and the source and amount of non-Federal funds used in the project.

(3) The consortium guarantees that it will be responsible for payment for all costs of the project that are not paid under this section and that the maximum amount of payment that may be made to the consortium under this section shall not exceed the amount specified in subsection (d)(3).

(d) COVERAGE AS MEDICARE PART B SERVICES.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, services related to the treatment or management of (including prevention of complications from) diabetes for medicare beneficiaries furnished under the project shall be considered to be services covered under part B of title XVIII of the Social Security Act.

(2) PAYMENTS.—

(A) IN GENERAL.—Subject to paragraph (3), payment for such services shall be made at a rate of 50 percent of the costs that are reasonable and related to the provision of such services. In computing such costs, the Secretary shall include costs described in subparagraph (B), but may not include costs described in subparagraph (C).

(B) COSTS THAT MAY BE INCLUDED.—The costs described in this subparagraph are the permissible costs (as recognized by the Secretary) for the following:

(i) The acquisition of telemedicine equipment for use in patients' homes (but only in the case of patients located in medically underserved areas).

(ii) Curriculum development and training of health professionals in medical informatics and telemedicine.

(iii) Payment of telecommunications costs (including salaries and maintenance of equipment), including costs of telecommunications between patients' homes and the eligible network and between the network and other entities under the arrangements described in subsection (c)(1).

(iv) Payments to practitioners and providers under the medicare programs.

(C) COSTS NOT INCLUDED.—The costs described in this subparagraph are costs for any of the following:

(i) The purchase or installation of transmission equipment (other than such equipment used by health professionals to deliver medical informatics services under the project).

(ii) The establishment or operation of a telecommunications common carrier network.

(iii) Construction (except for minor renovations related to the installation of reimbursable equipment) or the acquisition or building of real property.

(3) LIMITATION.—The total amount of the payments that may be made under this section shall not exceed $30,000,000 for the period of the project (described in subsection (a)(4)).

(4) LIMITATION ON COST-SHARING.—The project may not impose cost sharing on a medicare beneficiary for the receipt of services under the project in excess of 20 percent of the costs that are reasonable and related to the provision of such services.

(e) REPORTS.—The Secretary shall submit to the Committee on Ways and Means and the Committee Commerce of the House of Representatives and the Committee on Finance of the Senate interim reports on the project and a final report on the project within 6 months after the conclusion of the project. The final report shall include an evaluation of the impact of the use of telemedicine and medical informatics on improving access of medicare beneficiaries to health care services, on reducing the costs of such services, and on improving the quality of life of such beneficiaries.

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

(1) INTERVENTIONAL INFORMATICS.—The term ''interventional informatics'' means using information technology and virtual reality technology to intervene in patient care.

(2) MEDICAL INFORMATICS.—The term ''medical informatics'' means the storage, retrieval, and use of biomedical and related information for problem solving and decision-making through computing and communications technologies.

(3) PROJECT.—The term ''project'' means the demonstration project under this section.

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

### CHAPTER 1—REVISIONS TO SANCTIONS FOR FRAUD AND ABUSE

**SEC. 4301. PERMANENT EXCLUSION FOR THOSE CONVICTED OF 3 HEALTH CARE RELATED CRIMES.**

Section 1128(c)(3) (42 U.S.C. 1320a–7(c)(3)) is amended—

(1) in subparagraph (A), by inserting ''or in the case described in subparagraph (G)'' after ''subsection (b)(12)'';

(2) in subparagraphs (B) and (D), by striking ''In the case'' and inserting ''Subject to subparagraph (G), in the case''; and

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

''(G) In the case of an exclusion of an individual under subsection (a) based on a conviction occurring on or after the date of the enactment of this subparagraph, if the individual has (before, on, or after such date) been convicted—

''(i) on one previous occasion of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be not less than 10 years, or

''(ii) on 2 or more previous occasions of one or more offenses for which an exclusion may be effected under such subsection, the period of the exclusion shall be permanent.''.

**SEC. 4302. AUTHORITY TO REFUSE TO ENTER INTO MEDICARE AGREEMENTS WITH INDIVIDUALS OR ENTITIES CONVICTED OF FELONIES.**

(a) MEDICARE PART A.—Section 1866(b)(2) (42 U.S.C. 1395cc(b)(2)) is amended—

(1) in subparagraph (B), by striking ''or'' at the end;

(2) in subparagraph (C), by striking the period at the end and inserting '', or''; and

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

''(D) has ascertained that the provider has been convicted of a felony under Federal or State law for an offense which the Secretary determines is detrimental to the best interests of the program or program beneficiaries.''.

(b) MEDICARE PART B.—Section 1842(h) (42 U.S.C. 1395u(h)) is amended by adding at the end the following new paragraph:

''(8) The Secretary may refuse to enter into an agreement with a physician or supplier under this subsection, or may terminate or refuse to renew such agreement, in the event that such physician or supplier has been convicted of a felony under Federal or State law for an offense which the Secretary determines is detrimental to the best interests of the program or program beneficiaries.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and apply to the entry and renewal of contracts on or after such date.

**SEC. 4303. EXCLUSION OF ENTITY CONTROLLED BY FAMILY MEMBER OF A SANCTIONED INDIVIDUAL.**

(a) IN GENERAL.—Section 1128 (42 U.S.C. 1320a–7) is amended—

(1) in subsection (b)(8)(A)—

(A) in clause (i), by striking ''or'' at the end;

(B) in clause (ii), by striking the dash at the end and inserting ''; or''; and

(C) by inserting after clause (ii) the following:

''(iii) who was described in clause (i) but is no longer so described because of a transfer of ownership or control interest, in anticipation of (or following) a conviction, assessment, or exclusion described in subparagraph (B) against the person, to an immediate family member (as defined in subsection (j)(1)) or a member of the household of the person (as defined in subsection (j)(2)) who continues to maintain an interest described in such clause—''; and

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

''(j) DEFINITION OF IMMEDIATE FAMILY MEMBER AND MEMBER OF HOUSEHOLD.—For purposes of subsection (b)(8)(A)(iii):

''(1) The term 'immediate family member' means, with respect to a person—

''(A) the husband or wife of the person;

''(B) the natural or adoptive parent, child, or sibling of the person;

''(C) the stepparent, stepchild, stepbrother, or stepsister of the person;

''(D) the father-, mother-, daughter-, son-, brother-, or sister-in-law of the person;

''(E) the grandparent or grandchild of the person; and

''(F) the spouse of a grandparent or grandchild of the person.

''(2) The term 'member of the household' means, with respect to any person, any individual sharing a common abode as part of a single family unit with the person, including domestic employees and others who live to-

gether as a family unit, but not including a roomer or boarder.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date that is 45 days after the date of the enactment of this Act.

**SEC. 4304. IMPOSITION OF CIVIL MONEY PENALTIES.**

(a) CIVIL MONEY PENALTIES FOR PERSONS THAT CONTRACT WITH EXCLUDED INDIVIDUALS.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(1) in paragraph (4), by striking ''or'' at the end;

(2) in paragraph (5), by adding ''or'' at the end; and

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

''(6) arranges or contracts (by employment or otherwise) with an individual or entity that the person knows or should know is excluded from participation in a Federal health care program (as defined in section 1128B(f)), for the provision of items or services for which payment may be made under such a program;''.

(b) CIVIL MONEY PENALTIES FOR KICKBACKS.—

(1) PERMITTING SECRETARY TO IMPOSE CIVIL MONEY PENALTY.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by subsection (a), is amended—

(A) in paragraph (5), by striking ''or'' at the end;

(B) in paragraph (6), by adding ''or'' at the end; and

(C) by adding after paragraph (6) the following new paragraph:

''(7) commits an act described in paragraph (1) or (2) of section 1128B(b);''.

(2) DESCRIPTION OF CIVIL MONEY PENALTY APPLICABLE.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by paragraph (1), is amended in the matter following paragraph (7)—

(A) by striking ''occurs).'' and inserting ''occurs; or in cases under paragraph (7), $50,000 for each such act).''; and

(B) by inserting after ''of such claim'' the following: ''(or, in cases under paragraph (7), damages of not more than 3 times the total amount of remuneration offered, paid, solicited, or received, without regard to whether a portion of such remuneration was offered, paid, solicited, or received for a lawful purpose)''.

(c) EFFECTIVE DATES.—

(1) CONTRACTS WITH EXCLUDED PERSONS.—The amendments made by subsection (a) shall apply to arrangements and contracts entered into after the date of the enactment of this Act.

(2) KICKBACKS.—The amendments made by subsection (b) shall apply to acts committed after the date of the enactment of this Act.

## CHAPTER 2—IMPROVEMENTS IN PROTECTING PROGRAM INTEGRITY

**SEC. 4311. IMPROVING INFORMATION TO MEDICARE BENEFICIARIES.**

(a) INCLUSION OF INFORMATION REGARDING MEDICARE WASTE, FRAUD, AND ABUSE IN ANNUAL NOTICE.—

(1) IN GENERAL.—Section 1804 (42 U.S.C. 1395b–2) is amended by adding at the end the following new subsection:

''(c) The notice provided under subsection (a) shall include—

''(1) a statement which indicates that because errors do occur and because medicare fraud, waste, and abuse is a significant problem, beneficiaries should carefully check any explanation of benefits or itemized statement furnished pursuant to section 1806 for accuracy and report any errors or questionable charges by calling the toll-free phone number described in paragraph (4);

''(2) a statement of the beneficiary's right to request an itemized statement for medicare items and services (as provided in section 1806(b));

''(3) a description of the program to collect information on medicare fraud and abuse established under section 203(b) of the Health Insurance Portability and Accountability Act of 1996; and

''(4) a toll-free telephone number maintained by the Inspector General in the Department of Health and Human Services for the receipt of complaints and information about waste, fraud, and abuse in the provision or billing of services under this title.''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to notices provided on or after January 1, 1998.

(b) CLARIFICATION OF REQUIREMENT TO PROVIDE EXPLANATION OF MEDICARE BENEFITS.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1805 (as added by section 4022) the following new section:

''EXPLANATION OF MEDICARE BENEFITS

''SEC. 1806. (a) IN GENERAL.—The Secretary shall furnish to each individual for whom payment has been made under this title (or would be made without regard to any deductible) a statement which—

''(1) lists the item or service for which payment has been made and the amount of such payment for each item or service; and

''(2) includes a notice of the individual's right to request an itemized statement (as provided in subsection (b)).

''(b) REQUEST FOR ITEMIZED STATEMENT FOR MEDICARE ITEMS AND SERVICES.—

''(1) IN GENERAL.—An individual may submit a written request to any physician, provider, supplier, or any other person (including an organization, agency, or other entity) for an itemized statement for any item or service provided to such individual by such person with respect to which payment has been made under this title.

''(2) 30-DAY PERIOD TO FURNISH STATEMENT.—

''(A) IN GENERAL.—Not later than 30 days after the date on which a request under paragraph (1) has been made, a person described in such paragraph shall furnish an itemized statement describing each item or service provided to the individual requesting the itemized statement.

''(B) PENALTY.—Whoever knowingly fails to furnish an itemized statement in accordance with subparagraph (A) shall be subject to a civil money penalty of not more than $100 for each such failure. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(3) REVIEW OF ITEMIZED STATEMENT.—

''(A) IN GENERAL.—Not later than 90 days after the receipt of an itemized statement furnished under paragraph (1), an individual may submit a written request for a review of the itemized statement to the Secretary.

''(B) SPECIFIC ALLEGATIONS.—A request for a review of the itemized statement shall identify—

''(i) specific items or services that the individual believes were not provided as claimed, or

''(ii) any other billing irregularity (including duplicate billing).

''(4) FINDINGS OF SECRETARY.—The Secretary shall, with respect to each written request submitted under paragraph (3), determine whether the itemized statement identifies specific items or services that were not provided as claimed or any other billing irregularity (including duplicate billing) that has resulted in unnecessary payments under this title.

''(5) RECOVERY OF AMOUNTS.—The Secretary shall take all appropriate measures to recover amounts unnecessarily paid under this title with respect to a statement described in paragraph (4).''.

(2) CONFORMING AMENDMENT.—Subsection (a) of section 203 of the Health Insurance Portability and Accountability Act of 1996 is repealed.

(3) EFFECTIVE DATES.—

(A) STATEMENT BY SECRETARY.—Paragraph (1) of section 1806(a) of the Social Security Act, as added by paragraph (1), and the repeal made by paragraph (2) shall take effect on the date of the enactment of this Act.

(B) ITEMIZED STATEMENT.—Paragraph (2) of section 1806(a) and section 1806(b) of the Social Security Act, as so added, shall take effect not later than January 1, 1999.

**SEC. 4312. DISCLOSURE OF INFORMATION AND SURETY BONDS.**

(a) DISCLOSURE OF INFORMATION AND SURETY BOND REQUIREMENT FOR SUPPLIERS OF DURABLE MEDICAL EQUIPMENT.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended by inserting after paragraph (15) the following new paragraph:

''(16) DISCLOSURE OF INFORMATION AND SURETY BOND.—The Secretary shall not provide for the issuance (or renewal) of a provider number for a supplier of durable medical equipment, for purposes of payment under this part for durable medical equipment furnished by the supplier, unless the supplier provides the Secretary on a continuing basis—

''(A) with—

''(i) full and complete information as to the identity of each person with an ownership or control interest (as defined in section 1124(a)(3)) in the supplier or in any subcontractor (as defined by the Secretary in regulations) in which the supplier directly or indirectly has a 5 percent or more ownership interest; and

''(ii) to the extent determined to be feasible under regulations of the Secretary, the name of any disclosing entity (as defined in section 1124(a)(2)) with respect to which a person with such an ownership or control interest in the supplier is a person with such an ownership or control interest in the disclosing entity; and

''(B) with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000.

The Secretary may waive the requirement of a bond under subparagraph (B) in the case of a supplier that provides a comparable surety bond under State law.''.

(b) SURETY BOND REQUIREMENT FOR HOME HEALTH AGENCIES.—

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

(A) in paragraph (6), by striking ''and'' at the end;

(B) by redesignating paragraph (7) as paragraph (8);

(C) by inserting after paragraph (6) the following new paragraph:

''(7) provides the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000; and''; and

(D) by adding at the end the following: ''The Secretary may waive the requirement of a surety bond under paragraph (7) in the case of an agency or organization that provides a comparable surety bond under State law.''.

(2) CONFORMING AMENDMENTS.—Section 1861(v)(1)(H) (42 U.S.C. 1395x(v)(1)(H)) is amended—

(A) in clause (i), by striking ''the financial security requirement described in subsection (o)(7)'' and inserting ''the surety bond requirement described in subsection (o)(7) and the financial security requirement described in subsection (o)(8)''; and

(B) in clause (ii), by striking ''the financial security requirement described in subsection (o)(7) applies'' and inserting ''the surety bond requirement described in subsection

(o)(7) and the financial security requirement described in subsection (o)(8) apply''.

(3) REFERENCE TO CURRENT DISCLOSURE REQUIREMENT.—For additional provisions requiring home health agencies to disclose information on ownership and control interests, see section 1124 of the Social Security Act (42 U.S.C. 1320a–3).

(c) AUTHORIZING APPLICATION OF DISCLOSURE AND SURETY BOND REQUIREMENTS TO OTHER HEALTH CARE PROVIDERS.—Section 1834(a)(16) (42 U.S.C. 1395m(a)(16)), as added by subsection (a), is amended by adding at the end the following: ''The Secretary, at the Secretary's discretion, may impose the requirements of the first sentence with respect to some or all providers of items or services under part A or some or all suppliers or other persons (other than physicians or other practitioners, as defined in section 1842(b)(18)(C)) who furnish items or services under this part.''.

(d) APPLICATION TO COMPREHENSIVE OUTPATIENT REHABILITATION FACILITIES (CORFS).—Section 1861(cc)(2) (42 U.S.C. 1395x(cc)(2)) is amended—

(1) in subparagraph (H), by striking ''and'' at the end;

(2) by redesignating subparagraph (I) as subparagraph (J);

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

''(I) provides the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000; and''; and

(4) by adding at the end the following flush sentence:

''The Secretary may waive the requirement of a surety bond under subparagraph (I) in the case of a facility that provides a comparable surety bond under State law.''.

(e) APPLICATION TO REHABILITATION AGENCIES.—Section 1861(p) (42 U.S.C. 1395x(p)) is amended—

(1) in paragraph (4)(A)(v), by inserting after ''as the Secretary may find necessary,'' the following: ''and provides the Secretary on a continuing basis with a surety bond in a form specified by the Secretary and in an amount that is not less than $50,000,'', and

(2) by adding at the end the following: ''The Secretary may waive the requirement of a surety bond under paragraph (4)(A)(v) in the case of a clinic or agency that provides a comparable surety bond under State law.''.

(f) EFFECTIVE DATES.—

(1) SUPPLIERS OF DURABLE MEDICAL EQUIPMENT.—The amendment made by subsection (a) shall apply to suppliers of durable medical equipment with respect to such equipment furnished on or after January 1, 1998.

(2) HOME HEALTH AGENCIES.—The amendments made by subsection (b) shall apply to home health agencies with respect to services furnished on or after January 1, 1998. The Secretary of Health and Human Services shall modify participation agreements under section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1)) with respect to home health agencies to provide for implementation of such amendments on a timely basis.

(3) OTHER AMENDMENTS.—The amendments made by subsections (c) through (e) shall take effect on the date of the enactment of this Act and may be applied with respect to items and services furnished on or after January 1, 1998.

**SEC. 4313. PROVISION OF CERTAIN IDENTIFICATION NUMBERS.**

(a) REQUIREMENTS TO DISCLOSE EMPLOYER IDENTIFICATION NUMBERS (EINS) AND SOCIAL SECURITY ACCOUNT NUMBERS (SSNS).—Section 1124(a)(1) (42 U.S.C. 1320a–3(a)(1)) is amended by inserting before the period at the end the following: ''and supply the Secretary with the both the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 205(c)(2)(B)) of the disclosing entity, each person with an ownership or control interest (as defined in subsection (a)(3)), and any subcontractor in which the entity directly or indirectly has a 5 percent or more ownership interest.

(b) OTHER MEDICARE PROVIDERS.—Section 1124A (42 U.S.C. 1320a–3a) is amended—

(1) in subsection (a)—

(A) in paragraph (1), by striking ''and'' at the end;

(B) in paragraph (2), by striking the period at the end and inserting ''; and''; and

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

''(3) including the employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986) and social security account number (assigned under section 205(c)(2)(B)) of the disclosing part B provider and any person, managing employee, or other entity identified or described under paragraph (1) or (2).''; and

(2) in subsection (c)(1), by inserting ''(or, for purposes of subsection (a)(3), any entity receiving payment)'' after ''on an assignment-related basis''.

(c) VERIFICATION BY SOCIAL SECURITY ADMINISTRATION (SSA).—Section 1124A (42 U.S.C. 1320a–3a), as amended by subsection (b), is amended—

(1) by redesignating subsection (c) as subsection (d); and

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

''(c) VERIFICATION.—

''(1) TRANSMITTAL BY HHS.—The Secretary shall transmit—

''(A) to the Commissioner of Social Security information concerning each social security account number (assigned under section 205(c)(2)(B)), and

''(B) to the Secretary of the Treasury information concerning each employer identification number (assigned pursuant to section 6109 of the Internal Revenue Code of 1986),

supplied to the Secretary pursuant to subsection (a)(3) or section 1124(c) to the extent necessary for verification of such information in accordance with paragraph (2).

''(2) VERIFICATION.—The Commissioner of Social Security and the Secretary of the Treasury shall verify the accuracy of, or correct, the information supplied by the Secretary to such official pursuant to paragraph (1), and shall report such verifications or corrections to the Secretary.

''(3) FEES FOR VERIFICATION.—The Secretary shall reimburse the Commissioner and Secretary of the Treasury, at a rate negotiated between the Secretary and such official, for the costs incurred by such official in performing the verification and correction services described in this subsection.''.

(d) REPORT.—Before the amendments made by this section may become effective, the Secretary of Health and Human Services shall submit to Congress a report on steps the Secretary has taken to assure the confidentiality of social security account numbers that will be provided to the Secretary under such amendments.

(e) EFFECTIVE DATES.—

(1) DISCLOSURE REQUIREMENTS.—The amendment made by subsection (a) shall apply to the application of conditions of participation, and entering into and renewal of contracts and agreements, occurring more than 90 days after the date of submission of the report under subsection (d).

(2) OTHER PROVIDERS.—The amendments made by subsection (b) shall apply to payment for items and services furnished more than 90 days after the date of submission of such report.

**SEC. 4314. ADVISORY OPINIONS REGARDING CERTAIN PHYSICIAN SELF-REFERRAL PROVISIONS.**

Section 1877(g) (42 U.S.C. 1395nn(g)) is amended by adding at the end the following new paragraph:

''(6) ADVISORY OPINIONS.—

''(A) IN GENERAL.—The Secretary shall issue written advisory opinions concerning whether a referral relating to designated health services (other than clinical laboratory services) is prohibited under this section. Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

''(B) APPLICATION OF CERTAIN RULES.—The Secretary shall, to the extent practicable, apply the rules under subsections (b)(3) and (b)(4) and take into account the regulations promulgated under subsection (b)(5) of section 1128D in the issuance of advisory opinions under this paragraph.

''(C) REGULATIONS.—In order to implement this paragraph in a timely manner, the Secretary may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

''(D) APPLICABILITY.—This paragraph shall apply to requests for advisory opinions made after the date which is 90 days after the date of the enactment of this paragraph and before the close of the period described in section 1128D(b)(6).''.

**SEC. 4315. REPLACEMENT OF REASONABLE CHARGE METHODOLOGY BY FEE SCHEDULES.**

(a) APPLICATION OF FEE SCHEDULE.—Section 1842 (42 U.S.C. 1395u) is amended by adding at the end the following new subsection:

''(s)(1) The Secretary may implement a statewide or other areawide fee schedule to be used for payment of any item or service described in paragraph (2) which is paid on a reasonable charge basis. Any fee schedule established under this paragraph for such item or service shall be updated each year by the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year, except that in no event shall a fee schedule for an item described in paragraph (2)(D) be updated before 2003.

''(2) The items and services described in this paragraph are as follows:

''(A) Medical supplies.

''(B) Home dialysis supplies and equipment (as defined in section 1881(b)(8)).

''(C) Therapeutic shoes.

''(D) Parenteral and enteral nutrients, equipment, and supplies.

''(E) Electromyogram devices

''(F) Salivation devices.

''(G) Blood products.

''(H) Transfusion medicine.''.

(b) CONFORMING AMENDMENT.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking ''and (P)'' and inserting ''(P)''; and

(B) by striking the semicolon at the end and inserting the following: '', and (Q) with respect to items or services for which fee schedules are established pursuant to section 1842(s), the amounts paid shall be 80 percent of the lesser of the actual charge or the fee schedule established in such section;''.

(c) EFFECTIVE DATES.—The amendments made by this section to the extent such amendments substitute fee schedules for reasonable charges, shall apply to particular services as of the date specified by the Secretary of Health and Human Services.

(d) INITIAL BUDGET NEUTRALITY.—The Secretary, in developing a fee schedule for particular services (under the amendments made by this section), shall set amounts for the first year period to which the fee sched-

ule applies at a level so that the total payments under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for those services for that year period shall be approximately equal to the estimated total payments if such fee schedule had not been implemented.

**SEC. 4316. APPLICATION OF INHERENT REASONABLENESS TO ALL PART B SERVICES OTHER THAN PHYSICIANS' SERVICES.**

(a) IN GENERAL.—Paragraphs (8) and (9) of section 1842(b) (42 U.S.C. 1395u(b)) are amended to read as follows:

''(8)(A)(i) The Secretary shall by regulation—

''(I) describe the factors to be used in determining the cases (of particular items or services) in which the application of this part (other than to physicians' services paid under section 1848) results in the determination of an amount that, because of its being grossly excessive or grossly deficient, is not inherently reasonable, and

''(II) provide in those cases for the factors to be considered in determining an amount that is realistic and equitable.

''(ii) Notwithstanding the determination made in clause (i), the Secretary may not apply factors that would increase or decrease the payment under this part during any year for any particular item or service by more than 15 percent from such payment during the preceding year except as provided in subparagraph (B).

''(B) The Secretary may make a determination under this subparagraph that would result in an increase or decrease under subparagraph (A) of more than 15 percent of the payment amount for a year, but only if—

''(i) the Secretary's determination takes into account the factors described in subparagraph (C) and any additional factors the Secretary determines appropriate,

''(ii) the Secretary's determination takes into account the potential impacts described in subparagraph (D), and

''(iii) the Secretary complies with the procedural requirements of paragraph (9).

''(C) The factors described in this subparagraph are as follows:

''(i) The programs established under this title and title XIX are the sole or primary sources of payment for an item or service.

''(ii) The payment amount does not reflect changing technology, increased facility with that technology, or reductions in acquisition or production costs.

''(iii) The payment amount for an item or service under this part is substantially higher or lower than the payment made for the item or service by other purchasers.

''(D) The potential impacts of a determination under subparagraph (B) on quality, access, and beneficiary liability, including the likely effects on assignment rates and participation rates.

''(9)(A) The Secretary shall consult with representatives of suppliers or other individuals who furnish an item or service before making a determination under paragraph (8)(B) with regard to that item or service.

''(B) The Secretary shall publish notice of a proposed determination under paragraph (8)(B) in the Federal Register—

''(i) specifying the payment amount proposed to be established with respect to an item or service,

''(ii) explaining the factors and data that the Secretary took into account in determining the payment amount so specified, and

''(iii) explaining the potential impacts described in paragraph (8)(D).

''(C) After publication of the notice required by subparagraph (B), the Secretary shall allow not less than 60 days for public comment on the proposed determination.

''(D)(i) Taking into consideration the comments made by the public, the Secretary shall publish in the Federal Register a final determination under paragraph (8)(B) with respect to the payment amount to be established with respect to the item or service.

''(ii) A final determination published pursuant to clause (i) shall explain the factors and data that the Secretary took into consideration in making the final determination.''.

(b) CONFORMING AMENDMENT.—Section 1834(a)(10)(B) (42 U.S.C. 1395m(a)(10)(B)) is amended—

(1) by striking ''For covered items furnished on or after January 1, 1991, the'' and inserting ''The'';

(2) by striking ''(other than subparagraph (D))''; and

(3) by striking all that follows ''payments under this subsection'' and inserting a period.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

**SEC. 4317. REQUIREMENT TO FURNISH DIAGNOSTIC INFORMATION.**

(a) INCLUSION OF NON-PHYSICIAN PRACTITIONERS IN REQUIREMENT TO PROVIDE DIAGNOSTIC CODES FOR PHYSICIAN SERVICES.—Paragraphs (1) and (2) of section 1842(p) (42 U.S.C. 1395u(p)) are each amended by inserting ''or practitioner specified in subsection (b)(18)(C)'' after ''by a physician''.

(b) REQUIREMENT TO PROVIDE DIAGNOSTIC INFORMATION WHEN ORDERING CERTAIN ITEMS OR SERVICES FURNISHED BY ANOTHER ENTITY.—Section 1842(p) (42 U.S.C. 1395u(p)), is amended by adding at the end the following new paragraph:

''(4) In the case of an item or service defined in paragraph (3), (6), (8), or (9) of subsection 1861(s) ordered by a physician or a practitioner specified in subsection (b)(18)(C), but furnished by another entity, if the Secretary (or fiscal agent of the Secretary) requires the entity furnishing the item or service to provide diagnostic or other medical information in order for payment to be made to the entity, the physician or practitioner shall provide that information to the entity at the time that the item or service is ordered by the physician or practitioner.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 1998.

**SEC. 4318. REPORT BY GAO ON OPERATION OF FRAUD AND ABUSE CONTROL PROGRAM.**

Section 1817(k)(6) (42 U.S.C. 1395i(k)(6)) is amended by inserting ''June 1, 1998, and'' after ''Not later than''.

**SEC. 4319. COMPETITIVE BIDDING DEMONSTRATION PROJECTS.**

(a) GENERAL RULE.—Part B of title XVIII (42 U.S.C. 1395j et seq.) is amended by inserting after section 1846 the following new section:

**''SEC. 1847. DEMONSTRATION PROJECTS FOR COMPETITIVE ACQUISITION OF ITEMS AND SERVICES.**

''(a) ESTABLISHMENT OF DEMONSTRATION PROJECT BIDDING AREAS.—

''(1) IN GENERAL.—The Secretary shall implement not more than 5 demonstration projects under which competitive acquisition areas are established for contract award purposes for the furnishing under this part of the items and services described in subsection (d).

''(2) PROJECT REQUIREMENTS.—Each demonstration project under paragraph (1)—

''(A) shall include such group of items and services as the Secretary may prescribe,

''(B) shall be conducted in not more than 3 competitive acquisition areas, and

''(C) shall be operated over a 3-year period.

''(3) CRITERIA FOR ESTABLISHMENT OF COMPETITIVE ACQUISITION AREAS.—Each competitive acquisition area established under a demonstration project implemented under paragraph (1)—

''(A) shall be, or shall be within, a metropolitan statistical area (as defined by the Secretary of Commerce), and

''(B) shall be chosen based on the availability and accessibility of entities able to furnish items and services, and the probable savings to be realized by the use of competitive bidding in the furnishing of items and services in such area.

''(b) AWARDING OF CONTRACTS IN AREAS.—

''(1) IN GENERAL.—The Secretary shall conduct a competition among individuals and entities supplying items and services described in subsection (c) for each competitive acquisition area established under a demonstration project implemented under subsection (a).

''(2) CONDITIONS FOR AWARDING CONTRACT.—The Secretary may not award a contract to any entity under the competition conducted pursuant to paragraph (1) to furnish an item or service unless the Secretary finds that the entity meets quality standards specified by the Secretary that the total amounts to be paid under the contract are expected to be less than the total amounts that would otherwise be paid.

''(3) CONTENTS OF CONTRACT.—A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify.

''(4) LIMIT ON NUMBER OF CONTRACTORS.—The Secretary may limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for items and services covered under the contracts.

''(c) EXPANSION OF PROJECTS.—

''(1) EVALUATIONS.—The Secretary shall evaluate the impact of the implementation of the demonstration projects on medicare program payments, access, diversity of product selection, and quality. The Secretary shall make annual reports to the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate on the results of the evaluation described in the preceding sentence and a final report not later than 6 months after the termination date specified in subsection (e).

''(2) EXPANSION.—If the Secretary determines from the evaluations under paragraph (1) that there is clear evidence that any demonstration project—

''(A) results in a decrease in Federal expenditures under this title, and

''(B) does not reduce program access, diversity of product selection, and quality under this title,

the Secretary may expand the project to additional competitive acquisition areas.

''(d) SERVICES DESCRIBED.—The items and services to which this section applies are all items and services covered under this part (except for physicians' services as defined in section 1861(s)(1)) that the Secretary may specify. At least one demonstration project shall include oxygen and oxygen equipment.

''(e) TERMINATION.—Notwithstanding any other provision of this section, all projects under this section shall terminate not later than December 31, 2002.''.

(b) ITEMS AND SERVICES TO BE FURNISHED ONLY THROUGH COMPETITIVE ACQUISITION.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) by striking ''or'' at the end of paragraph (15),

(2) by striking the period at the end of paragraph (16) and inserting ''; or'', and

(3) by inserting after paragraph (16) the following new paragraph:

''(17) where the expenses are for an item or service furnished in a competitive acquisi-

tion area (as established by the Secretary under section 1847(a)) by an entity other than an entity with which the Secretary has entered into a contract under section 1847(b) for the furnishing of such an item or service in that area, unless the Secretary finds that the expenses were incurred in a case of urgent need, or in other circumstances specified by the Secretary.''.

(c) STUDY BY GAO.—The Comptroller of the United States shall study the effectiveness of the establishment of competitive acquisition areas under section 1847(a) of the Social Security Act, as added by this section.

**SEC. 4320. PROHIBITING UNNECESSARY AND WASTEFUL MEDICARE PAYMENTS FOR CERTAIN ITEMS.**

Section 1861(v) (42 U.S.C. 1395x(v)) is amended by adding at the end the following new paragraph:

''(8) ITEMS UNRELATED TO PATIENT CARE.—Reasonable costs do not include costs for the following—

''(i) entertainment, including tickets to sporting and other entertainment events;

''(ii) gifts or donations;

''(iii) personal use of motor vehicles;

''(iv) costs for fines and penalties resulting from violations of Federal, State, or local laws; and

''(iv) education expenses for spouses or other dependents of providers of services, their employees or contractors.''.

**SEC. 4321. NONDISCRIMINATION IN POST-HOSPITAL REFERRAL TO HOME HEALTH AGENCIES AND OTHER ENTITIES.**

(a) NOTIFICATION OF AVAILABILITY OF HOME HEALTH AGENCIES AND OTHER ENTITIES AS PART OF DISCHARGE PLANNING PROCESS.—Section 1861(ee)(2) (42 U.S.C. 1395x(ee)(2)) is amended—

(1) in subparagraph (D), by inserting before the period the following: '', including the availability of home health services through individuals and entities that participate in the program under this title and that serve the area in which the patient resides and that request to be listed by the hospital as available''; and

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

''(H) Consistent with section 1802, the discharge plan shall—

''(i) not specify or otherwise limit the qualified provider which may provide post-hospital home health services, and

''(ii) identify (in a form and manner specified by the Secretary) any entity to whom the individual is referred in which the hospital has a disclosable financial interest (as specified by the Secretary consistent with section 1866(a)(1)(S)) or which has such an interest in the hospital.''.

(b) MAINTENANCE AND DISCLOSURE OF INFORMATION ON POST-HOSPITAL HOME HEALTH AGENCIES AND OTHER ENTITIES.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(1) by striking ''and'' at the end of subparagraph (Q),

(2) by striking the period at the end of subparagraph (R), and

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

''(S) in the case of a hospital that has a financial interest (as specified by the Secretary in regulations) in an entity to which individuals are referred as described in section 1861(ee)(2)(H)(ii), or in which such an entity has such a financial interest, or in which another entity has such a financial interest (directly or indirectly) with such hospital and such an entity, to maintain and disclose to the Secretary (in a form and manner specified by the Secretary) information on—

''(i) the nature of such financial interest,

''(ii) the number of individuals who were discharged from the hospital and who were identified as requiring home health services, and

''(iii) the percentage of such individuals who received such services from such provider (or another such provider).''.

(c) DISCLOSURE OF INFORMATION TO THE PUBLIC.—Title XI is amended by inserting after section 1145 the following new section:

''PUBLIC DISCLOSURE OF CERTAIN INFORMATION ON HOSPITAL FINANCIAL INTEREST AND REFERRAL PATTERNS

''SEC. 1146. The Secretary shall make available to the public, in a form and manner specified by the Secretary, information disclosed to the Secretary pursuant to section 1866(a)(1)(S).''.

(d) EFFECTIVE DATES.—

(1) The amendments made by subsection (a) shall apply to discharges occurring on or after the date which is 90 days after the date of the enactment of this Act.

(2) The Secretary of Health and Human Services shall issue regulations by not later than the date which is 1 year after the date of the enactment of this Act to carry out the amendments made by subsections (b) and (c) and such amendments shall take effect as of such date (on or after the issuance of such regulations) as the Secretary specifies in such regulations.

## CHAPTER 3—CLARIFICATIONS AND TECHNICAL CHANGES

**SEC. 4331. OTHER FRAUD AND ABUSE RELATED PROVISIONS.**

(a) REFERENCE CORRECTION.—(1) Section 1128D(b)(2)(D) (42 U.S.C. 1320a–7d(b)(2)(D)), as added by section 205 of the Health Insurance Portability and Accountability Act of 1996, is amended by striking ''1128B(b)'' and inserting ''1128A(b)''.

(2) Section 1128E(g)(3)(C) (42 U.S.C. 1320a–7e(g)(3)(C)) is amended by striking ''Veterans' Administration'' and inserting ''Department of Veterans Affairs''.

(b) LANGUAGE IN DEFINITION OF CONVICTION.—Section 1128E(g)(5) (42 U.S.C. 1320a–7e(g)(5)), as inserted by section 221(a) of the Health Insurance Portability and Accountability Act of 1996, is amended by striking ''paragraph (4)'' and inserting ''paragraphs (1) through (4)''.

(c) IMPLEMENTATION OF EXCLUSIONS.—Section 1128 (42 U.S.C. 1320a–7) is amended—

(1) in subsection (a), by striking ''any program under title XVIII and shall direct that the following individuals and entities be excluded from participation in any State health care program (as defined in subsection (h))'' and inserting ''any Federal health care program (as defined in section 1128B(f))''; and

(2) in subsection (b), by striking ''any program under title XVIII and may direct that the following individuals and entities be excluded from participation in any State health care program'' and inserting ''any Federal health care program (as defined in section 1128B(f))''.

(d) SANCTIONS FOR FAILURE TO REPORT.—Section 1128E(b) (42 U.S.C. 1320a–7e(b)), as inserted by section 221(a) of the Health Insurance Portability and Accountability Act of 1996, is amended by adding at the end the following:

''(6) SANCTIONS FOR FAILURE TO REPORT.—

''(A) HEALTH PLANS.—Any health plan that fails to report information on an adverse action required to be reported under this subsection shall be subject to a civil money penalty of not more than $25,000 for each such adverse action not reported. Such penalty shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.

''(B) GOVERNMENTAL AGENCIES.—The Secretary shall provide for a publication of a public report that identifies those Government agencies that have failed to report information on adverse actions as required to be reported under this subsection.''.

(e) CLARIFICATION OF TREATMENT OF CERTAIN WAIVERS AND PAYMENTS OF PREMIUMS.—Section 1128A(i)(6) (42 U.S.C. 1320a–7a(i)(6)) is amended—

(1) in subparagraph (A)(iii)—

(A) in subclause (I), by adding ''or'' at the end;

(B) in subclause (II), by striking ''or'' at the end; and

(C) by striking subclause (III);

(2) by redesignating subparagraphs (B) and (C) as subparagraphs (C) and (D); and

(3) by inserting after subparagraph (A) the following:

''(B) any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary;''.

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in this subsection, the amendments made by this section shall be effective as if included in the enactment of the Health Insurance Portability and Accountability Act of 1996.

(2) FEDERAL HEALTH PROGRAM.—The amendments made by subsection (c) shall take effect on the date of the enactment of this Act.

(3) SANCTION FOR FAILURE TO REPORT.—The amendment made by subsection (d) shall apply to failures occurring on or after the date of the enactment of this Act.

## Subtitle E—Provisions Relating to Part A Only

## CHAPTER 1—PAYMENT OF PPS HOSPITALS

**SEC. 4401. PPS HOSPITAL PAYMENT UPDATE.**

(a) IN GENERAL.—Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

(1) by striking ''and'' at the end of subclause (XII), and

(2) by striking subclause (XIII) and inserting the following:

''(XIII) for fiscal year 1998, 0 percent,

''(XIV) for fiscal year 1999, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,

''(XV) for fiscal year 2000, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,

''(XVI) for each of fiscal years 2001 and 2002, the market basket percentage increase minus 1.1 percentage point for hospitals in all areas, and

''(XVII) for fiscal year 2003 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.''.

(b) TEMPORARY RELIEF FOR CERTAIN NON-TEACHING, NON-DSH HOSPITALS.—

(1) IN GENERAL.—In the case of a hospital described in paragraph (2) for its cost reporting period—

(A) beginning in fiscal year 1998 the amount of payment made to the hospital under section 1886(d) of the Social Security Act for discharges occurring during such fiscal year only shall be increased as though the applicable percentage increase (otherwise applicable to discharges occurring during fiscal year 1998 under section 1886(b)(3)(B)(i)(XIII) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)(XIII))) had been increased by 0.5 percentage points; and

(B) beginning in fiscal year 1999 the amount of payment made to the hospital under section 1886(d) of the Social Security Act for discharges occurring during such fiscal year only shall be increased as though the applicable percentage increase (otherwise applicable to discharges occurring during fiscal year 1999 under section 1886(b)(3)(B)(i)(XIII) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)(XIII))) had been increased by 0.3 percentage points.

Subparagraph (A) shall not apply in computing the increase under subparagraph (B)

and neither subparagraph shall affect payment for discharges for any hospital occurring during a fiscal year after fiscal year 1999. Payment increases under this subsection for discharges occurring during a fiscal year are subject to settlement after the close of the fiscal year.

(2) HOSPITALS COVERED.—A hospital described in this paragraph for a cost reporting period is a hospital—

(A) that is described in paragraph (3) for such period;

(B) that is located in a State in which the amount of the aggregate payments under section 1886(d) of such Act for hospitals located in the State and described in paragraph (3) for their cost reporting periods beginning during fiscal year 1995 is less than the aggregate allowable operating costs of inpatient hospital services (as defined in section 1886(a)(4) of such Act) for all such hospitals in such State with respect to such cost reporting periods; and

(C) with respect to which the payments under section 1886(d) of such Act (42 U.S.C. 1395ww(d)) for discharges occurring in the cost reporting period involved, as estimated by the Secretary, is less than the allowable operating costs of inpatient hospital services (as defined in section 1886(a)(4) of such Act (42 U.S.C. 1395ww(a)(4)) for such hospital for such period, as estimated by the Secretary.

(3) NON-TEACHING, NON-DSH HOSPITALS DESCRIBED.—A hospital described in this paragraph for a cost reporting period is a subsection (d) hospital (as defined in section 1886(d)(1)(B) of such Act (42 U.S.C. 1395ww(d)(1)(B))) that—

(A) is not receiving any additional payment amount described in section 1886(d)(5)(F) of such Act (42 U.S.C. 1395ww(d)(5)(F)) for discharges occurring during the period;

(B) is not receiving any additional payment under section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)) or a payment under section 1886(h) of such Act (42 U.S.C. 1395ww(h)) for discharges occurring during the period; and

(C) does not qualify for payment under section 1886(d)(5)(G) of such Act (42 U.S.C. 1395ww(d)(5)(G)) for the period.

**SEC. 4402. MAINTAINING SAVINGS FROM TEMPORARY REDUCTION IN CAPITAL PAYMENTS FOR PPS HOSPITALS.**

Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended by adding at the end the following: ''In addition to the reduction described in the preceding sentence, for discharges occurring on or after October 1, 1997, the Secretary shall apply the budget neutrality adjustment factor used to determine the Federal capital payment rate in effect on September 30, 1995 (as described in section 412.352 of title 42 of the Code of Federal Regulations), to (i) the unadjusted standard Federal capital payment rate (as described in section 412.308(c) of that title, as in effect on September 30, 1997), and (ii) the unadjusted hospital-specific rate (as described in section 412.328(e)(1) of that title, as in effect on September 30, 1997), and, for discharges occurring on or after October 1, 1997, and before September 30, 2002, reduce the rates described in clauses (i) and (ii) by 2.1 percent.''.

**SEC. 4403. DISPROPORTIONATE SHARE.**

(a) IN GENERAL.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(1) in clause (i) by inserting ''and before October 1, 1997'' after ''May 1, 1986'';

(2) in clause (ii), by striking ''The amount'' and inserting ''Subject to clause (ix), the amount''; and

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

''(ix) In the case of discharges occurring—

''(I) during fiscal year 1998, the additional payment amount otherwise determined under clause (ii) shall be reduced by 1 percent;

''(II) during fiscal year 1999, such additional payment amount shall be reduced by 2 percent;

''(III) during fiscal year 2000, such additional payment amount shall be reduced by 3 percent;

''(IV) during fiscal year 2001, such additional payment amount shall be reduced by 4 percent;

''(V) during fiscal year 2002, such additional payment amount shall be reduced by 5 percent; and

''(VI) during fiscal year 2003 and each subsequent fiscal year, such additional payment amount shall be reduced by 0 percent.''.

(b) REPORT ON NEW PAYMENT FORMULA.—

(1) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report that contains a formula for determining additional payment amounts to hospitals under section 1886(d)(5)(F) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)).

(2) FACTORS IN DETERMINATION OF FORMULA.—In determining such formula the Secretary shall—

(A) establish a single threshold for costs incurred by hospitals in serving low-income patients, and

(B) consider the costs described in paragraph (3).

(3) The costs described in this paragraph are as follows:

(A) The costs incurred by the hospital during a period (as determined by the Secretary) of furnishing hospital services to individuals who are entitled to benefits under part A of title XVIII of the Social Security Act and who receive supplemental security income benefits under title XVI of such Act (excluding any supplementation of those benefits by a State under section 1616 of such Act (42 U.S.C. 1382e)).

(B) The costs incurred by the hospital during a period (as so determined) of furnishing hospital services to individuals who receive medical assistance under the State plan under title XIX of such Act and are not entitled to benefits under part A of title XVIII of such Act (including individuals enrolled in a managed care organization (as defined in section 1903(m)(1)(A) of such Act (42 U.S.C. 1396b(m)(1)(A)) or any other managed care plan under such title and individuals who receive medical assistance under such title pursuant to a waiver approved by the Secretary under section 1115 of such Act (42 U.S.C. 1315)).

(c) DATA COLLECTION.—In developing the formula described in subsection (b), the Secretary of Health and Human Services may require any subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B))) receiving additional payments by reason of section 1886(d)(5)(F) of such Act (42 U.S.C. 1395ww(d)(5)(F)) to submit to the Secretary any information that the Secretary determines is necessary to develop such formula.

**SEC. 4404. MEDICARE CAPITAL ASSET SALES PRICE EQUAL TO BOOK VALUE.**

(a) IN GENERAL.—Section 1861(v)(1)(O) (42 U.S.C. 1395x(v)(1)(O)) is amended—

(1) in clause (i)—

(A) by striking ''and (if applicable) a return on equity capital'';

(B) by striking ''hospital or skilled nursing facility'' and inserting ''provider of services'';

(C) by striking ''clause (iv)'' and inserting ''clause (iii)''; and

(D) by striking ''the lesser of the allowable acquisition cost'' and all that follows and inserting ''the historical cost of the asset, as recognized under this title, less depreciation allowed, to the owner of record as of the date of enactment of the Balanced Budget Act of 1997 (or, in the case of an asset not in existence as of that date, the first owner of record of the asset after that date).'';

(2) by striking clause (ii); and

(3) by redesignating clauses (iii) and (iv) as clauses (ii) and (iii), respectively.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to changes of ownership that occur after the third month beginning after the date of enactment of this section.

**SEC. 4405. ELIMINATION OF IME AND DSH PAYMENTS ATTRIBUTABLE TO OUTLIER PAYMENTS.**

(a) INDIRECT MEDICAL EDUCATION.—Section 1886(d)(5)(B)(i)(I) (42 U.S.C. 1395ww(d)(5)(B)(i)(I)) is amended by inserting '', for cases qualifying for additional payment under subparagraph (A)(i),'' before ''the amount paid to the hospital under subparagraph (A)''.

(b) DISPROPORTIONATE SHARE ADJUSTMENTS.—Section 1886(d)(5)(F)(ii)(I) (42 U.S.C. 1395ww(d)(5)(F)(ii)(I)) is amended by inserting '', for cases qualifying for additional payment under subparagraph (A)(i),'' before ''the amount paid to the hospital under subparagraph (A)''.

(c) COST OUTLIER PAYMENTS.—Section 1886(d)(5)(A)(ii) (42 U.S.C. 1395ww(d)(5)(A)(ii)) is amended by striking ''exceed the applicable DRG prospective payment rate'' and inserting ''exceed the sum of the applicable DRG prospective payment rate plus any amounts payable under subparagraphs (B) and (F)''.

(d) EFFECTIVE DATE.—The amendments made by this section apply to discharges occurring after September 30, 1997.

**SEC. 4406. INCREASE BASE PAYMENT RATE TO PUERTO RICO HOSPITALS.**

Section 1886(d)(9)(A) (42 U.S.C. 1395ww(d)(9)(A)) is amended—

(1) in the matter preceding clause (i), by striking ''in a fiscal year beginning on or after October 1, 1987,'',

(2) in clause (i), by striking ''75 percent'' and inserting, ''for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)'', and

(3) in clause (ii), by striking ''25 percent'' and inserting, ''for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987 and September 30, 1997, 25 percent)''.

**SEC. 4407. CERTAIN HOSPITAL DISCHARGES TO POST ACUTE CARE.**

Section 1886(d)(5) (42 U.S.C. 1395ww(d)(5)) is amended—

(1) in subparagraph (I)(ii) by inserting ''not taking in account the effect of subparagraph (J),'' after ''in a fiscal year, ''; and

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

''(J)(i) The Secretary shall treat the term 'transfer case' (as defined in subparagraph (I)(ii)) as including the case of a qualified discharge (as defined in clause (ii)), which is classified within a diagnosis-related group described in clause (iii), and which occurs on or after October 1, 1998. In the case of a qualified discharge for which a substantial portion of the costs of care are incurred in the early days of the inpatient stay (as defined by the Secretary), in no case may the payment amount otherwise provided under this subsection exceed an amount equal to the sum of—

''(I) 50 percent of the amount of payment under this subsection for transfer cases (as established under subparagraph (I)(i)), and

''(II) 50 percent of the amount of payment which would have been made under this sub-

section with respect to the qualified discharge if no transfer were involved.

''(ii) For purposes of clause (i), subject to clause (iii), the term 'qualified discharge' means a discharge classified with a diagnosis-related group (described in clause (iii)) of an individual from a subsection (d) hospital, if upon such discharge the individual—

''(I) is admitted as an inpatient to a hospital or hospital unit that is not a subsection (d) hospital for the provision of inpatient hospital services;

''(II) is admitted to a skilled nursing facility;

''(III) is provided home health services from a home health agency, if such services relate to the condition or diagnosis for which such individual received inpatient hospital services from the subsection (d) hospital, and if such services are provided within an appropriate period (as determined by the Secretary); or

''(IV) for discharges occurring on or after October 1, 2000, the individual receives post discharge services described in clause (iv)(I).

''(iii) Subject to clause (iv), a diagnosis-related group described in this clause is—

''(I) 1 of 10 diagnosis-related groups selected by the Secretary based upon a high volume of discharges classified within such groups and a disproportionate use of post discharge services described in clause (ii); and

''(II) a diagnosis-related group specified by the Secretary under clause (iv)(II).

''(iv) The Secretary shall include in the proposed rule published under subsection (e)(5)(A) for fiscal year 2001, a description of the effect of this subparagraph. The Secretary may include in the proposed rule (and in the final rule published under paragraph (6)) for fiscal year 2001 or a subsequent fiscal year, a description of—

''(I) post-discharge services not described in subclauses (I), (II), and (III) of clause (ii), the receipt of which results in a qualified discharge; and

''(II) diagnosis-related groups described in clause (iii)(I) in addition to the 10 selected under such clause.''.

**SEC. 4408. RECLASSIFICATION OF CERTAIN COUNTIES AS LARGE URBAN AREAS UNDER MEDICARE PROGRAM.**

(a) IN GENERAL.—For purposes of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), the large urban area of Charlotte-Gastonia-Rock Hill-North Carolina-South Carolina may be deemed to include Stanly County, North Carolina.

(b) EFFECTIVE DATE.—This section shall apply with respect to discharges occurring on or after October 1, 1997.

**SEC. 4409. GEOGRAPHIC RECLASSIFICATION FOR CERTAIN DISPROPORTIONATELY LARGE HOSPITALS.**

(a) NEW GUIDELINES FOR RECLASSIFICATION.—Notwithstanding the guidelines published under section 1886(d)(10)(D)(i)(I) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(D)(i)(I)), the Secretary of Health and Human Services shall publish and use alternative guidelines under which a hospital described in subsection (b) qualifies for geographic reclassification under such section for a fiscal year beginning with fiscal year 1998.

(b) HOSPITALS COVERED.—A hospital described in this subsection is a hospital that demonstrates that—

(1) the average hourly wage paid by the hospital is not less than 108 percent of the average hourly wage paid by all other hospitals located in the Metropolitan Statistical Area (or the New England County Metropolitan Area) in which the hospital is located;

(2) not less than 40 percent of the adjusted uninflated wages paid by all hospitals located in such Area is attributable to wages paid by the hospital; and

(3) the hospital submitted an application requesting reclassification for purposes of wage index under section 1886(d)(10)(C) of such Act (42 U.S.C. 1395ww(d)(10)(C)) in each of fiscal years 1992 through 1997 and that such request was approved for each of such fiscal years.

**SEC. 4410. FLOOR ON AREA WAGE INDEX.**

(a) IN GENERAL.—For purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)) may not be less than the area wage index applicable under such section to hospitals located in rural areas in the State in which the hospital is located.

(b) IMPLEMENTATION.—The Secretary of Health and Human Services shall adjust the area wage index referred to in subsection (a) for hospitals not described in such subsection in a manner which assures that the aggregate payments made under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) in a fiscal year for the operating costs of inpatient hospital services are not greater or less than those which would have been made in the year if this section did not apply.

(c) EXCLUSION OF CERTAIN WAGES.—In the case of a hospital that is owned by a municipality and that was reclassified as an urban hospital under section 1886(d)(10) of the Social Security Act for fiscal year 1996, in calculating the hospital's average hourly wage for purposes of geographic reclassification under such section for fiscal year 1998, the Secretary of Health and Human Services shall exclude the general service wages and hours of personnel associated with a skilled nursing facility that is owned by the hospital of the same municipality and that is physically separated from the hospital to the extent that such wages and hours of such personnel are not shared with the hospital and are separately documented. A hospital that applied for and was denied reclassification as an urban hospital for fiscal year 1998, but that would have received reclassification had the exclusion required by this section been applied to it, shall be reclassified as an urban hospital for fiscal year 1998.

## CHAPTER 2—PAYMENT OF PPS-EXEMPT HOSPITALS

### Subchapter A—General Payment Provisions

**SEC. 4411. PAYMENT UPDATE.**

(a) IN GENERAL.—Section 1886(b)(3)(B) (42 U.S.C. 1395ww(b)(3)(B)) is amended—

(1) in clause (ii)—

(A) by striking ''and'' at the end of subclause (V),

(B) by redesignating subclause (VI) as subclause (VIII); and

(C) by inserting after subclause (V), the following subclauses:

''(VI) for fiscal year 1998, is 0 percent;

''(VII) for fiscal years 1999 through 2002, is the applicable update factor specified under clause (vi) for the fiscal year; and''; and

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

''(vi) For purposes of clause (ii)(VII) for a fiscal year, if a hospital's allowable operating costs of inpatient hospital services recognized under this title for the most recent cost reporting period for which information is available—

''(I) is equal to, or exceeds, 110 percent of the hospital's target amount (as determined under subparagraph (A)) for such cost reporting period, the applicable update factor specified under this clause is the market basket percentage;

''(II) exceeds 100 percent, but is less than 110 percent, of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 0.25 percentage points for each percentage point by which such allowable operating costs (expressed as a percentage of such target amount) is less than 110 percent of such target amount;

''(III) is equal to, or less than 100 percent, but exceeds ⅔ of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent or, if greater, the market basket percentage minus 2.5 percentage points; or

''(IV) does not exceed ⅔ of such target amount for the hospital, the applicable update factor specified under this clause is 0 percent.''.

(b) NO EFFECT OF PAYMENT REDUCTION ON EXCEPTIONS AND ADJUSTMENTS.—Section 1886(b)(4)(A)(ii) (42 U.S.C. 1395ww(b)(4)(A)(ii)) is amended by adding at the end the following new sentence: ''In making such reductions, the Secretary shall treat the applicable update factor described in paragraph (3)(B)(vi) for a fiscal year as being equal to the market basket percentage for that year.''.

**SEC. 4412. REDUCTIONS TO CAPITAL PAYMENTS FOR CERTAIN PPS-EXEMPT HOSPITALS AND UNITS.**

Section 1886(g) (42 U.S.C. 1395ww(g)) is amended by adding at the end the following new paragraph:

''(4) In determining the amount of the payments that are attributable to portions of cost reporting periods occurring during fiscal years 1998 through 2002 and that may be made under this title with respect to capital-related costs of inpatient hospital services of a hospital which is described in clause (i), (ii), or (iv) of subsection (d)(1)(B) or a unit described in the matter after clause (v) of such subsection, the Secretary shall reduce the amounts of such payments otherwise determined under this title by 15 percent.''.

**SEC. 4413. REBASING.**

(a) OPTION OF REBASING FOR HOSPITALS IN OPERATION BEFORE 1990.—Section 1886(b)(3)(42 U.S.C. 1395ww(b)(3)) is amended—

(1) in subparagraph (A) by striking ''subparagraphs (C), (D), and (E)'' and inserting ''subparagraph (C) and succeeding subparagraphs'', and

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

''(F)(i) In the case of a hospital (or unit described in the matter following clause (v) of subsection (d)(1)(B)) that received payment under this subsection for inpatient hospital services furnished during cost reporting periods beginning before October 1, 1990, that is within a class of hospital described in clause (iii), and that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, the target amount for the hospital's 12-month cost reporting period beginning during fiscal year 1998 is equal to the average described in clause (ii).

''(ii) The average described in this clause for a hospital or unit shall be determined by the Secretary as follows:

''(I) The Secretary shall determine the allowable operating costs for inpatient hospital services for the hospital or unit for each of the 5 cost reporting periods for which the Secretary has the most recent settled cost reports as of the date of the enactment of this subparagraph.

''(II) The Secretary shall increase the amount determined under subclause (I) for each cost reporting period by the applicable percentage increase under subparagraph (B)(ii) for each subsequent cost reporting period up to the cost reporting period described in clause (i).

''(III) The Secretary shall identify among such 5 cost reporting periods the cost report-

ing periods for which the amount determined under subclause (II) is the highest, and the lowest.

''(IV) The Secretary shall compute the averages of the amounts determined under subclause (II) for the 3 cost reporting periods not identified under subclause (III).

''(iii) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

''(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

''(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

''(III) Hospitals described in clause (iii) of such subsection.

''(IV) Hospitals described in clause (iv) of such subsection.

''(V) Hospitals described in clause (v) of such subsection.''.

(b) CERTAIN LONG-TERM CARE HOSPITALS.—Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)), as amended by subsection (a), is amended by adding at the end the following new subparagraph:

''(G)(i) In the case of a qualified long-term care hospital (as defined in clause (ii)) that elects (in a form and manner determined by the Secretary) this subparagraph to apply to the hospital, the target amount for the hospital's 12-month cost reporting period beginning during fiscal year 1998 is equal to the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period beginning during fiscal year 1996, increased by the applicable percentage increase for the cost reporting period beginning during fiscal year 1997.

''(ii) In clause (i), a 'qualified long-term care hospital' means, with respect to a cost reporting period, a hospital described in clause (iv) of subsection (d)(1)(B) during each of the 2 cost reporting periods for which the Secretary has the most recent settled cost reports as of the date of the enactment of this subparagraph for each of which—

''(I) the hospital's allowable operating costs of inpatient hospital services recognized under this title exceeded 115 percent of the hospital's target amount, and

''(II) the hospital would have a disproportionate patient percentage of at least 70 percent (as determined by the Secretary under subsection (d)(5)(F)(vi)) if the hospital were a subsection (d) hospital.''.

**SEC. 4414. CAP ON TEFRA LIMITS.**

Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)), as amended by section 4413, is amended by adding at the end the following new subparagraph:

''(H)(i) In the case of a hospital or unit that is within a class of hospital described in clause (iv), the Secretary shall estimate the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods ending during fiscal year 1996.

''(ii) The Secretary shall update the amount determined under clause (i), for each cost reporting period after the cost reporting period described in such clause and up to the first cost reporting period beginning on or after October 1, 1997, by a factor equal to the market basket percentage increase.

''(iii) For cost reporting periods beginning during each of fiscal years 1999 through 2002, the Secretary shall update such amount by a factor equal to the market basket percentage increase.

''(iv) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

''(I) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

''(II) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

''(III) Hospitals described in clause (iv) of such subsection.''.

**SEC. 4415. BONUS AND RELIEF PAYMENTS.**

(a) CHANGE IN BONUS PAYMENT.—Section 1886(b)(1) (42 U.S.C. 1395ww(b)(1)) is amended in subparagraph (A) by striking all that follows ''plus—'' and inserting the following:

''(i) 15 percent of the amount by which the target amount exceeds the amount of the operating costs, or

''(ii) 2 percent of the target amount,

whichever is less;''.

(b) CONTINUOUS IMPROVEMENT BONUS PAYMENTS.—Section 1886(b) (42 U.S.C. 1395ww(b)) is amended—

(1) in paragraph (1), by inserting ''plus the amount, if any, provided under paragraph (2)'' before ''except that in no case''; and

(2) by inserting after paragraph (1), the following new paragraph:

''(2)(A) In addition to the payment computed under paragraph (1), in the case of an eligible hospital (described in subparagraph (B)) for a cost reporting period beginning on or after October 1, 1997, the amount of payment on a per discharge basis under paragraph (1) shall be increased by the lesser of—

''(i) 50 percent of the amount by which the operating costs are less than the expected costs (as defined in subparagraph (D)) for the period; or

''(ii) 1 percent of the target amount for the period.

''(B) For purposes of this paragraph, an 'eligible hospital' means with respect to a cost reporting period, a hospital—

''(i) that has received payments under this subsection for at least 3 full cost reporting periods before that cost reporting period, and

''(ii) whose operating costs for the period are less than the least of its target amount, its trended costs (as defined in subparagraph (C)), or its expected costs (as defined in subparagraph (D)) for the period.

''(C) For purposes of subparagraph (B)(ii), the term 'trended costs' means for a hospital cost reporting period ending in a fiscal year—

''(i) in the case of a hospital for which its cost reporting period ending in fiscal year 1996 was its third or subsequent full cost reporting period for which it receives payments under this subsection, the lesser of the operating costs or target amount for that hospital for its cost reporting period ending in fiscal year 1996, or

''(ii) in the case of any other hospital, the operating costs for that hospital for its third full cost reporting period for which it receives payments under this subsection,

increased (in a compounded manner) for each succeeding fiscal year (through the fiscal year involved) by the market basket percentage increase for the fiscal year.

''(D) For purposes of this paragraph, the term 'expected costs', with respect to the cost reporting period ending in a fiscal year, means the lesser of the operating costs of inpatient hospital services or target amount per discharge for the previous cost reporting period updated by the market basket percentage increase (as defined in paragraph (3)(B)(iii)) for the fiscal year.''.

(c) CHANGE IN RELIEF PAYMENTS.—Section 1886(b)(1) (42 U.S.C. 1395ww(b)(1)), as amended in subsections (a) and (b), is further amended—

(1) by redesignating subparagraph (B) as subparagraph (C)

(2) in subparagraph (C), as so redesignated—

(A) by striking ''greater than the target amount'' and inserting ''greater than 110 percent of the target amount'', and

(B) by striking ''exceed the target amount'' and inserting ''exceed 110 percent of the target amount'', and

(3) by inserting after subparagraph (A), the following new subparagraph:

''(B) are greater than the target amount but do not exceed 110 percent of the target amount, the amount of the payment with respect to those operating costs payable under part A on a per discharge basis shall equal the target amount; or''.

(d) REPORT.—Not later than October 1, 1999, the Secretary of Health and Human Services shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report that describes the effect of the amendments to section 1886(b)(1) of the Social Security Act (42 U.S.C. 1395ww(b)(1)), made under this section, on psychiatric hospitals (as defined in section 1886(d)(1)(B)(i) of such Act (42 U.S.C. 1395ww(d)(1)(B)(i)) that have approved medical residency training programs under title XVIII of such Act (42 U.S.C. 1395 et seq.)).

(e) EFFECTIVE DATE.—The amendments made by subsections (a) and (c) shall apply with respect to cost reporting periods beginning on or after October 1, 1997.

**SEC. 4416. CHANGE IN PAYMENT AND TARGET AMOUNT FOR NEW PROVIDERS.**

Section 1886(b) (42 U.S.C. 1395ww(b)) is amended—

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

''(7)(A) Notwithstanding paragraph (1), in the case of a hospital or unit that is within a class of hospital described in subparagraph (B) which first receives payments under this section on or after October 1, 1997—

''(i) for each of the first 2 cost reporting periods for which the hospital has a settled cost report, the amount of the payment with respect to operating costs described in paragraph (1) under part A on a per discharge or per admission basis (as the case may be) is equal to the lesser of—

''(I) the amount of operating costs for such respective period, or

''(II) 110 percent of the national median of the target amount for hospitals in the same class as the hospital for cost reporting periods ending during fiscal year 1996, updated by the hospital market basket increase percentage to the fiscal year in which the hospital first received payments under this section, as adjusted under subparagraph (C); and

''(ii) for purposes of computing the target amount for the subsequent cost reporting period, the target amount for the preceding cost reporting period is equal to the amount determined under clause (i) for such preceding period.

''(B) For purposes of this paragraph, each of the following shall be treated as a separate class of hospital:

''(i) Hospitals described in clause (i) of subsection (d)(1)(B) and psychiatric units described in the matter following clause (v) of such subsection.

''(ii) Hospitals described in clause (ii) of such subsection and rehabilitation units described in the matter following clause (v) of such subsection.

''(iii) Hospitals described in clause (iv) of such subsection.

''(C) In applying subparagraph (A)(i)(II) in the case of a hospital or unit, the Secretary shall provide for an appropriate adjustment to the labor-related portion of the amount determined under such subparagraph to take into account differences between average wage-related costs in the area of the hospital and the national average of such costs within the same class of hospital.''; and

(2) in paragraph (3)(A), as amended in sections 4413 and 4414, by inserting ''and in paragraph (7)(A)(ii),'' before ''for purposes of''.

**SEC. 4417. TREATMENT OF CERTAIN LONG-TERM CARE HOSPITALS.**

(a) IN GENERAL.—(1) Section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) is amended by adding at the end the following new sentence: ''A hospital that was classified by the Secretary on or before September 30, 1995, as a hospital described in clause (iv) shall continue to be so classified notwithstanding that it is located in the same building as, or on the same campus as, another hospital.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to discharges occurring on or after October 1, 1995.

(b) CERTAIN LONG-TERM CARE HOSPITALS THAT TREAT CANCER PATIENTS.—(1) Section 1886(d)(1)(B)(iv) (42 U.S.C. 1395ww(d)(1)(B)(iv)) is amended—

(A) by inserting ''(I)'' after ''(iv)''; and

(B) by adding at the end the following:

''(II) a hospital that first received payment under this subsection in 1986 which has an average inpatient length of stay (as determined by the Secretary) of greater than 20 days and that has 80 percent or more of its annual medicare inpatient discharges with a principal diagnosis that reflects a finding of neoplastic disease in the 12-month cost reporting period ending in fiscal year 1997, or''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to cost reporting periods beginning on or after the date of the enactment of this Act.

**SEC. 4418. TREATMENT OF CERTAIN CANCER HOSPITALS.**

(a) IN GENERAL.—Section 1886(d)(1) (42 U.S.C. 1395ww(d)(1)) is amended—

(1) in subparagraph (B)(v)—

(A) by inserting ''(I)'' after ''(v)'';

(B) by striking the semicolon at the end and inserting '', or''; and

(C) by adding at the end the following:

''(II) a hospital that was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983, that is located in a State which, as of December 19, 1989, was not operating a demonstration project under section 1814(b), that applied and was denied, on or before December 31, 1990, for classification as a hospital involved extensively in treatment for or research on cancer under this clause (as in effect on the day before the date of the enactment of this subclause), that as of the date of the enactment of this subclause, is licensed for less than 50 acute care beds, and that demonstrates for the 4-year period ending on December 31, 1996, that at least 50 percent of its total discharges have a principal finding of neoplastic disease, as defined in subparagraph (E);'' and

(2) by adding at the end the following:

''(E) For purposes of subparagraph (B)(v)(II) only, the term 'principal finding of neoplastic disease' means the condition established after study to be chiefly responsible for occasioning the admission of a patient to a hospital, except that only discharges with ICD–9–CM principal diagnosis codes of 140 through 239, V58.0, V58.1, V66.1, V66.2, or 990 will be considered to reflect such a principal diagnosis.''.

(b) PAYMENT.—

(1) APPLICATION TO COST REPORTING PERIODS.—Any classification by reason of section 1886(d)(1)(B)(v)(II) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(v)(II)) (as added by subsection (a)) shall apply to all cost reporting periods beginning on or after January 1, 1991.

(2) BASE YEAR.—Notwithstanding the provisions of section 1886(b)(3)(E) of such Act (42 U.S.C. 1395ww(b)(3)(E)) or other provisions to the contrary, the base cost reporting period for purposes of determining the target amount for any hospital classified by reason of section 1886(d)(1)(B)(v)(II) of such Act shall be either—

(A) the hospital's cost reporting period beginning during fiscal year 1990, or

(B) pursuant to an election under 1886(b)(3)(G) of such Act (42 U.S.C. 1395ww(b)(3)(G)), as added in section 4413(b), the period provided for under such section.

(3) DEADLINE FOR PAYMENTS.—Any payments owed to a hospital by reason of this subsection shall be made expeditiously, but in no event later than 1 year after the date of the enactment of this Act.

**SEC. 4419. ELIMINATION OF EXEMPTIONS FOR CERTAIN HOSPITALS.**

(a) REDUCTION OF EXEMPTIONS.—

(1) IN GENERAL.—Section 1886(b)(4)(A)(i) (42 U.S.C. 1395ww(b)(4)(A)(i)) is amended in the first sentence by striking ''The Secretary shall provide for an exemption from, or an exception and adjustment to, '' and inserting ''The Secretary shall provide for an exception and adjustment to (and in the case of a hospital or unit described in subsection (d)(1)(B)(iii), may provide an exemption from)''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to hospitals or units that first qualify as a hospital or unit described in section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) for cost reporting periods beginning on or after October 1, 1997.

(b) REPORT ON EXCEPTIONS.—The Secretary of Health and Human Services shall publish annually in the Federal Register a report describing the total amount of payments made to hospitals by reason of section 1886(b)(4) of the Social Security Act (42 U.S.C. 1395ww(b)(4)), as amended by subsection (a), ending during the previous fiscal year.

**Subchapter B—Prospective Payment System for PPS-Exempt Hospitals**

**SEC. 4421. PROSPECTIVE PAYMENT FOR INPATIENT REHABILITATION HOSPITAL SERVICES.**

(a) IN GENERAL.—Section 1886 (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

''(j) PROSPECTIVE PAYMENT FOR INPATIENT REHABILITATION SERVICES.—

''(1) PAYMENT DURING TRANSITION PERIOD.—

''(A) IN GENERAL.—Notwithstanding section 1814(b), but subject to the provisions of section 1813, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation hospital or a rehabilitation unit (in this subsection referred to as a 'rehabilitation facility'), in a cost reporting period beginning on or after October 1, 2000, and before October 1, 2002, is equal to the sum of—

''(i) the TEFRA percentage (as defined in subparagraph (C)) of the amount that would have been paid under part A with respect to such costs if this subsection did not apply, and

''(ii) the prospective payment percentage (as defined in subparagraph (C)) of the product of (I) the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs, and (II) the number of such payment units occurring in the cost reporting period.

''(B) FULLY IMPLEMENTED SYSTEM.—Notwithstanding section 1814(b), but subject to the provisions of section 1813, the amount of the payment with respect to the operating and capital costs of inpatient hospital services of a rehabilitation facility for a payment unit in a cost reporting period beginning on or after October 1, 2002, is equal to the per unit payment rate established under this subsection for the fiscal year in which the payment unit of service occurs.

''(C) TEFRA AND PROSPECTIVE PAYMENT PERCENTAGES SPECIFIED.—For purposes of subparagraph (A), for a cost reporting period beginning—

''(i) on or after October 1, 2000, and before October 1, 2001, the 'TEFRA percentage' is 66⅔ percent and the 'prospective payment percentage' is 33⅓ percent; and

''(ii) on or after October 1, 2001, and before October 1, 2002, the 'TEFRA percentage' is 33⅓ percent and the 'prospective payment percentage' is 66⅔ percent.

''(D) PAYMENT UNIT.—For purposes of this subsection, the term 'payment unit' means a discharge, day of inpatient hospital services, or other unit of payment defined by the Secretary.

''(2) PATIENT CASE MIX GROUPS.—

''(A) ESTABLISHMENT.—The Secretary shall establish—

''(i) classes of patients of rehabilitation facilities (each in this subsection referred to as a 'case mix group'), based on such factors as the Secretary deems appropriate, which may include impairment, age, related prior hospitalization, comorbidities, and functional capability of the patient; and

''(ii) a method of classifying specific patients in rehabilitation facilities within these groups.

''(B) WEIGHTING FACTORS.—For each case mix group the Secretary shall assign an appropriate weighting which reflects the relative facility resources used with respect to patients classified within that group compared to patients classified within other groups.

''(C) ADJUSTMENTS FOR CASE MIX.—

''(i) IN GENERAL.—The Secretary shall from time to time adjust the classifications and weighting factors established under this paragraph as appropriate to reflect changes in treatment patterns, technology, case mix, number of payment units for which payment is made under this title, and other factors which may affect the relative use of resources. Such adjustments shall be made in a manner so that changes in aggregate payments under the classification system are a result of real changes and are not a result of changes in coding that are unrelated to real changes in case mix.

''(ii) ADJUSTMENT.—Insofar as the Secretary determines that such adjustments for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under the classification system during the fiscal year that are a result of changes in the coding or classification of patients that do not reflect real changes in case mix, the Secretary shall adjust the per payment unit payment rate for subsequent years so as to eliminate the effect of such coding or classification changes.

''(D) DATA COLLECTION.—The Secretary is authorized to require rehabilitation facilities that provide inpatient hospital services to submit such data as the Secretary deems necessary to establish and administer the prospective payment system under this subsection.

''(3) PAYMENT RATE.—

''(A) IN GENERAL.—The Secretary shall determine a prospective payment rate for each payment unit for which such rehabilitation facility is entitled to receive payment under this title. Subject to subparagraph (B), such rate for payment units occurring during a fiscal year shall be based on the average payment per payment unit under this title for inpatient operating and capital costs of rehabilitation facilities using the most recent data available (as estimated by the Secretary as of the date of establishment of the system) adjusted—

''(i) by updating such per-payment-unit amount to the fiscal year involved by the weighted average of the applicable percentage increases provided under subsection (b)(3)(B)(ii) (for cost reporting periods begin-

ning during the fiscal year) covering the period from the midpoint of the period for such data through the midpoint of fiscal year 2000 and by an increase factor (described in subparagraph (C)) specified by the Secretary for subsequent fiscal years up to the fiscal year involved;

''(ii) by reducing such rates by a factor equal to the proportion of payments under this subsection (as estimated by the Secretary) based on prospective payment amounts which are additional payments described in paragraph (4) (relating to outlier and related payments);

''(iii) for variations among rehabilitation facilities by area under paragraph (6);

''(iv) by the weighting factors established under paragraph (2)(B); and

''(v) by such other factors as the Secretary determines are necessary to properly reflect variations in necessary costs of treatment among rehabilitation facilities.

''(B) BUDGET NEUTRAL RATES.—The Secretary shall establish the prospective payment amounts under this subsection for payment units during fiscal years 2001 and 2002 at levels such that, in the Secretary's estimation, the amount of total payments under this subsection for such fiscal years (including any payment adjustments pursuant to paragraphs (4) and (6)) shall be equal to 98 percent of the amount of payments that would have been made under this title during the fiscal years for operating and capital costs of rehabilitation facilities had this subsection not been enacted. In establishing such payment amounts, the Secretary shall consider the effects of the prospective payment system established under this subsection on the total number of payment units from rehabilitation facilities and other factors described in subparagraph (A).

''(C) INCREASE FACTOR.—For purposes of this subsection for payment units in each fiscal year (beginning with fiscal year 2001), the Secretary shall establish an increase factor. Such factor shall be based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under this subsection, which may be the market basket percentage increase described in subsection (b)(3)(B)(iii).

''(4) OUTLIER AND SPECIAL PAYMENTS.—

''(A) OUTLIERS.—

''(i) IN GENERAL.—The Secretary may provide for an additional payment to a rehabilitation facility for patients in a case mix group, based upon the patient being classified as an outlier based on an unusual length of stay, costs, or other factors specified by the Secretary.

''(ii) PAYMENT BASED ON MARGINAL COST OF CARE.—The amount of such additional payment under clause (i) shall be determined by the Secretary and shall approximate the marginal cost of care beyond the cutoff point applicable under clause (i).

''(iii) TOTAL PAYMENTS.—The total amount of the additional payments made under this subparagraph for payment units in a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on prospective payment rates for payment units in that year.

''(B) ADJUSTMENT.—The Secretary may provide for such adjustments to the payment amounts under this subsection as the Secretary deems appropriate to take into account the unique circumstances of rehabilitation facilities located in Alaska and Hawaii.

''(5) PUBLICATION.—The Secretary shall provide for publication in the Federal Register, on or before August 1 before each fiscal year (beginning with fiscal year 2001), of the classification and weighting factors for case mix groups under paragraph (2) for such fiscal year and a description of the methodology and data used in computing the prospective payment rates under this subsection for that fiscal year.

''(6) AREA WAGE ADJUSTMENT.—The Secretary shall adjust the proportion (as estimated by the Secretary from time to time) of rehabilitation facilities' costs which are attributable to wages and wage-related costs, of the prospective payment rates computed under paragraph (3) for area differences in wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the rehabilitation facility compared to the national average wage level for such facilities. Not later than October 1, 2001 (and at least every 36 months thereafter), the Secretary shall update the factor under the preceding sentence on the basis of information available to the Secretary (and updated as appropriate) of the wages and wage-related costs incurred in furnishing rehabilitation services. Any adjustments or updates made under this paragraph for a fiscal year shall be made in a manner that assures that the aggregated payments under this subsection in the fiscal year are not greater or less than those that would have been made in the year without such adjustment.

''(7) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the establishment of—

''(A) case mix groups, of the methodology for the classification of patients within such groups, and of the appropriate weighting factors thereof under paragraph (2),

''(B) the prospective payment rates under paragraph (3),

''(C) outlier and special payments under paragraph (4), and

''(D) area wage adjustments under paragraph (6).''.

(b) CONFORMING AMENDMENTS.—Section 1886(b) (42 U.S.C. 1395ww(b)) is amended—

(1) in paragraph (1), by inserting ''and other than a rehabilitation facility described in subsection (j)(1)'' after ''subsection (d)(1)(B)'', and

(2) in paragraph (3)(B)(i), by inserting ''and subsection (j)'' after ''For purposes of subsection (d)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 2000, except that the Secretary of Health and Human Services may require the submission of data under section 1886(j)(2)(D) of the Social Security Act (as added by subsection (a)) on and after the date of the enactment of this section.

**SEC. 4422. DEVELOPMENT OF PROPOSAL ON PAYMENTS FOR LONG-TERM CARE HOSPITALS.**

(a) IN GENERAL.—

(1) LEGISLATIVE PROPOSAL.—The Secretary of Health and Human Services shall develop a legislative proposal for establishing a case-mix adjusted prospective payment system for payment of long-term care hospitals described in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)) under the medicare program. Such system shall include an adequate patient classification system that reflects the differences in patient resource use and costs among such hospitals.

(2) COLLECTION OF DATA AND EVALUATION.—In developing the legislative proposal described in paragraph (1), the Secretary—

(A) may require such long-term care hospitals to submit such information to the Secretary as the Secretary may require to develop the proposal; and

(B) shall consider several payment methodologies, including the feasibility of expanding the current diagnosis-related groups and prospective payment system established under section 1886(d) of the Social Security Act to apply to payments under the medicare program to long-term care hospitals.

(b) REPORT.—Not later than October 1, 1999, the Secretary shall submit to the appropriate committees of Congress a report that includes the legislative proposal developed under subsection (a)(1).

## CHAPTER 3—PAYMENT FOR SKILLED NURSING FACILITIES

**SEC. 4431. EXTENSION OF COST LIMITS.**

The last sentence of section 1888(a) (42 U.S.C. 1395yy(a)) is amended by striking ''subsection'' the last place it appears and all that follows and inserting ''subsection, except that the limits effective for cost reporting periods beginning on or after October 1, 1997, shall be based on the limits effective for cost reporting periods beginning on or after October 1, 1996.''.

**SEC. 4432. PROSPECTIVE PAYMENT FOR SKILLED NURSING FACILITY SERVICES.**

(a) IN GENERAL.—Section 1888 (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

''(e) PROSPECTIVE PAYMENT.—

''(1) PAYMENT PROVISION.—Notwithstanding any other provision of this title, subject to paragraph (7), the amount of the payment for all costs (as defined in paragraph (2)(B)) of covered skilled nursing facility services (as defined in paragraph (2)(A)) for each day of such services furnished—

''(A) in a cost reporting period during the transition period (as defined in paragraph (2)(E)), is equal to the sum of—

''(i) the non-Federal percentage of the facility-specific per diem rate (computed under paragraph (3)), and

''(ii) the Federal percentage of the adjusted Federal per diem rate (determined under paragraph (4)) applicable to the facility; and

''(B) after the transition period is equal to the adjusted Federal per diem rate applicable to the facility.

''(2) DEFINITIONS.—For purposes of this subsection:

''(A) COVERED SKILLED NURSING FACILITY SERVICES.—

''(i) IN GENERAL.—The term 'covered skilled nursing facility services'—

''(I) means post-hospital extended care services as defined in section 1861(i) for which benefits are provided under part A; and

''(II) includes all items and services (other than services described in clause (ii)) for which payment may be made under part B and which are furnished to an individual who is a resident of a skilled nursing facility during the period in which the individual is provided covered post-hospital extended care services.

''(ii) SERVICES EXCLUDED.—Services described in this clause are physicians' services, services described by clauses (i) through (iii) of section 1861(s)(2)(K), certified nurse-midwife services, qualified psychologist services, services of a certified registered nurse anesthetist, items and services described in subparagraphs (F) and (O) of section 1861(s)(2), and, only with respect to services furnished during 1998, the transportation costs of electrocardiogram equipment for electrocardiogram test services (HCPCS Code R0076). Services described in this clause do not include any physical, occupational, or speech-language therapy services regardless of whether or not the services are furnished by, or under the supervision of, a physician or other health care professional.

''(B) ALL COSTS.—The term 'all costs' means routine service costs, ancillary costs, and capital-related costs of covered skilled nursing facility services, but does not include costs associated with approved educational activities.

''(C) NON-FEDERAL PERCENTAGE; FEDERAL PERCENTAGE.—For—

''(i) the first cost reporting period (as defined in subparagraph (D)) of a facility, the 'non-Federal percentage' is 75 percent and the 'Federal percentage' is 25 percent;

''(ii) the next cost reporting period of such facility, the 'non-Federal percentage' is 50 percent and the 'Federal percentage' is 50 percent; and

''(iii) the subsequent cost reporting period of such facility, the 'non-Federal percentage' is 25 percent and the 'Federal percentage' is 75 percent.

''(D) FIRST COST REPORTING PERIOD.—The term 'first cost reporting period' means, with respect to a skilled nursing facility, the first cost reporting period of the facility beginning on or after July 1, 1998.

''(E) TRANSITION PERIOD.—

''(i) IN GENERAL.—The term 'transition period' means, with respect to a skilled nursing facility, the 3 cost reporting periods of the facility beginning with the first cost reporting period.

''(ii) TREATMENT OF NEW SKILLED NURSING FACILITIES.—In the case of a skilled nursing facility that first received payment for services under this title on or after October 1, 1995, payment for such services shall be made under this subsection as if all services were furnished after the transition period.

''(3) DETERMINATION OF FACILITY SPECIFIC PER DIEM RATES.—The Secretary shall determine a facility-specific per diem rate for each skilled nursing facility not described in paragraph (2)(E)(ii) for a cost reporting period as follows:

''(A) DETERMINING BASE PAYMENTS.—The Secretary shall determine, on a per diem basis, the total of—

''(i) the allowable costs of extended care services for the facility for cost reporting periods beginning in fiscal year 1995, including costs associated with facilities described in subsection (d), with appropriate adjustments (as determined by the Secretary) to non-settled cost reports, and

''(ii) an estimate of the amounts that would be payable under part B (disregarding any applicable deductibles, coinsurance, and copayments) for covered skilled nursing facility services described in paragraph (2)(A)(i)(II) furnished during such period to an individual who is a resident of the facility, regardless of whether or not the payment was made to the facility or to another entity.

In making appropriate adjustments under clause (i), the Secretary shall take into account exceptions and shall take into account exemptions but, with respect to exemptions, only to the extent that routine costs do not exceed 150 percent of the routine cost limits otherwise applicable but for the exemption.

''(B) UPDATE TO FIRST COST REPORTING PERIOD.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase minus 1 percentage point.

''(ii) CERTAIN DEMONSTRATION PROJECTS.—In the case of a facility participating in the Nursing Home Case-Mix and Quality Demonstration (RUGS–III), there shall be substituted for the amount described in clause (i) the RUGS–III rate received by the facility for 1997.

''(C) UPDATING TO APPLICABLE COST REPORTING PERIOD.—The Secretary shall update the amount determined under subparagraph (B) for each cost reporting period beginning with the first cost reporting period and up to and including the cost reporting period involved by a factor equal to the facility-specific update factor.

''(D) FACILITY-SPECIFIC UPDATE FACTOR.—For purposes of this paragraph, the 'facility-specific update factor' for cost reporting periods beginning during—

''(i) during each of fiscal years 1998 and 1999, is equal to the skilled nursing facility market basket percentage increase for such fiscal year minus 1 percentage point, and

''(ii) during each subsequent fiscal year is equal to the skilled nursing facility market basket percentage increase for such fiscal year.

''(4) FEDERAL PER DIEM RATE.—

''(A) DETERMINATION OF HISTORICAL PER DIEM FOR FACILITIES.—For each skilled nursing facility that received payments for post-hospital extended care services during a cost reporting period beginning in fiscal year 1995 and that was subject to (and not exempted from) the per diem limits referred to in paragraph (1) or (2) of subsection (a) (and facilities described in subsection (d)), the Secretary shall estimate, on a per diem basis for such cost reporting period, the total of—

''(i) the allowable costs of extended care services (excluding exceptions payments) for the facility for cost reporting periods beginning in 1995 with appropriate adjustments (as determined by the Secretary) to non-settled cost reports, and

''(ii) an estimate of the amounts that would be payable under part B (disregarding any applicable deductibles, coinsurance, and copayments) for covered skilled nursing facility services described in paragraph (2)(A)(i)(II) furnished during such period to an individual who is a resident of the facility, regardless of whether or not the payment was made to the facility or to another entity.

''(B) UPDATE TO FIRST FISCAL YEAR.—The Secretary shall update the amount determined under subparagraph (A), for each cost reporting period after the cost reporting period described in subparagraph (A)(i) and up to the first cost reporting period by a factor equal to the skilled nursing facility market basket percentage increase reduced (on an annualized basis) by 1 percentage point.

''(C) COMPUTATION OF STANDARDIZED PER DIEM RATE.—The Secretary shall standardize the amount updated under subparagraph (B) for each facility by—

''(i) adjusting for variations among facilities by area in the average facility wage level per diem, and

''(ii) adjusting for variations in case mix per diem among facilities.

''(D) COMPUTATION OF WEIGHTED AVERAGE PER DIEM RATES.—

''(i) ALL FACILITIES.—The Secretary shall compute a weighted average per diem rate for all facilities by computing an average of the standardized amounts computed under subparagraph (C), weighted for each facility by the number of days of extended care services furnished during the cost reporting period referred to in subparagraph (A).

''(ii) FREESTANDING FACILITIES.—The Secretary shall compute a weighted average per diem rate for freestanding facilities by computing an average of the standardized amounts computed under subparagraph (C) only for such facilities, weighted for each facility by the number of days of extended care services furnished during the cost reporting period referred to in subparagraph (A).

''(iii) SEPARATE COMPUTATION.—The Secretary may compute and apply such averages separately for facilities located in urban and rural areas (as defined in section 1886(d)(2)(D)).

''(E) UPDATING.—

''(i) INITIAL PERIOD.—For the initial period beginning on July 1, 1998, and ending on September 30, 1999, the Secretary shall compute for skilled nursing facilities an unadjusted federal per diem rate equal to the average of the weighted average per diem rates computed under clauses (i) and (ii) of subparagraph (D), increased by skilled nursing facility market basket percentage change for such period minus 1 percentage point.

''(ii) SUBSEQUENT FISCAL YEARS.—The Secretary shall compute an unadjusted federal per diem rate equal to the federal per diem rate computed under this subparagraph—

''(I) for fiscal year 2000, the rate computed for the initial period described in clause (i), increased by the skilled nursing facility market basket percentage change for the initial period minus 1 percentage point;

''(II) for each of fiscal years 2001 and 2002, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved minus 1 percentage point; and

''(III) for each subsequent fiscal year, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved.

''(F) ADJUSTMENT FOR CASE MIX CREEP.—Insofar as the Secretary determines that the adjustments under subparagraph (G)(i) for a previous fiscal year (or estimates that such adjustments for a future fiscal year) did (or are likely to) result in a change in aggregate payments under this subsection during the fiscal year that are a result of changes in the coding or classification of residents that do not reflect real changes in case mix, the Secretary may adjust unadjusted Federal per diem rates for subsequent fiscal years so as to eliminate the effect of such coding or classification changes.

''(G) DETERMINATION OF FEDERAL RATE.—The Secretary shall compute for each skilled nursing facility for each fiscal year (beginning with the initial period described in subparagraph (E)(i)) an adjusted Federal per diem rate equal to the unadjusted Federal per diem rate determined under subparagraph (E), as adjusted under subparagraph (F), and as further adjusted as follows:

''(i) ADJUSTMENT FOR CASE MIX.—The Secretary shall provide for an appropriate adjustment to account for case mix. Such adjustment shall be based on a resident classification system, established by the Secretary, that accounts for the relative resource utilization of different patient types. The case mix adjustment shall be based on resident assessment data and other data that the Secretary considers appropriate.

''(ii) ADJUSTMENT FOR GEOGRAPHIC VARIATIONS IN LABOR COSTS.—The Secretary shall adjust the portion of such per diem rate attributable to wages and wage-related costs for the area in which the facility is located compared to the national average of such costs using an appropriate wage index as determined by the Secretary. Such adjustment shall be done in a manner that does not result in aggregate payments under this subsection that are greater or less than those that would otherwise be made if such adjustment had not been made.

''(H) PUBLICATION OF INFORMATION ON PER DIEM RATES.—The Secretary shall provide for publication in the Federal Register, before May 1, 1998 (with respect to fiscal period described in subparagraph (E)(i)) and before the August 1 preceding each succeeding fiscal year (with respect to that succeeding fiscal year), of—

''(i) the unadjusted Federal per diem rates to be applied to days of covered skilled nursing facility services furnished during the fiscal year,

''(ii) the case mix classification system to be applied under subparagraph (G)(i) with respect to such services during the fiscal year, and

''(iii) the factors to be applied in making the area wage adjustment under subparagraph (G)(ii) with respect to such services.

''(5) SKILLED NURSING FACILITY MARKET BASKET INDEX AND PERCENTAGE.—For purposes of this subsection:

''(A) SKILLED NURSING FACILITY MARKET BASKET INDEX.—The Secretary shall establish a skilled nursing facility market basket index that reflects changes over time in the prices of an appropriate mix of goods and services included in covered skilled nursing facility services.

''(B) SKILLED NURSING FACILITY MARKET BASKET PERCENTAGE.—The term 'skilled nursing facility market basket percentage' means, for a fiscal year or other annual period and as calculated by the Secretary, the percentage change in the skilled nursing facility market basket index (established under subparagraph (A)) from the midpoint of the prior fiscal year (or period) to the midpoint of the fiscal year (or other period) involved.

''(6) SUBMISSION OF RESIDENT ASSESSMENT DATA.—A skilled nursing facility, or a facility described in paragraph (7)(B), shall provide the Secretary, in a manner and within the timeframes prescribed by the Secretary, the resident assessment data necessary to develop and implement the rates under this subsection. For purposes of meeting such requirement, a skilled nursing facility, or a facility described in paragraph (7), may submit the resident assessment data required under section 1819(b)(3), using the standard instrument designated by the State under section 1819(e)(5).

''(7) TRANSITION FOR MEDICARE SWING BED HOSPITALS.—

''(A) IN GENERAL.—The Secretary shall determine an appropriate manner in which to apply this subsection to the facilities described in subparagraph (B), taking into account the purposes of this subsection, and shall provide that at the end of the transition period (as defined in paragraph (2)(E)) such facilities shall be paid only under this subsection. Payment shall not be made under this subsection to such facilities for cost reporting periods beginning before such date (not earlier than July 1, 1999) as the Secretary specifies.

''(B) FACILITIES DESCRIBED.—The facilities described in this subparagraph are facilities that have in effect an agreement described in section 1883, for which payment is made for the furnishing of extended care services on a reasonable cost basis under section 1814(l) (as in effect on and after such date).

''(8) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

''(A) the establishment of Federal per diem rates under paragraph (4), including the computation of the standardized per diem rates under paragraph (4)(C), adjustments and corrections for case mix under paragraphs (4)(F) and (4)(G)(i), and adjustments for variations in labor-related costs under paragraph (4)(G)(ii);

''(B) the establishment of facility specific rates before January 1, 1999, (except any determination of costs paid under part A of this title); and

''(C) the establishment of transitional amounts under paragraph (7).''.

(b) CONSOLIDATED BILLING.—

(1) FOR SNF SERVICES.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by 4319(b), is amended—

(A) by striking ''or'' at the end of paragraph (16),

(B) by striking the period at the end of paragraph (17) and inserting ''; or'', and

(C) by inserting after paragraph (17) the following new paragraph:

''(18) which are covered skilled nursing facility services described in section 1888(e)(2)(A)(i) and which are furnished to an individual who is a resident of a skilled nursing facility or of a part of a facility that includes a skilled nursing facility (as determined under regulations), by an entity other than the skilled nursing facility, unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the skilled nursing facility.''.

(2) REQUIRING PAYMENT FOR ALL PART B ITEMS AND SERVICES TO BE MADE TO FACILITY.—The first sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended—

(A) by striking ''and (D)'' and inserting ''(D)''; and

(B) by striking the period at the end and inserting the following: '', and (E) in the case of an item or service (other than services described in section 1888(e)(2)(A)(ii)) furnished to an individual who (at the time the item or service is furnished) is a resident of a skilled nursing facility or of a part of a facility that includes a skilled nursing facility (as determined under regulations), payment shall be made to the facility (without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise).''.

(3) PAYMENT RULES.—Section 1888(e) (42 U.S.C. 1395yy(e)), as added by subsection (a), is amended by adding at the end the following:

''(9) PAYMENT FOR CERTAIN SERVICES.—In the case of an item or service furnished to a resident of a skilled nursing facility or a part of a facility that includes a skilled nursing facility (as determined under regulations) for which payment would (but for this paragraph) be made under part B in an amount determined in accordance with section 1833(a)(2)(B), the amount of the payment under such part shall be the amount provided under the fee schedule for such item or service.

''(10) REQUIRED CODING.—No payment may be made under part B for items and services (other than services described in paragraph (2)(A)(ii)) furnished to an individual who is a resident of a skilled nursing facility or of a part of a facility that includes a skilled nursing facility (as determined under regulations), unless the claim for such payment includes a code (or codes) under a uniform coding system specified by the Secretary that identifies the items or services furnished.''

(4) FACILITY PROVIDER NUMBER REQUIRED ON CLAIMS SUBMITTED BY PHYSICIANS.—Section 1842 (42 U.S.C. 1395u) is amended by adding at the end the following new section:

''(t) Each request for payment, or bill submitted, for an item or service furnished by a physician to an individual who is a resident of a skilled nursing facility or of a part of a facility that includes a skilled nursing facility (as determined under regulations), for which payment may be made under this part shall include the facility's medicare provider number.''

(5) CONFORMING AMENDMENTS.—

(A) Section 1819(b)(3)(C)(i) (42 U.S.C. 1395i–3(b)(3)(C)(i)) is amended by striking ''Such'' and inserting ''Subject to the timeframes prescribed by the Secretary under section 1888(e)(6), such''.

(B) Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)) is amended by striking ''(2);'' and inserting ''(2) and section 1842(b)(6)(E);''.

(C) Section 1833(a)(2)(B) (42 U.S.C. 1395l(a)(2)(B)) is amended by inserting ''or section 1888(e)(9)'' after ''section 1886''.

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

(i) in the opening paragraph, by striking ''paragraphs (3) and (6)'' and inserting ''paragraphs (3), (6), and (7)'', and

(ii) in paragraph (7), after ''skilled nursing facilities'', by inserting '', or by others under arrangements with them made by the facility''.

(E) Section 1861(v)(7)(D) (42 U.S.C. 1395x(v)(7)(D)) is amended by inserting ''subsections (a) through (c) of'' before ''section 1888.''.

(F) Section 1866(a)(1)(H) (42 U.S.C. 1395cc(a)(1)(H)) is amended—

(i) by redesignating clauses (i) and (ii) as subclauses (I) and (II) respectively,

(ii) by inserting ''(i)'' after ''(H)'', and

(iii) by adding after clause (i), as so redesignated, the following new clause:

''(ii) in the case of skilled nursing facilities which provide covered skilled nursing facility services—

''(I) that are furnished to an individual who is a resident of the skilled nursing facility, and

''(II) for which the individual is entitled to have payment made under this title,

to have items and services (other than services described in section 1888(e)(2)(A)(ii)) furnished by the skilled nursing facility or otherwise under arrangements (as defined in section 1861(w)(1)) made by the skilled nursing facility,''.

(G) Section 1883(a)(2)(B)(ii)(II) (42 U.S.C. 1395tt(a)(2)(B)(ii)(II)) is amended by inserting ''subsections (a) through (d) of'' before ''section 1888''.

(H) Section 1888(d)(1) (42 U.S.C. 1395yy(d)(1)) is amended by striking ''Any skilled nursing facility'' and inserting ''Subject to subsection (e), any skilled nursing facility''.

(c) MEDICAL REVIEW PROCESS.—In order to ensure that medicare beneficiaries are furnished appropriate services in skilled nursing facilities, the Secretary of Health and Human Services shall establish and implement a thorough medical review process to examine the effects of the amendments made by this section on the quality of covered skilled nursing facility services furnished to medicare beneficiaries. In developing such a medical review process, the Secretary shall place a particular emphasis on the quality of non-routine covered services and physicians' services for which payment is made under title XVIII of the Social Security Act.

(d) EFFECTIVE DATE.—The amendments made by this section are effective for cost reporting periods beginning on or after July 1, 1998; except that the amendments made by subsection (b) shall apply to items and services furnished on or after July 1, 1998.

## CHAPTER 4—PROVISIONS RELATED TO HOSPICE SERVICES

### SEC. 4441. PAYMENTS FOR HOSPICE SERVICES.

(a) PAYMENT UPDATE.—Section 1814(i)(1)(C)(ii) (42 U.S.C. 1395f(i)(1)(C)(ii)) is amended—

(1) in subclause (V), by striking ''and'' at the end;

(2) by redesignating subclause (VI) as subclause (VII); and

(3) by inserting after subclause (V) the following new subclause:

''(VI) for each of fiscal years 1998 through 2002, the market basket percentage increase for the fiscal year involved minus 1.0 percentage points; and''.

(b) COLLECTION OF DATA.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

''(3) Hospice programs providing hospice care for which payment is made under this subsection shall submit to the Secretary such data with respect to the costs for providing such care for each fiscal year, beginning with fiscal year 1999, as the Secretary determines necessary.''.

### SEC. 4442. PAYMENT FOR HOME HOSPICE CARE BASED ON LOCATION WHERE CARE IS FURNISHED.

(a) IN GENERAL.—Section 1814(i)(2) (42 U.S.C. 1395f(i)(2)) is amended by adding at the end the following:

''(D) A hospice program shall submit claims for payment for hospice care furnished in an individual's home under this title only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to cost reporting periods beginning on or after October 1, 1997.

**SEC. 4443. HOSPICE CARE BENEFITS PERIODS.**

(a) RESTRUCTURING OF BENEFIT PERIOD.—Section 1812 (42 U.S.C. 1395d) is amended in subsections (a)(4) and (d)(1) by striking '', a subsequent period of 30 days, and a subsequent extension period'' and inserting ''and an unlimited number of subsequent periods of 60 days each''.

(b) CONFORMING AMENDMENTS.—(1) Section 1812 (42 U.S.C. 1395d) is amended in subsection (d)(2)(B) by striking ''90- or 30-day period or a subsequent extension period'' and inserting ''90-day period or a subsequent 60-day period''.

(2) Section 1814(a)(7)(A) (42 U.S.C. 1395f(a)(7)(A)) is amended—

(A) in clause (i), by inserting ''and'' at the end;

(B) in clause (ii)—

(i) by striking ''30-day'' and inserting ''60-day''; and

(ii) by striking '', and'' at the end and inserting a period; and

(C) by striking clause (iii).

**SEC. 4444. OTHER ITEMS AND SERVICES INCLUDED IN HOSPICE CARE.**

(a) IN GENERAL.—Section 1861(dd)(1) (42 U.S.C. 1395x(dd)(1)) is amended—

(1) in subparagraph (G), by striking ''and'' at the end;

(2) in subparagraph (H), by striking the period at the end and inserting '', and''; and

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

''(I) any other item or service which is specified in the plan and for which payment may otherwise be made under this title.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to items or services furnished on or after April 1, 1998.

**SEC. 4445. CONTRACTING WITH INDEPENDENT PHYSICIANS OR PHYSICIAN GROUPS FOR HOSPICE CARE SERVICES PERMITTED.**

Section 1861(dd)(2) (42 U.S.C. 1395x(dd)(2)) is amended—

(1) in subparagraph (A)(ii)(I), by striking ''(F),''; and

(2) in subparagraph (B)(i), by inserting ''or, in the case of a physician described in subclause (I), under contract with'' after ''employed by''.

**SEC. 4446. WAIVER OF CERTAIN STAFFING REQUIREMENTS FOR HOSPICE CARE PROGRAMS IN NONURBANIZED AREAS.**

Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended—

(1) in subparagraph (B), by inserting ''or (C)'' after ''subparagraph (A)'' each place it appears; and

(2) by adding at the end the following:

''(C) The Secretary may waive the requirements of paragraph (2)(A)(i) and (2)(A)(ii) for an agency or organization with respect to the services described in paragraph (1)(B) and, with respect to dietary counseling, paragraph (1)(H), if such agency or organization—

''(i) is located in an area which is not an urbanized area (as defined by the Bureau of Census), and

''(ii) demonstrates to the satisfaction of the Secretary that the agency or organization has been unable, despite diligent efforts, to recruit appropriate personnel.''.

**SEC. 4447. LIMITATION ON LIABILITY OF BENEFICIARIES FOR CERTAIN HOSPICE COVERAGE DENIALS.**

Section 1879(g) (42 U.S.C. 1395pp(g)) is amended—

(1) by redesignating paragraphs (1) and (2) as subparagraphs (A) and (B), respectively, and moving such subparagraphs 2 ems to the right;

(2) by striking ''is,'' and inserting ''is—'';

(3) by making the remaining text of subsection (g), as amended, that follows ''is—'' a new paragraph (1) and indenting such paragraph 2 ems to the right;

(4) by striking the period at the end and inserting ''; and''; and

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

''(2) with respect to the provision of hospice care to an individual, a determination that the individual is not terminally ill.''.

**SEC. 4448. EXTENDING THE PERIOD FOR PHYSICIAN CERTIFICATION OF AN INDIVIDUAL'S TERMINAL ILLNESS.**

Section 1814(a)(7)(A)(i) (42 U.S.C. 1395f(a)(7)(A)(i)) is amended in the matter following subclause (II) by striking '', not later than 2 days after hospice care is initiated (or, if each certify verbally not later than 2 days after hospice care is initiated, not later than 8 days after such care is initiated)'' and inserting ''at the beginning of the period''.

**SEC. 4449. EFFECTIVE DATE.**

Except as otherwise provided in this chapter, the amendments made by this chapter apply to benefits provided on or after the date of the enactment of this chapter, regardless of whether or not an individual has made an election under section 1812(d) of the Social Security Act (42 U.S.C. 1395d(d)) before such date.

## CHAPTER 5—OTHER PAYMENT PROVISIONS

**SEC. 4451. REDUCTIONS IN PAYMENTS FOR ENROLLEE BAD DEBT.**

Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

''(T) In determining such reasonable costs for hospitals, no reduction in copayments under section 1833(t)(5)(B) shall be treated as a bad debt and the amount of bad debts otherwise treated as allowable costs which are attributable to the deductibles and coinsurance amounts under this title shall be reduced—

''(i) for cost reporting periods beginning during fiscal year 1998, by 25 percent of such amount otherwise allowable,

''(ii) for cost reporting periods beginning during fiscal year 1999, by 40 percent of such amount otherwise allowable, and

''(iii) for cost reporting periods beginning during a subsequent fiscal year, by 45 percent of such amount otherwise allowable.''.

**SEC. 4452. PERMANENT EXTENSION OF HEMOPHILIA PASS-THROUGH PAYMENT.**

Section 6011(d) of OBRA–1989 (as amended by section 13505 of OBRA–1993) is amended by striking ''and shall expire September 30, 1994.'' and inserting ''and on or before September 30, 1994, and on or after October 1, 1997.''.

**SEC. 4453. REDUCTION IN PART A MEDICARE PREMIUM FOR CERTAIN PUBLIC RETIREES.**

(a) IN GENERAL.—Section 1818(d) (42 U.S.C. 1395i–2(d)) is amended—

(1) in paragraph (2), by striking ''paragraph (4)'' and inserting ''paragraphs (4) and (5)''; and

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

''(5)(A) The amount of the monthly premium shall be zero in the case of an individual who is a person described in subparagraph (B) for a month, if—

''(i) the individual's premium under this section for the month is not (and will not be) paid for, in whole or in part, by a State (under title XIX or otherwise), a political subdivision of a State, or an agency or instrumentality of one or more States or political subdivisions thereof; and

''(ii) in each of 84 months before such month, the individual was enrolled in this part under this section and the payment of the individual's premium under this section for the month was not paid for, in whole or in part, by a State (under title XIX or otherwise), a political subdivision of a State, or an agency or instrumentality of one or more States or political subdivisions thereof.

''(B) A person described in this subparagraph for a month is a person who establishes to the satisfaction of the Secretary that, as of the last day of the previous month—

''(i)(I) the person was receiving cash benefits under a qualified State or local government retirement system (as defined in subparagraph (C)) on the basis of the person's employment in one or more positions covered under any such system, and (II) the person would have at least 40 quarters of coverage under title II if remuneration for medicare qualified government employment (as defined in paragraph (1) of section 210(p), but determined without regard to paragraph (3) of such section) paid to such person were treated as wages paid to such person and credited for purposes of determining quarters of coverage under section 213;

''(ii)(I) the person was married (and had been married for the previous 1-year period) to an individual who is described in clause (i), or (II) the person met the requirement of clause (i)(II) and was married (and had been married for the previous 1-year period) to an individual described in clause (i)(I);

''(iii) the person had been married to an individual for a period of at least 1 year (at the time of such individual's death) if (I) the individual was described in clause (i) at the time of the individual's death, or (II) the person met the requirement of clause (i)(II) and the individual was described in clause (i)(I) at the time of the individual's death; or

''(iv) the person is divorced from an individual and had been married to the individual for a period of at least 10 years (at the time of the divorce) if (I) the individual was described in clause (i) at the time of the divorce, or (II) the person met the requirement of clause (i)(II) and the individual was described in clause (i)(I) at the time of the divorce.

''(C) For purposes of subparagraph (B)(i)(I), the term 'qualified State or local government retirement system' means a retirement system that—

''(i) is established or maintained by a State or political subdivision thereof, or an agency or instrumentality of one or more States or political subdivisions thereof;

''(ii) covers positions of some or all employees of such a State, subdivision, agency, or instrumentality; and

''(iii) does not adjust cash retirement benefits based on eligibility for a reduction in premium under this paragraph.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to premiums for months beginning with January 1998, and months before such month may be taken into account for purposes of meeting the requirement of section 1818(d)(5)(B)(iii) of the Social Security Act, as added by subsection (a).

**SEC. 4454. COVERAGE OF SERVICES IN RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTIONS UNDER THE MEDICARE AND MEDICAID PROGRAMS.**

(a) MEDICARE COVERAGE.—

(1) IN GENERAL.—Section 1861 (42 U.S.C. 1395x) (as amended by sections 4103 and 4106) is amended—

(A) in the sixth sentence of subsection (e)—

(i) by striking ''includes'' and all that follows up to ''but only'' and inserting ''includes a religious nonmedical health care institution (as defined in subsection (ss)(1)),'', and

(ii) by inserting ''consistent with section 1821'' before the period;

(B) in subsection (y)—

(i) by amending the heading to read as follows:

''Extended Care in Religious Nonmedical Health Care Institutions'',

(ii) in paragraph (1), by striking ''includes'' and all that follows up to ''but only'' and inserting ''includes a religious nonmedical health care institution (as defined in subsection (ss)(1)),'', and

(iii) by inserting ''consistent with section 1821'' before the period; and

(C) by adding at the end the following:

''Religious Nonmedical Health Care Institution

''(ss)(1) The term 'religious nonmedical health care institution' means an institution that—

''(A) is described in subsection (c)(3) of section 501 of the Internal Revenue Code of 1986 and is exempt from taxes under subsection (a) of such section;

''(B) is lawfully operated under all applicable Federal, State, and local laws and regulations;

''(C) provides only nonmedical nursing items and services exclusively to patients who choose to rely solely upon a religious method of healing and for whom the acceptance of medical health services would be inconsistent with their religious beliefs;

''(D) provides such nonmedical items and services exclusively through nonmedical nursing personnel who are experienced in caring for the physical needs of such patients;

''(E) provides such nonmedical items and services to inpatients on a 24-hour basis;

''(F) on the basis of its religious beliefs, does not provide through its personnel or otherwise medical items and services (including any medical screening, examination, diagnosis, prognosis, treatment, or the administration of drugs) for its patients;

''(G)(i) is not owed by, under common ownership with, or has an ownership interest in, a provider of medical treatment of services;

''(ii) is not affiliated with—

''(I) a provider of medical treatment or services, or

''(II) an individual who has an ownership interest in a provider of medical treatment or services;

''(H) has in effect a utilization review plan which—

''(i) provides for the review of admissions to the institution, of the duration of stays therein, of cases of continuous extended duration, and of the items and services furnished by the institution,

''(ii) requires that such reviews be made by an appropriate committee of the institution that includes the individuals responsible for overall administration and for supervision of nursing personnel at the institution,

''(iii) provides that records be maintained of the meetings, decisions, and actions of such committee, and

''(iv) meets such other requirements as the Secretary finds necessary to establish an effective utilization review plan;

''(I) provides the Secretary with such information as the Secretary may require to implement section 1821, including information relating to quality of care and coverage determinations; and

''(J) meets such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution.

''(2) To the extent that the Secretary finds that the accreditation of an institution by a State, regional, or national agency or association provides reasonable assurances that any or all of the requirements of paragraph (1) are met or exceeded, the Secretary may treat such institution as meeting the condition or conditions with respect to which the Secretary made such finding.

''(3)(A)(i) In administering this subsection and section 1821, the Secretary shall not require any patient of a religious nonmedical health care institution to undergo medical screening, examination, diagnosis, prognosis, or treatment or to accept any other medical health care service, if such patient (or legal representative of the patient) objects thereto on religious grounds.

''(ii) Clause (i) shall not be construed as preventing the Secretary from requiring under section 1821(a)(2) the provision of sufficient information regarding an individual's condition as a condition for receipt of benefits under part A for services provided in such an institution.

''(B)(i) In administering this subsection and section 1821, the Secretary shall not subject a religious nonmedical health care institution or its personnel to any medical supervision, regulation, or control, insofar as such supervision, regulation, or control would be contrary to the religious beliefs observed by the institution or such personnel.

''(ii) Clause (i) shall not be construed as preventing the Secretary from reviewing items and services billed by the institution to the extent the Secretary determines such review to be necessary to determine whether such items and services were not covered under part A, are excessive, or are fraudulent.

''(4)(A) For purposes of paragraph (1)(G)(i), an ownership interest of less than 5 percent shall not be taken into account.

''(B) For purposes of paragraph (1)(G)(ii), none of the following shall be considered to create an affiliation:

''(i) An individual serving as an uncompensated director, trustee, officer, or other member of the governing body of a religious nonmedical health care institution.

''(ii) An individual who is a director, trustee, officer, employee, or staff member of a religious nonmedical health care institution having a family relationship with an individual who is affiliated with (or has an ownership interest in) a provider of medical treatment or services.

''(iii) An individual or entity furnishing goods or services as a vendor to both providers of medical treatment or services and religious nonmedical health care institutions.''.

(2) CONDITIONS OF COVERAGE.—Part A of title XVIII is amended by adding at the end the following new section:

''CONDITIONS FOR COVERAGE OF RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTIONAL SERVICES

''SEC. 1821. (a) IN GENERAL.—Subject to subsections (c) and (d), payment under this part may be made for inpatient hospital services or post-hospital extended care services furnished an individual in a religious nonmedical health care institution only if—

''(1) the individual has an election in effect for such benefits under subsection (b); and

''(2) the individual has a condition such that the individual would qualify for benefits under this part for inpatient hospital services or extended care services, respectively, if the individual were an inpatient or resident in a hospital or skilled nursing facility that was not such an institution.

''(b) ELECTION.—

''(1) IN GENERAL.—An individual may make an election under this subsection in a form and manner specified by the Secretary consistent with this subsection. Unless otherwise provided, such an election shall take effect immediately upon its execution. Such an election, once made, shall continue in effect until revoked.

''(2) FORM.—The election form under this subsection shall include the following:

''(A) A written statement, signed by the individual (or such individual's legal representative), that—

''(i) the individual is conscientiously opposed to acceptance of nonexcepted medical treatment; and

''(ii) the individual's acceptance of nonexcepted medical treatment would be inconsistent with the individual's sincere religious beliefs.

''(B) A statement that the receipt of nonexcepted medical services shall constitute a revocation of the election and may limit further receipt of services described in subsection (a).

''(3) REVOCATION.—An election under this subsection by an individual may be revoked by voluntarily notifying the Secretary in writing of such revocation and shall be deemed to be revoked if the individual receives nonexcepted medical treatment for which reimbursement is made under this title.

''(4) LIMITATION ON SUBSEQUENT ELECTIONS.—Once an individual's election under this subsection has been made and revoked twice—

''(A) the next election may not become effective until the date that is 1 year after the date of most recent previous revocation, and

''(B) any succeeding election may not become effective until the date that is 5 years after the date of the most recent previous revocation.

''(5) EXCEPTED MEDICAL TREATMENT.—For purposes of this subsection:

''(A) EXCEPTED MEDICAL TREATMENT.—The term 'excepted medical treatment' means medical care or treatment (including medical and other health services)—

''(i) received involuntarily, or

''(ii) required under Federal or State law or law of a political subdivision of a State.

''(B) NONEXCEPTED MEDICAL TREATMENT.—The term 'nonexcepted medical treatment' means medical care or treatment (including medical and other health services) other than excepted medical treatment.

''(c) MONITORING AND SAFEGUARD AGAINST EXCESSIVE EXPENDITURES.—

''(1) ESTIMATE OF EXPENDITURES.—Before the beginning of each fiscal year (beginning with fiscal year 2000), the Secretary shall estimate the level of expenditures under this part for services described in subsection (a) for that fiscal year.

''(2) ADJUSTMENT IN PAYMENTS.—

''(A) PROPORTIONAL ADJUSTMENT.—If the Secretary determines that the level estimated under paragraph (1) for a fiscal year will exceed the trigger level (as defined in subparagraph (C)) for that fiscal year, the Secretary shall, subject to subparagraph (B), provide for such a proportional reduction in payment amounts under this part for services described in subsection (a) for the fiscal year involved as will assure that such level (taking into account any adjustment under subparagraph (B)) does not exceed the trigger level for that fiscal year.

''(B) ALTERNATIVE ADJUSTMENTS.—The Secretary may, instead of making some or all of the reduction described in subparagraph (A), impose such other conditions or limitations with respect to the coverage of covered services (including limitations on new elections of coverage and new facilities) as may be appropriate to reduce the level of expenditures

described in paragraph (1) to the trigger level.

''(C) TRIGGER LEVEL.—For purposes of this subsection—

''(i) IN GENERAL.—Subject to adjustment under paragraph (3)(B), the 'trigger level' for a year is the unadjusted trigger level described in clause (ii).

''(ii) UNADJUSTED TRIGGER LEVEL.—The 'unadjusted trigger level' for—

''(I) fiscal year 1998, is $20,000,000, or

''(II) a succeeding fiscal year is the amount specified under this clause for the previous fiscal year increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) for the 12-month period ending with July preceding the beginning of the fiscal year.

''(D) PROHIBITION OF ADMINISTRATIVE AND JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the estimation of expenditures under subparagraph (A) or the application of reduction amounts under subparagraph (B).

''(E) EFFECT ON BILLING.—Notwithstanding any other provision of this title, in the case of a reduction in payment provided under this subsection for services of a religious nonmedical health care institution provided to an individual, the amount that the institution is otherwise permitted to charge the individual for such services is increased by the amount of such reduction.

''(3) MONITORING EXPENDITURE LEVEL.—

''(A) IN GENERAL.—The Secretary shall monitor the expenditure level described in paragraph (2)(A) for each fiscal year (beginning with fiscal year 1999).

''(B) ADJUSTMENT IN TRIGGER LEVEL.—

''(i) IN GENERAL.—If the Secretary determines that such level for a fiscal year exceeded, or was less than, the trigger level for that fiscal year, then, subject to clause (ii), the trigger level for the succeeding fiscal year shall be reduced, or increased, respectively, by the amount of such excess or deficit.

''(ii) LIMITATION ON CARRYFORWARD.—In no case may the increase effected under clause (i) for a fiscal year exceed $50,000,000.

''(d) SUNSET.—If the Secretary determines that the level of expenditures described in subsection (c)(1) for 3 consecutive fiscal years (with the first such year being not earlier than fiscal year 2002) exceeds the trigger level for such expenditures for such years (as determined under subsection (c)(2)), benefits shall be paid under this part for services described in subsection (a) and furnished on or after the first January 1 that occurs after such 3 consecutive years only with respect to an individual who has an election in effect under subsection (b) as of such January 1 and only during the duration of such election.

''(e) ANNUAL REPORT.—At the beginning of each fiscal year (beginning with fiscal year 1999), the Secretary shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate an annual report on coverage and expenditures for services described in subsection (a) under this part and under State plans under title XIX. Such report shall include—

''(1) level of expenditures described in subsection (c)(1) for the previous fiscal year and estimated for the fiscal year involved;

''(2) trends in such level; and

''(3) facts and circumstances of any significant change in such level from the level in previous fiscal years.''.

(b) MEDICAID.—

(1) The third sentence of section 1902(a) (42 U.S.C. 1396a(a)) is amended by striking all that follows ''shall not apply'' and inserting ''to a religious nonmedical health care institution (as defined in section 1861(ss)(1)).''.

(2) Section 1908(e)(1) (42 U.S.C. 1396g–1(e)(1)) is amended by striking all that follows ''does not include'' and inserting ''a religious nonmedical health care institution (as defined in section 1861(ss)(1)).''.

(c) CONFORMING AMENDMENTS.—

(1) Section 1122(h) (42 U.S.C. 1320a–1(h)) is amended by striking all that follows ''shall not apply to'' and inserting ''a religious nonmedical health care institution (as defined in section 1861(ss)(1)).''.

(2) Section 1162 (42 U.S.C. 1320c–11) is amended—

(A) by amending the heading to read as follows:

''EXEMPTIONS FOR RELIGIOUS NONMEDICAL HEALTH CARE INSTITUTIONS''; and

(B) by striking all that follows ''shall not apply with respect to a'' and inserting ''religious nonmedical health care institution (as defined in section 1861(ss)(1)).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act and shall apply to items and services furnished on or after such date. By not later than July 1, 1998, the Secretary of Health and Human Services shall first issue regulations to carry out such amendments. Such regulations may be issued so they are effective on an interim basis pending notice and opportunity for public comment. For periods before the effective date of such regulations, such regulations shall recognize elections entered into in good faith in order to comply with the requirements of section 1821(b) of the Social Security Act.

**Subtitle F—Provisions Relating to Part B Only**

**CHAPTER 1—SERVICES OF HEALTH PROFESSIONALS**

**Subchapter A—Physicians' Services**

**SEC. 4501. ESTABLISHMENT OF SINGLE CONVERSION FACTOR FOR 1998.**

(a) IN GENERAL.—Section 1848(d)(1) (42 U.S.C. 1395w–4(d)(1)) is amended—

(1) by redesignating subparagraph (C) as subparagraph (D), and

(2) by inserting after subparagraph (B) the following:

''(C) SPECIAL RULES FOR 1998.—The single conversion factor for 1998 under this subsection shall be the conversion factor for primary care services for 1997, increased by the Secretary's estimate of the weighted average of the three separate updates that would otherwise occur were it not for the enactment of chapter 1 of subtitle F of title IV of the Balanced Budget Act of 1997.''.

(b) CONFORMING AMENDMENTS.—Section 1848 (42 U.S.C. 1395w–4) is amended—

(1) by striking ''(or factors)'' each place it appears in subsection (d)(1)(A) and (d)(1)(D)(ii) (as redesignated by subsection (a)(1)),

(2) in subsection (d)(1)(A), by striking ''or updates'',

(3) in subsection (d)(1)(D) (as redesignated by subsection (a)(1)), by striking ''(or updates)'' each place it appears, and

(4) in subsection (j)(1), by striking ''The term'' and inserting ''For services furnished before January 1, 1998, the term''..

**SEC. 4502. ESTABLISHING UPDATE TO CONVERSION FACTOR TO MATCH SPENDING UNDER SUSTAINABLE GROWTH RATE.**

(a) UPDATE.—

(1) IN GENERAL.—Section 1848(d)(3) (42 U.S.C. 1395w–4(d)(3)) is amended to read as follows:

''(3) UPDATE.—

''(A) IN GENERAL.—Unless otherwise provided by law, subject to subparagraph (D) and the budget-neutrality factor determined by the Secretary under subsection (c)(2)(B)(ii), the update to the single conversion factor established in paragraph (1)(C) for a year beginning with 1999 is equal to the product of—

''(i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year (divided by 100), and

''(ii) 1 plus the Secretary's estimate of the update adjustment factor for the year (divided by 100),

minus 1 and multiplied by 100.

''(B) UPDATE ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(ii), the 'update adjustment factor' for a year is equal (as estimated by the Secretary) to—

''(i) the difference between (I) the sum of the allowed expenditures for physicians' services (as determined under subparagraph (C)) for the period beginning April 1, 1997, and ending on March 31 of the year involved, and (II) the amount of actual expenditures for physicians' services furnished during the period beginning April 1, 1997, and ending on March 31 of the preceding year; divided by

''(ii) the actual expenditures for physicians' services for the 12-month period ending on March 31 of the preceding year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

''(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of this paragraph, the allowed expenditures for physicians' services for the 12-month period ending with March 31 of—

''(i) 1997 is equal to the actual expenditures for physicians' services furnished during such 12-month period, as estimated by the Secretary; or

''(ii) a subsequent year is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during such 12-month period.

''(D) RESTRICTION ON VARIATION FROM MEDICARE ECONOMIC INDEX.—Notwithstanding the amount of the update adjustment factor determined under subparagraph (B) for a year, the update in the conversion factor under this paragraph for the year may not be—

''(i) greater than 100 times the following amount: (1.03 + (MEI percentage/100)) −1; or

''(ii) less than 100 times the following amount: (0.93 + (MEI percentage/100)) −1,

where 'MEI percentage' means the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for the year involved.''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall apply to the update for years beginning with 1999.

(b) ELIMINATION OF REPORT.—Section 1848(d) (42 U.S.C. 1395w–4(d)) is amended by striking paragraph (2).

**SEC. 4503. REPLACEMENT OF VOLUME PERFORMANCE STANDARD WITH SUSTAINABLE GROWTH RATE.**

(a) IN GENERAL.—Section 1848(f) (42 U.S.C. 1395w–4(f)) is amended by striking paragraphs (2) through (5) and inserting the following:

''(2) SPECIFICATION OF GROWTH RATE.—The sustainable growth rate for all physicians' services for a fiscal year (beginning with fiscal year 1998) shall be equal to the product of—

''(A) 1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services in the fiscal year involved,

''(B) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than Medicare+Choice plan enrollees) from the previous fiscal year to the fiscal year involved,

''(C) 1 plus the Secretary's estimate of the projected percentage growth in real gross do-

mestic product per capita (divided by 100) from the previous fiscal year to the fiscal year involved, and

''(D) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the fiscal year (compared with the previous fiscal year) which will result from changes in law and regulations, determined without taking into account estimated changes in expenditures resulting from the update adjustment factor determined under subsection (d)(3)(B), minus 1 and multiplied by 100.

''(3) DEFINITIONS.—In this subsection:

''(A) SERVICES INCLUDED IN PHYSICIANS' SERVICES.—The term 'physicians' services' includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a Medicare+Choice plan enrollee.

''(B) MEDICARE+CHOICE PLAN ENROLLEE.—The term 'Medicare+Choice plan enrollee' means, with respect to a fiscal year, an individual enrolled under this part who has elected to receive benefits under this title for the fiscal year through a Medicare+Choice plan offered under part C, and also includes an individual who is receiving benefits under this part through enrollment with an eligible organization with a risk-sharing contract under section 1876.''.

(b) CONFORMING AMENDMENT.—So much of section 1848(f) (42 U.S.C. 1395w–4(f)) as precedes paragraph (2) is amended to read as follows:

''(f) SUSTAINABLE GROWTH RATE.—

''(1) PUBLICATION.—The Secretary shall cause to have published in the Federal Register the sustainable growth rate for each fiscal year beginning with fiscal year 1998. Such publication shall occur by not later than August 1 before each fiscal year, except that such rate for fiscal year 1998 shall be published not later than November 1, 1997.''.

**SEC. 4504. PAYMENT RULES FOR ANESTHESIA SERVICES.**

(a) IN GENERAL.—Section 1848(d)(1) (42 U.S.C. 1395w–4(d)(1)), as amended by section 4501(a), is amended—

(1) in subparagraph (C), by striking ''The single'' and inserting ''Except as provided in subparagraph (D), the single'';

(2) by redesignating subparagraph (D) as subparagraph (E); and

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

''(D) SPECIAL RULES FOR ANESTHESIA SERVICES.—The separate conversion factor for anesthesia services for a year shall be equal to 46 percent of the single conversion factor established for other physicians' services, except as adjusted for changes in work, practice expense, or malpractice relative value units.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to services furnished on or after January 1, 1998.

**SEC. 4505. IMPLEMENTATION OF RESOURCE-BASED METHODOLOGIES.**

(a) 1-YEAR DELAY IN IMPLEMENTATION.—Section 1848(c) (42 U.S.C. 1395w–4(c)) is amended—

(1) in paragraph (2)(C)(ii), in the matter before subclause (I) and after subclause (II), by striking ''1998'' and inserting ''1999'' each place it appears; and

(2) in paragraph (3)(C)(ii), by striking ''1998'' and inserting ''1999''.

(b) PHASED-IN IMPLEMENTATION.—

(1) IN GENERAL.—Section 1848(c)(2)(C)(ii) (42 U.S.C. 1395w–4(c)(2)(C)(ii)) is further amended—

(A) by striking the comma at the end of clause (ii) and inserting a period and the following:

''For 1999, such number of units shall be determined based 75 percent on such product and based 25 percent on the relative practice expense resources involved in furnishing the service. For 2000, such number of units shall be determined based 50 percent on such product and based 50 percent on such relative practice expense resources. For 2001, such number of units shall be determined based 25 percent on such product and based 75 percent on such relative practice expense resources. For a subsequent year, such number of units shall be determined based entirely on such relative practice expense resources.''.

(2) CONFORMING AMENDMENT.—Section 1848(c)(3)(C)(ii) (42 U.S.C. 1395w–4(c)(3)(C)(ii)), as amended by subsection (a)(2), is amended by striking ''1999'' and inserting ''2002''.

(c) REVIEW BY COMPTROLLER GENERAL.—The Comptroller General of the United States shall review and evaluate the proposed rule on resource-based methodology for practice expenses issued by the Secretary of Health and Human Services. The Comptroller General shall, within 6 months of the date of the enactment of this Act, report to the Committees on Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate the results of its evaluation, including an analysis of—

(1) the adequacy of the data used in preparing the rule,

(2) categories of allowable costs,

(3) methods for allocating direct and indirect expenses,

(4) the potential impact of the rule on beneficiary access to services, and

(5) any other matters related to the appropriateness of resource-based methodology for practice expenses.

The Comptroller General shall consult with representatives of physicians' organizations with respect to matters of both data and methodology.

(d) REQUIREMENTS FOR DEVELOPING NEW RESOURCE-BASED PRACTICE EXPENSE RELATIVE VALUE UNITS.—

(1) DEVELOPMENT.—For purposes of section 1848(c)(2)(C)(ii) of the Social Security Act, the Secretary of Health and Human Services shall develop new resource-based relative value units. In developing such units the Secretary shall—

(A) utilize, to the maximum extent practicable, generally accepted cost accounting principles which (i) recognize all staff, equipment, supplies, and expenses, not just those which can be tied to specific procedures, and (ii) use actual data on equipment utilization and other key assumptions;

(B) consult with organizations representing physicians regarding methodology and data to be used; and

(C) develop a refinement process to be used during each of the 4 years of the transition period.

(2) REPORT.—The Secretary shall transmit a report by March 1, 1998, on the development of resource-based relative value units under paragraph (1) to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate. The report shall include a presentation of data to be used in developing the value units and an explanation of the methodology.

(3) NOTICE OF PROPOSED RULEMAKING.—The Secretary shall publish a notice of proposed rulemaking with the new resource-based relative value units on or before May 1, 1998, and shall allow for a 90-day public comment period.

(4) ITEMS INCLUDED.—The new proposed rule shall consider the following:

(A) Impact projections which compare new proposed payment amounts on data on actual physician practice expenses.

(B) Impact projections for hospital-based and other specialties, geographic payment localities, and urban versus rural localities.

(e) ADJUSTMENTS TO RELATIVE VALUE UNITS FOR 1998.—Section 1848(c)(2) (42 U.S.C. 1395w–4(c)(2)) is amended by adding at the end the following new subparagraph:

''(G) ADJUSTMENTS IN RELATIVE VALUE UNITS FOR 1998.—

''(i) IN GENERAL.—The Secretary shall—

''(I) subject to clauses (iv) and (v), reduce the practice expense relative value units applied to any services described in clause (ii) furnished in 1998 to a number equal to 110 percent of the number of work relative value units, and

''(II) increase the practice expense relative value units for office visit procedure codes during 1998 by a uniform percentage which the Secretary estimates will result in an aggregate increase in payments for such services equal to the aggregate decrease in payments by reason of subclause (I).

''(ii) SERVICES COVERED.—For purposes of clause (i), the services described in this clause are physicians' services that are not described in clause (iii) and for which—

''(I) there are work relative value units, and

''(II) the number of practice expense relative value units (determined for 1998) exceeds 110 percent of the number of work relative value units (determined for such year).

''(iii) EXCLUDED SERVICES.—For purposes of clause (ii), the services described in this clause are services which the Secretary determines at least 75 percent of which are provided under this title in an office setting.

''(iv) LIMITATION ON AGGREGATE REALLOCATION.—If the application of clause (i)(I) would result in an aggregate amount of reductions under such clause in excess of $390,000,000, such clause shall be applied by substituting for 110 percent such greater percentage as the Secretary estimates will result in the aggregate amount of such reductions equaling $390,000,000.

''(v) NO REDUCTION FOR CERTAIN SERVICES.—Practice expense relative value units for a procedure performed in an office or in a setting out of an office shall not be reduced under clause (i) if the in-office or out-of-office practice expense relative value, respectively, for the procedure would increase under the proposed rule on resource-based practice expenses issued by the Secretary on June 18, 1997 (62 Federal Register 33158 et seq.).''.

(f) APPLICATION OF RESOURCE-BASED METHODOLOGY TO MALPRACTICE RELATIVE VALUE UNITS.—

(1) IN GENERAL.—Section 1848(c)(2)(C)(iii) (42 U.S.C. 1395w–4(c)(2)(C)(iii)) is amended—

(A) in paragraph (2)(C)(iii)—

(i) by inserting ''for the service for years before 2000'' before ''equal'', and

(ii) by striking the period at the end and inserting a comma and by adding at the end the following flush matter:

''and for years beginning with 2000 based on the malpractice expense resources involved in furnishing the service.''; and

(B) in paragraph (3)(C)(iii), by striking ''The malpractice'' and inserting ''For years before 1999, the malpractice''.

(2) APPLICATION OF CERTAIN BUDGET NEUTRALITY PROVISIONS.—In implementing the amendment made by paragraph (1)(A)(ii), the provisions of clauses (ii)(II) and (iii) of section 1848(c)(2)(B) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)) shall apply in the same manner as they apply to adjustments under clause (ii)(I) of such section.

**SEC. 4506. DISSEMINATION OF INFORMATION ON HIGH PER DISCHARGE RELATIVE VALUES FOR IN-HOSPITAL PHYSICIANS' SERVICES.**

(a) DETERMINATION AND NOTICE CONCERNING HOSPITAL-SPECIFIC PER DISCHARGE RELATIVE VALUES.—

(1) IN GENERAL.—For 1999 and 2001 the Secretary of Health and Human Services shall determine for each hospital—

(A) the hospital-specific per discharge relative value under subsection (b); and

(B) whether the hospital-specific relative value is projected to be excessive (as determined based on such value represented as a percentage of the median of hospital-specific per discharge relative values determined under subsection (b)).

(2) NOTICE TO SUBSET OF MEDICAL STAFFS; EVALUATION OF RESPONSES.—The Secretary shall notify the medical executive committee of a subset of the hospitals identified under paragraph (1)(B) as having an excessive hospital-specific relative value, of the determinations made with respect to the medical staff under paragraph (1). The Secretary shall evaluate the responses of the hospitals so notified with the responses of other hospitals so identified that were not so notified.

(b) DETERMINATION OF HOSPITAL-SPECIFIC PER DISCHARGE RELATIVE VALUES.—

(1) IN GENERAL.—For purposes of this section, the hospital-specific per discharge relative value for the medical staff of a hospital (other than a teaching hospital) for a year shall be equal to the average per discharge relative value (as determined under section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding that calendar year, adjusted for variations in case-mix among hospitals and disproportionate share status and teaching status among hospitals (as determined by the Secretary under paragraph (3)).

(2) SPECIAL RULE FOR TEACHING HOSPITALS.—The hospital-specific relative value projected for a teaching hospital in a year shall be equal to the sum of—

(A) the average per discharge relative value (as determined under section 1848(c)(2) of such Act) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding that calendar year, and

(B) the equivalent per discharge relative value (as determined under such section) for physicians' services furnished to inpatients of the hospital by interns and residents of the hospital during the second year preceding that calendar year, adjusted for variations in case-mix among hospitals, and in disproportionate share status and teaching status among hospitals (as determined by the Secretary under paragraph (3)).

The Secretary shall determine the equivalent relative value unit per discharge for interns and residents based on the best available data and may make such adjustment in the aggregate.

(3) ADJUSTMENT FOR TEACHING AND DISPROPORTIONATE SHARE HOSPITALS.—The Secretary shall adjust the allowable per discharge relative values otherwise determined under this subsection to take into account the needs of teaching hospitals and hospitals receiving additional payments under subparagraphs (F) and (G) of section 1886(d)(5) of the Social Security Act (42 U.S.C. 1395ww(d)(5)). The adjustment for teaching status or disproportionate share shall not be less than zero.

(c) DEFINITIONS.—For purposes of this section:

(1) HOSPITAL.—The term ''hospital'' means a subsection (d) hospital as defined in section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) .

(2) MEDICAL STAFF.—An individual furnishing a physician's service is considered to be on the medical staff of a hospital—

(A) if (in accordance with requirements for hospitals established by the Joint Commission on Accreditation of Health Organizations)—

(i) the individual is subject to bylaws, rules, and regulations established by the hospital to provide a framework for the self-governance of medical staff activities,

(ii) subject to the bylaws, rules, and regulations, the individual has clinical privileges granted by the hospital's governing body, and

(iii) under the clinical privileges, the individual may provide physicians' services independently within the scope of the individual's clinical privileges, or

(B) if the physician provides at least one service to an individual entitled to benefits under this title in that hospital.

(3) PHYSICIANS' SERVICES.—The term ''physicians' services'' means the services described in section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)).

(4) RURAL AREA; URBAN AREA.—The terms ''rural area'' and ''urban area'' have the meaning given those terms under section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)).

(5) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(6) TEACHING HOSPITAL.—The term ''teaching hospital'' means a hospital which has a teaching program approved as specified in section 1861(b)(6) of the Social Security Act (42 U.S.C. 1395x(b)(6)).

**SEC. 4507. USE OF PRIVATE CONTRACTS BY MEDICARE BENEFICIARIES.**

(a) ITEMS OR SERVICES PROVIDED THROUGH PRIVATE CONTRACTS.—

(1) IN GENERAL.—Section 1802 (42 U.S.C. 1395a) is amended by adding at the end the following new subsection:

''(b) USE OF PRIVATE CONTRACTS BY MEDICARE BENEFICIARIES.—

''(1) IN GENERAL.—Subject to the provisions of this subsection, nothing in this title shall prohibit a physician or practitioner from entering into a private contract with a medicare beneficiary for any item or service—

''(A) for which no claim for payment is to be submitted under this title, and

''(B) for which the physician or practitioner receives—

''(i) no reimbursement under this title directly or on a capitated basis, and

''(ii) receives no amount for such item or service from an organization which receives reimbursement for such item or service under this title directly or on a capitated basis.

''(2) BENEFICIARY PROTECTIONS.—

''(A) IN GENERAL.—Paragraph (1) shall not apply to any contract unless—

''(i) the contract is in writing and is signed by the medicare beneficiary before any item or service is provided pursuant to the contract;

''(ii) the contract contains the items described in subparagraph (B); and

''(iii) the contract is not entered into at a time when the medicare beneficiary is facing an emergency or urgent health care situation.

''(B) ITEMS REQUIRED TO BE INCLUDED IN CONTRACT.—Any contract to provide items and services to which paragraph (1) applies shall clearly indicate to the medicare beneficiary that by signing such contract the beneficiary—

''(i) agrees not to submit a claim (or to request that the physician or practitioner submit a claim) under this title for such items or services even if such items or services are otherwise covered by this title;

''(ii) agrees to be responsible, whether through insurance or otherwise, for payment of such items or services and understands that no reimbursement will be provided under this title for such items or services;

''(iii) acknowledges that no limits under this title (including the limits under section 1848(g)) apply to amounts that may be charged for such items or services;

''(iv) acknowledges that Medigap plans under section 1882 do not, and other supplemental insurance plans may elect not to, make payments for such items and services because payment is not made under this title; and

''(v) acknowledges that the medicare beneficiary has the right to have such items or services provided by other physicians or practitioners for whom payment would be made under this title.

Such contract shall also clearly indicate whether the physician or practitioner is excluded from participation under the medicare program under section 1128.

''(3) PHYSICIAN OR PRACTITIONER REQUIREMENTS.—

''(A) IN GENERAL.—Paragraph (1) shall not apply to any contract entered into by a physician or practitioner unless an affidavit described in subparagraph (B) is in effect during the period any item or service is to be provided pursuant to the contract.

''(B) AFFIDAVIT.—An affidavit is described in this subparagraph if—

''(i) the affidavit identifies the physician or practitioner and is in writing and is signed by the physician or practitioner;

''(ii) the affidavit provides that the physician or practitioner will not submit any claim under this title for any item or service provided to any medicare beneficiary (and will not receive any reimbursement or amount described in paragraph (1)(B) for any such item or service) during the 2-year period beginning on the date the affidavit is signed; and

''(iii) a copy of the affidavit is filed with the Secretary no later than 10 days after the first contract to which such affidavit applies is entered into.

''(C) ENFORCEMENT.—If a physician or practitioner signing an affidavit under subparagraph (B) knowingly and willfully submits a claim under this title for any item or service provided during the 2-year period described in subparagraph (B)(ii) (or receives any reimbursement or amount described in paragraph (1)(B) for any such item or service) with respect to such affidavit—

''(i) this subsection shall not apply with respect to any items and services provided by the physician or practitioner pursuant to any contract on and after the date of such submission and before the end of such period; and

''(ii) no payment shall be made under this title for any item or service furnished by the physician or practitioner during the period described in clause (i) (and no reimbursement or payment of any amount described in paragraph (1)(B) shall be made for any such item or service).

''(4) LIMITATION ON ACTUAL CHARGE AND CLAIM SUBMISSION REQUIREMENT NOT APPLICABLE.—Section 1848(g) shall not apply with respect to any item or service provided to a medicare beneficiary under a contract described in paragraph (1).

''(5) DEFINITIONS.—In this subsection:

''(A) MEDICARE BENEFICIARY.—The term 'medicare beneficiary' means an individual who is entitled to benefits under part A or enrolled under part B.

''(B) PHYSICIAN.—The term 'physician' has the meaning given such term by section 1861(r)(1).

''(C) PRACTITIONER.—The term 'practitioner' has the meaning given such term by section 1842(b)(18)(C).''

(2) CONFORMING AMENDMENTS.—

(A) Section 1802 (42 U.S.C. 1395a) is amended by striking ''Any'' and inserting ''(a) BASIC FREEDOM OF CHOICE.—Any''.

(B) Section 1862(a) (42 U.S.C. 1395y(a)), as amended by sections 4319(b) and 4432, is amended by striking ''or'' at the end of paragraph (17), by striking the period at the end of paragraph (18) and inserting ''; or'', and by adding after paragraph (18) the following new paragraph:

''(19) which are for items or services which are furnished pursuant to a private contract described in section 1802(b).''

(b) REPORT.—Not later than October 1, 2001, the Secretary of Health and Human Services shall submit a report to Congress on the effect on the program under this title of private contracts entered into under the amendment made by subsection (a). Such report shall include—

(1) analyses regarding—

(A) the fiscal impact of such contracts on total Federal expenditures under title XVIII of the Social Security Act and on out-of-pocket expenditures by medicare beneficiaries for health services under such title; and

(B) the quality of the health services provided under such contracts; and

(2) recommendations as to whether medicare beneficiaries should continue to be able to enter private contracts under section 1802(b) of such Act (as added by subsection (a)) and if so, what legislative changes, if any should be made to improve such contracts.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to contracts entered into on and after January 1, 1998.

### Subchapter B—Other Health Care Professionals

**SEC. 4511. INCREASED MEDICARE REIMBURSEMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.**

(a) REMOVAL OF RESTRICTIONS ON SETTINGS.—

(1) IN GENERAL.—Clause (ii) of section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is amended to read as follows:

''(ii) services which would be physicians' services if furnished by a physician (as defined in subsection (r)(1)) and which are performed by a nurse practitioner or clinical nurse specialist (as defined in subsection (aa)(5)) working in collaboration (as defined in subsection (aa)(6)) with a physician (as defined in subsection (r)(1)) which the nurse practitioner or clinical nurse specialist is legally authorized to perform by the State in which the services are performed, and such services and supplies furnished as an incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services;''.

(2) CONFORMING AMENDMENTS.—(A) Section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is further amended—

(i) in clause (i), by inserting ''and such services and supplies furnished as incident to such services as would be covered under subparagraph (A) if furnished incident to a physician's professional service; and'' after ''are performed,''; and

(ii) by striking clauses (iii) and (iv).

(B) Section 1861(b)(4) (42 U.S.C. 1395x(b)(4)) is amended by striking ''clauses (i) or (iii) of subsection (s)(2)(K)'' and inserting ''subsection (s)(2)(K)''.

(C) Section 1862(a)(14) (42 U.S.C. 1395y(a)(14)) is amended by striking ''section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)'' and inserting ''section 1861(s)(2)(K)''.

(D) Section 1866(a)(1)(H) (42 U.S.C. 1395cc(a)(1)(H)) is amended by striking ''section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii)'' and inserting ''section 1861(s)(2)(K)''.

(E) Section 1888(e)(2)(A)(ii) (42 U.S.C. 1395yy(e)(2)(A)(ii)), as added by section 4432(a) (relating to prospective payment system for rehabilitation hospitals), is amended by striking ''through (iii)'' and inserting ''and (ii)''.

(b) INCREASED PAYMENT.—

(1) FEE SCHEDULE AMOUNT.—Subparagraph (O) of section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended to read as follows: ''(O) with respect to services described in section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services), the amounts paid shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848, or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery; and''.

(2) CONFORMING AMENDMENTS.—Section 1833(r) (42 U.S.C. 1395l(r)) is amended—

(A) in paragraph (1), by striking ''section 1861(s)(2)(K)(iii) (relating to nurse practitioner or clinical nurse specialist services provided in a rural area)'' and inserting ''section 1861(s)(2)(K)(ii) (relating to nurse practitioner or clinical nurse specialist services)'';

(B) by striking paragraph (2);

(C) in paragraph (3), by striking ''section 1861(s)(2)(K)(iii)'' and inserting ''section 1861(s)(2)(K)(ii)''; and

(D) by redesignating paragraph (3) as paragraph (2).

(c) DIRECT PAYMENT FOR NURSE PRACTITIONERS AND CLINICAL NURSE SPECIALISTS.—Section 1832(a)(2)(B)(iv) (42 U.S.C. 1395k(a)(2)(B)(iv)) is amended by striking ''provided in a rural area (as defined in section 1886(d)(2)(D))'' and inserting ''but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services''.

(d) DEFINITION OF CLINICAL NURSE SPECIALIST CLARIFIED.—Section 1861(aa)(5) (42 U.S.C. 1395x(aa)(5)) is amended—

(1) by inserting ''(A)'' after ''(5)'';

(2) by striking ''The term 'physician assistant'' and all that follows through ''who performs'' and inserting ''The term 'physician assistant' and the term 'nurse practitioner' mean, for purposes of this title, a physician assistant or nurse practitioner who performs''; and

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

''(B) The term 'clinical nurse specialist' means, for purposes of this title, an individual who—

''(i) is a registered nurse and is licensed to practice nursing in the State in which the clinical nurse specialist services are performed; and

''(ii) holds a master's degree in a defined clinical area of nursing from an accredited educational institution.''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished and supplies provided on and after January 1, 1998.

**SEC. 4512. INCREASED MEDICARE REIMBURSEMENT FOR PHYSICIAN ASSISTANTS.**

(a) REMOVAL OF RESTRICTION ON SETTINGS.—Section 1861(s)(2)(K)(i) (42 U.S.C. 1395x(s)(2)(K)(i)), as amended by section 4511, is amended—

(1) by striking ''(I) in a hospital'' and all that follows through ''shortage area,'', and

(2) by adding at the end the following: ''but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services,''.

(b) INCREASED PAYMENT.—

(1) FEE SCHEDULE AMOUNT.—Section 1833(a)(1)(O) (42 U.S.C. 1395l(a)(1)(O)), as amended by section 4511, is further amended—

(A) by striking ''section 1861(s)(2)(K)(ii)'' and inserting ''1861(s)(2)(K)'', and

(B) by striking ''nurse practitioner or clinical nurse specialist services'' and inserting ''services furnished by physician assistants, nurse practitioners, or clinic nurse specialists''.

(2) CONFORMING AMENDMENT.—Paragraph (12) of section 1842(b) (42 U.S.C. 1395u(b)) is repealed.

(c) REMOVAL OF RESTRICTION ON EMPLOYMENT RELATIONSHIP.—Section 1842(b)(6) (42 U.S.C. 1395u(b)(6)), as amended by section 4205, is amended by adding at the end the following new sentence: ''For purposes of subparagraph (C) of the first sentence of this paragraph, an employment relationship may include any independent contractor arrangement, and employer status shall be determined in accordance with the law of the State in which the services described in such clause are performed.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services furnished and supplies provided on and after January 1, 1998.

**SEC. 4513. NO X-RAY REQUIRED FOR CHIROPRACTIC SERVICES.**

(a) IN GENERAL.—Section 1861(r)(5) (42 U.S.C. 1395x(r)(5)) is amended by striking ''demonstrated by X-ray to exist''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to services furnished on or after January 1, 2000.

(c) UTILIZATION GUIDELINES.—The Secretary of Health and Human Services shall develop and implement utilization guidelines relating to the coverage of chiropractic services under part B of title XVIII of the Social Security Act in cases in which a subluxation has not been demonstrated by X-ray to exist.

## CHAPTER 2—PAYMENT FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES

**SEC. 4521. ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS (FDO) FOR CERTAIN OUTPATIENT HOSPITAL SERVICES.**

(a) ELIMINATION OF FDO FOR AMBULATORY SURGICAL CENTER PROCEDURES.—Section 1833(i)(3)(B)(i)(II) (42 U.S.C. 1395l(i)(3)(B)(i)(II)) is amended—

(1) by striking ''of 80 percent''; and

(2) by striking the period at the end and inserting the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).''.

(b) ELIMINATION OF FDO FOR RADIOLOGY SERVICES AND DIAGNOSTIC PROCEDURES.—Section 1833(n)(1)(B)(i) (42 U.S.C. 1395l(n)(1)(B)(i)) is amended—

(1) by striking ''of 80 percent'', and

(2) by inserting before the period at the end the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished during portions of cost reporting periods occurring on or after October 1, 1997.

**SEC. 4522. EXTENSION OF REDUCTIONS IN PAYMENTS FOR COSTS OF HOSPITAL OUTPATIENT SERVICES.**

(a) REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS.—Section 1861(v)(1)(S)(ii)(I) (42 U.S.C. 1395x(v)(1)(S)(ii)(I)) is amended by striking ''through 1998'' and inserting ''through 1999 and during fiscal year 2000 before January 1, 2000''.

(b) REDUCTION IN PAYMENTS FOR OTHER COSTS.—Section 1861(v)(1)(S)(ii)(II) (42 U.S.C. 1395x(v)(1)(S)(ii)(II)) is amended by striking ''through 1998'' and inserting ''through 1999 and during fiscal year 2000 before January 1, 2000''.

**SEC. 4523. PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.**

(a) IN GENERAL.—Section 1833 (42 U.S.C. 1395l) is amended by adding at the end the following:

''(t) PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—

''(1) AMOUNT OF PAYMENT.—

''(A) IN GENERAL.—With respect to covered OPD services (as defined in subparagraph (B)) furnished during a year beginning with 1999, the amount of payment under this part shall be determined under a prospective payment system established by the Secretary in accordance with this subsection.

''(B) DEFINITION OF COVERED OPD SERVICES.—For purposes of this subsection, the term 'covered OPD services'—

''(i) means hospital outpatient services designated by the Secretary;

''(ii) subject to clause (iii), includes inpatient hospital services designated by the Secretary that are covered under this part and furnished to a hospital inpatient who (I) is entitled to benefits under part A but has exhausted benefits for inpatient hospital services during a spell of illness, or (II) is not so entitled; but

''(iii) does not include any therapy services described in subsection (a)(8) or ambulance services, for which payment is made under a fee schedule described in section 1834(k) or section 1834(l).

''(2) SYSTEM REQUIREMENTS.—Under the payment system—

''(A) the Secretary shall develop a classification system for covered OPD services;

''(B) the Secretary may establish groups of covered OPD services, within the classification system described in subparagraph (A), so that services classified within each group are comparable clinically and with respect to the use of resources;

''(C) the Secretary shall, using data on claims from 1996 and using data from the most recent available cost reports, establish relative payment weights for covered OPD services (and any groups of such services described in subparagraph (B)) based on median hospital costs and shall determine projections of the frequency of utilization of each such service (or group of services) in 1999;

''(D) the Secretary shall determine a wage adjustment factor to adjust the portion of payment and coinsurance attributable to labor-related costs for relative differences in labor and labor-related costs across geographic regions in a budget neutral manner;

''(E) the Secretary shall establish other adjustments, in a budget neutral manner, as determined to be necessary to ensure equitable payments, such as outlier adjustments or adjustments for certain classes of hospitals; and

''(F) the Secretary shall develop a method for controlling unnecessary increases in the volume of covered OPD services.

''(3) CALCULATION OF BASE AMOUNTS.—

''(A) AGGREGATE AMOUNTS THAT WOULD BE PAYABLE IF DEDUCTIBLES WERE DISREGARDED.—The Secretary shall estimate the sum of—

''(i) the total amounts that would be payable from the Trust Fund under this part for covered OPD services in 1999, determined without regard to this subsection, as though the deductible under section 1833(b) did not apply, and

''(ii) the total amounts of copayments estimated to be paid under this subsection by beneficiaries to hospitals for covered OPD services in 1999, as though the deductible under section 1833(b) did not apply.

''(B) UNADJUSTED COPAYMENT AMOUNT.—

''(i) IN GENERAL.—For purposes of this subsection, subject to clause (ii), the 'unadjusted copayment amount' applicable to a covered OPD service (or group of such services) is 20 percent of the national median of the charges for the service (or services within the group) furnished during 1996, updated to 1999 using the Secretary's estimate of charge growth during the period.

''(ii) ADJUSTED TO BE 20 PERCENT WHEN FULLY PHASED IN.—If the pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year would be equal to or exceed 80 percent, then the unadjusted copayment amount shall be 20 percent of amount determined under subparagraph (D).

''(iii) RULES FOR NEW SERVICES.—The Secretary shall establish rules for establishment of an unadjusted copayment amount for a covered OPD service not furnished during 1996, based upon its classification within a group of such services.

''(C) CALCULATION OF CONVERSION FACTORS.—

''(i) FOR 1999.—

''(I) IN GENERAL.—The Secretary shall establish a 1999 conversion factor for determining the medicare OPD fee schedule amounts for each covered OPD service (or group of such services) furnished in 1999. Such conversion factor shall be established on the basis of the weights and frequencies described in paragraph (2)(C) and in such a manner that the sum for all services and groups of the products (described in subclause (II) for each such service or group) equals the total projected amount described in subparagraph (A).

''(II) PRODUCT DESCRIBED.—The Secretary shall determine for each service or group the product of the medicare OPD fee schedule amounts (taking into account appropriate adjustments described in paragraphs (2)(D) and (2)(E)) and the estimated frequencies for such service or group.

''(ii) SUBSEQUENT YEARS.—Subject to paragraph (8)(B), the Secretary shall establish a conversion factor for covered OPD services furnished in subsequent years in an amount equal to the conversion factor established under this subparagraph and applicable to such services furnished in the previous year increased by the OPD fee schedule increase factor specified under clause (iii) for the year involved.

''(iii) OPD FEE SCHEDULE INCREASE FACTOR.—For purposes of this subparagraph, the 'OPD fee schedule increase factor' for services furnished in a year is equal to the market basket percentage increase applicable under section 1886(b)(3)(B)(iii) to hospital discharges occurring during the fiscal year ending in such year, reduced by 1 percentage point for such factor for services furnished in each of 2000, 2001, and 2002. In applying the previous sentence for years beginning with 2000, the Secretary may substitute for the market basket percentage increase an annual percentage increase that is computed and applied with respect to covered OPD services furnished in a year in the same manner as the market basket percentage increase is determined and applied to inpatient hospital services for discharges occurring in a fiscal year.

''(D) CALCULATION OF MEDICARE OPD FEE SCHEDULE AMOUNTS.—The Secretary shall compute a medicare OPD fee schedule amount for each covered OPD service (or group of such services) furnished in a year, in an amount equal to the product of—

''(i) the conversion factor computed under subparagraph (C) for the year, and

''(ii) the relative payment weight (determined under paragraph (2)(C)) for the service or group.

''(E) PRE-DEDUCTIBLE PAYMENT PERCENTAGE.—The pre-deductible payment percentage for a covered OPD service (or group of such services) furnished in a year is equal to the ratio of—

''(i) the medicare OPD fee schedule amount established under subparagraph (D) for the year, minus the unadjusted copayment amount determined under subparagraph (B) for the service or group, to

''(ii) the medicare OPD fee schedule amount determined under subparagraph (D) for the year for such service or group.

''(4) MEDICARE PAYMENT AMOUNT.—The amount of payment made from the Trust Fund under this part for a covered OPD service (and such services classified within a group) furnished in a year is determined as follows:

''(A) FEE SCHEDULE ADJUSTMENTS.—The medicare OPD fee schedule amount (computed under paragraph (3)(D)) for the service or group and year is adjusted for relative differences in the cost of labor and other factors determined by the Secretary, as computed under paragraphs (2)(D) and (2)(E).

''(B) SUBTRACT APPLICABLE DEDUCTIBLE.—Reduce the adjusted amount determined under subparagraph (A) by the amount of the deductible under section 1833(b), to the extent applicable.

''(C) APPLY PAYMENT PROPORTION TO REMAINDER.—The amount of payment is the amount so determined under subparagraph (B) multiplied by the pre-deductible payment percentage (as determined under paragraph (3)(E)) for the service or group and year involved.

''(5) COPAYMENT AMOUNT.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the copayment amount under this subsection is the amount by which the amount described in paragraph (4)(B) exceeds the amount of payment determined under paragraph (4)(C).

''(B) ELECTION TO OFFER REDUCED COPAYMENT AMOUNT.—The Secretary shall establish a procedure under which a hospital, before the beginning of a year (beginning with 1999), may elect to reduce the copayment amount otherwise established under subparagraph (A) for some or all covered OPD services to an amount that is not less than 20 percent of the medicare OPD fee schedule amount (computed under paragraph (3)(D)) for the service involved. Under such procedures, such reduced copayment amount may not be further reduced or increased during the year involved and the hospital may disseminate information on the reduction of copayment amount effected under this subparagraph.

''(C) NO IMPACT ON DEDUCTIBLES.—Nothing in this paragraph shall be construed as affecting a hospital's authority to waive the charging of a deductible under section 1833(b).

''(6) PERIODIC REVIEW AND ADJUSTMENTS COMPONENTS OF PROSPECTIVE PAYMENT SYSTEM.—

''(A) PERIODIC REVIEW.—The Secretary may periodically review and revise the groups, the relative payment weights, and the wage and other adjustments described in paragraph (2) to take into account changes in medical practice, changes in technology, the addition of new services, new cost data, and other relevant information and factors.

''(B) BUDGET NEUTRALITY ADJUSTMENT.—If the Secretary makes adjustments under subparagraph (A), then the adjustments for a year may not cause the estimated amount of expenditures under this part for the year to increase or decrease from the estimated amount of expenditures under this part that would have been made if the adjustments had not been made.

''(C) UPDATE FACTOR.—If the Secretary determines under methodologies described in paragraph (2)(F) that the volume of services paid for under this subsection increased beyond amounts established through those methodologies, the Secretary may appropriately adjust the update to the conversion

factor otherwise applicable in a subsequent year.

''(7) SPECIAL RULE FOR AMBULANCE SERVICES.—The Secretary shall pay for hospital outpatient services that are ambulance services on the basis described in the matter in subsection (a)(1) preceding subparagraph (A), or, if applicable, the fee schedule established under section 1834(l).

''(8) SPECIAL RULES FOR CERTAIN HOSPITALS.—In the case of hospitals described in section 1886(d)(1)(B)(v)—

''(A) the system under this subsection shall not apply to covered OPD services furnished before January 1, 2000; and

''(B) the Secretary may establish a separate conversion factor for such services in a manner that specifically takes into account the unique costs incurred by such hospitals by virtue of their patient population and service intensity.

''(9) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

''(A) the development of the classification system under paragraph (2), including the establishment of groups and relative payment weights for covered OPD services, of wage adjustment factors, other adjustments, and methods described in paragraph (2)(F);

''(B) the calculation of base amounts under paragraph (3);

''(C) periodic adjustments made under paragraph (6); and

''(D) the establishment of a separate conversion factor under paragraph (8)(B).''.

(b) COINSURANCE.—Section 1866(a)(2)(A)(ii) (42 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by adding at the end the following: ''In the case of items and services for which payment is made under part B under the prospective payment system established under section 1833(t), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge, the applicable copayment amount established under section 1833(t)(5).''.

(c) TREATMENT OF REDUCTION IN COPAYMENT AMOUNT.—Section 1128A(i)(6) (42 U.S.C. 1320a–7a(i)(6)) is amended—

(1) by striking ''or'' at the end of subparagraph (B),

(2) by striking the period at the end of subparagraph (C) and inserting ''; or'', and

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

''(D) a reduction in the copayment amount for covered OPD services under section 1833(t)(5)(B).''.

(d) CONFORMING AMENDMENTS.—

(1) APPROVED ASC PROCEDURES PERFORMED IN HOSPITAL OUTPATIENT DEPARTMENTS.—

(A)(i) Section 1833(i)(3)(A) (42 U.S.C. 1395l(i)(3)(A)) is amended—

(I) by inserting ''before January 1, 1999,'' after ''furnished'', and

(II) by striking ''in a cost reporting period''.

(ii) The amendment made by clause (i) shall apply to services furnished on or after January 1, 1999.

(B) Section 1833(a)(4) (42 U.S.C. 1395l(a)(4)) is amended by inserting ''or subsection (t)'' before the semicolon.

(2) RADIOLOGY AND OTHER DIAGNOSTIC PROCEDURES.—

(A) Section 1833(n)(1)(A) (42 U.S.C. 1395l(n)(1)(A)) is amended by inserting ''and before January 1, 1999,'' after ''October 1, 1988,'' and after ''October 1, 1989,''.

(B) Section 1833(a)(2)(E) (42 U.S.C. 1395l(a)(2)(E)) is amended by inserting ''or, for services or procedures performed on or after January 1, 1999, subsection (t)'' before the semicolon.

(3) OTHER HOSPITAL OUTPATIENT SERVICES.—Section 1833(a)(2)(B) (42 U.S.C. 1395l(a)(2)(B)) is amended—

(A) in clause (i), by inserting ''furnished before January 1, 1999,'' after ''(i)'',

(B) in clause (ii), by inserting ''before January 1, 1999,'' after ''furnished'',

(C) by redesignating clause (iii) as clause (iv), and

(D) by inserting after clause (ii), the following new clause:

''(iii) if such services are furnished on or after January 1, 1999, the amount determined under subsection (t), or''.

## CHAPTER 3—AMBULANCE SERVICES

### SEC. 4531. PAYMENTS FOR AMBULANCE SERVICES.

(a) INTERIM REDUCTIONS.—

(1) PAYMENTS DETERMINED ON REASONABLE COST BASIS.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)), as amended by section 4451, is amended by adding at the end the following new subparagraph:

''(U) In determining the reasonable cost of ambulance services (as described in subsection (s)(7)) provided during fiscal year 1998, during fiscal year 1999, and during so much of fiscal year 2000 as precedes January 1, 2000, the Secretary shall not recognize the costs per trip in excess of costs recognized as reasonable for ambulance services provided on a per trip basis during the previous fiscal year (after application of this subparagraph), increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the fiscal year involved reduced by 1.0 percentage point. For ambulance services provided after June 30, 1998, the Secretary may provide that claims for such services must include a code (or codes) under a uniform coding system specified by the Secretary that identifies the services furnished.''.

(2) PAYMENTS DETERMINED ON REASONABLE CHARGE BASIS.—Section 1842(b) (42 U.S.C. 1395u(b)) is amended by adding at the end the following new paragraph:

''(19) For purposes of section 1833(a)(1), the reasonable charge for ambulance services (as described in section 1861(s)(7)) provided during calendar year 1998 and calendar year 1999 may not exceed the reasonable charge for such services provided during the previous calendar year (after application of this paragraph), increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) as estimated by the Secretary for the 12-month period ending with the midpoint of the year involved reduced by 1.0 percentage point.''.

(b) ESTABLISHMENT OF PROSPECTIVE FEE SCHEDULE.—

(1) PAYMENT IN ACCORDANCE WITH FEE SCHEDULE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)), as amended by section 4315(b), is amended—

(A) by striking ''and (Q)'' and inserting ''(Q)''; and

(B) by striking the semicolon at the end and inserting the following: '', and (R) with respect to ambulance service, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary under section 1834(l);''.

(2) ESTABLISHMENT OF SCHEDULE.—Section 1834 (42 U.S.C. 1395m), as amended by section 4541, is amended by adding at the end the following new subsection:

''(l) ESTABLISHMENT OF FEE SCHEDULE FOR AMBULANCE SERVICES.—

''(1) IN GENERAL.—The Secretary shall establish a fee schedule for payment for ambulance services whether provided directly by a supplier or provider or under arrangement with a provider under this part through a negotiated rulemaking process described in title 5, United States Code, and in accordance with the requirements of this subsection.

''(2) CONSIDERATIONS.—In establishing such fee schedule, the Secretary shall—

''(A) establish mechanisms to control increases in expenditures for ambulance services under this part;

''(B) establish definitions for ambulance services which link payments to the type of services provided;

''(C) consider appropriate regional and operational differences;

''(D) consider adjustments to payment rates to account for inflation and other relevant factors; and

''(E) phase in the application of the payment rates under the fee schedule in an efficient and fair manner.

''(3) SAVINGS.—In establishing such fee schedule, the Secretary shall—

''(A) ensure that the aggregate amount of payments made for ambulance services under this part during 2000 does not exceed the aggregate amount of payments which would have been made for such services under this part during such year if the amendments made by section 4531(a) of the Balanced Budget Act of 1997 continued in effect, except that in making such determination the Secretary shall assume an update in such payments for 2002 equal to percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced in the case of 2001 and 2002 by 1.0 percentage points; and

''(B) set the payment amounts provided under the fee schedule for services furnished in 2001 and each subsequent year at amounts equal to the payment amounts under the fee schedule for services furnished during the previous year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced in the case of 2001 and 2002 by 1.0 percentage points.

''(4) CONSULTATION.—In establishing the fee schedule for ambulance services under this subsection, the Secretary shall consult with various national organizations representing individuals and entities who furnish and regulate ambulance services and share with such organizations relevant data in establishing such schedule.

''(5) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869 or otherwise of the amounts established under the fee schedule for ambulance services under this subsection, including matters described in paragraph (2).

''(6) RESTRAINT ON BILLING.—The provisions of subparagraphs (A) and (B) of section 1842(b)(18) shall apply to ambulance services for which payment is made under this subsection in the same manner as they apply to services provided by a practitioner described in section 1842(b)(18)(C).

''(7) CODING SYSTEM.—The Secretary may require the claim for any services for which the amount of payment is determined under this subsection to include a code (or codes) under a uniform coding system specified by the Secretary that identifies the services furnished.''

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after January 1, 2000.

(c) AUTHORIZING PAYMENT FOR PARAMEDIC INTERCEPT SERVICE PROVIDERS IN RURAL COMMUNITIES.—In promulgating regulations to carry out section 1861(s)(7) of the Social Security Act (42 U.S.C. 1395x(s)(7)) with respect to the coverage of ambulance service, the Secretary of Health and Human Services may include coverage of advanced life support services (in this subsection referred to as ''ALS intercept services'') provided by a paramedic intercept service provider in a rural area if the following conditions are met:

(1) The ALS intercept services are provided under a contract with one or more volunteer ambulance services and are medically necessary based on the health condition of the individual being transported.

(2) The volunteer ambulance service involved—

(A) is certified as qualified to provide ambulance service for purposes of such section,

(B) provides only basic life support services at the time of the intercept, and

(C) is prohibited by State law from billing for any services.

(3) The entity supplying the ALS intercept services—

(A) is certified as qualified to provide such services under the medicare program under title XVIII of the Social Security Act, and

(B) bills all recipients who receive ALS intercept services from the entity, regardless of whether or not such recipients are medicare beneficiaries.

**SEC. 4532. DEMONSTRATION OF COVERAGE OF AMBULANCE SERVICES UNDER MEDICARE THROUGH CONTRACTS WITH UNITS OF LOCAL GOVERNMENT.**

(a) DEMONSTRATION PROJECT CONTRACTS WITH LOCAL GOVERNMENTS.—The Secretary of Health and Human Services shall establish up to 3 demonstration projects under which, at the request of a unit of local government, the Secretary enters into a contract with the unit of local government under which—

(1) the unit of local government furnishes (or arranges for the furnishing of) ambulance services for which payment may be made under part B of title XVIII of the Social Security Act for individuals residing in the unit of local government who are enrolled under such part, except that the unit of local government may not enter into the contract unless the contract covers at least 80 percent of the individuals residing in the unit of local government who are enrolled under such part but not in a Medicare+Choice plan;

(2) any individual or entity furnishing ambulance services under the contract meets the requirements otherwise applicable to individuals and entities furnishing such services under such part; and

(3) for each month during which the contract is in effect, the Secretary makes a capitated payment to the unit of local government in accordance with subsection (b).

The projects may extend over a period of not to exceed 3 years each.

(b) AMOUNT OF PAYMENT.—

(1) IN GENERAL.—The amount of the monthly payment made for months occurring during a calendar year to a unit of local government under a demonstration project contract under subsection (a) shall be equal to the product of—

(A) the Secretary's estimate of the number of individuals covered under the contract for the month; and

(B) 1/12 of the capitated payment rate for the year established under paragraph (2).

(2) CAPITATED PAYMENT RATE DEFINED.—In this subsection, the ''capitated payment rate'' applicable to a contract under this subsection for a calendar year is equal to 95 percent of—

(A) for the first calendar year for which the contract is in effect, the average annual per capita payment made under part B of title XVIII of the Social Security Act with respect to ambulance services furnished to such individuals during the 3 most recent calendar years for which data on the amount of such payment is available; and

(B) for a subsequent year, the amount provided under this paragraph for the previous year increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

(c) OTHER TERMS OF CONTRACT.—The Secretary and the unit of local government may include in a contract under this section such other terms as the parties consider appropriate, including—

(1) covering individuals residing in additional units of local government (under arrangements entered into between such units and the unit of local government involved);

(2) permitting the unit of local government to transport individuals to non-hospital providers if such providers are able to furnish quality services at a lower cost than hospital providers; or

(3) implementing such other innovations as the unit of local government may propose to improve the quality of ambulance services and control the costs of such services.

(d) CONTRACT PAYMENTS IN LIEU OF OTHER BENEFITS.—Payments under a contract to a unit of local government under this section shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under part B of title XVIII of the Social Security Act for the services covered under the contract which are furnished to individuals who reside in the unit of local government.

(e) REPORT ON EFFECTS OF CAPITATED CONTRACTS.—

(1) STUDY.—The Secretary shall evaluate the demonstration projects conducted under this section. Such evaluation shall include an analysis of the quality and cost-effectiveness of ambulance services furnished under the projects.

(2) REPORT.—Not later than January 1, 2000, the Secretary shall submit a report to Congress on the study conducted under paragraph (1), and shall include in the report such recommendations as the Secretary considers appropriate, including recommendations regarding modifications to the methodology used to determine the amount of payments made under such contracts and extending or expanding such projects.

## CHAPTER 4—PROSPECTIVE PAYMENT FOR OUTPATIENT REHABILITATION SERVICES

**SEC. 4541. PROSPECTIVE PAYMENT FOR OUTPATIENT REHABILITATION SERVICES.**

(a) PAYMENT BASED ON FEE SCHEDULE.—

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

(A) in paragraph (2) in the matter before subparagraph (A), by inserting ''(C),'' before ''(D)'';

(B) in paragraph (3), by striking ''subparagraphs (D) and (E) of section 1832(a)(2)'' and inserting ''section 1832(a)(2)(D)'';

(C) in paragraph (6), by striking ''and'' at the end;

(D) in paragraph (7), by striking the period at the end and inserting a semicolon; and

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

''(8) in the case of—

''(A) outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services furnished—

''(i) by a rehabilitation agency, public health agency, clinic, comprehensive outpatient rehabilitation facility, or skilled nursing facility,

''(ii) by a home health agency to an individual who is not homebound, or

''(iii) by another entity under an arrangement with an entity described in clause (i) or (ii); and

''(B) outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services furnished—

''(i) by a hospital to an outpatient or to a hospital inpatient who is entitled to benefits under part A but has exhausted benefits for inpatient hospital services during a spell of illness or is not so entitled to benefits under part A, or

''(ii) by another entity under an arrangement with a hospital described in clause (i), the amounts described in section 1834(k); and

''(9) in the case of services described in section 1832(a)(2)(E) that are not described in paragraph (8), the amounts described in section 1834(k).''.

(2) PAYMENT RATES.—Section 1834 (42 U.S.C. 1395m) is amended by adding at the end the following new subsection:

''(k) PAYMENT FOR OUTPATIENT THERAPY SERVICES AND COMPREHENSIVE OUTPATIENT REHABILITATION SERVICES.—

''(1) IN GENERAL.—With respect to services described in section 1833(a)(8) or 1833(a)(9) for which payment is determined under this subsection, the payment basis shall be—

''(A) for services furnished during 1998, the amount determined under paragraph (2); or

''(B) for services furnished during a subsequent year, 80 percent of the lesser of—

''(i) the actual charge for the services, or

''(ii) the applicable fee schedule amount (as defined in paragraph (3)) for the services.

''(2) PAYMENT IN 1998 BASED UPON ADJUSTED REASONABLE COSTS.—The amount under this paragraph for services is the lesser of—

''(A) the charges imposed for the services, or

''(B) the adjusted reasonable costs (as defined in paragraph (4)) for the services,

less 20 percent of the amount of the charges imposed for such services.

''(3) APPLICABLE FEE SCHEDULE AMOUNT.—In this subsection, the term 'applicable fee schedule amount' means, with respect to services furnished in a year, the amount determined under the fee schedule established under section 1848 for such services furnished during the year or, if there is no such fee schedule established for such services, the amount determined under the fee schedule established for such comparable services as the Secretary specifies.

''(4) ADJUSTED REASONABLE COSTS.—In paragraph (2), the term 'adjusted reasonable costs' means, with respect to any services, reasonable costs determined for such services, reduced by 10 percent. The 10-percent reduction shall not apply to services described in section 1833(a)(8)(B) (relating to services provided by hospitals).

''(5) UNIFORM CODING.—For claims for services submitted on or after April 1, 1998, for which the amount of payment is determined under this subsection, the claim shall include a code (or codes) under a uniform coding system specified by the Secretary that identifies the services furnished.

''(6) RESTRAINT ON BILLING.—The provisions of subparagraphs (A) and (B) of section 1842(b)(18) shall apply to therapy services for which payment is made under this subsection in the same manner as they apply to services provided by a practitioner described in section 1842(b)(18)(C).''.

(3) CONFORMING CHANGE IN BILLING.—Section 1866(a)(2)(A)(ii) (42 U.S.C. 1395cc(a)(2)(A)(ii)) is amended by adding at the end the following: ''In the case of services described in section 1833(a)(8) or section 1833(a)(9) for which payment is made under part B under section 1834(k), clause (ii) of the first sentence shall be applied by substituting for 20 percent of the reasonable charge for such services 20 percent of the lesser of the actual charge or the applicable fee schedule amount (as defined in such section) for such services.''.

(b) APPLICATION OF STANDARDS TO OUTPATIENT OCCUPATIONAL AND PHYSICAL THERAPY SERVICES PROVIDED AS AN INCIDENT TO A PHYSICIAN'S PROFESSIONAL SERVICES.—Section 1862(a), as amended by sections 4319(b), 4432(b), and 4507(a)(2)(B), (42 U.S.C. 1395y(a)) is amended—

(1) by striking ''or'' at the end of paragraph (18);

(2) by striking the period at the end of paragraph (19) and inserting ''; or''; and

(3) by inserting after paragraph (19) the following:

''(20) in the case of outpatient occupational therapy services or outpatient physical therapy services furnished as an incident to a physician's professional services (as described in section 1861(s)(2)(A)), that do not meet the standards and conditions (other than any licensing requirement specified by the Secretary) under the second sentence of section 1861(p) (or under such sentence through the operation of section 1861(g)) as such standards and conditions would apply to such therapy services if furnished by a therapist.''.

(c) APPLYING FINANCIAL LIMITATION TO ALL REHABILITATION SERVICES.—Section 1833(g) (42 U.S.C. 1395l(g)) is amended—

(1) in the first sentence, by striking ''services described in the second sentence of section 1861(p)'' and inserting ''physical therapy services of the type described in section 1861(p), but not described in section 1833(a)(8)(B), and physical therapy services of such type which are furnished by a physician or as incident to physicians' services'', and

(2) in the second sentence, by striking ''outpatient occupational therapy services which are described in the second sentence of section 1861(p) through the operation of section 1861(g)'' and inserting ''occupational therapy services (of the type that are described in section 1861(p) (but not described in section 1833(a)(8)(B)) through the operation of section 1861(g) and of such type which are furnished by a physician or as incident to physicians' services)''.

(d) INDEXING LIMITATION.—

(1) IN GENERAL.—Section 1833(g) (42 U.S.C. 1395l(g)), as amended by subsection (c), is further amended—

(A) by striking ''$900'' each place it appears and inserting ''the amount specified in paragraph (2) for the year'',

(B) by inserting ''(1)'' after ''(g)'',

(C) by designating the last sentence as a paragraph (3), and

(D) by inserting before paragraph (3), as so designated, the following:

''(2) The amount specified in this paragraph—

''(A) for 1999, 2000, and 2001, is $1,500, and

''(B) for a subsequent year is the amount specified in this paragraph for the preceding year increased by the percentage increase in the MEI (as defined in section 1842(i)(3)) for such subsequent year;

except that if an increase under subparagraph (B) for a year is not a multiple of $10, it shall be rounded to the nearest multiple of $10.''.

(2) REPORT.—By not later than January 1, 2001, the Secretary of Health and Human Services shall submit to Congress a report that includes recommendations on the establishment of a revised coverage policy of outpatient physical therapy services and outpatient occupational therapy services under the Social Security Act based on classification of individuals by diagnostic category and prior use of services, in both inpatient and outpatient settings, in place of the uniform dollar limitations specified in section 1833(g) of such Act, as amended by paragraph (1). The recommendations shall include how such a system of durational limits by diagnostic category might be implemented in a budget-neutral manner.

(e) EFFECTIVE DATES.—

(1) The amendments made by subsections (a)(1), (a)(2), and (b) apply to services furnished on or after January 1, 1998, including portions of cost reporting periods occurring on or after such date, except that section 1834(k) of the Social Security Act (as added by subsection (a)(2)) shall not apply to services described in section 1833(a)(8)(B) of such Act (as added by subsection (a)(1)) that are furnished during 1998.

(2) The amendments made by subsections (a)(3) and (c) apply to services furnished on or after January 1, 1999.

(3) The amendments made by subsection (d)(1) apply to expenses incurred on or after January 1, 1999.

## CHAPTER 5—OTHER PAYMENT PROVISIONS

### SEC. 4551. PAYMENTS FOR DURABLE MEDICAL EQUIPMENT.

(a) REDUCTION IN PAYMENT AMOUNTS FOR ITEMS OF DURABLE MEDICAL EQUIPMENT.—

(1) FREEZE IN UPDATE FOR COVERED ITEMS.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended—

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

(B) in subparagraph (B)—

(i) by striking ''a subsequent year'' and inserting ''1993, 1994, 1995, 1996, and 1997'', and

(ii) by striking the period at the end and inserting a semicolon; and

(C) by adding at the end the following new subparagraphs:

''(C) for each of the years 1998 through 2002, 0 percentage points; and

''(D) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.''.

(2) UPDATE FOR ORTHOTICS AND PROSTHETICS.—Section 1834(h)(4)(A) (42 U.S.C. 1395m(h)(4)(A)) is amended—

(A) in clause (iii), by striking '', and'' at the end and inserting a semicolon;

(B) in clause (iv), by striking ''a subsequent year'' and inserting ''1996 and 1997''; and

(C) by adding at the end the following new clauses:

''(v) for each of the years 1998 through 2002, 1 percent, and

''(vi) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;''.

(b) PAYMENT FREEZE FOR PARENTERAL AND ENTERAL NUTRIENTS, SUPPLIES, AND EQUIPMENT.—In determining the amount of payment under part B of title XVIII of the Social Security Act with respect to parenteral and enteral nutrients, supplies, and equipment during each of the years 1998 through 2002, the charges determined to be reasonable with respect to such nutrients, supplies, and equipment may not exceed the charges determined to be reasonable with respect to such nutrients, supplies, and equipment during 1995.

(c) UPGRADED DURABLE MEDICAL EQUIPMENT.—

(1) IN GENERAL.—Section 1834(a) (42 U.S.C. 1395m(a)), as amended by section 4312(a), is amended by inserting after paragraph (16) the following new paragraph:

''(17) CERTAIN UPGRADED ITEMS.—

''(A) INDIVIDUAL'S RIGHT TO CHOOSE UPGRADED ITEM.—Notwithstanding any other provision of this title, the Secretary may issue regulations under which an individual may purchase or rent from a supplier an item of upgraded durable medical equipment for which payment would be made under this subsection if the item were a standard item.

''(B) PAYMENTS TO SUPPLIER.—In the case of the purchase or rental of an upgraded item under subparagraph (A)—

''(i) the supplier shall receive payment under this subsection with respect to such item as if such item were a standard item; and

''(ii) the individual purchasing or renting the item shall pay the supplier an amount equal to the difference between the supplier's charge and the amount under clause (i).

In no event may the supplier's charge for an upgraded item exceed the applicable fee schedule amount (if any) for such item.

''(C) CONSUMER PROTECTION SAFEGUARDS.—Any regulations under subparagraph (A) shall provide for consumer protection standards with respect to the furnishing of upgraded equipment under subparagraph (A). Such regulations shall provide for—

''(i) determination of fair market prices with respect to an upgraded item;

''(ii) full disclosure of the availability and price of standard items and proof of receipt of such disclosure information by the beneficiary before the furnishing of the upgraded item;

''(iii) conditions of participation for suppliers in the billing arrangement;

''(iv) sanctions of suppliers who are determined to engage in coercive or abusive practices, including exclusion; and

''(v) such other safeguards as the Secretary determines are necessary.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to purchases or rentals after the effective date of any regulations issued pursuant to such amendment.

### SEC. 4552. OXYGEN AND OXYGEN EQUIPMENT.

(a) IN GENERAL.—Section 1834(a)(9)(B) (42 U.S.C. 1395m(a)(9)(B)) is amended—

(1) in clause (iii), by striking ''and'' at the end;

(2) in clause (iv)—

(A) by striking ''each subsequent year'' and inserting ''1995, 1996, and 1997'', and

(B) by striking the period at the end and inserting a semicolon; and

(3) by adding at the end the following new clauses:

''(v) for 1998, 75 percent of the amount determined under this subparagraph for 1997; and

''(vi) for 1999 and each subsequent year, 70 percent of the amount determined under this subparagraph for 1997.''.

(b) ESTABLISHMENT OF CLASSES FOR PAYMENT.—Section 1848(a)(9) (42 U.S.C. 1395m(a)(9)) is amended by adding at the end the following new subparagraph:

''(D) AUTHORITY TO CREATE CLASSES.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary may establish separate classes for any item of oxygen and oxygen equipment and separate national limited monthly payment rates for each of such classes.

''(ii) BUDGET NEUTRALITY.—The Secretary may take actions under clause (i) only to the extent such actions do not result in expenditures for any year to be more or less than the expenditures which would have been made if such actions had not been taken.''.

(c) STANDARDS.—The Secretary shall as soon as practicable establish service standards for persons seeking payment under part B of title XVIII of the Social Security Act for the providing of oxygen and oxygen equipment to beneficiaries within their homes.

(d) ACCESS TO HOME OXYGEN EQUIPMENT.—

(1) STUDY.—The Comptroller General of the United States shall study issues relating to access to home oxygen equipment and shall, within 18 months after the date of the enactment of this Act, report to the Committees on Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate the results of the study, including recommendations (if any) for legislation.

(2) PEER REVIEW EVALUATION.—The Secretary of Health and Human Services shall arrange for peer review organizations estab-

lished under section 1154 of the Social Security Act to evaluate access to, and quality of, home oxygen equipment.

(e) EFFECTIVE DATE.—

(1) OXYGEN.—The amendments made by subsection (a) shall apply to items furnished on and after January 1, 1998.

(2) OTHER PROVISIONS.—The amendments made by this section other than subsection (a) shall take effect on the date of the enactment of this Act.

**SEC. 4553. REDUCTION IN UPDATES TO PAYMENT AMOUNTS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS; STUDY ON LABORATORY TESTS.**

(a) CHANGE IN UPDATE.—Section 1833(h)(2)(A)(ii)(IV) (42 U.S.C. 1395l(h)(2)(A)(ii)(IV)) is amended by inserting ''and 1998 through 2002'' after ''1995''.

(b) LOWERING CAP ON PAYMENT AMOUNTS.—Section 1833(h)(4)(B) (42 U.S.C. 1395l(h)(4)(B)) is amended—

(1) in clause (vi), by striking ''and'' at the end;

(2) in clause (vii)—

(A) by inserting ''and before January 1, 1998,'' after ''1995,'', and

(B) by striking the period at the end and inserting '', and''; and

(3) by adding at the end the following new clause:

''(viii) after December 31, 1997, is equal to 74 percent of such median.''.

(c) STUDY AND REPORT ON CLINICAL LABORATORY TESTS.—

(1) IN GENERAL.—The Secretary shall request the Institute of Medicine of the National Academy of Sciences to conduct a study of payments under part B of title XVIII of the Social Security Act for clinical laboratory tests. The study shall include a review of the adequacy of the current methodology and recommendations regarding alternative payment systems. The study shall also analyze and discuss the relationship between such payment systems and access to high quality laboratory tests for medicare beneficiaries, including availability and access to new testing methodologies.

(2) REPORT TO CONGRESS.—The Secretary shall, not later than 2 years after the date of enactment of this section, report to the Committees on Ways and Means and Commerce of the House of Representatives and the Committee on Finance of the Senate the results of the study described in paragraph (1), including any recommendations for legislation.

**SEC. 4554. IMPROVEMENTS IN ADMINISTRATION OF LABORATORY TESTS BENEFIT.**

(a) SELECTION OF REGIONAL CARRIERS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall—

(A) divide the United States into no more than 5 regions, and

(B) designate a single carrier for each such region, for the purpose of payment of claims under part B of title XVIII of the Social Security Act with respect to clinical diagnostic laboratory tests furnished on or after such date (not later than July 1, 1999) as the Secretary specifies.

(2) DESIGNATION.—In designating such carriers, the Secretary shall consider, among other criteria—

(A) a carrier's timeliness, quality, and experience in claims processing, and

(B) a carrier's capacity to conduct electronic data interchange with laboratories and data matches with other carriers.

(3) SINGLE DATA RESOURCE.—The Secretary shall select one of the designated carriers to serve as a central statistical resource for all claims information relating to such clinical diagnostic laboratory tests handled by all the designated carriers under such part.

(4) ALLOCATION OF CLAIMS.—The allocation of claims for clinical diagnostic laboratory tests to particular designated carriers shall be based on whether a carrier serves the geographic area where the laboratory specimen was collected or other method specified by the Secretary.

(5) SECRETARIAL EXCLUSION.—Paragraph (1) shall not apply with respect to clinical diagnostic laboratory tests furnished by physician office laboratories if the Secretary determines that such offices would be unduly burdened by the application of billing responsibilities with respect to more than one carrier.

(b) ADOPTION OF NATIONAL POLICIES FOR CLINICAL LABORATORY TESTS BENEFIT.—

(1) IN GENERAL.—Not later than January 1, 1999, the Secretary shall first adopt, consistent with paragraph (2), national coverage and administrative policies for clinical diagnostic laboratory tests under part B of title XVIII of the Social Security Act, using a negotiated rulemaking process under subchapter III of chapter 5 of title 5, United States Code.

(2) CONSIDERATIONS IN DESIGN OF NATIONAL POLICIES.—The policies under paragraph (1) shall be designed to promote program integrity and national uniformity and simplify administrative requirements with respect to clinical diagnostic laboratory tests payable under such part in connection with the following:

(A) Beneficiary information required to be submitted with each claim or order for laboratory tests.

(B) The medical conditions for which a laboratory test is reasonable and necessary (within the meaning of section 1862(a)(1)(A) of the Social Security Act).

(C) The appropriate use of procedure codes in billing for a laboratory test, including the unbundling of laboratory services.

(D) The medical documentation that is required by a medicare contractor at the time a claim is submitted for a laboratory test in accordance with section 1833(e) of the Social Security Act.

(E) Recordkeeping requirements in addition to any information required to be submitted with a claim, including physicians' obligations regarding such requirements.

(F) Procedures for filing claims and for providing remittances by electronic media.

(G) Limitation on frequency of coverage for the same tests performed on the same individual.

(3) CHANGES IN LABORATORY POLICIES PENDING ADOPTION OF NATIONAL POLICY.—During the period that begins on the date of the enactment of this Act and ends on the date the Secretary first implements national policies pursuant to regulations promulgated under this subsection, a carrier under such part may implement changes relating to requirements for the submission of a claim for clinical diagnostic laboratory tests.

(4) USE OF INTERIM POLICIES.—After the date the Secretary first implements such national policies, the Secretary shall permit any carrier to develop and implement interim policies of the type described in paragraph (1), in accordance with guidelines established by the Secretary, in cases in which a uniform national policy has not been established under this subsection and there is a demonstrated need for a policy to respond to aberrant utilization or provision of unnecessary tests. Except as the Secretary specifically permits, no policy shall be implemented under this paragraph for a period of longer than 2 years.

(5) INTERIM NATIONAL POLICIES.—After the date the Secretary first designates regional carriers under subsection (a), the Secretary shall establish a process under which designated carriers can collectively develop and implement interim national policies of the type described in paragraph (1). No such policy shall be implemented under this paragraph for a period of longer than 2 years.

(6) BIENNIAL REVIEW PROCESS.—Not less often than once every 2 years, the Secretary shall solicit and review comments regarding changes in the national policies established under this subsection. As part of such biennial review process, the Secretary shall specifically review and consider whether to incorporate or supersede interim policies developed under paragraph (4) or (5). Based upon such review, the Secretary may provide for appropriate changes in the national policies previously adopted under this subsection.

(7) REQUIREMENT AND NOTICE.—The Secretary shall ensure that any policies adopted under paragraph (3), (4), or (5) shall apply to all laboratory claims payable under part B of title XVIII of the Social Security Act, and shall provide for advance notice to interested parties and a 45-day period in which such parties may submit comments on the proposed change.

(c) INCLUSION OF LABORATORY REPRESENTATIVE ON CARRIER ADVISORY COMMITTEES.—The Secretary shall direct that any advisory committee established by a carrier to advise such carrier with respect to coverage and administrative policies under part B of title XVIII of the Social Security Act shall include an individual to represent the independent clinical laboratories and such other laboratories as the Secretary deems appropriate. The Secretary shall consider recommendations from national and local organizations that represent independent clinical laboratories in such selection.

**SEC. 4555. UPDATES FOR AMBULATORY SURGICAL SERVICES.**

Section 1833(i)(2)(C) (42 U.S.C. 1395l(i)(2)(C)) is amended by inserting at the end the following new sentence: ''In each of the fiscal years 1998 through 2002, the increase under this subparagraph shall be reduced (but not below zero) by 2.0 percentage points.''.

**SEC. 4556. REIMBURSEMENT FOR DRUGS AND BIOLOGICALS.**

(a) IN GENERAL.—Section 1842 (42 U.S.C. 1395u) is amended by inserting after subsection (n) the following new subsection:

''(o)(1) If a physician's, supplier's, or any other person's bill or request for payment for services includes a charge for a drug or biological for which payment may be made under this part and the drug or biological is not paid on a cost or prospective payment basis as otherwise provided in this part, the amount payable for the drug or biological is equal to 95 percent of the average wholesale price.

''(2) If payment for a drug or biological is made to a licensed pharmacy approved to dispense drugs or biologicals under this part, the Secretary may pay a dispensing fee (less the applicable deductible and coinsurance amounts) to the pharmacy.''.

(b) CONFORMING AMENDMENT.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)), as amended by sections 4315(b) and 4531(b)(1), is amended—

(1) by striking ''and (R)'' and inserting ''(R)''; and

(2) by striking the semicolon at the end and inserting the following: '', and (S) with respect to drugs and biologicals not paid on a cost or prospective payment basis as otherwise provided in this part (other than items and services described in subparagraph (B)), the amounts paid shall be 80 percent of the lesser of the actual charge or the payment amount established in section 1842(o);''.

(c) STUDY AND REPORT.—The Secretary of Health and Human Services shall study the effect on the average wholesale price of drugs and biologicals of the amendments made by subsection (a) and shall report to the Committees on Ways and Means and

Commerce of the House of Representatives and the Committee on Finance of the Senate the result of such study not later than July 1, 1999.

(d) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to drugs and biologicals furnished on or after January 1, 1998.

**SEC. 4557. COVERAGE OF ORAL ANTI-NAUSEA DRUGS UNDER CHEMOTHERAPEUTIC REGIMEN.**

(a) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended by sections 4104 and 4105, is amended—

(1) by striking ''and'' at the end of subparagraph (R); and

(2) by inserting after subparagraph (S) the following new subparagraph:

''(T) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an acute anti-emetic used as part of an anticancer chemotherapeutic regimen if the drug is administered by a physician (or as prescribed by a physician)—

''(i) for use immediately before, at, or within 48 hours after the time of the administration of the anticancer chemotherapeutic agent; and

''(ii) as a full replacement for the anti-emetic therapy which would otherwise be administered intravenously.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to items and services furnished on or after January 1, 1998.

**SEC. 4558. RENAL DIALYSIS-RELATED SERVICES.**

(a) AUDITING OF COST REPORTS.—Beginning with cost reports for 1996, the Secretary shall audit cost reports of each renal dialysis provider at least once every 3 years.

(b) IMPLEMENTATION OF QUALITY STANDARDS.—The Secretary of Health and Human Services shall develop, by not later than January 1, 1999, and implement, by not later than January 1, 2000, a method to measure and report quality of renal dialysis services provided under the medicare program under title XVIII of the Social Security Act.

**SEC. 4559. TEMPORARY COVERAGE RESTORATION FOR PORTABLE ELECTROCARDIOGRAM TRANSPORTATION.**

(a) IN GENERAL.—Effective only for electrocardiogram tests furnished during 1998, the Secretary of Health and Human Services shall restore separate payment, under part B of title XVIII of the Social Security Act, for the transportation of electrocardiogram equipment (HCPCS code R0076) based upon payment methods in effect for such service as of December 31, 1996.

(b) DETERMINATION.—By not later than July 1, 1998, the Secretary of Health and Human Services shall make a recommendation to the Committees on Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate as to whether coverage of portable electrocardiogram transportation should be provided under part B of title XVIII of the Social Security Act. In making such recommendation, the Secretary shall take into account the study of coverage of portable electrocardiogram transportation conducted by the Comptroller General of the United States and other relevant information, including information submitted by interested parties.

## CHAPTER 6—PART B PREMIUM AND RELATED PROVISIONS

### Subchapter A—Determination of Part B Premium Amount

**SEC. 4571. PART B PREMIUM.**

(a) IN GENERAL.—Section 1839(a)(3) (42 U.S.C. 1395r(a)(3)) is amended by striking the first 3 sentences and inserting the following: ''The Secretary, during September of each year, shall determine and promulgate a monthly premium rate for the succeeding calendar year that is equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1), for that succeeding calendar year.''.

(b) CONFORMING AND TECHNICAL AMENDMENTS.—

(1) SECTION 1839.—Section 1839 (42 U.S.C. 1395r) is amended—

(A) in subsection (a)(2), by striking ''(b) and (e)'' and inserting ''(b), (c), and (f)'';

(B) in the last sentence of subsection (a)(3)—

(i) by inserting ''rate'' after ''premium'', and

(ii) by striking ''and the derivation of the dollar amounts specified in this paragraph'';

(C) in the first sentence of subsection (b), by striking ''or (e)'';

(D) by striking subsection (e); and

(E) by redesignating subsection (g) as subsection (e) and inserting that subsection after subsection (d).

(2) SECTION 1844.—Subparagraphs (A)(i) and (B)(i) of section 1844(a)(1) (42 U.S.C. 1395w(a)(1)) are each amended by striking ''or 1839(e), as the case may be''.

### Subchapter B—Other Provisions Related to Part B Premium

**SEC. 4581. PROTECTIONS UNDER THE MEDICARE PROGRAM FOR DISABLED WORKERS WHO LOSE BENEFITS UNDER A GROUP HEALTH PLAN.**

(a) NO PREMIUM PENALTY FOR LATE ENROLLMENT.—The first sentence of section 1839(b) (42 U.S.C. 1395r(b)) is amended by inserting ''and not pursuant to a special enrollment period under section 1837(i)(4)'' after ''section 1837)''.

(b) SPECIAL MEDICARE ENROLLMENT PERIOD.—

(1) IN GENERAL.—Section 1837(i) (42 U.S.C. 1395p(i)) is amended by adding at the end the following new paragraph:

''(4)(A) In the case of an individual who is entitled to benefits under part A pursuant to section 226(b) and—

''(i) who at the time the individual first satisfies paragraph (1) of section 1836—

''(I) is enrolled in a group health plan described in section 1862(b)(1)(A)(v) by reason of the individual's current or former employment or by reason of the current or former employment status of a member of the individual's family, and

''(II) has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period; and

''(ii) whose continuous enrollment under such group health plan is involuntarily terminated at a time when the enrollment under the plan is not by reason of the individual's current employment or by reason of the current employment of a member of the individual's family,

there shall be a special enrollment period described in subparagraph (B).

''(B) The special enrollment period referred to in subparagraph (A) is the 6-month period beginning on the first day of the month which includes the date of the enrollment termination described in subparagraph (A)(ii).''.

(2) COVERAGE PERIOD.—Section 1838(e) (42 U.S.C. 1395q(e)) is amended—

(A) by inserting ''or 1837(i)(4)(B)'' after ''1837(i)(3)'' the first place it appears, and

(B) by inserting ''or specified in section 1837(i)(4)(A)(i)'' after ''1837(i)(3)'' the second place it appears.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to involuntary terminations of coverage under a group health plan occurring on or after the date of the enactment of this Act.

**SEC. 4582. GOVERNMENTAL ENTITIES ELIGIBLE TO ELECT TO PAY PART B PREMIUMS FOR ELIGIBLE INDIVIDUALS.**

Section 1839(e)(1) (as amended by section 4571(b)) is amended—

(1) by inserting ''(or any appropriate State or local governmental entity specified by the Secretary)'' after ''State'' the first place it appears, and

(2) by inserting ''(or such entity)'' after ''State'' the second and third place it appears.

### Subtitle G—Provisions Relating to Parts A and B

## CHAPTER 1—HOME HEALTH SERVICES AND BENEFITS

### Subchapter A—Payments For Home Health Services

**SEC. 4601. RECAPTURING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES FOR HOME HEALTH SERVICES.**

(a) BASING UPDATES TO PER VISIT COST LIMITS ON LIMITS FOR FISCAL YEAR 1993.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)) is amended by adding at the end the following:

''(iv) In establishing limits under this subparagraph for cost reporting periods beginning after September 30, 1997, the Secretary shall not take into account any changes in the home health market basket, as determined by the Secretary, with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996.''.

(b) NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.—The Secretary of Health and Human Services shall not consider the amendment made by subsection (a) in making any exemptions and exceptions pursuant to section 1861(v)(1)(L)(ii) of the Social Security Act (42 U.S.C. 1395x(v)(1)(L)(ii)).

**SEC. 4602. INTERIM PAYMENTS FOR HOME HEALTH SERVICES.**

(a) REDUCTIONS IN COST LIMITS.—Section 1861(v)(1)(L)(i) (42 U.S.C. 1395x(v)(1)(L)(i)) is amended—

(1) by moving the indentation of subclauses (I) through (III) 2-ems to the left;

(2) in subclause (I), by inserting ''of the mean of the labor-related and nonlabor per visit costs for freestanding home health agencies'' before the comma at the end;

(3) in subclause (II), by striking '', or'' and inserting ''of such mean,'';

(4) in subclause (III)—

(A) by inserting ''and before October 1, 1997,'' after ''July 1, 1987,'', and

(B) by striking the comma at the end and inserting ''of such mean, or''; and

(5) by striking the matter following subclause (III) and inserting the following:

''(IV) October 1, 1997, 105 percent of the median of the labor-related and nonlabor per visit costs for freestanding home health agencies.''.

(b) DELAY IN UPDATES.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by inserting '', or on or after July 1, 1997, and before October 1, 1997'' after ''July 1, 1996''.

(c) ADDITIONS TO COST LIMITS.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)) (as amended by section 4601(a)) is amended by adding at the end the following new clauses:

''(v) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the Secretary shall provide for an interim system of limits. Payment shall not exceed the costs determined under the preceding provisions of this subparagraph or, if lower, the product of—

''(I) an agency-specific per beneficiary annual limitation calculated based 75 percent on 98 percent of the reasonable costs (including nonroutine medical supplies) for the agency's 12-month cost reporting period ending during fiscal year 1994, and based 25 per-

cent on 98 percent of the standardized regional average of such costs for the agency's census division, as applied to such agency, for cost reporting periods ending during fiscal year 1994, such costs updated by the home health market basket index; and

''(II) the agency's unduplicated census count of patients (entitled to benefits under this title) for the cost reporting period subject to the limitation.

''(vi) For services furnished by home health agencies for cost reporting periods beginning on or after October 1, 1997, the following rules apply:

''(I) For new providers and those providers without a 12-month cost reporting period ending in fiscal year 1994, the per beneficiary limitation shall be equal to the median of these limits (or the Secretary's best estimates thereof) applied to other home health agencies as determined by the Secretary. A home health agency that has altered its corporate structure or name shall not be considered a new provider for this purpose.

''(II) For beneficiaries who use services furnished by more than one home health agency, the per beneficiary limitations shall be prorated among the agencies.

''(vii)(I) Not later than January 1, 1998, the Secretary shall establish per visit limits applicable for fiscal year 1998, and not later than April 1, 1998, the Secretary shall establish per beneficiary limits under clause (v)(I) for fiscal year 1998.

''(II) Not later than August 1 of each year (beginning in 1998) the Secretary shall establish the limits applicable under this subparagraph for services furnished during the fiscal year beginning October 1 of the year.''.

(d) DEVELOPMENT OF CASE MIX SYSTEM.—The Secretary of Health and Human Services shall expand research on a prospective payment system for home health agencies under the medicare program that ties prospective payments to a unit of service, including an intensive effort to develop a reliable case mix adjuster that explains a significant amount of the variances in costs.

(e) SUBMISSION OF DATA FOR CASE MIX SYSTEM.—Effective for cost reporting periods beginning on or after October 1, 1997, the Secretary of Health and Human Services may require all home health agencies to submit additional information that the Secretary considers necessary for the development of a reliable case mix system.

**SEC. 4603. PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.**

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.) (as amended by section 4801) is amended by adding at the end the following:

''PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

''SEC. 1895. (a) IN GENERAL.—Notwithstanding section 1861(v), the Secretary shall provide, for cost reporting periods beginning on or after October 1, 1999, for payments for home health services in accordance with a prospective payment system established by the Secretary under this section.

''(b) SYSTEM OF PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.—

''(1) IN GENERAL.—The Secretary shall establish under this subsection a prospective payment system for payment for all costs of home health services. Under the system under this subsection all services covered and paid on a reasonable cost basis under the medicare home health benefit as of the date of the enactment of this section, including medical supplies, shall be paid for on the basis of a prospective payment amount determined under this subsection and applicable to the services involved. In implementing the system, the Secretary may provide for a transition (of not longer than 4 years) during which a portion of such payment is based on agency-specific costs, but only if such transition does not result in aggregate payments under this title that exceed the aggregate payments that would be made if such a transition did not occur.

''(2) UNIT OF PAYMENT.—In defining a prospective payment amount under the system under this subsection, the Secretary shall consider an appropriate unit of service and the number, type, and duration of visits provided within that unit, potential changes in the mix of services provided within that unit and their cost, and a general system design that provides for continued access to quality services.

''(3) PAYMENT BASIS.—

''(A) INITIAL BASIS.—

''(i) IN GENERAL.—Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts). Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for fiscal year 2000 shall be equal to the total amount that would have been made if the system had not been in effect but if the reduction in limits described in clause (ii) had been in effect. Such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and wage levels among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.

''(ii) REDUCTION.—The reduction described in this clause is a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1861(v)(1)(L), as those limits are in effect on September 30, 1999.

''(B) ANNUAL UPDATE.—

''(i) IN GENERAL.—The standard prospective payment amount (or amounts) shall be adjusted for each fiscal year (beginning with fiscal year 2001) in a prospective manner specified by the Secretary by the home health market basket percentage increase applicable to the fiscal year involved.

''(ii) HOME HEALTH MARKET BASKET PERCENTAGE INCREASE.—For purposes of this subsection, the term 'home health market basket percentage increase' means, with respect to a fiscal year, a percentage (estimated by the Secretary before the beginning of the fiscal year) determined and applied with respect to the mix of goods and services included in home health services in the same manner as the market basket percentage increase under section 1886(b)(3)(B)(iii) is determined and applied to the mix of goods and services comprising inpatient hospital services for the fiscal year.

''(C) ADJUSTMENT FOR OUTLIERS.—The Secretary shall reduce the standard prospective payment amount (or amounts) under this paragraph applicable to home health services furnished during a period by such proportion as will result in an aggregate reduction in payments for the period equal to the aggregate increase in payments resulting from the application of paragraph (5) (relating to outliers).

''(4) PAYMENT COMPUTATION.—

''(A) IN GENERAL.—The payment amount for a unit of home health services shall be the applicable standard prospective payment amount adjusted as follows:

''(i) CASE MIX ADJUSTMENT.—The amount shall be adjusted by an appropriate case mix adjustment factor (established under subparagraph (B)).

''(ii) AREA WAGE ADJUSTMENT.—The portion of such amount that the Secretary estimates to be attributable to wages and wage-related costs shall be adjusted for geographic differences in such costs by an area wage adjustment factor (established under subparagraph (C)) for the area in which the services are furnished or such other area as the Secretary may specify.

''(B) ESTABLISHMENT OF CASE MIX ADJUSTMENT FACTORS.—The Secretary shall establish appropriate case mix adjustment factors for home health services in a manner that explains a significant amount of the variation in cost among different units of services.

''(C) ESTABLISHMENT OF AREA WAGE ADJUSTMENT FACTORS.—The Secretary shall establish area wage adjustment factors that reflect the relative level of wages and wage-related costs applicable to the furnishing of home health services in a geographic area compared to the national average applicable level. Such factors may be the factors used by the Secretary for purposes of section 1886(d)(3)(E).

''(5) OUTLIERS.—The Secretary may provide for an addition or adjustment to the payment amount otherwise made in the case of outliers because of unusual variations in the type or amount of medically necessary care. The total amount of the additional payments or payment adjustments made under this paragraph with respect to a fiscal year may not exceed 5 percent of the total payments projected or estimated to be made based on the prospective payment system under this subsection in that year.

''(6) PRORATION OF PROSPECTIVE PAYMENT AMOUNTS.—If a beneficiary elects to transfer to, or receive services from, another home health agency within the period covered by the prospective payment amount, the payment shall be prorated between the home health agencies involved.

''(c) REQUIREMENTS FOR PAYMENT INFORMATION.—With respect to home health services furnished on or after October 1, 1998, no claim for such a service may be paid under this title unless—

''(1) the claim has the unique identifier (provided under section 1842(r)) for the physician who prescribed the services or made the certification described in section 1814(a)(2) or 1835(a)(2)(A); and

''(2) in the case of a service visit described in paragraph (1), (2), (3), or (4) of section 1861(m), the claim contains a code (or codes) specified by the Secretary that identifies the length of time of the service visit, as measured in 15 minute increments.

''(d) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of—

''(1) the establishment of a transition period under subsection (b)(1);

''(2) the definition and application of payment units under subsection (b)(2);

''(3) the computation of initial standard prospective payment amounts under subsection (b)(3)(A) (including the reduction described in clause (ii) of such subsection);

''(4) the establishment of the adjustment for outliers under subsection (b)(3)(C);

''(5) the establishment of case mix and area wage adjustments under subsection (b)(4); and

''(6) the establishment of any adjustments for outliers under subsection (b)(5).''.

(b) ELIMINATION OF PERIODIC INTERIM PAYMENTS FOR HOME HEALTH AGENCIES.—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

(1) by inserting ''and'' at the end of subparagraph (C),

(2) by striking subparagraph (D), and

(3) by redesignating subparagraph (E) as subparagraph (D).

(c) CONFORMING AMENDMENTS.—

(1) PAYMENTS UNDER PART A.—Section 1814(b) (42 U.S.C. 1395f(b)) is amended in the matter preceding paragraph (1) by striking ''and 1886'' and inserting ''1886, and 1895''.

(2) TREATMENT OF ITEMS AND SERVICES PAID UNDER PART B.—

(A) PAYMENTS UNDER PART B.—Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended—

(i) by amending subparagraph (A) to read as follows:

''(A) with respect to home health services (other than a covered osteoporosis drug) (as defined in section 1861(kk)), the amount determined under the prospective payment system under section 1895;'';

(ii) by striking ''and'' at the end of subparagraph (E);

(iii) by adding ''and'' at the end of subparagraph (F); and

(iv) by adding at the end the following new subparagraph:

''(G) with respect to items and services described in section 1861(s)(10)(A), the lesser of—

''(i) the reasonable cost of such services, as determined under section 1861(v), or

''(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);''.

(B) REQUIRING PAYMENT FOR ALL ITEMS AND SERVICES TO BE MADE TO AGENCY.—

(i) IN GENERAL.—The first sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) (as amended by section 4432(b)(2)) is amended—

(I) by striking ''and (E)'' and inserting ''(E)''; and

(II) by striking the period at the end and inserting the following: '', and (F) in the case of home health services furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home health agency, payment shall be made to the agency (without regard to whether or not the item or service was furnished by the agency, by others under arrangement with them made by the agency, or when any other contracting or consulting arrangement, or otherwise).''.

(ii) CONFORMING AMENDMENT.—Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)) (as amended by section 4432(b)(5)(B)) is amended by striking ''section 1842(b)(6)(E);'' and inserting ''subparagraphs (E) and (F) of section 1842(b)(6);''.

(C) EXCLUSIONS FROM COVERAGE.—Section 1862(a) (42 U.S.C. 1395y(a)) (as amended by sections 4319(b), 4432(b), 4507(a)(2)(B) and 4541(b)) is amended—

(i) by striking ''or'' at the end of paragraph (19);

(ii) by striking the period at the end of paragraph (20) and inserting ''; or''; and

(iii) by inserting after paragraph (20) the following:

''(21) where such expenses are for home health services furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency.''.

(d) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 1999.

(e) CONTINGENCY.—If the Secretary of Health and Human Services for any reason does not establish and implement the prospective payment system for home health services described in section 1895(b) of the Social Security Act (as added by subsection (a)) for cost reporting periods described in subsection (d), for such cost reporting periods the Secretary shall provide for a reduction by 15 percent in the cost limits and per beneficiary limits described in section 1861(v)(1)(L) of such Act, as those limits would otherwise be in effect on September 30, 1999.

**SEC. 4604. PAYMENT BASED ON LOCATION WHERE HOME HEALTH SERVICE IS FURNISHED.**

(a) CONDITIONS OF PARTICIPATION.—Section 1891 (42 U.S.C. 1395bbb) is amended by adding at the end the following:

''(g) PAYMENT ON BASIS OF LOCATION OF SERVICE.—A home health agency shall submit claims for payment for home health services under this title only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.''.

(b) WAGE ADJUSTMENT.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by striking ''agency is located'' and inserting ''service is furnished''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to cost reporting periods beginning on or after October 1, 1997.

## Subchapter B—Home Health Benefits

**SEC. 4611. MODIFICATION OF PART A HOME HEALTH BENEFIT FOR INDIVIDUALS ENROLLED UNDER PART B.**

(a) IN GENERAL.—Section 1812 (42 U.S.C. 1395d) is amended—

(1) in subsection (a)(3), by striking ''home health services'' and inserting ''for individuals not enrolled in part B, home health services, and for individuals so enrolled, post-institutional home health services furnished during a home health spell of illness for up to 100 visits during such spell of illness''; and

(2) in subsection (b), by adding after and below paragraph (3) the following:

''Payment under this part for post-institutional home health services furnished an individual during a home health spell of illness may not be made for such services beginning after such services have been furnished for a total of 100 visits such spell.''.

(b) POST-INSTITUTIONAL HOME HEALTH SERVICES DEFINED.—Section 1861 (42 U.S.C. 1395x), as amended by sections 4103(a), 4104(a), 4105(a), 4106(a), and 4454, is amended by adding at the end the following:

''Post-Institutional Home Health Services; Home Health Spell of Illness

''(tt)(1) The term 'post-institutional home health services' means home health services furnished to an individual—

''(A) after discharge from a hospital or rural primary care hospital in which the individual was an inpatient for not less than 3 consecutive days before such discharge if such home health services were initiated within 14 days after the date of such discharge; or

''(B) after discharge from a skilled nursing facility in which the individual was provided post-hospital extended care services if such home health services were initiated within 14 days after the date of such discharge.

''(2) The term 'home health spell of illness' with respect to any individual means a period of consecutive days—

''(A) beginning with the first day (not included in a previous home health spell of illness) (i) on which such individual is furnished post-institutional home health services, and (ii) which occurs in a month for which the individual is entitled to benefits under part A, and

''(B) ending with the close of the first period of 60 consecutive days thereafter on each of which the individual is neither an inpatient of a hospital or rural primary care hospital nor an inpatient of a facility described in section 1819(a)(1) or subsection (y)(1) nor provided home health services.''.

(c) MAINTAINING APPEAL RIGHTS FOR HOME HEALTH SERVICES.—Section 1869(b)(2)(B) (42 U.S.C. 1395ff(b)(2)(B)) is amended by inserting ''(or $100 in the case of home health services)'' after ''$500''.

(d) MAINTAINING SEAMLESS ADMINISTRATION THROUGH FISCAL INTERMEDIARIES.—Section 1842(b)(2) (42 U.S.C. 1395u(b)(2)) is amended by adding at the end the following:

''(E) With respect to the payment of claims for home health services under this part that, but for the amendments made by section 4611 of the Balanced Budget Act of 1997, would be payable under part A instead of under this part, the Secretary shall continue administration of such claims through fiscal intermediaries under section 1816.''.

(e) TRANSITION.—

(1) IN GENERAL.—Notwithstanding any provision of title XVIII of the Social Security Act, the Secretary of Health and Human Services shall establish a transition for the aggregate amount of expenditures that are transferred from part A, to part B, of title XVIII of the Social Security Act, as a result of the amendments made by this section, during each of the years during the period beginning with 1998 and ending with 2002 according to this subsection. Under the transition for each such year, the Secretary shall effect such transfer, between the trust funds under such parts, as will result in only the proportion (specified in paragraph (2)) of such aggregate expenditures for the year being transferred from such part A to such part B.

(2) PROPORTION SPECIFIED.—The proportion specified in this paragraph for—

(A) 1998 is 1/6,

(B) 1999 is 1/3,

(C) 2000 is 1/2,

(D) 2001 is 2/3, and

(E) 2002 is 5/6.

(3) APPLICATION IN ESTABLISHING MONTHLY PREMIUMS FOR 1998 THROUGH 2003.—

(A) IN GENERAL.—For purposes only of computing the monthly premium under section 1839 of the Social Security Act (42 U.S.C. 1395r), the monthly actuarial rate for enrollees age 65 and over shall be computed as though any reference in paragraph (1) of this subsection to 2002 were a reference to 2003 and as if the following proportions were substituted for the proportions specified in paragraph (2):

(i) For 1998, 1/7.

(ii) For 1999, 2/7.

(iii) For 2000, 3/7.

(iv) For 2001, 4/7.

(v) For 2002, 5/7.

(vi) For 2003, 6/7.

(B) NO IMPACT ON GOVERNMENT CONTRIBUTION.—Subparagraph (A) does not apply in determining the amount of the Government contribution under section 1844 of the Social Security Act (42 U.S.C. 1395w).

(f) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after January 1, 1998. For purpose of applying such amendments, any home health spell of illness that began, but did not end, before such date shall be considered to have begun as of such date.

**SEC. 4612. CLARIFICATION OF PART-TIME OR INTERMITTENT NURSING CARE.**

(a) IN GENERAL.—Section 1861(m) (42 U.S.C. 1395x(m)) is amended by adding at the end the following: ''For purposes of paragraphs (1) and (4), the term 'part-time or intermittent services' means skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours per week). For purposes of sections 1814(a)(2)(C) and 1835(a)(2)(A), 'intermittent' means skilled nursing care that is either provided or needed on fewer

than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to services furnished on or after October 1, 1997.

**SEC. 4613. STUDY ON DEFINITION OF HOMEBOUND.**

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of the criteria that should be applied, and the method of applying such criteria, in the determination of whether an individual is homebound for purposes of qualifying for receipt of benefits for home health services under the medicare program. Such criteria shall include the extent and circumstances under which a person may be absent from the home but nonetheless qualify.

(b) REPORT.—Not later than October 1, 1998, the Secretary shall submit a report to Congress on the study conducted under subsection (a). The report shall include specific recommendations on such criteria and methods.

**SEC. 4614. NORMATIVE STANDARDS FOR HOME HEALTH CLAIMS DENIALS.**

(a) IN GENERAL.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)) (as amended by section 4104(c)) is amended—

(1) by striking ''and'' at the end of subparagraph (G),

(2) by striking the semicolon at the end of subparagraph (H) and inserting '', and'', and

(3) by inserting after subparagraph (H) the following new subparagraph:

''(I) the frequency and duration of home health services which are in excess of normative guidelines that the Secretary shall establish by regulation;''.

(b) NOTIFICATION.—The Secretary of Health and Human Services may establish a process for notifying a physician in cases in which the number of home health visits, furnished under title XVIII of the Social Security Act pursuant to a prescription or certification of the physician, significantly exceeds such threshold (or thresholds) as the Secretary specifies. The Secretary may adjust such threshold to reflect demonstrated differences in the need for home health services among different beneficiaries.

(c) EFFECTIVE DATE.—The amendments made by this section apply to services furnished on or after October 1, 1997.

**SEC. 4615. NO HOME HEALTH BENEFITS BASED SOLELY ON DRAWING BLOOD.**

(a) IN GENERAL.—Sections 1814(a)(2)(C) and 1835(a)(2)(A) (42 U.S.C. 1395f(a)(2)(C), 1395n(a)(2)(A)) are each amended by inserting ''(other than solely venipuncture for the purpose of obtaining a blood sample)'' after ''skilled nursing care''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to home health services furnished after the 6-month period beginning after the date of enactment of this Act.

**SEC. 4616. REPORTS TO CONGRESS REGARDING HOME HEALTH COST CONTAINMENT.**

(a) ESTIMATE.—Not later than October 1, 1997, the Secretary of Health and Human Services shall submit to the Committees on Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report that includes an estimate of the outlays that will be made under parts A and B of title XVIII of the Social Security Act for the provision of home health services during each of fiscal years 1998 through 2002.

(b) ANNUAL REPORT.—Not later than the end of each of years 1999 through 2002, the Secretary shall submit to such Committees a report that compares the actual outlays under such parts for such services during the fiscal year ending in the year, to the outlays estimated under subsection (a) for such fiscal year. If the Secretary finds that such actual outlays were greater than such estimated outlays for the fiscal year, the Secretary shall include in the report recommendations regarding beneficiary copayments for home health services provided under the medicare program or such other methods as will reduce the growth in outlays for home health services under the medicare program.

## CHAPTER 2—GRADUATE MEDICAL EDUCATION

### Subchapter A—Indirect Medical Education

**SEC. 4621. INDIRECT GRADUATE MEDICAL EDUCATION PAYMENTS.**

(a) MULTIYEAR TRANSITION REGARDING PERCENTAGES.—

(1) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended to read as follows:

''(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to c (((1+r) to the nth power) − 1), where 'r' is the ratio of the hospital's full-time equivalent interns and residents to beds and 'n' equals .405. For discharges occurring—

''(I) on or after October 1, 1988, and before October 1, 1997, 'c' is equal to 1.89;

''(II) during fiscal year 1998, 'c' is equal to 1.72;

''(III) during fiscal year 1999, 'c' is equal to 1.6;

''(IV) during fiscal year 2000, 'c' is equal to 1.47; and

''(V) on or after October 1, 2000, 'c' is equal to 1.35.''.

(2) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by adding at the end the following: ''except that the Secretary shall not take into account any reduction in the amount of additional payments under paragraph (5)(B)(ii) resulting from the amendment made by section 4621(a)(1) of the Balanced Budget Act of 1997,''.

(b) LIMITATION ON NUMBER OF RESIDENTS FOR CERTAIN FISCAL YEARS.—

(1) IN GENERAL.—Section 1886(d)(5)(B) (42 U.S.C. 1395ww(d)(5)(B)) is amended by adding after clause (iv) the following:

''(v) In determining the adjustment with respect to a hospital for discharges occurring on or after October 1, 1997, the total number of full-time equivalent interns and residents in the fields of allopathic and osteopathic medicine in either a hospital or nonhospital setting may not exceed the number of such full-time equivalent interns and residents in the hospital with respect to the hospital's most recent cost reporting period ending on or before December 31, 1996.

''(vi) For purposes of clause (ii)—

''(I) 'r' may not exceed the ratio of the number of interns and residents, subject to the limit under clause (v), with respect to the hospital for its most recent cost reporting period to the hospital's available beds (as defined by the Secretary) during that cost reporting period, and

''(II) for the hospital's cost reporting periods beginning on or after October 1, 1997, subject to the limits described in clauses (iv) and (v), the total number of full-time equivalent residents for payment purposes shall equal the average of the actual full-time equivalent resident count for the cost reporting period and the preceding two cost reporting periods.

In the case of the first cost reporting period beginning on or after October 1, 1997, subclause (II) shall be applied by using the average for such period and the preceding cost reporting period.

''(vii) If any cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent residency count pursuant to subclause (II) of clause (vi) is based on the equivalent of full twelve-month cost reporting periods.

''(viii) Rules similar to the rules of subsection (h)(4)(H) shall apply for purposes of clauses (v) and (vi).''.

(2) PAYMENT FOR INTERNS AND RESIDENTS PROVIDING OFF-SITE SERVICES.—Section 1886(d)(5)(B)(iv) (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amended to read as follows:

''(iv) Effective for discharges occurring on or after October 1, 1997, all the time spent by an intern or resident in patient care activities under an approved medical residency training program at an entity in a nonhospital setting shall be counted towards the determination of full-time equivalency if the hospital incurs all, or substantially all, of the costs for the training program in that setting.''.

**SEC. 4622. PAYMENT TO HOSPITALS OF INDIRECT MEDICAL EDUCATION COSTS FOR MEDICARE+CHOICE ENROLLEES.**

Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by adding at the end the following:

''(11) ADDITIONAL PAYMENTS FOR MANAGED CARE ENROLLEES.—

''(A) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount for each applicable discharge of any subsection (d) hospital that has an approved medical residency training program.

''(B) APPLICABLE DISCHARGE.—For purposes of this paragraph, the term 'applicable discharge' means the discharge of any individual who is enrolled under a risk-sharing contract with an eligible organization under section 1876 and who is entitled to benefits under part A or any individual who is enrolled with a Medicare+Choice organization under part C.

''(C) DETERMINATION OF AMOUNT.—The amount of the payment under this paragraph with respect to any applicable discharge shall be equal to the applicable percentage (as defined in subsection (h)(3)(D)(ii)) of the estimated average per discharge amount that would otherwise have been paid under paragraph (5)(B) if the individuals had not been enrolled as described in subparagraph (B).

''(D) SPECIAL RULE FOR HOSPITALS UNDER REIMBURSEMENT SYSTEM.—The Secretary shall establish rules for the application of this paragraph to a hospital reimbursed under a reimbursement system authorized under section 1814(b)(3) in the same manner as it would apply to the hospital if it were not reimbursed under such section.''.

### Subchapter B—Direct Graduate Medical Education

**SEC. 4623. LIMITATION ON NUMBER OF RESIDENTS AND ROLLING AVERAGE FTE COUNT.**

Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended by adding after subparagraph (E) the following:

''(F) LIMITATION ON NUMBER OF RESIDENTS IN ALLOPATHIC AND OSTEOPATHIC MEDICINE.—Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1997, the total number of full-time equivalent residents before application of weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic medicine and osteopathic medicine may not exceed the number of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.

''(G) COUNTING INTERNS AND RESIDENTS FOR FY 1998 AND SUBSEQUENT YEARS.—

''(i) IN GENERAL.—For cost reporting periods beginning during fiscal years beginning on or after October 1, 1997, subject to the limit described in subparagraph (F), the total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.

''(ii) ADJUSTMENT FOR SHORT PERIODS.—If any cost reporting period beginning on or after October 1, 1997, is not equal to twelve months, the Secretary shall make appropriate modifications to ensure that the average full-time equivalent resident counts pursuant to clause (i) are based on the equivalent of full twelve-month cost reporting periods.

''(iii) TRANSITION RULE FOR 1998.—In the case of a hospital's first cost reporting period beginning on or after October 1, 1997, clause (i) shall be applied by using the average for such period and the preceding cost reporting period.

''(H) SPECIAL RULES FOR APPLICATION OF SUBPARAGRAPHS (F) AND (G).—

''(i) NEW FACILITIES.—The Secretary shall, consistent with the principles of subparagraphs (F) and (G), prescribe rules for the application of such subparagraphs in the case of medical residency training programs established on or after January 1, 1995. In promulgating such rules for purposes of subparagraph (F), the Secretary shall give special consideration to facilities that meet the needs of underserved rural areas.

''(ii) AGGREGATION.—The Secretary may prescribe rules which allow institutions which are members of the same affiliated group (as defined by the Secretary) to elect to apply the limitation of subparagraph (F) on an aggregate basis.

''(iii) DATA COLLECTION.—The Secretary may require any entity that operates a medical residency training program and to which subparagraphs (F) and (G) apply to submit to the Secretary such additional information as the Secretary considers necessary to carry out such subparagraphs.''

**SEC. 4624. PAYMENTS TO HOSPITALS FOR DIRECT COSTS OF GRADUATE MEDICAL EDUCATION OF MEDICARE+CHOICE ENROLLEES.**

Section 1886(h)(3) (42 U.S.C. 1395ww(h)(3)) is amended by adding after subparagraph (C) the following:

''(D) PAYMENT FOR MANAGED CARE ENROLLEES.—

''(i) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount under this subsection for services furnished to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 and who are entitled to part A or with a Medicare+Choice organization under part C. The amount of such a payment shall equal the applicable percentage of the product of—

''(I) the aggregate approved amount (as defined in subparagraph (B)) for that period; and

''(II) the fraction of the total number of inpatient-bed days (as established by the Secretary) during the period which are attributable to such enrolled individuals.

''(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i), the applicable percentage is—

''(I) 20 percent in 1998,

''(II) 40 percent in 1999,

''(III) 60 percent in 2000,

''(IV) 80 percent in 2001, and

''(V) 100 percent in 2002 and subsequent years.

''(iii) SPECIAL RULE FOR HOSPITALS UNDER REIMBURSEMENT SYSTEM.—The Secretary shall establish rules for the application of this subparagraph to a hospital reimbursed under a reimbursement system authorized under section 1814(b)(3) in the same manner as it would apply to the hospital if it were not reimbursed under such section.''.

**SEC. 4625. PERMITTING PAYMENT TO NONHOSPITAL PROVIDERS.**

(a) IN GENERAL.—Section 1886 (42 U.S.C. 1395ww), as amended by section 4421(a), is amended by adding at the end the following:

''(k) PAYMENT TO NONHOSPITAL PROVIDERS.—

''(1) IN GENERAL.—For cost reporting periods beginning on or after October 1, 1997, the Secretary may establish rules for payment to qualified nonhospital providers for their direct costs of medical education, if those costs are incurred in the operation of an approved medical residency training program described in subsection (h). Such rules shall specify the amounts, form, and manner in which such payments will be made and the portion of such payments that will be made from each of the trust funds under this title.

''(2) QUALIFIED NONHOSPITAL PROVIDERS.—For purposes of this subsection, the term 'qualified nonhospital providers' means—

''(A) a Federally qualified health center, as defined in section 1861(aa)(4);

''(B) a rural health clinic, as defined in section 1861(aa)(2);

''(C) Medicare+Choice organizations; and

''(D) such other providers (other than hospitals) as the Secretary determines to be appropriate.''.

(b) PROHIBITION ON DOUBLE PAYMENTS.—Section 1886(h)(3)(B) (42 U.S.C. 1395ww(h)(3)(B)) is amended by adding at the end the following:

''The Secretary shall reduce the aggregate approved amount to the extent payment is made under subsection (k) for residents included in the hospital's count of full-time equivalent residents.''.

**SEC. 4626. INCENTIVE PAYMENTS UNDER PLANS FOR VOLUNTARY REDUCTION IN NUMBER OF RESIDENTS.**

(a) IN GENERAL.—Section 1886(h) (42 U.S.C. 1395ww(h)) is amended by adding at the end the following new paragraph:

''(6) INCENTIVE PAYMENT UNDER PLANS FOR VOLUNTARY REDUCTION IN NUMBER OF RESIDENTS.—

''(A) IN GENERAL.—In the case of a voluntary residency reduction plan for which an application is approved under subparagraph (B), subject to subparagraph (F), each hospital which is part of the qualifying entity submitting the plan shall be paid an applicable hold harmless percentage (as specified in subparagraph (E)) of the sum of—

''(i) the amount (if any) by which—

''(I) the amount of payment which would have been made under this subsection if there had been a 5-percent reduction in the number of full-time equivalent residents in the approved medical education training programs of the hospital as of June 30, 1997, exceeds

''(II) the amount of payment which is made under this subsection, taking into account the reduction in such number effected under the reduction plan; and

''(ii) the amount of the reduction in payment under subsection (d)(5)(B) for the hospital that is attributable to the reduction in number of residents effected under the plan below 95 percent of the number of full-time equivalent residents in such programs of the hospital as of June 30, 1997.

The determination of the amounts under clauses (i) and (ii) for any year shall be made on the basis of the provisions of this title in effect on the application deadline date for the first calendar year to which the reduction plan applies.

''(B) APPROVAL OF PLAN APPLICATIONS.—The Secretary may not approve the application of an qualifying entity unless—

''(i) the application is submitted in a form and manner specified by the Secretary and by not later than November 1, 1999,

''(ii) the application provides for the operation of a plan for the reduction in the number of full-time equivalent residents in the approved medical residency training programs of the entity consistent with the requirements of subparagraph (D);

''(iii) the entity elects in the application the period of residency training years (not greater than 5) over which the reduction will occur;

''(iv) the entity will not reduce the proportion of its residents in primary care (to the total number of residents) below such proportion as in effect as of the applicable time described in subparagraph (D)(v); and

''(v) the Secretary determines that the application and the entity and such plan meet such other requirements as the Secretary specifies in regulations.

''(C) QUALIFYING ENTITY.—For purposes of this paragraph, any of the following may be a qualifying entity:

''(i) Individual hospitals operating one or more approved medical residency training programs.

''(ii) Two or more hospitals that operate such programs and apply for treatment under this paragraph as a single qualifying entity.

''(iii) A qualifying consortium (as described in section 4628 of the Balanced Budget Act of 1997).

''(D) RESIDENCY REDUCTION REQUIREMENTS.—

''(i) INDIVIDUAL HOSPITAL APPLICANTS.—In the case of a qualifying entity described in subparagraph (C)(i), the number of full-time equivalent residents in all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

''(I) If the base number of residents exceeds 750 residents, by a number equal to at least 20 percent of such base number.

''(II) Subject to subclause (IV), if the base number of residents exceeds 600 but is less than 750 residents, by 150 residents.

''(III) Subject to subclause (IV), if the base number of residents does not exceed 600 residents, by a number equal to at least 25 percent of such base number.

''(IV) In the case of a qualifying entity which is described in clause (v) and which elects treatment under this subclause, by a number equal to at least 20 percent of the base number.

''(ii) JOINT APPLICANTS.—In the case of a qualifying entity described in subparagraph (C)(ii), the number of full-time equivalent residents in the aggregate for all the approved medical residency training programs operated by or through the entity shall be reduced as follows:

''(I) Subject to subclause (II), by a number equal to at least 25 percent of the base number.

''(II) In the case of such a qualifying entity which is described in clause (v) and which elects treatment under this subclause, by a number equal to at least 20 percent of the base number.

''(iii) CONSORTIA.—In the case of a qualifying entity described in subparagraph (C)(iii), the number of full-time equivalent residents in the aggregate for all the approved medical residency training programs operated by or through the entity shall be reduced by a number equal to at least 20 percent of the base number.

''(iv) MANNER OF REDUCTION.—The reductions specified under the preceding provisions of this subparagraph for a qualifying entity shall be below the base number of

residents for that entity and shall be fully effective not later than the 5th residency training year in which the application under subparagraph (B) is effective.

''(v) ENTITIES PROVIDING ASSURANCE OF INCREASE IN PRIMARY CARE RESIDENTS.—An entity is described in this clause if—

''(I) the base number of residents for the entity is less than 750 or the entity is described in subparagraph (C)(ii); and

''(II) the entity represents in its application under subparagraph (B) that it will increase the number of full-time equivalent residents in primary care by at least 20 percent (from such number included in the base number of residents) by not later than the 5th residency training year in which the application under subparagraph (B) is effective.

If a qualifying entity fails to comply with the representation described in subclause (II) by the end of such 5th residency training year, the entity shall be subject to repayment of all amounts paid under this paragraph, in accordance with procedures established to carry out subparagraph (F).

''(vi) BASE NUMBER OF RESIDENTS DEFINED.—For purposes of this paragraph, the term 'base number of residents' means, with respect to a qualifying entity (or its participating hospitals) operating approved medical residency training programs, the number of full-time equivalent residents in such programs (before application of weighting factors) of the entity as of the most recent residency training year ending before June 30, 1997, or, if less, for any subsequent residency training year that ends before the date the entity makes application under this paragraph.

''(E) APPLICABLE HOLD HARMLESS PERCENTAGE.—For purposes of subparagraph (A), the 'applicable hold harmless percentage' for the—

''(i) first and second residency training years in which the reduction plan is in effect, 100 percent,

''(ii) third such year, 75 percent,

''(iii) fourth such year, 50 percent, and

''(iv) fifth such year, 25 percent.

''(F) PENALTY FOR NONCOMPLIANCE.—

''(i) IN GENERAL.—No payment may be made under this paragraph to a hospital for a residency training year if the hospital has failed to reduce the number of full-time equivalent residents (in the manner required under subparagraph (D)) to the number agreed to by the Secretary and the qualifying entity in approving the application under this paragraph with respect to such year.

''(ii) INCREASE IN NUMBER OF RESIDENTS IN SUBSEQUENT YEARS.—If payments are made under this paragraph to a hospital, and if the hospital increases the number of full-time equivalent residents above the number of such residents permitted under the reduction plan as of the completion of the plan, then, as specified by the Secretary, the entity is liable for repayment to the Secretary of the total amounts paid under this paragraph to the entity.

''(G) TREATMENT OF ROTATING RESIDENTS.—In applying this paragraph, the Secretary shall establish rules regarding the counting of residents who are assigned to institutions the medical residency training programs in which are not covered under approved applications under this paragraph.''.

(b) RELATION TO DEMONSTRATION PROJECTS AND AUTHORITY.—

(1) Section 1886(h)(6) of the Social Security Act, added by subsection (a), other than subparagraph (F)(ii) thereof, shall not apply to any residency training program with respect to which a demonstration project described in paragraph (3) has been approved by the Health Care Financing Administration as of May 27, 1997.

(2) Effective May 27, 1997, the Secretary of Health and Human Services is not authorized to approve any demonstration project described in paragraph (3) for any residency training year beginning before July 1, 2006.

(3) A demonstration project described in this paragraph is a project that primarily provides for additional payments under title XVIII of the Social Security Act in connection with a reduction in the number of residents in a medical residency training program.

(c) INTERIM, FINAL REGULATIONS.—In order to carry out the amendment made by subsection (a) in a timely manner, the Secretary of Health and Human Services may first promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment, by not later than 6 months after the date of the enactment of this Act.

**SEC. 4627. MEDICARE SPECIAL REIMBURSEMENT RULE FOR PRIMARY CARE COMBINED RESIDENCY PROGRAMS.**

(a) IN GENERAL.—Section 1886(h)(5)(G) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(G)) is amended—

(1) in clause (i), by striking ''and (iii)'' and inserting '', (iii), and (iv)''; and

(2) by adding at the end the following:

''(iv) SPECIAL RULE FOR CERTAIN PRIMARY CARE COMBINED RESIDENCY PROGRAMS.—(I) In the case of a resident enrolled in a combined medical residency training program in which all of the individual programs (that are combined) are for training a primary care resident (as defined in subparagraph (H)), the period of board eligibility shall be the minimum number of years of formal training required to satisfy the requirements for initial board eligibility in the longest of the individual programs plus one additional year.

''(II) A resident enrolled in a combined medical residency training program that includes an obstetrics and gynecology program shall qualify for the period of board eligibility under subclause (I) if the other programs such resident combines with such obstetrics and gynecology program are for training a primary care resident.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to combined medical residency training programs in effect for residency years beginning on or after July 1, 1997.

**SEC. 4628. DEMONSTRATION PROJECT ON USE OF CONSORTIA.**

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a demonstration project under which, instead of making payments to teaching hospitals pursuant to section 1886(h) of the Social Security Act, the Secretary shall make payments under this section to each consortium that meets the requirements of subsection (b) and that applies to be included under the project.

(b) QUALIFYING CONSORTIA.—For purposes of subsection (a), a consortium meets the requirements of this subsection if the consortium is in compliance with the following:

(1) The consortium consists of a teaching hospital with one or more approved medical residency training programs and one or more of the following entities:

(A) A school of allopathic medicine or osteopathic medicine.

(B) Another teaching hospital, which may be a children's hospital.

(C) A Federally qualified health center.

(D) A medical group practice.

(E) A managed care entity.

(F) An entity furnishing outpatient services.

(G) Such other entity as the Secretary determines to be appropriate.

(2) The members of the consortium have agreed to participate in the programs of graduate medical education that are operated by the entities in the consortium.

(3) With respect to the receipt by the consortium of payments made pursuant to this section, the members of the consortium have agreed on a method for allocating the payments among the members.

(4) The consortium meets such additional requirements as the Secretary may establish.

(c) AMOUNT AND SOURCE OF PAYMENT.—The total of payments to a qualifying consortium for a fiscal year pursuant to subsection (a) shall not exceed the amount that would have been paid under section 1886 (h) or (k) of the Social Security Act for the teaching hospital (or hospitals) in the consortium. Such payments shall be made in such proportion from each of the trust funds established under title XVIII of such Act as the Secretary specifies.

**SEC. 4629. RECOMMENDATIONS ON LONG-TERM POLICIES REGARDING TEACHING HOSPITALS AND GRADUATE MEDICAL EDUCATION.**

(a) IN GENERAL.—The Medicare Payment Advisory Commission (established under section 1805 of the Social Security Act and in this section referred to as the ''Commission'') shall examine and develop recommendations on whether and to what extent medicare payment policies and other Federal policies regarding teaching hospitals and graduate medical education should be changed. Such recommendations shall include recommendations regarding each of the following:

(1) Possible methodologies for making payments for graduate medical education and the selection of entities to receive such payments. Matters considered under this paragraph shall include—

(A) issues regarding children's hospitals and approved medical residency training programs in pediatrics, and

(B) whether and to what extent payments are being made (or should be made) for training in the nursing and other allied health professions.

(2) Federal policies regarding international medical graduates.

(3) The dependence of schools of medicine on service-generated income.

(4) Whether and to what extent the needs of the United States regarding the supply of physicians, in the aggregate and in different specialties, will change during the 10-year period beginning on October 1, 1997, and whether and to what extent any such changes will have significant financial effects on teaching hospitals.

(5) Methods for promoting an appropriate number, mix, and geographical distribution of health professionals.

(b) CONSULTATION.—In conducting the study under subsection (a), the Commission shall consult with the Council on Graduate Medical Education and individuals with expertise in the area of graduate medical education, including—

(1) deans from allopathic and osteopathic schools of medicine;

(2) chief executive officers (or equivalent administrative heads) from academic health centers, integrated health care systems, approved medical residency training programs, and teaching hospitals that sponsor approved medical residency training programs;

(3) chairs of departments or divisions from allopathic and osteopathic schools of medicine, schools of dentistry, and approved medical residency training programs in oral surgery;

(4) individuals with leadership experience from representative fields of non-physician health professionals;

(5) individuals with substantial experience in the study of issues regarding the composi-

tion of the health care workforce of the United States; and

(6) individuals with expertise in health care payment policies.

(c) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Commission shall submit to the Congress a report providing its recommendations under this section and the reasons and justifications for such recommendations.

**SEC. 4630. STUDY OF HOSPITAL OVERHEAD AND SUPERVISORY PHYSICIAN COMPONENTS OF DIRECT MEDICAL EDUCATION COSTS.**

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a study with respect to—

(1) variations among hospitals in the hospital overhead and supervisory physician components of their direct medical education costs taken into account under section 1886(h) of the Social Security Act, and

(2) the reasons for such variations.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall report the results of the study conducted under subsection (a) to the appropriate committees of Congress, including recommendations for legislation reducing variations described in subsection (a) that the Secretary finds inappropriate.

## CHAPTER 3—PROVISIONS RELATING TO MEDICARE SECONDARY PAYER

**SEC. 4631. PERMANENT EXTENSION AND REVISION OF CERTAIN SECONDARY PAYER PROVISIONS.**

(a) APPLICATION TO DISABLED INDIVIDUALS IN LARGE GROUP HEALTH PLANS.—

(1) IN GENERAL.—Section 1862(b)(1)(B) (42 U.S.C. 1395y(b)(1)(B)) is amended—

(A) in clause (i), by striking ''clause (iv)'' and inserting ''clause (iii)'';

(B) by striking clause (iii); and

(C) by redesignating clause (iv) as clause (iii).

(2) CONFORMING AMENDMENTS.—Paragraphs (1) through (3) of section 1837(i) (42 U.S.C. 1395p(i)) and the second sentence of section 1839(b) (42 U.S.C. 1395r(b)) are each amended by striking ''1862(b)(1)(B)(iv)'' each place it appears and inserting ''1862(b)(1)(B)(iii)''.

(b) INDIVIDUALS WITH END STAGE RENAL DISEASE.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the last sentence by striking ''October 1, 1998'' and inserting ''the date of enactment of the Balanced Budget Act of 1997''; and

(2) by adding at the end the following: ''Effective for items and services furnished on or after the date of enactment of the Balanced Budget Act of 1997, (with respect to periods beginning on or after the date that is 18 months prior to such date), clauses (i) and (ii) shall be applied by substituting '30-month' for '12-month' each place it appears.''.

(c) IRS–SSA–HCFA DATA MATCH.—

(1) SOCIAL SECURITY ACT.—Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) INTERNAL REVENUE CODE.—Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

**SEC. 4632. CLARIFICATION OF TIME AND FILING LIMITATIONS.**

(a) EXTENSION OF CLAIMS FILING PERIOD.—Section 1862(b)(2)(B) (42 U.S.C. 1395y(b)(2)(B)) is amended by adding at the end the following new clause:

''(v) CLAIMS-FILING PERIOD.—Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.''.

(b) EFFECTIVE DATE.—The amendments made by this section apply to items and services furnished on or after the date of the enactment of this Act.

**SEC. 4633. PERMITTING RECOVERY AGAINST THIRD PARTY ADMINISTRATORS.**

(a) PERMITTING RECOVERY AGAINST THIRD PARTY ADMINISTRATORS OF PRIMARY PLANS.—Section 1862(b)(2)(B)(ii) (42 U.S.C. 1395y(b)(2)(B)(ii)) is amended—

(1) by striking ''under this subsection to pay'' and inserting ''(directly, as a third-party administrator, or otherwise) to make payment''; and

(2) by adding at the end the following: ''The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan and is not employed by or under contract with the employer or group health plan at the time the action for recovery is initiated by the United States or for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.''.

(b) CLARIFICATION OF BENEFICIARY LIABILITY.—Section 1862(b)(1) (42 U.S.C. 1395y(b)(1)) is amended by adding at the end the following new subparagraph:

''(F) LIMITATION ON BENEFICIARY LIABILITY.—An individual who is entitled to benefits under this title and is furnished an item or service for which such benefits are incorrectly paid is not liable for repayment of such benefits under this paragraph unless payment of such benefits was made to the individual.''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to items and services furnished on or after the date of the enactment of this Act.

## CHAPTER 4—OTHER PROVISIONS

**SEC. 4641. PLACEMENT OF ADVANCE DIRECTIVE IN MEDICAL RECORD.**

(a) IN GENERAL.—Section 1866(f)(1)(B) (42 U.S.C. 1395cc(f)(1)(B)) is amended by striking ''in the individual's medical record'' and inserting ''in a prominent part of the individual's current medical record''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to provider agreements entered into, renewed, or extended on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary of Health and Human Services specifies.

**SEC. 4642. INCREASED CERTIFICATION PERIOD FOR CERTAIN ORGAN PROCUREMENT ORGANIZATIONS.**

Section 1138(b)(1)(A)(ii) (42 U.S.C. 1320b–8(b)(1)(A)(ii)) is amended by striking ''two years'' and inserting ''2 years (4 years if the Secretary determines appropriate for an organization on the basis of its past practices)''.

**SEC. 4643. OFFICE OF THE CHIEF ACTUARY IN THE HEALTH CARE FINANCING ADMINISTRATION.**

Section 1117 (42 U.S.C. 1317) is amended—

(1) in the heading, by inserting ''AND CHIEF ACTUARY'' after ''THE ADMINISTRATOR'';

(2) by inserting ''(a)'' before ''The Administrator''; and

(3) by adding at the end the following:

''(b)(1) There is established in the Health Care Financing Administration the position of Chief Actuary. The Chief Actuary shall be appointed by, and in direct line of authority to, the Administrator of such Administration. The Chief Actuary shall be appointed from among individuals who have demonstrated, by their education and experience, superior expertise in the actuarial sciences. The Chief Actuary shall exercise such duties as are appropriate for the office of the Chief Actuary and in accordance with professional standards of actuarial independence. The Chief Actuary may be removed only for cause.

''(2) The Chief Actuary shall be compensated at the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5, United States Code.''.

**SEC. 4644. CONFORMING AMENDMENTS TO COMPLY WITH CONGRESSIONAL REVIEW OF AGENCY RULEMAKING.**

(a) DRG PROSPECTIVE PAYMENT RATE METHODOLOGY.—

(1) IN GENERAL.—Section 1886(d)(6) (42 U.S.C. 1395ww(d)(6)) is amended by striking ''September 1'' and inserting ''August 1''.

(2) TRANSITION RULE FOR FISCAL YEAR 1998.—With respect to the publication in the Federal Register of the DRG prospective payment rate methodology under such section for fiscal year 1998, the term ''60 days'' in section 801(a)(3)(A) and section 802(a) of title 5, United States Code, is deemed to be a reference to ''30 days''.

(b) HOSPITAL PAYMENT UPDATES.—

(1) IN GENERAL.—Section 1886(e) (42 U.S.C. 1395ww(e) is amended—

(A) in paragraph (5)(A) by striking ''May 1'' and inserting ''April 1''; and

(B) in paragraph (5)(B) by striking ''September 1'' and inserting ''August 1''.

(2) TRANSITION RULE FOR FISCAL YEAR 1998.—With respect to the publication in the Federal Register of the appropriate change factor for inpatient hospital services for discharges in fiscal year 1998 under section 1886(e)(5)(B) (42 U.S.C. 1395ww(e)(5)(B)), the term ''60 days'' in section 801(a)(3)(A) and section 802(a) of title 5, United States Code, is deemed to be a reference to ''30 days''.

(c) APPLICATIONS FOR GEOGRAPHIC RECLASSIFICATION.—

(1) IN GENERAL.—Section 1886(d)(10)(C) (42 U.S.C. 1395ww(d)(10)(C)) is amended in clause (ii), by striking ''the first day of the preceding fiscal year.'' and inserting ''the first day of the 13-month period ending on September 30 of the preceding fiscal year.''

(2) SPECIAL RULE FOR APPLICATIONS RECEIVED IN FISCAL YEAR 1997.—In the case of an application for a change in geographic classification under such section for fiscal year 1999, the Secretary of Health and Human Services shall shorten the deadlines under such section so as to permit completion of a final decision by the Secretary by June 15, 1998.

(d) PHYSICIAN FEE SCHEDULE.—Section 1848(b)(1) (42 U.S.C. 1395w–4(b)(1)) is amended by striking ''Before January 1 of each year beginning with 1992'' and inserting ''Before November 1 of the preceding year, for each year beginning with 1998''.

## Subtitle H—Medicaid

## CHAPTER 1—MANAGED CARE

**SEC. 4701. STATE OPTION OF USING MANAGED CARE; CHANGE IN TERMINOLOGY.**

(a) USE OF MANAGED CARE GENERALLY.—Title XIX is amended by redesignating section 1932 as section 1933 and by inserting after section 1931 the following new section:

''PROVISIONS RELATING TO MANAGED CARE

''SEC. 1932. (a) STATE OPTION TO USE MANAGED CARE.—

''(1) USE OF MEDICAID MANAGED CARE ORGANIZATIONS AND PRIMARY CARE CASE MANAGERS.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this section, and notwithstanding paragraph (1), (10)(B), or (23)(A) of section 1902(a), a State—

''(i) may require an individual who is eligible for medical assistance under the State

plan under this title to enroll with a managed care entity as a condition of receiving such assistance (and, with respect to assistance furnished by or under arrangements with such entity, to receive such assistance through the entity), if—

''(I) the entity and the contract with the State meet the applicable requirements of this section and section 1903(m) or section 1905(t), and

''(II) the requirements described in the succeeding paragraphs of this subsection are met; and

''(ii) may restrict the number of provider agreements with managed care entities under the State plan if such restriction does not substantially impair access to services.

''(B) DEFINITION OF MANAGED CARE ENTITY.—In this section, the term 'managed care entity' means—

''(i) a medicaid managed care organization, as defined in section 1903(m)(1)(A), that provides or arranges for services for enrollees under a contract pursuant to section 1903(m); and

''(ii) a primary care case manager, as defined in section 1905(t)(2).

''(2) SPECIAL RULES.—

''(A) EXEMPTION OF CERTAIN CHILDREN WITH SPECIAL NEEDS.—A State may not require under paragraph (1) the enrollment in a managed care entity of an individual under 19 years of age who—

''(i) is eligible for supplemental security income under title XVI;

''(ii) is described in section 501(a)(1)(D);

''(iii) is described in section 1902(e)(3);

''(iv) is receiving foster care or adoption assistance under part E of title IV; or

''(v) is in foster care or otherwise in an out-of-home placement.

''(B) EXEMPTION OF MEDICARE BENEFICIARIES.—A State may not require under paragraph (1) the enrollment in a managed care entity of an individual who is a qualified medicare beneficiary (as defined in section 1905(p)(1)) or an individual otherwise eligible for benefits under title XVIII.

''(C) INDIAN ENROLLMENT.—A State may not require under paragraph (1) the enrollment in a managed care entity of an individual who is an Indian (as defined in section 4(c) of the Indian Health Care Improvement Act of 1976 (25 U.S.C. 1603(c)) unless the entity is one of the following (and only if such entity is participating under the plan):

''(i) The Indian Health Service.

''(ii) An Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act (25 U.S.C. 450 et seq.).

''(iii) An urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

''(3) CHOICE OF COVERAGE.—

''(A) IN GENERAL.—A State must permit an individual to choose a managed care entity from not less than two such entities that meet the applicable requirements of this section, and of section 1903(m) or section 1905(t).

''(B) STATE OPTION.—At the option of the State, a State shall be considered to meet the requirements of subparagraph (A) in the case of an individual residing in a rural area, if the State requires the individual to enroll with a managed care entity if such entity—

''(i) permits the individual to receive such assistance through not less than two physicians or case managers (to the extent that at least two physicians or case managers are available to provide such assistance in the area), and

(ii) permits the individual to obtain such assistance from any other provider in appropriate circumstances (as established by the State under regulations of the Secretary).

''(C) TREATMENT OF CERTAIN COUNTY-OPERATED HEALTH INSURING ORGANIZATIONS.—A State shall be considered to meet the requirement of subparagraph (A) if—

''(i) the managed care entity in which the individual is enrolled is a health-insuring organization which—

''(I) first became operational prior to January 1, 1986, or

''(II) is described in section 9517(c)(3) of the Omnibus Budget Reconciliation Act of 1985 (as added by section 4734(2) of the Omnibus Budget Reconciliation Act of 1990), and

''(ii) the individual is given a choice between at least two providers within such entity.

''(4) PROCESS FOR ENROLLMENT AND TERMINATION AND CHANGE OF ENROLLMENT.—As conditions under paragraph (1)(A)—

''(A) IN GENERAL.—The State, enrollment broker (if any), and managed care entity shall permit an individual eligible for medical assistance under the State plan under this title who is enrolled with the entity under this title to terminate (or change) such enrollment—

''(i) for cause at any time (consistent with section 1903(m)(2)(A)(vi)), and

''(ii) without cause—

''(I) during the 90-day period beginning on the date the individual receives notice of such enrollment, and

''(II) at least every 12 months thereafter.

''(B) NOTICE OF TERMINATION RIGHTS.—The State shall provide for notice to each such individual of the opportunity to terminate (or change) enrollment under such conditions. Such notice shall be provided at least 60 days before each annual enrollment opportunity described in subparagraph (A)(ii)(II).

''(C) ENROLLMENT PRIORITIES.—In carrying out paragraph (1)(A), the State shall establish a method for establishing enrollment priorities in the case of a managed care entity that does not have sufficient capacity to enroll all such individuals seeking enrollment under which individuals already enrolled with the entity are given priority in continuing enrollment with the entity.

''(D) DEFAULT ENROLLMENT PROCESS.—In carrying out paragraph (1)(A), the State shall establish a default enrollment process—

''(i) under which any such individual who does not enroll with a managed care entity during the enrollment period specified by the State shall be enrolled by the State with such an entity which has not been found to be out of substantial compliance with the applicable requirements of this section and of section 1903(m) or section 1905(t); and

''(ii) that takes into consideration—

''(I) maintaining existing provider-individual relationships or relationships with providers that have traditionally served beneficiaries under this title; and

''(II) if maintaining such provider relationships is not possible, the equitable distribution of such individuals among qualified managed care entities available to enroll such individuals, consistent with the enrollment capacities of the entities.

''(5) PROVISION OF INFORMATION.—

''(A) INFORMATION IN EASILY UNDERSTOOD FORM.—Each State, enrollment broker, or managed care entity shall provide all enrollment notices and informational and instructional materials relating to such an entity under this title in a manner and form which may be easily understood by enrollees and potential enrollees of the entity who are eligible for medical assistance under the State plan under this title.

''(B) INFORMATION TO ENROLLEES AND POTENTIAL ENROLLEES.—Each managed care entity that is a medicaid managed care organization shall, upon request, make available to enrollees and potential enrollees in the organization's service area information concerning the following:

''(i) PROVIDERS.—The identity, locations, qualifications, and availability of health care providers that participate with the organization.

''(ii) ENROLLEE RIGHTS AND RESPONSIBILITIES.—The rights and responsibilities of enrollees.

''(iii) GRIEVANCE AND APPEAL PROCEDURES.—The procedures available to an enrollee and a health care provider to challenge or appeal the failure of the organization to cover a service.

''(iv) INFORMATION ON COVERED ITEMS AND SERVICES.—All items and services that are available to enrollees under the contract between the State and the organization that are covered either directly or through a method of referral and prior authorization. Each managed care entity that is a primary care case manager shall, upon request, make available to enrollees and potential enrollees in the organization's service area the information described in clause (iii).

''(C) COMPARATIVE INFORMATION.—A State that requires individuals to enroll with managed care entities under paragraph (1)(A) shall annually (and upon request) provide, directly or through the managed care entity, to such individuals a list identifying the managed care entities that are (or will be) available and information (presented in a comparative, chart-like form) relating to the following for each such entity offered:

''(i) BENEFITS AND COST-SHARING.—The benefits covered and cost-sharing imposed by the entity.

''(ii) SERVICE AREA.—The service area of the entity.

''(iii) QUALITY AND PERFORMANCE.—To the extent available, quality and performance indicators for the benefits under the entity.

''(D) INFORMATION ON BENEFITS NOT COVERED UNDER MANAGED CARE ARRANGEMENT.—A State, directly or through managed care entities, shall, on or before an individual enrolls with such an entity under this title, inform the enrollee in a written and prominent manner of any benefits to which the enrollee may be entitled to under this title but which are not made available to the enrollee through the entity. Such information shall include information on where and how such enrollees may access benefits not made available to the enrollee through the entity.''.

(b) CHANGE IN TERMINOLOGY.—

(1) IN GENERAL.—Section 1903(m)(1)(A) (42 U.S.C. 1396b(m)) is amended—

(A) by striking ''The term'' and all that follows through ''and—'' and inserting ''The term 'medicaid managed care organization' means a health maintenance organization, an eligible organization with a contract under section 1876 or a Medicare+Choice organization with a contract under part C of title XVIII, a provider sponsored organization, or any other public or private organization, which meets the requirement of section 1902(w) and—''; and

(B) by adding after and below clause (ii) the following:

''An organization that is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) is deemed to meet the requirements of clauses (i) and (ii).''.

(2) CONFORMING CHANGES IN TERMINOLOGY.—(A) Each of the following provisions is amended by striking ''health maintenance organization'' and inserting ''medicaid managed care organization'':

(i) Section 1902(a)(23) (42 U.S.C. 1396a(a)(23)).

(ii) Section 1902(a)(57) (42 U.S.C. 1396a(a)(57)).

(iii) Section 1902(p)(2) (42 U.S.C. 1396a(p)(2)).

(iv) Section 1902(w)(2)(E) (42 U.S.C. 1396a(w)(2)(E)).

(v) Section 1903(k) (42 U.S.C. 1396b(k)).

(vi) In section 1903(m)(1)(B).

(vii) In subparagraphs (A)(i) and (H)(i) of section 1903(m)(2) (42 U.S.C. 1396b(m)(2)).

(viii) Section 1903(m)(4)(A) (42 U.S.C. 1396b(m)(4)(A)), the first place it appears.

(ix) Section 1925(b)(4)(D)(iv) (42 U.S.C. 1396r–6(b)(4)(D)(iv)).

(x) Section 1927(j)(1) (42 U.S.C. 1396r–8(j)(1)) is amended by striking ''***Health Maintenance Organizations, including those organizations'' and inserting ''health maintenance organizations, including medicaid managed care organizations''.

(B) Section 1903(m)(2)(H) (42 U.S.C. 1396b(m)(2)(H)) is amended, in the matter following clause (iii), by striking ''health maintenance''.

(C) Clause (viii) of section 1903(w)(7)(A) (42 U.S.C. 1396b(w)(7)(A)) is amended to read as follows:

''(viii) Services of a medicaid managed care organization with a contract under section 1903(m).''.

(D) Section 1925(b)(4)(D)(iv) (42 U.S.C. 1396r–6(b)(4)(D)(iv)) is amended—

(i) in the heading, by striking ''HMO'' and inserting ''MEDICAID MANAGED CARE ORGANIZATION''; and

(ii) by inserting ''and the applicable requirements of section 1932'' before the period at the end.

(c) COMPLIANCE OF CONTRACT WITH NEW REQUIREMENTS.—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is amended—

(1) by striking ''and'' at the end of clause (x),

(2) by striking the period at the end of clause (xi) and inserting ''; and''; and

(3) by adding at the end the following:

''(xi) such contract, and the entity complies with the applicable requirements of section 1932.''.

(d) CONFORMING AMENDMENTS TO FREEDOM-OF-CHOICE AND TERMINATION OF ENROLLMENT REQUIREMENTS.—

(1) Section 1902(a)(23) (42 U.S.C. 1396a(a)(23)), as amended by section 4724(d), is amended by striking ''and in section 1915'' and inserting '', in section 1915, and in section 1932(a)''.

(2) Section 1903(m)(2) (42 U.S.C. 1396b(m)(2)) is amended—

(A) in paragraph (A)(vi)—

(i) by striking ''except as provided under subparagraph (F),'',

(ii) by striking ''without cause'' and all that follows through ''for such termination'' and inserting ''in accordance with section 1932(a)(4);'',

(iii) by inserting ''in accordance with such section'' after ''provides for notification''; and

(B) by striking subparagraph (F).

**SEC. 4702. PRIMARY CARE CASE MANAGEMENT SERVICES AS STATE OPTION WITHOUT NEED FOR WAIVER.**

(a) IN GENERAL.—Section 1905 (42 U.S.C. 1396d) is amended—

(1) in subsection (a)—

(A) by striking ''and'' at the end of paragraph (24);

(B) by redesignating paragraph (25) as paragraph (26) and by striking the period at the end of such paragraph and inserting a comma; and

(C) by inserting after paragraph (24) the following new paragraph:

''(25) primary care case management services (as defined in subsection (t)); and''; and

(2) by adding at the end the following new subsection:

''(t)(1) The term 'primary care case management services' means case-management related services (including locating, coordinating, and monitoring of health care services) provided by a primary care case manager under a primary care case management contract.

''(2) The term 'primary care case manager' means any of the following that provides services of the type described in paragraph (1) under a contract referred to in such paragraph:

''(A) A physician, a physician group practice, or an entity employing or having other arrangements with physicians to provide such services.

''(B) At State option—

''(i) a nurse practitioner (as described in section 1905(a)(21));

''(ii) a certified nurse-midwife (as defined in section 1861(gg)); or

''(iii) a physician assistant (as defined in section 1861(aa)(5)).

''(3) The term 'primary care case management contract' means a contract between a primary care case manager and a State under which the manager undertakes to locate, coordinate, and monitor covered primary care (and such other covered services as may be specified under the contract) to all individuals enrolled with the manager, and which—

''(A) provides for reasonable and adequate hours of operation, including 24-hour availability of information, referral, and treatment with respect to medical emergencies;

''(B) restricts enrollment to individuals residing sufficiently near a service delivery site of the manager to be able to reach that site within a reasonable time using available and affordable modes of transportation;

''(C) provides for arrangements with, or referrals to, sufficient numbers of physicians and other appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

''(D) prohibits discrimination on the basis of health status or requirements for health care services in enrollment, disenrollment, or reenrollment of individuals eligible for medical assistance under this title;

''(E) provides for a right for an enrollee to terminate enrollment in accordance with section 1932(a)(4); and

''(F) complies with the other applicable provisions of section 1932.

''(4) For purposes of this subsection, the term 'primary care' includes all health care services customarily provided in accordance with State licensure and certification laws and regulations, and all laboratory services customarily provided by or through, a general practitioner, family medicine physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.''.

(b) CONFORMING AMENDMENTS.—

(1) APPLICATION OF REENROLLMENT PROVISIONS TO PCCMS.—Section 1903(m)(2)(H) (42 U.S.C. 1396b(m)(2)(H)) is amended—

(A) in clause (i), by inserting before the comma the following: ''or with a primary care case manager with a contract described in section 1905(t)(3)''; and

(B) by inserting before the period at the end the following: ''or with the manager described in such clause if the manager continues to have a contract described in section 1905(t)(3) with the State''.

(2) CONFORMING CROSS-REFERENCE.—Section 1902(j) (42 U.S.C. 1396a(j)) is amended by striking ''paragraphs (1) through (25)'' and inserting ''a numbered paragraph of''.

**SEC. 4703. ELIMINATION OF 75:25 RESTRICTION ON RISK CONTRACTS.**

(a) IN GENERAL.—Section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is amended by striking clause (ii).

(b) CONFORMING AMENDMENTS.—

(1) Section 1903(m)(2) (42 U.S.C. 1396b(m)(2)) is amended—

(A) by striking subparagraphs (C), (D), and (E); and

(B) in subparagraph (G), by striking ''clauses (i) and (ii)'' and inserting ''clause (i)''.

(2) Section 1925(b)(4)(D)(iv) (42 U.S.C. 1396r–6(b)(4)(D)(iv)) is amended by striking ''less than 50 percent'' and all that follows up to the period at the end.

**SEC. 4704. INCREASED BENEFICIARY PROTECTIONS.**

(a) IN GENERAL.—Section 1932, as added by section 4701(a), is amended by adding at the end the following:

''(b) BENEFICIARY PROTECTIONS.—

''(1) SPECIFICATION OF BENEFITS.—Each contract with a managed care entity under section 1903(m) or under section 1905(t)(3) shall specify the benefits the provision (or arrangement) for which the entity is responsible.

''(2) ASSURING COVERAGE TO EMERGENCY SERVICES.—

''(A) IN GENERAL.—Each contract with a medicaid managed care organization under section 1903(m) and each contract with a primary care case manager under section 1905(t)(3) shall require the organization or manager—

''(i) to provide coverage for emergency services (as defined in subparagraph (B)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization or manager, and

''(ii) to comply with guidelines established under section 1852(d)(2) (respecting coordination of post-stabilization care) in the same manner as such guidelines apply to Medicare+Choice plans offered under part C of title XVIII.

The requirement under clause (ii) shall first apply 30 days after the date of promulgation of the guidelines referred to in such clause.

''(B) EMERGENCY SERVICES DEFINED.—In subparagraph (A)(i), the term 'emergency services' means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

''(i) are furnished by a provider that is qualified to furnish such services under this title, and

''(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (C)).

''(C) EMERGENCY MEDICAL CONDITION DEFINED.—In subparagraph (B)(ii), the term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

''(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

''(ii) serious impairment to bodily functions, or

''(iii) serious dysfunction of any bodily organ or part.

''(3) PROTECTION OF ENROLLEE-PROVIDER COMMUNICATIONS.—

''(A) IN GENERAL.—Subject to subparagraphs (B) and (C), under a contract under section 1903(m) a medicaid managed care organization (in relation to an individual enrolled under the contract) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under

the contract, if the professional is acting within the lawful scope of practice.

''(B) CONSTRUCTION.—Subparagraph (A) shall not be construed as requiring a medicaid managed care organization to provide, reimburse for, or provide coverage of, a counseling or referral service if the organization—

''(i) objects to the provision of such service on moral or religious grounds; and

''(ii) in the manner and through the written instrumentalities such organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization adopts a change in policy regarding such a counseling or referral service.

Nothing in this subparagraph shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

''(C) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this paragraph, the term 'health care professional' means a physician (as defined in section 1861(r)) or other health care professional if coverage for the professional's services is provided under the contract referred to in subparagraph (A) for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

''(4) GRIEVANCE PROCEDURES.—Each medicaid managed care organization shall establish an internal grievance procedure under which an enrollee who is eligible for medical assistance under the State plan under this title, or a provider on behalf of such an enrollee, may challenge the denial of coverage of or payment for such assistance.

''(5) DEMONSTRATION OF ADEQUATE CAPACITY AND SERVICES.—Each medicaid managed care organization shall provide the State and the Secretary with adequate assurances (in a time and manner determined by the Secretary) that the organization, with respect to a service area, has the capacity to serve the expected enrollment in such service area, including assurances that the organization—

''(A) offers an appropriate range of services and access to preventive and primary care services for the population expected to be enrolled in such service area, and

''(B) maintains a sufficient number, mix, and geographic distribution of providers of services.

''(6) PROTECTING ENROLLEES AGAINST LIABILITY FOR PAYMENT.—Each medicaid managed care organization shall provide that an individual eligible for medical assistance under the State plan under this title who is enrolled with the organization may not be held liable—

''(A) for the debts of the organization, in the event of the organization's insolvency,

''(B) for services provided to the individual—

''(i) in the event of the organization failing to receive payment from the State for such services; or

''(ii) in the event of a health care provider with a contractual, referral, or other arrangement with the organization failing to receive payment from the State or the organization for such services, or

''(C) for payments to a provider that furnishes covered services under a contractual, referral, or other arrangement with the organization in excess of the amount that would be owed by the individual if the organization had directly provided the services.

''(7) ANTIDISCRIMINATION.—A medicaid managed care organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit an organization from including providers only to the extent necessary to meet the needs of the organization's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization.

''(8) COMPLIANCE WITH CERTAIN MATERNITY AND MENTAL HEALTH REQUIREMENTS.—Each medicaid managed care organization shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply and are effective with respect to a health insurance issuer that offers group health insurance coverage.''.

(b) PROTECTION OF ENROLLEES AGAINST BALANCE BILLING THROUGH SUBCONTRACTORS.—Section 1128B(d)(1) (42 U.S.C. 1320a–7b(d)(1)) is amended by inserting ''(or, in the case of services provided to an individual enrolled with a medicaid managed care organization under title XIX under a contract under section 1903(m) or under a contractual, referral, or other arrangement under such contract, at a rate in excess of the rate permitted under such contract)'' before the comma at the end.

**SEC. 4705. QUALITY ASSURANCE STANDARDS.**

(a) IN GENERAL.—Section 1932 is further amended by adding at the end the following:

''(c) QUALITY ASSURANCE STANDARDS.—

''(1) QUALITY ASSESSMENT AND IMPROVEMENT STRATEGY.—

''(A) IN GENERAL.—If a State provides for contracts with medicaid managed care organizations under section 1903(m), the State shall develop and implement a quality assessment and improvement strategy consistent with this paragraph. Such strategy shall include the following:

''(i) ACCESS STANDARDS.—Standards for access to care so that covered services are available within reasonable timeframes and in a manner that ensures continuity of care and adequate primary care and specialized services capacity.

''(ii) OTHER MEASURES.—Examination of other aspects of care and service directly related to the improvement of quality of care (including grievance procedures and marketing and information standards).

''(iii) MONITORING PROCEDURES.—Procedures for monitoring and evaluating the quality and appropriateness of care and services to enrollees that reflect the full spectrum of populations enrolled under the contract and that includes requirements for provision of quality assurance data to the State using the data and information set that the Secretary has specified for use under part C of title XVIII or such alternative data as the Secretary approves, in consultation with the State.

''(iv) PERIODIC REVIEW.—Regular, periodic examinations of the scope and content of the strategy.

''(B) STANDARDS.—The strategy developed under subparagraph (A) shall be consistent with standards that the Secretary first establishes within 1 year after the date of the enactment of this section. Such standards shall not preempt any State standards that are more stringent than such standards. Guidelines relating to quality assurance that are applied under section 1915(b)(1) shall apply under this subsection until the effective date of standards for quality assurance established under this subparagraph.

''(C) MONITORING.—The Secretary shall monitor the development and implementation of strategies under subparagraph (A).

''(D) CONSULTATION.—The Secretary shall conduct activities under subparagraphs (B) and (C) in consultation with the States.

''(2) EXTERNAL INDEPENDENT REVIEW OF MANAGED CARE ACTIVITIES.—

''(A) REVIEW OF CONTRACTS.—

''(i) IN GENERAL.—Each contract under section 1903(m) with a medicaid managed care organization shall provide for an annual (as appropriate) external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible under the contract. The requirement for such a review shall not apply until after the date that the Secretary establishes the identification method described in clause (ii).

''(ii) QUALIFICATIONS OF REVIEWER.—The Secretary, in consultation with the States, shall establish a method for the identification of entities that are qualified to conduct reviews under clause (i).

''(iii) USE OF PROTOCOLS.—The Secretary, in coordination with the National Governors' Association, shall contract with an independent quality review organization (such as the National Committee for Quality Assurance) to develop the protocols to be used in external independent reviews conducted under this paragraph on and after January 1, 1999.

''(iv) AVAILABILITY OF RESULTS.—The results of each external independent review conducted under this subparagraph shall be available to participating health care providers, enrollees, and potential enrollees of the organization, except that the results may not be made available in a manner that discloses the identity of any individual patient.

''(B) NONDUPLICATION OF ACCREDITATION.—A State may provide that, in the case of a medicaid managed care organization that is accredited by a private independent entity (such as those described in section 1852(e)(4)) or that has an external review conducted under section 1852(e)(3), the external review activities conducted under subparagraph (A) with respect to the organization shall not be duplicative of review activities conducted as part of the accreditation process or the external review conducted under such section.

''(C) DEEMED COMPLIANCE FOR MEDICARE MANAGED CARE ORGANIZATIONS.—At the option of a State, the requirements of subparagraph (A) shall not apply with respect to a medicaid managed care organization if the organization is an eligible organization with a contract in effect under section 1876 or a Medicare+Choice organization with a contract in effect under C of title XVIII and the organization has had a contract in effect under section 1903(m) at least during the previous 2-year period.

(b) INCREASED FFP FOR EXTERNAL QUALITY REVIEW ORGANIZATIONS.—Section 1903(a)(3)(C) (42 U.S.C. 1396b(a)(3)(C)) is amended—

(1) by inserting ''(i)'' after ''(C)'', and

(2) by adding at the end the following new clause:

''(ii) 75 percent of the sums expended with respect to costs incurred during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to the performance of independent external reviews conducted under section 1932(c)(2); and''.

(c) STUDIES AND REPORTS.—

(1) GAO STUDY AND REPORT ON QUALITY ASSURANCE AND ACCREDITATION STANDARDS.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study and

analysis of the quality assurance programs and accreditation standards applicable to managed care entities operating in the private sector, or to such entities that operate under contracts under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such study shall determine—

(i) if such programs and standards include consideration of the accessibility and quality of the health care items and services delivered under such contracts to low-income individuals; and

(ii) the appropriateness of applying such programs and standards to medicaid managed care organizations under section 1932(c) of such Act.

(B) REPORT.—The Comptroller General shall submit a report to the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate on the study conducted under subparagraph (A).

(2) STUDY AND REPORT ON SERVICES PROVIDED TO INDIVIDUALS WITH SPECIAL HEALTH CARE NEEDS.—

(A) STUDY.—The Secretary of Health and Human Services, in consultation with States, managed care organizations, the National Academy of State Health Policy, representatives of beneficiaries with special health care needs, experts in specialized health care, and others, shall conduct a study concerning safeguards (if any) that may be needed to ensure that the health care needs of individuals with special health care needs and chronic conditions who are enrolled with medicaid managed care organizations are adequately met.

(B) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to Committees described in paragraph (1)(B) a report on such study.

**SEC. 4706. SOLVENCY STANDARDS.**

Section 1903(m)(1) (42 U.S.C. 1396b(m)(1)) is amended—

(1) in subparagraph (A)(ii), by inserting ", meets the requirements of subparagraph (C)(i) (if applicable)," after "provision is satisfactory to the State", and

(2) by adding at the end the following:

"(C)(i) Subject to clause (ii), a provision meets the requirements of this subparagraph for an organization if the organization meets solvency standards established by the State for private health maintenance organizations or is licensed or certified by the State as a risk-bearing entity.

"(ii) Clause (i) shall not apply to an organization if—

"(I) the organization is not responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and physicians' services;

"(II) the organization is a public entity;

"(III) the solvency of the organization is guaranteed by the State; or

"(IV) the organization is (or is controlled by) one or more Federally-qualified health centers and meets solvency standards established by the State for such an organization.

For purposes of subclause (IV), the term 'control' means the possession, whether direct or indirect, of the power to direct or cause the direction of the management and policies of the organization through membership, board representation, or an ownership interest equal to or greater than 50.1 percent.".

**SEC. 4707. PROTECTIONS AGAINST FRAUD AND ABUSE.**

(a) IN GENERAL.—Section 1932 (42 U.S.C. 1396v) is further amended by adding at the end the following:

"(d) PROTECTIONS AGAINST FRAUD AND ABUSE.—

"(1) PROHIBITING AFFILIATIONS WITH INDIVIDUALS DEBARRED BY FEDERAL AGENCIES.—

"(A) IN GENERAL.—A managed care entity may not knowingly—

"(i) have a person described in subparagraph (C) as a director, officer, partner, or person with beneficial ownership of more than 5 percent of the entity's equity, or

"(ii) have an employment, consulting, or other agreement with a person described in such subparagraph for the provision of items and services that are significant and material to the entity's obligations under its contract with the State.

"(B) EFFECT OF NONCOMPLIANCE.—If a State finds that a managed care entity is not in compliance with clause (i) or (ii) of subparagraph (A), the State—

"(i) shall notify the Secretary of such noncompliance;

"(ii) may continue an existing agreement with the entity unless the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) directs otherwise; and

"(iii) may not renew or otherwise extend the duration of an existing agreement with the entity unless the Secretary (in consultation with the Inspector General of the Department of Health and Human Services) provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

"(C) PERSONS DESCRIBED.—A person is described in this subparagraph if such person—

"(i) is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order; or

"(ii) is an affiliate (as defined in such Act) of a person described in clause (i).

"(2) RESTRICTIONS ON MARKETING.—

"(A) DISTRIBUTION OF MATERIALS.—

"(i) IN GENERAL.—A managed care entity, with respect to activities under this title, may not distribute directly or through any agent or independent contractor marketing materials within any State—

"(I) without the prior approval of the State, and

"(II) that contain false or materially misleading information.

The requirement of subclause (I) shall not apply with respect to a State until such date as the Secretary specifies in consultation with such State.

"(ii) CONSULTATION IN REVIEW OF MARKET MATERIALS.—In the process of reviewing and approving such materials, the State shall provide for consultation with a medical care advisory committee.

"(B) SERVICE MARKET.—A managed care entity shall distribute marketing materials to the entire service area of such entity covered under the contract under section 1903(m) or section 1903(t)(3).

"(C) PROHIBITION OF TIE-INS.—A managed care entity, or any agency of such entity, may not seek to influence an individual's enrollment with the entity in conjunction with the sale of any other insurance.

"(D) PROHIBITING MARKETING FRAUD.—Each managed care entity shall comply with such procedures and conditions as the Secretary prescribes in order to ensure that, before an individual is enrolled with the entity, the individual is provided accurate oral and written information sufficient to make an informed decision whether or not to enroll.

"(E) PROHIBITION OF 'COLD-CALL' MARKETING.—Each managed care entity shall not, directly or indirectly, conduct door-to-door, telephonic, or other 'cold-call' marketing of enrollment under this title.

"(3) STATE CONFLICT-OF-INTEREST SAFEGUARDS IN MEDICAID RISK CONTRACTING.—A medicaid managed care organization may not enter into a contract with any State under section 1903(m) unless the State has in effect conflict-of-interest safeguards with respect to officers and employees of the State with responsibilities relating to contracts with such organizations or to the default enrollment process described in subsection (a)(4)(C)(ii) that are at least as effective as the Federal safeguards provided under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423), against conflicts of interest that apply with respect to Federal procurement officials with comparable responsibilities with respect to such contracts.

"(4) USE OF UNIQUE PHYSICIAN IDENTIFIER FOR PARTICIPATING PHYSICIANS.—Each medicaid managed care organization shall require each physician providing services to enrollees eligible for medical assistance under the State plan under this title to have a unique identifier in accordance with the system established under section 1173(b).

"(e) SANCTIONS FOR NONCOMPLIANCE.—

"(1) USE OF INTERMEDIATE SANCTIONS BY THE STATE TO ENFORCE REQUIREMENTS.—

"(A) IN GENERAL.—A State may not enter into or renew a contract under section 1903(m) unless the State has established intermediate sanctions, which may include any of the types described in paragraph (2), other than the termination of a contract with a medicaid managed care organization, which the State may impose against a medicaid managed care organization with such a contract, if the organization—

"(i) fails substantially to provide medically necessary items and services that are required (under law or under such organization's contract with the State) to be provided to an enrollee covered under the contract;

"(ii) imposes premiums or charges on enrollees in excess of the premiums or charges permitted under this title;

"(iii) acts to discriminate among enrollees on the basis of their health status or requirements for health care services, including expulsion or refusal to reenroll an individual, except as permitted by this title, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the organization by eligible individuals whose medical condition or history indicates a need for substantial future medical services;

"(iv) misrepresents or falsifies information that is furnished—

"(I) to the Secretary or the State under this title; or

"(II) to an enrollee, potential enrollee, or a health care provider under such title; or

"(v) fails to comply with the applicable requirements of section 1903(m)(2)(A)(x).

The State may also impose such intermediate sanction against a managed care entity if the State determines that the entity distributed directly or through any agent or independent contractor marketing materials in violation of subsection (d)(2)(A)(i)(II)..

"(B) RULE OF CONSTRUCTION.—Clause (i) of subparagraph (A) shall not apply to the provision of abortion services, except that a State may impose a sanction on any medicaid managed care organization that has a contract to provide abortion services if the organization does not provide such services as provided for under the contract.

"(2) INTERMEDIATE SANCTIONS.—The sanctions described in this paragraph are as follows:

"(A) Civil money penalties as follows:

"(i) Except as provided in clause (ii), (iii), or (iv), not more than $25,000 for each determination under paragraph (1)(A).

''(ii) With respect to a determination under clause (iii) or (iv)(I) of paragraph (1)(A), not more than $100,000 for each such determination.

''(iii) With respect to a determination under paragraph (1)(A)(ii), double the excess amount charged in violation of such subsection (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned).

''(iv) Subject to clause (ii), with respect to a determination under paragraph (1)(A)(iii), $15,000 for each individual not enrolled as a result of a practice described in such subsection.

''(B) The appointment of temporary management—

''(i) to oversee the operation of the medicaid managed care organization upon a finding by the State that there is continued egregious behavior by the organization or there is a substantial risk to the health of enrollees; or

''(ii) to assure the health of the organization's enrollees, if there is a need for temporary management while—

''(I) there is an orderly termination or reorganization of the organization; or

''(II) improvements are made to remedy the violations found under paragraph (1),

except that temporary management under this subparagraph may not be terminated until the State has determined that the medicaid managed care organization has the capability to ensure that the violations shall not recur.

''(C) Permitting individuals enrolled with the managed care entity to terminate enrollment without cause, and notifying such individuals of such right to terminate enrollment.

''(D) Suspension or default of all enrollment of individuals under this title after the date the Secretary or the State notifies the entity of a determination of a violation of any requirement of section 1903(m) or this section.

''(E) Suspension of payment to the entity under this title for individuals enrolled after the date the Secretary or State notifies the entity of such a determination and until the Secretary or State is satisfied that the basis for such determination has been corrected and is not likely to recur.

''(3) TREATMENT OF CHRONIC SUBSTANDARD ENTITIES.—In the case of a medicaid managed care organization which has repeatedly failed to meet the requirements of section 1903(m) and this section, the State shall (regardless of what other sanctions are provided) impose the sanctions described in subparagraphs (B) and (C) of paragraph (2).

''(4) AUTHORITY TO TERMINATE CONTRACT.—

''(A) IN GENERAL.—In the case of a managed care entity which has failed to meet the requirements of this part or a contract under section 1903(m) or 1905(t)(3), the State shall have the authority to terminate such contract with the entity and to enroll such entity's enrollees with other managed care entities (or to permit such enrollees to receive medical assistance under the State plan under this title other than through a managed care entity).

''(B) AVAILABILITY OF HEARING PRIOR TO TERMINATION OF CONTRACT.—A State may not terminate a contract with a managed care entity under subparagraph (A) unless the entity is provided with a hearing prior to the termination.

''(C) NOTICE AND RIGHT TO DISENROLL IN CASES OF TERMINATION HEARING.—A State may—

''(i) notify individuals enrolled with a managed care entity which is the subject of a hearing to terminate the entity's contract with the State of the hearing, and

''(ii) in the case of such an entity, permit such enrollees to disenroll immediately with the entity without cause.

''(5) OTHER PROTECTIONS FOR MANAGED CARE ENTITIES AGAINST SANCTIONS IMPOSED BY STATE.—Before imposing any sanction against a managed care entity other than termination of the entity's contract, the State shall provide the entity with notice and such other due process protections as the State may provide, except that a State may not provide a managed care entity with a pre-termination hearing before imposing the sanction described in paragraph (2)(B).''.

(b) LIMITATION ON AVAILABILITY OF FFP FOR USE OF ENROLLMENT BROKERS.—Section 1903(b) (42 U.S.C. 1396b(b)) is amended by adding at the end the following:

''(4) Amounts expended by a State for the use an enrollment broker in marketing medicaid managed care organizations and other managed care entities to eligible individuals under this title shall be considered, for purposes of subsection (a)(7), to be necessary for the proper and efficient administration of the State plan but only if the following conditions are met with respect to the broker:

''(A) The broker is independent of any such entity and of any health care providers (whether or not any such provider participates in the State plan under this title) that provide coverage of services in the same State in which the broker is conducting enrollment activities.

''(B) No person who is an owner, employee, consultant, or has a contract with the broker either has any direct or indirect financial interest with such an entity or health care provider or has been excluded from participation in the program under this title or title XVIII or debarred by any Federal agency, or subject to a civil money penalty under this Act.''.

(c) APPLICATION OF DISCLOSURE REQUIREMENTS TO MANAGED CARE ENTITIES.—Section 1124(a)(2)(A) (42 U.S.C. 1320a–3(a)(2)(A)) is amended by inserting ''a managed care entity, as defined in section 1932(a)(1)(B),'' after ''renal disease facility,''.

**SEC. 4708. IMPROVED ADMINISTRATION.**

(a) CHANGE IN THRESHOLD AMOUNT FOR CONTRACTS REQUIRING SECRETARY'S PRIOR APPROVAL.—Section 1903(m)(2)(A)(iii) (42 U.S.C. 1396b(m)(2)(A)(iii)) is amended by striking ''$100,000'' and inserting ''$1,000,000 for 1998 and, for a subsequent year, the amount established under this clause for the previous year increased by the percentage increase in the consumer price index for all urban consumers over the previous year''.

(b) PERMITTING SAME COPAYMENTS IN HEALTH MAINTENANCE ORGANIZATIONS AS IN FEE-FOR-SERVICE.—Section 1916 (42 U.S.C. 1396o) is amended—

(1) in subsection (a)(2)(D), by striking ''or services furnished'' and all that follows through ''enrolled,''; and

(2) in subsection (b)(2)(D), by striking ''or (at the option'' and all that follows through ''enrolled,''.

(c) ASSURING TIMELINESS OF PROVIDER PAYMENTS.—Section 1932 is further amended by adding at the end the following:

''(f) TIMELINESS OF PAYMENT.—A contract under section 1903(m) with a medicaid managed care organization shall provide that the organization shall make payment to health care providers for items and services which are subject to the contract and that are furnished to individuals eligible for medical assistance under the State plan under this title who are enrolled with the organization on a timely basis consistent with the claims payment procedures described in section 1902(a)(37)(A), unless the health care provider and the organization agree to an alternate payment schedule.''.

(d) CLARIFICATION OF APPLICATION OF FFP DENIAL RULES TO PAYMENTS MADE PURSUANT TO MANAGED CARE ENTITIES.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended by adding at the end the following new sentence: ''Paragraphs (1), (2), (16), (17), and (18) shall apply with respect to items or services furnished and amounts expended by or through a managed care entity (as defined in section 1932(a)(1)(B)) in the same manner as such paragraphs apply to items or services furnished and amounts expended directly by the State.''.

**SEC. 4709. 6-MONTH GUARANTEED ELIGIBILITY FOR ALL INDIVIDUALS ENROLLED IN MANAGED CARE.**

Section 1902(e)(2) (42 U.S.C. 1396a(e)(2)) is amended—

(1) by striking ''who is enrolled'' and all that follows through ''section 1903(m)(2)(A)'' and inserting ''who is enrolled with a medicaid managed care organization (as defined in section 1903(m)(1)(A)), with a primary care case manager (as defined in section 1905(t)),''; and

(2) by inserting before the period ''or by or through the case manager''.

**SEC. 4710. EFFECTIVE DATES.**

(a) GENERAL EFFECTIVE DATE.—Except as otherwise provided in this chapter and section 4759, the amendments made by this chapter shall take effect on the date of the enactment of this Act and shall apply to contracts entered into or renewed on or after October 1, 1997.

(b) SPECIFIC EFFECTIVE DATES.—Subject to subsection (c) and section 4759—

(1) PCCM OPTION.—The amendments made by section 4702 shall apply to primary care case management services furnished on or after October 1, 1997.

(2) 75:25 RULE.—The amendments made by section 4703 apply to contracts under section 1903(m) of the Social Security Act (42 U.S.C. 1396b(m)) on and after June 20, 1997.

(3) QUALITY STANDARDS.—Section 1932(c)(1) of the Social Security Act, as added by section 4705(a), shall take effect on January 1, 1999.

(4) SOLVENCY STANDARDS.—

(A) IN GENERAL.—The amendments made by section 4706 shall apply to contracts entered into or renewed on or after October 1, 1998.

(B) TRANSITION RULE.—In the case of an organization that as of the date of the enactment of this Act has entered into a contract under section 1903(m) of the Social Security Act with a State for the provision of medical assistance under title XIX of such Act under which the organization assumes full financial risk and is receiving capitation payments, the amendment made by section 4706 shall not apply to such organization until 3 years after the date of the enactment of this Act.

(5) SANCTIONS FOR NONCOMPLIANCE.—Section 1932(e) of the Social Security Act, as added by section 4707(a), shall apply to contracts entered into or renewed on or after April 1, 1998.

(6) LIMITATION ON FFP FOR ENROLLMENT BROKERS.—The amendment made by section 4707(b) shall apply to amounts expended on or after October 1, 1997.

(7) 6-MONTH GUARANTEED ELIGIBILITY.—The amendments made by section 4709 shall take effect on October 1, 1997.

(c) NONAPPLICATION TO WAIVERS.—Nothing in this chapter (or the amendments made by this chapter) shall be construed as affecting the terms and conditions of any waiver, or the authority of the Secretary of Health and Human Services with respect to any such waiver, under section 1115 or 1915 of the Social Security Act (42 U.S.C. 1315, 1396n).

## CHAPTER 2—FLEXIBILITY IN PAYMENT OF PROVIDERS

**SEC. 4711. FLEXIBILITY IN PAYMENT METHODS FOR HOSPITAL, NURSING FACILITY, ICF/MR, AND HOME HEALTH SERVICES.**

(a) REPEAL OF BOREN REQUIREMENTS.—Section 1902(a)(13) (42 U.S.C. 1396a(a)(13)) is amended—

(1) by striking all that precedes subparagraph (D) and inserting the following:

''(13) provide—

''(A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which—

''(i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,

''(ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,

''(iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and

''(iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1923) the situation of hospitals which serve a disproportionate number of low-income patients with special needs;'';

(2) by redesignating subparagraphs (D) and (E) as subparagraphs (B) and (C), respectively;

(3) in subparagraph (B), as so redesignated, by adding ''and'' at the end;

(4) in subparagraph (C), as so redesignated, by striking ''and'' at the end; and

(5) by striking subparagraph (F).

(b) STUDY AND REPORT.—

(1) STUDY.—The Secretary of Health and Human Services shall study the effect on access to, and the quality of, services provided to beneficiaries of the rate-setting methods used by States pursuant to section 1902(a)(13)(A) of the Social Security Act (42 U.S.C. 1396a(a)(13)(A)), as amended by subsection (a).

(2) REPORT.—Not later than 4 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit a report to the appropriate committees of Congress on the conclusions of the study conducted under paragraph (1), together with any recommendations for legislation as a result of such conclusions.

(c) CONFORMING AMENDMENTS.—

(1) Section 1905(o)(3) (42 U.S.C. 1396d(o)(3)) is amended by striking ''amount described in section 1902(a)(13)(D)'' and inserting ''amount determined in section 1902(a)(13)(B)''.

(2) Section 1923 (42 U.S.C. 1396r–4) is amended, in subsections (a)(1) and (e)(1), by striking ''1902(a)(13)(A)'' each place it appears and inserting ''1902(a)(13)(A)(iv)''.

(d) EFFECTIVE DATE.—This section shall take effect on the date of the enactment of this Act and the amendments made by subsections (a) and (c) shall apply to payment for items and services furnished on or after October 1, 1997.

**SEC. 4712. PAYMENT FOR CENTER AND CLINIC SERVICES.**

(a) PHASE-OUT OF PAYMENT BASED ON REASONABLE COSTS.—Section 1902(a)(13)(C) (42 U.S.C. 1396a(a)(13)(C)), as redesignated by section 4711(a)(2), is amended by inserting ''(or 95 percent for services furnished during fiscal year 2000, 90 percent for services furnished during fiscal year 2001, 85 percent for services furnished during fiscal year 2002, or 70 percent for services furnished during fiscal year 2003)'' after ''100 percent''.

(b) TRANSITIONAL SUPPLEMENTAL PAYMENT FOR SERVICES FURNISHED UNDER CERTAIN MANAGED CARE CONTRACTS.—

(1) IN GENERAL.—Section 1902(a)(13)(C) (42 U.S.C. 1396a(a)(13)(C)), as so redesignated, is further amended—

(A) by inserting ''(i)'' after ''(C)'', and

(B) by inserting before the semicolon at the end the following: ''and (ii) in carrying out clause (i) in the case of services furnished by a Federally-qualified health center or a rural health clinic pursuant to a contract between the center and an organization under section 1903(m), for payment to the center or clinic at least quarterly by the State of a supplemental payment equal to the amount (if any) by which the amount determined under clause (i) exceeds the amount of the payments provided under such contract''.

(2) CONFORMING AMENDMENT TO MANAGED CARE CONTRACT REQUIREMENT.—Clause (ix) of section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is amended to read as follows:

''(ix) such contract provides, in the case of an entity that has entered into a contract for the provision of services with a Federally-qualified health center or a rural health clinic, that the entity shall provide payment that is not less than the level and amount of payment which the entity would make for the services if the services were furnished by a provider which is not a Federally-qualified health center or a rural health clinic;''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services furnished on or after October 1, 1997.

(c) END OF TRANSITIONAL PAYMENT RULES.—Effective for services furnished on or after October 1, 2003—

(1) subparagraph (C) of section 1902(a)(13) (42 U.S.C. 1396a(a)(13)), as so redesignated, is repealed, and

(2) clause (ix) of section 1903(m)(2)(A) (42 U.S.C. 1396b(m)(2)(A)) is repealed.

(d) FLEXIBILITY IN COVERAGE OF NON-FREE-STANDING LOOK-ALIKES.—

(1) IN GENERAL.—Section 1905(l)(2)(B)(iii) (42 U.S.C. 1396d(l)(2)(B)(iii)) is amended by inserting ''including requirements of the Secretary that an entity may not be owned, controlled, or operated by another entity,'' after ''such a grant,''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after the date of the enactment of this Act.

**SEC. 4713. ELIMINATION OF OBSTETRICAL AND PEDIATRIC PAYMENT RATE REQUIREMENTS.**

(a) IN GENERAL.—Section 1926 (42 U.S.C. 1396r–7) is repealed.

(b) EFFECTIVE DATE.—The repeal made by subsection (a) shall apply to services furnished on or after October 1, 1997.

**SEC. 4714. MEDICAID PAYMENT RATES FOR CERTAIN MEDICARE COST-SHARING.**

(a) CLARIFICATION REGARDING STATE LIABILITY FOR MEDICARE COST-SHARING.—

(1) IN GENERAL.—Section 1902(n) (42 U.S.C. 1396a(n)) is amended—

(A) by inserting ''(1)'' after ''(n)'', and

(B) by adding at the end the following:

''(2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a medicare beneficiary.

''(3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2)—

''(A) for purposes of applying any limitation under title XVIII on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under title XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;

''(B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1903(m)(1)(A) for the service; and

''(C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this title or title XVIII shall apply to the imposition of any charge imposed upon the individual in such case.

This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.''.

(2) CONFORMING CLARIFICATION.—Section 1905(p)(3) (42 U.S.C. 1396d(p)(3)) is amended by inserting ''(subject to section 1902(n)(2))'' after ''means''.

(b) LIMITATION ON MEDICARE PROVIDERS.—

(1) PROVIDER AGREEMENTS.—Section 1866(a)(1)(A) (42 U.S.C. 1395cc(a)(1)(A)) is amended—

(A) by inserting ''(i)'' after ''(A)'', and

(B) by inserting before the comma at the end the following: '', and (ii) not to impose any charge that is prohibited under section 1902(n)(3)''.

(2) NONPARTICIPATING PROVIDERS.—Section 1848(g)(3)(A) (42 U.S.C. 1395w–4(g)(3)(A)) is amended by inserting before the period at the end the following: ''and the provisions of section 1902(n)(3)(A) apply to further limit permissible charges under this section''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payment for (and with respect to provider agreements with respect to) items and services furnished on or after the date of the enactment of this Act. The amendments made by subsection (a) shall also apply to payment by a State for items and services furnished before such date if such payment is the subject of a law suit that is based on the provisions of sections 1902(n) and 1905(p) of the Social Security Act and that is pending as of, or is initiated after, the date of the enactment of this Act.

**SEC. 4715. TREATMENT OF VETERANS' PENSIONS UNDER MEDICAID.**

(a) POST-ELIGIBILITY TREATMENT.—Section 1902(r)(1) (42 U.S.C. 1396a(r)(1)) is amended—

(1) by inserting ''(A)'' after ''(r)(1)'',

(2) by inserting '', the treatment described in subparagraph (B) shall apply,'' after ''under such a waiver'';

(3) by striking ''and,'' and inserting '', and''; and

(4) by adding at the end the following:

''(B)(i) In the case of a veteran who does not have a spouse or a child, if the veteran—

''(I) receives, after the veteran has been determined to be eligible for medical assistance under the State plan under this title, a veteran's pension in excess of $90 per month, and

''(II) resides in a State veterans home with respect to which the Secretary of Veterans Affairs makes per diem payments for nursing home care pursuant to section 1741(a) of title 38, United States Code,

any such pension payment, including any payment made due to the need for aid and attendance, or for unreimbursed medical expenses, that is in excess of $90 per month shall be counted as income only for the purpose of applying such excess payment to the State veterans home's cost of providing nursing home care to the veteran.

''(ii) The provisions of clause (i) shall apply with respect to a surviving spouse of a vet-

eran who does not have a child in the same manner as they apply to a veteran described in such clause.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply on and after October 1, 1997.

**CHAPTER 3—FEDERAL PAYMENTS TO STATES**

**SEC. 4721. REFORMING DISPROPORTIONATE SHARE PAYMENTS UNDER STATE MEDICAID PROGRAMS.**

(a) ADJUSTMENT OF STATE DSH ALLOTMENTS.—

(1) IN GENERAL.—Section 1923(f) (42 U.S.C. 1396r–4(f)) is amended to read as follows:

''(f) LIMITATION ON FEDERAL FINANCIAL PARTICIPATION.—

''(1) IN GENERAL.—Payment under section 1903(a) shall not be made to a State with respect to any payment adjustment made under this section for hospitals in a State for quarters in a fiscal year in excess of the disproportionate share hospital (in this subsection referred to as 'DSH') allotment for the State for the fiscal year, as specified in paragraphs (2) and (3).

''(2) STATE DSH ALLOTMENTS FOR FISCAL YEARS 1998 THROUGH 2002.—The DSH allotment for a State for each fiscal year during the period beginning with fiscal year 1998 and ending with fiscal year 2002 is determined in accordance with the following table:

| State or District | DSH Allotment (in millions of dollars) | | | | |
|---|---|---|---|---|---|
| | *FY 98* | *FY 99* | *FY 00* | *FY 01* | *FY 02* |
| Alabama | 293 | 269 | 248 | 246 | 246 |
| Alaska | 10 | 10 | 10 | 9 | 9 |
| Arizona | 81 | 81 | *81* | 81 | 81 |
| Arkansas | 2 | 2 | 2 | 2 | 2 |
| California | 1,085 | 1,068 | 986 | 931 | 877 |
| Colorado | 93 | 85 | 79 | 74 | 74 |
| Connecticut | 200 | 194 | 164 | 160 | 160 |
| Delaware | 4 | 4 | 4 | 4 | 4 |
| District of Columbia | 23 | 23 | 23 | 23 | 23 |
| Florida | 207 | 203 | 197 | 188 | 160 |
| Georgia | 253 | 248 | 241 | 228 | 215 |
| Hawaii | 0 | 0 | 0 | 0 | 0 |
| Idaho | 1 | 1 | 1 | 1 | 1 |
| Illinois | 203 | 199 | 193 | 182 | 172 |
| Indiana | 201 | 197 | 191 | 181 | 171 |
| Iowa | 8 | 8 | 8 | 8 | 8 |
| Kansas | 51 | 49 | 42 | 36 | 33 |
| Kentucky | 137 | 134 | 130 | 123 | 116 |
| Louisiana | 880 | 795 | 713 | 658 | 631 |
| Maine | 103 | 99 | 84 | 84 | 84 |
| Maryland | 72 | 70 | 68 | 64 | 61 |
| Massachusetts | 288 | 282 | 273 | 259 | 244 |
| Michigan | 249 | 244 | 237 | 224 | 212 |
| Minnesota | 16 | 16 | 16 | 16 | 16 |
| Mississippi | 143 | 141 | 136 | 129 | 122 |
| Missouri | 436 | 423 | 379 | 379 | 379 |
| Montana | 0.2 | 0.2 | 0.2 | 0.2 | 0.2 |
| Nebraska | 5 | 5 | 5 | 5 | 5 |
| Nevada | 37 | 37 | 37 | 37 | 37 |
| New Hampshire | 140 | 136 | 130 | 130 | 130 |
| New Jersey | 600 | 582 | 515 | 515 | 515 |
| New Mexico | 5 | 5 | 5 | 5 | 5 |
| New York | 1,512 | 1,482 | 1,436 | 1,361 | 1,285 |
| North Carolina | 278 | 272 | 264 | 250 | 236 |
| North Dakota | 1 | 1 | 1 | 1 | 1 |
| Ohio | 382 | 374 | 363 | 344 | 325 |
| Oklahoma | 16 | 16 | 16 | 16 | 16 |
| Oregon | 20 | 20 | 20 | 20 | 20 |
| Pennsylvania | 529 | 518 | 502 | 476 | 449 |
| Rhode Island | 62 | 60 | 58 | 55 | 52 |
| South Carolina | 313 | 303 | 262 | 262 | 262 |
| South Dakota | 1 | 1 | 1 | 1 | 1 |
| Tennessee | 0 | 0 | 0 | 0 | 0 |
| Texas | 979 | 950 | 806 | 765 | 765 |
| Utah | 3 | 3 | 3 | 3 | 3 |
| Vermont | 18 | 18 | 18 | 18 | 18 |
| Virginia | 70 | 68 | 66 | 63 | 59 |
| Washington | 174 | 171 | 166 | 157 | 148 |
| West Virginia | 64 | 63 | 61 | 58 | 54 |
| Wisconsin | 7 | 7 | 7 | 7 | 7 |
| Wyoming | 0 | 0 | 0 | 0 | 0. |

''(3) STATE DSH ALLOTMENTS FOR FISCAL YEAR 2003 AND THEREAFTER.—

''(A) IN GENERAL.—The DSH allotment for any State for fiscal year 2003 and each succeeding fiscal year is equal to the DSH allotment for the State for the preceding fiscal year under paragraph (2) or this paragraph, increased, subject to subparagraph (B), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year.

''(B) LIMITATION.—The DSH allotment for a State shall not be increased under subparagraph (A) for a fiscal year to the extent that such an increase would result in the DSH allotment for the year exceeding the greater of—

''(i) the DSH allotment for the previous year, or

''(ii) 12 percent of the total amount of expenditures under the State plan for medical assistance during the fiscal year.

''(4) DEFINITION OF STATE.— In this subsection, the term 'State' means the 50 States and the District of Columbia.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to payment adjustments attributable to DSH allotments for fiscal years beginning with fiscal year 1998.

(b) LIMITATION ON PAYMENTS TO INSTITUTIONS FOR MENTAL DISEASES.—Section 1923 of the Social Security Act (42 U.S.C. 1396r–4) is amended by adding at the end the following:

''(h) LIMITATION ON CERTAIN STATE DSH EXPENDITURES.—

''(1) IN GENERAL.—Payment under section 1903(a) shall not be made to a State with respect to any payment adjustments made under this section for quarters in a fiscal year (beginning with fiscal year 1998) to institutions for mental diseases or other mental health facilities, to the extent the aggregate of such adjustments in the fiscal year exceeds the lesser of the following:

''(A) 1995 IMD DSH PAYMENT ADJUSTMENTS.—The total State DSH expenditures that are attributable to fiscal year 1995 for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary).

''(B) APPLICABLE PERCENTAGE OF 1995 TOTAL DSH PAYMENT ALLOTMENT.—The amount of such payment adjustments which are equal to the applicable percentage of the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for the State for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary).

''(2) APPLICABLE PERCENTAGE.—

''(A) IN GENERAL.—For purposes of paragraph (1), the applicable percentage with respect to—

''(i) each of fiscal years 1998, 1999, and 2000, is the percentage determined under subparagraph (B); or

''(ii) a succeeding fiscal year is the lesser of the percentage determined under subparagraph (B) or the following percentage:

''(I) For fiscal year 2001, 50 percent.

''(II) For fiscal year 2002, 40 percent.

''(III) For each succeeding fiscal year, 33 percent.

''(B) 1995 PERCENTAGE.—The percentage determined under this subparagraph is the ratio (determined as a percentage) of—

''(i) the Federal share of payment adjustments made to hospitals in the State under subsection (c) that are attributable to the 1995 DSH allotment for the State (as reported by the State not later than January 1, 1997, on HCFA Form 64, and as approved by the Secretary) for payments to institutions for mental diseases and other mental health facilities, to

''(ii) the State 1995 DSH spending amount.

''(C) STATE 1995 DSH SPENDING AMOUNT.—For purposes of subparagraph (B)(ii), the 'State 1995 DSH spending amount', with respect to a State, is the Federal medical assistance percentage (for fiscal year 1995) of the payment adjustments made under subsection (c) under the State plan that are attributable to the fiscal year 1995 DSH allotment for the State (as reported by the State not later than January 1, 1997, on HCFA Form 64, and as approved by the Secretary).''.

(c) DESCRIPTION OF TARGETING PAYMENTS.—Section 1923(a)(2) (42 U.S.C. 1396r–4(a)(2)) is amended by adding at the end the following:

''(D) A State plan under this title shall not be considered to meet the requirements of section 1902(a)(13)(A)(iv) (insofar as it requires payments to hospitals to take into account the situation of hospitals that serve a disproportionate number of low-income patients with special needs), as of October 1, 1998, unless the State has submitted to the Secretary by such date a description of the methodology used by the State to identify and to make payments to disproportionate share hospitals, including children's hospitals, on the basis of the proportion of low-income and medicaid patients served by such hospitals. The State shall provide an annual report to the Secretary describing the disproportionate share payments to each such disproportionate share hospital.''.

(d) DIRECT PAYMENT BY STATE FOR MANAGED CARE ENROLLEES.—Section 1923 (42 U.S.C. 1396r–4) is amended by adding at the end the following:

''(i) REQUIREMENT FOR DIRECT PAYMENT.—

''(1) IN GENERAL.—No payment may be made under section 1903(a)(1) with respect to a payment adjustment made under this section, for services furnished by a hospital on or after October 1, 1997, with respect to individuals eligible for medical assistance under the State plan who are enrolled with a managed care entity (as defined in section 1932(a)(1)(B)) or under any other managed care arrangement unless a payment, equal to the amount of the payment adjustment—

''(A) is made directly to the hospital by the State; and

''(B) is not used to determine the amount of a prepaid capitation payment under the State plan to the entity or arrangement with respect to such individuals.

''(2) EXCEPTION FOR CURRENT ARRANGEMENTS.—Paragraph (1) shall not apply to a payment adjustment provided pursuant to a payment arrangement in effect on July 1, 1997.''.

(e) TRANSITION RULE.—Effective July 1, 1997, section 1923(g)(2)(A) of the Social Security Act (42 U.S.C. 1396r–4(g)(2)(A)) shall be applied to the State of California as though—

(1) ''(or that begins on or after July 1, 1997, and before July 1, 1999)'' were inserted in such section after ''January 1, 1995,''; and

(2) ''(or 175 percent in the case of a State fiscal year that begins on or after July 1, 1997, and before July 1, 1999)'' were inserted in such section after ''200 percent''.

**SEC. 4722. TREATMENT OF STATE TAXES IMPOSED ON CERTAIN HOSPITALS.**

(a) EXCEPTION FROM TAX DOES NOT DISQUALIFY AS BROAD-BASED TAX.—Section 1903(w)(3) (42 U.S.C. 1396b(w)(3)) is amended—

(1) in subparagraph (B), by striking ''and (E)'' and inserting ''(E), and (F)''; and

(2) by adding at the end the following:

''(F) In no case shall a tax not qualify as a broad-based health care related tax under this paragraph because it does not apply to a hospital that is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code and that does not accept payment under the State plan under this title or under title XVIII.''.

(b) REDUCTION IN FEDERAL FINANCIAL PARTICIPATION IN CASE OF IMPOSITION OF TAX.—Section 1903(b) (42 U.S.C. 1396b(b)), as amended by section 4707(b), is amended by adding at the end the following:

''(5) Notwithstanding the preceding provisions of this section, the amount determined under subsection (a)(1) for any State shall be decreased in a quarter by the amount of any health care related taxes (described in section 1902(w)(3)(A)) that are imposed on a hospital described in subsection (w)(3)(F) in that quarter.''.

(c) WAIVER OF CERTAIN PROVIDER TAX PROVISIONS.—Notwithstanding any other provision of law, taxes, fees, or assessments, as defined in section 1903(w)(3)(A) of the Social Security Act (42 U.S.C. 1396b(w)(3)(A)), that were collected by the State of New York from a health care provider before June 1, 1997, and for which a waiver of the provisions of subparagraph (B) or (C) of section 1903(w)(3) of such Act has been applied for, or that would, but for this subsection require that such a waiver be applied for, in accordance with subparagraph (E) of such section, and (if so applied for) upon which action by the Secretary of Health and Human Services (including any judicial review of any such proceeding) has not been completed as of July 23, 1997, are deemed to be permissible health care related taxes and in compliance with the requirements of subparagraphs (B) and (C) of section 1903(w)(3) of such Act.

(d) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to taxes imposed before, on, or after the date of the enactment of this Act and the amendment made by subsection (b) shall apply to taxes imposed on or after such date.

**SEC. 4723. ADDITIONAL FUNDING FOR STATE EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS.**

(a) TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.—There are available for allotments under this section for each of the 4 consecutive fiscal years (beginning with fiscal year 1998) $25,000,000 for payments to certain States under this section.

(b) STATE ALLOTMENT AMOUNT.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall compute an allotment for each fiscal year beginning with fiscal year 1998 and ending with fiscal year 2001 for each of the 12 States with the highest number of undocumented aliens. The amount of such allotment for each such State for a fiscal year shall bear the same ratio to the total amount available for allotments under subsection (a) for the fiscal year as the ratio of the number of undocumented aliens in the State in the fiscal year bears to the total of such numbers for all such States for such fiscal year. The amount of allotment to a State provided under this paragraph for a fiscal year that is not paid out under subsection (c) shall be available for payment during the subsequent fiscal year.

(2) DETERMINATION.—For purposes of paragraph (1), the number of undocumented aliens in a State under this section shall be determined based on estimates of the resident illegal alien population residing in each State prepared by the Statistics Division of the Immigration and Naturalization Service as of October 1992 (or as of such later date if such date is at least 1 year before the beginning of the fiscal year involved).

(c) USE OF FUNDS.—From the allotments made under subsection (b), the Secretary shall pay to each State amounts the State demonstrates were paid by the State (or by a political subdivision of the State) for emergency health services furnished to undocumented aliens.

(d) STATE DEFINED.—For purposes of this section, the term ''State'' includes the District of Columbia.

(e) STATE ENTITLEMENT.—This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided under this section.

**SEC. 4724. ELIMINATION OF WASTE, FRAUD, AND ABUSE.**

(a) BAN ON SPENDING FOR NONHEALTH RELATED ITEMS.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended—

(1) in paragraphs (2) and (16), by striking the period at the end and inserting ''; or'';

(2) in paragraphs (10)(B), (11), and (13), by adding ''or'' at the end; and

(3) by inserting after paragraph (16), the following:

''(17) with respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under a State plan under this title.''.

(b) SURETY BOND REQUIREMENT FOR HOME HEALTH AGENCIES.—

(1) IN GENERAL.—Section 1903(i) (42 U.S.C. 1396b(i)), as amended by subsection (a), is amended—

(1) in paragraph (17), by striking the period at the end and inserting ''; or''; and

(2) by inserting after paragraph (17), the following:

''(18) with respect to any amount expended for home health care services provided by an agency or organization unless the agency or organization provides the State agency on a continuing basis a surety bond in a form specified by the Secretary under paragraph (7) of section 1861(o) and in an amount that is not less than $50,000 or such comparable surety bond as the Secretary may permit under the last sentence of such section.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to home health care services furnished on or after January 1, 1998.

(c) CONFLICT OF INTEREST SAFEGUARDS.—

(1) IN GENERAL.—Section 1902(a)(4)(C) (42 U.S.C. 1396a(a)(4)(C)) is amended—

(A) by striking ''and (C)'' and inserting ''(C)'';

(B) by striking ''local officer or employee'' and inserting ''local officer, employee, or independent contractor'';

(C) by striking ''such an officer or employee'' the first 2 places it appears and inserting ''such an officer, employee, or contractor''; and

(D) by inserting before the semicolon the following: '', and (D) that each State or local officer, employee, or independent contractor who is responsible for selecting, awarding, or otherwise obtaining items and services under the State plan shall be subject to safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423) to persons described in subsection (a)(2) of such section of that Act''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on January 1, 1998.

(d) AUTHORITY TO REFUSE TO ENTER INTO MEDICAID AGREEMENTS WITH INDIVIDUALS OR ENTITIES CONVICTED OF FELONIES.—Section 1902(a)(23) (42 U.S.C. 1396(a)) is amended—

(1) by striking ''except as provided in subsection (g) and in section 1915 and except in the case of Puerto Rico, the Virgin Islands, and Guam,''; and

(2) by inserting before the semicolon at the end the following: '', except as provided in subsection (g) and in section 1915, except that this paragraph shall not apply in the case of Puerto Rico, the Virgin Islands, and Guam, and except that nothing in this paragraph shall be construed as requiring a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under Federal or State law for an offense which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan''.

(e) MONITORING PAYMENTS FOR DUAL ELIGIBLES.—The Administrator of the Health Care Financing Administration shall develop mechanisms to improve the monitoring of, and to prevent, inappropriate payments under the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) in the case of individuals who are dually eligible for benefits under such program and under the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.).

(f) BENEFICIARY AND PROGRAM PROTECTION AGAINST WASTE, FRAUD, AND ABUSE.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(1) by striking ''and'' at the end of paragraph (62);

(2) by striking the period at the end of paragraph (63) and inserting ''; and''; and

(3) by inserting after paragraph (63) the following:

''(64) provide, not later than 1 year after the date of the enactment of this paragraph, a mechanism to receive reports from beneficiaries and others and compile data concerning alleged instances of waste, fraud, and abuse relating to the operation of this title;''.

(g) DISCLOSURE OF INFORMATION AND SURETY BOND REQUIREMENT FOR SUPPLIERS OF DURABLE MEDICAL EQUIPMENT.—

(1) REQUIREMENT.—Section 1902(a) (42 U.S.C. 1396a(a)), as amended by subsection (f), is amended—

(A) by striking ''and'' at the end of paragraph (63);

(B) by striking the period at the end of paragraph (64) and inserting ''; and''; and

(C) by inserting after paragraph (64) the following:

''(65) provide that the State shall issue provider numbers for all suppliers of medical assistance consisting of durable medical equipment, as defined in section 1861(n), and the State shall not issue or renew such a supplier number for any such supplier unless—

''(A)(i) full and complete information as to the identity of each person with an ownership or control interest (as defined in section 1124(a)(3)) in the supplier or in any subcontractor (as defined by the Secretary in regulations) in which the supplier directly or indirectly has a 5 percent or more ownership interest; and

''(ii) to the extent determined to be feasible under regulations of the Secretary, the name of any disclosing entity (as defined in section 1124(a)(2)) with respect to which a person with such an ownership or control interest in the supplier is a person with such an ownership or control interest in the disclosing entity; and

''(B) a surety bond in a form specified by the Secretary under section 1834(a)(16)(B) and in an amount that is not less than $50,000 or such comparable surety bond as the Secretary may permit under the second sentence of such section.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to suppliers of medical assistance consisting of durable medical equipment furnished on or after January 1, 1998.

**SEC. 4725. INCREASED FMAPS.**

(a) ALASKA.—Notwithstanding the first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), the Federal medical assistance percentage determined under such sentence for Alaska shall be 59.8 percent but only with respect to—

(1) items and services furnished under a State plan under title XIX or under a State child health plan under title XXI of such Act during fiscal years 1998, 1999, and 2000;

(2) payments made on a capitation or other risk-basis under such titles for coverage occurring during such period; and

(3) payments under title XIX of such Act attributable to DSH allotments for such State determined under section 1923(f) of such Act (42 U.S.C. 1396r–4(f)) for such fiscal years.

(b) DISTRICT OF COLUMBIA.—

(1) IN GENERAL.—The first sentence of section 1905(b) (42 U.S.C. 1396d(b)) is amended—

(A) by striking ''and (2)'' and inserting '', (2)'', and

(B) by inserting before the period at the end the following: '', and (3) for purposes of this title and title XXI, the Federal medical assistance percentage for the District of Columbia shall be 70 percent''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to—

(A) items and services furnished on or after October 1, 1997;

(B) payments made on a capitation or other risk-basis for coverage occurring on or after such date; and

(C) payments attributable to DSH allotments for such States determined under section 1923(f) of such Act (42 U.S.C. 1396r–4(f)) for fiscal years beginning with fiscal year 1998.

**SEC. 4726. INCREASE IN PAYMENT LIMITATION FOR TERRITORIES.**

Section 1108 (42 U.S.C. 1308) is amended—

(1) in subsection (f), by striking ''The'' and inserting ''Subject to subsection (g), the''; and

(2) by adding at the end the following:

''(g) MEDICAID PAYMENTS TO TERRITORIES FOR FISCAL YEAR 1998 AND THEREAFTER.—

''(1) FISCAL YEAR 1998.—With respect to fiscal year 1998, the amounts otherwise determined for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa under subsection (f) for such fiscal year shall be increased by the following amounts:

''(A) For Puerto Rico, $30,000,000.

''(B) For the Virgin Islands, $750,000.

''(C) For Guam, $750,000.

''(D) For the Northern Mariana Islands, $500,000.

''(E) For American Samoa, $500,000.

''(2) FISCAL YEAR 1999 AND THEREAFTER.—Notwithstanding subsection (f), with respect to fiscal year 1999 and any fiscal year thereafter, the total amount certified by the Secretary under title XIX for payment to—

''(A) Puerto Rico shall not exceed the sum of the amount provided in this subsection for the preceding fiscal year increased by the percentage increase in the medical care component of the Consumer Price Index for all urban consumers (as published by the Bureau of Labor Statistics) for the 12-month period ending in March preceding the beginning of the fiscal year, rounded to the nearest $100,000;

''(B) the Virgin Islands shall not exceed the sum of the amount provided in this subsection for the preceding fiscal year increased by the percentage increase referred to in subparagraph (A), rounded to the nearest $10,000;

''(C) Guam shall not exceed the sum of the amount provided in this subsection for the preceding fiscal year increased by the percentage increase referred to in subparagraph (A), rounded to the nearest $10,000;

''(D) the Northern Mariana Islands shall not exceed the sum of the amount provided in this subsection for the preceding fiscal year increased by the percentage increase referred to in subparagraph (A), rounded to the nearest $10,000; and

''(E) American Samoa shall not exceed the sum of the amount provided in this subsection for the preceding fiscal year increased by the percentage increase referred to in subparagraph (A), rounded to the nearest $10,000.''.

## CHAPTER 4—ELIGIBILITY

**SEC. 4731. STATE OPTION OF CONTINUOUS ELIGIBILITY FOR 12 MONTHS; CLARIFICATION OF STATE OPTION TO COVER CHILDREN.**

(a) CONTINUOUS ELIGIBILITY OPTION.—Section 1902(e) (42 U.S.C. 1396a(e)) is amended by adding at the end the following new paragraph:

''(12) At the option of the State, the plan may provide that an individual who is under an age specified by the State (not to exceed 19 years of age) and who is determined to be eligible for benefits under a State plan approved under this title under subsection (a)(10)(A) shall remain eligible for those benefits until the earlier of—

''(A) the end of a period (not to exceed 12 months) following the determination; or

''(B) the time that the individual exceeds that age.''.

(b) CLARIFICATION OF STATE OPTION TO COVER ALL CHILDREN UNDER 19 YEARS OF AGE.—Section 1902(l)(1)(D) (42 U.S.C. 1396a(l)(1)(D)) is amended by inserting ''(or, at the option of a State, after any earlier date)'' after ''children born after September 30, 1983''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to medical assistance for items and services furnished on or after October 1, 1997.

**SEC. 4732. PAYMENT OF PART B PREMIUMS.**

(a) ELIGIBILITY.—Section 1902(a)(10)(E) (42 U.S.C. 1396a(a)(10)(E)) is amended—

(1) by striking ''and'' at the end of clause (ii); and

(2) by inserting after clause (iii) the following:

''(iv) subject to sections 1933 and 1905(p)(4), for making medical assistance available (but

only for premiums payable with respect to months during the period beginning with January 1998, and ending with December 2002)—

''(I) for medicare cost-sharing described in section 1905(p)(3)(A)(ii) for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) and is at least 120 percent, but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan, and

''(II) for the portion of medicare cost-sharing described in section 1905(p)(3)(A)(ii) that is attributable to the operation of the amendments made by (and subsection (e)(3) of) section 4611 of the Balanced Budget Act of 1997 for individuals who would be described in subclause (I) if '135 percent' and '175 percent' were substituted for '120 percent' and '135 percent' respectively; and''.

(b) CONFORMING AMENDMENT.—Section 1905(b) (42 U.S.C. 1396d(b)) is amended by striking ''The term'' and inserting ''Subject to section 1933(d), the term''.

(c) TERMS AND CONDITIONS OF COVERAGE.—Title XIX (42 U.S.C. 1395 et seq.), as amended by section 4701(a), is amended by redesignating section 1933 as section 1934 and by inserting after section 1932 the following new section:

''STATE COVERAGE OF MEDICARE COST-SHARING FOR ADDITIONAL LOW-INCOME MEDICARE BENEFICIARIES

''SEC. 1933. (a) IN GENERAL.—A State plan under this title shall provide, under section 1902(a)(10)(E)(iv) and subject to the succeeding provisions of this section and through a plan amendment, for medical assistance for payment of the cost of medicare cost-sharing described in such section on behalf of all individuals described in such section (in this section referred to as 'qualifying individuals') who are selected to receive such assistance under subsection (b).

''(b) SELECTION OF QUALIFYING INDIVIDUALS.—A State shall select qualifying individuals, and provide such individuals with assistance, under this section consistent with the following:

''(1) ALL QUALIFYING INDIVIDUALS MAY APPLY.—The State shall permit all qualifying individuals to apply for assistance during a calendar year.

''(2) SELECTION ON FIRST-COME, FIRST-SERVED BASIS.—

''(A) IN GENERAL.—For each calendar year (beginning with 1998), from (and to the extent of) the amount of the allocation under subsection (c) for the State for the fiscal year ending in such calendar year, the State shall select qualifying individuals who apply for the assistance in the order in which they apply.

''(B) CARRYOVER.—For calendar years after 1998, the State shall give preference to individuals who were provided such assistance (or other assistance described in section 1902(a)(10)(E)) in the last month of the previous year and who continue to be (or become) qualifying individuals.

''(3) LIMIT ON NUMBER OF INDIVIDUALS BASED ON ALLOCATION.—The State shall limit the number of qualifying individuals selected with respect to assistance in a calendar year so that the aggregate amount of such assistance provided to such individuals in such year is estimated to be equal to (but not exceed) the State's allocation under subsection (c) for the fiscal year ending in such calendar year.

''(4) RECEIPT OF ASSISTANCE DURING DURATION OF YEAR.—If a qualifying individual is selected to receive assistance under this section for a month in year, the individual is entitled to receive such assistance for the remainder of the year if the individual continues to be a qualifying individual. The fact that an individual is selected to receive assistance under this section at any time during a year does not entitle the individual to continued assistance for any succeeding year.

''(c) ALLOCATION.—

''(1) TOTAL ALLOCATION.—The total amount available for allocation under this section for—

''(A) fiscal year 1998 is $200,000,000;

''(B) fiscal year 1999 is $250,000,000;

''(C) fiscal year 2000 is $300,000,000;

''(D) fiscal year 2001 is $350,000,000; and

''(E) fiscal year 2002 is $400,000,000.

''(2) ALLOCATION TO STATES.—The Secretary shall provide for the allocation of the total amount described in paragraph (1) for a fiscal year, among the States that executed a plan amendment in accordance with subsection (a), based upon the Secretary's estimate of the ratio of—

''(A) an amount equal to the sum of—

''(i) twice the total number of individuals described in section 1902(a)(10)(E)(iv)(I) in the State, and

''(ii) the total number of individuals described in section 1902(a)(10)(E)(iv)(II) in the State; to

''(B) the sum of the amounts computed under subparagraph (A) for all eligible States.

''(d) APPLICABLE FMAP.—With respect to assistance described in section 1902(a)(10)(E)(iv) furnished in a State for calendar quarters in a calendar year —

''(1) to the extent that such assistance does not exceed the State's allocation under subsection (c) for the fiscal year ending in the calendar year, the Federal medical assistance percentage shall be equal to 100 percent; and

''(2) to the extent that such assistance exceeds such allocation, the Federal medical assistance percentage is 0 percent.

''(e) LIMITATION ON ENTITLEMENT.—Except as specifically provided under this section, nothing in this title shall be construed as establishing any entitlement of individuals described in section 1902(a)(10)(E)(iv) to assistance described in such section.

''(f) COVERAGE OF COSTS THROUGH PART B OF THE MEDICARE PROGRAM.—For each fiscal year, the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1841 to the appropriate account in the Treasury that provides for payments under section 1903(a) with respect to medical assistance provided under this section, of an amount equivalent to the total of the amount of payments made under such section that is attributable to this section and such transfer shall be treated as an expenditure from such Trust Fund for purposes of section 1839.''.

**SEC. 4733. STATE OPTION TO PERMIT WORKERS WITH DISABILITIES TO BUY INTO MEDICAID.**

Section 1902(a)(10)(A)(ii) (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(1) in subclause (XI), by striking ''or'' at the end;

(2) in subclause (XII), by adding ''or'' at the end; and

(3) by adding at the end the following:

''(XIII) who are in families whose income is less than 250 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved, and who but for earnings in excess of the limit established under section 1905(q)(2)(B), would be considered to be receiving supplemental security income (subject, notwithstanding section 1916, to payment of premiums or other cost-sharing charges (set on a sliding scale based on income) that the State may determine);''.

**SEC. 4734. PENALTY FOR FRAUDULENT ELIGIBILITY.**

Section 1128B(a) (42 U.S.C. 1320a–7b(a)), as amended by section 217 of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2008), is amended—

(1) by striking paragraph (6) and inserting the following:

''(6) for a fee knowingly and willfully counsels or assists an individual to dispose of assets (including by any transfer in trust) in order for the individual to become eligible for medical assistance under a State plan under title XIX, if disposing of the assets results in the imposition of a period of ineligibility for such assistance under section 1917(c),''; and

(2) in clause (ii) of the matter following such paragraph, by striking ''failure, or conversion by any other person'' and inserting ''failure, conversion, or provision of counsel or assistance by any other person''.

**SEC. 4735. TREATMENT OF CERTAIN SETTLEMENT PAYMENTS.**

(a) IN GENERAL.—Notwithstanding any other provision of law, the payments described in subsection (b) shall not be considered income or resources in determining eligibility for, or the amount of benefits under, a State plan of medical assistance approved under title XIX of the Social Security Act.

(b) PAYMENTS DESCRIBED.—The payments described in this subsection are—

(1) payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corporation, et al., 96–C–5024 (N.D. Ill.); and

(2) payments made pursuant to a release of all claims in a case—

(A) that is entered into in lieu of the class settlement referred to in paragraph (1); and

(B) that is signed by all affected parties in such case on or before the later of—

(i) December 31, 1997, or

(ii) the date that is 270 days after the date on which such release is first sent to the persons (or the legal representative of such persons) to whom the payment is to be made.

## CHAPTER 5—BENEFITS

**SEC. 4741. ELIMINATION OF REQUIREMENT TO PAY FOR PRIVATE INSURANCE.**

(a) REPEAL OF STATE PLAN PROVISION.—Section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) is amended—

(1) by striking subparagraph (G); and

(2) by redesignating subparagraphs (H) and (I) as subparagraphs (G) and (H), respectively.

(b) MAKING PROVISION OPTIONAL.—Section 1906 (42 U.S.C. 1396e) is amended—

(1) in subsection (a)—

(A) by striking ''For purposes of section 1902(a)(25)(G) and subject to subsection (d), each'' and inserting ''Each'';

(B) in paragraph (1), by striking ''shall'' and inserting ''may''; and

(C) in paragraph (2), by striking ''shall'' and inserting ''may''; and

(2) by striking subsection (d).

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

**SEC. 4742. PHYSICIAN QUALIFICATION REQUIREMENTS.**

(a) IN GENERAL.—Section 1903(i) (42 U.S.C. 1396b(i)) is amended by striking paragraph (12).

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after the date of the enactment of this Act.

**SEC. 4743. ELIMINATION OF REQUIREMENT OF PRIOR INSTITUTIONALIZATION WITH RESPECT TO HABILITATION SERVICES FURNISHED UNDER A WAIVER FOR HOME OR COMMUNITY-BASED SERVICES.**

(a) IN GENERAL.—Section 1915(c)(5) (42 U.S.C. 1396n(c)(5)) is amended, in the matter preceding subparagraph (A), by striking '', with respect to individuals who receive such services after discharge from a nursing facility or intermediate care facility for the mentally retarded''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) apply to services furnished on or after October 1, 1997.

**SEC. 4744. STUDY AND REPORT ON EPSDT BENEFIT.**

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with Governors, directors of State medicaid programs, the American Academy of Actuaries, and representatives of appropriate provider and beneficiary organizations, shall conduct a study of the provision of early and periodic screening, diagnostic, and treatment services under the medicaid program under title XIX of the Social Security Act in accordance with the requirements of section 1905(r) of such Act (42 U.S.C. 1396d(r)).

(2) REQUIRED CONTENTS.—The study conducted under paragraph (1) shall include examination of the actuarial value of the provision of such services under the medicaid program and an examination of the portions of such actuarial value that are attributable to paragraph (5) of section 1905(r) of such Act and to the second sentence of such section.

(b) REPORT.—Not later than 12 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit a report to Congress on the results of the study conducted under subsection (a).

## CHAPTER 6—ADMINISTRATION AND MISCELLANEOUS

**SEC. 4751. ELIMINATION OF DUPLICATIVE INSPECTION OF CARE REQUIREMENTS FOR ICFS/MR AND MENTAL HOSPITALS.**

(a) MENTAL HOSPITALS.—Section 1902(a)(26) (42 U.S.C. 1396a(a)(26)) is amended—

(1) by striking ''provide—

''(A) with respect to each patient'' and inserting ''provide, with respect to each patient''; and

(2) by striking subparagraphs (B) and (C).

(b) ICFS/MR.—Section 1902(a)(31) (42 U.S.C. 1396a(a)(31)) is amended—

(1) by striking ''provide—

''(A) with respect to each patient'' and inserting ''provide, with respect to each patient''; and

(2) by striking subparagraphs (B) and (C).

(c) EFFECTIVE DATE.—The amendments made by this section take effect on the date of the enactment of this Act.

**SEC. 4752. ALTERNATIVE SANCTIONS FOR NONCOMPLIANT ICFS/MR.**

(a) IN GENERAL.—Section 1902(i)(1)(B) (42 U.S.C. 1396a(i)(1)(B)) is amended by striking ''provide'' and inserting ''establish alternative remedies if the State demonstrates to the Secretary's satisfaction that the alternative remedies are effective in deterring noncompliance and correcting deficiencies, and may provide''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) takes effect on the date of the enactment of this Act.

**SEC. 4753. MODIFICATION OF MMIS REQUIREMENTS.**

(a) IN GENERAL.—Section 1903(r) (42 U.S.C. 1396b(r)) is amended—

(1) by striking all that precedes paragraph (5) and inserting the following:

''(r)(1) In order to receive payments under subsection (a) for use of automated data systems in administration of the State plan under this title, a State must have in operation mechanized claims processing and information retrieval systems that meet the requirements of this subsection and that the Secretary has found—

''(A) are adequate to provide efficient, economical, and effective administration of such State plan;

''(B) are compatible with the claims processing and information retrieval systems used in the administration of title XVIII, and for this purpose—

''(i) have a uniform identification coding system for providers, other payees, and beneficiaries under this title or title XVIII;

''(ii) provide liaison between States and carriers and intermediaries with agreements under title XVIII to facilitate timely exchange of appropriate data; and

''(iii) provide for exchange of data between the States and the Secretary with respect to persons sanctioned under this title or title XVIII;

''(C) are capable of providing accurate and timely data;

''(D) are complying with the applicable provisions of part C of title XI;

''(E) are designed to receive provider claims in standard formats to the extent specified by the Secretary; and

''(F) effective for claims filed on or after January 1, 1999, provide for electronic transmission of claims data in the format specified by the Secretary and consistent with the Medicaid Statistical Information System (MSIS) (including detailed individual enrollee encounter data and other information that the Secretary may find necessary).'';

(2) in paragraph (5)—

(A) by striking subparagraph (B);

(B) by striking all that precedes clause (i) and inserting the following:

''(2) In order to meet the requirements of this paragraph, mechanized claims processing and information retrieval systems must meet the following requirements:'';

(C) in clause (iii), by striking ''under paragraph (6)''; and

(D) by redesignating clauses (i) through (iii) as paragraphs (A) through (C); and

(3) by striking paragraphs (6), (7), and (8).

(b) CONFORMING AMENDMENTS.—Section 1902(a)(25)(A)(ii) (42 U.S.C. 1396a(a)(25)(A)(ii)) is amended by striking all that follows ''shall'' and inserting the following: ''be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval systems required under section 1903(r);''.

(c) EFFECTIVE DATE.—Except as otherwise specifically provided, the amendments made by this section shall take effect on January 1, 1998.

**SEC. 4754. FACILITATING IMPOSITION OF STATE ALTERNATIVE REMEDIES ON NONCOMPLIANT NURSING FACILITIES.**

(a) IN GENERAL.—Section 1919(h)(3)(D) (42 U.S.C. 1396r(h)(3)(D)) is amended—

(1) by inserting ''and'' at the end of clause (i);

(2) by striking '', and'' at the end of clause (ii) and inserting a period; and

(3) by striking clause (iii).

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on the date of the enactment of this Act.

**SEC. 4755. REMOVAL OF NAME FROM NURSE AIDE REGISTRY.**

(a) MEDICARE.—Section 1819(g)(1) (42 U.S.C. 1395i–3(g)(1)) is amended—

(1) by redesignating subparagraph (D) as subparagraph (E), and

(2) by inserting after subparagraph (C) the following:

''(D) REMOVAL OF NAME FROM NURSE AIDE REGISTRY.—

''(i) IN GENERAL.—In the case of a finding of neglect under subparagraph (C), the State shall establish a procedure to permit a nurse aide to petition the State to have his or her name removed from the registry upon a determination by the State that—

''(I) the employment and personal history of the nurse aide does not reflect a pattern of abusive behavior or neglect; and

''(II) the neglect involved in the original finding was a singular occurrence.

''(ii) TIMING OF DETERMINATION.—In no case shall a determination on a petition submitted under clause (i) be made prior to the expiration of the 1-year period beginning on the date on which the name of the petitioner was added to the registry under subparagraph (C).''.

(b) MEDICAID.—Section 1919(g)(1) (42 U.S.C. 1396r(g)(1)) is amended—

(1) by redesignating subparagraph (D) as subparagraph (E), and

(2) by inserting after subparagraph (C) the following:

''(D) REMOVAL OF NAME FROM NURSE AIDE REGISTRY.—

''(i) IN GENERAL.—In the case of a finding of neglect under subparagraph (C), the State shall establish a procedure to permit a nurse aide to petition the State to have his or her name removed from the registry upon a determination by the State that—

''(I) the employment and personal history of the nurse aide does not reflect a pattern of abusive behavior or neglect; and

''(II) the neglect involved in the original finding was a singular occurrence.

''(ii) TIMING OF DETERMINATION.—In no case shall a determination on a petition submitted under clause (i) be made prior to the expiration of the 1-year period beginning on the date on which the name of the petitioner was added to the registry under subparagraph (C).''.

(c) RETROACTIVE REVIEW.—The procedures developed by a State under the amendments made by subsection (a) and (b) shall permit an individual to petition for a review of any finding made by a State under section 1819(g)(1)(C) or 1919(g)(1)(C) of the Social Security Act (42 U.S.C. 1395i–3(g)(1)(C) or 1396r(g)(1)(C)) after January 1, 1995.

**SEC. 4756. MEDICALLY ACCEPTED INDICATION.**

Section 1927(g)(1)(B)(i) (42 U.S.C. 1396r–8(g)(1)(B)(i)) is amended—

(1) by striking ''and'' at the end of subclause (II),

(2) by redesignating subclause (III) as subclause (IV), and

(3) by inserting after subclause (II) the following:

''(III) the DRUGDEX Information System; and''.

**SEC. 4757. CONTINUATION OF STATE-WIDE SECTION 1115 MEDICAID WAIVERS.**

(a) IN GENERAL.—Section 1115 (42 U.S.C. 1315) is amended by adding at the end the following new subsection:

''(e)(1) The provisions of this subsection shall apply to the extension of any State-wide comprehensive demonstration project (in this subsection referred to as 'waiver project') for which a waiver of compliance with requirements of title XIX is granted under subsection (a).

''(2) During the 6-month period ending 1 year before the date the waiver under subsection (a) with respect to a waiver project would otherwise expire, the chief executive officer of the State which is operating the project may submit to the Secretary a written request for an extension, of up to 3 years, of the project.

''(3) If the Secretary fails to respond to the request within 6 months after the date it is submitted, the request is deemed to have been granted.

''(4) If such a request is granted, the deadline for submittal of a final report under the

waiver project is deemed to have been extended until the date that is 1 year after the date the waiver project would otherwise have expired.

''(5) The Secretary shall release an evaluation of each such project not later than 1 year after the date of receipt of the final report.

''(6) Subject to paragraphs (4) and (7), the extension of a waiver project under this subsection shall be on the same terms and conditions (including applicable terms and conditions relating to quality and access of services, budget neutrality, data and reporting requirements, and special population protections) that applied to the project before its extension under this subsection.

''(7) If an original condition of approval of a waiver project was that Federal expenditures under the project not exceed the Federal expenditures that would otherwise have been made, the Secretary shall take such steps as may be necessary to ensure that, in the extension of the project under this subsection, such condition continues to be met. In applying the previous sentence, the Secretary shall take into account the Secretary's best estimate of rates of change in expenditures at the time of the extension.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to demonstration projects initially approved before, on, or after the date of the enactment of this Act.

**SEC. 4758. EXTENSION OF MORATORIUM.**

Section 6408(a)(3) of the Omnibus Budget Reconciliation Act of 1989, as amended by section 13642 of the Omnibus Budget Reconciliation Act of 1993, is amended by striking ''December 31, 1995'' and inserting ''December 31, 2002''.

**SEC. 4759. EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.**

In the case of a State plan under title XIX of the Social Security Act which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by a provision of this subtitle, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

**Subtitle I—Programs of All-Inclusive Care for the Elderly (PACE)**

**SEC. 4801. COVERAGE OF PACE UNDER THE MEDICARE PROGRAM.**

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new section:

''PAYMENTS TO, AND COVERAGE OF BENEFITS UNDER, PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

''SEC. 1894. (a) RECEIPT OF BENEFITS THROUGH ENROLLMENT IN PACE PROGRAM; DEFINITIONS FOR PACE PROGRAM RELATED TERMS.—

''(1) BENEFITS THROUGH ENROLLMENT IN A PACE PROGRAM.—In accordance with this section, in the case of an individual who is entitled to benefits under part A or enrolled under part B and who is a PACE program eligible individual (as defined in paragraph (5)) with respect to a PACE program offered by a PACE provider under a PACE program agreement—

''(A) the individual may enroll in the program under this section; and

''(B) so long as the individual is so enrolled and in accordance with regulations—

''(i) the individual shall receive benefits under this title solely through such program; and

''(ii) the PACE provider is entitled to payment under and in accordance with this section and such agreement for provision of such benefits.

''(2) PACE PROGRAM DEFINED.—For purposes of this section, the term 'PACE program' means a program of all-inclusive care for the elderly that meets the following requirements:

''(A) OPERATION.—The entity operating the program is a PACE provider (as defined in paragraph (3)).

''(B) COMPREHENSIVE BENEFITS.—The program provides comprehensive health care services to PACE program eligible individuals in accordance with the PACE program agreement and regulations under this section.

''(C) TRANSITION.—In the case of an individual who is enrolled under the program under this section and whose enrollment ceases for any reason (including that the individual no longer qualifies as a PACE program eligible individual, the termination of a PACE program agreement, or otherwise), the program provides assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual's medical records available to new providers.

''(3) PACE PROVIDER DEFINED.—

''(A) IN GENERAL.—For purposes of this section, the term 'PACE provider' means an entity that—

''(i) subject to subparagraph (B), is (or is a distinct part of) a public entity or a private, nonprofit entity organized for charitable purposes under section 501(c)(3) of the Internal Revenue Code of 1986; and

''(ii) has entered into a PACE program agreement with respect to its operation of a PACE program.

''(B) TREATMENT OF PRIVATE, FOR-PROFIT PROVIDERS.—Clause (i) of subparagraph (A) shall not apply—

''(i) to entities subject to a demonstration project waiver under subsection (h); and

''(ii) after the date the report under section 4804(b) of the Balanced Budget Act of 1997 is submitted, unless the Secretary determines that any of the findings described in subparagraph (A), (B), (C), or (D) of paragraph (2) of such section are true.

''(4) PACE PROGRAM AGREEMENT DEFINED.—For purposes of this section, the term 'PACE program agreement' means, with respect to a PACE provider, an agreement, consistent with this section, section 1934 (if applicable), and regulations promulgated to carry out such sections, between the PACE provider and the Secretary, or an agreement between the PACE provider and a State administering agency for the operation of a PACE program by the provider under such sections.

''(5) PACE PROGRAM ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, the term 'PACE program eligible individual' means, with respect to a PACE program, an individual who—

''(A) is 55 years of age or older;

''(B) subject to subsection (c)(4), is determined under subsection (c) to require the level of care required under the State medicaid plan for coverage of nursing facility services;

''(C) resides in the service area of the PACE program; and

''(D) meets such other eligibility conditions as may be imposed under the PACE program agreement for the program under subsection (e)(2)(A)(ii).

''(6) PACE PROTOCOL.—For purposes of this section, the term 'PACE protocol' means the Protocol for the Program of All-inclusive Care for the Elderly (PACE), as published by On Lok, Inc., as of April 14, 1995, or any successor protocol that may be agreed upon between the Secretary and On Lok, Inc.

''(7) PACE DEMONSTRATION WAIVER PROGRAM DEFINED.—For purposes of this section, the term 'PACE demonstration waiver program' means a demonstration program under either of the following sections (as in effect before the date of their repeal):

''(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21), as extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

''(B) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

''(8) STATE ADMINISTERING AGENCY DEFINED.—For purposes of this section, the term 'State administering agency' means, with respect to the operation of a PACE program in a State, the agency of that State (which may be the single agency responsible for administration of the State plan under title XIX in the State) responsible for administering PACE program agreements under this section and section 1934 in the State.

''(9) TRIAL PERIOD DEFINED.—

''(A) IN GENERAL.—For purposes of this section, the term 'trial period' means, with respect to a PACE program operated by a PACE provider under a PACE program agreement, the first 3 contract years under such agreement with respect to such program.

''(B) TREATMENT OF ENTITIES PREVIOUSLY OPERATING PACE DEMONSTRATION WAIVER PROGRAMS.—Each contract year (including a year occurring before the effective date of this section) during which an entity has operated a PACE demonstration waiver program shall be counted under subparagraph (A) as a contract year during which the entity operated a PACE program as a PACE provider under a PACE program agreement.

''(10) REGULATIONS.—For purposes of this section, the term 'regulations' refers to interim final or final regulations promulgated under subsection (f) to carry out this section and section 1934.

''(b) SCOPE OF BENEFITS; BENEFICIARY SAFEGUARDS.—

''(1) IN GENERAL.—Under a PACE program agreement, a PACE provider shall—

''(A) provide to PACE program eligible individuals enrolled with the provider, regardless of source of payment and directly or under contracts with other entities, at a minimum—

''(i) all items and services covered under this title (for individuals enrolled under this section) and all items and services covered under title XIX, but without any limitation or condition as to amount, duration, or scope and without application of deductibles, copayments, coinsurance, or other cost-sharing that would otherwise apply under this title or such title, respectively; and

''(ii) all additional items and services specified in regulations, based upon those required under the PACE protocol;

''(B) provide such enrollees access to necessary covered items and services 24 hours per day, every day of the year;

''(C) provide services to such enrollees through a comprehensive, multidisciplinary health and social services delivery system which integrates acute and long-term care services pursuant to regulations; and

''(D) specify the covered items and services that will not be provided directly by the entity, and to arrange for delivery of those items and services through contracts meeting the requirements of regulations.

''(2) QUALITY ASSURANCE; PATIENT SAFEGUARDS.—The PACE program agreement shall require the PACE provider to have in effect at a minimum—

''(A) a written plan of quality assurance and improvement, and procedures implementing such plan, in accordance with regulations; and

''(B) written safeguards of the rights of enrolled participants (including a patient bill of rights and procedures for grievances and appeals) in accordance with regulations and with other requirements of this title and Federal and State law that are designed for the protection of patients.

''(c) ELIGIBILITY DETERMINATIONS.—

''(1) IN GENERAL.—The determination of whether an individual is a PACE program eligible individual—

''(A) shall be made under and in accordance with the PACE program agreement; and

''(B) who is entitled to medical assistance under title XIX, shall be made (or who is not so entitled, may be made) by the State administering agency.

''(2) CONDITION.—An individual is not a PACE program eligible individual (with respect to payment under this section) unless the individual's health status has been determined by the Secretary or the State administering agency, in accordance with regulations, to be comparable to the health status of individuals who have participated in the PACE demonstration waiver programs. Such determination shall be based upon information on health status and related indicators (such as medical diagnoses and measures of activities of daily living, instrumental activities of daily living, and cognitive impairment) that are part of a uniform minimum data set collected by PACE providers on potential PACE program eligible individuals.

''(3) ANNUAL ELIGIBILITY RECERTIFICATIONS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the determination described in subsection (a)(5)(B) for an individual shall be reevaluated at least annually.

''(B) EXCEPTION.—The requirement of annual reevaluation under subparagraph (A) may be waived during a period in accordance with regulations in those cases where the State administering agency determines that there is no reasonable expectation of improvement or significant change in an individual's condition during the period because of the severity of chronic condition, or degree of impairment of functional capacity of the individual involved.

''(4) CONTINUATION OF ELIGIBILITY.—An individual who is a PACE program eligible individual may be deemed to continue to be such an individual notwithstanding a determination that the individual no longer meets the requirement of subsection (a)(5)(B) if, in accordance with regulations, in the absence of continued coverage under a PACE program the individual reasonably would be expected to meet such requirement within the succeeding 6-month period.

''(5) ENROLLMENT; DISENROLLMENT.—

''(A) VOLUNTARY DISENROLLMENT AT ANY TIME.—The enrollment and disenrollment of PACE program eligible individuals in a PACE program shall be pursuant to regulations and the PACE program agreement and shall permit enrollees to voluntarily disenroll without cause at any time.

''(B) LIMITATIONS ON DISENROLLMENT.—

''(i) IN GENERAL.—Regulations promulgated by the Secretary under this section and section 1934, and the PACE program agreement, shall provide that the PACE program may not disenroll a PACE program eligible individual except—

''(I) for nonpayment of premiums (if applicable) on a timely basis; or

''(II) for engaging in disruptive or threatening behavior, as defined in such regulations (developed in close consultation with State administering agencies).

''(ii) NO DISENROLLMENT FOR NONCOMPLIANT BEHAVIOR.—Except as allowed under regulations promulgated to carry out clause (i)(II), a PACE program may not disenroll a PACE program eligible individual on the ground that the individual has engaged in noncompliant behavior if such behavior is related to a mental or physical condition of the individual. For purposes of the preceding sentence, the term 'noncompliant behavior' includes repeated noncompliance with medical advice and repeated failure to appear for appointments.

''(iii) TIMELY REVIEW OF PROPOSED NONVOLUNTARY DISENROLLMENT.—A proposed disenrollment, other than a voluntary disenrollment, shall be subject to timely review and final determination by the Secretary or by the State administering agency (as applicable), prior to the proposed disenrollment becoming effective.

''(d) PAYMENTS TO PACE PROVIDERS ON A CAPITATED BASIS.—

''(1) IN GENERAL.—In the case of a PACE provider with a PACE program agreement under this section, except as provided in this subsection or by regulations, the Secretary shall make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under the agreement under this section in the same manner and from the same sources as payments are made to a Medicare+Choice organization under section 1853 (or, for periods beginning before January 1, 1999, to an eligible organization under a risk-sharing contract under section 1876). Such payments shall be subject to adjustment in the manner described in section 1853(a)(2) or section 1876(a)(1)(E), as the case may be.

''(2) CAPITATION AMOUNT.—The capitation amount to be applied under this subsection for a provider for a contract year shall be an amount specified in the PACE program agreement for the year. Such amount shall be based upon payment rates established for purposes of payment under section 1853 (or, for periods before January 1, 1999, for purposes of risk-sharing contracts under section 1876) and shall be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. Such amount under such an agreement shall be computed in a manner so that the total payment level for all PACE program eligible individuals enrolled under a program is less than the projected payment under this title for a comparable population not enrolled under a PACE program.

''(e) PACE PROGRAM AGREEMENT.—

''(1) REQUIREMENT.—

''(A) IN GENERAL.—The Secretary, in close cooperation with the State administering agency, shall establish procedures for entering into, extending, and terminating PACE program agreements for the operation of PACE programs by entities that meet the requirements for a PACE provider under this section, section 1934, and regulations.

''(B) NUMERICAL LIMITATION.—

''(i) IN GENERAL.—The Secretary shall not permit the number of PACE providers with which agreements are in effect under this section or under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 to exceed—

''(I) 40 as of the date of the enactment of this section; or

''(II) as of each succeeding anniversary of such date, the numerical limitation under this subparagraph for the preceding year plus 20.

Subclause (II) shall apply without regard to the actual number of agreements in effect as of a previous anniversary date.

''(ii) TREATMENT OF CERTAIN PRIVATE, FOR-PROFIT PROVIDERS.—The numerical limitation in clause (i) shall not apply to a PACE provider that—

''(I) is operating under a demonstration project waiver under subsection (h); or

''(II) was operating under such a waiver and subsequently qualifies for PACE provider status pursuant to subsection (a)(3)(B)(ii).

''(2) SERVICE AREA AND ELIGIBILITY.—

''(A) IN GENERAL.—A PACE program agreement for a PACE program—

''(i) shall designate the service area of the program;

''(ii) may provide additional requirements for individuals to qualify as PACE program eligible individuals with respect to the program;

''(iii) shall be effective for a contract year, but may be extended for additional contract years in the absence of a notice by a party to terminate and is subject to termination by the Secretary and the State administering agency at any time for cause (as provided under the agreement);

''(iv) shall require a PACE provider to meet all applicable State and local laws and requirements; and

''(v) shall contain such additional terms and conditions as the parties may agree to, so long as such terms and conditions are consistent with this section and regulations.

''(B) SERVICE AREA OVERLAP.—In designating a service area under a PACE program agreement under subparagraph (A)(i), the Secretary (in consultation with the State administering agency) may exclude from designation an area that is already covered under another PACE program agreement, in order to avoid unnecessary duplication of services and avoid impairing the financial and service viability of an existing program.

''(3) DATA COLLECTION; DEVELOPMENT OF OUTCOME MEASURES.—

''(A) DATA COLLECTION.—

''(i) IN GENERAL.—Under a PACE program agreement, the PACE provider shall—

''(I) collect data;

''(II) maintain, and afford the Secretary and the State administering agency access to, the records relating to the program, including pertinent financial, medical, and personnel records; and

''(III) make available to the Secretary and the State administering agency reports that the Secretary finds (in consultation with State administering agencies) necessary to monitor the operation, cost, and effectiveness of the PACE program under this section and section 1934 .

''(ii) REQUIREMENTS DURING TRIAL PERIOD.—During the first 3 years of operation of a PACE program (either under this section or under a PACE demonstration waiver program), the PACE provider shall provide such additional data as the Secretary specifies in regulations in order to perform the oversight required under paragraph (4)(A).

''(B) DEVELOPMENT OF OUTCOME MEASURES.—Under a PACE program agreement, the PACE provider, the Secretary, and the State administering agency shall jointly cooperate in the development and implementation of health status and quality of life outcome measures with respect to PACE program eligible individuals.

''(4) OVERSIGHT.—

''(A) ANNUAL, CLOSE OVERSIGHT DURING TRIAL PERIOD.—During the trial period (as defined in subsection (a)(9)) with respect to a PACE program operated by a PACE provider, the Secretary (in cooperation with the State administering agency) shall conduct a comprehensive annual review of the operation of the PACE program by the provider in order to assure compliance with the requirements of this section and regulations. Such a review shall include—

''(i) an on-site visit to the program site;

''(ii) comprehensive assessment of a provider's fiscal soundness;

''(iii) comprehensive assessment of the provider's capacity to provide all PACE services to all enrolled participants;

''(iv) detailed analysis of the entity's substantial compliance with all significant requirements of this section and regulations; and

''(v) any other elements the Secretary or State administering agency considers necessary or appropriate.

''(B) CONTINUING OVERSIGHT.—After the trial period, the Secretary (in cooperation with the State administering agency) shall continue to conduct such review of the operation of PACE providers and PACE programs as may be appropriate, taking into account the performance level of a provider and compliance of a provider with all significant requirements of this section and regulations.

''(C) DISCLOSURE.—The results of reviews under this paragraph shall be reported promptly to the PACE provider, along with any recommendations for changes to the provider's program, and shall be made available to the public upon request.

''(5) TERMINATION OF PACE PROVIDER AGREEMENTS.—

''(A) IN GENERAL.—Under regulations—

''(i) the Secretary or a State administering agency may terminate a PACE program agreement for cause; and

''(ii) a PACE provider may terminate an agreement after appropriate notice to the Secretary, the State agency, and enrollees.

''(B) CAUSES FOR TERMINATION.—In accordance with regulations establishing procedures for termination of PACE program agreements, the Secretary or a State administering agency may terminate a PACE program agreement with a PACE provider for, among other reasons, the fact that—

''(i) the Secretary or State administering agency determines that—

''(I) there are significant deficiencies in the quality of care provided to enrolled participants; or

''(II) the provider has failed to comply substantially with conditions for a program or provider under this section or section 1934; and

''(ii) the entity has failed to develop and successfully initiate, within 30 days of the date of the receipt of written notice of such a determination, a plan to correct the deficiencies, or has failed to continue implementation of such a plan.

''(C) TERMINATION AND TRANSITION PROCEDURES.—An entity whose PACE provider agreement is terminated under this paragraph shall implement the transition procedures required under subsection (a)(2)(C).

''(6) SECRETARY'S OVERSIGHT; ENFORCEMENT AUTHORITY.—

''(A) IN GENERAL.—Under regulations, if the Secretary determines (after consultation with the State administering agency) that a PACE provider is failing substantially to comply with the requirements of this section and regulations, the Secretary (and the State administering agency) may take any or all of the following actions:

''(i) Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

''(ii) Withhold some or all further payments under the PACE program agreement under this section or section 1934 with respect to PACE program services furnished by such provider until the deficiencies have been corrected.

''(iii) Terminate such agreement.

''(B) APPLICATION OF INTERMEDIATE SANCTIONS.—Under regulations, the Secretary may provide for the application against a PACE provider of remedies described in section 1857(g)(2) (or, for periods before January 1, 1999, section 1876(i)(6)(B)) or 1903(m)(5)(B) in the case of violations by the provider of the type described in section 1857(g)(1) (or section 1876(i)(6)(A) for such periods) or 1903(m)(5)(A), respectively (in relation to agreements, enrollees, and requirements under this section or section 1934, respectively).

''(7) PROCEDURES FOR TERMINATION OR IMPOSITION OF SANCTIONS.—Under regulations, the provisions of section 1857(h) (or for periods before January 1, 1999, section 1876(i)(9)) shall apply to termination and sanctions respecting a PACE program agreement and PACE provider under this subsection in the same manner as they apply to a termination and sanctions with respect to a contract and a Medicare+Choice organization under part C (or for such periods an eligible organization under section 1876).

''(8) TIMELY CONSIDERATION OF APPLICATIONS FOR PACE PROGRAM PROVIDER STATUS.—In considering an application for PACE provider program status, the application shall be deemed approved unless the Secretary, within 90 days after the date of the submission of the application to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information that is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

''(f) REGULATIONS.—

''(1) IN GENERAL.—The Secretary shall issue interim final or final regulations to carry out this section and section 1934.

''(2) USE OF PACE PROTOCOL.—

''(A) IN GENERAL.—In issuing such regulations, the Secretary shall, to the extent consistent with the provisions of this section, incorporate the requirements applied to PACE demonstration waiver programs under the PACE protocol.

''(B) FLEXIBILITY.—In order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may determine it appropriate to use nonstaff physicians according to State licensing law requirements) under this section and section 1934, the Secretary (in close consultation with State administering agencies) may modify or waive provisions of the PACE protocol so long as any such modification or waiver is not inconsistent with and would not impair the essential elements, objectives, and requirements of this section, but may not modify or waive any of the following provisions:

''(i) The focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility.

''(ii) The delivery of comprehensive, integrated acute and long-term care services.

''(iii) The interdisciplinary team approach to care management and service delivery.

''(iv) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.

''(v) The assumption by the provider of full financial risk.

''(3) APPLICATION OF CERTAIN ADDITIONAL BENEFICIARY AND PROGRAM PROTECTIONS.—

''(A) IN GENERAL.—In issuing such regulations and subject to subparagraph (B), the Secretary may apply with respect to PACE programs, providers, and agreements such requirements of part C (or, for periods before January 1, 1999, section 1876) and sections 1903(m) and 1932 relating to protection of beneficiaries and program integrity as would apply to Medicare+Choice organizations under part C (or for such periods eligible organizations under risk-sharing contracts under section 1876) and to medicaid managed care organizations under prepaid capitation agreements under section 1903(m).

''(B) CONSIDERATIONS.—In issuing such regulations, the Secretary shall—

''(i) take into account the differences between populations served and benefits provided under this section and under part C (or, for periods before January 1, 1999, section 1876) and section 1903(m);

''(ii) not include any requirement that conflicts with carrying out PACE programs under this section; and

''(iii) not include any requirement restricting the proportion of enrollees who are eligible for benefits under this title or title XIX.

''(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the Secretary from including in regulations provisions to ensure the health and safety of individuals enrolled in a PACE program under this section that are in addition to those otherwise provided under paragraphs (2) and (3).

''(g) WAIVERS OF REQUIREMENTS.—With respect to carrying out a PACE program under this section, the following requirements of this title (and regulations relating to such requirements) are waived and shall not apply:

''(1) Section 1812, insofar as it limits coverage of institutional services.

''(2) Sections 1813, 1814, 1833, and 1886, insofar as such sections relate to rules for payment for benefits.

''(3) Sections 1814(a)(2)(B), 1814(a)(2)(C), and 1835(a)(2)(A), insofar as they limit coverage of extended care services or home health services.

''(4) Section 1861(i), insofar as it imposes a 3-day prior hospitalization requirement for coverage of extended care services.

''(5) Paragraphs (1) and (9) of section 1862(a), insofar as they may prevent payment for PACE program services to individuals enrolled under PACE programs.

''(h) DEMONSTRATION PROJECT FOR FOR-PROFIT ENTITIES.—

''(1) IN GENERAL.—In order to demonstrate the operation of a PACE program by a private, for-profit entity, the Secretary (in close consultation with State administering agencies) shall grant waivers from the requirement under subsection (a)(3) that a PACE provider may not be a for-profit, private entity.

''(2) SIMILAR TERMS AND CONDITIONS.—

''(A) IN GENERAL.—Except as provided under subparagraph (B), and paragraph (1), the terms and conditions for operation of a PACE program by a provider under this subsection shall be the same as those for PACE providers that are nonprofit, private organizations.

''(B) NUMERICAL LIMITATION.—The number of programs for which waivers are granted under this subsection shall not exceed 10. Programs with waivers granted under this subsection shall not be counted against the numerical limitation specified in subsection (e)(1)(B).

''(i) MISCELLANEOUS PROVISIONS.—Nothing in this section or section 1934 shall be construed as preventing a PACE provider from entering into contracts with other governmental or 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. 4802. ESTABLISHMENT OF PACE PROGRAM AS MEDICAID STATE OPTION.**

(a) IN GENERAL.—Title XIX is amended—

(1) in section 1905(a) (42 U.S.C. 1396d(a)), as amended by section 4702(a)(1)—

(A) by striking ''and'' at the end of paragraph (25);

(B) by redesignating paragraph (26) as paragraph (27); and

(C) by inserting after paragraph (25) the following new paragraph:

''(26) services furnished under a PACE program under section 1934 to PACE program eligible individuals enrolled under the program under such section; and'';

(2) by redesignating section 1934, as redesignated by section 4732, as section 1935; and

(3) by inserting after section 1933, as added by such section, the following new section:

''PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

''SEC. 1934. (a) STATE OPTION.—

''(1) IN GENERAL.—A State may elect to provide medical assistance under this section with respect to PACE program services to PACE program eligible individuals who are eligible for medical assistance under the State plan and who are enrolled in a PACE program under a PACE program agreement. Such individuals need not be eligible for benefits under part A, or enrolled under part B, of title XVIII to be eligible to enroll under this section. In the case of an individual enrolled with a PACE program pursuant to such an election—

''(A) the individual shall receive benefits under the plan solely through such program, and

''(B) the PACE provider shall receive payment in accordance with the PACE program agreement for provision of such benefits.

A State may establish a numerical limit on the number of individuals who may be enrolled in a PACE program under a PACE program agreement.

''(2) PACE PROGRAM DEFINED.—For purposes of this section, the term 'PACE program' means a program of all-inclusive care for the elderly that meets the following requirements:

''(A) OPERATION.—The entity operating the program is a PACE provider (as defined in paragraph (3)).

''(B) COMPREHENSIVE BENEFITS.—The program provides comprehensive health care services to PACE program eligible individuals in accordance with the PACE program agreement and regulations under this section.

''(C) TRANSITION.—In the case of an individual who is enrolled under the program under this section and whose enrollment ceases for any reason (including that the individual no longer qualifies as a PACE program eligible individual, the termination of a PACE program agreement, or otherwise), the program provides assistance to the individual in obtaining necessary transitional care through appropriate referrals and making the individual's medical records available to new providers.

''(3) PACE PROVIDER DEFINED.—

''(A) IN GENERAL.—For purposes of this section, the term 'PACE provider' means an entity that—

''(i) subject to subparagraph (B), is (or is a distinct part of) a public entity or a private, nonprofit entity organized for charitable purposes under section 501(c)(3) of the Internal Revenue Code of 1986, and

''(ii) has entered into a PACE program agreement with respect to its operation of a PACE program.

''(B) TREATMENT OF PRIVATE, FOR-PROFIT PROVIDERS.—Clause (i) of subparagraph (A) shall not apply—

''(i) to entities subject to a demonstration project waiver under subsection (h); and

''(ii) after the date the report under section 4804(b) of the Balanced Budget Act of 1997 is submitted, unless the Secretary determines that any of the findings described in subparagraph (A), (B), (C), or (D) of paragraph (2) of such section are true.

''(4) PACE PROGRAM AGREEMENT DEFINED.—For purposes of this section, the term 'PACE program agreement' means, with respect to a PACE provider, an agreement, consistent with this section, section 1894 (if applicable), and regulations promulgated to carry out such sections, among the PACE provider, the Secretary, and a State administering agency for the operation of a PACE program by the provider under such sections.

''(5) PACE PROGRAM ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, the term 'PACE program eligible individual' means, with respect to a PACE program, an individual who—

''(A) is 55 years of age or older;

''(B) subject to subsection (c)(4), is determined under subsection (c) to require the level of care required under the State medicaid plan for coverage of nursing facility services;

''(C) resides in the service area of the PACE program; and

''(D) meets such other eligibility conditions as may be imposed under the PACE program agreement for the program under subsection (e)(2)(A)(ii).

''(6) PACE PROTOCOL.—For purposes of this section, the term 'PACE protocol' means the Protocol for the Program of All-inclusive Care for the Elderly (PACE), as published by On Lok, Inc., as of April 14, 1995, or any successor protocol that may be agreed upon between the Secretary and On Lok, Inc.

''(7) PACE DEMONSTRATION WAIVER PROGRAM DEFINED.—For purposes of this section, the term 'PACE demonstration waiver program' means a demonstration program under either of the following sections (as in effect before the date of their repeal):

''(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21), as extended by section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

''(B) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

''(8) STATE ADMINISTERING AGENCY DEFINED.—For purposes of this section, the term 'State administering agency' means, with respect to the operation of a PACE program in a State, the agency of that State (which may be the single agency responsible for administration of the State plan under this title in the State) responsible for administering PACE program agreements under this section and section 1894 in the State.

''(9) TRIAL PERIOD DEFINED.—

''(A) IN GENERAL.—For purposes of this section, the term 'trial period' means, with respect to a PACE program operated by a PACE provider under a PACE program agreement, the first 3 contract years under such agreement with respect to such program.

''(B) TREATMENT OF ENTITIES PREVIOUSLY OPERATING PACE DEMONSTRATION WAIVER PROGRAMS.—Each contract year (including a year occurring before the effective date of this section) during which an entity has operated a PACE demonstration waiver program shall be counted under subparagraph (A) as a contract year during which the entity operated a PACE program as a PACE provider under a PACE program agreement.

''(10) REGULATIONS.—For purposes of this section, the term 'regulations' refers to interim final or final regulations promulgated under subsection (f) to carry out this section and section 1894.

''(b) SCOPE OF BENEFITS; BENEFICIARY SAFEGUARDS.—

''(1) IN GENERAL.—Under a PACE program agreement, a PACE provider shall—

''(A) provide to PACE program eligible individuals, regardless of source of payment and directly or under contracts with other entities, at a minimum—

''(i) all items and services covered under title XVIII (for individuals enrolled under section 1894) and all items and services covered under this title, but without any limitation or condition as to amount, duration, or scope and without application of deductibles, copayments, coinsurance, or other cost-sharing that would otherwise apply under such title or this title, respectively; and

''(ii) all additional items and services specified in regulations, based upon those required under the PACE protocol;

''(B) provide such enrollees access to necessary covered items and services 24 hours per day, every day of the year;

''(C) provide services to such enrollees through a comprehensive, multidisciplinary health and social services delivery system which integrates acute and long-term care services pursuant to regulations; and

''(D) specify the covered items and services that will not be provided directly by the entity, and to arrange for delivery of those items and services through contracts meeting the requirements of regulations.

''(2) QUALITY ASSURANCE; PATIENT SAFEGUARDS.—The PACE program agreement shall require the PACE provider to have in effect at a minimum—

''(A) a written plan of quality assurance and improvement, and procedures implementing such plan, in accordance with regulations, and

''(B) written safeguards of the rights of enrolled participants (including a patient bill of rights and procedures for grievances and appeals) in accordance with regulations and with other requirements of this title and Federal and State law designed for the protection of patients.

''(c) ELIGIBILITY DETERMINATIONS.—

''(1) IN GENERAL.—The determination of—

''(A) whether an individual is a PACE program eligible individual shall be made under and in accordance with the PACE program agreement, and

''(B) who is entitled to medical assistance under this title shall be made (or who is not so entitled, may be made) by the State administering agency.

''(2) CONDITION.—An individual is not a PACE program eligible individual (with respect to payment under this section) unless the individual's health status has been determined by the Secretary or the State administering agency, in accordance with regulations, to be comparable to the health status of individuals who have participated in the PACE demonstration waiver programs. Such determination shall be based upon information on health status and related indicators (such as medical diagnoses and measures of activities of daily living, instrumental activities of daily living, and cognitive impairment) that are part of a uniform minimum data set collected by PACE providers on potential eligible individuals.

''(3) ANNUAL ELIGIBILITY RECERTIFICATIONS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the determination described in subsection (a)(5)(B) for an individual shall be reevaluated at least annually.

''(B) EXCEPTION.—The requirement of annual reevaluation under subparagraph (A) may be waived during a period in accordance with regulations in those cases in which the State administering agency determines that there is no reasonable expectation of improvement or significant change in an individual's condition during the period because of the severity of chronic condition, or degree of impairment of functional capacity of the individual involved.

''(4) CONTINUATION OF ELIGIBILITY.—An individual who is a PACE program eligible individual may be deemed to continue to be such an individual notwithstanding a determination that the individual no longer meets the requirement of subsection (a)(5)(B) if, in accordance with regulations, in the absence of continued coverage under a PACE program the individual reasonably would be expected to meet such requirement within the succeeding 6-month period.

''(5) ENROLLMENT; DISENROLLMENT.—

''(A) VOLUNTARY DISENROLLMENT AT ANY TIME.—The enrollment and disenrollment of PACE program eligible individuals in a PACE program shall be pursuant to regulations and the PACE program agreement and shall permit enrollees to voluntarily disenroll without cause at any time.

''(B) LIMITATIONS ON DISENROLLMENT.—

''(i) IN GENERAL.—Regulations promulgated by the Secretary under this section and section 1894, and the PACE program agreement, shall provide that the PACE program may not disenroll a PACE program eligible individual except—

''(I) for nonpayment of premiums (if applicable) on a timely basis; or

''(II) for engaging in disruptive or threatening behavior, as defined in such regulations (developed in close consultation with State administering agencies).

''(ii) NO DISENROLLMENT FOR NONCOMPLIANT BEHAVIOR.—Except as allowed under regulations promulgated to carry out clause (i)(II), a PACE program may not disenroll a PACE program eligible individual on the ground that the individual has engaged in noncompliant behavior if such behavior is related to a mental or physical condition of the individual. For purposes of the preceding sentence, the term 'noncompliant behavior' includes repeated noncompliance with medical advice and repeated failure to appear for appointments.

''(iii) TIMELY REVIEW OF PROPOSED NONVOLUNTARY DISENROLLMENT.—A proposed disenrollment, other than a voluntary disenrollment, shall be subject to timely review and final determination by the Secretary or by the State administering agency (as applicable), prior to the proposed disenrollment becoming effective.

''(d) PAYMENTS TO PACE PROVIDERS ON A CAPITATED BASIS.—

''(1) IN GENERAL.—In the case of a PACE provider with a PACE program agreement under this section, except as provided in this subsection or by regulations, the State shall make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under the agreement under this section.

''(2) CAPITATION AMOUNT.—The capitation amount to be applied under this subsection for a provider for a contract year shall be an amount specified in the PACE program agreement for the year. Such amount shall be an amount, specified under the PACE agreement, which is less than the amount that would otherwise have been made under the State plan if the individuals were not so enrolled and shall be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. The payment under this section shall be in addition to any payment made under section 1894 for individuals who are enrolled in a PACE program under such section.

''(e) PACE PROGRAM AGREEMENT.—

''(1) REQUIREMENT.—

''(A) IN GENERAL.—The Secretary, in close cooperation with the State administering agency, shall establish procedures for entering into, extending, and terminating PACE program agreements for the operation of PACE programs by entities that meet the requirements for a PACE provider under this section, section 1894, and regulations.

''(B) NUMERICAL LIMITATION.—

''(i) IN GENERAL.—The Secretary shall not permit the number of PACE providers with which agreements are in effect under this section or under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 to exceed—

''(I) 40 as of the date of the enactment of this section, or

''(II) as of each succeeding anniversary of such date, the numerical limitation under this subparagraph for the preceding year plus 20.

Subclause (II) shall apply without regard to the actual number of agreements in effect as of a previous anniversary date.

''(ii) TREATMENT OF CERTAIN PRIVATE, FOR-PROFIT PROVIDERS.—The numerical limitation in clause (i) shall not apply to a PACE provider that—

''(I) is operating under a demonstration project waiver under subsection (h), or

''(II) was operating under such a waiver and subsequently qualifies for PACE provider status pursuant to subsection (a)(3)(B)(ii).

''(2) SERVICE AREA AND ELIGIBILITY.—

''(A) IN GENERAL.—A PACE program agreement for a PACE program—

''(i) shall designate the service area of the program;

''(ii) may provide additional requirements for individuals to qualify as PACE program eligible individuals with respect to the program;

''(iii) shall be effective for a contract year, but may be extended for additional contract years in the absence of a notice by a party to terminate, and is subject to termination by the Secretary and the State administering agency at any time for cause (as provided under the agreement);

''(iv) shall require a PACE provider to meet all applicable State and local laws and requirements; and

''(v) shall contain such additional terms and conditions as the parties may agree to, so long as such terms and conditions are consistent with this section and regulations.

''(B) SERVICE AREA OVERLAP.—In designating a service area under a PACE program agreement under subparagraph (A)(i), the Secretary (in consultation with the State administering agency) may exclude from designation an area that is already covered under another PACE program agreement, in order to avoid unnecessary duplication of services and avoid impairing the financial and service viability of an existing program.

''(3) DATA COLLECTION; DEVELOPMENT OF OUTCOME MEASURES.—

''(A) DATA COLLECTION.—

''(i) IN GENERAL.—Under a PACE program agreement, the PACE provider shall—

''(I) collect data;

''(II) maintain, and afford the Secretary and the State administering agency access to, the records relating to the program, including pertinent financial, medical, and personnel records; and

''(III) submit to the Secretary and the State administering agency such reports as the Secretary finds (in consultation with State administering agencies) necessary to monitor the operation, cost, and effectiveness of the PACE program.

''(ii) REQUIREMENTS DURING TRIAL PERIOD.—During the first 3 years of operation of a PACE program (either under this section or under a PACE demonstration waiver program), the PACE provider shall provide such additional data as the Secretary specifies in regulations in order to perform the oversight required under paragraph (4)(A).

''(B) DEVELOPMENT OF OUTCOME MEASURES.—Under a PACE program agreement, the PACE provider, the Secretary, and the State administering agency shall jointly cooperate in the development and implementation of health status and quality of life outcome measures with respect to PACE program eligible individuals.

''(4) OVERSIGHT.—

''(A) ANNUAL, CLOSE OVERSIGHT DURING TRIAL PERIOD.—During the trial period (as defined in subsection (a)(9)) with respect to a PACE program operated by a PACE provider, the Secretary (in cooperation with the State administering agency) shall conduct a comprehensive annual review of the operation of the PACE program by the provider in order to assure compliance with the requirements of this section and regulations. Such a review shall include—

''(i) an onsite visit to the program site;

''(ii) comprehensive assessment of a provider's fiscal soundness;

''(iii) comprehensive assessment of the provider's capacity to provide all PACE services to all enrolled participants;

''(iv) detailed analysis of the entity's substantial compliance with all significant requirements of this section and regulations; and

''(v) any other elements the Secretary or the State administering agency considers necessary or appropriate.

''(B) CONTINUING OVERSIGHT.—After the trial period, the Secretary (in cooperation with the State administering agency) shall continue to conduct such review of the operation of PACE providers and PACE programs as may be appropriate, taking into account the performance level of a provider and compliance of a provider with all significant requirements of this section and regulations.

''(C) DISCLOSURE.—The results of reviews under this paragraph shall be reported promptly to the PACE provider, along with any recommendations for changes to the provider's program, and shall be made available to the public upon request.

''(5) TERMINATION OF PACE PROVIDER AGREEMENTS.—

''(A) IN GENERAL.—Under regulations—

''(i) the Secretary or a State administering agency may terminate a PACE program agreement for cause, and

''(ii) a PACE provider may terminate such an agreement after appropriate notice to the Secretary, the State administering agency, and enrollees.

''(B) CAUSES FOR TERMINATION.—In accordance with regulations establishing procedures for termination of PACE program agreements, the Secretary or a State administering agency may terminate a PACE program agreement with a PACE provider for, among other reasons, the fact that—

''(i) the Secretary or State administering agency determines that—

''(I) there are significant deficiencies in the quality of care provided to enrolled participants; or

''(II) the provider has failed to comply substantially with conditions for a program or provider under this section or section 1894; and

''(ii) the entity has failed to develop and successfully initiate, within 30 days of the date of the receipt of written notice of such a determination, a plan to correct the deficiencies, or has failed to continue implementation of such a plan.

''(C) TERMINATION AND TRANSITION PROCEDURES.—An entity whose PACE provider agreement is terminated under this paragraph shall implement the transition procedures required under subsection (a)(2)(C).

''(6) SECRETARY'S OVERSIGHT; ENFORCEMENT AUTHORITY.—

''(A) IN GENERAL.—Under regulations, if the Secretary determines (after consultation with the State administering agency) that a PACE provider is failing substantially to comply with the requirements of this section and regulations, the Secretary (and the State administering agency) may take any or all of the following actions:

''(i) Condition the continuation of the PACE program agreement upon timely execution of a corrective action plan.

''(ii) Withhold some or all further payments under the PACE program agreement under this section or section 1894 with respect to PACE program services furnished by

such provider until the deficiencies have been corrected.

''(iii) Terminate such agreement.

''(B) APPLICATION OF INTERMEDIATE SANCTIONS.—Under regulations, the Secretary may provide for the application against a PACE provider of remedies described in section 1857(g)(2) (or, for periods before January 1, 1999, section 1876(i)(6)(B)) or 1903(m)(5)(B) in the case of violations by the provider of the type described in section 1857(g)(1) (or 1876(i)(6)(A) for such periods) or 1903(m)(5)(A), respectively (in relation to agreements, enrollees, and requirements under section 1894 or this section, respectively).

''(7) PROCEDURES FOR TERMINATION OR IMPOSITION OF SANCTIONS.—Under regulations, the provisions of section 1857(h) (or for periods before January 1, 1999, section 1876(i)(9)) shall apply to termination and sanctions respecting a PACE program agreement and PACE provider under this subsection in the same manner as they apply to a termination and sanctions with respect to a contract and a Medicare+Choice organization under part C of title XVIII (or for such periods an eligible organization under section 1876).

''(8) TIMELY CONSIDERATION OF APPLICATIONS FOR PACE PROGRAM PROVIDER STATUS.—In considering an application for PACE provider program status, the application shall be deemed approved unless the Secretary, within 90 days after the date of the submission of the application to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information that is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the application shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

''(f) REGULATIONS.—

''(1) IN GENERAL.—The Secretary shall issue interim final or final regulations to carry out this section and section 1894.

''(2) USE OF PACE PROTOCOL.—

''(A) IN GENERAL.—In issuing such regulations, the Secretary shall, to the extent consistent with the provisions of this section, incorporate the requirements applied to PACE demonstration waiver programs under the PACE protocol.

''(B) FLEXIBILITY.—In order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may determine it appropriate to use nonstaff physicians according to State licensing law requirements) under this section and section 1894, the Secretary (in close consultation with State administering agencies) may modify or waive provisions of the PACE protocol so long as any such modification or waiver is not inconsistent with and would not impair the essential elements, objectives, and requirements of this section, but may not modify or waive any of the following provisions:

''(i) The focus on frail elderly qualifying individuals who require the level of care provided in a nursing facility.

''(ii) The delivery of comprehensive, integrated acute and long-term care services.

''(iii) The interdisciplinary team approach to care management and service delivery.

''(iv) Capitated, integrated financing that allows the provider to pool payments received from public and private programs and individuals.

''(v) The assumption by the provider of full financial risk.

''(3) APPLICATION OF CERTAIN ADDITIONAL BENEFICIARY AND PROGRAM PROTECTIONS.—

''(A) IN GENERAL.—In issuing such regulations and subject to subparagraph (B), the Secretary may apply with respect to PACE programs, providers, and agreements such requirements of part C of title XVIII (or, for periods before January 1, 1999, section 1876) and sections 1903(m) and 1932 relating to protection of beneficiaries and program integrity as would apply to Medicare+Choice organizations under such part C (or for such periods eligible organizations under risk-sharing contracts under section 1876) and to medicaid managed care organizations under prepaid capitation agreements under section 1903(m).

''(B) CONSIDERATIONS.—In issuing such regulations, the Secretary shall—

''(i) take into account the differences between populations served and benefits provided under this section and under part C of title XVIII (or, for periods before January 1, 1999, section 1876) and section 1903(m);

''(ii) not include any requirement that conflicts with carrying out PACE programs under this section; and

''(iii) not include any requirement restricting the proportion of enrollees who are eligible for benefits under this title or title XVIII.

''(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the Secretary from including in regulations provisions to ensure the health and safety of individuals enrolled in a PACE program under this section that are in addition to those otherwise provided under paragraphs (2) and (3).

''(g) WAIVERS OF REQUIREMENTS.—With respect to carrying out a PACE program under this section, the following requirements of this title (and regulations relating to such requirements) shall not apply:

''(1) Section 1902(a)(1), relating to any requirement that PACE programs or PACE program services be provided in all areas of a State.

''(2) Section 1902(a)(10), insofar as such section relates to comparability of services among different population groups.

''(3) Sections 1902(a)(23) and 1915(b)(4), relating to freedom of choice of providers under a PACE program.

''(4) Section 1903(m)(2)(A), insofar as it restricts a PACE provider from receiving prepaid capitation payments.

''(5) Such other provisions of this title that, as added or amended by the Balanced Budget Act of 1997, the Secretary determines are inapplicable to carrying out a PACE program under this section.

''(h) DEMONSTRATION PROJECT FOR FOR-PROFIT ENTITIES.—

''(1) IN GENERAL.—In order to demonstrate the operation of a PACE program by a private, for-profit entity, the Secretary (in close consultation with State administering agencies) shall grant waivers from the requirement under subsection (a)(3) that a PACE provider may not be a for-profit, private entity.

''(2) SIMILAR TERMS AND CONDITIONS.—

''(A) IN GENERAL.—Except as provided under subparagraph (B), and paragraph (1), the terms and conditions for operation of a PACE program by a provider under this subsection shall be the same as those for PACE providers that are nonprofit, private organizations.

''(B) NUMERICAL LIMITATION.—The number of programs for which waivers are granted under this subsection shall not exceed 10. Programs with waivers granted under this subsection shall not be counted against the numerical limitation specified in subsection (e)(1)(B).

''(i) POST-ELIGIBILITY TREATMENT OF INCOME.—A State may provide for post-eligibility treatment of income for individuals enrolled in PACE programs under this section in the same manner as a State treats post-eligibility income for individuals receiving services under a waiver under section 1915(c).

''(j) MISCELLANEOUS PROVISIONS.—Nothing in this section or section 1894 shall be construed as preventing a PACE provider from entering into contracts with other governmental or nongovernmental payers for the care of PACE program eligible individuals who are not eligible for benefits under part A, or enrolled under part B, of title XVIII or eligible for medical assistance under this title.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1924(a)(5) (42 U.S.C. 1396r–5(a)(5)) is amended—

(A) in the heading, by striking ''FROM ORGANIZATIONS RECEIVING CERTAIN WAIVERS'' and inserting ''UNDER PACE PROGRAMS''; and

(B) by striking ''from any organization'' and all that follows and inserting ''under a PACE demonstration waiver program (as defined in section 1934(a)(7)) or under a PACE program under section 1934 or 1894.''.

(2) Section 1903(f)(4)(C) (42 U.S.C. 1396b(f)(4)(C)) is amended by inserting ''or who is a PACE program eligible individual enrolled in a PACE program under section 1934,'' after ''section 1902(a)(10)(A),''.

**SEC. 4803. EFFECTIVE DATE; TRANSITION.**

(a) TIMELY ISSUANCE OF REGULATIONS; EFFECTIVE DATE.—The Secretary of Health and Human Services shall promulgate regulations to carry out this subtitle in a timely manner. Such regulations shall be designed so that entities may establish and operate PACE programs under sections 1894 and 1934 of the Social Security Act (as added by sections 4801 and 4802 of this subtitle) for periods beginning not later than 1 year after the date of the enactment of this Act.

(b) EXPANSION AND TRANSITION FOR PACE DEMONSTRATION PROJECT WAIVERS.—

(1) EXPANSION IN CURRENT NUMBER AND EXTENSION OF DEMONSTRATION PROJECTS.—Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, as amended by section 4118(g) of the Omnibus Budget Reconciliation Act of 1987, is amended—

(A) in paragraph (1), by inserting before the period at the end the following: '', except that the Secretary shall grant waivers of such requirements to up to the applicable numerical limitation specified in sections 1894(e)(1)(B) and 1934(e)(1)(B) of the Social Security Act''; and

(B) in paragraph (2)—

(i) in subparagraph (A), by striking '', including permitting the organization to assume progressively (over the initial 3-year period of the waiver) the full financial risk''; and

(ii) in subparagraph (C), by adding at the end the following: ''In granting further extensions, an organization shall not be required to provide for reporting of information which is only required because of the demonstration nature of the project.''.

(2) ELIMINATION OF REPLICATION REQUIREMENT.—Section 9412(b)(2)(B) of such Act, as so amended, shall not apply to waivers granted under such section after the date of the enactment of this Act.

(3) TIMELY CONSIDERATION OF APPLICATIONS.—In considering an application for waivers under such section before the effective date of the repeals under subsection (d), subject to the numerical limitation under the amendment made by paragraph (1), the application shall be deemed approved unless the Secretary of Health and Human Services, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the applicant in writing with respect to any additional information which is needed in order to make a final determination with respect to the application. After the date the Secretary receives such additional information, the ap-

plication shall be deemed approved unless the Secretary, within 90 days of such date, denies such request.

(c) PRIORITY AND SPECIAL CONSIDERATION IN APPLICATION.—During the 3-year period beginning on the date of the enactment of this Act:

(1) PROVIDER STATUS.—The Secretary of Health and Human Services shall give priority in processing applications of entities to qualify as PACE programs under section 1894 or 1934 of the Social Security Act—

(A) first, to entities that are operating a PACE demonstration waiver program (as defined in sections 1894(a)(7) and 1934(a)(7) of such Act); and

(B) then to entities that have applied to operate such a program as of May 1, 1997.

(2) NEW WAIVERS.—The Secretary shall give priority, in the awarding of additional waivers under section 9412(b) of the Omnibus Budget Reconciliation Act of 1986—

(A) to any entities that have applied for such waivers under such section as of May 1, 1997; and

(B) to any entity that, as of May 1, 1997, has formally contracted with a State to provide services for which payment is made on a capitated basis with an understanding that the entity was seeking to become a PACE provider.

(3) SPECIAL CONSIDERATION.—The Secretary shall give special consideration, in the processing of applications described in paragraph (1) and the awarding of waivers described in paragraph (2), to an entity which as of May 1, 1997, through formal activities (such as entering into contracts for feasibility studies) has indicated a specific intent to become a PACE provider.

(d) REPEAL OF CURRENT PACE DEMONSTRATION PROJECT WAIVER AUTHORITY.—

(1) IN GENERAL.—Subject to paragraph (2), the following provisions of law are repealed:

(A) Section 603(c) of the Social Security Amendments of 1983 (Public Law 98–21).

(B) Section 9220 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272).

(C) Section 9412(b) of the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509).

(2) DELAY IN APPLICATION TO CURRENT WAIVERS.—

(A) IN GENERAL.—Subject to subparagraph (B), in the case of waivers granted with respect to a PACE program before the initial effective date of regulations described in subsection (a), the repeals made by paragraph (1) shall not apply until the end of a transition period (of up to 24 months) that begins on the initial effective date of such regulations, and that allows sufficient time for an orderly transition from demonstration project authority to general authority provided under the amendments made by this subtitle.

(B) STATE OPTION TO SEEK EXTENSION OF CURRENT PERIOD.—A State may elect to maintain the PACE programs which (as of the date of the enactment of this Act) were operating in the State under the authority described in paragraph (1) until a date (specified by the State) that is not later than 3 years after the initial effective date of regulations described in subsection (a). If a State makes such an election, the repeals made by paragraph (1) shall not apply to the programs until the date so specified, but only so long as such programs continue to operate under the same terms and conditions as apply to such programs as of the date of the enactment of this Act, and subparagraph (A) shall not apply to such programs.

**SEC. 4804. STUDY AND REPORTS.**

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in close consultation with State administering agencies, as defined in sections 1894(a)(8) and 1934(a)(8) of the Social Security Act) shall conduct a study of the quality and cost of providing PACE program services under the medicare and medicaid programs under the amendments made by this subtitle.

(2) STUDY OF PRIVATE, FOR-PROFIT PROVIDERS.—Such study shall specifically compare the costs, quality, and access to services by entities that are private, for-profit entities operating under demonstration projects waivers granted under sections 1894(h) and 1934(h) of the Social Security Act with the costs, quality, and access to services of other PACE providers.

(b) REPORT.—

(1) IN GENERAL.—Not later than 4 years after the date of the enactment of this Act, the Secretary shall provide for a report to Congress on the impact of such amendments on quality and cost of services. The Secretary shall include in such report such recommendations for changes in the operation of such amendments as the Secretary deems appropriate.

(2) TREATMENT OF PRIVATE, FOR-PROFIT PROVIDERS.—The report shall include specific findings on whether any of the following findings is true:

(A) The number of covered lives enrolled with entities operating under demonstration project waivers under sections 1894(h) and 1934(h) of the Social Security Act is fewer than 800 (or such lesser number as the Secretary may find statistically sufficient to make determinations respecting findings described in the succeeding subparagraphs).

(B) The population enrolled with such entities is less frail than the population enrolled with other PACE providers.

(C) Access to or quality of care for individuals enrolled with such entities is lower than such access or quality for individuals enrolled with other PACE providers.

(D) The application of such section has resulted in an increase in expenditures under the medicare or medicaid programs above the expenditures that would have been made if such section did not apply.

(c) INFORMATION INCLUDED IN ANNUAL RECOMMENDATIONS.—The Medicare Payment Advisory Commission shall include in its annual report under section 1805(b)(1)(B) of the Social Security Act recommendations on the methodology and level of payments made to PACE providers under sections 1894(d) and 1934(d) of such Act and on the treatment of private, for-profit entities as PACE providers.

## Subtitle J—State Children's Health Insurance Program

## CHAPTER 1—STATE CHILDREN'S HEALTH INSURANCE PROGRAM

**SEC. 4901. ESTABLISHMENT OF PROGRAM.**

(a) ESTABLISHMENT.—The Social Security Act is amended by adding at the end the following new title:

''TITLE XXI—STATE CHILDREN'S HEALTH INSURANCE PROGRAM

**"SEC. 2101. PURPOSE; STATE CHILD HEALTH PLANS.**

''(a) PURPOSE.—The purpose of this title is to provide funds to States to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner that is coordinated with other sources of health benefits coverage for children. Such assistance shall be provided primarily for obtaining health benefits coverage through—

''(1) obtaining coverage that meets the requirements of section 2103, or

''(2) providing benefits under the State's medicaid plan under title XIX,

or a combination of both.

''(b) STATE CHILD HEALTH PLAN REQUIRED.—A State is not eligible for payment under section 2105 unless the State has submitted to the Secretary under section 2106 a plan that—

''(1) sets forth how the State intends to use the funds provided under this title to provide child health assistance to needy children consistent with the provisions of this title, and

''(2) has been approved under section 2106.

''(c) STATE ENTITLEMENT.—This title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States of amounts provided under section 2104.

''(d) EFFECTIVE DATE.—No State is eligible for payments under section 2105 for child health assistance for coverage provided for periods beginning before October 1, 1997.

**"SEC. 2102. GENERAL CONTENTS OF STATE CHILD HEALTH PLAN; ELIGIBILITY; OUTREACH.**

''(a) GENERAL BACKGROUND AND DESCRIPTION.—A State child health plan shall include a description, consistent with the requirements of this title, of—

''(1) the extent to which, and manner in which, children in the State, including targeted low-income children and other classes of children classified by income and other relevant factors, currently have creditable health coverage (as defined in section 2110(c)(2));

''(2) current State efforts to provide or obtain creditable health coverage for uncovered children, including the steps the State is taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs and health insurance programs that involve public-private partnerships;

''(3) how the plan is designed to be coordinated with such efforts to increase coverage of children under creditable health coverage;

''(4) the child health assistance provided under the plan for targeted low-income children, including the proposed methods of delivery, and utilization control systems;

''(5) eligibility standards consistent with subsection (b);

''(6) outreach activities consistent with subsection (c); and

''(7) methods (including monitoring) used—

''(A) to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan, and

''(B) to assure access to covered services, including emergency services.

''(b) GENERAL DESCRIPTION OF ELIGIBILITY STANDARDS AND METHODOLOGY.—

''(1) ELIGIBILITY STANDARDS.—

''(A) IN GENERAL.—The plan shall include a description of the standards used to determine the eligibility of targeted low-income children for child health assistance under the plan. Such standards may include (to the extent consistent with this title) those relating to the geographic areas to be served by the plan, age, income and resources (including any standards relating to spenddowns and disposition of resources), residency, disability status (so long as any standard relating to such status does not restrict eligibility), access to or coverage under other health coverage, and duration of eligibility. Such standards may not discriminate on the basis of diagnosis.

''(B) LIMITATIONS ON ELIGIBILITY STANDARDS.—Such eligibility standards—

''(i) shall, within any defined group of covered targeted low-income children, not cover such children with higher family income without covering children with a lower family income, and

''(ii) may not deny eligibility based on a child having a preexisting medical condition.

''(2) METHODOLOGY.—The plan shall include a description of methods of establishing and continuing eligibility and enrollment.

''(3) ELIGIBILITY SCREENING; COORDINATION WITH OTHER HEALTH COVERAGE PROGRAMS.—The plan shall include a description of procedures to be used to ensure—

''(A) through both intake and followup screening, that only targeted low-income children are furnished child health assistance under the State child health plan;

''(B) that children found through the screening to be eligible for medical assistance under the State medicaid plan under title XIX are enrolled for such assistance under such plan;

''(C) that the insurance provided under the State child health plan does not substitute for coverage under group health plans;

''(D) the provision of child health assistance to targeted low-income children in the State who are Indians (as defined in section 4(c) of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c)); and

''(E) coordination with other public and private programs providing creditable coverage for low-income children.

''(4) NONENTITLEMENT.—Nothing in this title shall be construed as providing an individual with an entitlement to child health assistance under a State child health plan.

''(c) OUTREACH AND COORDINATION.—A State child health plan shall include a description of the procedures to be used by the State to accomplish the following:

''(1) OUTREACH.—Outreach to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs to inform these families of the availability of, and to assist them in enrolling their children in, such a program.

''(2) COORDINATION WITH OTHER HEALTH INSURANCE PROGRAMS.—Coordination of the administration of the State program under this title with other public and private health insurance programs.

**''SEC. 2103. COVERAGE REQUIREMENTS FOR CHILDREN'S HEALTH INSURANCE.**

''(a) REQUIRED SCOPE OF HEALTH INSURANCE COVERAGE.—The child health assistance provided to a targeted low-income child under the plan in the form described in paragraph (1) of section 2101(a) shall consist, consistent with subsection (c)(5), of any of the following:

''(1) BENCHMARK COVERAGE.—Health benefits coverage that is equivalent to the benefits coverage in a benchmark benefit package described in subsection (b).

''(2) BENCHMARK-EQUIVALENT COVERAGE.—Health benefits coverage that meets the following requirements:

''(A) INCLUSION OF BASIC SERVICES.—The coverage includes benefits for items and services within each of the categories of basic services described in subsection (c)(1).

''(B) AGGREGATE ACTUARIAL VALUE EQUIVALENT TO BENCHMARK PACKAGE.—The coverage has an aggregate actuarial value that is at least actuarially equivalent to one of the benchmark benefit packages.

''(C) SUBSTANTIAL ACTUARIAL VALUE FOR ADDITIONAL SERVICES INCLUDED IN BENCHMARK PACKAGE.—With respect to each of the categories of additional services described in subsection (c)(2) for which coverage is provided under the benchmark benefit package used under subparagraph (B), the coverage has an actuarial value that is equal to at least 75 percent of the actuarial value of the coverage of that category of services in such package.

''(3) EXISTING COMPREHENSIVE STATE-BASED COVERAGE.—Health benefits coverage under an existing comprehensive State-based program, described in subsection (d)(1).

''(4) SECRETARY-APPROVED COVERAGE.—Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population of targeted low-income children proposed to be provided such coverage.

''(b) BENCHMARK BENEFIT PACKAGES.—The benchmark benefit packages are as follows:

''(1) FEHBP-EQUIVALENT CHILDREN'S HEALTH INSURANCE COVERAGE.—The standard Blue Cross/Blue Shield preferred provider option service benefit plan, described in and offered under section 8903(1) of title 5, United States Code.

''(2) STATE EMPLOYEE COVERAGE.—A health benefits coverage plan that is offered and generally available to State employees in the State involved.

''(3) COVERAGE OFFERED THROUGH HMO.—The health insurance coverage plan that—

''(A) is offered by a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act), and

''(B) has the largest insured commercial, non-medicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved.

''(c) CATEGORIES OF SERVICES; DETERMINATION OF ACTUARIAL VALUE OF COVERAGE.—

''(1) CATEGORIES OF BASIC SERVICES.—For purposes of this section, the categories of basic services described in this paragraph are as follows:

''(A) Inpatient and outpatient hospital services.

''(B) Physicians' surgical and medical services.

''(C) Laboratory and x-ray services.

''(D) Well-baby and well-child care, including age-appropriate immunizations.

''(2) CATEGORIES OF ADDITIONAL SERVICES.—For purposes of this section, the categories of additional services described in this paragraph are as follows:

''(A) Coverage of prescription drugs.

''(B) Mental health services.

''(C) Vision services.

''(D) Hearing services.

''(3) TREATMENT OF OTHER CATEGORIES.—Nothing in this subsection shall be construed as preventing a State child health plan from providing coverage of benefits that are not within a category of services described in paragraph (1) or (2).

''(4) DETERMINATION OF ACTUARIAL VALUE.—The actuarial value of coverage of benchmark benefit packages, coverage offered under the State child health plan, and coverage of any categories of additional services under benchmark benefit packages and under coverage offered by such a plan, shall be set forth in an actuarial opinion in an actuarial report that has been prepared—

''(A) by an individual who is a member of the American Academy of Actuaries;

''(B) using generally accepted actuarial principles and methodologies;

''(C) using a standardized set of utilization and price factors;

''(D) using a standardized population that is representative of privately insured children of the age of children who are expected to be covered under the State child health plan;

''(E) applying the same principles and factors in comparing the value of different coverage (or categories of services);

''(F) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and

''(G) taking into account the ability of a State to reduce benefits by taking into account the increase in actuarial value of benefits coverage offered under the State child health plan that results from the limitations on cost sharing under such coverage.

The actuary preparing the opinion shall select and specify in the memorandum the standardized set and population to be used under subparagraphs (C) and (D).

''(5) CONSTRUCTION ON PROHIBITED COVERAGE.—Nothing in this section shall be construed as requiring any health benefits coverage offered under the plan to provide coverage for items or services for which payment is prohibited under this title, notwithstanding that any benchmark benefit package includes coverage for such an item or service.

''(d) DESCRIPTION OF EXISTING COMPREHENSIVE STATE-BASED COVERAGE.—

''(1) IN GENERAL.—A program described in this paragraph is a child health coverage program that—

''(A) includes coverage of a range of benefits;

''(B) is administered or overseen by the State and receives funds from the State;

''(C) is offered in New York, Florida, or Pennsylvania; and

''(D) was offered as of the date of the enactment of this title.

''(2) MODIFICATIONS.—A State may modify a program described in paragraph (1) from time to time so long as it continues to meet the requirement of subparagraph (A) and does not reduce the actuarial value of the coverage under the program below the lower of—

''(A) the actuarial value of the coverage under the program as of the date of the enactment of this title, or

''(B) the actuarial value described in subsection (a)(2)(B),

evaluated as of the time of the modification.

''(e) COST-SHARING.—

''(1) DESCRIPTION; GENERAL CONDITIONS.—

''(A) DESCRIPTION.—A State child health plan shall include a description, consistent with this subsection, of the amount (if any) of premiums, deductibles, coinsurance, and other cost sharing imposed. Any such charges shall be imposed pursuant to a public schedule.

''(B) PROTECTION FOR LOWER INCOME CHILDREN.—The State child health plan may only vary premiums, deductibles, coinsurance, and other cost sharing based on the family income of targeted low-income children in a manner that does not favor children from families with higher income over children from families with lower income.

''(2) NO COST SHARING ON BENEFITS FOR PREVENTIVE SERVICES.—The State child health plan may not impose deductibles, coinsurance, or other cost sharing with respect to benefits for services within the category of services described in subsection (c)(1)(D).

''(3) LIMITATIONS ON PREMIUMS AND COST-SHARING.—

''(A) CHILDREN IN FAMILIES WITH INCOME BELOW 150 PERCENT OF POVERTY LINE.—In the case of a targeted low-income child whose family income is at or below 150 percent of the poverty line, the State child health plan may not impose—

''(i) an enrollment fee, premium, or similar charge that exceeds the maximum monthly charge permitted consistent with standards established to carry out section 1916(b)(1) (with respect to individuals described in such section); and

''(ii) a deductible, cost sharing, or similar charge that exceeds an amount that is nominal (as determined consistent with regulations referred to in section 1916(a)(3), with such appropriate adjustment for inflation or other reasons as the Secretary determines to be reasonable).

''(B) OTHER CHILDREN.—For children not described in subparagraph (A), subject to paragraphs (1)(B) and (2), any premiums, deductibles, cost sharing or similar charges imposed under the State child health plan may be imposed on a sliding scale related to income, except that the total annual aggre-

gate cost-sharing with respect to all targeted low-income children in a family under this title may not exceed 5 percent of such family's income for the year involved.

''(4) RELATION TO MEDICAID REQUIREMENTS.—Nothing in this subsection shall be construed as affecting the rules relating to the use of enrollment fees, premiums, deductions, cost sharing, and similar charges in the case of targeted low-income children who are provided child health assistance in the form of coverage under a medicaid program under section 2101(a)(2).

''(f) APPLICATION OF CERTAIN REQUIREMENTS.—

''(1) RESTRICTION ON APPLICATION OF PREEXISTING CONDITION EXCLUSIONS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the State child health plan shall not permit the imposition of any preexisting condition exclusion for covered benefits under the plan.

''(B) GROUP HEALTH PLANS AND GROUP HEALTH INSURANCE COVERAGE.—If the State child health plan provides for benefits through payment for, or a contract with, a group health plan or group health insurance coverage, the plan may permit the imposition of a preexisting condition exclusion but only insofar as it is permitted under the applicable provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 and title XXVII of the Public Health Service Act.

''(2) COMPLIANCE WITH OTHER REQUIREMENTS.—Coverage offered under this section shall comply with the requirements of subpart 2 of part A of title XXVII of the Public Health Service Act insofar as such requirements apply with respect to a health insurance issuer that offers group health insurance coverage.

**"SEC. 2104. ALLOTMENTS.**

''(a) APPROPRIATION; TOTAL ALLOTMENT.—For the purpose of providing allotments to States under this section, there is appropriated, out of any money in the Treasury not otherwise appropriated—

''(1) for fiscal year 1998, $4,275,000,000;

''(2) for fiscal year 1999, $4,275,000,000;

''(3) for fiscal year 2000, $4,275,000,000;

''(4) for fiscal year 2001, $4,275,000,000;

''(5) for fiscal year 2002, $3,150,000,000;

''(6) for fiscal year 2003, $3,150,000,000;

''(7) for fiscal year 2004, $3,150,000,000;

''(8) for fiscal year 2005, $4,050,000,000;

''(9) for fiscal year 2006, $4,050,000,000; and

''(10) for fiscal year 2007, $5,000,000,000.

''(b) ALLOTMENTS TO 50 STATES AND DISTRICT OF COLUMBIA.—

''(1) IN GENERAL.—Subject to paragraph (4) and subsection (d), of the amount available for allotment under subsection (a) for a fiscal year, reduced by the amount of allotments made under subsection (c) for the fiscal year, the Secretary shall allot to each State (other than a State described in such subsection) with a State child health plan approved under this title the same proportion as the ratio of—

''(A) the product of (i) the number of children described in paragraph (2) for the State for the fiscal year and (ii) the State cost factor for that State (established under paragraph (3)); to

''(B) the sum of the products computed under subparagraph (A).

''(2) NUMBER OF CHILDREN.—

''(A) IN GENERAL.—The number of children described in this paragraph for a State for—

''(i) each of fiscal years 1998 through 2000 is equal to the number of low-income children in the State with no health insurance coverage for the fiscal year;

''(ii) fiscal year 2001 is equal to—

''(I) 75 percent of the number of low-income children in the State for the fiscal year with no health insurance coverage, plus

''(II) 25 percent of the number of low-income children in the State for the fiscal year; and

''(iii) each succeeding fiscal year is equal to—

''(I) 50 percent of the number of low-income children in the State for the fiscal year with no health insurance coverage, plus

''(II) 50 percent of the number of low-income children in the State for the fiscal year.

''(B) DETERMINATION OF NUMBER OF CHILDREN.—For purposes of subparagraph (A), a determination of the number of low-income children (and of such children who have no health insurance coverage) for a State for a fiscal year shall be made on the basis of the arithmetic average of the number of such children, as reported and defined in the 3 most recent March supplements to the Current Population Survey of the Bureau of the Census before the beginning of the fiscal year.

''(3) ADJUSTMENT FOR GEOGRAPHIC VARIATIONS IN HEALTH COSTS.—

''(A) IN GENERAL.—For purposes of paragraph (1)(A)(ii), the 'State cost factor' for a State for a fiscal year equal to the sum of—

''(i) 0.15, and

''(ii) 0.85 multiplied by the ratio of—

''(I) the annual average wages per employee for the State for such year (as determined under subparagraph (B)), to

''(II) the annual average wages per employee for the 50 States and the District of Columbia.

''(B) ANNUAL AVERAGE WAGES PER EMPLOYEE.—For purposes of subparagraph (A), the 'annual average wages per employee' for a State, or for all the States. for a fiscal year is equal to the average of the annual wages per employee for the State or for the 50 States and the District of Columbia for employees in the health services industry (SIC code 8000), as reported by the Bureau of Labor Statistics of the Department of Labor for each of the most recent 3 years before the beginning of the fiscal year involved.

''(4) FLOOR FOR STATES.—Subject to paragraph (5), in no case shall the amount of the allotment under this subsection for one of the 50 States or the District of Columbia for a year be less than $2,000,000. To the extent that the application of the previous sentence results in an increase in the allotment to a State above the amount otherwise provided, the allotments for the other States and the District of Columbia under this subsection shall be reduced in a pro rata manner (but not below $2,000,000) so that the total of such allotments in a fiscal year does not exceed the amount otherwise provided for allotment under paragraph (1) for that fiscal year.

''(c) ALLOTMENTS TO TERRITORIES.—

''(1) IN GENERAL.—Of the amount available for allotment under subsection (a) for a fiscal year, subject to subsection (d), the Secretary shall allot 0.25 percent among each of the commonwealths and territories described in paragraph (3) in the same proportion as the percentage specified in paragraph (2) for such commonwealth or territory bears to the sum of such percentages for all such commonwealths or territories so described.

''(2) PERCENTAGE.—The percentage specified in this paragraph for—

''(A) Puerto Rico is 91.6 percent,

''(B) Guam is 3.5 percent,

''(C) Virgin Islands is 2.6 percent,

''(D) American Samoa is 1.2 percent, and

''(E) the Northern Mariana Islands is 1.1 percent.

''(3) COMMONWEALTHS AND TERRITORIES.—A commonwealth or territory described in this paragraph is any of the following if it has a State child health plan approved under this title:

''(A) Puerto Rico.

''(B) Guam.

''(C) the Virgin Islands.

''(D) American Samoa.

''(E) the Northern Mariana Islands.

''(d) CERTAIN MEDICAID EXPENDITURES COUNTED AGAINST INDIVIDUAL STATE ALLOTMENTS.—The amount of the allotment otherwise provided to a State under subsection (b) or (c) for a fiscal year shall be reduced by the sum of—

''(1) the amount (if any) of the payments made to that State under section 1903(a) for calendar quarters during such fiscal year that is attributable to the provision of medical assistance to a child during a presumptive eligibility period under section 1920A, and

''(2) the amount of payments under such section during such period that is attributable to the provision of medical assistance to a child for which payment is made under section 1903(a)(1) on the basis of an enhanced FMAP under section 1905(b).

''(e) 3-YEAR AVAILABILITY OF AMOUNTS ALLOTTED.—Amounts allotted to a State pursuant to this section for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year; except that amounts reallotted to a State under subsection (f) shall be available for expenditure by the State through the end of the fiscal year in which they are reallotted.

''(f) PROCEDURE FOR REDISTRIBUTION OF UNUSED ALLOTMENTS.—The Secretary shall determine an appropriate procedure for redistribution of allotments from States that were provided allotments under this section for a fiscal year but that do not expend all of the amount of such allotments during the period in which such allotments are available for expenditure under subsection (e), to States that have fully expended the amount of their allotments under this section.

**"SEC. 2105. PAYMENTS TO STATES.**

''(a) IN GENERAL.—Subject to the succeeding provisions of this section, the Secretary shall pay to each State with a plan approved under this title, from its allotment under section 2104 (taking into account any adjustment under section 2104(d)), an amount for each quarter equal to the enhanced FMAP of expenditures in the quarter—

''(1) for child health assistance under the plan for targeted low-income children in the form of providing health benefits coverage that meets the requirements of section 2103; and

''(2) only to the extent permitted consistent with subsection (c)—

''(A) for payment for other child health assistance for targeted low-income children;

''(B) for expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children);

''(C) for expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and

''(D) for other reasonable costs incurred by the State to administer the plan.

''(b) ENHANCED FMAP.—For purposes of subsection (a), the 'enhanced FMAP', for a State for a fiscal year, is equal to the Federal medical assistance percentage (as defined in the first sentence of section 1905(b)) for the State increased by a number of percentage points equal to 30 percent of the number of percentage points by which (1) such Federal medical assistance percentage for the State, is less than (2) 100 percent; but in no case shall the enhanced FMAP for a State exceed 85 percent.

''(c) LIMITATION ON CERTAIN PAYMENTS FOR CERTAIN EXPENDITURES.—

''(1) GENERAL LIMITATIONS.—Funds provided to a State under this title shall only be used to carry out the purposes of this title

(as described in section 2101), and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

''(2) LIMITATION ON EXPENDITURES NOT USED FOR MEDICAID OR HEALTH INSURANCE ASSISTANCE.—

''(A) IN GENERAL.—Except as provided in this paragraph, payment shall not be made under subsection (a) for expenditures for items described in subsection (a) (other than paragraph (1)) for a quarter in a fiscal year to the extent the total of such expenditures exceeds 10 percent of the sum of—

''(i) the total Federal payments made under subsection (a) for such quarter in the fiscal year, and

''(ii) the total Federal payments made under section 1903(a)(1) based on an enhanced FMAP described in section 1905(u)(2) for such quarter.

''(B) WAIVER AUTHORIZED FOR COST-EFFECTIVE ALTERNATIVE.—The limitation under subparagraph (A) on expenditures for items described in subsection (a)(2) shall not apply to the extent that a State establishes to the satisfaction of the Secretary that—

''(i) coverage provided to targeted low-income children through such expenditures meets the requirements of section 2103;

''(ii) the cost of such coverage is not greater, on an average per child basis, than the cost of coverage that would otherwise be provided under section 2103; and

''(iii) such coverage is provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923.

''(3) WAIVER FOR PURCHASE OF FAMILY COVERAGE.—Payment may be made to a State under subsection (a)(1) for the purchase of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children only if the State establishes to the satisfaction of the Secretary that—

''(A) purchase of such coverage is cost-effective relative to the amounts that the State would have paid to obtain comparable coverage only of the targeted low-income children involved, and

''(B) such coverage shall not be provided if it would otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage.

''(4) USE OF NON-FEDERAL FUNDS FOR STATE MATCHING REQUIREMENT.—Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of non-Federal contributions required under subsection (a).

''(5) OFFSET OF RECEIPTS ATTRIBUTABLE TO PREMIUMS AND OTHER COST-SHARING.—For purposes of subsection (a), the amount of the expenditures under the plan shall be reduced by the amount of any premiums and other cost-sharing received by the State.

''(6) PREVENTION OF DUPLICATIVE PAYMENTS.—

''(A) OTHER HEALTH PLANS.—No payment shall be made to a State under this section for expenditures for child health assistance provided for a targeted low-income child under its plan to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided child health assistance under the plan.

''(B) OTHER FEDERAL GOVERNMENTAL PROGRAMS.—Except as otherwise provided by law, no payment shall be made to a State under this section for expenditures for child health assistance provided for a targeted low-income child under its plan to the extent that payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under any other federally operated or financed health care insurance program, other than an insurance program operated or financed by the Indian Health Service, as identified by the Secretary. For purposes of this paragraph, rules similar to the rules for overpayments under section 1903(d)(2) shall apply.

''(7) LIMITATION ON PAYMENT FOR ABORTIONS.—

''(A) IN GENERAL.—Payment shall not be made to a State under this section for any amount expended under the State plan to pay for any abortion or to assist in the purchase, in whole or in part, of health benefit coverage that includes coverage of abortion.

''(B) EXCEPTION.—Subparagraph (A) shall not apply to an abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

''(C) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as affecting the expenditure by a State, locality, or private person or entity of State, local, or private funds (other than funds expended under the State plan) for any abortion or for health benefits coverage that includes coverage of abortion.

''(d) MAINTENANCE OF EFFORT.—

''(1) IN MEDICAID ELIGIBILITY STANDARDS.—No payment may be made under subsection (a) with respect to child health assistance provided under a State child health plan if the State adopts income and resource standards and methodologies for purposes of determining a child's eligibility for medical assistance under the State plan under title XIX that are more restrictive than those applied as of June 1, 1997.

''(2) IN AMOUNTS OF PAYMENT EXPENDED FOR CERTAIN STATE-FUNDED HEALTH INSURANCE PROGRAMS FOR CHILDREN.—

''(A) IN GENERAL.—The amount of the allotment for a State in a fiscal year (beginning with fiscal year 1999) shall be reduced by the amount by which—

''(i) the total of the State children's health insurance expenditures in the preceding fiscal year, is less than

''(ii) the total of such expenditures in fiscal year 1996.

''(B) STATE CHILDREN'S HEALTH INSURANCE EXPENDITURES.—The term 'State children's health insurance expenditures' means the following:

''(i) The State share of expenditures under this title.

''(ii) The State share of expenditures under title XIX that are attributable to an enhanced FMAP under section 1905(u).

''(iii) State expenditures under health benefits coverage under an existing comprehensive State-based program, described section 2103(d).

''(e) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this section for each quarter on the basis of advance estimates of expenditures submitted by the State and such other investigation as the Secretary may find necessary, and may reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

**''SEC. 2106. PROCESS FOR SUBMISSION, APPROVAL, AND AMENDMENT OF STATE CHILD HEALTH PLANS.**

''(a) INITIAL PLAN.—

''(1) IN GENERAL.—As a condition of receiving payment under section 2105, a State shall submit to the Secretary a State child health plan that meets the applicable requirements of this title.

''(2) APPROVAL.—Except as the Secretary may provide under subsection (e), a State plan submitted under paragraph (1)—

''(A) shall be approved for purposes of this title, and

''(B) shall be effective beginning with a calendar quarter that is specified in the plan, but in no case earlier than October 1, 1997.

''(b) PLAN AMENDMENTS.—

''(1) IN GENERAL.—A State may amend, in whole or in part, its State child health plan at any time through transmittal of a plan amendment.

''(2) APPROVAL.—Except as the Secretary may provide under subsection (e), an amendment to a State plan submitted under paragraph (1)—

''(A) shall be approved for purposes of this title, and

''(B) shall be effective as provided in paragraph (3).

''(3) EFFECTIVE DATES FOR AMENDMENTS.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, an amendment to a State plan shall take effect on one or more effective dates specified in the amendment.

''(B) AMENDMENTS RELATING TO ELIGIBILITY OR BENEFITS.—

''(i) NOTICE REQUIREMENT.—Any plan amendment that eliminates or restricts eligibility or benefits under the plan may not take effect unless the State certifies that it has provided prior public notice of the change, in a form and manner provided under applicable State law.

''(ii) TIMELY TRANSMITTAL.—Any plan amendment that eliminates or restricts eligibility or benefits under the plan shall not be effective for longer than a 60-day period unless the amendment has been transmitted to the Secretary before the end of such period.

''(C) OTHER AMENDMENTS.—Any plan amendment that is not described in subparagraph (B) and that becomes effective in a State fiscal year may not remain in effect after the end of such fiscal year (or, if later, the end of the 90-day period on which it becomes effective) unless the amendment has been transmitted to the Secretary.

''(c) DISAPPROVAL OF PLANS AND PLAN AMENDMENTS.—

''(1) PROMPT REVIEW OF PLAN SUBMITTALS.—The Secretary shall promptly review State plans and plan amendments submitted under this section to determine if they substantially comply with the requirements of this title.

''(2) 90-DAY APPROVAL DEADLINES.—A State plan or plan amendment is considered approved unless the Secretary notifies the State in writing, within 90 days after receipt of the plan or amendment, that the plan or amendment is disapproved (and the reasons for disapproval) or that specified additional information is needed.

''(3) CORRECTION.—In the case of a disapproval of a plan or plan amendment, the Secretary shall provide a State with a reasonable opportunity for correction before taking financial sanctions against the State on the basis of such disapproval.

''(d) PROGRAM OPERATION.—

''(1) IN GENERAL.—The State shall conduct the program in accordance with the plan (and any amendments) approved under subsection (c) and with the requirements of this title.

''(2) VIOLATIONS.—The Secretary shall establish a process for enforcing requirements under this title. Such process shall provide for the withholding of funds in the case of substantial noncompliance with such requirements. In the case of an enforcement action against a State under this paragraph, the Secretary shall provide a State with a reasonable opportunity for correction before taking financial sanctions against the State on the basis of such an action.

''(e) CONTINUED APPROVAL.—An approved State child health plan shall continue in effect unless and until the State amends the plan under subsection (b) or the Secretary finds, under subsection (d), substantial noncompliance of the plan with the requirements of this title.

**''SEC. 2107. STRATEGIC OBJECTIVES AND PERFORMANCE GOALS; PLAN ADMINISTRATION.**

''(a) STRATEGIC OBJECTIVES AND PERFORMANCE GOALS.—

''(1) DESCRIPTION.—A State child health plan shall include a description of—

''(A) the strategic objectives,

''(B) the performance goals, and

''(C) the performance measures,

the State has established for providing child health assistance to targeted low-income children under the plan and otherwise for maximizing health benefits coverage for other low-income children and children generally in the State.

''(2) STRATEGIC OBJECTIVES.—Such plan shall identify specific strategic objectives relating to increasing the extent of creditable health coverage among targeted low-income children and other low-income children.

''(3) PERFORMANCE GOALS.—Such plan shall specify one or more performance goals for each such strategic objective so identified.

''(4) PERFORMANCE MEASURES.—Such plan shall describe how performance under the plan will be—

''(A) measured through objective, independently verifiable means, and

''(B) compared against performance goals, in order to determine the State's performance under this title.

''(b) RECORDS, REPORTS, AUDITS, AND EVALUATION.—

''(1) DATA COLLECTION, RECORDS, AND REPORTS.—A State child health plan shall include an assurance that the State will collect the data, maintain the records, and furnish the reports to the Secretary, at the times and in the standardized format the Secretary may require in order to enable the Secretary to monitor State program administration and compliance and to evaluate and compare the effectiveness of State plans under this title.

''(2) STATE ASSESSMENT AND STUDY.—A State child health plan shall include a description of the State's plan for the annual assessments and reports under section 2108(a) and the evaluation required by section 2108(b).

''(3) AUDITS.—A State child health plan shall include an assurance that the State will afford the Secretary access to any records or information relating to the plan for the purposes of review or audit.

''(c) PROGRAM DEVELOPMENT PROCESS.—A State child health plan shall include a description of the process used to involve the public in the design and implementation of the plan and the method for ensuring ongoing public involvement.

''(d) PROGRAM BUDGET.—A State child health plan shall include a description of the budget for the plan. The description shall be updated periodically as necessary and shall include details on the planned use of funds and the sources of the non-Federal share of plan expenditures, including any requirements for cost-sharing by beneficiaries.

''(e) APPLICATION OF CERTAIN GENERAL PROVISIONS.—The following sections of this Act shall apply to States under this title in the same manner as they apply to a State under title XIX:

''(1) TITLE XIX PROVISIONS.—

''(A) Section 1902(a)(4)(C) (relating to conflict of interest standards).

''(B) Paragraphs (2), (16), and (17) of section 1903(i) (relating to limitations on payment).

''(C) Section 1903(w) (relating to limitations on provider taxes and donations).

''(2) TITLE XI PROVISIONS.—

''(A) Section 1115 (relating to waiver authority).

''(B) Section 1116 (relating to administrative and judicial review), but only insofar as consistent with this title.

''(C) Section 1124 (relating to disclosure of ownership and related information).

''(D) Section 1126 (relating to disclosure of information about certain convicted individuals).

''(E) Section 1128A (relating to civil monetary penalties).

''(F) Section 1128B(d) (relating to criminal penalties for certain additional charges).

''(G) Section 1132 (relating to periods within which claims must be filed).

**''SEC. 2108. ANNUAL REPORTS; EVALUATIONS.**

''(a) ANNUAL REPORT.—The State shall—

''(1) assess the operation of the State plan under this title in each fiscal year, including the progress made in reducing the number of uncovered low-income children; and

''(2) report to the Secretary, by January 1 following the end of the fiscal year, on the result of the assessment.

''(b) STATE EVALUATIONS.—

''(1) IN GENERAL.—By March 31, 2000, each State that has a State child health plan shall submit to the Secretary an evaluation that includes each of the following:

''(A) An assessment of the effectiveness of the State plan in increasing the number of children with creditable health coverage.

''(B) A description and analysis of the effectiveness of elements of the State plan, including—

''(i) the characteristics of the children and families assisted under the State plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the State plan and after eligibility for the State plan ends,

''(ii) the quality of health coverage provided including the types of benefits provided,

''(iii) the amount and level (including payment of part or all of any premium) of assistance provided by the State,

''(iv) the service area of the State plan,

''(v) the time limits for coverage of a child under the State plan,

''(vi) the State's choice of health benefits coverage and other methods used for providing child health assistance, and

''(vii) the sources of non-Federal funding used in the State plan.

''(C) An assessment of the effectiveness of other public and private programs in the State in increasing the availability of affordable quality individual and family health insurance for children.

''(D) A review and assessment of State activities to coordinate the plan under this title with other public and private programs providing health care and health care financing, including medicaid and maternal and child health services.

''(E) An analysis of changes and trends in the State that affect the provision of accessible, affordable, quality health insurance and health care to children.

''(F) A description of any plans the State has for improving the availability of health insurance and health care for children.

''(G) Recommendations for improving the program under this title.

''(H) Any other matters the State and the Secretary consider appropriate.

''(2) REPORT OF THE SECRETARY.—The Secretary shall submit to Congress and make available to the public by December 31, 2001, a report based on the evaluations submitted by States under paragraph (1), containing any conclusions and recommendations the Secretary considers appropriate.

**''SEC. 2109. MISCELLANEOUS PROVISIONS.**

''(a) RELATION TO OTHER LAWS.—

''(1) HIPAA.—Health benefits coverage provided under section 2101(a)(1) (and coverage provided under a waiver under section 2105(c)(2)(B)) shall be treated as creditable coverage for purposes of part 7 of subtitle B of title II of the Employee Retirement Income Security Act of 1974, title XXVII of the Public Health Service Act, and subtitle K of the Internal Revenue Code of 1986.

''(2) ERISA.—Nothing in this title shall be construed as affecting or modifying section 514 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1144) with respect to a group health plan (as defined in section 2791(a)(1) of the Public Health Service Act (42 U.S.C. 300gg–91(a)(1)).

**''SEC. 2110. DEFINITIONS.**

''(a) CHILD HEALTH ASSISTANCE.—For purposes of this title, the term 'child health assistance' means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in section 2105(a)(2)(A), payment for part or all of the cost of providing any of the following), as specified under the State plan:

''(1) Inpatient hospital services.

''(2) Outpatient hospital services.

''(3) Physician services.

''(4) Surgical services.

''(5) Clinic services (including health center services) and other ambulatory health care services.

''(6) Prescription drugs and biologicals and the administration of such drugs and biologicals, only if such drugs and biologicals are not furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.

''(7) Over-the-counter medications.

''(8) Laboratory and radiological services.

''(9) Prenatal care and prepregnancy family planning services and supplies.

''(10) Inpatient mental health services, other than services described in paragraph (18) but including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services.

''(11) Outpatient mental health services, other than services described in paragraph (19) but including services furnished in a State-operated mental hospital and including community-based services.

''(12) Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).

''(13) Disposable medical supplies.

''(14) Home and community-based health care services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).

''(15) Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.

''(16) Abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest.

''(17) Dental services.

''(18) Inpatient substance abuse treatment services and residential substance abuse treatment services.

''(19) Outpatient substance abuse treatment services.

''(20) Case management services.

''(21) Care coordination services.

''(22) Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

''(23) Hospice care.

''(24) Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and only if the service is—

''(A) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,

''(B) performed under the general supervision or at the direction of a physician, or

''(C) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

''(25) Premiums for private health care insurance coverage.

''(26) Medical transportation.

''(27) Enabling services (such as transportation, translation, and outreach services) only if designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

''(28) Any other health care services or items specified by the Secretary and not excluded under this section.

''(b) TARGETED LOW-INCOME CHILD DEFINED.—For purposes of this title—

''(1) IN GENERAL.—Subject to paragraph (2), the term 'targeted low-income child' means a child—

''(A) who has been determined eligible by the State for child health assistance under the State plan;

''(B)(i) who is a low-income child, or

''(ii) is a child whose family income (as determined under the State child health plan) exceeds the medicaid applicable income level (as defined in paragraph (4)), but does not exceed 50 percentage points above the medicaid applicable income level; and

''(C) who is not found to be eligible for medical assistance under title XIX or covered under a group health plan or under health insurance coverage (as such terms are defined in section 2791 of the Public Health Service Act).

''(2) CHILDREN EXCLUDED.—Such term does not include—

''(A) a child who is an inmate of a public institution or a patient in an institution for mental diseases; or

''(B) a child who is a member of a family that is eligible for health benefits coverage under a State health benefits plan on the basis of a family member's employment with a public agency in the State.

''(3) SPECIAL RULE.—A child shall not be considered to be described in paragraph (1)(C) notwithstanding that the child is covered under a health insurance coverage program that has been in operation since before July 1, 1997, and that is offered by a State which receives no Federal funds for the program's operation.

''(4) MEDICAID APPLICABLE INCOME LEVEL.—The term 'medicaid applicable income level' means, with respect to a child, the effective income level (expressed as a percent of the poverty line) that has been specified under the State plan under title XIX (including under a waiver authorized by the Secretary or under section 1902(r)(2)), as of June 1, 1997, for the child to be eligible for medical assistance under section 1902(l)(2) for the age of such child.

''(c) ADDITIONAL DEFINITIONS.—For purposes of this title:

''(1) CHILD.—The term 'child' means an individual under 19 years of age.

''(2) CREDITABLE HEALTH COVERAGE.—The term 'creditable health coverage' has the meaning given the term 'creditable coverage' under section 2701(c) of the Public Health Service Act (42 U.S.C. 300gg(c)) and includes coverage that meets the requirements of section 2103 provided to a targeted low-income child under this title or under a waiver approved under section 2105(c)(2)(B) (relating to a direct service waiver).

''(3) GROUP HEALTH PLAN; HEALTH INSURANCE COVERAGE; ETC.—The terms 'group health plan', 'group health insurance coverage', and 'health insurance coverage' have the meanings given such terms in section 2191 of the Public Health Service Act.

''(4) LOW-INCOME.—The term 'low-income child' means a child whose family income is at or below 200 percent of the poverty line for a family of the size involved.

''(5) POVERTY LINE DEFINED.—The term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

''(6) PREEXISTING CONDITION EXCLUSION.—The term 'preexisting condition exclusion' has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).

''(7) STATE CHILD HEALTH PLAN; PLAN.—Unless the context otherwise requires, the terms 'State child health plan' and 'plan' mean a State child health plan approved under section 2106.

''(8) UNCOVERED CHILD.—The term 'uncovered child' means a child that does not have creditable health coverage.''.

(b) CONFORMING AMENDMENTS.—

(1) DEFINITION OF STATE.—Section 1101(a)(1) is amended—

(A) by striking ''and XIX'' and inserting ''XIX, and XXI'', and

(B) by striking ''title XIX'' and inserting ''titles XIX and XXI''.

(2) TREATMENT AS STATE HEALTH CARE PROGRAM.—Section 1128(h) (42 U.S.C. 1320a–7(h)) is amended by—

(A) in paragraph (2), by striking ''or'' at the end;

(B) in paragraph (3), by striking the period and inserting '', or''; and

(C) by adding at the end the following:

''(4) a State child health plan approved under title XXI.''.

## CHAPTER 2—EXPANDED COVERAGE OF CHILDREN UNDER MEDICAID

### SEC. 4911. OPTIONAL USE OF STATE CHILD HEALTH ASSISTANCE FUNDS FOR ENHANCED MEDICAID MATCH FOR EXPANDED MEDICAID ELIGIBILITY.

(a) INCREASED FMAP FOR MEDICAL ASSISTANCE FOR EXPANDED COVERAGE OF TARGETED LOW-INCOME CHILDREN.—Section 1905 of the Social Security Act (42 U.S.C. 1396d), as amended by section 4702(a)(2), is amended—

(1) in subsection (b), by adding at the end the following new sentence: ''Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1), with respect to expenditures described in subsection (u)(2)(A) or subsection (u)(3) the Federal medical assistance percentage is equal to the enhanced FMAP described in section 2105(b).''; and

(2) by adding at the end the following new subsection:

''(u)(1) The conditions described in this paragraph for a State plan are as follows:

''(A) The State is complying with the requirement of section 2105(d)(1).

''(B) The plan provides for such reporting of information about expenditures and payments attributable to the operation of this subsection as the Secretary deems necessary in order to carry out paragraph (2) and section 2104(d).

''(2)(A) For purposes of subsection (b), the expenditures described in this subparagraph are expenditures for medical assistance for optional targeted low-income children described in subparagraph (C), but not in excess, for a State for a fiscal year, of the amount described in subparagraph (B) for the State and fiscal year.

''(B) The amount described in this subparagraph, for a State for a fiscal year, is the amount of the State's allotment under section 2104 (not taking into account reductions under section 2104(d)(2)) for the fiscal year reduced by the amount of any payments made under section 2105 to the State from such allotment for such fiscal year.

''(C) For purposes of this paragraph, the term 'optional targeted low-income child' means a targeted low-income child as defined in section 2110(b)(1) who would not qualify for medical assistance under the State plan under this title based on such plan as in effect on April 15, 1997 (but taking into account the expansion of age of eligibility effected through the operation of section 1902(l)(2)(D)).

''(3) For purposes of subsection (b), the expenditures described in this subparagraph are expenditures for medical assistance for children who are born before October 1, 1983, and who would be described in section 1902(l)(1)(D) if they had been born on or after such date, and who are not eligible for such assistance under the State plan under this title based on such State plan as in effect as of April 15, 1997.''.

(b) ESTABLISHMENT OF OPTIONAL ELIGIBILITY CATEGORY.—Section 1902(a)(10)(A)(ii) (42 U.S.C. 1396a(a)(10)(A)(ii)), as amended by section 4733, is amended—

(1) in subclause (XII), by striking ''or'' at the end;

(2) in subclause (XIII), by adding ''or'' at the end; and

(3) by adding at the end the following:

''(XIV) who are optional targeted low-income children described in section 1905(u)(2)(C);''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to medical assistance for items and services furnished on or after October 1, 1997.

### SEC. 4912. MEDICAID PRESUMPTIVE ELIGIBILITY FOR LOW-INCOME CHILDREN.

(a) IN GENERAL.—Title XIX of the Social Security Act is amended by inserting after section 1920 the following new section:

''PRESUMPTIVE ELIGIBILITY FOR CHILDREN

''SEC. 1920A. (a) A State plan approved under section 1902 may provide for making medical assistance with respect to health care items and services covered under the State plan available to a child during a presumptive eligibility period.

''(b) For purposes of this section:

''(1) The term 'child' means an individual under 19 years of age.

''(2) The term 'presumptive eligibility period' means, with respect to a child, the period that—

''(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the family income of the child does not exceed the applicable income level of eligibility under the State plan, and

''(B) ends with (and includes) the earlier of—

''(i) the day on which a determination is made with respect to the eligibility of the

child for medical assistance under the State plan, or

''(ii) in the case of a child on whose behalf an application is not filed by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

''(3)(A) Subject to subparagraph (B), the term 'qualified entity' means any entity that—

''(i)(I) is eligible for payments under a State plan approved under this title and provides items and services described in subsection (a) or (II) is authorized to determine eligibility of a child to participate in a Head Start program under the Head Start Act (42 U.S.C. 9821 et seq.), eligibility of a child to receive child care services for which financial assistance is provided under the Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9858 et seq.), eligibility of an infant or child to receive assistance under the special supplemental nutrition program for women, infants, and children (WIC) under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786); and

''(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

''(B) The Secretary may issue regulations further limiting those entities that may become qualified entities in order to prevent fraud and abuse and for other reasons.

''(C) Nothing in this section shall be construed as preventing a State from limiting the classes of entities that may become qualified entities, consistent with any limitations imposed under subparagraph (B).

''(c)(1) The State agency shall provide qualified entities with—

''(A) such forms as are necessary for an application to be made on behalf of a child for medical assistance under the State plan, and

''(B) information on how to assist parents, guardians, and other persons in completing and filing such forms.

''(2) A qualified entity that determines under subsection (b)(1)(A) that a child is presumptively eligible for medical assistance under a State plan shall—

''(A) notify the State agency of the determination within 5 working days after the date on which determination is made, and

''(B) inform the parent or custodian of the child at the time the determination is made that an application for medical assistance under the State plan is required to be made by not later than the last day of the month following the month during which the determination is made.

''(3) In the case of a child who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the parent, guardian, or other person shall make application on behalf of the child for medical assistance under such plan by not later than the last day of the month following the month during which the determination is made, which application may be the application used for the receipt of medical assistance by individuals described in section 1902(l)(1).

''(d) Notwithstanding any other provision of this title, medical assistance for items and services described in subsection (a) that—

''(1) are furnished to a child—

''(A) during a presumptive eligibility period,

''(B) by a entity that is eligible for payments under the State plan; and

''(2) are included in the care and services covered by a State plan;

shall be treated as medical assistance provided by such plan for purposes of section 1903.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1902(a)(47) (42 U.S.C. 1396a(a)(47)) is amended by inserting before the semicolon at the end the following: ''and provide for making medical assistance for items and services described in subsection (a) of section 1920A available to children during a presumptive eligibility period in accordance with such section''.

(2) Section 1903(u)(1)(D)(v) (42 U.S.C. 1396b(u)(1)(D)(v)) is amended by inserting before the period at the end the following: ''or for items and services described in subsection (a) of section 1920A provided to a child during a presumptive eligibility period under such section''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of the enactment of this Act.

**SEC. 4913. CONTINUATION OF MEDICAID ELIGIBILITY FOR DISABLED CHILDREN WHO LOSE SSI BENEFITS.**

(a) IN GENERAL.—Section 1902(a)(10)(A)(i)(II) (42 U.S.C. 1396a(a)(10)(A)(i)(II)) is amended by inserting ''(or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104–193)) and would continue to be paid but for the enactment of that section'' after ''title XVI''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to medical assistance furnished on or after July 1, 1997.

## CHAPTER 3—DIABETES GRANT PROGRAMS

**SEC. 4921. SPECIAL DIABETES PROGRAMS FOR CHILDREN WITH TYPE I DIABETES.**

Subpart I of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.) is amended by adding at the end the following section:

**''SEC. 330B. SPECIAL DIABETES PROGRAMS FOR CHILDREN WITH TYPE I DIABETES.**

''(a) TYPE I DIABETES IN CHILDREN.—The Secretary shall make grants for services for the prevention and treatment of type I diabetes in children, and for research in innovative approaches to such services. Such grants may be made to children's hospitals; grantees under section 330 and other federally qualified health centers; State and local health departments; and other appropriate public or nonprofit private entities.

''(b) FUNDING.—Notwithstanding section 2104(a) of the Social Security Act, from the amounts appropriated in such section for each of fiscal years 1998 through 2002, $30,000,000 is hereby transferred and made available in such fiscal year for grants under this section.''.

**SEC. 4922. SPECIAL DIABETES PROGRAMS FOR INDIANS.**

Subpart I of part D of title III of the Public Health Service Act (42 U.S.C. 254b et seq.), as amended by section 4921, is further amended by adding at the end the following section:

**''SEC. 330C. SPECIAL DIABETES PROGRAMS FOR INDIANS.**

''(a) IN GENERAL.—The Secretary shall make grants for providing services for the prevention and treatment of diabetes in accordance with subsection (b).

''(b) SERVICES THROUGH INDIAN HEALTH FACILITIES.—For purposes of subsection (a), services under such subsection are provided in accordance with this subsection if the services are provided through any of the following entities:

''(1) The Indian Health Service.

''(2) An Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service pursuant to the Indian Self-Determination Act.

''(3) An urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

''(c) FUNDING.—Notwithstanding section 2104(a) of the Social Security Act, from the amounts appropriated in such section for each of fiscal years 1998 through 2002, $30,000,000 is hereby transferred and made available in such fiscal year for grants under this section.''.

**SEC. 4923. REPORT ON DIABETES GRANT PROGRAMS.**

(a) EVALUATION.—The Secretary of Health and Human Services shall conduct an evaluation of the diabetes grant programs established under the amendments made by this chapter.

(b) REPORTS.—The Secretary shall submit to the appropriate committees of Congress—

(1) an interim report on the evaluation conducted under subsection (a) not later than January 1, 2000, and

(2) a final report on such evaluation not later than January 1, 2002.

## TITLE V—WELFARE AND RELATED PROVISIONS

**SEC. 5000. TABLE OF CONTENTS; REFERENCES.**

(a) TABLE OF CONTENTS.—The table of contents of this title is as follows:

Sec. 5000. Table of contents; references.

Subtitle A—TANF Block Grant

Sec. 5001. Welfare-to-work grants.
Sec. 5002. Limitation on amount of Federal funds transferable to title XX programs.
Sec. 5003. Limitation on number of persons who may be treated as engaged in work by reason of participation in educational activities.
Sec. 5004. Penalty for failure of State to reduce assistance for recipients refusing without good cause to work.

Subtitle B—Supplemental Security Income

Sec. 5101. Extension of deadline to perform childhood disability redeterminations.
Sec. 5102. Fees for Federal administration of State supplementary payments.

Subtitle C—Child Support Enforcement

Sec. 5201. Clarification of authority to permit certain redisclosures of wage and claim information.

Subtitle D—Restricting Welfare and Public Benefits for Aliens

Sec. 5301. SSI eligibility for aliens receiving SSI on August 22, 1996, and disabled aliens lawfully residing in the United States on August 22, 1996.
Sec. 5302. Extension of eligibility period for refugees and certain other qualified aliens from 5 to 7 years for SSI and medicaid; status of Cuban and Haitian entrants.
Sec. 5303. Exceptions for certain Indians from limitation on eligibility for supplemental security income and medicaid benefits.
Sec. 5304. Exemption from restriction on supplemental security income program participation by certain recipients eligible on the basis of very old applications.
Sec. 5305. Reinstatement of eligibility for benefits.
Sec. 5306. Treatment of certain Amerasian immigrants as refugees.
Sec. 5307. Verification of eligibility for State and local public benefits.
Sec. 5308. Effective date.

Subtitle E—Unemployment Compensation

Sec. 5401. Clarifying provision relating to base periods.
Sec. 5402. Increase in Federal unemployment account ceiling.
Sec. 5403. Special distribution to States from Unemployment Trust Fund.

Sec. 5404. Interest-free advances to State accounts in Unemployment Trust Fund restricted to States which meet funding goals.
Sec. 5405. Exemption of service performed by election workers from the Federal unemployment tax.
Sec. 5406. Treatment of certain services performed by inmates.
Sec. 5407. Exemption of service performed for an elementary or secondary school operated primarily for religious purposes from the Federal unemployment tax.
Sec. 5408. State program integrity activities for unemployment compensation.

Subtitle F—Welfare Reform Technical Corrections

CHAPTER 1—BLOCK GRANTS FOR TEMPORARY ASSISTANCE TO NEEDY FAMILIES

Sec. 5501. Eligible States; State plan.
Sec. 5502. Grants to States.
Sec. 5503. Use of grants.
Sec. 5504. Mandatory work requirements.
Sec. 5505. Prohibitions; requirements.
Sec. 5506. Penalties.
Sec. 5507. Data collection and reporting.
Sec. 5508. Direct funding and administration by Indian Tribes.
Sec. 5509. Research, evaluations, and national studies.
Sec. 5510. Report on data processing.
Sec. 5511. Study on alternative outcomes measures.
Sec. 5512. Limitation on payments to the territories.
Sec. 5513. Conforming amendments to the Social Security Act.
Sec. 5514. Other conforming amendments.
Sec. 5515. Modifications to the job opportunities for certain low-income individuals program.
Sec. 5516. Denial of assistance and benefits for drug-related convictions.
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Sec. 5701. Increase in public debt limit.
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(b) REFERENCES.—Except as otherwise expressly provided, wherever in this title an amendment or repeal is expressed in terms of an amendment to, or repeal of a section or other provision, the reference shall be considered to be made to a section or other provision of the Social Security Act.

**Subtitle A—TANF Block Grant**

**SEC. 5001. WELFARE-TO-WORK GRANTS.**

(a) GRANTS TO STATES.—

(1) IN GENERAL.—Section 403(a) (42 U.S.C. 603(a)) is amended by adding at the end the following:

''(5) WELFARE-TO-WORK GRANTS.—

''(A) FORMULA GRANTS.—

''(i) ENTITLEMENT.—A State shall be entitled to receive from the Secretary of Labor a grant for each fiscal year specified in subparagraph (I) of this paragraph for which the State is a welfare-to-work State, in an amount that does not exceed the lesser of—

''(I) 2 times the total of the expenditures by the State (excluding qualified State expenditures (as defined in section 409(a)(7)(B)(i)) and any expenditure described in subclause (I), (II), or (IV) of section 409(a)(7)(B)(iv)) during the fiscal year for activities described in subparagraph (C)(i) of this paragraph; or

''(II) the allotment of the State under clause (iii) of this subparagraph for the fiscal year.

''(ii) WELFARE-TO-WORK STATE.—A State shall be considered a welfare-to-work State for a fiscal year for purposes of this paragraph if the Secretary of Labor determines that the State meets the following requirements:

''(I) The State has submitted to the Secretary of Labor and the Secretary of Health and Human Services (in the form of an addendum to the State plan submitted under section 402) a plan which—

''(aa) describes how, consistent with this subparagraph, the State will use any funds provided under this subparagraph during the fiscal year;

''(bb) specifies the formula to be used pursuant to clause (vi) to distribute funds in the State, and describes the process by which the formula was developed;

''(cc) contains evidence that the plan was developed in consultation and coordination with appropriate entitites in sub-State areas;

''(dd) contains assurances by the Governor of the State that the private industry council (and any alternate agency designated by the Governor under item (ee)) for a service delivery area in the State will coordinate the expenditure of any funds provided under this subparagraph for the benefit of the service delivery area with the expenditure of the funds provided to the State under section 403(a)(1); and

''(ee) if the Governor of the State desires to have an agency other than a private industry council administer the funds provided under this subparagraph for the benefit of 1 or more service delivery areas in the State, contains an application to the Secretary of Labor for a waiver of clause (vii)(I) with respect to the area or areas in order to permit an alternate agency designated by the Governor to so administer the funds.

''(II) The State has provided to the Secretary of Labor an estimate of the amount that the State intends to expend during the fiscal year (excluding expenditures described in section 409(a)(7)(B)(iv) (other than subclause (III) thereof)) pursuant to this paragraph.

''(III) The State has agreed to negotiate in good faith with the Secretary of Health and Human Services with respect to the substance and funding of any evaluation under section 413(j), and to cooperate with the conduct of any such evaluation.

''(IV) The State is an eligible State for the fiscal year.

''(V) The State certifies that qualified State expenditures (within the meaning of section 409(a)(7)) for the fiscal year will be not less than the applicable percentage of historic State expenditures (within the meaning of section 409(a)(7)) with respect to the fiscal year.

''(iii) ALLOTMENTS TO WELFARE-TO-WORK STATES.—

''(I) IN GENERAL.—Subject to this clause, the allotment of a welfare-to-work State for a fiscal year shall be the available amount for the fiscal year, multiplied by the State percentage for the fiscal year.

''(II) MINIMUM ALLOTMENT.—The allotment of a welfare-to-work State (other than Guam, the Virgin Islands, or American Samoa) for a fiscal year shall not be less than 0.25 percent of the available amount for the fiscal year.

''(III) PRO RATA REDUCTION.—Subject to subclause (II), the Secretary of Labor shall make pro rata reductions in the allotments to States under this clause for a fiscal year as necessary to ensure that the total of the allotments does not exceed the available amount for the fiscal year.

''(iv) AVAILABLE AMOUNT.—As used in this subparagraph, the term 'available amount' means, for a fiscal year, the sum of—

''(I) 75 percent of the sum of—

''(aa) the amount specified in subparagraph (I) for the fiscal year, minus the total of the amounts reserved pursuant to subparagraphs (E), (F), (G), and (H) for the fiscal year; and

''(bb) any amount reserved pursuant to subparagraph (F) for the immediately preceding fiscal year that has not been obligated; and

''(II) any available amount for the immediately preceding fiscal year that has not been obligated by a State or sub-State entity.

''(v) STATE PERCENTAGE.—As used in clause (iii), the term 'State percentage' means, with respect to a fiscal year, ½ of the sum of—

''(I) the percentage represented by the number of individuals in the State whose income is less than the poverty line divided by the number of such individuals in the United States; and

''(II) the percentage represented by the number of adults who are recipients of assistance under the State program funded under this part divided by the number of adults in the United States who are recipients of assistance under any State program funded under this part.

''(vi) PROCEDURE FOR DISTRIBUTION OF FUNDS WITHIN STATES.—

''(I) ALLOCATION FORMULA.—A State to which a grant is made under this subparagraph shall devise a formula for allocating not less than 85 percent of the amount of the grant among the service delivery areas in the State, which—

''(aa) determines the amount to be allocated for the benefit of a service delivery area in proportion to the number (if any) by which the population of the area with an income that is less than the poverty line exceeds 7.5 percent of the total population of the area, relative to such number for all such areas in the State with such an excess, and accords a weight of not less than 50 percent to this factor;

''(bb) may determine the amount to be allocated for the benefit of such an area in proportion to the number of adults residing in the area who have been recipients of assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 first applied to the State) for at least 30 months (whether or not consecutive) relative to the number of such adults residing in the State; and

''(cc) may determine the amount to be allocated for the benefit of such an area in proportion to the number of unemployed individuals residing in the area relative to the number of such individuals residing in the State.

''(II) DISTRIBUTION OF FUNDS.—

''(aa) IN GENERAL.—If the amount allocated by the formula to a service delivery area is at least $100,000, the State shall distribute the amount to the entity administering the grant in the area.

''(bb) SPECIAL RULE.—If the amount allocated by the formula to a service delivery area is less than $100,000, the sum shall be available for distribution in the State under subclause (III) during the fiscal year.

''(III) PROJECTS TO HELP LONG-TERM RECIPIENTS OF ASSISTANCE ENTER UNSUBSIDIZED JOBS.—The Governor of a State to which a grant is made under this subparagraph may distribute not more than 15 percent of the grant funds (plus any amount required to be distributed under this subclause by reason of subclause (II)(bb)) to projects that appear likely to help long-term recipients of assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 first applied to the State) enter unsubsidized employment.

''(vii) ADMINISTRATION.—

''(I) PRIVATE INDUSTRY COUNCILS.—The private industry council for a service delivery area in a State shall have sole authority, in coordination with the chief elected official (as described in section 103(c) of the Job Training Partnership Act) of the area, to expend the amounts distributed under clause (vi)(II)(aa) for the benefit of the service delivery area, in accordance with the assurances described in clause (ii)(I)(dd) provided by the Governor of the State.

''(II) ENFORCEMENT OF COORDINATION OF EXPENDITURES WITH OTHER EXPENDITURES UNDER THIS PART.—Notwithstanding subclause (I) of this clause, on a determination by the Governor of a State that a private industry council (or an alternate agency described in clause (ii)(I)(dd)) has used funds provided under this subparagraph in a manner inconsistent with the assurances described in clause (ii)(I)(dd)—

''(aa) the private industry council (or such alternate agency) shall remit the funds to the Governor; and

''(bb) the Governor shall apply to the Secretary of Labor for a waiver of subclause (I) of this clause with respect to the service delivery area or areas involved in order to permit an alternate agency designated by the Governor to administer the funds in accordance with the assurances.

''(III) AUTHORITY TO PERMIT USE OF ALTERNATE ADMINISTERING AGENCY.—The Secretary of Labor shall approve an application submitted under clause (ii)(I)(ee) or subclause (II)(bb) of this clause to waive subclause (I) of this clause with respect to 1 or more service delivery areas if the Secretary determines that the alternate agency designated in the application would improve the effectiveness or efficiency of the administration of amounts distributed under clause (vi)(II)(aa) for the benefit of the area or areas.

''(viii) DATA TO BE USED IN DETERMINING THE NUMBER OF ADULT TANF RECIPIENTS.—For purposes of this subparagraph, the number of adult recipients of assistance under a State program funded under this part for a fiscal year shall be determined using data for the most recent 12-month period for which such data is available before the beginning of the fiscal year.

''(B) COMPETITIVE GRANTS.—

''(i) IN GENERAL.—The Secretary of Labor shall award grants in accordance with this subparagraph, in fiscal years 1998 and 1999, for projects proposed by eligible applicants, based on the following:

''(I) The effectiveness of the proposal in—

''(aa) expanding the base of knowledge about programs aimed at moving recipients of assistance under State programs funded under this part who are least job ready into unsubsidized employment.

''(bb) moving recipients of assistance under State programs funded under this part who are least job ready into unsubsidized employment; and

''(cc) moving recipients of assistance under State programs funded under this part who are least job ready into unsubsidized employment, even in labor markets that have a shortage of low-skill jobs.

''(II) At the discretion of the Secretary of Labor, any of the following:

''(aa) The history of success of the applicant in moving individuals with multiple barriers into work.

''(bb) Evidence of the applicant's ability to leverage private, State, and local resources.

''(cc) Use by the applicant of State and local resources beyond those required by subparagraph (A).

''(dd) Plans of the applicant to coordinate with other organizations at the local and State level.

''(ee) Use by the applicant of current or former recipients of assistance under a State program funded under this part as mentors, case managers, or service providers.

''(ii) ELIGIBLE APPLICANTS.—As used in clause (i), the term 'eligible applicant' means a private industry council for a service delivery area in a State, a political subdivision of a State, or a private entity applying in conjunction with the private industry council for such a service delivery area or with such a political subdivision, that submits a proposal developed in consultation with the Governor of the State.

''(iii) DETERMINATION OF GRANT AMOUNT.—In determining the amount of a grant to be made under this subparagraph for a project proposed by an applicant, the Secretary of Labor shall provide the applicant with an amount sufficient to ensure that the project has a reasonable opportunity to be successful, taking into account the number of long-term recipients of assistance under a State program funded under this part, the level of unemployment, the job opportunities and job growth, the poverty rate, and such other factors as the Secretary of Labor deems appropriate, in the area to be served by the project.

''(iv) CONSIDERATION OF NEEDS OF RURAL AREAS AND CITIES WITH LARGE CONCENTRA-

TIONS OF POVERTY.—In making grants under this subparagraph, the Secretary of Labor shall consider the needs of rural areas and cities with large concentrations of residents with an income that is less than the poverty line.

''(v) FUNDING.—For grants under this subparagraph for each fiscal year specified in subparagraph (I), there shall be available to the Secretary of Labor an amount equal to the sum of—

''(I) 25 percent of the sum of—

''(aa) the amount specified in subparagraph (I) for the fiscal year, minus the total of the amounts reserved pursuant to subparagraphs (E), (F), (G), and (H) for the fiscal year; and

''(bb) any amount reserved pursuant to subparagraph (F) for the immediately preceding fiscal year that has not been obligated; and

''(II) any amount available for grants under this subparagraph for the immediately preceding fiscal year that has not been obligated.

''(C) LIMITATIONS ON USE OF FUNDS.—

''(i) ALLOWABLE ACTIVITIES.—An entity to which funds are provided under this paragraph shall use the funds to move individuals into and keep individuals in lasting unsubsidized employment by means of any of the following:

''(I) The conduct and administration of community service or work experience programs.

''(II) Job creation through public or private sector employment wage subsidies.

''(III) On-the-job training.

''(IV) Contracts with public or private providers of readiness, placement, and post-employment services.

''(V) Job vouchers for placement, readiness, and postemployment services.

''(VI) Job retention or support services if such services are not otherwise available.

Contracts or vouchers for job placement services supported by such funds must require that at least ½ of the payment occur after an eligible individual placed into the workforce has been in the workforce for 6 months.

''(ii) REQUIRED BENEFICIARIES.—An entity that operates a project with funds provided under this paragraph shall expend at least 70 percent of all funds provided to the project for the benefit of recipients of assistance under the program funded under this part of the State in which the entity is located, or for the benefit of noncustodial parents of minors whose custodial parent is such a recipient, who meet the requirements of each of the following subclauses:

''(I) At least 2 of the following apply to the recipient:

''(aa) The individual has not completed secondary school or obtained a certificate of general equivalency, and has low skills in reading or mathematics.

''(bb) The individual requires substance abuse treatment for employment.

''(cc) The individual has a poor work history.

''(II) The individual—

''(aa) has received assistance under the State program funded under this part (whether in effect before or after the amendments made by section 103 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 first apply to the State) for at least 30 months (whether or not consecutive); or

''(bb) within 12 months, will become ineligible for assistance under the State program funded under this part by reason of a durational limit on such assistance, without regard to any exemption provided pursuant to section 408(a)(7)(C) that may apply to the individual.

''(iii) TARGETING OF INDIVIDUALS WITH CHARACTERISTICS ASSOCIATED WITH LONG-TERM WELFARE DEPENDENCE.—An entity that operates a project with funds provided under this paragraph may expend not more than 30 percent of all funds provided to the project for programs that provide assistance in a form described in clause (i)—

''(I) to recipients of assistance under the program funded under this part of the State in which the entity is located who have characteristics associated with long-term welfare dependence (such as school dropout, teen pregnancy, or poor work history), including, at the option of the State, by providing assistance in such form as a condition of receiving assistance under the State program funded under this part; or

''(II) to individuals—

''(aa) who are noncustodial parents of minors whose custodial parent is such a recipient; and

''(bb) who have such characteristics.

To the extent that the entity does not expend such funds in accordance with the preceding sentence, the entity shall expend such funds in accordance with clause (ii).

''(iv) AUTHORITY TO PROVIDE WORK-RELATED SERVICES TO INDIVIDUALS WHO HAVE REACHED THE 5 YEAR LIMIT.—An entity that operates a project with funds provided under this paragraph may use the funds to provide assistance in a form described in clause (i) of this subparagraph to, or for the benefit of, individuals who (but for section 408(a)(7)) would be eligible for assistance under the program funded under this part of the State in which the entity is located.

''(v) RELATIONSHIP TO OTHER PROVISIONS OF THIS PART.—

''(I) RULES GOVERNING USE OF FUNDS.—The rules of section 404, other than subsections (b), (f), and (h) of section 404, shall not apply to a grant made under this paragraph.

''(II) RULES GOVERNING PAYMENTS TO STATES.—The Secretary of Labor shall carry out the functions otherwise assigned by section 405 to the Secretary of Health and Human Services with respect to the grants payable under this paragraph.

''(III) ADMINISTRATION.—Section 416 shall not apply to the programs under this paragraph.

''(vi) PROHIBITION AGAINST USE OF GRANT FUNDS FOR ANY OTHER FUND MATCHING REQUIREMENT.—An entity to which funds are provided under this paragraph shall not use any part of the funds, nor any part of State expenditures made to match the funds, to fulfill any obligation of any State, political subdivision, or private industry council to contribute funds under section 403(b) or 418 or any other provision of this Act or other Federal law.

''(vii) DEADLINE FOR EXPENDITURE.—An entity to which funds are provided under this paragraph shall remit to the Secretary of Labor any part of the funds that are not expended within 3 years after the date the funds are so provided.

''(viii) REGULATIONS.—Within 90 days after the date of the enactment of this paragraph, the Secretary of Labor, after consultation with the Secretary of Health and Human Services and the Secretary of Housing and Urban Development, shall prescribe such regulations as may be necessary to implement this paragraph.

''(D) DEFINITIONS.—

''(i) INDIVIDUALS WITH INCOME LESS THAN THE POVERTY LINE.—For purposes of this paragraph, the number of individuals with an income that is less than the poverty line shall be determined for a fiscal year—

''(I) based on the methodology used by the Bureau of the Census to produce and publish intercensal poverty data for States and counties (or, in the case of Puerto Rico, the Virgin Islands, Guam, and American Samoa, other poverty data selected by the Secretary of Labor); and

''(II) using data for the most recent year for which such data is available before the beginning of the fiscal year.

''(ii) PRIVATE INDUSTRY COUNCIL.—As used in this paragraph, the term 'private industry council' means, with respect to a service delivery area, the private industry council (or successor entity) established for the service delivery area pursuant to the Job Training Partnership Act.

''(iii) SERVICE DELIVERY AREA.—As used in this paragraph, the term 'service delivery area' shall have the meaning given such term (or the successor to such term) for purposes of the Job Training Partnership Act.

''(E) SET-ASIDE FOR SUCCESSFUL PERFORMANCE BONUS.—

''(i) IN GENERAL.—The Secretary of Labor shall make a grant in accordance with this subparagraph to each successful performance State in fiscal year 2000.

''(ii) AMOUNT OF GRANT.—The Secretary of Labor shall determine the amount of the grant payable under this subparagraph to a successful performance State, which shall be based on the score assigned to the State under clause (iv)(I)(aa) for such prior period as the Secretary of Labor deems appropriate.

''(iii) FORMULA FOR MEASURING STATE PERFORMANCE.—Not later than 1 year after the date of the enactment of this paragraph, the Secretary of Labor, in consultation with the Secretary of Health and Human Services, the National Governors' Association, and the American Public Welfare Association, shall develop a formula for measuring—

''(I) the success of States in placing individuals in private sector employment or in any kind of employment, through programs operated with funds provided under subparagraph (A);

''(II) the duration of such placements;

''(III) any increase in the earnings of such individuals; and

''(IV) such other factors as the Secretary of Labor deems appropriate concerning the activities of the States with respect to such individuals.

The formula may take into account general economic conditions on a State-by-State basis.

''(iv) SCORING OF STATE PERFORMANCE; SETTING OF PERFORMANCE THRESHOLDS.—

''(I) IN GENERAL.—The Secretary of Labor shall—

''(aa) use the formula developed under clause (iii) to assign a score to each State that was a welfare-to-work State for fiscal years 1998 and 1999; and

''(bb) prescribe a performance threshold in such a manner so as to ensure that the total amount of grants to be made under this paragraph equals $100,000,000.

''(II) AVAILABILITY OF WELFARE-TO-WORK DATA SUBMITTED TO THE SECRETARY OF HHS.—The Secretary of Health and Human Services shall provide the Secretary of Labor with the data reported by States under this part with respect to programs operated with funds provided under subparagraph (A).

''(v) SUCCESSFUL PERFORMANCE STATE DEFINED.—As used in this subparagraph, the term 'successful performance State' means a State whose score assigned pursuant to clause (iv)(I)(aa) equals or exceeds the performance threshold prescribed under clause (iv)(I)(bb).

''(vi) SET-ASIDE.—$100,000,000 of the amount specified in subparagraph (I) for fiscal year 1999 shall be reserved for grants under this subparagraph.

''(F) FUNDING FOR INDIAN TRIBES.—1 percent of the amount specified in subparagraph (I) for fiscal year 1998 and of the amount so specified for fiscal year 1999 shall be reserved for grants to Indian tribes under section 412(a)(3).

''(G) FUNDING FOR EVALUATIONS OF WELFARE-TO-WORK PROGRAMS.—0.6 percent of the amount specified in subparagraph (I) for fiscal year 1998 and of the amount so specified for fiscal year 1999 shall be reserved for use by the Secretary to carry out section 413(j).

''(H) FUNDING FOR EVALUATION OF ABSTINENCE EDUCATION PROGRAMS.—

''(i) IN GENERAL.—0.2 percent of the amount specified in subparagraph (I) for fiscal year 1998 and of the amount so specified for fiscal year 1999 shall be reserved for use by the Secretary to evaluate programs under section 510, directly or through grants, contracts, or interagency agreements.

''(ii) AUTHORITY TO USE FUNDS FOR EVALUATIONS OF WELFARE-TO-WORK PROGRAMS.—Any such amount not required for such evaluations shall be available for use by the Secretary to carry out section 413(j).

''(iii) DEADLINE FOR OUTLAYS.—Outlays from funds used pursuant to clause (i) for evaluation of programs under section 510 shall not be made after fiscal year 2001.

''(I) APPROPRIATIONS.—

''(i) IN GENERAL.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $1,500,000,000 for each of fiscal years 1998 and 1999 for grants under this paragraph.

''(ii) AVAILABILITY.—The amounts made available pursuant to clause (i) shall remain available for such period as is necessary to make the grants provided for in this paragraph.

''(J) WORKER PROTECTIONS.—

''(i) NONDISPLACEMENT IN WORK ACTIVITIES.—

''(I) GENERAL PROHIBITION.—Subject to this clause, an adult in a family receiving assistance attributable to funds provided under this paragraph may fill a vacant employment position in order to engage in a work activity.

''(II) PROHIBITION AGAINST VIOLATION OF CONTRACTS.—A work activity engaged in under a program operated with funds provided under this paragraph shall not violate an existing contract for services or a collective bargaining agreement, and such a work activity that would violate a collective bargaining agreement shall not be undertaken without the written concurrence of the labor organization and employer concerned.

''(III) OTHER PROHIBITIONS.—An adult participant in a work activity engaged in under a program operated with funds provided under this paragraph shall not be employed or assigned—

''(aa) when any other individual is on layoff from the same or any substantially equivalent job;

''(bb) if the employer has terminated the employment of any regular employee or otherwise caused an involuntary reduction in its workforce with the intention of filling the vacancy so created with the participant; or

''(cc) if the employer has caused an involuntary reduction to less than full time in hours of any employee in the same or a substantially equivalent job.

''(ii) HEALTH AND SAFETY.—Health and safety standards established under Federal and State law otherwise applicable to working conditions of employees shall be equally applicable to working conditions of other participants engaged in a work activity under a program operated with funds provided under this paragraph.

''(iii) NONDISCRIMINATION.—In addition to the protections provided under the provisions of law specified in section 408(c), an individual may not be discriminated against by reason of gender with respect to participation in work activities engaged in under a program operated with funds provided under this paragraph.

''(iv) GRIEVANCE PROCEDURE.—

''(I) IN GENERAL.—Each State to which a grant is made under this paragraph shall establish and maintain a procedure for grievances or complaints from employees alleging violations of clause (i) and participants in work activities alleging violations of clause (i), (ii), or (iii).

''(II) HEARING.—The procedure shall include an opportunity for a hearing.

''(III) REMEDIES.—The procedure shall include remedies for violation of clause (i), (ii), or (iii), which may continue during the pendency of the procedure, and which may include—

''(aa) suspension or termination of payments from funds provided under this paragraph;

''(bb) prohibition of placement of a participant with an employer that has violated clause (i), (ii), or (iii);

''(cc) where applicable, reinstatement of an employee, payment of lost wages and benefits, and reestablishment of other relevant terms, conditions and privileges of employment; and

''(dd) where appropriate, other equitable relief.

''(IV) APPEALS.—

''(aa) FILING.—Not later than 30 days after a grievant or complainant receives an adverse decision under the procedure established pursuant to subclause (I), the grievant or complainant may appeal the decision to a State agency designated by the State which shall be independent of the State or local agency that is administering the programs operated with funds provided under this paragraph and the State agency administering, or supervising the administration of, the State program funded under this part.

''(bb) FINAL DETERMINATION.—Not later than 120 days after the State agency designated under item (aa) receives a grievance or complaint made under the procedure established by a State pursuant to subclause (I), the State agency shall make a final determination on the appeal.

''(v) RULE OF INTERPRETATION.—This subparagraph shall not be construed to affect the authority of a State to provide or require workers' compensation.

''(vi) NONPREEMPTION OF STATE LAW.—The provisions of this subparagraph shall not be construed to preempt any provision of State law that affords greater protections to employees or to other participants engaged in work activities under a program funded under this part than is afforded by such provisions of this subparagraph.''.

(2) CONFORMING AMENDMENT.—Section 409(a)(7)(B)(iv) of such Act (42 U.S.C. 609(a)(7)(B)(iv)) is amended to read as follows:

''(iv) EXPENDITURES BY THE STATE.—The term 'expenditures by the State' does not include—

''(I) any expenditure from amounts made available by the Federal Government;

''(II) any State funds expended for the medicaid program under title XIX;

''(III) any State funds which are used to match Federal funds provided under section 403(a)(5); or

''(IV) any State funds which are expended as a condition of receiving Federal funds other than under this part.

Notwithstanding subclause (IV) of the preceding sentence, such term includes expenditures by a State for child care in a fiscal year to the extent that the total amount of the expenditures does not exceed the amount of State expenditures in fiscal year 1994 or 1995 (whichever is the greater) that equal the non-Federal share for the programs described in section 418(a)(1)(A).''.

(b) GRANTS TO OUTLYING AREAS.—Section 1108(a)(2) (42 U.S.C. 1308(a)(2)), as amended by section 5512(a) of this Act, is amended by inserting ''403(a)(5),'' after ''403(a)(4),''.

(c) GRANTS TO INDIAN TRIBES.—Section 412(a) (42 U.S.C. 612(a)) is amended by adding at the end the following:

''(3) WELFARE-TO-WORK GRANTS.—

''(A) IN GENERAL.—The Secretary of Labor shall award a grant in accordance with this paragraph to an Indian tribe for each fiscal year specified in section 403(a)(5)(I) for which the Indian tribe is a welfare-to-work tribe, in such amount as the Secretary of Labor deems appropriate, subject to subparagraph (B) of this paragraph.

''(B) WELFARE-TO-WORK TRIBE.—An Indian tribe shall be considered a welfare-to-work tribe for a fiscal year for purposes of this paragraph if the Indian tribe meets the following requirements:

''(i) The Indian tribe has submitted to the Secretary of Labor a plan which describes how, consistent with section 403(a)(5), the Indian tribe will use any funds provided under this paragraph during the fiscal year. If the Indian tribe has a tribal family assistance plan, the plan referred to in the preceding sentence shall be in the form of an addendum to the tribal family assistance plan.

''(ii) The Indian tribe is operating a program under a tribal family assistance plan approved by the Secretary of Health and Human Services, a program described in paragraph (2)(C), or an employment program funded through other sources under which substantial services are provided to recipients of assistance under a program funded under this part.

''(iii) The Indian tribe has provided the Secretary of Labor with an estimate of the amount that the Indian tribe intends to expend during the fiscal year (excluding tribal expenditures described in section 409(a)(7)(B)(iv) (other than subclause (III) thereof)) pursuant to this paragraph.

''(iv) The Indian tribe has agreed to negotiate in good faith with the Secretary of Health and Human Services with respect to the substance and funding of any evaluation under section 413(j), and to cooperate with the conduct of any such evaluation.

''(C) LIMITATIONS ON USE OF FUNDS.—

''(i) IN GENERAL.—Section 403(a)(5)(C) shall apply to funds provided to Indian tribes under this paragraph in the same manner in which such section applies to funds provided under section 403(a)(5).

''(ii) WAIVER AUTHORITY.—The Secretary of Labor may waive or modify the application of a provision of section 403(a)(5)(C) (other than clause (vii) thereof) with respect to an Indian tribe to the extent necessary to enable the Indian tribe to operate a more efficient or effective program with the funds provided under this paragraph.

''(iii) REGULATIONS.—Within 90 days after the date of the enactment of this paragraph, the Secretary of Labor, after consultation with the Secretary of Health and Human Services and the Secretary of Housing and Urban Development, shall prescribe such regulations as may be necessary to implement this paragraph.''.

(d) FUNDS RECEIVED FROM GRANTS TO BE DISREGARDED IN APPLYING DURATIONAL LIMIT ON ASSISTANCE.—Section 408(a)(7) (42 U.S.C. 608(a)(7)) is amended by adding at the end the following:

''(G) INAPPLICABILITY TO WELFARE-TO-WORK GRANTS AND ASSISTANCE.—For purposes of subparagraph (A) of this paragraph, a grant made under section 403(a)(5) shall not be considered a grant made under section 403, and noncash assistance from funds provided under section 403(a)(5) shall not be considered assistance.''.

(e) DATA COLLECTION AND REPORTING.—Section 411(a) (42 U.S.C. 611(a)(1)(A)), as amended by section 5507 of this Act, is amended—

(1) in paragraph (1)(A), by adding at the end the following:

''(xviii) With respect to families participating in a program operated with funds provided under section 403(a)(5)—

''(I) any activity described in section 403(a)(5)(C)(i) engaged in by a family member;

''(II) the total amount expended during the month on the family member for each such activity;

''(III) if the family member is engaged in subsidized employment or on-the-job training under the program, the wage paid to the family member and the amount of any wage subsidy provided to the family member from Federal or State funds; and

''(IV) if the participation of a family member in the program was ended during a month due to the family member obtaining employment, the wage of the family member in the employment and whether the participation was ended due to the family member obtaining unsubsidized employment, obtaining subsidized employment, receiving an increased wage, engaging in a work training activity funded under a program funded other than under section 403(a)(5), or for other reasons.'';

(2) in paragraph (2), by inserting '', with a separate statement of the percentage of such funds that are used to cover administrative costs or overhead incurred for programs operated with funds provided under section 403(a)(5)'' before the period;

(3) in paragraph (3), by inserting '', with a separate statement of the total amount expended by the State during the quarter on programs operated with funds provided under section 403(a)(5)'' before the period;

(4) in paragraph (4), by inserting '', with a separate statement of the number of such parents who participated in programs operated with funds provided under section 403(a)(5)'' before the period;

(5) in paragraph (6)—

(A) by striking ''and'' at the end of subparagraph (A);

(B) by striking the period at the end of subparagraph (B) and inserting ''; and''; and

(C) by adding at the end the following:

''(C) with respect to families and individuals participating in a program operated with funds provided under section 403(a)(5)—

''(i) the total number of such families and individuals; and

''(ii) the number of such families and individuals whose participation in such a program was terminated during a month.'' and

(6) in paragraph (7), by inserting '', and shall consult with the Secretary of Labor in defining the data elements with respect to programs operated with funds provided under section 403(a)(5)'' before the period.

(f) EVALUATIONS.—Section 413 (42 U.S.C. 613) is amended by adding at the end the following:

''(j) EVALUATION OF WELFARE-TO-WORK PROGRAMS.—

''(1) EVALUATION.—The Secretary, in consultation with the Secretary of Labor and the Secretary of Housing and Urban Development—

''(A) shall develop a plan to evaluate how grants made under sections 403(a)(5) and 412(a)(3) have been used;

''(B) may evaluate the use of such grants by such grantees as the Secretary deems appropriate, in accordance with an agreement entered into with the grantees after good-faith negotiations; and

''(C) is urged to include the following outcome measures in the plan developed under subparagraph (A):

''(i) Placements in unsubsidized employment, and placements in unsubsidized employment that last for at least 6 months.

''(ii) Placements in the private and public sectors.

''(iii) Earnings of individuals who obtain employment.

''(iv) Average expenditures per placement.

''(2) REPORTS TO THE CONGRESS.—

''(A) IN GENERAL.—Subject to subparagraphs (B) and (C), the Secretary, in consultation with the Secretary of Labor and the Secretary of Housing and Urban Development, shall submit to the Congress reports on the projects funded under section 403(a)(5) and 412(a)(3) and on the evaluations of the projects.

''(B) INTERIM REPORT.—Not later than January 1, 1999, the Secretary shall submit an interim report on the matter described in subparagraph (A).

''(C) FINAL REPORT.—Not later than January 1, 2001, (or at a later date, if the Secretary informs the Committees of the Congress with jurisdiction over the subject matter of the report) the Secretary shall submit a final report on the matter described in subparagraph (A).''.

(g) PENALTIES.—

(1) PENALTY FOR FAILURE OF STATE TO MAINTAIN HISTORIC EFFORT DURING YEAR IN WHICH WELFARE-TO-WORK GRANT IS RECEIVED.—

(A) IN GENERAL.—Section 409(a) (42 U.S.C. 609(a)) is amended by adding at the end the following:

''(13) PENALTY FOR FAILURE OF STATE TO MAINTAIN HISTORIC EFFORT DURING YEAR IN WHICH WELFARE-TO-WORK GRANT IS RECEIVED.—If a grant is made to a State under section 403(a)(5)(A) for a fiscal year and paragraph (7) of this subsection requires the grant payable to the State under section 403(a)(1) to be reduced for the immediately succeeding fiscal year, then the Secretary shall reduce the grant payable to the State under section 403(a)(1) for such succeeding fiscal year by the amount of the grant made to the State under section 403(a)(5)(A) for the fiscal year.''.

(B) INAPPLICABILITY OF GOOD CAUSE EXCEPTION.—Section 409(b)(2) of such Act (42 U.S.C. 609(b)(2)), as amended by section 5506(k) of this Act, is amended by striking ''or (12)'' and inserting ''(12), or (13)''.

(C) INAPPLICABILITY OF CORRECTIVE COMPLIANCE PLAN.—Section 409(c)(4) of such Act (42 U.S.C. 609(c)(4)), as amended by section 5506(m) of this Act, is amended by striking ''or (12)'' and inserting ''(12), or (13)''.

(2) PENALTY FOR MISUSE OF COMPETITIVE WELFARE-TO-WORK FUNDS.—Section 409(a)(1) of such Act (42 U.S.C. 609(a)(1)) is amended by adding at the end the following:

''(C) PENALTY FOR MISUSE OF COMPETITIVE WELFARE-TO-WORK FUNDS.—If the Secretary of Labor finds that an amount paid to an entity under section 403(a)(5)(B) has been used in violation of subparagraph (B) or (C) of section 403(a)(5), the entity shall remit to the Secretary of Labor an amount equal to the amount so used.''.

(h) CLARIFICATION THAT SANCTIONS AGAINST RECIPIENTS UNDER TANF PROGRAM ARE NOT WAGE REDUCTIONS.—

(1) IN GENERAL.—Section 408 (42 U.S.C. 608) is amended—

(A) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(B) by inserting after subsection (b) the following:

''(c) SANCTIONS AGAINST RECIPIENTS NOT CONSIDERED WAGE REDUCTIONS.—A penalty imposed by a State against the family of an individual by reason of the failure of the individual to comply with a requirement under the State program funded under this part shall not be construed to be a reduction in any wage paid to the individual.''.

(2) RETROACTIVITY.—The amendments made by paragraph (1) shall take effect as if included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

(i) GAO STUDY OF EFFECT OF FAMILY VIOLENCE ON NEED FOR PUBLIC ASSISTANCE.—

(1) STUDY.—The Comptroller General shall conduct a study of the effect of family violence on the use of public assistance programs, and in particular the extent to which family violence prolongs or increases the need for public assistance.

(2) REPORT.—Within 1 year after the date of the enactment of this Act, the Comptroller General shall submit to the Committees on Ways and Means and Education and the Workforce of the House of Representatives and the Committee on Finance of the Senate a report that contains the findings of the study required by paragraph (1).

**SEC. 5002. LIMITATION ON AMOUNT OF FEDERAL FUNDS TRANSFERABLE TO TITLE XX PROGRAMS.**

(a) IN GENERAL.—Section 404(d) (42 U.S.C. 604(d)) is amended—

(1) in paragraph (1), by striking ''A State may'' and inserting ''Subject to paragraph (2), a State may''; and

(2) by amending paragraph (2) to read as follows:

''(2) LIMITATION ON AMOUNT TRANSFERABLE TO TITLE XX PROGRAMS.—A State may use not more than 10 percent of the amount of any grant made to the State under section 403(a) for a fiscal year to carry out State programs pursuant to title XX.''.

(b) RETROACTIVITY.—The amendments made by subsection (a) of this section shall take effect as if included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

**SEC. 5003. LIMITATION ON NUMBER OF PERSONS WHO MAY BE TREATED AS ENGAGED IN WORK BY REASON OF PARTICIPATION IN EDUCATIONAL ACTIVITIES.**

(a) IN GENERAL.—Section 407(c)(2)(D) (42 U.S.C. 607(c)(2)(D)) is amended to read as follows:

''(D) LIMITATION ON NUMBER OF PERSONS WHO MAY BE TREATED AS ENGAGED IN WORK BY REASON OF PARTICIPATION IN EDUCATIONAL ACTIVITIES.—For purposes of determining monthly participation rates under paragraphs (1)(B)(i) and (2)(B) of subsection (b), not more than 30 percent of the number of individuals in all families and in 2-parent families, respectively, in a State who are treated as engaged in work for a month may consist of individuals who are determined to be engaged in work for the month by reason of participation in vocational educational training, or (if the month is in fiscal year 2000 or thereafter) deemed to be engaged in work for the month by reason of subparagraph (C) of this paragraph.''.

(b) RETROACTIVITY.—The amendment made by subsection (a) of this section shall take effect as if included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

**SEC. 5004. PENALTY FOR FAILURE OF STATE TO REDUCE ASSISTANCE FOR RECIPIENTS REFUSING WITHOUT GOOD CAUSE TO WORK.**

(a) IN GENERAL.—Section 409(a) (42 U.S.C. 609(a)), as amended by section 5001(f)(1)(A) of this Act, is amended by adding at the end the following:

''(14) PENALTY FOR FAILURE TO REDUCE ASSISTANCE FOR RECIPIENTS REFUSING WITHOUT GOOD CAUSE TO WORK.—

''(A) IN GENERAL.—If the Secretary determines that a State to which a grant is made under section 403 in a fiscal year has violated section 407(e) during the fiscal year, the Secretary shall reduce the grant payable to the State under section 403(a)(1) for the immediately succeeding fiscal year by an amount equal to not less than 1 percent and not more than 5 percent of the State family assistance grant.

''(B) PENALTY BASED ON SEVERITY OF FAILURE.—The Secretary shall impose reductions

under subparagraph (A) with respect to a fiscal year based on the degree of noncompliance.''.

(b) RETROACTIVITY.—The amendment made by subsection (a) of this section shall take effect as if included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

**Subtitle B—Supplemental Security Income**

**SEC. 5101. EXTENSION OF DEADLINE TO PERFORM CHILDHOOD DISABILITY REDETERMINATIONS.**

Section 211(d)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2190) is amended—

(1) in subparagraph (A)—

(A) in the 1st sentence, by striking ''1 year'' and inserting ''18 months''; and

(B) by inserting after the 1st sentence the following: ''Any redetermination required by the preceding sentence that is not performed before the end of the period described in the preceding sentence shall be performed as soon as is practicable thereafter.''; and

(2) in subparagraph (C), by adding at the end the following: ''Before commencing a redetermination under the 2nd sentence of subparagraph (A), in any case in which the individual involved has not already been notified of the provisions of this paragraph, the Commissioner of Social Security shall notify the individual involved of the provisions of this paragraph.''.

**SEC. 5102. FEES FOR FEDERAL ADMINISTRATION OF STATE SUPPLEMENTARY PAYMENTS.**

(a) FEE SCHEDULE.—

(1) OPTIONAL STATE SUPPLEMENTARY PAYMENTS.—

(A) IN GENERAL.—Section 1616(d)(2)(B) (42 U.S.C. 1382e(d)(2)(B)) is amended—

(i) by striking ''and'' at the end of clause (iii); and

(ii) by striking clause (iv) and inserting the following:

''(iv) for fiscal year 1997, $5.00;

''(v) for fiscal year 1998, $6.20;

''(vi) for fiscal year 1999, $7.60;

''(vii) for fiscal year 2000, $7.80;

''(viii) for fiscal year 2001, $8.10;

''(ix) for fiscal year 2002, $8.50; and

''(x) for fiscal year 2003 and each succeeding fiscal year—

''(I) the applicable rate in the preceding fiscal year, increased by the percentage, if any, by which the Consumer Price Index for the month of June of the calendar year of the increase exceeds the Consumer Price Index for the month of June of the calendar year preceding the calendar year of the increase, and rounded to the nearest whole cent; or

''(II) such different rate as the Commissioner determines is appropriate for the State.''.

(B) CONFORMING AMENDMENT.—Section 1616(d)(2)(C) of such Act (42 U.S.C. 1382e(d)(2)(C)) is amended by striking ''(B)(iv)'' and inserting ''(B)(x)(II)''.

(2) MANDATORY STATE SUPPLEMENTARY PAYMENTS.—

(A) IN GENERAL.—Section 212(b)(3)(B)(ii) of Public Law 93–66 (42 U.S.C. 1382 note) is amended—

(i) by striking ''and'' at the end of subclause (III); and

(ii) by striking subclause (IV) and inserting the following:

''(IV) for fiscal year 1997, $5.00;

''(V) for fiscal year 1998, $6.20;

''(VI) for fiscal year 1999, $7.60;

''(VII) for fiscal year 2000, $7.80;

''(VIII) for fiscal year 2001, $8.10;

''(IX) for fiscal year 2002, $8.50; and

''(X) for fiscal year 2003 and each succeeding fiscal year—

''(aa) the applicable rate in the preceding fiscal year, increased by the percentage, if any, by which the Consumer Price Index for the month of June of the calendar year of the increase exceeds the Consumer Price Index for the month of June of the calendar year preceding the calendar year of the increase, and rounded to the nearest whole cent; or

''(bb) such different rate as the Commissioner determines is appropriate for the State.''.

(B) CONFORMING AMENDMENT.—Section 212(b)(3)(B)(iii) of such Act (42 U.S.C. 1382 note) is amended by striking ''(ii)(IV)'' and inserting ''(ii)(X)(bb)''.

(b) USE OF NEW FEES TO DEFRAY THE SOCIAL SECURITY ADMINISTRATION'S ADMINISTRATIVE EXPENSES.—

(1) CREDIT TO SPECIAL FUND FOR FISCAL YEAR 1998 AND SUBSEQUENT YEARS.—

(A) OPTIONAL STATE SUPPLEMENTARY PAYMENT FEES.—Section 1616(d)(4) (42 U.S.C. 1382e(d)(4)) is amended to read as follows:

''(4)(A) The first $5 of each administration fee assessed pursuant to paragraph (2), upon collection, shall be deposited in the general fund of the Treasury of the United States as miscellaneous receipts.

''(B) That portion of each administration fee in excess of $5, and 100 percent of each additional services fee charged pursuant to paragraph (3), upon collection for fiscal year 1998 and each subsequent fiscal year, shall be credited to a special fund established in the Treasury of the United States for State supplementary payment fees. The amounts so credited, to the extent and in the amounts provided in advance in appropriations Acts, shall be available to defray expenses incurred in carrying out this title and related laws. The amounts so credited shall not be scored as receipts under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985, and the amounts so credited shall be credited as a discretionary offset to discretionary spending to the extent that the amounts so credited are made available for expenditure in appropriations Acts.''.

(B) MANDATORY STATE SUPPLEMENTARY PAYMENT FEES.—Section 212(b)(3)(D) of Public Law 93–66 (42 U.S.C. 1382 note) is amended to read as follows:

''(D)(i) The first $5 of each administration fee assessed pursuant to subparagraph (B), upon collection, shall be deposited in the general fund of the Treasury of the United States as miscellaneous receipts.

''(ii) The portion of each administration fee in excess of $5, and 100 percent of each additional services fee charged pursuant to subparagraph (C), upon collection for fiscal year 1998 and each subsequent fiscal year, shall be credited to a special fund established in the Treasury of the United States for State supplementary payment fees. The amounts so credited, to the extent and in the amounts provided in advance in appropriations Acts, shall be available to defray expenses incurred in carrying out this section and title XVI of the Social Security Act and related laws. The amounts so credited shall not be scored as receipts under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985, and the amounts so credited shall be credited as a discretionary offset to discretionary spending to the extent that the amounts so credited are made available for expenditure in appropriations Acts.''.

(2) LIMITATIONS ON AUTHORIZATION OF APPROPRIATIONS.—From amounts credited pursuant to section 1616(d)(4)(B) of the Social Security Act and section 212(b)(3)(D)(ii) of Public Law 93–66 to the special fund established in the Treasury of the United States for State supplementary payment fees, there is authorized to be appropriated an amount not to exceed $35,000,000 for fiscal year 1998, and such sums as may be necessary for each fiscal year thereafter.

**Subtitle C—Child Support Enforcement**

**SEC. 5201. CLARIFICATION OF AUTHORITY TO PERMIT CERTAIN REDISCLOSURES OF WAGE AND CLAIM INFORMATION.**

Section 303(h)(1)(C) (42 U.S.C. 503(h)(1)(C)) is amended by striking ''section 453(i)(1) in carrying out the child support enforcement program under title IV'' and inserting ''subsections (i)(1), (i)(3), and (j) of section 453''.

**Subtitle D—Restricting Welfare and Public Benefits for Aliens**

**SEC. 5301. SSI ELIGIBILITY FOR ALIENS RECEIVING SSI ON AUGUST 22, 1996 AND DISABLED ALIENS LAWFULLY RESIDING IN THE UNITED STATES ON AUGUST 22, 1996.**

(a) SSI ELIGIBILITY FOR ALIENS RECEIVING SSI ON AUGUST 22, 1996.—Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) is amended by adding after subparagraph (D) the following new subparagraph:

''(E) ALIENS RECEIVING SSI ON AUGUST 22, 1996.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply to an alien who is lawfully residing in the United States and who was receiving such benefits on August 22, 1996.''.

(b) SSI ELIGIBILITY FOR DISABLED ALIENS LAWFULLY RESIDING IN THE UNITED STATES ON AUGUST 22, 1996.—Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) is amended by adding at the end the following:

''(F) DISABLED ALIENS LAWFULLY RESIDING IN THE UNITED STATES ON AUGUST 22, 1996.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply to an alien who—

''(i) was lawfully residing in the United States on August 22, 1996; and

''(ii) is blind or disabled, as defined in section 1614(a)(2) or 1614(a)(3) of the Social Security Act (42 U.S.C. 1382c(a)(3)).''.

(c) EXTENSION OF GRANDFATHER PROVISION RELATING TO SSI ELIGIBILITY.—Section 402(a)(2)(D)(i) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(D)(i)) is amended—

(1) in subclause (I), by striking ''September 30, 1997,'' and inserting ''September 30, 1998,''; and

(2) in subclause (III), by striking ''September 30, 1997,'' and inserting ''September 30, 1998''.

**SEC. 5302. EXTENSION OF ELIGIBILITY PERIOD FOR REFUGEES AND CERTAIN OTHER QUALIFIED ALIENS FROM 5 TO 7 YEARS FOR SSI AND MEDICAID; STATUS OF CUBAN AND HAITIAN ENTRANTS.**

(a) SSI.—Section 402(a)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A)) is amended to read as follows:

''(A) TIME-LIMITED EXCEPTION FOR REFUGEES AND ASYLEES.—

''(i) SSI.—With respect to the specified Federal program described in paragraph (3)(A), paragraph (1) shall not apply to an alien until 7 years after the date—

''(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

''(II) an alien is granted asylum under section 208 of such Act;

''(III) an alien's deportation is withheld under section 243(h) of such Act; or

''(IV) an alien is granted status as a Cuban and Haitian entrant (as defined in section

501(e) of the Refugee Education Assistance Act of 1980).

''(ii) FOOD STAMPS.—With respect to the specified Federal program described in paragraph (3)(B), paragraph (1) shall not apply to an alien until 5 years after the date—

''(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

''(II) an alien is granted asylum under section 208 of such Act;

''(III) an alien's deportation is withheld under section 243(h) of such Act; or

''(IV) an alien is granted status as a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980).''.

(b) MEDICAID.—Section 402(b)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)(A)) is amended to read as follows:

''(A) TIME-LIMITED EXCEPTION FOR REFUGEES AND ASYLEES.—

''(i) MEDICAID.—With respect to the designated Federal program described in paragraph (3)(C), paragraph (1) shall not apply to an alien until 7 years after the date—

''(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

''(II) an alien is granted asylum under section 208 of such Act;

''(III) an alien's deportation is withheld under section 243(h) of such Act; or

''(IV) an alien is granted status as a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980).

''(ii) OTHER DESIGNATED FEDERAL PROGRAMS.—With respect to the designated Federal programs under paragraph (3) (other than subparagraph (C)), paragraph (1) shall not apply to an alien until 5 years after the date—

''(I) an alien is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

''(II) an alien is granted asylum under section 208 of such Act;

''(III) an alien's deportation is withheld under section 243(h) of such Act; or

''(IV) an alien is granted status as a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980).''.

(c) STATUS OF CUBAN AND HAITIAN ENTRANTS.—

(1) FEDERAL MEANS-TESTED PUBLIC BENEFITS.—

(A) Section 403(b)(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613(b)(1)) is amended by adding at the end the following new subparagraph:

''(D) An alien who is a Cuban and Haitian entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980.''.

(B) Section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613) is amended by striking subsection (d).

(2) STATE PUBLIC BENEFITS.—Section 412(b)(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1622(b)(1)) is amended by adding at the end the following new subparagraph:

''(D) An alien who is a Cuban and Haitian entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980 until 5 years after the alien is granted such status.''.

(3) QUALIFIED ALIEN DEFINED.—Section 431(b) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641(b)) is amended—

(A) in paragraph (5) by striking ''or'';

(B) in paragraph (6) by striking the period and inserting ''; or''; and

(C) by adding at the end the following new paragraph:

''(7) an alien who is a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980).''.

**SEC. 5303. EXCEPTIONS FOR CERTAIN INDIANS FROM LIMITATION ON ELIGIBILITY FOR SUPPLEMENTAL SECURITY INCOME AND MEDICAID BENEFITS.**

(a) EXCEPTION FROM LIMITATION ON SSI ELIGIBILITY.—Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) is amended by adding at the end the following:

''(G) SSI EXCEPTION FOR CERTAIN INDIANS.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), section 401(a) and paragraph (1) shall not apply to any individual—

''(i) who is an American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (8 U.S.C. 1359) apply; or

''(ii) who is a member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e))).''.

(b) EXCEPTION FROM LIMITATION ON MEDICAID ELIGIBILITY.—Section 402(b)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)) is amended by inserting at the end the following:

''(E) MEDICAID EXCEPTION FOR CERTAIN INDIANS.—With respect to eligibility for benefits for the program defined in paragraph (3)(C) (relating to the medicaid program), section 401(a) and paragraph (1) shall not apply to any individual described in subsection (a)(2)(G).''.

(c) SSI AND MEDICAID EXCEPTIONS FROM LIMITATION ON ELIGIBILITY OF NEW ENTRANTS.—Section 403 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613) is amended by adding after subsection (c) the following new subsection:

''(d) SSI AND MEDICAID BENEFITS FOR CERTAIN INDIANS.—Notwithstanding any other provision of law, the limitations under section 401(a) and subsection (a) shall not apply to an individual described in section 402(a)(2)(G), but only with respect to the programs specified in subsections (a)(3)(A) and (b)(3)(C) of section 402.''.

**SEC. 5304. EXEMPTION FROM RESTRICTION ON SUPPLEMENTAL SECURITY INCOME PROGRAM PARTICIPATION BY CERTAIN RECIPIENTS ELIGIBLE ON THE BASIS OF VERY OLD APPLICATIONS.**

Section 402(a)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)) is amended by adding at the end the following:

''(H) SSI EXCEPTION FOR CERTAIN RECIPIENTS ON THE BASIS OF VERY OLD APPLICATIONS.—With respect to eligibility for benefits for the program defined in paragraph (3)(A) (relating to the supplemental security income program), paragraph (1) shall not apply to any individual—

''(i) who is receiving benefits under such program for months after July 1996 on the basis of an application filed before January 1, 1979; and

''(ii) with respect to whom the Commissioner of Social Security lacks clear and convincing evidence that such individual is an alien ineligible for such benefits as a result of the application of this section.''.

**SEC. 5305. REINSTATEMENT OF ELIGIBILITY FOR BENEFITS.**

(a) FOOD STAMPS.—The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is amended by adding after section 435 the following new section:

**''SEC. 436. DERIVATIVE ELIGIBILITY FOR BENEFITS.**

''Notwithstanding any other provision of law, an alien who under the provisions of this title is ineligible for benefits under the food stamp program (as defined in section 402(a)(3)(B)) shall not be eligible for such benefits because the alien receives benefits under the supplemental security income program (as defined in section 402(a)(3)(A)).''.

(b) MEDICAID.—Section 402(b)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)) is amended by adding at the end the following:

''(F) MEDICAID EXCEPTION FOR ALIENS RECEIVING SSI.—An alien who is receiving benefits under the program defined in subsection (a)(3)(A) (relating to the supplemental security income program) shall be eligible for medical assistance under a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) under the same terms and conditions that apply to other recipients of benefits under the program defined in such subsection.''.

(c) CLERICAL AMENDMENT.—The table of sections as contained in section 2 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is amended by adding after the item relating to section 435 the following:

''Sec. 436. Derivative eligibility for benefits.''.

**SEC. 5306. TREATMENT OF CERTAIN AMERASIAN IMMIGRANTS AS REFUGEES.**

(a) FOR PURPOSES OF SSI AND FOOD STAMPS.—Section 402(a)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A)) as amended by section 5302 is amended—

(1) in clause (i)—

(A) by striking ''or'' at the end of subclause (III);

(B) by striking the period at the end of subclause (IV) and inserting ''; or''; and

(C) by adding at the end the following:

''(V) an alien is admitted to the United States as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988 (as contained in section 101(e) of Public Law 100–202 and amended by the 9th proviso under MIGRATION AND REFUGEE ASSISTANCE in title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1989, Public Law 100–461, as amended).''; and

(2) in clause (ii)—

(A) by striking ''or'' at the end of subclause (III);

(B) by striking the period at the end of subclause (IV) and inserting ''; or''; and

(C) by adding at the end the following:

''(V) an alien is admitted to the United States as an Amerasian immigrant as described in clause (i)(V).''.

(b) FOR PURPOSES OF TANF, SSBG, AND MEDICAID.—Section 402(b)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(b)(2)(A)) as amended by section 5302 is amended—

(1) in clause (i)—

(A) by striking ''or'' at the end of subclause (III);

(B) by striking the period at the end of subclause (IV) and inserting ''; or''; and

(C) by adding at the end the following:

''(V) an alien admitted to the United States as an Amerasian immigrant as described in subsection (a)(2)(A)(i)(V) until 5 years after the date of such alien's entry into the United States.''; and

(2) in clause (ii)—

(A) by striking ''or'' at the end of subclause (III);

(B) by striking the period at the end of subclause (IV) and inserting ''; or''; and

(C) by adding at the end the following:

''(V) an alien admitted to the United States as an Amerasian immigrant as described in subsection (a)(2)(A)(i)(V) until 5 years after the date of such alien's entry into the United States.''.

(c) FOR PURPOSES OF EXCEPTION FROM 5-YEAR LIMITED ELIGIBILITY OF QUALIFIED ALIENS.—Section 403(b)(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1613(b)(1)) is amended by adding at the end the following:

''(E) An alien admitted to the United States as an Amerasian immigrant as described in section 402(a)(2)(A)(i)(V).''.

(d) FOR PURPOSES OF CERTAIN STATE PROGRAMS.—Section 412(b)(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1622(b)(1)) is amended by adding at the end the following new subparagraph:

''(E) An alien admitted to the United States as an Amerasian immigrant as described in section 402(a)(2)(A)(i)(V).''.

**SEC. 5307. VERIFICATION OF ELIGIBILITY FOR STATE AND LOCAL PUBLIC BENEFITS.**

(a) IN GENERAL.—The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is amended by adding after section 412 the following new section:

**''SEC. 413. AUTHORIZATION FOR VERIFICATION OF ELIGIBILITY FOR STATE AND LOCAL PUBLIC BENEFITS.**

''A State or political subdivision of a State is authorized to require an applicant for State and local public benefits (as defined in section 411(c)) to provide proof of eligibility.''.

(b) CLERICAL AMENDMENT.—The table of sections as contained in section 2 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is amended by adding after the item relating to section 412 the following:

''Sec. 413. Authorization for verification of eligibility for state and local public benefits.''.

**SEC. 5308. EFFECTIVE DATE.**

Except as otherwise provided, the amendments made by this subtitle shall be effective as if included in the enactment of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

## Subtitle E—Unemployment Compensation

**SEC. 5401. CLARIFYING PROVISION RELATING TO BASE PERIODS.**

(a) IN GENERAL.—No provision of a State law under which the base period for such State is defined or otherwise determined shall, for purposes of section 303(a)(1) of the Social Security Act (42 U.S.C. 503(a)(1)), be considered a provision for a method of administration.

(b) DEFINITIONS.—For purposes of this section, the terms ''State law'', ''base period'', and ''State'' shall have the meanings given them under section 205 of the Federal-State Extended Unemployment Compensation Act of 1970 (26 U.S.C. 3304 note).

(c) EFFECTIVE DATE.—This section shall apply for purposes of any period beginning before, on, or after the date of the enactment of this Act.

**SEC. 5402. INCREASE IN FEDERAL UNEMPLOYMENT ACCOUNT CEILING.**

(a) IN GENERAL.—Section 902(a)(2) (42 U.S.C. 1102(a)(2)) is amended by striking ''0.25 percent'' and inserting ''0.5 percent''.

(b) EFFECTIVE DATE.—This section and the amendment made by this section—

(1) shall take effect on October 1, 2001, and

(2) shall apply to fiscal years beginning on or after that date.

**SEC. 5403. SPECIAL DISTRIBUTION TO STATES FROM UNEMPLOYMENT TRUST FUND.**

(a) IN GENERAL.—Subsection (a) of section 903 (42 U.S.C. 1103(a)) is amended by adding at the end the following new paragraph:

''(3)(A) Notwithstanding any other provision of this section, for purposes of carrying out this subsection with respect to any excess amount (referred to in paragraph (1)) remaining in the employment security administration account as of the close of fiscal year 1999, 2000, or 2001, such amount shall—

''(i) to the extent of any amounts not in excess of $100,000,000, be subject to subparagraph (B), and

''(ii) to the extent of any amounts in excess of $100,000,000, be subject to subparagraph (C).

''(B) Paragraphs (1) and (2) shall apply with respect to any amounts described in subparagraph (A)(i), except that—

''(i) in carrying out the provisions of paragraph (2)(B) with respect to such amounts (to determine the portion of such amounts which is to be allocated to a State for a succeeding fiscal year), the ratio to be applied under such provisions shall be the same as the ratio that—

''(I) the amount of funds to be allocated to such State for such fiscal year pursuant to the base allocation formula under title III, bears to

''(II) the total amount of funds to be allocated to all States for such fiscal year pursuant to the base allocation formula under title III,

as determined by the Secretary of Labor, and

''(ii) the amounts allocated to a State pursuant to this subparagraph shall be available to such State, subject to the last sentence of subsection (c)(2).

Nothing in this paragraph shall preclude the application of subsection (b) with respect to any allocation determined under this subparagraph.

''(C) Any amounts described in clause (ii) of subparagraph (A) (remaining in the employment security administration account as of the close of any fiscal year specified in such subparagraph) shall, as of the beginning of the succeeding fiscal year, accrue to the Federal unemployment account, without regard to the limit provided in section 902(a).''

(b) CONFORMING AMENDMENT.—Paragraph (2) of section 903(c) of the Social Security Act is amended by adding at the end, as a flush left sentence, the following:

''Any amount allocated to a State under this section for fiscal year 2000, 2001, or 2002 may be used by such State only to pay expenses incurred by it for the administration of its unemployment compensation law, and may be so used by it without regard to any of the conditions prescribed in any of the preceding provisions of this paragraph.''

**SEC. 5404. INTEREST-FREE ADVANCES TO STATE ACCOUNTS IN UNEMPLOYMENT TRUST FUND RESTRICTED TO STATES WHICH MEET FUNDING GOALS.**

(a) IN GENERAL.—Paragraph (2) of section 1202(b) (42 U.S.C. 1322(b)) is amended—

(1) by striking ''and'' at the end of subparagraph (A),

(2) by striking the period at the end of subparagraph (B) and inserting '', and'', and

(3) by adding at the end the following new subparagraph:

''(C) such State meets funding goals, established under regulations issued by the Secretary of Labor, relating to the accounts of the States in the Unemployment Trust Fund.''

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to calendar years beginning after the date of the enactment of this Act.

**SEC. 5405. EXEMPTION OF SERVICE PERFORMED BY ELECTION WORKERS FROM THE FEDERAL UNEMPLOYMENT TAX.**

(a) IN GENERAL.—Paragraph (3) of section 3309(b) of the Internal Revenue Code of 1986 (relating to exemption for certain services) is amended—

(1) by striking ''or'' at the end of subparagraph (D),

(2) by adding ''or'' at the end of subparagraph (E), and

(3) by inserting after subparagraph (E) the following new subparagraph:

''(F) as an election official or election worker if the amount of remuneration received by the individual during the calendar year for services as an election official or election worker is less than $1,000;''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to service performed after the date of the enactment of this Act.

**SEC. 5406. TREATMENT OF CERTAIN SERVICES PERFORMED BY INMATES.**

(a) IN GENERAL.—Subsection (c) of section 3306 of the Internal Revenue Code of 1986 (defining employment) is amended—

(1) by striking ''or'' at the end of paragraph (19),

(2) by striking the period at the end of paragraph (20) and inserting ''; or'', and

(3) by adding at the end the following new paragraph:

''(21) service performed by a person committed to a penal institution.''

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to service performed after January 1, 1994.

**SEC. 5407. EXEMPTION OF SERVICE PERFORMED FOR AN ELEMENTARY OR SECONDARY SCHOOL OPERATED PRIMARILY FOR RELIGIOUS PURPOSES FROM THE FEDERAL UNEMPLOYMENT TAX.**

(a) IN GENERAL.—Paragraph (1) of section 3309(b) of the Internal Revenue Code of 1986 (relating to exemption for certain services) is amended—

(1) by striking ''or'' at the end of subparagraph (A), and

(2) by inserting before the semicolon at the end the following: '', or (C) an elementary or secondary school which is operated primarily for religious purposes, which is described in section 501(c)(3), and which is exempt from tax under section 501(a)''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to service performed after the date of the enactment of this Act.

**SEC. 5408. STATE PROGRAM INTEGRITY ACTIVITIES FOR UNEMPLOYMENT COMPENSATION.**

Section 901(c) (42 U.S.C. 1101(c)) is amended by adding at the end the following new paragraph:

''(5)(A) There are authorized to be appropriated out of the employment security administration account to carry out program integrity activities, in addition to any amounts available under paragraph (1)(A)(i)—

''(i) $89,000,000 for fiscal year 1998;

''(ii) $91,000,000 for fiscal year 1999;

''(iii) $93,000,000 fiscal year 2000;

''(iv) $96,000,000 for fiscal year 2001; and

''(v) $98,000,000 for fiscal year 2002.

''(B) In any fiscal year in which a State receives funds appropriated pursuant to this paragraph, the State shall expend a proportion of the funds appropriated pursuant to paragraph (1)(A)(i) to carry out program integrity activities that is not less than the proportion of the funds appropriated under such paragraph that was expended by the State to carry out program integrity activities in fiscal year 1997.

''(C) For purposes of this paragraph, the term 'program integrity activities' means initial claims review activities, eligibility review activities, benefit payments control activities, and employer liability auditing activities.''.

**Subtitle F—Welfare Reform Technical Corrections**

**CHAPTER 1—BLOCK GRANTS FOR TEMPORARY ASSISTANCE TO NEEDY FAMILIES**

**SEC. 5501. ELIGIBLE STATES; STATE PLAN.**

(a) LATER DEADLINE FOR SUBMISSION OF STATE PLANS.—Section 402(a) (42 U.S.C. 602(a)) is amended by striking ''2-year period immediately preceding'' and inserting ''27-month period ending with the close of the 1st quarter of''.

(b) CLARIFICATION OF SCOPE OF WORK PROVISIONS.—Section 402(a)(1)(A)(ii) (42 U.S.C. 602(a)(1)(A)(ii)) is amended by inserting '', consistent with section 407(e)(2)'' before the period.

(c) CORRECTION OF CROSS-REFERENCE.—Section 402(a)(1)(A)(v) (42 U.S.C. 602(a)(1)(A)(v)) is amended by striking ''403(a)(2)(B)'' and inserting ''403(a)(2)(C)(iii)''.

(d) NOTIFICATION OF PLAN AMENDMENTS.—Section 402 (42 U.S.C. 602) is amended—

(1) by redesignating subsection (b) as subsection (c) and inserting after subsection (a) the following:

''(b) PLAN AMENDMENTS.—Within 30 days after a State amends a plan submitted pursuant to subsection (a), the State shall notify the Secretary of the amendment.''; and

(2) in subsection (c) (as so redesignated), by inserting ''or plan amendment'' after ''plan''.

**SEC. 5502. GRANTS TO STATES.**

(a) BONUS FOR DECREASE IN ILLEGITIMACY MODIFIED TO TAKE ACCOUNT OF CERTAIN TERRITORIES.—

(1) IN GENERAL.—Section 403(a)(2)(B) (42 U.S.C. 603(a)(2)(B)) is amended to read as follows:

''(B) AMOUNT OF GRANT.—

''(i) IN GENERAL.—If, for a bonus year, none of the eligible States is Guam, the Virgin Islands, or American Samoa, then the amount of the grant shall be—

''(I) $20,000,000 if there are 5 eligible States; or

''(II) $25,000,000 if there are fewer than 5 eligible States.

''(ii) AMOUNT IF CERTAIN TERRITORIES ARE ELIGIBLE.—If, for a bonus year, Guam, the Virgin Islands, or American Samoa is an eligible State, then the amount of the grant shall be—

''(I) in the case of such a territory, 25 percent of the mandatory ceiling amount (as defined in section 1108(c)(4)) with respect to the territory; and

''(II) in the case of a State that is not such a territory—

''(aa) if there are 5 eligible States other than such territories, $20,000,000, minus ⅕ of the total amount of the grants payable under this paragraph to such territories for the bonus year; or

''(bb) if there are fewer than 5 such eligible States, $25,000,000, or such lesser amount as may be necessary to ensure that the total amount of grants payable under this paragraph for the bonus year does not exceed $100,000,000.''.

(2) CERTAIN TERRITORIES TO BE IGNORED IN RANKING OTHER STATES.—Section 403(a)(2)(C)(i)(I)(aa) (42 U.S.C. 603(a)(2)(C)(i)(I)(aa)) is amended by adding at the end the following: ''In the case of a State that is not a territory specified in subparagraph (B), the comparative magnitude of the decrease for the State shall be determined without regard to the magnitude of the corresponding decrease for any such territory.''.

(b) COMPUTATION OF BONUS BASED ON RATIOS OF OUT-OF-WEDLOCK BIRTHS TO ALL BIRTHS INSTEAD OF NUMBERS OF OUT-OF-WEDLOCK BIRTHS.—Section 403(a)(2) (42 U.S.C. 603(a)(2)) is amended—

(1) in the paragraph heading, by inserting ''RATIO'' before the period;

(2) in subparagraph (A), by striking all that follows ''bonus year'' and inserting a period; and

(3) in subparagraph (C)—

(A) in clause (i)—

(i) in subclause (I)(aa)—

(I) by striking ''number of out-of-wedlock births that occurred in the State during'' and inserting ''illegitimacy ratio of the State for''; and

(II) by striking ''number of such births that occurred during'' and inserting ''illegitimacy ratio of the State for''; and

(ii) in subclause (II)(aa)—

(I) by striking ''number of out-of-wedlock births that occurred in'' each place such term appears and inserting ''illegitimacy ratio of''; and

(II) by striking ''calculate the number of out-of-wedlock births'' and inserting ''calculate the illegitimacy ratio''; and

(B) by adding at the end the following:

''(iii) ILLEGITIMACY RATIO.—The term 'illegitimacy ratio' means, with respect to a State and a period—

''(I) the number of out-of-wedlock births to mothers residing in the State that occurred during the period; divided by

''(II) the number of births to mothers residing in the State that occurred during the period.''.

(c) USE OF CALENDAR YEAR DATA INSTEAD OF FISCAL YEAR DATA IN CALCULATING BONUS FOR DECREASE IN ILLEGITIMACY RATIO.—Section 403(a)(2)(C) (42 U.S.C. 603(a)(2)(C)) is amended—

(1) in clause (i)—

(A) in subclause (I)(bb)—

(i) by striking ''the fiscal year'' and inserting ''the calendar year for which the most recent data are available''; and

(ii) by striking ''fiscal year 1995'' and inserting ''calendar year 1995'';

(B) in subclause (II), by striking ''fiscal'' each place such term appears and inserting ''calendar''; and

(2) in clause (ii), by striking ''fiscal years'' and inserting ''calendar years''.

(d) CORRECTION OF HEADING.—Section 403(a)(3)(C)(ii) (42 U.S.C. 603(a)(3)(C)(ii)) is amended in the heading by striking ''1997'' and inserting ''1998''.

(e) CLARIFICATION OF CONTINGENCY FUND PROVISION.—Section 403(b) (42 U.S.C. 603(b)) is amended—

(1) in paragraph (6), by striking ''(5)'' and inserting ''(4)'';

(2) by striking paragraph (4) and redesignating paragraphs (5) and (6) as paragraphs (4) and (5), respectively; and

(3) by inserting after paragraph (5) the following:

''(6) ANNUAL RECONCILIATION.—

''(A) IN GENERAL.—Notwithstanding paragraph (3), if the Secretary makes a payment to a State under this subsection in a fiscal year, then the State shall remit to the Secretary, within 1 year after the end of the first subsequent period of 3 consecutive months for which the State is not a needy State, an amount equal to the amount (if any) by which—

''(i) the total amount paid to the State under paragraph (3) of this subsection in the fiscal year; exceeds

''(ii) the product of—

''(I) the Federal medical assistance percentage for the State (as defined in section 1905(b), as such section was in effect on September 30, 1995);

''(II) the State's reimbursable expenditures for the fiscal year; and

''(III) 1/12 times the number of months during the fiscal year for which the Secretary made a payment to the State under such paragraph (3).

''(B) DEFINITIONS.—As used in subparagraph (A):

''(i) REIMBURSABLE EXPENDITURES.—The term 'reimbursable expenditures' means, with respect to a State and a fiscal year, the amount (if any) by which—

''(I) countable State expenditures for the fiscal year; exceeds

''(II) historic State expenditures (as defined in section 409(a)(7)(B)(iii)), excluding any amount expended by the State for child care under subsection (g) or (i) of section 402 (as in effect during fiscal year 1994) for fiscal year 1994.

''(ii) COUNTABLE STATE EXPENDITURES.—The term 'countable expenditures' means, with respect to a State and a fiscal year—

''(I) the qualified State expenditures (as defined in section 409(a)(7)(B)(i) (other than the expenditures described in subclause (I)(bb) of such section)) under the State program funded under this part for the fiscal year; plus

''(II) any amount paid to the State under paragraph (3) during the fiscal year that is expended by the State under the State program funded under this part.''.

(f) ADMINISTRATION OF CONTINGENCY FUND TRANSFERRED TO THE SECRETARY OF HHS.—Section 403(b)(7) (42 U.S.C. 603(b)(7)) is amended to read as follows:

''(7) STATE DEFINED.—As used in this subsection, the term 'State' means each of the 50 States and the District of Columbia.''.

**SEC. 5503. USE OF GRANTS.**

Section 404(a)(2) (42 U.S.C. 604(a)(2)) is amended by inserting '', or (at the option of the State) August 21, 1996'' before the period.

**SEC. 5504. MANDATORY WORK REQUIREMENTS.**

(a) FAMILY WITH A DISABLED PARENT NOT TREATED AS A 2-PARENT FAMILY.—Section 407(b)(2) (42 U.S.C. 607(b)(2)) is amended by adding at the end the following:

''(C) FAMILY WITH A DISABLED PARENT NOT TREATED AS A 2-PARENT FAMILY.—A family that includes a disabled parent shall not be considered a 2-parent family for purposes of subsections (a) and (b) of this section.''.

(b) CORRECTION OF HEADING.—Section 407(b)(3) (42 U.S.C. 607(b)(3)) is amended in the heading by inserting ''AND NOT RESULTING FROM CHANGES IN STATE ELIGIBILITY CRITERIA'' before the period.

(c) STATE OPTION TO INCLUDE INDIVIDUALS RECEIVING ASSISTANCE UNDER A TRIBAL WORK PROGRAM IN PARTICIPATION RATE CALCULATION.—Section 407(b)(4) (42 U.S.C. 607(b)(4)) is amended—

(1) in the heading, by inserting ''OR TRIBAL WORK PROGRAM'' before the period; and

(2) by inserting ''or under a tribal work program to which funds are provided under this part'' before the period.

(d) SHARING OF 35-HOUR WORK REQUIREMENT BETWEEN PARENTS IN 2-PARENT FAMILIES.—Section 407(c)(1)(B) (42 U.S.C. 607(c)(1)(B)) is amended—

(1) in clause (i)—

(A) by striking ''is'' and inserting ''and the other parent in the family are''; and

(B) by inserting ''a total of'' before ''at least''; and

(2) in clause (ii)—

(A) by striking ''individual's spouse is'' and inserting ''individual and the other parent in the family are'';

(B) by inserting ''for a total of at least 55 hours per week'' before ''during the month'';

(C) by striking ''20'' and inserting ''50''; and

(D) by striking ''or (7)'' and inserting ''(6), (7), (8), or (12)''.

(e) CLARIFICATION OF EFFORT REQUIRED IN WORK ACTIVITIES.—Section 407(c)(1)(B) (42 U.S.C. 607(c)(1)(B)) is amended by striking ''making progress'' each place such term appears and inserting ''participating''.

(f) ADDITIONAL CONDITION UNDER WHICH 12 WEEKS OF JOB SEARCH MAY COUNT AS WORK.—Section 407(c)(2)(A)(i) (42 U.S.C. 607(c)(2)(A)(i)) is amended by inserting ''or

the State is a needy State (within the meaning of section 403(b)(6))'' after ''United States''.

(g) CARETAKER RELATIVE OF CHILD UNDER AGE 6 DEEMED TO BE MEETING WORK REQUIREMENTS IF ENGAGED IN WORK FOR 20 HOURS PER WEEK.—Section 407(c)(2)(B) (42 U.S.C. 607(c)(2)(B)) is amended—

(1) in the heading, by inserting ''OR RELATIVE'' after ''PARENT'' each place such term appears; and

(2) by striking ''in a 1-parent family who is the parent'' and inserting ''who is the only parent or caretaker relative in the family''.

(h) EXTENSION TO MARRIED TEENS OF RULE THAT RECEIPT OF SUFFICIENT EDUCATION IS ENOUGH TO MEET WORK PARTICIPATION REQUIREMENTS.—Section 407(c)(2)(C) (42 U.S.C. 607(c)(2)(C)) is amended—

(1) in the heading, by striking ''TEEN HEAD OF HOUSEHOLD'' and inserting ''SINGLE TEEN HEAD OF HOUSEHOLD OR MARRIED TEEN'';

(2) by striking ''a single'' and inserting ''married or a''; and

(3) by striking '', subject to subparagraph (D) of this paragraph,''.

(i) CLARIFICATION OF NUMBER OF HOURS OF PARTICIPATION IN EDUCATION DIRECTLY RELATED TO EMPLOYMENT THAT ARE REQUIRED IN ORDER FOR SINGLE TEEN HEAD OF HOUSEHOLD OR MARRIED TEEN TO BE DEEMED TO BE ENGAGED IN WORK.—Section 407(c)(2)(C)(ii) (42 U.S.C. 607(c)(2)(C)(ii)) is amended by striking ''at least'' and all that follows through ''subsection'' and inserting ''an average of at least 20 hours per week during the month''.

(j) CLARIFICATION OF REFUSAL TO WORK FOR PURPOSES OF WORK PENALTIES FOR INDIVIDUALS.—Section 407(e)(2) (42 U.S.C. 607(e)(2)) is amended by striking ''work'' and inserting ''engage in work required in accordance with this section''.

**SEC. 5505. PROHIBITIONS; REQUIREMENTS.**

(a) ELIMINATION OF REDUNDANT LANGUAGE; CLARIFICATION OF HOME RESIDENCE REQUIREMENT.—Section 408(a)(1) (42 U.S.C. 608(a)(1)) is amended to read as follows:

''(1) NO ASSISTANCE FOR FAMILIES WITHOUT A MINOR CHILD.—A State to which a grant is made under section 403 shall not use any part of the grant to provide assistance to a family, unless the family includes a minor child who resides with the family (consistent with paragraph (10)) or a pregnant individual.''.

(b) CLARIFICATION OF TERMINOLOGY.—Section 408(a)(3) (42 U.S.C. 608(a)(3)) is amended—

(1) by striking ''leaves'' the 1st, 3rd, and 4th places such term appears and inserting ''ceases to receive assistance under''; and

(2) by striking ''the date the family leaves the program'' the 2nd place such term appears and inserting ''such date''.

(c) ELIMINATION OF SPACE.—Section 408(a)(5)(A)(ii) (42 U.S.C. 608(a)(5)(A)(ii)) is amended by striking ''DESCRIBED.— For'' and inserting ''DESCRIBED.—For''.

(d) CORRECTIONS TO 5-YEAR LIMIT ON ASSISTANCE.—

(1) CLARIFICATION OF LIMITATION ON HARDSHIP EXEMPTION.—Section 408(a)(7)(C)(ii) (42 U.S.C. 608(a)(7)(C)(ii)) is amended—

(A) by striking ''The number'' and inserting ''The average monthly number''; and

(B) by inserting ''during the fiscal year or the immediately preceding fiscal year (but not both), as the State may elect'' before the period.

(2) RESIDENCE EXCEPTION MADE MORE UNIFORM AND EASIER TO ADMINISTER.—Section 408(a)(7)(D) (42 U.S.C. 608(a)(7)(D)) is amended to read as follows:

''(D) DISREGARD OF MONTHS OF ASSISTANCE RECEIVED BY ADULT WHILE LIVING IN INDIAN COUNTRY OR AN ALASKAN NATIVE VILLAGE WITH 50 PERCENT UNEMPLOYMENT.—

''(i) IN GENERAL.—In determining the number of months for which an adult has received assistance under a State or tribal program funded under this part, the State or tribe shall disregard any month during which the adult lived in Indian country or an Alaskan Native village if the most reliable data available with respect to the month (or a period including the month) indicate that at least 50 percent of the adults living in Indian country or in the village were not employed.

''(ii) INDIAN COUNTRY DEFINED.—As used in clause (i), the term 'Indian country' has the meaning given such term in section 1151 of title 18, United States Code.''.

(e) REINSTATEMENT OF DEEMING AND OTHER RULES APPLICABLE TO ALIENS WHO ENTERED THE UNITED STATES UNDER AFFIDAVITS OF SUPPORT FORMERLY USED.—Section 408 (42 U.S.C. 608), as amended by section 5001(h)(1) of this Act, is amended by striking subsection (e) and inserting the following:

''(e) SPECIAL RULES RELATING TO TREATMENT OF CERTAIN ALIENS.—For special rules relating to the treatment of certain aliens, see title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

''(f) SPECIAL RULES RELATING TO THE TREATMENT OF NON-213A ALIENS.—The following rules shall apply if a State elects to take the income or resources of any sponsor of a non-213A alien into account in determining whether the alien is eligible for assistance under the State program funded under this part, or in determining the amount or types of such assistance to be provided to the alien:

''(1) DEEMING OF SPONSOR'S INCOME AND RESOURCES.—For a period of 3 years after a non-213A alien enters the United States:

''(A) INCOME DEEMING RULE.—The income of any sponsor of the alien and of any spouse of the sponsor is deemed to be income of the alien, to the extent that the total amount of the income exceeds the sum of—

''(i) the lesser of—

''(I) 20 percent of the total of any amounts received by the sponsor or any such spouse in the month as wages or salary or as net earnings from self-employment, plus the full amount of any costs incurred by the sponsor and any such spouse in producing self-employment income in such month; or

''(II) $175;

''(ii) the cash needs standard established by the State for purposes of determining eligibility for assistance under the State program funded under this part for a family of the same size and composition as the sponsor and any other individuals living in the same household as the sponsor who are claimed by the sponsor as dependents for purposes of determining the sponsor's Federal personal income tax liability but whose needs are not taken into account in determining whether the sponsor's family has met the cash needs standard;

''(iii) any amounts paid by the sponsor or any such spouse to individuals not living in the household who are claimed by the sponsor as dependents for purposes of determining the sponsor's Federal personal income tax liability; and

''(iv) any payments of alimony or child support with respect to individuals not living in the household.

''(B) RESOURCE DEEMING RULE.—The resources of a sponsor of the alien and of any spouse of the sponsor are deemed to be resources of the alien to the extent that the aggregate value of the resources exceeds $1,500.

''(C) SPONSORS OF MULTIPLE NON-213A ALIENS.—If a person is a sponsor of 2 or more non-213A aliens who are living in the same home, the income and resources of the sponsor and any spouse of the sponsor that would be deemed income and resources of any such alien under subparagraph (A) shall be divided into a number of equal shares equal to the number of such aliens, and the State shall deem the income and resources of each such alien to include 1 such share.

''(2) INELIGIBILITY OF NON-213A ALIENS SPONSORED BY AGENCIES; EXCEPTION.—A non-213A alien whose sponsor is or was a public or private agency shall be ineligible for assistance under a State program funded under this part, during a period of 3 years after the alien enters the United States, unless the State agency administering the program determines that the sponsor either no longer exists or has become unable to meet the alien's needs.

''(3) INFORMATION PROVISIONS.—

''(A) DUTIES OF NON-213A ALIENS.—A non-213A alien, as a condition of eligibility for assistance under a State program funded under this part during the period of 3 years after the alien enters the United States, shall be required to provide to the State agency administering the program—

''(i) such information and documentation with respect to the alien's sponsor as may be necessary in order for the State agency to make any determination required under this subsection, and to obtain any cooperation from the sponsor necessary for any such determination; and

''(ii) such information and documentation as the State agency may request and which the alien or the alien's sponsor provided in support of the alien's immigration application.

''(B) DUTIES OF FEDERAL AGENCIES.—The Secretary shall enter into agreements with the Secretary of State and the Attorney General under which any information available to them and required in order to make any determination under this subsection will be provided by them to the Secretary (who may, in turn, make the information available, upon request, to a concerned State agency).

''(4) NON-213A ALIEN DEFINED.—An alien is a non-213A alien for purposes of this subsection if the affidavit of support or similar agreement with respect to the alien that was executed by the sponsor of the alien's entry into the United States was executed other than pursuant to section 213A of the Immigration and Nationality Act.

''(5) INAPPLICABILITY TO ALIEN MINOR SPONSORED BY A PARENT.—This subsection shall not apply to an alien who is a minor child if the sponsor of the alien or any spouse of the sponsor is a parent of the alien.

''(6) INAPPLICABILITY TO CERTAIN CATEGORIES OF ALIENS.—This subsection shall not apply to an alien who is—

''(A) admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

''(B) paroled into the United States under section 212(d)(5) of such Act for a period of at least 1 year; or

''(C) granted political asylum by the Attorney General under section 208 of such Act.''.

**SEC. 5506. PENALTIES.**

(a) STATES GIVEN MORE TIME TO FILE QUARTERLY REPORTS.—Section 409(a)(2)(A) (42 U.S.C. 609(a)(2)(A)) is amended by striking ''1 month'' and inserting ''45 days''.

(b) TREATMENT OF SUPPORT PAYMENTS PASSED THROUGH TO FAMILIES AS QUALIFIED STATE EXPENDITURES.—Section 409(a)(7)(B)(i)(I)(aa) (42 U.S.C. 609(a)(7)(B)(i)(I)(aa)) is amended by inserting '', including any amount collected by the State as support pursuant to a plan approved under part D, on behalf of a family receiving assistance under the State program funded under this part, that is distributed to the family under section 457(a)(1)(B) and disregarded in determining the eligibility of the

family for, and the amount of, such assistance'' before the period.

(c) DISREGARD OF EXPENDITURES MADE TO REPLACE PENALTY GRANT REDUCTIONS.—Section 409(a)(7)(B)(i) (42 U.S.C. 609(a)(7)(B)(i)) is amended by redesignating subclause (III) as subclause (IV) and by inserting after subclause (II) the following:

''(III) EXCLUSION OF AMOUNTS EXPENDED TO REPLACE PENALTY GRANT REDUCTIONS.—Such term does not include any amount expended in order to comply with paragraph (12).''.

(d) TREATMENT OF FAMILIES OF CERTAIN ALIENS AS ELIGIBLE FAMILIES.—Section 409(a)(7)(B)(i)(IV) (42 U.S.C. 609(a)(7)(B)(i)(IV)), as so redesignated by subsection (c) of this section, is amended—

(1) by striking ''and families'' and inserting ''families''; and

(2) by striking ''Act or section 402'' and inserting ''Act, and families of aliens lawfully present in the United States that would be eligible for such assistance but for the application of title IV''.

(e) ELIMINATION OF MEANINGLESS LANGUAGE.—Section 409(a)(7)(B)(ii) (42 U.S.C. 609(a)(7)(B)(ii)) is amended by striking ''reduced (if appropriate) in accordance with subparagraph (C)(ii)''.

(f) CLARIFICATION OF SOURCE OF DATA TO BE USED IN DETERMINING HISTORIC STATE EXPENDITURES.—Section 409(a)(7)(B) (42 U.S.C. 609(a)(7)(B)) is amended by adding at the end the following:

''(v) SOURCE OF DATA.—In determining expenditures by a State for fiscal years 1994 and 1995, the Secretary shall use information which was reported by the State on ACF Form 231 or (in the case of expenditures under part F) ACF Form 331, available as of the dates specified in clauses (ii) and (iii) of section 403(a)(1)(D).''.

(g) CONFORMING TITLE IV–A PENALTIES TO TITLE IV–D PERFORMANCE-BASED STANDARDS.—Section 409(a)(8) (42 U.S.C. 609(a)(8)) is amended to read as follows:

''(8) NONCOMPLIANCE OF STATE CHILD SUPPORT ENFORCEMENT PROGRAM WITH REQUIREMENTS OF PART D.—

''(A) IN GENERAL.—If the Secretary finds, with respect to a State's program under part D, in a fiscal year beginning on or after October 1, 1997—

''(i)(I) on the basis of data submitted by a State pursuant to section 454(15)(B), or on the basis of the results of a review conducted under section 452(a)(4), that the State program failed to achieve the paternity establishment percentages (as defined in section 452(g)(2)), or to meet other performance measures that may be established by the Secretary;

''(II) on the basis of the results of an audit or audits conducted under section 452(a)(4)(C)(i) that the State data submitted pursuant to section 454(15)(B) is incomplete or unreliable; or

''(III) on the basis of the results of an audit or audits conducted under section 452(a)(4)(C) that a State failed to substantially comply with 1 or more of the requirements of part D; and

''(ii) that, with respect to the succeeding fiscal year—

''(I) the State failed to take sufficient corrective action to achieve the appropriate performance levels or compliance as described in subparagraph (A)(i); or

''(II) the data submitted by the State pursuant to section 454(15)(B) is incomplete or unreliable;

the amounts otherwise payable to the State under this part for quarters following the end of such succeeding fiscal year, prior to quarters following the end of the first quarter throughout which the State program has achieved the paternity establishment percentages or other performance measures as described in subparagraph (A)(i)(I), or is in substantial compliance with 1 or more of the requirements of part D as described in subparagraph (A)(i)(III), as appropriate, shall be reduced by the percentage specified in subparagraph (B).

''(B) AMOUNT OF REDUCTIONS.—The reductions required under subparagraph (A) shall be—

''(i) not less than 1 nor more than 2 percent;

''(ii) not less than 2 nor more than 3 percent, if the finding is the 2nd consecutive finding made pursuant to subparagraph (A); or

''(iii) not less than 3 nor more than 5 percent, if the finding is the 3rd or a subsequent consecutive such finding.

''(C) DISREGARD OF NONCOMPLIANCE WHICH IS OF A TECHNICAL NATURE.—For purposes of this section and section 452(a)(4), a State determined as a result of an audit—

''(i) to have failed to have substantially complied with 1 or more of the requirements of part D shall be determined to have achieved substantial compliance only if the Secretary determines that the extent of the noncompliance is of a technical nature which does not adversely affect the performance of the State's program under part D; or

''(ii) to have submitted incomplete or unreliable data pursuant to section 454(15)(B) shall be determined to have submitted adequate data only if the Secretary determines that the extent of the incompleteness or unreliability of the data is of a technical nature which does not adversely affect the determination of the level of the State's paternity establishment percentages (as defined under section 452(g)(2)) or other performance measures that may be established by the Secretary.''.

(h) CORRECTION OF REFERENCE TO 5-YEAR LIMIT ON ASSISTANCE.—Section 409(a)(9) (42 U.S.C. 609(a)(9)) is amended by striking ''408(a)(1)(B)'' and inserting ''408(a)(7)''.

(i) CORRECTION OF ERRORS IN PENALTY FOR FAILURE TO MEET MAINTENANCE OF EFFORT REQUIREMENT APPLICABLE TO THE CONTINGENCY FUND.—Section 409(a)(10) (42 U.S.C. 609(a)(10)) is amended—

(1) by striking ''the expenditures under the State program funded under this part for the fiscal year (excluding any amounts made available by the Federal Government)'' and inserting ''the qualified State expenditures (as defined in paragraph (7)(B)(i) (other than the expenditures described in subclause (I)(bb) of that paragraph)) under the State program funded under this part for the fiscal year'';

(2) by inserting ''excluding any amount expended by the State for child care under subsection (g) or (i) of section 402 (as in effect during fiscal year 1994) for fiscal year 1994,'' after ''(as defined in paragraph (7)(B)(iii) of this subsection),''; and

(3) by inserting ''that the State has not remitted under section 403(b)(6)'' before the period.

(j) PENALTY FOR STATE FAILURE TO EXPEND ADDITIONAL STATE FUNDS TO REPLACE GRANT REDUCTIONS.—Section 409(a)(12) (42 U.S.C. 609(a)(12)) is amended—

(1) in the heading—

(A) by striking ''FAILURE'' and inserting ''REQUIREMENT''; and

(B) by striking ''REDUCTIONS'' and inserting ''REDUCTIONS; PENALTY FOR FAILURE TO DO SO''; and

(2) by adding at the end the following: ''If the State fails during such succeeding fiscal year to make the expenditure required by the preceding sentence from its own funds, the Secretary may reduce the grant payable to the State under section 403(a)(1) for the fiscal year that follows such succeeding fiscal year by an amount equal to the sum of—

''(A) not more than 2 percent of the State family assistance grant; and

''(B) the amount of the expenditure required by the preceding sentence.''.

(k) ELIMINATION OF CERTAIN REASONABLE CAUSE EXCEPTIONS.—Section 409(b)(2) (42 U.S.C. 609(b)(2)) is amended by striking ''(7) or (8)'' and inserting ''(6), (7), (8), (10), or (12)''.

(l) CLARIFICATION OF WHAT IT MEANS TO CORRECT A VIOLATION.—Section 409(c) (42 U.S.C. 609(c)) is amended—

(1) in each of subparagraphs (A) and (B) of paragraph (1), by inserting ''or discontinue, as appropriate,'' after ''correct'';

(2) in paragraph (2)—

(A) in the heading, by inserting ''OR DISCONTINUING'' after ''CORRECTING''; and

(B) by inserting ''or discontinues, as appropriate'' after ''corrects''; and

(3) in paragraph (3)—

(A) in the heading, by inserting ''OR DISCONTINUE'' after ''CORRECT''; and

(B) by inserting ''or discontinue, as appropriate,'' before ''the violation''.

(m) CERTAIN PENALTIES NOT AVOIDABLE THROUGH CORRECTIVE COMPLIANCE PLANS.—Section 409(c)(4) (42 U.S.C. 609(c)(4)) is amended to read as follows:

''(4) INAPPLICABILITY TO CERTAIN PENALTIES.—This subsection shall not apply to the imposition of a penalty against a State under paragraph (6), (7), (8), (10), or (12) of subsection (a).''.

(n) FAILURE TO SATISFY MINIMUM PARTICIPATION RATES.—Section 409(a)(3) (42 U.S.C. 609(a)(3)) is amended—

(1) in subparagraph (A), by striking ''not more than''; and

(2) in subparagraph (C), by inserting before the period the following: ''or if the noncompliance is due to extraordinary circumstances such as a natural disaster or regional recession. The Secretary shall provide a written report to Congress to justify any waiver or penalty reduction due to such extraordinary circumstances''.

**SEC. 5507. DATA COLLECTION AND REPORTING.**

Section 411(a) (42 U.S.C. 611(a)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (A)—

(i) by striking clause (ii) and inserting the following:

''(ii) Whether a child receiving such assistance or an adult in the family is receiving—

''(I) Federal disability insurance benefits;

''(II) benefits based on Federal disability status;

''(III) aid under a State plan approved under title XIV (as in effect without regard to the amendment made by section 301 of the Social Security Amendments of 1972));

''(IV) aid or assistance under a State plan approved under title XVI (as in effect without regard to such amendment) by reason of being permanently and totally disabled; or

''(V) supplemental security income benefits under title XVI (as in effect pursuant to such amendment) by reason of disability.'';

(ii) in clause (iv), by striking ''youngest child in'' and inserting ''head of'';

(iii) in each of clauses (vii) and (viii), by striking ''status'' and inserting ''level''; and

(iv) by adding at the end the following:

''(xvii) With respect to each individual in the family who has not attained 20 years of age, whether the individual is a parent of a child in the family.''; and

(B) in subparagraph (B)—

(i) in the heading, by striking ''ESTIMATES'' and inserting ''SAMPLES''; and

(ii) in clause (i), by striking ''an estimate which is obtained'' and inserting ''disaggregated case record information on a sample of families selected''; and

(2) by redesignating paragraph (6) as paragraph (7) and inserting after paragraph (5) the following:

''(6) REPORT ON FAMILIES RECEIVING ASSISTANCE.—The report required by paragraph (1) for a fiscal quarter shall include for each month in the quarter—

''(A) the number of families and individuals receiving assistance under the State program funded under this part (including the number of 2-parent and 1-parent families); and

''(B) the total dollar value of such assistance received by all families.''.

**SEC. 5508. DIRECT FUNDING AND ADMINISTRATION BY INDIAN TRIBES.**

(a) PRORATING OF TRIBAL FAMILY ASSISTANCE GRANTS.—Section 412(a)(1)(A) (42 U.S.C. 612(a)(1)(A)) is amended by inserting ''which shall be reduced for a fiscal year, on a pro rata basis for each quarter, in the case of a tribal family assistance plan approved during a fiscal year for which the plan is to be in effect,'' before ''and shall''.

(b) TRIBAL OPTION TO OPERATE WORK ACTIVITIES PROGRAM.—Section 412(a)(2)(A) (42 U.S.C. 612(a)(2)(A)) is amended by striking ''The Secretary'' and all that follows through ''2002'' and inserting ''For each of fiscal years 1997, 1998, 1999, 2000, 2001, and 2002, the Secretary shall pay to each eligible Indian tribe that proposes to operate a program described in subparagraph (C)''.

(c) DISCRETION OF TRIBES TO SELECT POPULATION TO BE SERVED BY TRIBAL WORK ACTIVITIES PROGRAM.—Section 412(a)(2)(C) (42 U.S.C. 612(a)(2)(C)) is amended by striking ''members of the Indian tribe'' and inserting ''such population and such service area or areas as the tribe specifies''.

(d) REDUCTION OF APPROPRIATION FOR TRIBAL WORK ACTIVITIES PROGRAMS.—Section 412(a)(2)(D) (42 U.S.C. 612(a)(2)(D)) is amended by striking ''$7,638,474'' and inserting ''$7,633,287''.

(e) AVAILABILITY OF CORRECTIVE COMPLIANCE PLANS TO INDIAN TRIBES.—Section 412(f)(1) (42 U.S.C. 612(f)(1)) is amended by striking ''and (b)'' and inserting ''(b), and (c)''.

(f) ELIGIBILITY OF TRIBES FOR FEDERAL LOANS FOR WELFARE PROGRAMS.—Section 412 (42 U.S.C. 612) is amended by redesignating subsections (f), (g), and (h) as subsections (g), (h), and (i), respectively, and by inserting after subsection (e) the following:

''(f) ELIGIBILITY FOR FEDERAL LOANS.—Section 406 shall apply to an Indian tribe with an approved tribal assistance plan in the same manner as such section applies to a State, except that section 406(c) shall be applied by substituting 'section 412(a)' for 'section 403(a)'.''.

**SEC. 5509. RESEARCH, EVALUATIONS, AND NATIONAL STUDIES.**

(a) RESEARCH.—

(1) METHODS.—Section 413(a) (42 U.S.C. 613(a)) is amended by inserting '', directly or through grants, contracts, or interagency agreements,'' before ''shall conduct''.

(2) CORRECTION OF CROSS REFERENCE.—Section 413(a) (42 U.S.C. 613(a)) is amended by striking ''409'' and inserting ''407''.

(b) CORRECTION OF ERRONEOUSLY INDENTED PARAGRAPH.—Section 413(e)(1) (42 U.S.C. 613(e)(1)) is amended to read as follows:

''(1) IN GENERAL.—The Secretary shall annually rank States to which grants are made under section 403 based on the following ranking factors:

''(A) ABSOLUTE OUT-OF-WEDLOCK RATIOS.—The ratio represented by—

''(i) the total number of out-of-wedlock births in families receiving assistance under the State program under this part in the State for the most recent year for which information is available; over

''(ii) the total number of births in families receiving assistance under the State program under this part in the State for the year.

''(B) NET CHANGES IN THE OUT-OF-WEDLOCK RATIO.—The difference between the ratio described in subparagraph (A) with respect to a State for the most recent year for which such information is available and the ratio with respect to the State for the immediately preceding year.''.

(c) FUNDING OF PRIOR AUTHORIZED DEMONSTRATIONS.—Section 413(h)(1)(D) (42 U.S.C. 613(h)(1)(D)) is amended by striking ''September 30, 1995'' and inserting ''August 22, 1996''.

(d) CHILD POVERTY REPORTS.—

(1) DELAYED DUE DATE FOR INITIAL REPORT.—Section 413(i)(1) (42 U.S.C. 613(i)(1)) is amended by striking ''90 days after the date of the enactment of this part'' and inserting ''May 31, 1998''.

(2) MODIFICATION OF FACTORS TO BE USED IN ESTABLISHING METHODOLOGY FOR USE IN DETERMINING CHILD POVERTY RATES.—Section 413(i)(5) (42 U.S.C. 613(i)(5)) is amended by striking ''the county-by-county'' and inserting '', to the extent available, county-by-county''.

**SEC. 5510. REPORT ON DATA PROCESSING.**

Section 106(a)(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2164) is amended by striking ''(whether in effect before or after October 1, 1995)''.

**SEC. 5511. STUDY ON ALTERNATIVE OUTCOMES MEASURES.**

Section 107(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2164) is amended by striking ''409(a)(7)(C)'' and inserting ''408(a)(7)(C)''.

**SEC. 5512. LIMITATION ON PAYMENTS TO THE TERRITORIES.**

(a) CERTAIN PAYMENTS TO BE DISREGARDED IN DETERMINING LIMITATION.—Section 1108(a) (42 U.S.C. 1308) is amended to read as follows:

''(a) LIMITATION ON TOTAL PAYMENTS TO EACH TERRITORY.—

''(1) IN GENERAL.—Notwithstanding any other provision of this Act (except for paragraph (2) of this subsection), the total amount certified by the Secretary of Health and Human Services under titles I, X, XIV, and XVI, under parts A and E of title IV, and under subsection (b) of this section, for payment to any territory for a fiscal year shall not exceed the ceiling amount for the territory for the fiscal year.

''(2) CERTAIN PAYMENTS DISREGARDED.—Paragraph (1) of this subsection shall be applied without regard to any payment made under section 403(a)(2), 403(a)(4), 406, or 413(f).''.

(b) CERTAIN CHILD CARE AND SOCIAL SERVICES EXPENDITURES BY TERRITORIES TREATED AS IV–A EXPENDITURES FOR PURPOSES OF MATCHING GRANT.—Section 1108(b)(1)(A) (42 U.S.C. 1308(b)(1)(A)) is amended by inserting '', including any amount paid to the State under part A of title IV that is transferred in accordance with section 404(d) and expended under the program to which transferred'' before the semicolon.

(c) ELIMINATION OF DUPLICATIVE MAINTENANCE OF EFFORT REQUIREMENT.—Section 1108 (42 U.S.C. 1308) is amended by striking subsection (e).

**SEC. 5513. CONFORMING AMENDMENTS TO THE SOCIAL SECURITY ACT.**

(a) AMENDMENTS TO PART D OF TITLE IV.—

(1) CORRECTIONS TO DETERMINATION OF PATERNITY ESTABLISHMENT PERCENTAGES.—Section 452 (42 U.S.C. 652) is amended—

(A) in subsection (d)(3)(A), by striking all that follows ''for purposes of'' and inserting ''section 409(a)(8), to achieve the paternity establishment percentages (as defined under section 452(g)(2)) and other performance measures that may be established by the Secretary, and to submit data under section 454(15)(B) that is complete and reliable, and to substantially comply with the requirements of this part; and''; and

(B) in subsection (g)(1), by striking ''section 403(h)'' and inserting ''section 409(a)(8)''.

(2) ELIMINATION OF OBSOLETE LANGUAGE.—Section 108(c)(8)(C) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2165) is amended by inserting ''and all that follows through 'the best interests of such child to do so'' before ''and inserting''.

(3) INSERTION OF LANGUAGE INADVERTENTLY OMITTED.—Section 108(c)(13) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2166) is amended by inserting ''and inserting 'pursuant to section 408(a)(3)'' before the period.

(4) ELIMINATION OF OBSOLETE CROSS REFERENCE.—Section 464(a)(1) (42 U.S.C. 664(a)(1)) is amended by striking ''section 402(a)(26)'' and inserting ''section 408(a)(3)''.

(b) AMENDMENTS TO PART E OF TITLE IV.—Each of the following is amended by striking ''June 1, 1995'' each place such term appears and inserting ''July 16, 1996'':

(1) Section 472(a) (42 U.S.C. 672(a)).

(2) Section 472(h) (42 U.S.C. 672(h)).

(3) Section 473(a)(2) (42 U.S.C. 673(a)(2)).

(4) Section 473(b) (42 U.S.C. 673(b)).

**SEC. 5514. OTHER CONFORMING AMENDMENTS.**

(a) ELIMINATION OF AMENDMENTS INCLUDED INADVERTENTLY.—Section 110(l) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2173) is amended—

(1) by striking paragraphs (1), (4), (5), and (7);

(2) by redesignating paragraphs (2), (3), (6), and (8) as paragraphs (1), (2), (3), and (4), respectively; and

(3) by adding ''and'' at the end of paragraph (3), as so redesignated.

(b) CORRECTION OF CITATION.—Section 109(f) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2177) is amended by striking ''93–186'' and inserting ''93–86''.

(c) CORRECTION OF INTERNAL CROSS REFERENCE.—Section 103(a)(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2112) is amended by striking ''603(b)(2)'' and inserting ''603(b)''.

(d) CORRECTION OF REFERENCES.—Section 416 (42 U.S.C. 616) is amended by striking ''amendment made by section 2103 of the Personal Responsibility and Work Opportunity'' and inserting ''amendments made by section 103 of the Personal Responsibility and Work Opportunity Reconciliation''.

**SEC. 5515. MODIFICATIONS TO THE JOB OPPORTUNITIES FOR CERTAIN LOW-INCOME INDIVIDUALS PROGRAM.**

Section 112(5) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2177) is amended in each of subparagraphs (A) and (B) by inserting ''under'' after ''funded''.

**SEC. 5516. DENIAL OF ASSISTANCE AND BENEFITS FOR DRUG-RELATED CONVICTIONS.**

(a) EXTENSION OF CERTAIN REQUIREMENTS COORDINATED WITH DELAYED EFFECTIVE DATE FOR SUCCESSOR PROVISIONS.—Section 115(d)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2181) is amended by striking ''convictions'' and inserting ''a conviction if the conviction is for conduct''.

(b) IMMEDIATE EFFECTIVENESS OF PROVISIONS RELATING TO RESEARCH, EVALUATIONS, AND NATIONAL STUDIES.—Section 116(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2181) is amended by adding at the end the following:

''(6) RESEARCH, EVALUATIONS, AND NATIONAL STUDIES.—Section 413 of the Social Security Act, as added by the amendment made by section 103(a) of this Act, shall take effect on the date of the enactment of this Act.''.

**SEC. 5517. TRANSITION RULE.**

Section 116 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2181) is amended—

(1) in subsection (a)(2), by inserting ''(but subject to subsection (b)(1)(A)(ii))'' after ''this section''; and

(2) in subsection (b)(1)(A)(ii), by striking ''June 30, 1997'' and inserting ''the later of June 30, 1997, or the day before the date described in subsection (a)(2)(B) of this section''.

**SEC. 5518. EFFECTIVE DATES.**

(a) AMENDMENTS TO PART A OF TITLE IV OF THE SOCIAL SECURITY ACT.—The amendments made by this chapter to a provision of part A of title IV of the Social Security Act shall take effect as if the amendments had been included in section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 at the time such section became law.

(b) AMENDMENTS TO PARTS D AND E OF TITLE IV OF THE SOCIAL SECURITY ACT.—The amendments made by section 5513 of this Act shall take effect as if the amendments had been included in section 108 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 at the time such section 108 became law.

(c) AMENDMENTS TO OTHER AMENDATORY PROVISIONS.—The amendments made by section 5514(a) of this Act shall take effect as if the amendments had been included in section 110 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 at the time such section 110 became law.

(d) AMENDMENTS TO FREESTANDING PROVISIONS OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996.—The amendments made by this chapter to a provision of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 that have not become part of another statute shall take effect as if the amendments had been included in the provision at the time the provision became law.

## CHAPTER 2—SUPPLEMENTAL SECURITY INCOME

**SEC. 5521. CONFORMING AND TECHNICAL AMENDMENTS RELATING TO ELIGIBILITY RESTRICTIONS.**

(a) DENIAL OF SSI BENEFITS FOR FUGITIVE FELONS AND PROBATION AND PAROLE VIOLATORS.—Section 1611(e)(6) (42 U.S.C. 1382(e)(6)) is amended by inserting ''and section 1106(c) of this Act'' after ''of 1986''.

(b) TREATMENT OF PRISONERS.—Section 1611(e)(1)(I)(i)(II) (42 U.S.C. 1382(e)(1)(I)(i)(II)) is amended by striking ''inmate of the institution'' and all that follows through ''this subparagraph'' and inserting ''individual who receives in the month preceding the first month throughout which such individual is an inmate of the jail, prison, penal institution, or correctional facility that furnishes information respecting such individual pursuant to subclause (I), or is confined in the institution (that so furnishes such information) as described in section 202(x)(1)(A)(ii), a benefit under this title for such preceding month, and who is determined by the Commissioner to be ineligible for benefits under this title by reason of confinement based on the information provided by such institution''.

(c) CORRECTION OF REFERENCE.—Section 1611(e)(1)(I)(i)(I) (42 U.S.C. 1382(e)(1)(I)(i)(I)) is amended by striking ''paragraph (1)'' and inserting ''this paragraph''.

**SEC. 5522. CONFORMING AND TECHNICAL AMENDMENTS RELATING TO BENEFITS FOR DISABLED CHILDREN.**

(a) ELIGIBILITY REDETERMINATIONS AND CONTINUING DISABILITY REVIEWS.—

(1) DISABILITY ELIGIBILITY REDETERMINATIONS REQUIRED FOR SSI RECIPIENTS WHO ATTAIN 18 YEARS OF AGE.—Section 1614(a)(3)(H)(iii) (42 U.S.C. 1382c(a)(3)(H)(iii)) is amended by striking subclauses (I) and (II) and all that follows and inserting the following:

''(I) by applying the criteria used in determining initial eligibility for individuals who are age 18 or older; and

''(II) either during the 1-year period beginning on the individual's 18th birthday or, in lieu of a continuing disability review, whenever the Commissioner determines that an individual's case is subject to a redetermination under this clause.

With respect to any redetermination under this clause, paragraph (4) shall not apply.''.

(2) CONTINUING DISABILITY REVIEW REQUIRED FOR LOW BIRTH WEIGHT BABIES.—Section 1614(a)(3)(H)(iv) (42 U.S.C. 1382c(a)(3)(H)(iv)) is amended—

(A) in subclause (I), by striking ''Not'' and inserting ''Except as provided in subclause (VI), not''; and

(B) by adding at the end the following:

''(VI) Subclause (I) shall not apply in the case of an individual described in that subclause who, at the time of the individual's initial disability determination, the Commissioner determines has an impairment that is not expected to improve within 12 months after the birth of that individual, and who the Commissioner schedules for a continuing disability review at a date that is after the individual attains 1 year of age.''.

(b) ADDITIONAL ACCOUNTABILITY REQUIREMENTS.—Section 1631(a)(2)(F) (42 U.S.C. 1383(a)(2)(F)) is amended—

(1) in clause (ii)(III)(bb), by striking ''the total amount'' and all that follows through ''1613(c)'' and inserting ''in any case in which the individual knowingly misapplies benefits from such an account, the Commissioner shall reduce future benefits payable to such individual (or to such individual and his spouse) by an amount equal to the total amount of such benefits so misapplied''; and

(2) by striking clause (iii) and inserting the following:

''(iii) The representative payee may deposit into the account established under clause (i) any other funds representing past due benefits under this title to the eligible individual, provided that the amount of such past due benefits is equal to or exceeds the maximum monthly benefit payable under this title to an eligible individual (including State supplementary payments made by the Commissioner pursuant to an agreement under section 1616 or section 212(b) of Public Law 93–66).''.

(c) REDUCTION IN CASH BENEFITS PAYABLE TO INSTITUTIONALIZED INDIVIDUALS WHOSE MEDICAL COSTS ARE COVERED BY PRIVATE INSURANCE.—Section 1611(e) (42 U.S.C. 1382(e)) is amended—

(1) in paragraph (1)(B)—

(A) in the matter preceding clause (i), by striking ''hospital, extended care facility, nursing home, or intermediate care facility'' and inserting ''medical treatment facility'';

(B) in clause (ii)—

(i) in the matter preceding subclause (I), by striking ''hospital, home or''; and

(ii) in subclause (I), by striking ''hospital, home, or'';

(C) in clause (iii), by striking ''hospital, home, or''; and

(D) in the matter following clause (iii), by striking ''hospital, extended care facility, nursing home, or intermediate care facility which is a 'medical institution or nursing facility' within the meaning of section 1917(c)'' and inserting ''medical treatment facility that provides services described in section 1917(c)(1)(C)'';

(2) in paragraph (1)(E)—

(A) in clause (i)(II), by striking ''hospital, extended care facility, nursing home, or intermediate care facility'' and inserting ''medical treatment facility''; and

(B) in clause (iii), by striking ''hospital, extended care facility, nursing home, or intermediate care facility'' and inserting ''medical treatment facility'';

(3) in paragraph (1)(G), in the matter preceding clause (i)—

(A) by striking ''or which is a hospital, extended care facility, nursing home, or intermediate care'' and inserting ''or is in a medical treatment''; and

(B) by inserting ''or, in the case of an individual who is a child under the age of 18, under any health insurance policy issued by a private provider of such insurance'' after ''title XIX''; and

(4) in paragraph (3)—

(A) by striking ''same hospital, home, or facility'' and inserting ''same medical treatment facility''; and

(B) by striking ''same such hospital, home, or facility'' and inserting ''same such facility''.

(d) CORRECTION OF U.S.C. CITATION.—Section 211(c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2189) is amended by striking ''1382(a)(4)'' and inserting ''1382c(a)(4)''.

**SEC. 5523. ADDITIONAL TECHNICAL AMENDMENTS TO TITLE XVI.**

Section 1615(d) (42 U.S.C. 1382d(d)) is amended—

(1) in the first sentence, by inserting a comma after ''subsection (a)(1)''; and

(2) in the last sentence, by striking ''him'' and inserting ''the Commissioner''.

**SEC. 5524. ADDITIONAL TECHNICAL AMENDMENTS RELATING TO TITLE XVI.**

Section 1110(a)(3) (42 U.S.C. 1310(a)(3)) is amended—

(1) by inserting ''(or the Commissioner, with respect to any jointly financed cooperative agreement or grant concerning title XVI)'' after ''Secretary'' the first place it appears; and

(2) by inserting ''(or the Commissioner, as applicable)'' after ''Secretary'' the second place it appears.

**SEC. 5525. TECHNICAL AMENDMENTS RELATING TO DRUG ADDICTS AND ALCOHOLICS.**

(a) CLARIFICATION RELATING TO THE EFFECTIVE DATE OF THE DENIAL OF SSI DISABILITY BENEFITS TO DRUG ADDICTS AND ALCOHOLICS.—Section 105(b)(5) of the Contract with America Advancement Act of 1996 (Public Law 104–121; 110 Stat. 853) is amended—

(1) in subparagraph (A), by striking ''by the Commissioner of Social Security'' and ''by the Commissioner''; and

(2) by redesignating subparagraph (D) as subparagraph (F) and by inserting after subparagraph (C) the following new subparagraphs:

''(D) For purposes of this paragraph, an individual's claim, with respect to supplemental security income benefits under title XVI of the Social Security Act based on disability, which has been denied in whole before the date of the enactment of this Act, may not be considered to be finally adjudicated before such date if, on or after such date—

''(i) there is pending a request for either administrative or judicial review with respect to such claim, or

''(ii) there is pending, with respect to such claim, a readjudication by the Commissioner of Social Security pursuant to relief in a class action or implementation by the Commissioner of a court remand order.

''(E) Notwithstanding the provisions of this paragraph, with respect to any individual for whom the Commissioner does not perform the eligibility redetermination before the date prescribed in subparagraph (C), the Commissioner shall perform such eligibility redetermination in lieu of a continuing disability review whenever the Commissioner determines that the individual's eligibility is subject to redetermination based on the preceding provisions of this paragraph, and the provisions of section 1614(a)(4) of the Social Security Act shall not apply to such redetermination.''.

(b) CORRECTIONS TO EFFECTIVE DATE OF PROVISIONS CONCERNING REPRESENTATIVE PAYEES AND TREATMENT REFERRALS OF SSI BENEFICIARIES WHO ARE DRUG ADDICTS AND ALCOHOLICS.—Section 105(b)(5)(B) of such Act (Public Law 104–121; 110 Stat. 853) is amended to read as follows:

''(B) The amendments made by paragraphs (2) and (3) shall take effect on July 1, 1996, with respect to any individual—

''(i) whose claim for benefits is finally adjudicated on or after the date of the enactment of this Act, or

''(ii) whose eligibility for benefits is based upon an eligibility redetermination made pursuant to subparagraph (C).''.

(c) REPEAL OF OBSOLETE REPORTING REQUIREMENTS.—Subsections (a)(3)(B) and (b)(3)(B)(ii) of section 201 of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103–296; 108 Stat. 1497, 1504) are repealed.

**SEC. 5526. ADVISORY BOARD PERSONNEL.**

Section 703(i) (42 U.S.C. 903(i)) is amended—

(1) in the first sentence, by striking '', and three'' and all that follows through ''Board,''; and

(2) in the last sentence, by striking ''clerical''.

**SEC. 5527. TIMING OF DELIVERY OF OCTOBER 1, 2000, SSI BENEFIT PAYMENTS.**

Notwithstanding the provisions of section 708(a) of the Social Security Act (42 U.S.C. 908(a)), the day designated for delivery of benefit payments under title XVI of such Act for October 2000 shall be the second day of such month.

**SEC. 5528. EFFECTIVE DATES.**

(a) IN GENERAL.—Except as provided in this section, the amendments made by this chapter shall take effect as if included in the enactment of title II of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2185).

(b) SECTION 5524 AMENDMENTS.—The amendments made by section 5524 of this Act shall take effect as if included in the enactment of the Social Security Independence and Program Improvements Act of 1994 (Public Law 103–296; 108 Stat. 1464).

(c) SECTION 5525 AMENDMENTS.—

(1) IN GENERAL.—The amendments made by subsections (a) and (b) of section 5525 of this Act shall take effect as if included in the enactment of section 105 of the Contract with America Advancement Act of 1996 (Public Law 104–121; 110 Stat. 852 et seq.).

(2) REPEALS.—The repeals made by section 5525(c) shall take effect on the date of the enactment of this Act.

(d) SECTION 5526 AMENDMENTS.—The amendments made by section 5526 of this Act shall take effect as if included in the enactment of section 108 of the Contract with America Advancement Act of 1996 (Public Law 104–121; 110 Stat. 857).

(e) SECTION 5227.—Section 5227 shall take effect on the date of the enactment of this Act.

## CHAPTER 3—CHILD SUPPORT

**SEC. 5531. STATE OBLIGATION TO PROVIDE CHILD SUPPORT ENFORCEMENT SERVICES.**

(a) INDIVIDUALS SUBJECT TO FEE FOR CHILD SUPPORT ENFORCEMENT SERVICES.—Section 454(6)(B) (42 U.S.C. 654(6)(B)) is amended by striking ''individuals not receiving assistance under any State program funded under part A, which'' and inserting ''an individual, other than an individual receiving assistance under a State program funded under part A or E, or under a State plan approved under title XIX, or who is required by the State to cooperate with the State agency administering the program under this part pursuant to subsection (l) or (m) of section 6 of the Food Stamp Act of 1977, and''.

(b) CORRECTION OF REFERENCE.—Section 464(a)(2)(A) (42 U.S.C. 654(a)(2)(A)) is amended in the first sentence by striking ''section 454(6)'' and inserting ''section 454(4)(A)(ii)''.

**SEC. 5532. DISTRIBUTION OF COLLECTED SUPPORT.**

(a) CONTINUATION OF ASSIGNMENTS.—Section 457(b) (42 U.S.C. 657(b)) is amended—

(1) by striking ''which were assigned'' and inserting ''assigned''; and

(2) by striking ''and which were in effect'' and all that follows and inserting ''and in effect on September 30, 1997 (or such earlier date, on or after August 22, 1996, as the State may choose), shall remain assigned after such date.''.

(b) STATE OPTION FOR APPLICABILITY.—

(1) IN GENERAL.—Section 457(a) (42 U.S.C. 657(a)) is amended by adding at the end the following:

''(6) STATE OPTION FOR APPLICABILITY.—Notwithstanding any other provision of this subsection, a State may elect to apply the rules described in clauses (i)(II), (ii)(II), and (v) of paragraph (2)(B) to support arrearages collected on and after October 1, 1998, and, if the State makes such an election, shall apply the provisions of this section, as in effect and applied on the day before the date of enactment of section 302 of the Personal Responsibility and Work Opportunity Act of 1996 (Public Law 104–193, 110 Stat. 2200), other than subsection (b)(1) (as so in effect), to amounts collected before October 1, 1998.''.

(2) CONFORMING AMENDMENTS.—Section 408(a)(3)(A) (42 U.S.C. 608(a)(3)(A)) is amended—

(A) in clause (i), by inserting ''(I)'' after ''(i)'';

(B) in clause (ii)—

(i) by striking ''(ii)'' and inserting ''(II)''; and

(ii) by striking the period and inserting ''; or''; and

(C) by adding at the end the following:

''(ii) if the State elects to distribute collections under section 457(a)(6), the date the family ceases to receive assistance under the program, if the assignment is executed on or after October 1, 1998.''.

(c) DISTRIBUTION OF COLLECTIONS WITH RESPECT TO FAMILIES RECEIVING ASSISTANCE.—Section 457(a)(1) (42 U.S.C. 657(a)(1)) is amended by adding at the end the following flush language:

''In no event shall the total of the amounts paid to the Federal Government and retained by the State exceed the total of the amounts that have been paid to the family as assistance by the State.''.

(d) FAMILIES UNDER CERTAIN AGREEMENTS.—Section 457(a)(4) (42 U.S.C. 657(a)(4)) is amended to read as follows:

''(4) FAMILIES UNDER CERTAIN AGREEMENTS.—In the case of an amount collected for a family in accordance with a cooperative agreement under section 454(33), distribute the amount so collected pursuant to the terms of the agreement.''.

(e) STUDY AND REPORT.—Section 457(a)(5) (42 U.S.C. 657(a)(5)) is amended by striking ''1998'' and inserting ''1999''.

(f) CORRECTIONS OF REFERENCES.—Section 457(a)(2)(B) (42 U.S.C. 657(a)(2)(B)) is amended—

(1) in clauses (i)(I) and (ii)(I)—

(A) by striking ''(other than subsection (b)(1))'' each place it appears; and

(B) by inserting ''(other than subsection (b)(1) (as so in effect))'' after ''1996'' each place it appears; and

(2) in clause (ii)(II), by striking ''paragraph (4)'' and inserting ''paragraph (5)''.

(g) CORRECTION OF TERRITORIAL MATCH.—Section 457(c)(3)(A) (42 U.S.C. 657(c)(3)(A)) is amended by striking ''the Federal medical assistance percentage (as defined in section 1118)'' and inserting ''75 percent''.

(h) DEFINITIONS.—

(1) FEDERAL SHARE.—Section 457(c)(2) (42 U.S.C. 657(c)(2)) is amended by striking ''collected'' the second place it appears and inserting ''distributed''.

(2) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—Section 457(c)(3)(B) (42 U.S.C. 657(c)(3)(B)) is amended by striking ''as in effect on September 30, 1996'' and inserting ''as such section was in effect on September 30, 1995''.

(i) CONFORMING AMENDMENTS.—

(1) Section 464(a)(2)(A) (42 U.S.C. 664(a)(2)(A)) is amended, in the penultimate sentence, by inserting ''in accordance with section 457'' after ''owed''.

(2) Section 466(a)(3)(B) (42 U.S.C. 666(a)(3)(B)) is amended by striking ''457(b)(4) or (d)(3)'' and inserting ''457''.

**SEC. 5533. CIVIL PENALTIES RELATING TO STATE DIRECTORY OF NEW HIRES.**

Section 453A (42 U.S.C. 653a) is amended—

(1) in subsection (d)—

(A) in the matter preceding paragraph (1), by striking ''shall be less than'' and inserting ''shall not exceed''; and

(B) in paragraph (1), by striking ''$25'' and inserting ''$25 per failure to meet the requirements of this section with respect to a newly hired employee''; and

(2) in subsection (g)(2)(B), by striking ''extracts'' and all that follows through ''Labor'' and inserting ''information''.

**SEC. 5534. FEDERAL PARENT LOCATOR SERVICE.**

(a) IN GENERAL.—Section 453 (42 U.S.C. 653) is amended—

(1) in subsection (a)—

(A) by inserting ''(1)'' after ''(a)''; and

(B) by striking ''to obtain'' and all that follows through the period and inserting ''for the purposes specified in paragraphs (2) and (3).

''(2) For the purpose of establishing parentage, establishing, setting the amount of, modifying, or enforcing child support obligations, the Federal Parent Locator Service shall obtain and transmit to any authorized person specified in subsection (c)—

''(A) information on, or facilitating the discovery of, the location of any individual—

''(i) who is under an obligation to pay child support;

''(ii) against whom such an obligation is sought; or

''(iii) to whom such an obligation is owed, including the individual's social security number (or numbers), most recent address, and the name, address, and employer identification number of the individual's employer;

''(B) information on the individual's wages (or other income) from, and benefits of, employment (including rights to or enrollment in group health care coverage); and

''(C) information on the type, status, location, and amount of any assets of, or debts owed by or to, any such individual.

''(3) For the purpose of enforcing any Federal or State law with respect to the unlaw-

ful taking or restraint of a child, or making or enforcing a child custody or visitation determination, as defined in section 463(d)(1), the Federal Parent Locator Service shall be used to obtain and transmit the information specified in section 463(c) to the authorized persons specified in section 463(d)(2).'';

(2) by striking subsection (b) and inserting the following:

''(b)(1) Upon request, filed in accordance with subsection (d), of any authorized person, as defined in subsection (c) for the information described in subsection (a)(2), or of any authorized person, as defined in section 463(d)(2) for the information described in section 463(c), the Secretary shall, notwithstanding any other provision of law, provide through the Federal Parent Locator Service such information to such person, if such information—

''(A) is contained in any files or records maintained by the Secretary or by the Department of Health and Human Services; or

''(B) is not contained in such files or records, but can be obtained by the Secretary, under the authority conferred by subsection (e), from any other department, agency, or instrumentality of the United States or of any State,

and is not prohibited from disclosure under paragraph (2).

''(2) No information shall be disclosed to any person if the disclosure of such information would contravene the national policy or security interests of the United States or the confidentiality of census data. The Secretary shall give priority to requests made by any authorized person described in subsection (c)(1). No information shall be disclosed to any person if the State has notified the Secretary that the State has reasonable evidence of domestic violence or child abuse and the disclosure of such information could be harmful to the custodial parent or the child of such parent, provided that—

''(A) in response to a request from an authorized person (as defined in subsection (c) of this section and section 463(d)(2)), the Secretary shall advise the authorized person that the Secretary has been notified that there is reasonable evidence of domestic violence or child abuse and that information can only be disclosed to a court or an agent of a court pursuant to subparagraph (B); and

''(B) information may be disclosed to a court or an agent of a court described in subsection (c)(2) of this section or section 463(d)(2)(B), if—

''(i) upon receipt of information from the Secretary, the court determines whether disclosure to any other person of that information could be harmful to the parent or the child; and

''(ii) if the court determines that disclosure of such information to any other person could be harmful, the court and its agents shall not make any such disclosure.

''(3) Information received or transmitted pursuant to this section shall be subject to the safeguard provisions contained in section 454(26).''; and

(3) in subsection (c)—

(A) in paragraph (1), by striking ''or to seek to enforce orders providing child custody or visitation rights''; and

(B) in paragraph (2)—

(i) by inserting ''or to serve as the initiating court in an action to seek an order'' after ''issue an order''; and

(ii) by striking ''or to issue an order against a resident parent for child custody or visitation rights''.

(b) USE OF THE FEDERAL PARENT LOCATOR SERVICE.—Section 463 (42 U.S.C. 663) is amended—

(1) in subsection (a)—

(A) in the matter preceding paragraph (1)—

(i) by striking ''any State which is able and willing to do so,'' and inserting ''every State''; and

(ii) by striking ''such State'' and inserting ''each State''; and

(B) in paragraph (2), by inserting ''or visitation'' after ''custody'';

(2) in subsection (b)(2), by inserting ''or visitation'' after ''custody'';

(3) in subsection (d)—

(A) in paragraph (1), by inserting ''or visitation'' after ''custody''; and

(B) in subparagraphs (A) and (B) of paragraph (2), by inserting ''or visitation'' after ''custody'' each place it appears;

(4) in subsection (f)(2), by inserting ''or visitation'' after ''custody''; and

(5) by striking ''noncustodial'' each place it appears.

**SEC. 5535. ACCESS TO REGISTRY DATA FOR RESEARCH PURPOSES.**

(a) IN GENERAL.—Section 453(j)(5) (42 U.S.C. 653(j)(5)) is amended by inserting ''data in each component of the Federal Parent Locator Service maintained under this section and to'' before ''information''.

(b) CONFORMING AMENDMENTS.—Section 453 (42 U.S.C. 653) is amended—

(1) in subsection (j)(3)(B), by striking ''registries'' and inserting ''components''; and

(2) in subsection (k)(2), by striking ''subsection (j)(3)'' and inserting ''section 453A(g)(2)''.

**SEC. 5536. COLLECTION AND USE OF SOCIAL SECURITY NUMBERS FOR USE IN CHILD SUPPORT ENFORCEMENT.**

Section 466(a)(13) (42 U.S.C. 666(a)(13)) is amended—

(1) in subparagraph (A)—

(A) by striking ''commercial''; and

(B) by inserting ''recreational license,'' after ''occupational license,''; and

(2) in the matter following subparagraph (C), by inserting ''to be used on the face of the document while the social security number is kept on file at the agency'' after ''other than the social security number''.

**SEC. 5537. ADOPTION OF UNIFORM STATE LAWS.**

Section 466(f) (42 U.S.C. 666(f)) is amended by striking ''together'' and all that follows and inserting ''and as in effect on August 22, 1996, including any amendments officially adopted as of such date by the National Conference of Commissioners on Uniform State Laws.''.

**SEC. 5538. STATE LAWS PROVIDING EXPEDITED PROCEDURES.**

Section 466(c) (42 U.S.C. 666(c)) is amended—

(1) in paragraph (1)—

(A) in subparagraph (E), by inserting '', part E,'' after ''part A''; and

(B) in subparagraph (G), by inserting ''any current support obligation and'' after ''to satisfy''; and

(2) in paragraph (2)(A)—

(A) in clause (i), by striking ''the tribunal and''; and

(B) in clause (ii)—

(i) by striking ''tribunal may'' and inserting ''court or administrative agency of competent jurisdiction shall''; and

(ii) by striking ''filed with the tribunal'' and inserting ''filed with the State case registry''.

**SEC. 5539. VOLUNTARY PATERNITY ACKNOWLEDGEMENT.**

Section 466(a)(5)(C)(i) (42 U.S.C. 666(a)(5)(C)(i)) is amended by inserting '', or through the use of video or audio equipment,'' after ''orally''.

**SEC. 5540. CALCULATION OF PATERNITY ESTABLISHMENT PERCENTAGE.**

Section 452(g)(2) (42 U.S.C. 652(g)(2)) is amended, in the matter following subparagraph (C), by striking ''subparagraph (A)'' and inserting ''subparagraphs (A) and (B)''.

**SEC. 5541. MEANS AVAILABLE FOR PROVISION OF TECHNICAL ASSISTANCE AND OPERATION OF FEDERAL PARENT LOCATOR SERVICE.**

(a) TECHNICAL ASSISTANCE.—Section 452(j) (42 U.S.C. 652(j)) is amended, in the matter preceding paragraph (1), by striking ''to cover costs incurred by the Secretary'' and inserting ''which shall be available for use by the Secretary, either directly or through grants, contracts, or interagency agreements,''.

(b) OPERATION OF FEDERAL PARENT LOCATOR SERVICE.—

(1) MEANS AVAILABLE.—Section 453(o) (42 U.S.C. 653(o)) is amended—

(A) in the heading, by striking ''RECOVERY OF COSTS'' and inserting ''USE OF SET-ASIDE FUNDS''; and

(B) by striking ''to cover costs incurred by the Secretary'' and inserting ''which shall be available for use by the Secretary, either directly or through grants, contracts, or interagency agreements,''.

(2) AVAILABILITY OF FUNDS.—Section 453(o) (42 U.S.C. 653(o)) is amended by adding at the end the following: ''Amounts appropriated under this subsection for each of fiscal years 1997 through 2001 shall remain available until expended.''.

**SEC. 5542. AUTHORITY TO COLLECT SUPPORT FROM FEDERAL EMPLOYEES.**

(a) RESPONSE TO NOTICE OR PROCESS.—Section 459(c)(2)(C) (42 U.S.C. 659(c)(2)(C)) is amended by striking ''respond to the order, process, or interrogatory'' and inserting ''withhold available sums in response to the order or process, or answer the interrogatory''.

(b) MONEYS SUBJECT TO PROCESS.—Section 459(h)(1) (42 U.S.C. 659(h)(1)) is amended—

(1) in the matter preceding subparagraph (A) and in subparagraph (A)(i), by striking ''paid or'' each place it appears;

(2) in subparagraph (A)—

(A) in clause (ii)(V), by striking ''and'' at the end;

(B) in clause (iii)—

(i) by inserting ''or payable'' after ''paid''; and

(ii) by striking ''but'' and inserting ''; and''; and

(C) by inserting after clause (iii), the following:

''(iv) benefits paid or payable under the Railroad Retirement System, but''; and

(3) in subparagraph (B)—

(A) in clause (i), by striking ''or'' at the end;

(B) in clause (ii), by striking the period and inserting ''; or''; and

(C) by adding at the end the following:

''(iii) of periodic benefits under title 38, United States Code, except as provided in subparagraph (A)(ii)(V).''.

(c) CONFORMING AMENDMENT.—Section 454(19)(B)(ii) (42 U.S.C. 654(19)(B)(ii)) is amended by striking ''section 462(e)'' and inserting ''section 459(i)(5)''.

**SEC. 5543. DEFINITION OF SUPPORT ORDER.**

Section 453(p) (42 U.S.C. 653(p)), is amended by striking ''a child and'' and inserting ''of''.

**SEC. 5544. STATE LAW AUTHORIZING SUSPENSION OF LICENSES.**

Section 466(a)(16) (42 U.S.C. 666(a)(16)) is amended by inserting ''and sporting'' after ''recreational''.

**SEC. 5545. INTERNATIONAL SUPPORT ENFORCEMENT.**

Section 454(32)(A) (42 U.S.C. 654(32)(A)) is amended by striking ''section 459A(d)(2)'' and inserting ''section 459A(d)''.

**SEC. 5546. CHILD SUPPORT ENFORCEMENT FOR INDIAN TRIBES.**

(a) COOPERATIVE AGREEMENTS BY INDIAN TRIBES AND STATES FOR CHILD SUPPORT ENFORCEMENT.—Section 454(33) (42 U.S.C. 654(33)) is amended—

(1) by striking ''and enforce support orders, and'' and inserting ''or enforce support orders, or'';

(2) by striking ''guidelines established by such tribe or organization'' and inserting ''guidelines established or adopted by such tribe or organization'';

(3) by striking ''funding collected'' and inserting ''collections''; and

(4) by striking ''such funding'' and inserting ''such collections''.

(b) CORRECTION OF SUBSECTION DESIGNATION.—Section 455 (42 U.S.C. 655) is amended by redesignating subsection (b), as added by section 375(b) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193, 110 Stat. 2256), as subsection (f).

(c) DIRECT GRANTS TO TRIBES.—Section 455(f) (42 U.S.C. 655(f)), as so redesignated by subsection (b) of this section, is amended to read as follows:

''(f) The Secretary may make direct payments under this part to an Indian tribe or tribal organization that demonstrates to the satisfaction of the Secretary that it has the capacity to operate a child support enforcement program meeting the objectives of this part, including establishment of paternity, establishment, modification, and enforcement of support orders, and location of absent parents. The Secretary shall promulgate regulations establishing the requirements which must be met by an Indian tribe or tribal organization to be eligible for a grant under this subsection.''.

**SEC. 5547. CONTINUATION OF RULES FOR DISTRIBUTION OF SUPPORT IN THE CASE OF A TITLE IV–E CHILD.**

Section 457 (42 U.S.C. 657) is amended—

(1) in subsection (a), in the matter preceding paragraph (1), by striking ''subsection (e)'' and inserting ''subsections (e) and (f)''; and

(2) by adding at the end the following:

''(f) Notwithstanding the preceding provisions of this section, amounts collected by a State as child support for months in any period on behalf of a child for whom a public agency is making foster care maintenance payments under part E—

''(1) shall be retained by the State to the extent necessary to reimburse it for the foster care maintenance payments made with respect to the child during such period (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing);

''(2) shall be paid to the public agency responsible for supervising the placement of the child to the extent that the amounts collected exceed the foster care maintenance payments made with respect to the child during such period but not the amounts required by a court or administrative order to be paid as support on behalf of the child during such period; and the responsible agency may use the payments in the manner it determines will serve the best interests of the child, including setting such payments aside for the child's future needs or making all or a part thereof available to the person responsible for meeting the child's day-to-day needs; and

''(3) shall be retained by the State, if any portion of the amounts collected remains after making the payments required under paragraphs (1) and (2), to the extent that such portion is necessary to reimburse the State (with appropriate reimbursement to the Federal Government to the extent of its participation in the financing) for any past foster care maintenance payments (or payments of assistance under the State program funded under part A) which were made with respect to the child (and with respect to which past collections have not previously been retained);

and any balance shall be paid to the State agency responsible for supervising the placement of the child, for use by such agency in accordance with paragraph (2).''.

**SEC. 5548. GOOD CAUSE IN FOSTER CARE AND FOOD STAMP CASES.**

(a) STATE PLAN.—Section 454(4)(A)(i) (42 U.S.C. 654(4)(A)(i)) is amended—

(1) by striking ''or'' before ''(III)''; and

(2) by inserting ''or (IV) cooperation is required pursuant to section 6(l)(1) of the Food Stamp Act of 1977 (7 U.S.C. 2015(l)(1)),'' after ''title XIX,''.

(b) CONFORMING AMENDMENTS.—Section 454(29) (42 U.S.C. 654(29)) is amended—

(1) in subparagraph (A)—

(A) in the matter preceding clause (i), by striking ''part A of this title or the State program under title XIX'' and inserting ''part A, the State program under part E, the State program under title XIX, or the food stamp program, as defined under section 3(h) of the Food Stamp Act of 1977 (7 U.S.C. 2012(h)),''; and

(B) by striking clauses (i) and (ii) and all that follows through the semicolon and inserting the following:

''(i) in the case of the State program funded under part A, the State program under part E, or the State program under title XIX shall, at the option of the State, be defined, taking into account the best interests of the child, and applied in each case, by the State agency administering such program; and

''(ii) in the case of the food stamp program, as defined under section 3(h) of the Food Stamp Act of 1977 (7 U.S.C. 2012(h)), shall be defined and applied in each case under that program in accordance with section 6(l)(2) of the Food Stamp Act of 1977 (7 U.S.C. 2015(l)(2));'';

(2) in subparagraph (D), by striking ''or the State program under title XIX'' and inserting ''the State program under part E, the State program under title XIX, or the food stamp program, as defined under section 3(h) of the Food Stamp Act of 1977 (7 U.S.C. 2012(h))''; and

(3) in subparagraph (E), by striking ''individual,'' and all that follows through ''XIX,'' and inserting ''individual and the State agency administering the State program funded under part A, the State agency administering the State program under part E, the State agency administering the State program under title XIX, or the State agency administering the food stamp program, as defined under section 3(h) of the Food Stamp Act of 1977 (7 U.S.C. 2012(h)),''.

**SEC. 5549. DATE OF COLLECTION OF SUPPORT.**

Section 454B(c)(1) (42 U.S.C. 654B(c)(1)) is amended by adding at the end the following: ''The date of collection for amounts collected and distributed under this part is the date of receipt by the State disbursement unit, except that if current support is withheld by an employer in the month when due and is received by the State disbursement unit in a month other than the month when due, the date of withholding may be deemed to be the date of collection.''.

**SEC. 5550. ADMINISTRATIVE ENFORCEMENT IN INTERSTATE CASES.**

(a) PROCEDURES.—Section 466(a)(14) (42 U.S.C. 666(a)(14)) is amended to read as follows:

''(14) HIGH-VOLUME, AUTOMATED ADMINISTRATIVE ENFORCEMENT IN INTERSTATE CASES.—

''(A) IN GENERAL.—Procedures under which—

''(i) the State shall use high-volume automated administrative enforcement, to the same extent as used for intrastate cases, in response to a request made by another State to enforce support orders, and shall promptly report the results of such enforcement procedure to the requesting State;

''(ii) the State may, by electronic or other means, transmit to another State a request for assistance in enforcing support orders through high-volume, automated administrative enforcement, which request—

''(I) shall include such information as will enable the State to which the request is transmitted to compare the information about the cases to the information in the data bases of the State; and

''(II) shall constitute a certification by the requesting State—

''(aa) of the amount of support under an order the payment of which is in arrears; and

''(bb) that the requesting State has complied with all procedural due process requirements applicable to each case;

''(iii) if the State provides assistance to another State pursuant to this paragraph with respect to a case, neither State shall consider the case to be transferred to the caseload of such other State; and

''(iv) the State shall maintain records of—

''(I) the number of such requests for assistance received by the State;

''(II) the number of cases for which the State collected support in response to such a request; and

''(III) the amount of such collected support.

''(B) HIGH-VOLUME AUTOMATED ADMINISTRATIVE ENFORCEMENT.—In this part, the term 'high-volume automated administrative enforcement' means the use of automatic data processing to search various State data bases, including license records, employment service data, and State new hire registries, to determine whether information is available regarding a parent who owes a child support obligation.''.

(b) INCENTIVE PAYMENTS.—Section 458(d) (42 U.S.C. 658(d)) is amended by inserting '', including amounts collected under section 466(a)(14),'' after ''another State''.

**SEC. 5551. WORK ORDERS FOR ARREARAGES.**

Section 466(a)(15) (42 U.S.C. 666(a)(15)) is amended to read as follows:

''(15) PROCEDURES TO ENSURE THAT PERSONS OWING OVERDUE SUPPORT WORK OR HAVE A PLAN FOR PAYMENT OF SUCH SUPPORT.—Procedures under which the State has the authority, in any case in which an individual owes overdue support with respect to a child receiving assistance under a State program funded under part A, to issue an order or to request that a court or an administrative process established pursuant to State law issue an order that requires the individual to—

''(A) pay such support in accordance with a plan approved by the court, or, at the option of the State, a plan approved by the State agency administering the State program under this part; or

''(B) if the individual is subject to such a plan and is not incapacitated, participate in such work activities (as defined in section 407(d)) as the court, or, at the option of the State, the State agency administering the State program under this part, deems appropriate.''.

**SEC. 5552. ADDITIONAL TECHNICAL STATE PLAN AMENDMENTS.**

Section 454 (42 U.S.C. 654) is amended—

(1) in paragraph (8)—

(A) in the matter preceding subparagraph (A)—

(i) by striking ''noncustodial''; and

(ii) by inserting '', for the purpose of establishing parentage, establishing, setting the amount of, modifying, or enforcing child support obligations, or making or enforcing a child custody or visitation determination, as defined in section 463(d)(1)'' after ''provide that'';

(B) in subparagraph (A), by striking the comma and inserting a semicolon;

(C) in subparagraph (B), by striking the semicolon and inserting a comma; and

(D) by inserting after subparagraph (B), the following flush language:

''and shall, subject to the privacy safeguards required under paragraph (26), disclose only the information described in sections 453 and 463 to the authorized persons specified in such sections for the purposes specified in such sections;'';

(2) in paragraph (17)—

(A) by striking ''in the case of a State which has'' and inserting ''provide that the State will have''; and

(B) by inserting ''and'' after ''section 453,''; and

(3) in paragraph (26)—

(A) in the matter preceding subparagraph (A), by striking ''will'';

(B) in subparagraph (A)—

(i) by inserting '', modify,'' after ''establish'', the second place it appears; and

(ii) by inserting '', or to make or enforce a child custody determination'' after ''support'';

(C) in subparagraph (B)—

(i) by inserting ''or the child'' after ''1 party'';

(ii) by inserting ''or the child'' after ''former party''; and

(iii) by striking ''and'' at the end;

(D) in subparagraph (C)—

(i) by inserting ''or the child'' after ''1 party'';

(ii) by striking ''another party'' and inserting ''another person'';

(iii) by inserting ''to that person'' after ''release of the information''; and

(iv) by striking ''former party'' and inserting ''party or the child''; and

(E) by adding at the end the following:

''(D) in cases in which the prohibitions under subparagraphs (B) and (C) apply, the requirement to notify the Secretary, for purposes of section 453(b)(2), that the State has reasonable evidence of domestic violence or child abuse against a party or the child and that the disclosure of such information could be harmful to the party or the child; and

''(E) procedures providing that when the Secretary discloses information about a parent or child to a State court or an agent of a State court described in section 453(c)(2) or 463(d)(2)(B), and advises that court or agent that the Secretary has been notified that there is reasonable evidence of domestic violence or child abuse pursuant to section 453(b)(2), the court shall determine whether disclosure to any other person of information received from the Secretary could be harmful to the parent or child and, if the court determines that disclosure to any other person could be harmful, the court and its agents shall not make any such disclosure;''.

**SEC. 5553. FEDERAL CASE REGISTRY OF CHILD SUPPORT ORDERS.**

Section 453(h) (42 U.S.C. 653(h)) is amended—

(1) in paragraph (1), by inserting ''and order'' after ''with respect to each case''; and

(2) in paragraph (2)—

(A) in the heading, by inserting ''AND ORDER'' after ''CASE'';

(B) by inserting ''or an order'' after ''with respect to a case'' and

(C) by inserting ''or order'' after ''and the State or States which have the case''.

**SEC. 5554. FULL FAITH AND CREDIT FOR CHILD SUPPORT ORDERS.**

Section 1738B(f) of title 28, United States Code, is amended—

(1) in paragraph (4), by striking ''a court may'' and all that follows and inserting ''a court having jurisdiction over the parties shall issue a child support order, which must be recognized.''; and

(2) in paragraph (5), by inserting ''under subsection (d)'' after ''jurisdiction''.

**SEC. 5555. DEVELOPMENT COSTS OF AUTOMATED SYSTEMS.**

(a) DEFINITION OF STATE.—Section 455(a)(3)(B) (42 U.S.C. 655(a)(3)(B)) is amended—

(1) in clause (i)—

(A) by inserting ''or system described in clause (iii)'' after ''each State''; and

(B) by inserting ''or system'' after ''the State''; and

(2) by adding at the end the following:

''(iii) For purposes of clause (i), a system described in this clause is a system that has been approved by the Secretary to receive enhanced funding pursuant to the Family Support Act of 1988 (Public Law 100–485; 102 Stat. 2343) for the purpose of developing a system that meets the requirements of sections 454(16) (as in effect on and after September 30, 1995) and 454A, including systems that have received funding for such purpose pursuant to a waiver under section 1115(a).''.

(b) TEMPORARY LIMITATION ON PAYMENTS.—Section 344(b)(2) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (42 U.S.C. 655 note) is amended—

(1) in subparagraph (B)—

(A) by inserting ''or a system described in subparagraph (C)'' after ''to a State''; and

(B) by inserting ''or system'' after ''for the State''; and

(2) in subparagraph (C), by striking ''Act,'' and all that follows and inserting ''Act, and among systems that have been approved by the Secretary to receive enhanced funding pursuant to the Family Support Act of 1988 (Public Law 100–485; 102 Stat. 2343) for the purpose of developing a system that meets the requirements of sections 454(16) (as in effect on and after September 30, 1995) and 454A, including systems that have received funding for such purpose pursuant to a waiver under section 1115(a), which shall take into account—

''(i) the relative size of such State and system caseloads under part D of title IV of the Social Security Act; and

''(ii) the level of automation needed to meet the automated data processing requirements of such part.''.

**SEC. 5556. ADDITIONAL TECHNICAL AMENDMENTS.**

(a) ELIMINATION OF SURPLUSAGE.—Section 466(c)(1)(F) (42 U.S.C. 666(c)(1)(F)) is amended by striking ''of section 466''.

(b) CORRECTION OF AMBIGUOUS AMENDMENT.—Section 344(a)(1)(F) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2234) is amended by inserting ''the first place such term appears'' before ''and all that follows''.

(c) CORRECTION OF ERRONEOUSLY DRAFTED PROVISION.—Section 215 of the Department of Health and Human Services Appropriations Act, 1997, (as contained in section 101(e) of the Omnibus Consolidated Appropriations Act, 1997) is amended to read as follows:

''SEC. 215. Sections 452(j) and 453(o) of the Social Security Act (42 U.S.C. 652(j) and 653(o)), as amended by section 345 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2237) are each amended by striking 'section 457(a)' and inserting 'a plan approved under this part'. Amounts available under such sections 452(j) and 453(o) shall be calculated as though the amendments made by this section were effective October 1, 1995.''.

(d) ELIMINATION OF SURPLUSAGE.—Section 456(a)(2)(B) (42 U.S.C. 656(a)(2)(B)) is amended by striking '', and'' and inserting a period.

(e) CORRECTION OF DATE.—Section 466(a)(1)(B) (42 U.S.C. 666(a)(1)(B)) is amended by striking ''October 1, 1996'' and inserting ''January 1, 1994''.

**SEC. 5557. EFFECTIVE DATE.**

(a) IN GENERAL.—Except as provided in subsection (b), the amendments made by this chapter shall take effect as if included in the enactment of title III of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2105).

(b) EXCEPTION.—The amendments made by section 5532(b)(2) of this Act shall take effect as if the amendments had been included in the enactment of section 103(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2112).

## CHAPTER 4—RESTRICTING WELFARE AND PUBLIC BENEFITS FOR ALIENS

### Subchapter A—Eligibility for Federal Benefits

**SEC. 5561. ALIEN ELIGIBILITY FOR FEDERAL BENEFITS: LIMITED APPLICATION TO MEDICARE AND BENEFITS UNDER THE RAILROAD RETIREMENT ACT.**

(a) LIMITED APPLICATION TO MEDICARE.—Section 401(b) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1611(b)) is amended by adding at the end the following:

''(3) Subsection (a) shall not apply to any benefit payable under title XVIII of the Social Security Act (relating to the medicare program) to an alien who is lawfully present in the United States as determined by the Attorney General and, with respect to benefits payable under part A of such title, who was authorized to be employed with respect to any wages attributable to employment which are counted for purposes of eligibility for such benefits.''.

(b) LIMITED APPLICATION TO BENEFITS UNDER THE RAILROAD RETIREMENT ACT.—Section 401(b) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1611(b)) (as amended by subsection (a)) is amended by inserting at the end the following:

''(4) Subsection (a) shall not apply to any benefit payable under the Railroad Retirement Act of 1974 or the Railroad Unemployment Insurance Act to an alien who is lawfully present in the United States as determined by the Attorney General or to an alien residing outside the United States.''.

**SEC. 5562. EXCEPTIONS TO BENEFIT LIMITATIONS: CORRECTIONS TO REFERENCE CONCERNING ALIENS WHOSE DEPORTATION IS WITHHELD.**

Sections 402(a)(2)(A), 402(b)(2)(A), 403(b)(1)(C), 412(b)(1)(C), and 431(b)(5) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(A), 1612(b)(2)(A), 1613(b)(1)(C), 1622(b)(1)(C), and 1641(b)(5)) as amended by this Act are each amended by striking ''section 243(h) of such Act'' each place it appears and inserting ''section 243(h) of such Act (as in effect immediately before the effective date of section 307 of division C of Public Law 104–208) or section 241(b)(3) of such Act (as amended by section 305(a) of division C of Public Law 104–208)''.

**SEC. 5563. VETERANS EXCEPTION: APPLICATION OF MINIMUM ACTIVE DUTY SERVICE REQUIREMENT; EXTENSION TO UNREMARRIED SURVIVING SPOUSE; EXPANDED DEFINITION OF VETERAN.**

(a) APPLICATION OF MINIMUM ACTIVE DUTY SERVICE REQUIREMENT.—Sections 402(a)(2)(C)(i), 402(b)(2)(C)(i), 403(b)(2)(A), and 412(b)(3)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(C)(i), 1612(b)(2)(C)(i), 1613(b)(2)(A), and 1622(b)(3)(A)) are each amended by inserting ''and who fulfills the minimum active-duty service requirements of section 5303A(d) of title 38, United States Code'' after ''alienage''.

(b) EXCEPTION APPLICABLE TO UNREMARRIED SURVIVING SPOUSE.—Sections 402(a)(2)(C)(iii), 402(b)(2)(C)(iii), 403(b)(2)(C), and 412(b)(3)(C)

of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(C)(iii), 1612(b)(2)(C)(iii), 1613(b)(2)(C), and 1622(b)(3)(C)) are each amended by inserting before the period ''or the unremarried surviving spouse of an individual described in clause (i) or (ii) who is deceased if the marriage fulfills the requirements of section 1304 of title 38, United States Code''.

(c) EXPANDED DEFINITION OF VETERAN.—Sections 402(a)(2)(C)(i), 402(b)(2)(C)(i), 403(b)(2)(A), and 412(b)(3)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1612(a)(2)(C)(i), 1612(b)(2)(C)(i), 1613(b)(2)(A), and 1622(b)(3)(A)) are each amended by inserting '', 1101, or 1301, or as described in section 107'' after ''section 101''.

**SEC. 5564. NOTIFICATION CONCERNING ALIENS NOT LAWFULLY PRESENT: CORRECTION OF TERMINOLOGY.**

Section 1631(e)(9) of the Social Security Act (42 U.S.C. 1383(e)(9)) and section 27 of the United States Housing Act of 1937, as added by section 404 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, are each amended by striking ''unlawfully in the United States'' each place it appears and inserting ''not lawfully present in the United States''.

**SEC. 5565. FREELY ASSOCIATED STATES: CONTRACTS AND LICENSES.**

Sections 401(c)(2)(A) and 411(c)(2)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1611(c)(2)(A) and 1621(c)(2)(A)) are each amended by inserting before the semicolon at the end '', or to a citizen of a freely associated state, if section 141 of the applicable compact of free association approved in Public Law 99–239 or 99–658 (or a successor provision) is in effect''.

**SEC. 5566. CONGRESSIONAL STATEMENT REGARDING BENEFITS FOR HMONG AND OTHER HIGHLAND LAO VETERANS.**

(a) FINDINGS.—The Congress makes the following findings:

(1) Hmong and other Highland Lao tribal peoples were recruited, armed, trained, and funded for military operations by the United States Department of Defense, Central Intelligence Agency, Department of State, and Agency for International Development to further United States national security interests during the Vietnam conflict.

(2) Hmong and other Highland Lao tribal forces sacrificed their own lives and saved the lives of American military personnel by rescuing downed American pilots and aircrews and by engaging and successfully fighting North Vietnamese troops.

(3) Thousands of Hmong and other Highland Lao veterans who fought in special guerilla units on behalf of the United States during the Vietnam conflict, along with their families, have been lawfully admitted to the United States in recent years.

(4) The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193), the new national welfare reform law, restricts certain welfare benefits for noncitizens of the United States and the exceptions for noncitizen veterans of the Armed Forces of the United States do not extend to Hmong veterans of the Vietnam conflict era, making Hmong veterans and their families receiving certain welfare benefits subject to restrictions despite their military service on behalf of the United States.

(b) CONGRESSIONAL STATEMENT.—It is the sense of the Congress that Hmong and other Highland Lao veterans who fought on behalf of the Armed Forces of the United States during the Vietnam conflict and have lawfully been admitted to the United States for permanent residence should be considered veterans for purposes of continuing certain welfare benefits consistent with the exceptions provided other noncitizen veterans under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

## Subchapter B—General Provisions

**SEC. 5571. DETERMINATION OF TREATMENT OF BATTERED ALIENS AS QUALIFIED ALIENS; INCLUSION OF ALIEN CHILD OF BATTERED PARENT AS QUALIFIED ALIEN.**

(a) DETERMINATION OF STATUS BY AGENCY PROVIDING BENEFITS.—Section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641) is amended in subsections (c)(1)(A) and (c)(2)(A) by striking ''Attorney General, which opinion is not subject to review by any court)'' each place it appears and inserting ''agency providing such benefits)''.

(b) GUIDANCE ISSUED BY ATTORNEY GENERAL.—Section 431(c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641(c)) is amended by adding at the end the following new undesignated paragraph:

''After consultation with the Secretaries of Health and Human Services, Agriculture, and Housing and Urban Development, the Commissioner of Social Security, and with the heads of such Federal agencies administering benefits as the Attorney General considers appropriate, the Attorney General shall issue guidance (in the Attorney General's sole and unreviewable discretion) for purposes of this subsection and section 421(f), concerning the meaning of the terms 'battery' and 'extreme cruelty', and the standards and methods to be used for determining whether a substantial connection exists between battery or cruelty suffered and an individual's need for benefits under a specific Federal, State, or local program.''.

(c) INCLUSION OF ALIEN CHILD OF BATTERED PARENT AS QUALIFIED ALIEN.—Section 431(c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641(c)) is amended—

(1) at the end of paragraph (1)(B)(iv) by striking ''or'';

(2) at the end of paragraph (2)(B) by striking the period and inserting ''; or''; and

(3) by inserting after paragraph (2)(B) and before the last sentence of such subsection the following new paragraph:

''(3) an alien child who—

''(A) resides in the same household as a parent who has been battered or subjected to extreme cruelty in the United States by that parent's spouse or by a member of the spouse's family residing in the same household as the parent and the spouse consented or acquiesced to such battery or cruelty, but only if (in the opinion of the agency providing such benefits) there is a substantial connection between such battery or cruelty and the need for the benefits to be provided; and

''(B) who meets the requirement of subparagraph (B) of paragraph (1).''.

(d) INCLUSION OF ALIEN CHILD OF BATTERED PARENT UNDER SPECIAL RULE FOR ATTRIBUTION OF INCOME.—Section 421(f)(1)(A) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1631(f)(1)(A)) is amended—

(1) at the end of clause (i) by striking ''or''; and

(2) by striking ''and the battery or cruelty described in clause (i) or (ii)'' and inserting ''or (iii) the alien is a child whose parent (who resides in the same household as the alien child) has been battered or subjected to extreme cruelty in the United States by that parent's spouse, or by a member of the spouse's family residing in the same household as the parent and the spouse consented to, or acquiesced in, such battery or cruelty, and the battery or cruelty described in clause (i), (ii), or (iii)''.

**SEC. 5572. VERIFICATION OF ELIGIBILITY FOR BENEFITS.**

(a) REGULATIONS AND GUIDANCE.—Section 432(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1642(a)) is amended—

(1) by inserting at the end of paragraph (1) the following: ''Not later than 90 days after the date of the enactment of the Balanced Budget Act of 1997, the Attorney General of the United States, after consultation with the Secretary of Health and Human Services, shall issue interim verification guidance.''; and

(2) by adding after paragraph (2) the following new paragraph:

''(3) Not later than 90 days after the date of the enactment of the Balanced Budget Act of 1997, the Attorney General shall promulgate regulations which set forth the procedures by which a State or local government can verify whether an alien applying for a State or local public benefit is a qualified alien, a nonimmigrant under the Immigration and Nationality Act, or an alien paroled into the United States under section 212(d)(5) of the Immigration and Nationality Act for less than 1 year, for purposes of determining whether the alien is ineligible for benefits under section 411 of this Act.''.

(b) DISCLOSURE OF INFORMATION FOR VERIFICATION.—Section 384(b) of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (division C of Public Law 104–208) is amended by adding after paragraph (4) the following new paragraph:

''(5) The Attorney General is authorized to disclose information, to Federal, State, and local public and private agencies providing benefits, to be used solely in making determinations of eligibility for benefits pursuant to section 431(c) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.''.

**SEC. 5573. QUALIFYING QUARTERS: DISCLOSURE OF QUARTERS OF COVERAGE INFORMATION; CORRECTION TO ASSURE THAT CREDITING APPLIES TO ALL QUARTERS EARNED BY PARENTS BEFORE CHILD IS 18.**

(a) DISCLOSURE OF QUARTERS OF COVERAGE INFORMATION.—Section 435 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1645) is amended by adding at the end the following: ''Notwithstanding section 6103 of the Internal Revenue Code of 1986, the Commissioner of Social Security is authorized to disclose quarters of coverage information concerning an alien and an alien's spouse or parents to a government agency for the purposes of this title.''.

(b) CORRECTION TO ASSURE THAT CREDITING APPLIES TO ALL QUARTERS EARNED BY PARENTS BEFORE CHILD IS 18.—Section 435(1) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1645(1)) is amended by striking ''while the alien was under age 18,'' and inserting ''before the date on which the alien attains age 18,''.

**SEC. 5574. STATUTORY CONSTRUCTION: BENEFIT ELIGIBILITY LIMITATIONS APPLICABLE ONLY WITH RESPECT TO ALIENS PRESENT IN THE UNITED STATES.**

Section 433 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1643) is amended—

(1) by redesignating subsections (b) and (c) as subsections (c) and (d); and

(2) by adding after subsection (a) the following new subsection:

''(b) BENEFIT ELIGIBILITY LIMITATIONS APPLICABLE ONLY WITH RESPECT TO ALIENS PRESENT IN THE UNITED STATES.—Notwithstanding any other provision of this title, the limitations on eligibility for benefits under this title shall not apply to eligibility

for benefits of aliens who are not residing, or present, in the United States with respect to—

''(1) wages, pensions, annuities, and other earned payments to which an alien is entitled resulting from employment by, or on behalf of, a Federal, State, or local government agency which was not prohibited during the period of such employment or service under section 274A or other applicable provision of the Immigration and Nationality Act; or

''(2) benefits under laws administered by the Secretary of Veterans Affairs.''.

**Subchapter C—Miscellaneous Clerical and Technical Amendments; Effective Date**

**SEC. 5581. CORRECTING MISCELLANEOUS CLERICAL AND TECHNICAL ERRORS.**

(a) INFORMATION REPORTING UNDER TITLE IV OF THE SOCIAL SECURITY ACT.—Effective July 1, 1997, section 408 (42 U.S.C. 608), as amended by sections 5001(h)(1) and 5505(e) of this Act, is amended by adding at the end the following new subsection:

''(g) STATE REQUIRED TO PROVIDE CERTAIN INFORMATION.—Each State to which a grant is made under section 403 shall, at least 4 times annually and upon request of the Immigration and Naturalization Service, furnish the Immigration and Naturalization Service with the name and address of, and other identifying information on, any individual who the State knows is not lawfully present in the United States.''.

(b) MISCELLANEOUS CLERICAL AND TECHNICAL CORRECTIONS.—

(1) Section 411(c)(3) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1621(c)(3)) is amended by striking ''4001(c)'' and inserting ''401(c)''.

(2) Section 422(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1632(a)) is amended by striking ''benefits (as defined in section 412(c)),'' and inserting ''benefits,''.

(3) Section 412(b)(1)(C) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1622(b)(1)(C)) is amended by striking ''with-holding'' and inserting ''withholding''.

(4) The subtitle heading for subtitle D of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is amended to read as follows:

**''Subtitle D—General Provisions''.**

(5) The subtitle heading for subtitle F of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 is amended to read as follows:

**''Subtitle F—Earned Income Credit Denied to Unauthorized Employees''.**

(6) Section 431(c)(2)(B) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641(c)(2)(B)) is amended by striking ''clause (ii) of subparagraph (A)'' and inserting ''subparagraph (B) of paragraph (1)''.

(7) Section 431(c)(1)(B) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (8 U.S.C. 1641(c)(1)(B)) is amended—

(A) in clause (iii) by striking '', or'' and inserting ''(as in effect prior to April 1, 1997),''; and

(B) by adding after clause (iv) the following new clause:

''(v) cancellation of removal pursuant to section 240A(b)(2) of such Act;''.

**SEC. 5582. EFFECTIVE DATE.**

Except as otherwise provided, the amendments made by this chapter shall be effective as if included in the enactment of title IV of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

**CHAPTER 5—CHILD PROTECTION**

**SEC. 5591. CONFORMING AND TECHNICAL AMENDMENTS RELATING TO CHILD PROTECTION.**

(a) METHODS PERMITTED FOR CONDUCT OF STUDY OF CHILD WELFARE.—Section 429A(a) (42 U.S.C. 628b(a)) is amended by inserting ''(directly, or by grant, contract, or interagency agreement)'' after ''conduct''.

(b) REDESIGNATION OF PARAGRAPH.—Section 471(a) (42 U.S.C. 671(a)) is amended—

(1) by striking ''and'' at the end of paragraph (17);

(2) by striking the period at the end of paragraph (18) (as added by section 1808(a) of the Small Business Job Protection Act of 1996 (Public Law 104–188; 110 Stat. 1903)) and inserting ''; and''; and

(3) by redesignating paragraph (18) (as added by section 505(3) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2278)) as paragraph (19).

**SEC. 5592. ADDITIONAL TECHNICAL AMENDMENTS RELATING TO CHILD PROTECTION.**

(a) PART B AMENDMENTS.—

(1) IN GENERAL.—Part B of title IV (42 U.S.C. 620–635) is amended—

(A) in section 422(b)—

(i) by striking the period at the end of the paragraph (9) (as added by section 554(3) of the Improving America's Schools Act of 1994 (Public Law 103–382; 108 Stat. 4057)) and inserting a semicolon;

(ii) by redesignating paragraph (10) as paragraph (11); and

(iii) by redesignating paragraph (9), as added by section 202(a)(3) of the Social Security Act Amendments of 1994 (Public Law 103–432, 108 Stat. 4453), as paragraph (10);

(B) in sections 424(b) and 425(a), by striking ''422(b)(9)'' each place it appears and inserting ''422(b)(10)''; and

(C) by transferring section 429A (as added by section 503 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2277)) to the end of subpart 1.

(2) CLARIFICATION OF CONFLICTING AMENDMENTS.—Section 204(a)(2) of the Social Security Act Amendments of 1994 (Public Law 103–432; 108 Stat. 4456) is amended by inserting ''(as added by such section 202(a))'' before ''and inserting''.

(b) PART E AMENDMENTS.—Section 472(d) (42 U.S.C. 672(d)) is amended by striking ''422(b)(9)'' and inserting ''422(b)(10)''.

**SEC. 5593. EFFECTIVE DATE.**

The amendments made by this chapter shall take effect as if included in the enactment of title V of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2277).

**CHAPTER 6—CHILD CARE**

**SEC. 5601. CONFORMING AND TECHNICAL AMENDMENTS RELATING TO CHILD CARE.**

(a) FUNDING.—Section 418(a) (42 U.S.C. 618(a)) is amended—

(1) in paragraph (1)—

(A) in the matter preceding subparagraph (A), by inserting ''the greater of'' after ''equal to'';

(B) in subparagraph (A)—

(i) by striking ''the sum of'';

(ii) by striking ''amounts expended'' and inserting ''expenditures''; and

(iii) by striking ''section—'' and all that follows and inserting ''subsections (g) and (i) of section 402 (as in effect before October 1, 1995); or'';

(C) in subparagraph (B)—

(i) by striking ''sections'' and inserting ''subsections''; and

(ii) by striking the semicolon at the end and inserting a period; and

(D) in the matter following subparagraph (B), by striking ''whichever is greater.''; and

(2) in paragraph (2)—

(A) by striking subparagraph (B) and inserting the following:

''(B) ALLOTMENTS TO STATES.—The total amount available for payments to States under this paragraph, as determined under subparagraph (A), shall be allotted among the States based on the formula used for determining the amount of Federal payments to each State under section 403(n) (as in effect before October 1, 1995).'';

(B) by striking subparagraph (C) and inserting the following:

''(C) FEDERAL MATCHING OF STATE EXPENDITURES EXCEEDING HISTORICAL EXPENDITURES.—The Secretary shall pay to each eligible State for a fiscal year an amount equal to the lesser of the State's allotment under subparagraph (B) or the Federal medical assistance percentage for the State for the fiscal year (as defined in section 1905(b), as such section was in effect on September 30, 1995) of so much of the State's expenditures for child care in that fiscal year as exceed the total amount of expenditures by the State (including expenditures from amounts made available from Federal funds) in fiscal year 1994 or 1995 (whichever is greater) for the programs described in paragraph (1)(A).''; and

(C) in subparagraph (D)(i)—

(i) by striking ''amounts under any grant awarded'' and inserting ''any amounts allotted''; and

(ii) by striking ''the grant is made'' and inserting ''such amounts are allotted''.

(b) DATA USED TO DETERMINE HISTORIC STATE EXPENDITURES.—Section 418(a) (42 U.S.C. 618(a)) is amended by adding at the end the following:

''(5) DATA USED TO DETERMINE STATE AND FEDERAL SHARES OF EXPENDITURES.—In making the determinations concerning expenditures required under paragraphs (1) and (2)(C), the Secretary shall use information that was reported by the State on ACF Form 231 and available as of the applicable dates specified in clauses (i)(I), (ii), and (iii)(III) of section 403(a)(1)(D).''.

(c) DEFINITION OF STATE.—Section 418(d) (42 U.S.C. 618(d)) is amended by striking ''or'' and inserting ''and''.

**SEC. 5602. ADDITIONAL CONFORMING AND TECHNICAL AMENDMENTS.**

The Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9858 et seq.) is amended—

(1) in section 658E(c)(2)(E)(ii), by striking ''tribal organization'' and inserting ''tribal organizations'';

(2) in section 658K(a)—

(A) in paragraph (1)—

(i) in subparagraph (B)—

(I) by striking clause (iv) and inserting the following:

''(iv) whether the head of the family unit is a single parent;'';

(II) in clause (v)—

(aa) in the matter preceding subclause (I), by striking ''including the amount obtained from (and separately identified)—'' and inserting ''including—''; and

(bb) by striking subclause (II) and inserting the following:

''(II) cash or other assistance under—

''(aa) the temporary assistance for needy families program under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.); and

''(bb) a State program for which State spending is counted toward the maintenance of effort requirement under section 409(a)(7) of the Social Security Act (42 U.S.C. 609(a)(7));''; and

(III) in clause (x), by striking ''week'' and inserting ''month''; and

(ii) by striking subparagraph (D) and inserting the following:

''(D) USE OF SAMPLES.—

''(i) AUTHORITY.—A State may comply with the requirement to collect the information described in subparagraph (B) through the use of disaggregated case record information on a sample of families selected through the use of scientifically acceptable sampling methods approved by the Secretary.

''(ii) SAMPLING AND OTHER METHODS.—The Secretary shall provide the States with such case sampling plans and data collection procedures as the Secretary deems necessary to produce statistically valid samples of the information described in subparagraph (B). The Secretary may develop and implement procedures for verifying the quality of data submitted by the States.''; and

(B) in paragraph (2)—

(i) in the heading, by striking ''BIANNUAL'' and inserting ''ANNUAL''; and

(ii) by striking ''6'' and inserting ''12'';

(3) in section 658L, by striking ''1997'' and inserting ''1998'';

(4) in section 658O(c)(6)(C), by striking ''(A)'' and inserting ''(B)''; and

(5) in section 658P(13), by striking ''or'' and inserting ''and''.

**SEC. 5603. EFFECTIVE DATES.**

(a) IN GENERAL.—Except as provided in subsection (b), this chapter and the amendments made by this chapter shall take effect as if included in the enactment of title VI of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2278).

(b) EXCEPTIONS.—The amendment made by section 5601(a)(2)(B) shall take effect on October 1, 1997.

## CHAPTER 7—ERISA AMENDMENTS RELATING TO MEDICAL CHILD SUPPORT ORDERS

**SEC. 5611. AMENDMENTS RELATING TO SECTION 303 OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996.**

(a) PRIVACY SAFEGUARDS FOR MEDICAL CHILD SUPPORT ORDERS.—Section 609(a)(3)(A) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1169(a)(3)(A)) is amended by adding at the end the following: ''except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such alternate recipient,''.

(b) PAYMENT TO STATE OFFICIAL TREATED AS SATISFACTION OF PLAN'S OBLIGATION.—Section 609(a) of such Act (29 U.S.C. 1169(a)) is amended by adding at the end the following new paragraph:

''(9) PAYMENT TO STATE OFFICIAL TREATED AS SATISFACTION OF PLAN'S OBLIGATION TO MAKE PAYMENT TO ALTERNATE RECIPIENT.—Payment of benefits by a group health plan to an official of a State or a political subdivision thereof whose name and address have been substituted for the name and address of an alternate recipient in a qualified medical child support order, pursuant to paragraph (3)(A), shall be treated, for purposes of this title, as payment of benefits to the alternate recipient.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to medical child support orders issued on or after the date of the enactment of this Act.

**SEC. 5612. AMENDMENT RELATING TO SECTION 381 OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996.**

(a) CLARIFICATION OF EFFECT OF ADMINISTRATIVE NOTICES.—Section 609(a)(2)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1169(a)(2)(B)) is amended by adding at the end the following new sentence: ''For purposes of this subparagraph, an administrative notice which is issued pursuant to an administrative process referred to in subclause (II) of the preceding sentence and which has the effect of an order described in clause (i) or (ii) of the preceding sentence shall be treated as such an order.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall be effective as if included in the enactment of section 381 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104–193; 110 Stat. 2257).

**SEC. 5613. AMENDMENTS RELATING TO SECTION 382 OF THE PERSONAL RESPONSIBILITY AND WORK OPPORTUNITY RECONCILIATION ACT OF 1996.**

(a) ELIMINATION OF REQUIREMENT THAT ORDERS SPECIFY AFFECTED PLANS.—Section 609(a)(3) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1169(a)(3)) is amended—

(1) in subparagraph (B), by striking ''by the plan'';

(2) by adding ''and'' at the end of subparagraph (B);

(3) in subparagraph (C), by striking '', and'' and inserting a period; and

(4) by striking subparagraph (D).

(b) CLARIFICATION OF APPLICABILITY OF ORDERS.—Section 609(a)(1) of such Act (29 U.S.C. 1169(a)(1)) is amended by adding at the end the following new sentence: ''A qualified medical child support order with respect to any participant or beneficiary shall be deemed to apply to each group health plan which has received such order, from which the participant or beneficiary is eligible to receive benefits, and with respect to which the requirements of paragraph (4) are met.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to medical child support orders issued on or after the date of the enactment of this Act.

### Subtitle G—Miscellaneous

**SEC. 5701. INCREASE IN PUBLIC DEBT LIMIT.**

Subsection (b) of section 3101 of title 31, United States Code, is amended by striking the dollar amount contained therein and inserting ''$5,950,000,000,000''.

**SEC. 5702. AUTHORIZATION OF APPROPRIATIONS FOR ENFORCEMENT INITIATIVES RELATED TO THE EARNED INCOME TAX CREDIT.**

In addition to any other funds available therefor, there are authorized to be appropriated to the Secretary of the Treasury, for improved application of the earned income credit under section 32 of the Internal Revenue Code of 1986, not more than—

(1) $138,000,000 for fiscal year 1998;

(2) $143,000,000 for fiscal year 1999;

(3) $144,000,000 for fiscal year 2000;

(4) $145,000,000 for fiscal year 2001; and

(5) $146,000,000 for fiscal year 2002.

## TITLE VI—EDUCATION AND RELATED PROVISIONS

### Subtitle A—Higher Education

**SEC. 6101. MANAGEMENT AND RECOVERY OF RESERVES.**

(a) AMENDMENT.—Section 422 of the Higher Education Act of 1965 (20 U.S.C. 1072) is amended by adding after subsection (g) the following new subsection:

''(h) RECALL OF RESERVES; LIMITATIONS ON USE OF RESERVE FUNDS AND ASSETS.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall, except as otherwise provided in this subsection, recall $1,000,000,000 from the reserve funds held by guaranty agencies on September 1, 2002.

''(2) DEPOSIT.—Funds recalled by the Secretary under this subsection shall be deposited in the Treasury.

''(3) REQUIRED SHARE.—The Secretary shall require each guaranty agency to return reserve funds under paragraph (1) based on the agency's required share of recalled reserve funds held by guaranty agencies as of September 30, 1996. For purposes of this paragraph, a guaranty agency's required share of recalled reserve funds shall be determined as follows:

''(A) The Secretary shall compute each guaranty agency's reserve ratio by dividing (i) the amount held in the agency's reserve funds as of September 30, 1996 (but reflecting later accounting or auditing adjustments approved by the Secretary), by (ii) the original principal amount of all loans for which the agency has an outstanding insurance obligation as of such date, including amounts of outstanding loans transferred to the agency from another guaranty agency.

''(B) If the reserve ratio of any guaranty agency as computed under subparagraph (A) exceeds 2.0 percent, the agency's required share shall include so much of the amounts held in the agency's reserve funds as exceed a reserve ratio of 2.0 percent.

''(C) If any additional amount is required to be recalled under paragraph (1) (after deducting the total of the required shares calculated under subparagraph (B)), such additional amount shall be obtained by imposing on each guaranty agency an equal percentage reduction in the amount of the agency's reserve funds remaining after deduction of the amount recalled under subparagraph (B), except that such percentage reduction under this subparagraph shall not result in the agency's reserve ratio being reduced below 0.58 percent. The equal percentage reduction shall be the percentage obtained by dividing—

''(i) the additional amount required to be recalled (after deducting the total of the required shares calculated under subparagraph (B)), by

''(ii) the total amount of all such agencies' reserve funds remaining (after deduction of the required shares calculated under such subparagraph).

''(D) If any additional amount is required to be recalled under paragraph (1) (after deducting the total of the required shares calculated under subparagraphs (B) and (C)), such additional amount shall be obtained by imposing on each guaranty agency with a reserve ratio (after deducting the required shares calculated under such subparagraphs) in excess of 0.58 percent an equal percentage reduction in the amount of the agency's reserve funds remaining (after such deduction) that exceed a reserve ratio of 0.58 percent. The equal percentage reduction shall be the percentage obtained by dividing—

''(i) the additional amount to be recalled under paragraph (1) (after deducting the amount recalled under subparagraphs (B) and (C)), by

''(ii) the total amount of all such agencies' reserve funds remaining (after deduction of the required shares calculated under such subparagraphs) that exceed a reserve ratio of 0.58 percent.

''(4) RESTRICTED ACCOUNTS REQUIRED.—

''(A) IN GENERAL.—Within 90 days after the beginning of each of the fiscal years 1998 through 2002, each guaranty agency shall transfer a portion of the agency's required share determined under paragraph (3) to a restricted account established by the agency that is of a type selected by the agency with the approval of the Secretary. Funds transferred to such restricted accounts shall be invested in obligations issued or guaranteed by the United States or in other similarly low-risk securities.

''(B) REQUIREMENT.—A guaranty agency shall not use the funds in such a restricted account for any purpose without the express written permission of the Secretary, except that a guaranty agency may use the earnings from such restricted account for default reduction activities.

''(C) INSTALLMENTS.—In each of fiscal years 1998 through 2002, each guaranty agency shall transfer the agency's required share to such restricted account in 5 equal annual installments, except that—

''(i) a guaranty agency that has a reserve ratio (as computed under subparagraph (3)(A)) equal to or less than 1.10 percent may transfer the agency's required share to such account in 4 equal installments beginning in fiscal year 1999; and

''(ii) a guaranty agency may transfer such required share to such account in accordance with such other payment schedules as are approved by the Secretary.

''(5) SHORTAGE.—If, on September 1, 2002, the total amount in the restricted accounts described in paragraph (4) is less than the amount the Secretary is required to recall under paragraph (1), the Secretary shall require the return of the amount of the shortage from other reserve funds held by guaranty agencies under procedures established by the Secretary. The Secretary shall first attempt to obtain the amount of such shortage from each guaranty agency that failed to transfer the agency's required share to the agency's restricted account in accordance with paragraph (4).

''(6) ENFORCEMENT.—

''(A) IN GENERAL.—The Secretary may take such reasonable measures, and require such information, as may be necessary to ensure that guaranty agencies comply with the requirements of this subsection.

''(B) PROHIBITION.—If the Secretary determines that a guaranty agency has failed to transfer to a restricted account any portion of the agency's required share under this subsection, the agency may not receive any other funds under this part until the Secretary determines that the agency has so transferred the agency's required share.

''(C) WAIVER.—The Secretary may waive the requirements of subparagraph (B) for a guaranty agency described in such subparagraph if the Secretary determines that there are extenuating circumstances beyond the control of the agency that justify such waiver.

''(7) LIMITATION.—

''(A) RESTRICTION ON OTHER AUTHORITY.—The Secretary shall not have any authority to direct a guaranty agency to return reserve funds under subsection (g)(1)(A) during the period from the date of enactment of the Balanced Budget Act of 1997 through September 30, 2002.

''(B) USE OF TERMINATION COLLECTIONS.—Any reserve funds directed by the Secretary to be returned to the Secretary under subsection (g)(1)(B) during such period that do not exceed a guaranty agency's required share of recalled reserve funds under paragraph (3)—

''(i) shall be used to satisfy the agency's required share of recalled reserve funds; and

''(ii) shall be deposited in the restricted account established by the agency under paragraph (4), without regard to whether such funds exceed the next installment required under such paragraph.

''(C) USE OF SANCTIONS COLLECTIONS.—Any reserve funds directed by the Secretary to be returned to the Secretary under subsection (g)(1)(C) during such period that do not exceed a guaranty agency's next installment under paragraph (4)—

''(i) shall be used to satisfy the agency's next installment; and

''(ii) shall be deposited in the restricted account established by the agency under paragraph (4).

''(D) BALANCE AVAILABLE TO SECRETARY.—Any reserve funds directed by the Secretary to be returned to the Secretary under subparagraph (B) or (C) of subsection (g)(1) that remain after satisfaction of the requirements of subparagraphs (B) and (C) of this paragraph shall be deposited in the Treasury.

''(8) DEFINITIONS.—For the purposes of this subsection:

''(A) DEFAULT REDUCTION ACTIVITIES.—The term 'default reduction activities' means activities to reduce student loan defaults that improve, strengthen, and expand default prevention activities, such as—

''(i) establishing a program of partial loan cancellation to reward disadvantaged borrowers for good repayment histories with their lenders;

''(ii) establishing a financial and debt management counseling program for high-risk borrowers that provides long-term training (beginning prior to the first disbursement of the borrower's first student loan and continuing through the completion of the borrower's program of education or training) in budgeting and other aspects of financial management, including debt management;

''(iii) establishing a program of placement counseling to assist high-risk borrowers in identifying employment or additional training opportunities; and

''(iv) developing public service announcements that would detail consequences of student loan default and provide information regarding a toll-free telephone number established by the guaranty agency for use by borrowers seeking assistance in avoiding default.

''(B) RESERVE FUNDS.—The term 'reserve funds' when used with respect to a guaranty agency—

''(i) includes any reserve funds in cash or liquid assets held by the guaranty agency, or held by, or under the control of, any other entity; and

''(ii) does not include buildings, equipment, or other nonliquid assets.''.

(b) CONFORMING AMENDMENT.—Section 428(c)(9)(A) of the Higher Education Act of 1965 (20 U.S.C. 1078(c)(9)(A)) is amended—

(1) in the first sentence, by striking ''for the fiscal year of the agency that begins in 1993''; and

(2) by striking the third sentence.

**SEC. 6102. REPEAL OF DIRECT LOAN ORIGINATION FEES TO INSTITUTIONS OF HIGHER EDUCATION.**

Section 452 of the Higher Education Act of 1965 (20 U.S.C. 1087b) is amended—

(1) by striking subsection (b); and

(2) by redesignating subsections (c) and (d) as subsections (b) and (c), respectively.

**SEC. 6103. FUNDS FOR ADMINISTRATIVE EXPENSES.**

Subsection (a) of section 458 of the Higher Education Act of 1965 (20 U.S.C. 1087h(a)) is amended to read as follows:

''(a) ADMINISTRATIVE EXPENSES.—

''(1) IN GENERAL.—Each fiscal year, there shall be available to the Secretary from funds not otherwise appropriated, funds to be obligated for—

''(A) administrative costs under this part and part B, including the costs of the direct student loan programs under this part, and

''(B) administrative cost allowances payable to guaranty agencies under part B and calculated in accordance with paragraph (2),

not to exceed (from such funds not otherwise appropriated) $532,000,000 in fiscal year 1998, $610,000,000 in fiscal year 1999, $705,000,000 in fiscal year 2000, $750,000,000 in fiscal year 2001, and $750,000,000 in fiscal year 2002. Administrative cost allowances under subparagraph (B) of this paragraph shall be paid quarterly and used in accordance with section 428(f). The Secretary may carry over funds available under this section to a subsequent fiscal year.

''(2) CALCULATION BASIS.—Administrative cost allowances payable to guaranty agencies under paragraph (1)(B) shall be calculated on the basis of 0.85 percent of the total principal amount of loans upon which insurance was issued in excess of $8,200,000,000 in fiscal year 1997 and upon which insurance is issued on or after October 1, 1997, except that such allowances shall not exceed—

''(A) $170,000,000 for each of the fiscal years 1998 and 1999; or

''(B) $150,000,000 for each of the fiscal years 2000, 2001, and 2002.''.

**SEC. 6104. EXTENSION OF STUDENT AID PROGRAMS.**

Title IV of the Higher Education Act of 1965 (20 U.S.C. 1070 et seq.) is amended—

(1) in section 424(a), by striking ''1998.'' and ''2002.'' and inserting ''2002.'' and ''2006.'', respectively;

(2) in section 428(a)(5), by striking ''1998,'' and ''2002.'' and inserting ''2002,'' and ''2006.'', respectively; and

(3) in section 428C(e), by striking ''1998.'' and inserting ''2002.''.

## Subtitle B—Repeal of Smith-Hughes Vocational Education Act

**SEC. 6201. REPEAL OF SMITH-HUGHES VOCATIONAL EDUCATION ACT.**

The Act of February 23, 1917 (39 Stat. 929, chapter 114; 20 U.S.C. 11 et seq.) (commonly known as the ''Smith-Hughes Vocational Education Act''), is repealed.

## TITLE VII—CIVIL SERVICE RETIREMENT AND RELATED PROVISIONS

**SEC. 7001. INCREASED CONTRIBUTIONS TO FEDERAL CIVILIAN RETIREMENT SYSTEMS.**

(a) CIVIL SERVICE RETIREMENT SYSTEM.—

(1) AGENCY CONTRIBUTIONS.—

(A) IN GENERAL.— Notwithstanding section 8334 (a)(1) or (k)(1) of title 5, United States Code, during the period beginning on October 1, 1997, through September 30, 2002, each employing agency (other than the United States Postal Service or the Metropolitan Washington Airports Authority) shall contribute—

(i) 8.51 percent of the basic pay of an employee;

(ii) 9.01 percent of the basic pay of a congressional employee, a law enforcement officer, a member of the Capitol police, or a firefighter; and

(iii) 9.51 percent of the basic pay of a Member of Congress, a Court of Federal Claims judge, a United States magistrate, a judge of the United States Court of Appeals for the Armed Forces, or a bankruptcy judge;

in lieu of the agency contributions otherwise required under section 8334(a)(1) of title 5, United States Code.

(B) APPLICATION.—For purposes of subparagraph (A) and notwithstanding the amendments made by paragraph (3), during the period beginning on January 1, 1999 through December 31, 2002, with respect to the United States Postal Service and the Metropolitan Washington Airports Authority, the agency contribution shall be determined as though those amendments had not been made.

(2) NO REDUCTION IN AGENCY CONTRIBUTIONS BY THE POSTAL SERVICE.—Contributions by the Treasury of the United States or the United States Postal Service under section 8348 (g), (h), or (m) of title 5, United States Code—

(A) shall not be reduced as a result of the amendments made under paragraph (3) of this subsection; and

(B) shall be computed as though such amendments had not been enacted.

(3) INDIVIDUAL DEDUCTIONS, WITHHOLDINGS, AND DEPOSITS.—

(A) DEDUCTIONS.—The first sentence of section 8334(a)(1) of title 5, United States Code, is amended to read as follows: ''The employing agency shall deduct and withhold from the basic pay of an employee, Member, Congressional employee, law enforcement offi-

cer, firefighter, bankruptcy judge, judge of the United States Court of Appeals for the Armed Forces, United States magistrate, Court of Federal Claims judge, or member of the Capitol Police, as the case may be, the percentage of basic pay applicable under subsection (c).''.

(B) DEPOSITS.—The table under section 8334(c) of title 5, United States Code, is amended—

(i) in the matter relating to an employee by striking:

| | |
|---|---|
| ''7 ..... | After December 31, 1969.''; |

and inserting the following:

| | |
|---|---|
| ''7 ..... | January 1, 1970, to December 31, 1998. |
| 7.25 ..... | January 1, 1999, to December 31, 1999. |
| 7.4 ..... | January 1, 2000, to December 31, 2000. |
| 7.5 ..... | January 1, 2001, to December 31, 2002. |
| 7 ..... | After December 31, 2002.''; |

(ii) in the matter relating to a Member or employee for congressional employee service by striking:

| | |
|---|---|
| ''7½ ..... | After December 31, 1969.''; |

and inserting the following:

| | |
|---|---|
| ''7.5 ..... | January 1, 1970, to December 31, 1998. |
| 7.75 ..... | January 1, 1999, to December 31, 1999. |
| 7.9 ..... | January 1, 2000, to December 31, 2000. |
| 8 ..... | January 1, 2001, to December 31, 2002. |
| 7.5 ..... | After December 31, 2002.''; |

(iii) in the matter relating to a Member for Member service by striking:

| | |
|---|---|
| ''8 ..... | After December 31, 1969.''; |

and inserting the following:

| | |
|---|---|
| ''8 ..... | January 1, 1970, to December 31, 1998. |
| 8.25 ..... | January 1, 1999, to December 31, 1999. |
| 8.4 ..... | January 1, 2000, to December 31, 2000. |
| 8.5 ..... | January 1, 2001, to December 31, 2002. |
| 8 ..... | After December 31, 2002.''; |

(iv) in the matter relating to a law enforcement officer for law enforcement service and firefighter for firefighter service by striking:

| | |
|---|---|
| ''7½ ..... | After December 31, 1974.''; |

and inserting the following:

| | |
|---|---|
| ''7.5 ..... | January 1, 1975, to December 31, 1998. |
| 7.75 ..... | January 1, 1999, to December 31, 1999. |
| 7.9 ..... | January 1, 2000, to December 31, 2000. |
| 8 ..... | January 1, 2001, to December 31, 2002. |
| 7.5 ..... | After December 31, 2002.''; |

(v) in the matter relating to a bankruptcy judge by striking:

| | |
|---|---|
| ''8 ..... | After December 31, 1983.''; |

and inserting the following:

| | |
|---|---|
| ''8 ..... | January 1, 1984, to December 31, 1998. |
| 8.25 ..... | January 1, 1999, to December 31, 1999. |
| 8.4 ..... | January 1, 2000, to December 31, 2000. |
| 8.5 ..... | January 1, 2001, to December 31, 2002. |
| 8 ..... | After December 31, 2002.''; |

(vi) in the matter relating to a judge of the United States Court of Appeals for the Armed Forces for service as a judge of that court by striking:

| | |
|---|---|
| ''8 ..... | On and after the date of the enactment of the Department of Defense Authorization Act, 1984.''; |

and inserting the following:

| | |
|---|---|
| ''8 ..... | The date of enactment of the Department of Defense Authorization Act, 1984, to December 31, 1998. |
| 8.25 ..... | January 1, 1999, to December 31, 1999. |
| 8.4 ..... | January 1, 2000, to December 31, 2000. |
| 8.5 ..... | January 1, 2001, to December 31, 2002. |
| 8 ..... | After December 31, 2002.''; |

(vii) in the matter relating to a United States magistrate by striking:

| | |
|---|---|
| ''8 ..... | After September 30, 1987.''; |

and inserting the following:

| | |
|---|---|
| ''8 ..... | October 1, 1987, to December 31, 1998. |
| 8.25 ..... | January 1, 1999, to December 31, 1999. |
| 8.4 ..... | January 1, 2000, to December 31, 2000. |
| 8.5 ..... | January 1, 2001, to December 31, 2002. |
| 8 ..... | After December 31, 2002.''; |

(viii) in the matter relating to a Court of Federal Claims judge by striking:

| | |
|---|---|
| ''8 ..... | After September 30, 1988.''; |

and insert the following:

| | |
|---|---|
| ''8 ..... | October 1, 1988, to December 31, 1998. |
| 8.25 ..... | January 1, 1999, to December 31, 1999. |
| 8.4 ..... | January 1, 2000, to December 31, 2000. |
| 8.5 ..... | January 1, 2001, to December 31, 2002. |
| 8 ..... | After December 31, 2002.''; |

and

(ix) by inserting after the matter relating to a Court of Federal Claims judge the following:

| | | |
|---|---|---|
| ''Member of the Capitol Police | 2.5 ..... | August 1, 1920, to June 30, 1926. |
| | .5 ..... | July 1, 1926, to June 30, 1942. |
| | 5 ..... | July 1, 1942, to June 30, 1948. |
| | 6 ..... | July 1, 1948, to October 31, 1956. |
| | 6.5 ..... | November 1, 1956, to December 31, 1969. |
| | 7.5 ..... | January 1, 1970, to December 31, 1998. |
| | 7.75 ..... | January 1, 1999, to December 31, 1999. |
| | 7.9 ..... | January 1, 2000, to December 31, 2000. |
| | 8 ..... | January 1, 2001, to December 31, 2002. |
| | 7.5 ..... | After December 31, 2002.''. |

(4) OTHER SERVICE.—

(A) MILITARY SERVICE.—Section 8334(j) of title 5, United States Code, is amended—

(i) in paragraph (1)(A) by inserting ''and subject to paragraph (5),'' after ''Except as provided in subparagraph (B),''; and

(ii) by adding at the end the following new paragraph:

''(5) Effective with respect to any period of military service after December 31, 1998, the percentage of basic pay under section 204 of title 37 payable under paragraph (1) shall be equal to the same percentage as would be applicable under subsection (c) of this section for that same period for service as an employee, subject to paragraph (1)(B).''.

(B) VOLUNTEER SERVICE.—Section 8334(l) of title 5, United States Code, is amended—

(i) in paragraph (1) by adding at the end the following: ''This paragraph shall be subject to paragraph (4).''; and

(ii) by adding at the end the following new paragraph:

''(4) Effective with respect to any period of service after December 31, 1998, the percentage of the readjustment allowance or stipend (as the case may be) payable under paragraph (1) shall be equal to the same percentage as would be applicable under subsection (c) of this section for the same period for service as an employee.''.

(b) FEDERAL EMPLOYEES' RETIREMENT SYSTEM.—

(1) INDIVIDUAL DEDUCTIONS AND WITHHOLDINGS.—

(A) IN GENERAL.—Section 8422(a) of title 5, United States Code, is amended by striking paragraph (2) and inserting the following:

''(2) The percentage to be deducted and withheld from basic pay for any pay period shall be equal to—

''(A) the applicable percentage under paragraph (3), minus

''(B) the percentage then in effect under section 3101(a) of the Internal Revenue Code of 1986 (relating to rate of tax for old-age, survivors, and disability insurance).

''(3) The applicable percentage under this paragraph for civilian service shall be as follows:

| | | |
|---|---|---|
| ''Employee ..... | 7 ..... | January 1, 1987, to December 31, 1998. |
| | 7.25 ..... | January 1, 1999, to December 31, 1999. |
| | 7.4 ..... | January 1, 2000, to December 31, 2000. |
| | 7.5 ..... | January 1, 2001, to December 31, 2002. |
| | 7 ..... | After December 31, 2002. |
| Congressional employee .... | 7.5 ..... | January 1, 1987, to December 31, 1998. |
| | 7.75 ..... | January 1, 1999, to December 31, 1999. |
| | 7.9 ..... | January 1, 2000, to December 31, 2000. |
| | 8 ..... | January 1, 2001, to December 31, 2002. |
| | 7.5 ..... | After December 31, 2002. |
| Member ..... | 7.5 ..... | January 1, 1987, to December 31, 1998. |
| | 7.75 ..... | January 1, 1999, to December 31, 1999. |
| | 7.9 ..... | January 1, 2000, to December 31, 2000. |
| | 8 ..... | January 1, 2001, to December 31, 2002. |
| | 7.5 ..... | After December 31, 2002. |
| Law enforcement officer, firefighter, member of the Capitol Police, or air traffic controller. | 7.5 ..... | January 1, 1987, to December 31, 1998. |
| | 7.75 ..... | January 1, 1999, to December 31, 1999. |
| | 7.9 ..... | January 1, 2000, to December 31, 2000. |
| | 8 ..... | January 1, 2001, to December 31, 2002. |
| | 7.5 ..... | After December 31, 2002.''. |

(B) MILITARY SERVICE.—Section 8422(e) of title 5, United States Code, is amended—

(i) in paragraph (1)(A) by inserting ''and subject to paragraph (6),'' after ''Except as provided in subparagraph (B),''; and

(ii) by adding at the end the following:

''(6) The percentage of basic pay under section 204 of title 37 payable under paragraph (1), with respect to any period of military service performed during—

''(A) January 1, 1999, through December 31, 1999, shall be 3.25 percent;

''(B) January 1, 2000, through December 31, 2000, shall be 3.4 percent; and

''(C) January 1, 2001, through December 31, 2002, shall be 3.5 percent.''.

(C) VOLUNTEER SERVICE.—Section 8422(f) of title 5, United States Code, is amended—

(i) in paragraph (1) by adding at the end the following: ''This paragraph shall be subject to paragraph (4).''; and

(ii) by adding at the end the following:

''(4) The percentage of the readjustment allowance or stipend (as the case may be) payable under paragraph (1), with respect to any period of volunteer service performed during—

''(A) January 1, 1999, through December 31, 1999, shall be 3.25 percent;

''(B) January 1, 2000, through December 31, 2000, shall be 3.4 percent; and

''(C) January 1, 2001, through December 31, 2002, shall be 3.5 percent.''.

(2) NO REDUCTION IN AGENCY CONTRIBUTIONS.—Contributions under section 8423 (a) and (b) of title 5, United States Code, shall not be reduced as a result of the amendments made under paragraph (1) of this subsection.

(c) CENTRAL INTELLIGENCE AGENCY RETIREMENT AND DISABILITY SYSTEM.—

(1) AGENCY CONTRIBUTIONS.—Notwithstanding section 211(a)(2) of the Central Intelligence Agency Retirement Act (50 U.S.C. 2021(a)(2)), during the period beginning on October 1, 1997, through September 30, 2002, the Central Intelligence Agency shall contribute 8.51 percent of the basic pay of an employee participating in the Central Intelligence Agency Retirement and Disability System in lieu of the agency contribution otherwise required under section 211(a)(2) of such Act.

(2) INDIVIDUAL DEDUCTIONS, WITHHOLDINGS, AND DEPOSITS.—Notwithstanding section 211(a)(1) of the Central Intelligence Agency Retirement Act (50 U.S.C. 2021(a)(1)) beginning on January 1, 1999, through December 31, 2002, the percentage deducted and withheld from the basic pay of an employee participating in the Central Intelligence Agency Retirement and Disability System shall be as follows:

| | |
|---|---|
| 7.25 ..... | January 1, 1999, to December 31, 1999. |
| 7.4 ..... | January 1, 2000, to December 31, 2000. |
| 7.5 ..... | January 1, 2001, to December 31, 2002. |

(3) MILITARY SERVICE.—Section 252(h)(1) of the Central Intelligence Agency Retirement Act (50 U.S.C. 2082(h)(1)), is amended to read as follows:

''(h)(1)(A) Each participant who has performed military service before the date of separation on which entitlement to an annuity under this title is based may pay to the Agency an amount equal to 7 percent of the amount of basic pay paid under section 204 of title 37, United States Code, to the participant for each period of military service after December 1956; except, the amount to be paid for military service performed beginning on January 1, 1999, through December 31, 2002, shall be as follows:

| | |
|---|---|
| ''7.25 percent of basic pay | January 1, 1999, to December 31, 1999. |
| 7.4 percent of basic pay .. | January 1, 2000, to December 31, 2000. |
| 7.5 percent of basic pay .. | January 1, 2001, to December 31, 2002. |

''(B) The amount of such payments shall be based on such evidence of basic pay for military service as the participant may provide or, if the Director determines sufficient evidence has not been provided to adequately determine basic pay for military service, such payment shall be based upon estimates of such basic pay provided to the Director under paragraph (4).''.

(d) FOREIGN SERVICE RETIREMENT AND DISABILITY SYSTEM.—

(1) AGENCY CONTRIBUTIONS.—Notwithstanding section 805(a) (1) and (2) of the Foreign Service Act of 1980 (22 U.S.C. 4045(a) (1) and (2)), during the period beginning on October 1, 1997, through September 30, 2002, each agency employing a participant in the Foreign Service Retirement and Disability System shall contribute to the Foreign Service Retirement and Disability Fund—

(A) 8.51 percent of the basic pay of each participant covered under section 805(a)(1) of such Act participating in the Foreign Service Retirement and Disability System; and

(B) 9.01 percent of the basic pay of each participant covered under section 805(a)(2) of such Act participating in the Foreign Service Retirement and Disability System;

in lieu of the agency contribution otherwise required under section 805(a) (1) and (2) of such Act.

(2) INDIVIDUAL DEDUCTIONS, WITHHOLDINGS, AND DEPOSITS.—

(A) IN GENERAL.—Notwithstanding section 805(a)(1) of the Foreign Service Act of 1980 (22 U.S.C. 4045(a)(1)), beginning on January 1, 1999, through December 31, 2002, the amount withheld and deducted from the basic pay of a participant in the Foreign Service Retirement and Disability System shall be as follows:

| | |
|---|---|
| 7.25 ..... | January 1, 1999, to December 31, 1999. |
| 7.4 ..... | January 1, 2000, to December 31, 2000. |
| 7.5 ..... | January 1, 2001, to December 31, 2002. |

(B) FOREIGN SERVICE CRIMINAL INVESTIGATORS/INSPECTORS OF THE OFFICE OF THE INSPECTOR GENERAL, AGENCY FOR INTERNATIONAL DEVELOPMENT.—Notwithstanding section 805(a)(2) of the Foreign Service Act of 1980 (22 U.S.C. 4045(a)(2)), beginning on January 1, 1999, through December 31, 2002, the amount withheld and deducted from the basic pay of an eligible Foreign Service criminal investigator/inspector of the Office of the Inspector General, Agency for International Development participating in the Foreign Service Retirement and Disability System shall be as follows:

| | |
|---|---|
| 7.75 ..... | January 1, 1999, to December 31, 1999. |
| 7.9 ..... | January 1, 2000, to December 31, 2000. |
| 8 ..... | January 1, 2001, to December 31, 2002. |

(C) CONFORMING AMENDMENT.—Section 805(d)(1) of the Foreign Service Act of 1980 (22 U.S.C. 4045(d)(1)) is amended in the table in the matter following subparagraph (B) by striking:

| | |
|---|---|
| ''On and after January 1, 1970 ..... | 7''; |

and inserting the following:

| | |
|---|---|
| ''January 1, 1970, through December 31, 1998, inclusive ..... | 7 |
| January 1, 1999, through December 31, 1999, inclusive ..... | 7.25 |
| January 1, 2000, through December 31, 2000, inclusive ..... | 7.4 |
| January 1, 2001, through December 31, 2002, inclusive ..... | 7.5 |
| After December 31, 2002 ..... | 7''. |

(D) MILITARY SERVICE.—Section 805(e) of the Foreign Service Act of 1980 (22 U.S.C. 4045(e)) is amended—

(i) in subsection (e)(1) by striking ''Each'' and inserting ''Subject to paragraph (5), each''; and

(ii) by adding after paragraph (4) the following new paragraph:

''(5) Effective with respect to any period of military or naval service after December 31, 1998, the percentage of basic pay under section 204 of title 37, United States Code, payable under paragraph (1) shall be equal to the same percentage as would be applicable under section 8334(c) of title 5, United States Code, for that same period for service as an employee.''.

(e) FOREIGN SERVICE PENSION SYSTEM.—

(1) INDIVIDUAL DEDUCTIONS AND WITHHOLDINGS FROM PAY.—

(A) IN GENERAL.—Section 856(a) of the Foreign Service Act of 1980 (22 U.S.C. 4071e(a)) is amended to read as follows:

''(a)(1) The employing agency shall deduct and withhold from the basic pay of each participant the applicable percentage of basic pay specified in paragraph (2) of this subsection minus the percentage then in effect under section 3101(a) of the Internal Revenue Code of 1986 (26 U.S.C. 3101(a)) (relating to the rate of tax for old age, survivors, and disability insurance).

''(2) The applicable percentage under this subsection shall be as follows:

| | |
|---|---|
| ''7.5 ..... | Before January 1, 1999. |
| 7.75 ..... | January 1, 1999, to December 31, 1999. |
| 7.9 ..... | January 1, 2000, to December 31, 2000. |
| 8 ..... | January 1, 2001, to December 31, 2002. |
| 7.5 ..... | After December 31, 2002.''. |

(B) VOLUNTEER SERVICE.—Subsection 854(c) of the Foreign Service Act of 1980 (22 U.S.C. 4071c(c)) is amended to read as follows:

''(c)(1) Credit shall be given under this System to a participant for a period of prior satisfactory service as—

''(A) a volunteer or volunteer leader under the Peace Corps Act (22 U.S.C. 2501 et seq.),

''(B) a volunteer under part A of title VIII of the Economic Opportunity Act of 1964, or

''(C) a full-time volunteer for a period of service of at least 1 year's duration under part A, B, or C of title I of the Domestic Volunteer Service Act of 1973 (42 U.S.C. 4951 et seq.),

if the participant makes a payment to the Fund equal to 3 percent of pay received for the volunteer service; except, the amount to be paid for volunteer service beginning on January 1, 1999, through December 31, 2002, shall be as follows:

| | |
|---|---|
| ''3.25 ..... | January 1, 1999, to December 31, 1999. |
| 3.4 ..... | January 1, 2000, to December 31, 2000. |
| 3.5 ..... | January 1, 2001, to December 31, 2002. |

''(2) The amount of such payments shall be determined in accordance with regulations of the Secretary of State consistent with regulations for making corresponding determinations under chapter 83, title 5, United States Code, together with interest determined under regulations issued by the Secretary of State.''.

(2) NO REDUCTION IN AGENCY CONTRIBUTIONS.—Agency contributions under section 857 of the Foreign Service Act of 1980 (22 U.S.C. 4071f) shall not be reduced as a result of the amendments made under paragraph (1) of this subsection.

(f) EFFECTIVE DATE.—

(1) IN GENERAL.—This section shall take effect on—

(A) October 1, 1997; or

(B) if later, the date of enactment of this Act.

(2) SPECIAL RULE.—If the date of enactment of this Act is later than October 1, 1997, then any reference to October 1, 1997, in subsection (a)(1), (c)(1), or (d)(1) shall be treated as a reference to the date of enactment of this Act.

**SEC. 7002. GOVERNMENT CONTRIBUTIONS UNDER THE FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM.**

(a) IN GENERAL.—Section 8906 of title 5, United States Code, is amended by striking subsection (a) and all that follows through the end of paragraph (1) of subsection (b) and inserting the following:

''(a)(1) Not later than October 1 of each year, the Office of Personnel Management shall determine the weighted average of the subscription charges that will be in effect during the following contract year with respect to—

''(A) enrollments under this chapter for self alone; and

''(B) enrollments under this chapter for self and family.

''(2) In determining each weighted average under paragraph (1), the weight to be given to a particular subscription charge shall, with respect to each plan (and option) to which it is to apply, be commensurate with the number of enrollees enrolled in such plan (and option) as of March 31 of the year in which the determination is being made.

''(3) For purposes of paragraph (2), the term 'enrollee' means any individual who, during the contract year for which the weighted average is to be used under this section, will be eligible for a Government contribution for health benefits.

''(b)(1) Except as provided in paragraphs (2) and (3), the biweekly Government contribution for health benefits for an employee or annuitant enrolled in a health benefits plan under this chapter is adjusted to an amount equal to 72 percent of the weighted average under subsection (a)(1) (A) or (B), as applicable. For an employee, the adjustment begins on the first day of the employee's first pay period of each year. For an annuitant, the adjustment begins on the first day of the first period of each year for which an annuity payment is made.''.

(b) EFFECTIVE DATE.—This section shall take effect on the first day of the contract year that begins in 1999. Nothing in this subsection shall prevent the Office of Personnel Management from taking any action, before such first day, which it considers necessary in order to ensure the timely implementation of this section.

**SEC. 7003. REPEAL OF AUTHORIZATION OF TRANSITIONAL APPROPRIATIONS FOR THE UNITED STATES POSTAL SERVICE.**

(a) REPEAL.—

(1) IN GENERAL.—Section 2004 of title 39, United States Code, is repealed.

(2) TECHNICAL AND CONFORMING AMENDMENTS.—

(A) The table of sections for chapter 20 of such title is amended by repealing the item relating to section 2004.

(B) Section 2003(e)(2) of such title is amended by striking ''sections 2401 and 2004'' each place it appears and inserting ''section 2401''.

(b) CLARIFICATION THAT LIABILITIES FORMERLY PAID PURSUANT TO SECTION 2004 REMAIN LIABILITIES PAYABLE BY THE POSTAL SERVICE.—Section 2003 of title 39, United States Code, is amended by adding at the end the following:

''(h) Liabilities of the former Post Office Department to the Employees' Compensation Fund (appropriations for which were authorized by former section 2004, as in effect before the effective date of this subsection) shall be liabilities of the Postal Service payable out of the Fund.''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—This section and the amendments made by this section shall take effect on the date of the enactment of this Act or October 1, 1997, whichever is later.

(2) PROVISIONS RELATING TO PAYMENTS FOR FISCAL YEAR 1998.—

(A) AMOUNTS NOT YET PAID.—No payment may be made to the Postal Service Fund, on or after the date of the enactment of this Act, pursuant to any appropriation for fiscal year 1998 authorized by section 2004 of title 39, United States Code (as in effect before the effective date of this section).

(B) AMOUNTS PAID.—If any payment to the Postal Service Fund is or has been made pursuant to an appropriation for fiscal year 1998 authorized by such section 2004, then, an amount equal to the amount of such payment shall be paid from such Fund into the Treasury as miscellaneous receipts before October 1, 1998.

## TITLE VIII—VETERANS AND RELATED MATTERS

**SEC. 8001. SHORT TITLE; TABLE OF CONTENTS.**

(a) SHORT TITLE.—This title may be cited as the ''Veterans Reconciliation Act of 1997''.

(b) TABLE OF CONTENTS.—The table of contents for this title is as follows:

Sec. 8001. Short title; table of contents.

Subtitle A—Extension of Temporary Authorities

Sec. 8011. Enhanced loan asset sale authority.
Sec. 8012. Home loan fees.
Sec. 8013. Procedures applicable to liquidation sales on defaulted home loans guaranteed by the Department of Veterans Affairs.
Sec. 8014. Income verification authority.
Sec. 8015. Limitation on pension for certain recipients of medicaid-covered nursing home care.

Subtitle B—Copayments and Medical Care Cost Recovery

Sec. 8021. Authority to require that certain veterans make copayments in exchange for receiving health care benefits.
Sec. 8022. Medical care cost recovery authority.
Sec. 8023. Department of Veterans Affairs medical-care receipts.

Subtitle C—Other Matters

Sec. 8031. Rounding down of cost-of-living adjustments in compensation and DIC rates for fiscal years 1998 through 2002.
Sec. 8032. Increase in amount of home loan fees for the purchase of repossessed homes from the Department of Veterans Affairs.
Sec. 8033. Withholding of payments and benefits.

### Subtitle A—Extension of Temporary Authorities

**SEC. 8011. ENHANCED LOAN ASSET SALE AUTHORITY.**

Section 3720(h)(2) of title 38, United States Code, is amended by striking out ''December 31, 1997'' and inserting in lieu thereof ''December 31, 2002''.

**SEC. 8012. HOME LOAN FEES.**

Section 3729(a) of title 38, United States Code, is amended—

(1) in paragraph (4), by striking out ''October 1, 1998'' and inserting in lieu thereof ''October 1, 2002''; and

(2) in paragraph (5)(C), by striking out ''October 1, 1998'' and inserting in lieu thereof ''October 1, 2002''.

**SEC. 8013. PROCEDURES APPLICABLE TO LIQUIDATION SALES ON DEFAULTED HOME LOANS GUARANTEED BY THE DEPARTMENT OF VETERANS AFFAIRS.**

Section 3732(c)(11) of title 38, United States Code, is amended by striking out ''October 1, 1998'' and inserting in lieu thereof ''October 1, 2002''.

**SEC. 8014. INCOME VERIFICATION AUTHORITY.**

Section 5317(g) of title 38, United States Code, is amended by striking out ''September 30, 1998'' and inserting in lieu thereof ''September 30, 2002''.

**SEC. 8015. LIMITATION ON PENSION FOR CERTAIN RECIPIENTS OF MEDICAID-COVERED NURSING HOME CARE.**

Section 5503(f)(7) of title 38, United States Code, is amended by striking out ''September 30, 1998'' and inserting in lieu thereof ''September 30, 2002''.

### Subtitle B—Copayments and Medical Care Cost Recovery

**SEC. 8021. AUTHORITY TO REQUIRE THAT CERTAIN VETERANS MAKE COPAYMENTS IN EXCHANGE FOR RECEIVING HEALTH CARE BENEFITS.**

(a) HOSPITAL AND MEDICAL CARE.—

(1) EXTENSION.—Section 1710(f)(2)(B) of title 38, United States Code, is amended by inserting ''before September 30, 2002,'' after ''(B)''.

(2) REPEAL OF SUPERSEDED PROVISION.—Section 8013(e) of the Omnibus Budget Reconciliation Act of 1990 (38 U.S.C. 1710 note) is repealed.

(b) OUTPATIENT MEDICATIONS.—Section 1722A(c) of title 38, United States Code, is amended by striking out ''September 30, 1998'' and inserting in lieu thereof ''September 30, 2002''.

**SEC. 8022. MEDICAL CARE COST RECOVERY AUTHORITY.**

Section 1729(a)(2)(E) of title 38, United States Code, is amended by striking out ''October 1, 1998'' and inserting in lieu thereof ''October 1, 2002''.

**SEC. 8023. DEPARTMENT OF VETERANS AFFAIRS MEDICAL-CARE RECEIPTS.**

(a) ALLOCATION OF RECEIPTS.—(1) Chapter 17 of title 38, United States Code, is amended by inserting after section 1729 the following new section:

**''§ 1729A. Department of Veterans Affairs Medical Care Collections Fund**

''(a) There is in the Treasury a fund to be known as the Department of Veterans Affairs Medical Care Collections Fund.

''(b) Amounts recovered or collected after June 30, 1997, under any of the following provisions of law shall be deposited in the fund:

''(1) Section 1710(f) of this title.

''(2) Section 1710(g) of this title.

''(3) Section 1711 of this title.

''(4) Section 1722A of this title.

''(5) Section 1729 of this title.

''(6) Public Law 87–693, popularly known as the 'Federal Medical Care Recovery Act' (42 U.S.C. 2651 et seq.), to the extent that a recovery or collection under that law is based on medical care or services furnished under this chapter.

''(c)(1) Subject to the provisions of appropriations Acts, amounts in the fund shall be available, without fiscal year limitation, to the Secretary for the following purposes:

''(A) Furnishing medical care and services under this chapter, to be available during any fiscal year for the same purposes and subject to the same limitations (other than with respect to the period of availability for obligation) as apply to amounts appropriated from the general fund of the Treasury for that fiscal year for medical care.

''(B) Expenses of the Department for the identification, billing, auditing, and collection of amounts owed the United States by reason of medical care and services furnished under this chapter.

''(2) Amounts available under paragraph (1) may not be used for any purpose other than a purpose set forth in subparagraph (A) or (B) of that paragraph.

''(3)(A) If for fiscal year 1998 the Secretary determines that the total amount to be recovered under the provisions of law specified in subsection (b) will be less than the amount contained in the latest Congressional Budget Office baseline estimate (computed under section 257 of the Balanced Budget and Emergency Deficit Control Act of 1985) for the amount of such recoveries for fiscal year 1998 by at least $25,000,000, the Secretary shall promptly certify to the Secretary of the Treasury the amount of the shortfall (as estimated by the Secretary) that is in excess of $25,000,000. Upon receipt of such a certification, the Secretary of the Treasury shall, not later than 30 days after receiving the certification, deposit in the fund, from any unobligated amounts in the Treasury, an amount equal to the amount certified by the Secretary.

''(B) If for fiscal year 1998 a deposit is made under subparagraph (A) and the Secretary subsequently determines that the actual amount recovered for that fiscal year under the provisions of law specified in subsection (b) is greater than the amount estimated by the Secretary that was used for purposes of the certification by the Secretary under subparagraph (A), the Secretary shall pay into the general fund of the Treasury, from amounts available for medical care, an amount equal to the difference between the amount actually recovered and the amount so estimated (but not in excess of the amount of the deposit under subparagraph (A) pursuant to such certification).

''(C) If for fiscal year 1998 a deposit is made under subparagraph (A) and the Secretary subsequently determines that the actual amount recovered for that fiscal year under the provisions of law specified in subsection (b) is less than the amount estimated by the Secretary that was used for purposes of the certification by the Secretary under subparagraph (A), the Secretary shall promptly certify to the Secretary of the Treasury the amount of the shortfall. Upon receipt of such a certification, the Secretary of the Treasury shall, not later than 30 days after receiving the certification, deposit in the fund, from any unobligated amounts in the Treasury, an amount equal to the amount certified by the Secretary.

''(d)(1) Of the total amount recovered or collected by the Department during a fiscal year under the provisions of law referred to in subsection (b) and made available from the fund, the Secretary shall make available to each designated health care region of the Department an amount that bears the same ratio to the total amount so made available as the amount recovered or collected by such region during that fiscal year under such provisions of law bears to such total amount recovered or collected during that fiscal year. The Secretary shall make available to each region the entirety of the amount specified to be made available to such region by the preceding sentence.

''(2) In this subsection, the term 'designated health care regions of the Department' means the geographic areas designated by the Secretary for purposes of the management of, and allocation of resources for, health care services provided by the Department.

''(e)(1) The Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives quarterly reports on the operation of this section for fiscal years 1998, 1999, and 2000 and for the first quarter of fiscal year 2001. Each such report shall specify the amount collected under each of the provisions specified in subsection (b) during the preceding quarter and

the amount originally estimated to be collected under each such provision during such quarter.

''(2) A report under paragraph (1) for a quarter shall be submitted not later than 45 days after the end of that quarter.

''(f) Amounts recovered or collected under the provisions of law referred to in subsection (b) shall be treated for the purposes of sections 251 and 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 901, 902) as offsets to discretionary appropriations (rather than as offsets to direct spending) to the extent that such amounts are made available for expenditure in appropriations Acts for the purposes specified in subsection (c).''.

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1729 the following new item:

''1729A. Department of Veterans Affairs Medical Care Collections Fund.''

(b) CONFORMING AMENDMENTS.—Chapter 17 of such title is amended as follows:

(1) Section 1710(f) is amended by striking out paragraph (4) and redesignating paragraph (5) as paragraph (4).

(2) Section 1710(g) is amended by striking out paragraph (4).

(3) Section 1722A(b) is amended by striking out ''Department of Veterans Affairs Medical-Care Cost Recovery Fund'' and inserting in lieu thereof ''Department of Veterans Affairs Medical Care Collections Fund''.

(4) Section 1729 is amended by striking out subsection (g).

(c) DISPOSITION OF FUNDS IN MEDICAL-CARE COST RECOVERY FUND.—The amount of the unobligated balance remaining in the Department of Veterans Affairs Medical-Care Cost Recovery Fund (established pursuant to section 1729(g)(1) of title 38, United States Code) at the close of June 30, 1997, shall be deposited, not later than December 31, 1997, in the Treasury as miscellaneous receipts, and the Department of Veterans Affairs Medical-Care Cost Recovery Fund shall be terminated when the deposit is made.

(d) DETERMINATION OF AMOUNTS SUBJECT TO RECOVERY.—Section 1729 of title 38, United States Code, is amended—

(1) in subsection (a)(1), by striking out ''the reasonable cost of'' and inserting in lieu thereof ''reasonable charges for''; and

(2) in subsection (c)(2)—

(A) by striking out ''the reasonable cost of'' in the first sentence of subparagraph (A) and in subparagraph (B) and inserting in lieu thereof ''reasonable charges for''; and

(B) by striking out ''cost'' in the second sentence of subparagraph (A) and inserting in lieu thereof ''charges''.

(e) TECHNICAL AMENDMENT.—Paragraph (2) of section 712(b) of title 38, United States Code, is amended—

(1) by striking out subparagraph (B); and

(2) by redesignating subparagraph (C) as subparagraph (B).

(f) IMPLEMENTATION.—Not later than January 1, 1999, the Secretary of Veterans Affairs shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the implementation of this section. The report shall describe the collections under each of the provisions specified in section 1729A(b) of title 38, United States Code, as added by subsection (a). Information on such collections shall be shown for each of the health service networks (known as Veterans Integrated Service Networks) and, to the extent practicable for each facility within each such network. The Secretary shall include in the report an analysis of differences among the networks with respect to (A) the market in which the networks operates, (B) the effort expended to achieve collections, (C) the efficiency of such effort, and (D) any other relevant information.

(g) EFFECTIVE DATE.—(1) Except as provided in paragraph (2), this section and the amendments made by this section shall take effect on October 1, 1997.

(2) The amendments made by subsection (d) shall take effect on the date of the enactment of this Act.

**Subtitle C—Other Matters**

**SEC. 8031. ROUNDING DOWN OF COST-OF-LIVING ADJUSTMENTS IN COMPENSATION AND DIC RATES FOR FISCAL YEARS 1998 THROUGH 2002.**

(a) COMPENSATION COLAS.—(1) Chapter 11 of title 38, United States Code, is amended by inserting after section 1102 the following new section:

**''§ 1103. Cost-of-living adjustments**

''(a) In the computation of cost-of-living adjustments for fiscal years 1998 through 2002 in the rates of, and dollar limitations applicable to, compensation payable under this chapter, such adjustments shall be made by a uniform percentage that is no more than the percentage equal to the social security increase for that fiscal year, with all increased monthly rates and limitations (other than increased rates or limitations equal to a whole dollar amount) rounded down to the next lower whole dollar amount.

''(b) For purposes of this section, the term 'social security increase' means the percentage by which benefit amounts payable under title II of the Social Security Act (42 U.S.C. 401 et seq.) are increased for any fiscal year as a result of a determination under section 215(i) of such Act (42 U.S.C. 415(i)).''.

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1102 the following new item:

''1103. Cost-of-living adjustments.''.

(b) DIC COLAS.—(1) Chapter 13 of title 38, United States Code, is amended by inserting after section 1302 the following new section:

**''§ 1303. Cost-of-living adjustments**

''(a) In the computation of cost-of-living adjustments for fiscal years 1998 through 2002 in the rates of dependency and indemnity compensation payable under this chapter, such adjustments (except as provided in subsection (b)) shall be made by a uniform percentage that is no more than the percentage equal to the social security increase for that fiscal year, with all increased monthly rates (other than increased rates equal to a whole dollar amount) rounded down to the next lower whole dollar amount.

''(b) For purposes of this section, the term 'social security increase' means the percentage by which benefit amounts payable under title II of the Social Security Act (42 U.S.C. 401 et seq.) are increased for any fiscal year as a result of a determination under section 215(i) of such Act (42 U.S.C. 415(i)).''.

(2) The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 1302 the following new item:

''1303. Cost-of-living adjustments.''.

**SEC. 8032. INCREASE IN AMOUNT OF HOME LOAN FEES FOR THE PURCHASE OF REPOSSESSED HOMES FROM THE DEPARTMENT OF VETERANS AFFAIRS.**

Section 3729(a) of title 38, United States Code, is amended—

(1) in paragraph (2)—

(A) in subparagraph (A), by striking out ''or 3733(a)'';

(B) in subparagraph (D), by striking out ''and'' at the end;

(C) in subparagraph (E), by striking out the period at the end and inserting in lieu thereof ''; and''; and

(D) by adding at the end the following:

''(F) in the case of a loan made under section 3733(a) of this title, the amount of such fee shall be 2.25 percent of the total loan amount.''; and

(2) in paragraph (4), as amended by section 8012(1) of this Act, by striking out ''or (E)'' and inserting in lieu thereof ''(E), or (F)''.

**SEC. 8033. WITHHOLDING OF PAYMENTS AND BENEFITS.**

(a) NOTICE REQUIRED IN LIEU OF CONSENT OR COURT ORDER.—Section 3726 of title 38, United States Code, is amended—

(1) by inserting ''(a)'' before ''No officer''; and

(2) by striking out ''unless'' and all that follows and inserting in lieu thereof the following: ''unless the Secretary provides such veteran or surviving spouse with notice by certified mail with return receipt requested of the authority of the Secretary to waive the payment of indebtedness under section 5302(b) of this title.''; and

(3) by adding at the end the following new subsections:

''(b) If the Secretary does not waive the entire amount of the liability, the Secretary shall then determine whether the veteran or surviving spouse should be released from liability under section 3713(b) of this title.

''(c) If the Secretary determines that the veteran or surviving spouse should not be released from liability, the Secretary shall notify the veteran or surviving spouse of that determination and provide a notice of the procedure for appealing that determination, unless the Secretary has previously made such determination and notified the veteran or surviving spouse of the procedure for appealing the determination.''.

(b) CONFORMING AMENDMENT.—Section 5302(b) of such title is amended by inserting ''with return receipt requested'' after ''certified mail''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to any indebtedness to the United States arising pursuant to chapter 37 of title 38, United States Code, before, on, or after the date of enactment of this Act.

**TITLE IX—ASSET SALES, USER FEES, AND MISCELLANEOUS PROVISIONS**

**SEC. 9000. TABLE OF CONTENTS.**

The table of contents for this title is as follows:

TITLE IX—ASSET SALES, USER FEES, AND MISCELLANEOUS PROVISIONS

Sec. 9000. Table of contents.

Subtitle A—Asset Sales

Sec. 9101. Sale of Governors Island, New York.

Sec. 9102. Sale of air rights.

Subtitle B—User Fees

Sec. 9201. Extension of higher vessel tonnage duties.

Subtitle C—Miscellaneous Provisions

Sec. 9301. Temporary Federal share formula adjustment.

Sec. 9302. Increase in excise taxes on tobacco products.

Sec. 9303. Lease of excess strategic petroleum reserve capacity.

**Subtitle A—Asset Sales**

**SEC. 9101. SALE OF GOVERNORS ISLAND, NEW YORK.**

(a) IN GENERAL.—Notwithstanding any other provision of law, the Administrator of General Services shall, no earlier than fiscal year 2002, dispose of by sale at fair market value all rights, title, and interests of the United States in and to the land of, and improvements to, Governors Island, New York.

(b) RIGHT OF FIRST OFFER.—Before a sale is made under subsection (a) to any other parties, the State of New York and the city of New York shall be given the right of first offer to purchase all or part of Governors Island at fair market value as determined by

the Administrator of General Services. Not later than 90 days after notification by the Administrator of General Services, such right may be exercised by either the State of New York or the city of New York or by both parties acting jointly.

(c) PROCEEDS.—Proceeds from the disposal of Governors Island under subsection (a) shall be deposited in the general fund of the Treasury and credited as miscellaneous receipts.

**SEC. 9102. SALE OF AIR RIGHTS.**

(a) IN GENERAL.—Notwithstanding any other provision of law, the Administrator of General Services shall sell, at fair market value and in a manner to be determined by the Administrator, the air rights adjacent to Washington Union Station described in subsection (b), including air rights conveyed to the Administrator under subsection (d). The Administrator shall complete the sale by such date as is necessary to ensure that the proceeds from the sale will be deposited in accordance with subsection (c).

(b) DESCRIPTION.—The air rights referred to in subsection (a) total approximately 16.5 acres and are depicted on the plat map of the District of Columbia as follows:

(1) Part of lot 172, square 720.

(2) Part of lots 172 and 823, square 720.

(3) Part of lot 811, square 717.

(c) PROCEEDS.—Before September 30, 2002, proceeds from the sale of air rights under subsection (a) shall be deposited in the general fund of the Treasury and credited as miscellaneous receipts.

(d) CONVEYANCE OF AMTRAK AIR RIGHTS.—

(1) GENERAL RULE.—As a condition of future Federal financial assistance, Amtrak shall convey to the Administrator of General Services on or before December 31, 1997, at no charge, all of the air rights of Amtrak described in subsection (b).

(2) FAILURE TO COMPLY.—If Amtrak does not meet the condition established by paragraph (1), Amtrak shall be prohibited from obligating Federal funds after March 1, 1998.

**Subtitle B—User Fees**

**SEC. 9201. EXTENSION OF HIGHER VESSEL TONNAGE DUTIES.**

(a) EXTENSION OF DUTIES.—Section 36 of the Act of August 5, 1909 (36 Stat. 111; 46 U.S.C. App. 121) is amended by striking ''for fiscal years 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998,'' each place it appears and inserting ''for fiscal years 1991 through 2002,''.

(b) CONFORMING AMENDMENT.—The Act entitled ''An Act concerning tonnage duties on vessels entering otherwise than by sea'', approved March 8, 1910 (36 Stat. 234; 46 U.S.C. App. 132) is amended by striking ''for fiscal years 1991, 1992, 1993, 1994, 1995, 1996, 1997, 1998,'' and inserting ''for fiscal years 1991 through 2002,''.

**Subtitle C—Miscellaneous Provisions**

**SEC. 9301. TEMPORARY FEDERAL SHARE FORMULA ADJUSTMENT.**

The Federal share of the cost of assistance provided under the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5121 et seq.) for damages suffered in Kittson, Marshall, Polk, Norman, Clay, and Wilkin Counties, Minnesota, as a result of the 1997 floods in the Red River Valley in Minnesota and North Dakota shall be at least 90 percent.

**SEC. 9302. INCREASE IN EXCISE TAXES ON TOBACCO PRODUCTS.**

(a) CIGARETTES.—Subsection (b) of section 5701 of the Internal Revenue Code of 1986 is amended—

(1) by striking ''$12 per thousand ($10 per thousand on cigarettes removed during 1991 or 1992)'' in paragraph (1) and inserting ''$19.50 per thousand ($17 per thousand on cigarettes removed during 2000 or 2001)'', and

(2) by striking ''$25.20 per thousand ($21 per thousand on cigarettes removed during 1991 or 1992)'' in paragraph (2) and inserting ''$40.95 per thousand ($35.70 per thousand on cigarettes removed during 2000 or 2001)''.

(b) CIGARS.—Subsection (a) of section 5701 of such Code is amended—

(1) by striking ''$1.125 cents per thousand (93.75 cents per thousand on cigars removed during 1991 or 1992)'' in paragraph (1) and inserting ''$1.828 cents per thousand ($1.594 cents per thousand on cigars removed during 2000 or 2001)'', and

(2) by striking ''equal to'' and all that follows in paragraph (2) and inserting ''equal to 20.719 percent (18.063 percent on cigars removed during 2000 or 2001) of the price for which sold but not more than $48.75 per thousand ($42.50 per thousand on cigars removed during 2000 or 2001).''.

(c) CIGARETTE PAPERS.—Subsection (c) of section 5701 of such Code is amended by striking ''0.75 cent (0.625 cent on cigarette papers removed during 1991 or 1992)'' and inserting ''1.22 cents (1.06 cents on cigarette papers removed during 2000 or 2001)''.

(d) CIGARETTE TUBES.—Subsection (d) of section 5701 of such Code is amended by striking ''1.5 cents (1.25 cents on cigarette tubes removed during 1991 or 1992)'' and inserting ''2.44 cents (2.13 cents on cigarette tubes removed during 2000 or 2001)''.

(e) SMOKELESS TOBACCO.—Subsection (e) of section 5701 of such Code is amended—

(1) by striking ''36 cents (30 cents on snuff removed during 1991 or 1992)'' in paragraph (1) and inserting ''58.5 cents (51 cents on snuff removed during 2000 or 2001)'', and

(2) by striking ''12 cents (10 cents on chewing tobacco removed during 1991 or 1992)'' in paragraph (2) and inserting ''19.5 cents (17 cents on chewing tobacco removed during 2000 or 2001)''.

(f) PIPE TOBACCO.—Subsection (f) of section 5701 of such Code is amended by striking ''67.5 cents (56.25 cents on pipe tobacco removed during 1991 or 1992)'' and inserting ''$1.0969 cents (95.67 cents on pipe tobacco removed during 2000 or 2001)''.

(g) IMPOSITION OF EXCISE TAX ON MANUFACTURE OR IMPORTATION OF ROLL-YOUR-OWN TOBACCO.—

(1) IN GENERAL.—Section 5701 of such Code (relating to rate of tax) is amended by redesignating subsection (g) as subsection (h) and by inserting after subsection (f) the following new subsection:

''(g) ROLL-YOUR-OWN TOBACCO.—On roll-your-own tobacco, manufactured in or imported into the United States, there shall be imposed a tax of $1.0969 cents (95.67 cents on roll-your-own tobacco removed during 2000 or 2001) per pound (and a proportionate tax at the like rate on all fractional parts of a pound).''.

(2) ROLL-YOUR-OWN TOBACCO.—Section 5702 of such Code (relating to definitions) is amended by adding at the end the following new subsection:

''(p) ROLL-YOUR-OWN TOBACCO.—The term 'roll-your-own tobacco' means any tobacco which, because of its appearance, type, packaging, or labeling, is suitable for use and likely to be offered to, or purchased by, consumers as tobacco for making cigarettes.''.

(3) TECHNICAL AMENDMENTS.—

(A) Subsection (c) of section 5702 of such Code is amended by striking ''and pipe tobacco'' and inserting ''pipe tobacco, and roll-your-own tobacco''.

(B) Subsection (d) of section 5702 of such Code is amended—

(i) in the material preceding paragraph (1), by striking ''or pipe tobacco'' and inserting ''pipe tobacco, or roll-your-own tobacco'', and

(ii) by striking paragraph (1) and inserting the following new paragraph:

''(1) a person who produces cigars, cigarettes, smokeless tobacco, pipe tobacco, or roll-your-own tobacco solely for the person's own personal consumption or use, and''.

(C) The chapter heading for chapter 52 of such Code is amended to read as follows:

**''CHAPTER 52—TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES''.**

(D) The table of chapters for subtitle E of such Code is amended by striking the item relating to chapter 52 and inserting the following new item:

''CHAPTER 52. Tobacco products and cigarette papers and tubes.''.

(h) MODIFICATIONS OF CERTAIN TOBACCO TAX PROVISIONS.—

(1) EXEMPTION FOR EXPORTED TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES TO APPLY ONLY TO ARTICLES MARKED FOR EXPORT.—

(A) Subsection (b) of section 5704 of such Code is amended by adding at the end the following new sentence: ''Tobacco products and cigarette papers and tubes may not be transferred or removed under this subsection unless such products or papers and tubes bear such marks, labels, or notices as the Secretary shall by regulations prescribe.''.

(B) Section 5761 of such Code is amended by redesignating subsections (c) and (d) as subsections (d) and (e), respectively, and by inserting after subsection (b) the following new subsection:

''(c) SALE OF TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES FOR EXPORT.—Except as provided in subsections (b) and (d) of section 5704—

''(1) every person who sells, relands, or receives within the jurisdiction of the United States any tobacco products or cigarette papers or tubes which have been labeled or shipped for exportation under this chapter,

''(2) every person who sells or receives such relanded tobacco products or cigarette papers or tubes, and

''(3) every person who aids or abets in such selling, relanding, or receiving,

shall, in addition to the tax and any other penalty provided in this title, be liable for a penalty equal to the greater of $1,000 or 5 times the amount of the tax imposed by this chapter. All tobacco products and cigarette papers and tubes relanded within the jurisdiction of the United States, and all vessels, vehicles, and aircraft used in such relanding or in removing such products, papers, and tubes from the place where relanded, shall be forfeited to the United States.''.

(C) Subsection (a) of section 5761 of such Code is amended by striking ''subsection (b)'' and inserting ''subsection (b) or (c)''.

(D) Subsection (d) of section 5761 of such Code, as redesignated by subparagraph (B), is amended by striking ''The penalty imposed by subsection (b)'' and inserting ''The penalties imposed by subsections (b) and (c)''.

(E)(i) Subpart F of chapter 52 of such Code is amended by adding at the end the following new section:

**''SEC. 5754. RESTRICTION ON IMPORTATION OF PREVIOUSLY EXPORTED TOBACCO PRODUCTS.**

''(a) IN GENERAL.—Tobacco products and cigarette papers and tubes previously exported from the United States may be imported or brought into the United States only as provided in section 5704(d). For purposes of this section, section 5704(d), section 5761, and such other provisions as the Secretary may specify by regulations, references to exportation shall be treated as including a reference to shipment to the Commonwealth of Puerto Rico.

''(b) CROSS REFERENCE.—

**''For penalty for the sale of tobacco products and cigarette papers and tubes in the United States which are labeled for export, see section 5761(c).''.**

(ii) The table of sections for subpart F of chapter 52 of such Code is amended by adding at the end the following new item:

''Sec. 5754. Restriction on importation of previously exported tobacco products.''.

(2) IMPORTERS REQUIRED TO BE QUALIFIED.—

(A) Sections 5712, 5713(a), 5721, 5722, 5762(a)(1), and 5763 (b) and (c) of such Code are each amended by inserting ''or importer'' after ''manufacturer''.

(B) The heading of subsection (b) of section 5763 of such Code is amended by inserting ''QUALIFIED IMPORTERS,'' after ''MANUFACTURERS,''.

(C) The heading for subchapter B of chapter 52 of such Code is amended by inserting ''**and Importers**'' after ''**Manufacturers**''.

(D) The item relating to subchapter B in the table of subchapters for chapter 52 of such Code is amended by inserting ''and importers'' after ''manufacturers''.

(3) BOOKS OF 25 OR FEWER CIGARETTE PAPERS SUBJECT TO TAX.—Subsection (c) of section 5701 of such Code is amended by striking ''On each book or set of cigarette papers containing more than 25 papers,'' and inserting ''On cigarette papers,''.

(4) STORAGE OF TOBACCO PRODUCTS.—Subsection (k) of section 5702 of such Code is amended by inserting ''under section 5704'' after ''internal revenue bond''.

(5) AUTHORITY TO PRESCRIBE MINIMUM MANUFACTURING ACTIVITY REQUIREMENTS.—Section 5712 of such Code is amended by striking ''or'' at the end of paragraph (1), by redesignating paragraph (2) as paragraph (3), and by inserting after paragraph (1) the following new paragraph:

''(2) the activity proposed to be carried out at such premises does not meet such minimum capacity or activity requirements as the Secretary may prescribe, or''.

(i) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to articles removed (as defined in section 5702(k) of the Internal Revenue Code of 1986, as amended by this section) after December 31, 1999.

(2) TRANSITIONAL RULE.—Any person who—

(A) on the date of the enactment of this Act is engaged in business as a manufacturer of roll-your-own tobacco or as an importer of tobacco products or cigarette papers and tubes, and

(B) before January 1, 2000, submits an application under subchapter B of chapter 52 of such Code to engage in such business,

may, notwithstanding such subchapter B, continue to engage in such business pending final action on such application. Pending such final action, all provisions of such chapter 52 shall apply to such applicant in the same manner and to the same extent as if such applicant were a holder of a permit under such chapter 52 to engage in such business.

(j) FLOOR STOCKS TAXES.—

(1) IMPOSITION OF TAX.—On tobacco products and cigarette papers and tubes manufactured in or imported into the United States which are removed before any tax increase date, and held on such date for sale by any person, there is hereby imposed a tax in an amount equal to the excess of—

(A) the tax which would be imposed under section 5701 of the Internal Revenue Code of 1986 on the article if the article had been removed on such date, over

(B) the prior tax (if any) imposed under section 5701 of such Code on such article.

(2) AUTHORITY TO EXEMPT CIGARETTES HELD IN VENDING MACHINES.—To the extent provided in regulations prescribed by the Secretary, no tax shall be imposed by paragraph (1) on cigarettes held for retail sale on any tax increase date, by any person in any vending machine. If the Secretary provides such a benefit with respect to any person, the Secretary may reduce the $500 amount in paragraph (3) with respect to such person.

(3) CREDIT AGAINST TAX.—Each person shall be allowed as a credit against the taxes imposed by paragraph (1) an amount equal to $500. Such credit shall not exceed the amount of taxes imposed by paragraph (1) on any tax increase date, for which such person is liable.

(4) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(A) LIABILITY FOR TAX.—A person holding cigarettes on any tax increase date, to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(C) TIME FOR PAYMENT.—The tax imposed by paragraph (1) shall be paid on or before April 1 following any tax increase date.

(5) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (48 Stat. 998, 19 U.S.C. 81a) and any other provision of law, any article which is located in a foreign trade zone on any tax increase date, shall be subject to the tax imposed by paragraph (1) if—

(A) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the 1st proviso of section 3(a) of such Act, or

(B) such article is held on such date under the supervision of a customs officer pursuant to the 2d proviso of such section 3(a).

(6) DEFINITIONS.—For purposes of this subsection—

(A) IN GENERAL.—Terms used in this subsection which are also used in section 5702 of the Internal Revenue Code of 1986 shall have the respective meanings such terms have in such section, as amended by this Act.

(B) TAX INCREASE DATE.—The term ''tax increase date'' means January 1, 2000, and January 1, 2002.

(C) SECRETARY.—The term ''Secretary'' means the Secretary of the Treasury or the Secretary's delegate.

(7) CONTROLLED GROUPS.—Rules similar to the rules of section 5061(e)(3) of such Code shall apply for purposes of this subsection.

(8) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable with respect to the taxes imposed by section 5701 of such Code shall, insofar as applicable and not inconsistent with the provisions of this subsection, apply to the floor stocks taxes imposed by paragraph (1), to the same extent as if such taxes were imposed by such section 5701. The Secretary may treat any person who bore the ultimate burden of the tax imposed by paragraph (1) as the person to whom a credit or refund under such provisions may be allowed or made.

**SEC. 9303. LEASE OF EXCESS STRATEGIC PETROLEUM RESERVE CAPACITY.**

(a) AMENDMENT.—Part B of title I of the Energy Policy and Conservation Act (42 U.S.C. 6231 et seq.) is amended by adding at the end the following:

''USE OF UNDERUTILIZED FACILITIES

''SEC. 168. (a) AUTHORITY.—Notwithstanding any other provision of this title, the Secretary, by lease or otherwise, for any term and under such other conditions as the Secretary considers necessary or appropriate, may store in underutilized Strategic Petroleum Reserve facilities petroleum product owned by a foreign government or its representative. Petroleum products stored under this section are not part of the Strategic Petroleum Reserve and may be exported without license from the United States.

''(b) PROTECTION OF FACILITIES.—All agreements entered into pursuant to subsection (a) shall contain provisions providing for fees to fully compensate the United States for all related costs of storage and removals of petroleum products (including the proportionate cost of replacement facilities necessitated as a result of any withdrawals) incurred by the United States on behalf of the foreign government or its representative.

''(c) ACCESS TO STORED OIL.—The Secretary shall ensure that agreements to store petroleum products for foreign governments or their representatives do not impair the ability of the United States to withdraw, distribute, or sell petroleum products from the Strategic Petroleum Reserve in response to an energy emergency or to the obligations of the United States under the Agreement on an International Energy Program.

''(d) AVAILABILITY OF FUNDS.—Funds collected through the leasing of Strategic Petroleum Reserve facilities authorized by subsection (a) after September 30, 2007, shall be used by the Secretary of Energy without further appropriation for the purchase of petroleum products for the Strategic Petroleum Reserve.''.

(b) TABLE OF CONTENTS AMENDMENT.—The table of contents of part B of title I of the Energy Policy and Conservation Act is amended by adding at the end the following:

''Sec. 168. Use of underutilized facilities.''.

**SEC. 9304. IDENTIFICATION OF LIMITED TAX BENEFITS SUBJECT TO LINE ITEM VETO.**

Section 1021(a)(3) of the Congressional Budget Act of 1974 shall only apply to 3306(c)(21) of the Internal Revenue Code of 1986 (as added by section 5406 of this Act).

**SEC. 9305. PAYMENT OF BENEFITS IN APPROPRIATE FISCAL YEAR.**

Section 5120(e) of title 38, United States Code, shall not apply to benefit payments otherwise payable on October 1, 2000.

## TITLE X—BUDGET ENFORCEMENT AND PROCESS PROVISIONS

**SEC. 10001. SHORT TITLE; TABLE OF CONTENTS.**

(a) SHORT TITLE.—This title may be cited as the ''Budget Enforcement Act of 1997''.

(b) TABLE OF CONTENTS.—The table of contents for this title is as follows:

Sec. 10001. Short title; table of contents.

Subtitle A—Amendments to the Congressional Budget and Impoundment Control Act of 1974

Sec. 10101. Amendment to section 3.
Sec. 10102. Amendments to section 201.
Sec. 10103. Amendments to section 202.
Sec. 10104. Amendment to section 300.
Sec. 10105. Amendments to section 301.
Sec. 10106. Amendments to section 302.
Sec. 10107. Amendments to section 303.
Sec. 10108. Amendment to section 304.
Sec. 10109. Amendment to section 305.
Sec. 10110. Amendments to section 308.
Sec. 10111. Amendments to section 310.
Sec. 10112. Amendments to section 311.
Sec. 10113. Amendment to section 312.
Sec. 10114. Adjustments.
Sec. 10115. Effect of adoption of a special order of business in the House of Representatives.
Sec. 10116. Amendment to section 401 and repeal of section 402.
Sec. 10117. Amendments to title V.
Sec. 10118. Repeal of title VI.
Sec. 10119. Amendments to section 904.
Sec. 10120. Repeal of sections 905 and 906.
Sec. 10121. Amendments to sections 1022 and 1024.
Sec. 10122. Amendment to section 1026.
Sec. 10123. Senate task force on consideration of budget measures.

Subtitle B—Amendments to the Balanced Budget and Emergency Deficit Control Act of 1985

Sec. 10201. Purpose.

Sec. 10202. General statement and definitions.
Sec. 10203. Enforcing discretionary spending limits.
Sec. 10204. Violent crime reduction spending.
Sec. 10205. Enforcing pay-as-you-go.
Sec. 10206. Reports and orders.
Sec. 10207. Exempt programs and activities.
Sec. 10208. General and special sequestration rules.
Sec. 10209. The baseline.
Sec. 10210. Technical correction.
Sec. 10211. Judicial review.
Sec. 10212. Effective date.
Sec. 10213. Reduction of preexisting balances and exclusion of effects of this Act from paygo scorecard.

**Subtitle A—Amendments to the Congressional Budget and Impoundment Control Act of 1974**

**SEC. 10101. AMENDMENT TO SECTION 3.**

Section 3(9) of the Congressional Budget and Impoundment Control Act of 1974 is amended to read as follows:

''(9) The term 'entitlement authority' means—

''(A) the authority to make payments (including loans and grants), the budget authority for which is not provided for in advance by appropriation Acts, to any person or government if, under the provisions of the law containing that authority, the United States is obligated to make such payments to persons or governments who meet the requirements established by that law; and

''(B) the food stamp program.''.

**SEC. 10102. AMENDMENTS TO SECTION 201.**

(a) TERM OF OFFICE.—The first sentence of section 201(a)(3) of the Congressional Budget Act of 1974 is amended to read as follows: ''The term of office of the Director shall be 4 years and shall expire on January 3 of the year preceding each Presidential election.''.

(b) CONFORMING CHANGE.—Section 201(e) of the Congressional Budget Act of 1974 is amended by inserting ''and'' before ''the Library'', by striking ''and the Office of Technology Assessment,'', by inserting ''and'' before ''the Librarian'', and by striking '', and the Technology Assessment Board''.

(c) REDESIGNATION OF EXECUTED PROVISION.—Section 201 of the Congressional Budget Act of 1974 is amended by redesignating subsection (g) (relating to revenue estimates) as subsection (f).

**SEC. 10103. AMENDMENTS TO SECTION 202.**

(a) ASSISTANCE TO BUDGET COMMITTEES.—The first sentence of section 202(a) of the Congressional Budget Act of 1974 is amended by inserting ''primary'' before ''duty''.

(b) ELIMINATION OF EXECUTED PROVISION.—Section 202 of the Congressional Budget Act of 1974 is amended by striking subsection (e) and by redesignating subsections (f), (g), and (h) as subsections (e), (f), and (g), respectively.

(c) REPORTING REQUIREMENT.—The first sentence of section 202(e)(1) of the Congressional Budget Act of 1974 (as redesignated) is amended by—

(1) striking ''and'' before ''(B)''; and

(2) inserting before the period the following: '', and (C) a statement of the levels of budget authority and outlays for each program assumed to be extended in the baseline, as provided in section 257(b)(2)(A) and for excise taxes assumed to be extended under section 257(b)(2)(C) of the Balanced Budget and Emergency Deficit Control Act of 1985''.

**SEC. 10104. AMENDMENT TO SECTION 300.**

(a) TIMETABLE.—The item relating to February 25 in the timetable set forth in section 300 of the Congressional Budget Act of 1974 is amended by striking ''February 25'' and inserting ''Not later than 6 weeks after President submits budget''.

(b) CONFORMING AMENDMENTS.—(1) Clause 4(g) of rule X of the Rules of the House of Representatives is amended by striking ''on or before February 25 of each year'' and inserting ''not later than 6 weeks after the President submits his budget''.

(2) Clause 3(c) of rule XLVIII of the Rules of the House of Representatives is amended by striking ''On or before March 15 of each year'' and inserting ''Within 6 weeks after the President submits a budget under section 1105(a) of title 31, United States Code'' and by striking ''section 301(c)'' and inserting ''section 301(d)''.

**SEC. 10105. AMENDMENTS TO SECTION 301.**

(a) TERMS OF BUDGET RESOLUTIONS.—Section 301(a) of the Congressional Budget Act of 1974 is amended by striking '', and planning levels for each of the two ensuing fiscal years,'' and inserting ''and for at least each of the 4 ensuing fiscal years''.

(b) CONTENTS OF BUDGET RESOLUTIONS.—Paragraphs (1) and (4) of section 301(a) of the Congressional Budget Act of 1974 are amended by striking '', budget outlays, direct loan obligations, and primary loan guarantee commitments'' each place it appears and inserting ''and outlays''.

(c) ADDITIONAL MATTERS.—Section 301(b) of the Congressional Budget Act of 1974 is amended by—

(1) striking paragraph (7) and inserting the following:

''(7) set forth procedures in the Senate whereby committee allocations, aggregates, and other levels can be revised for legislation if that legislation would not increase the deficit, or would not increase the deficit when taken with other legislation enacted after the adoption of the resolution, for the first fiscal year or the total period of fiscal years covered by the resolution;'';

(2) in paragraph 8, striking the period and inserting ''; and''; and

(3) adding the following new paragraph:

''(9) set forth direct loan obligation and primary loan guarantee commitment levels.''.

(d) VIEWS AND ESTIMATES.—The first sentence of section 301(d) of the Congressional Budget Act of 1974 is amended by inserting ''or at such time as may be requested by the Committee on the Budget,'' after ''Code,''.

(e) HEARINGS AND REPORT.—Section 301(e) of the Congressional Budget Act of 1974 is amended—

(1) by striking ''In developing'' and inserting the following:

''(1) IN GENERAL.—In developing''; and

(2) by striking the sentence beginning with ''The report accompanying'' and all that follows through the end of the subsection and inserting the following:

''(2) REQUIRED CONTENTS OF REPORT.—The report accompanying the resolution shall include—

''(A) a comparison of the levels of total new budget authority, total outlays, total revenues, and the surplus or deficit for each fiscal year set forth in the resolution with those requested in the budget submitted by the President;

''(B) with respect to each major functional category, an estimate of total new budget authority and total outlays, with the estimates divided between discretionary and mandatory amounts;

''(C) the economic assumptions that underlie each of the matters set forth in the resolution and any alternative economic assumptions and objectives the committee considered;

''(D) information, data, and comparisons indicating the manner in which, and the basis on which, the committee determined each of the matters set forth in the resolution;

''(E) the estimated levels of tax expenditures (the tax expenditures budget) by major items and functional categories for the President's budget and in the resolution; and

''(F) allocations described in section 302(a).

''(3) ADDITIONAL CONTENTS OF REPORT.—The report accompanying the resolution may include—

''(A) a statement of any significant changes in the proposed levels of Federal assistance to State and local governments;

''(B) an allocation of the level of Federal revenues recommended in the resolution among the major sources of such revenues;

''(C) information, data, and comparisons on the share of total Federal budget outlays and of gross domestic product devoted to investment in the budget submitted by the President and in the resolution;

''(D) the assumed levels of budget authority and outlays for public buildings, with a division between amounts for construction and repair and for rental payments; and

''(E) other matters, relating to the budget and to fiscal policy, that the committee deems appropriate.''.

(f) SOCIAL SECURITY CORRECTIONS.—(1) Section 301(i) of the Congressional Budget Act of 1974 is amended by—

(A) inserting ''SOCIAL SECURITY POINT OF ORDER.—'' after ''(i)''; and

(B) striking ''as reported to the Senate'' and inserting ''(or amendment, motion, or conference report on the resolution)''; and

(2) Section 22 of House Concurrent Resolution 218 (103d Congress) is repealed.

**SEC. 10106. AMENDMENTS TO SECTION 302.**

(a) ALLOCATIONS AND SUBALLOCATIONS.—Section 302 of the Congressional Budget Act of 1974 is amended by striking subsections (a) and (b) and inserting the following:

''(a) COMMITTEE SPENDING ALLOCATIONS.—

''(1) ALLOCATION AMONG COMMITTEES.—The joint explanatory statement accompanying a conference report on a concurrent resolution on the budget shall include an allocation, consistent with the resolution recommended in the conference report, of the levels for the first fiscal year of the resolution, for at least each of the ensuing 4 fiscal years, and a total for that period of fiscal years (except in the case of the Committee on Appropriations only for the fiscal year of that resolution) of—

''(A) total new budget authority; and

''(B) total outlays;

among each committee of the House of Representatives or the Senate that has jurisdiction over legislation providing or creating such amounts.

''(2) NO DOUBLE COUNTING.—In the House of Representatives, any item allocated to one committee may not be allocated to another committee.

''(3) FURTHER DIVISION OF AMOUNTS.—

''(A) IN THE SENATE.—In the Senate, the amount allocated to the Committee on Appropriations shall be further divided among the categories specified in section 250(c)(4) of the Balanced Budget and Emergency Deficit Control Act of 1985 and shall not exceed the limits for each category set forth in section 251(c) of that Act.

''(B) IN THE HOUSE.—In the House of Representatives, the amounts allocated to each committee for each fiscal year, other than the Committee on Appropriations, shall be further divided between amounts provided or required by law on the date of filing of that conference report and amounts not so provided or required. The amounts allocated to the Committee on Appropriations shall be further divided—

''(i) between discretionary and mandatory amounts or programs, as appropriate; and

''(ii) consistent with the categories specified in section 250(c)(4) of the Balanced Budget and Emergency Deficit Control Act of 1985.

''(4) AMOUNTS NOT ALLOCATED.—In the House of Representatives or the Senate, if a

committee receives no allocation of new budget authority or outlays, that committee shall be deemed to have received an allocation equal to zero for new budget authority or outlays.

''(5) ADJUSTING ALLOCATION OF DISCRETIONARY SPENDING IN THE HOUSE OF REPRESENTATIVES.—(A) If a concurrent resolution on the budget is not adopted by April 15, the chairman of the Committee on the Budget of the House of Representatives shall submit to the House, as soon as practicable, an allocation under paragraph (1) to the Committee on Appropriations consistent with the discretionary spending levels in the most recently agreed to concurrent resolution on the budget for the appropriate fiscal year covered by that resolution.

''(B) As soon as practicable after an allocation under paragraph (1) is submitted under this section, the Committee on Appropriations shall make suballocations and report those suballocations to the House of Representatives.

''(b) SUBALLOCATIONS BY APPROPRIATIONS COMMITTEES.—As soon as practicable after a concurrent resolution on the budget is agreed to, the Committee on Appropriations of each House (after consulting with the Committee on Appropriations of the other House) shall suballocate each amount allocated to it for the budget year under subsection (a) among its subcommittees. Each Committee on Appropriations shall promptly report to its House suballocations made or revised under this subsection. The Committee on Appropriations of the House of Representatives shall further divide among its subcommittees the divisions made under subsection (a)(3)(B) and promptly report those divisions to the House.''.

(b) POINT OF ORDER.—Section 302(c) of the Congressional Budget Act of 1974 is amended to read as follows:

''(c) POINT OF ORDER.—After the Committee on Appropriations has received an allocation pursuant to subsection (a) for a fiscal year, it shall not be in order in the House of Representatives or the Senate to consider any bill, joint resolution, amendment, motion, or conference report within the jurisdiction of that committee providing new budget authority for that fiscal year, until that committee makes the suballocations required by subsection (b).''.

(c) ENFORCEMENT OF POINT OF ORDER.—

(1) IN THE HOUSE.—Section 302(f)(1) of the Congressional Budget Act of 1974 is amended by—

(A) striking ''providing new budget authority for such fiscal year or new entitlement authority effective during such fiscal year'' and inserting ''providing new budget authority for any fiscal year''; and

(B) striking ''appropriate allocation made pursuant to subsection (b)'' and all that follows through ''exceeded.'' and inserting ''applicable allocation of new budget authority made under subsection (a) or (b) for the first fiscal year or the total of fiscal years to be exceeded.''.

(2) IN THE SENATE.—Section 302(f)(2) of the Congressional Budget Act of 1974 is amended to read as follows:

''(2) IN THE SENATE.—After a concurrent resolution on the budget is agreed to, it shall not be in order in the Senate to consider any bill, joint resolution, amendment, motion, or conference report that would cause—

''(A) in the case of any committee except the Committee on Appropriations, the applicable allocation of new budget authority or outlays under subsection (a) for the first fiscal year or the total of fiscal years to be exceeded; or

''(B) in the case of the Committee on Appropriations, the applicable suballocation of new budget authority or outlays under subsection (b) to be exceeded.''.

(d) PAY-AS-YOU-GO EXCEPTION IN THE HOUSE.—Section 302(g) of the Congressional Budget Act of 1974 is amended to read as follows:

''(g) PAY-AS-YOU-GO EXCEPTION IN THE HOUSE.—

''(1) IN GENERAL.—(A) Subsection (f)(1) and, after April 15, section 303(a) shall not apply to any bill or joint resolution, as reported, amendment thereto, or conference report thereon if, for each fiscal year covered by the most recently agreed to concurrent resolution on the budget—

''(i) the enactment of that bill or resolution as reported;

''(ii) the adoption and enactment of that amendment; or

''(iii) the enactment of that bill or resolution in the form recommended in that conference report,

would not increase the deficit, and, if the sum of any revenue increases provided in legislation already enacted during the current session (when added to revenue increases, if any, in excess of any outlay increase provided by the legislation proposed for consideration) is at least as great as the sum of the amount, if any, by which the aggregate level of Federal revenues should be increased as set forth in that concurrent resolution and the amount, if any, by which revenues are to be increased pursuant to pay-as-you-go procedures under section 301(b)(8), if included in that concurrent resolution.

''(B) Section 311(a), as that section applies to revenues, shall not apply to any bill, joint resolution, amendment thereto, or conference report thereon if, for each fiscal year covered by the most recently agreed to concurrent resolution on the budget—

''(i) the enactment of that bill or resolution as reported;

''(ii) the adoption and enactment of that amendment; or

''(iii) the enactment of that bill or resolution in the form recommended in that conference report,

would not increase the deficit, and, if the sum of any outlay reductions provided in legislation already enacted during the current session (when added to outlay reductions, if any, in excess of any revenue reduction provided by the legislation proposed for consideration) is at least as great as the sum of the amount, if any, by which the aggregate level of Federal outlays should be reduced as required by that concurrent resolution and the amount, if any, by which outlays are to be reduced pursuant to pay-as-you-go procedures under section 301(b)(8), if included in that concurrent resolution.

''(2) REVISED ALLOCATIONS.—(A) As soon as practicable after Congress agrees to a bill or joint resolution that would have been subject to a point of order under subsection (f)(1) but for the exception provided in paragraph (1)(A) or would have been subject to a point of order under section 311(a) but for the exception provided in paragraph (1)(B), the chairman of the committee on the Budget of the House of Representatives shall file with the House appropriately revised allocations under section 302(a) and revised functional levels and budget aggregates to reflect that bill.

''(B) Such revised allocations, functional levels, and budget aggregates shall be considered for the purposes of this Act as allocations, functional levels, and budget aggregates contained in the most recently agreed to concurrent resolution on the budget.''.

**SEC. 10107. AMENDMENTS TO SECTION 303.**

(a) IN GENERAL.—Section 303 of the Congressional Budget Act of 1974 is amended to read as follows:

''CONCURRENT RESOLUTION ON THE BUDGET MUST BE ADOPTED BEFORE BUDGET-RELATED LEGISLATION IS CONSIDERED

''SEC. 303. (a) IN GENERAL.—Until the concurrent resolution on the budget for a fiscal year has been agreed to, it shall not be in order in the House of Representatives, with respect to the first fiscal year covered by that resolution, or the Senate, with respect to any fiscal year covered by that resolution, to consider any bill or joint resolution, amendment or motion thereto, or conference report thereon that—

''(1) first provides new budget authority for that fiscal year;

''(2) first provides an increase or decrease in revenues during that fiscal year;

''(3) provides an increase or decrease in the public debt limit to become effective during that fiscal year;

''(4) in the Senate only, first provides new entitlement authority for that fiscal year; or

''(5) in the Senate only, first provides for an increase or decrease in outlays for that fiscal year.

''(b) EXCEPTIONS IN THE HOUSE.— In the House of Representatives, subsection (a) does not apply—

''(1)(A) to any bill or joint resolution, as reported, providing advance discretionary new budget authority that first becomes available for the first or second fiscal year after the budget year; or

''(B) to any bill or joint resolution, as reported, first increasing or decreasing revenues in a fiscal year following the fiscal year to which the concurrent resolution applies;

''(2) after May 15, to any general appropriation bill or amendment thereto; or

''(3) to any bill or joint resolution unless it is reported by a committee.

''(c) APPLICATION TO APPROPRIATION MEASURES IN THE SENATE.—

''(1) IN GENERAL.—Until the concurrent resolution on the budget for a fiscal year has been agreed to and an allocation has been made to the Committee on Appropriations of the Senate under section 302(a) for that year, it shall not be in order in the Senate to consider any appropriation bill or joint resolution, amendment or motion thereto, or conference report thereon for that year or any subsequent year.

''(2) EXCEPTION.—Paragraph (1) does not apply to appropriations legislation making advance appropriations for the first or second fiscal year after the year the allocation referred to in that paragraph is made.''.

(b) CONFORMING AMENDMENT.—The item relating to section 303 in the table of contents set forth in section 1(b) of the Congressional Budget and Impoundment Control Act of 1974 is amended to read as follows:

''Sec. 303. Concurrent resolution on the budget must be adopted before budget-related legislation is considered.''.

**SEC. 10108. AMENDMENT TO SECTION 304.**

Section 304 of the Congressional Budget Act of 1974 is amended by—

(1) striking ''(a) IN GENERAL.—''; and

(2) striking subsection (b).

**SEC. 10109. AMENDMENT TO SECTION 305.**

(a) BUDGET ACT.—Section 305(a)(1) of the Congressional Budget Act of 1974 is amended to read as follows:

''(1) When a concurrent resolution on the budget has been reported by the Committee on the Budget of the House of Representatives and has been referred to the appropriate calendar of the House, it shall be in order on any day thereafter, subject to clause 2(l)(6) of rule XI of the Rules of the House of Representatives, to move to proceed to the consideration of the concurrent resolution. The motion is highly privileged and is not debatable. An amendment to the motion is not in order and it is not in order

to move to reconsider the vote by which the motion is agreed to or disagreed to.''.

(b) CONFORMING AMENDMENT IN THE HOUSE.—The first sentence of clause 2(l)(6) of rule XI of the Rules of the House of Representatives is amended by striking '', or as provided by section 305(a)(1)'' and all that follows thereafter through ''under that section)''.

**SEC. 10110. AMENDMENTS TO SECTION 308.**

Section 308 of the Congressional Budget Act of 1974 is amended—

(1)(A) in the heading of subsection (a), by striking '', NEW SPENDING AUTHORITY, OR NEW CREDIT AUTHORITY,'';

(B) in subsection (a)(1), by striking subparagraph (B) and by redesignating subparagraphs (C) and (D) as subparagraphs (B) and (C), respectively;

(C) in subsection (a)(1)(B) (as redesignated), by striking ''spending authority'' through ''commitments'' and inserting ''revenues, or tax expenditures''; and

(D) in paragraphs (1) and (2) of subsection (a), by striking '', new spending authority described in section 401(c)(2), or new credit authority,'' each place it appears;

(2) in subsection (b)(1), by striking '', new spending authority described in section 401(c)(2), or new credit authority,'';

(3) in subsection (c), by inserting ''and'' after the semicolon at the end of paragraph (3), by striking ''; and'' at the end of paragraph (4) and inserting a period; and by striking paragraph (5); and

(4) by inserting ''joint'' before ''resolution'' each place it appears except when ''concurrent'', ''such'', or ''reconciliation'' precedes ''resolution'' and, in subsection (b)(1), by inserting ''joint'' before ''resolutions'' each place it appears.

**SEC. 10111. AMENDMENTS TO SECTION 310.**

Section 310(c)(1)(A) of the Congressional Budget Act of 1974 is amended—

(1) by striking ''20 percent'' the first place it appears and all that follows thereafter through '', and'' and inserting the following:

''(I) in the Senate, 20 percent of the total of the amounts of the changes such committee was directed to make under paragraphs (1) and (2) of such subsection; or

''(II) in the House of Representatives, 20 percent of the sum of the absolute value of the changes the committee was directed to make under paragraph (1) and the absolute value of the changes the committee was directed to make under paragraph (2); and''; and

(2) by striking ''20 percent'' the second place it appears and all that follows thereafter through ''; and'' and inserting the following:

''(I) in the Senate, 20 percent of the total of the amounts of the changes such committee was directed to make under paragraphs (1) and (2) of such subsection; or

''(II) in the House of Representatives, 20 percent of the sum of the absolute value of the changes the committee was directed to make under paragraph (1) and the absolute value of the changes the committee was directed to make under paragraph (2); and''.

**SEC. 10112. AMENDMENTS TO SECTION 311.**

(a) IN GENERAL.—Section 311 of the Congressional Budget Act of 1974 is amended to read as follows:

''BUDGET-RELATED LEGISLATION MUST BE WITHIN APPROPRIATE LEVELS

''SEC. 311. (a) ENFORCEMENT OF BUDGET AGGREGATES.—

''(1) IN THE HOUSE OF REPRESENTATIVES.—Except as provided by subsection (c), after the Congress has completed action on a concurrent resolution on the budget for a fiscal year, it shall not be in order in the House of Representatives to consider any bill, joint resolution, amendment, motion, or conference report providing new budget authority or reducing revenues, if—

''(A) the enactment of that bill or resolution as reported;

''(B) the adoption and enactment of that amendment; or

''(C) the enactment of that bill or resolution in the form recommended in that conference report;

would cause the level of total new budget authority or total outlays set forth in the applicable concurrent resolution on the budget for the first fiscal year to be exceeded, or would cause revenues to be less than the level of total revenues set forth in that concurrent resolution for the first fiscal year or for the total of that first fiscal year and the ensuing fiscal years for which allocations are provided under section 302(a), except when a declaration of war by the Congress is in effect.

''(2) IN THE SENATE.—After a concurrent resolution on the budget is agreed to, it shall not be in order in the Senate to consider any bill, joint resolution, amendment, motion, or conference report that—

''(A) would cause the level of total new budget authority or total outlays set forth for the first fiscal year in the applicable resolution to be exceeded; or

''(B) would cause revenues to be less than the level of total revenues set forth for that first fiscal year or for the total of that first fiscal year and the ensuing fiscal years in the applicable resolution for which allocations are provided under section 302(a).

''(3) ENFORCEMENT OF SOCIAL SECURITY LEVELS IN THE SENATE.—After a concurrent resolution on the budget is agreed to, it shall not be in order in the Senate to consider any bill, joint resolution, amendment, motion, or conference report that would cause a decrease in social security surpluses or an increase in social security deficits relative to the levels set forth in the applicable resolution for the first fiscal year or for the total of that fiscal year and the ensuing fiscal years for which allocations are provided under section 302(a).

''(b) SOCIAL SECURITY LEVELS.—

''(1) IN GENERAL.—For purposes of subsection (a)(3), social security surpluses equal the excess of social security revenues over social security outlays in a fiscal year or years with such an excess and social security deficits equal the excess of social security outlays over social security revenues in a fiscal year or years with such an excess.

''(2) TAX TREATMENT.—For purposes of subsection (a)(3), no provision of any legislation involving a change in chapter 1 of the Internal Revenue Code of 1986 shall be treated as affecting the amount of social security revenues or outlays unless that provision changes the income tax treatment of social security benefits.

''(c) EXCEPTION IN THE HOUSE OF REPRESENTATIVES.—Subsection (a)(1) shall not apply in the House of Representatives to any bill, joint resolution, or amendment that provides new budget authority for a fiscal year or to any conference report on any such bill or resolution, if—

''(1) the enactment of that bill or resolution as reported;

''(2) the adoption and enactment of that amendment; or

''(3) the enactment of that bill or resolution in the form recommended in that conference report;

would not cause the appropriate allocation of new budget authority made pursuant to section 302(a) for that fiscal year to be exceeded.''.

(b) TABLE OF CONTENTS.—The table of contents set forth in section 1(b) of the Congressional Budget and Impoundment Control Act of 1974 is amended by striking the item relating to section 311 and inserting the following:

''Sec. 311. Budget-related legislation must be within appropriate levels.''.

**SEC. 10113. AMENDMENT TO SECTION 312.**

(a) IN GENERAL.—Section 312 of the Congressional Budget Act of 1974 is amended to read as follows:

''DETERMINATIONS AND POINTS OF ORDER

''SEC. 312. (a) BUDGET COMMITTEE DETERMINATIONS.—For purposes of this title and title IV, the levels of new budget authority, outlays, direct spending, new entitlement authority, and revenues for a fiscal year shall be determined on the basis of estimates made by the Committee on the Budget of the House of Representatives or the Senate, as applicable.

''(b) DISCRETIONARY SPENDING POINT OF ORDER IN THE SENATE.—

''(1) IN GENERAL.—Except as otherwise provided in this subsection, it shall not be in order in the Senate to consider any bill or resolution (or amendment, motion, or conference report on that bill or resolution) that would exceed any of the discretionary spending limits in section 251(c) of the Balanced Budget and Emergency Deficit Control Act of 1985.

''(2) EXCEPTIONS.—This subsection shall not apply if a declaration of war by the Congress is in effect or if a joint resolution pursuant to section 258 of the Balanced Budget and Emergency Deficit Control Act of 1985 has been enacted.

''(c) MAXIMUM DEFICIT AMOUNT POINT OF ORDER IN THE SENATE.—It shall not be in order in the Senate to consider any concurrent resolution on the budget for a fiscal year, or to consider any amendment to that concurrent resolution, or to consider a conference report on that concurrent resolution, if—

''(1) the level of total outlays for the first fiscal year set forth in that concurrent resolution or conference report exceeds; or

''(2) the adoption of that amendment would result in a level of total outlays for that fiscal year that exceeds;

the recommended level of Federal revenues for that fiscal year, by an amount that is greater than the maximum deficit amount, if any, specified in the Balanced Budget and Emergency Deficit Control Act of 1985 for that fiscal year.

''(d) TIMING OF POINTS OF ORDER IN THE SENATE.—A point of order under this Act may not be raised against a bill, resolution, amendment, motion, or conference report while an amendment or motion, the adoption of which would remedy the violation of this Act, is pending before the Senate.

''(e) POINTS OF ORDER IN THE SENATE AGAINST AMENDMENTS BETWEEN THE HOUSES.—Each provision of this Act that establishes a point of order against an amendment also establishes a point of order in the Senate against an amendment between the Houses. If a point of order under this Act is raised in the Senate against an amendment between the Houses and the point of order is sustained, the effect shall be the same as if the Senate had disagreed to the amendment.

''(f) EFFECT OF A POINT OF ORDER IN THE SENATE.—In the Senate, if a point of order under this Act against a bill or resolution is sustained, the Presiding Officer shall then recommit the bill or resolution to the committee of appropriate jurisdiction for further consideration.''.

(b) TECHNICAL AND CONFORMING AMENDMENTS.—

(1) IN GENERAL.—Section 313 of the Congressional Budget Act of 1974 is amended—

(A) by striking ''(c) When'' and inserting ''(d) CONFERENCE REPORTS.—When''; and

(B) by striking subsection (e) and redesignating subsection (d) as subsection (e).

(2) TABLE OF CONTENTS.—The item relating to section 312 in the table of contents set forth in section 1(b) of the Congressional Budget and Impoundment Control Act of 1974 is amended by striking ''Effect of points'' and inserting ''Determinations and points''.

**SEC. 10114. ADJUSTMENTS.**

(a) IN GENERAL.—Title III of the Congressional Budget Act of 1974 is amended by adding at the end the following new section:

''ADJUSTMENTS

''SEC. 314. (a) ADJUSTMENTS.—

''(1) IN GENERAL.—After the reporting of a bill or joint resolution, the offering of an amendment thereto, or the submission of a conference report thereon, the chairman of the Committee on the Budget of the House of Representatives or the Senate shall make the adjustments set forth in paragraph (2) for the amount of new budget authority in that measure (if that measure meets the requirements set forth in subsection (b)) and the outlays flowing from that budget authority.

''(2) MATTERS TO BE ADJUSTED.—The adjustments referred to in paragraph (1) are to be made to—

''(A) the discretionary spending limits, if any, set forth in the appropriate concurrent resolution on the budget;

''(B) the allocations made pursuant to the appropriate concurrent resolution on the budget pursuant to section 302(a); and

''(C) the budgetary aggregates as set forth in the appropriate concurrent resolution on the budget.

''(b) AMOUNTS OF ADJUSTMENTS.—The adjustment referred to in subsection (a) shall be—

''(1) an amount provided and designated as an emergency requirement pursuant to section 251(b)(2)(A) or 252(e) of the Balanced Budget and Emergency Deficit Control Act of 1985;

''(2) an amount provided for continuing disability reviews subject to the limitations in section 251(b)(2)(C) of that Act;

''(3) for any fiscal year through 2002, an amount provided that is the dollar equivalent of the Special Drawing Rights with respect to—

''(A) an increase in the United States quota as part of the International Monetary Fund Eleventh General Review of Quotas (United States Quota); or

''(B) any increase in the maximum amount available to the Secretary of the Treasury pursuant to section 17 of the Bretton Woods Agreements Act, as amended from time to time (New Arrangements to Borrow);

''(4) an amount provided not to exceed $1,884,000,000 for the period of fiscal years 1998 through 2000 for arrearages for international organizations, international peacekeeping, and multilateral development banks; or

''(5) an amount provided for an earned income tax credit compliance initiative but not to exceed—

''(A) with respect to fiscal year 1998, $138,000,000 in new budget authority;

''(B) with respect to fiscal year 1999, $143,000,000 in new budget authority;

''(C) with respect to fiscal year 2000, $144,000,000 in new budget authority;

''(D) with respect to fiscal year 2001, $145,000,000 in new budget authority; and

''(E) with respect to fiscal year 2002, $146,000,000 in new budget authority.

''(c) APPLICATION OF ADJUSTMENTS.—The adjustments made pursuant to subsection (a) for legislation shall—

''(1) apply while that legislation is under consideration;

''(2) take effect upon the enactment of that legislation; and

''(3) be published in the Congressional Record as soon as practicable.

''(d) REPORTING REVISED SUBALLOCATIONS.—Following any adjustment made under subsection (a), the Committees on Appropriations of the Senate and the House of Representatives may report appropriately revised suballocations under section 302(b) to carry out this section.

''(e) DEFINITIONS FOR CDRS.—As used in subsection (b)(2)—

''(1) the term 'continuing disability reviews' shall have the same meaning as provided in section 251(b)(2)(C)(ii) of the Balanced Budget and Emergency Deficit Control Act of 1985; and

''(2) the term 'new budget authority' shall have the same meaning as the term 'additional new budget authority' and the term 'outlays' shall have the same meaning as 'additional outlays' in that section.''.

(b) TABLE OF CONTENTS.—The table of contents set forth in section 1(b) of the Congressional Budget and Impoundment Control Act of 1974 is amended by adding after the item relating to section 313 the following new item:

''Sec. 314. Adjustments.''.

**SEC. 10115. EFFECT OF ADOPTION OF A SPECIAL ORDER OF BUSINESS IN THE HOUSE OF REPRESENTATIVES.**

(a) EFFECT OF POINTS OF ORDER.—Title III of the Congressional Budget Act of 1974 is amended by adding after section 314 the following new section:

''EFFECT OF ADOPTION OF A SPECIAL ORDER OF BUSINESS IN THE HOUSE OF REPRESENTATIVES

''SEC. 315. For purposes of a reported bill or joint resolution considered in the House of Representatives pursuant to a special order of business, the term 'as reported' in this title or title IV shall be considered to refer to the text made in order as an original bill or joint resolution for the purpose of amendment or to the text on which the previous question is ordered directly to passage, as the case may be.''.

(b) CONFORMING AMENDMENT.—The table of contents set forth in section 1(b) of the Congressional Budget and Impoundment Control Act of 1974 is amended by adding after the item relating to section 314 the following new item:

''Sec. 315. Effect of adoption of a special order of business in the House of Representatives.''.

**SEC. 10116. AMENDMENT TO SECTION 401 AND REPEAL OF SECTION 402.**

(a) SECTION 401.—

(1) CONTROLS.—Section 401 of the Congressional Budget Act of 1974 is amended by—

(A) striking the heading and inserting the following:

''BUDGET-RELATED LEGISLATION NOT SUBJECT TO APPROPRIATIONS''; and

(B) striking subsection (a) and inserting the following:

''(a) CONTROLS ON CERTAIN BUDGET-RELATED LEGISLATION NOT SUBJECT TO APPROPRIATIONS.—It shall not be in order in either the House of Representatives or the Senate to consider any bill or joint resolution (in the House of Representatives only, as reported), amendment, motion, or conference report that provides—

''(1) new authority to enter into contracts under which the United States is obligated to make outlays;

''(2) new authority to incur indebtedness (other than indebtedness incurred under chapter 31 of title 31 of the United States Code) for the repayment of which the United States is liable; or

''(3) new credit authority;

unless that bill, joint resolution, amendment, motion, or conference report also provides that the new authority is to be effective for any fiscal year only to the extent or in the amounts provided in advance in appropriation Acts.''.

(2) POINT OF ORDER.—Section 401(b) of the Congressional Budget Act of 1974 is amended—

(A) by inserting ''new'' before ''entitlement'' in the heading;

(B) by striking paragraph (1) and inserting the following:

''(1) POINT OF ORDER.—It shall not be in order in either the House of Representatives or the Senate to consider any bill or joint resolution (in the House of Representatives only, as reported), amendment, motion, or conference report that provides new entitlement authority that is to become effective during the current fiscal year.''; and

(C) in paragraph (2)—

(i) by striking ''new spending authority described in subsection (c)(2)(C)'' and inserting ''new entitlement authority''; and

(ii) by striking ''of that House'' and inserting ''of the Senate or may then be referred to the Committee on Appropriations of the House, as the case may be,''.

(3) DEFINITIONS.—Section 401 of the Congressional Budget Act of 1974 is amended by striking subsection (c).

(4) EXCEPTIONS.—Section 401(d) of the Congressional Budget Act of 1974 is amended—

(A) in paragraph (1), by striking ''new spending authority if the budget authority for outlays which result from such new spending authority is derived'' and inserting ''new authority described in those subsections if outlays from that new authority will flow'';

(B) by striking paragraph (2) and redesignating paragraph (3) as paragraph (2); and

(C) in paragraph (2), as redesignated, by striking ''new spending authority'' and inserting ''new authority described in those subsections''.

(5) REDESIGNATION.—Subsection (d) of section 401 of the Congressional Budget Act of 1974 is redesignated as subsection (c).

(6) CONFORMING AMENDMENTS.—(A) Clause 1(b)(4) of rule X of the Rules of the House of Representatives is amended to read as follows:

''(4) The amount of new authority to enter into contracts under which the United States is obligated to make outlays, the budget authority for which is not provided in advance by appropriation Acts; new authority to incur indebtedness (other than indebtedness incurred under chapter 31 of title 31 of the United States Code) for the repayment of which the United States is liable, the budget authority for which is not provided in advance by appropriation Acts; new entitlement authority as defined in section 3(9) of the Congressional Budget Act of 1974, including bills and resolutions (reported by other committees) which provide new entitlement authority as defined in section 3(9) of the Congressional Budget Act of 1974 and are referred to the committee under clause 4(a); authority to forego the collection by the United States of proprietary offsetting receipts, the budget authority for which is not provided in advance by appropriation Acts to offset such foregone receipts; and authority to make payments by the United States (including loans, grants, and payments from revolving funds) other than those covered by this subparagraph, the budget authority for which is not provided in advance by appropriation Acts.''.

(B) Clause 4(a)(2) of rule X of the Rules of the House of Representatives is amended by striking ''new spending authority described in section 401(c)(2)(C)'' and inserting ''new entitlement authority as defined in section 3(9)'' and by striking ''total amount of new spending authority'' and inserting ''total amount of new entitlement authority''.

(C) Clause 2(l)(3) of rule XI of the Rules of the House of Representatives is amended by striking ''new spending authority as described in section 401(c)(2)'' and by inserting ''new entitlement authority as defined in section 3(9)''.

(b) REPEALER OF SECTION 402.—Section 402 of the Congressional Budget Act of 1974 is repealed.

(c) CONFORMING AMENDMENTS.—

(1) REDESIGNATION.—Sections 403 through 407 of the Congressional Budget Act of 1974 are redesignated as sections 402 through 406, respectively.

(2) GAO ANALYSIS.—Section 404 (as redesignated) of the Congressional Budget Act of 1974 is amended by striking ''spending authority as described by section 401(c)(2) and which provide permanent appropriations,'' and inserting ''mandatory spending''.

(3) TABLE OF CONTENTS.—The table of contents set forth in section 1(b) of the Congressional Budget and Impoundment Control Act of 1974 is amended by—

(A) striking the item for section 401 and inserting the following:

''Sec. 401. Budget-related legislation not subject to appropriations.''; and

(B) striking the item relating to section 402 and redesignating the items relating to sections 403 through 407 as the items relating to sections 402 through 406, respectively.

(4) CONFORMING AMENDMENTS.—(A) Clause 2(l)(3) of rule XI of the Rules of the House of Representatives is amended by striking ''section 403'' and inserting ''section 402''.

(B) Clause 7(d) of rule XIII of the Rules of the House of Representatives is amended by striking ''section 403'' and inserting ''section 402''.

**SEC. 10117. AMENDMENTS TO TITLE V.**

(a) SECTION 502.—Section 502 of the Federal Credit Reform Act of 1990 is amended as follows:

(1) In the second sentence of paragraph (1), insert ''and financing arrangements that defer payment for more than 90 days, including the sale of a government asset on credit terms'' before the period.

(2) In paragraph (5)(A), insert ''or modification thereof'' before the first comma.

(3) In paragraph (5), strike subparagraphs (B) and (C) and insert the following:

''(B) The cost of a direct loan shall be the net present value, at the time when the direct loan is disbursed, of the following estimated cash flows:

''(i) loan disbursements;

''(ii) repayments of principal; and

''(iii) payments of interest and other payments by or to the Government over the life of the loan after adjusting for estimated defaults, prepayments, fees, penalties, and other recoveries;

including the effects of changes in loan terms resulting from the exercise by the borrower of an option included in the loan contract.

''(C) The cost of a loan guarantee shall be the net present value, at the time when the guaranteed loan is disbursed, of the following estimated cash flows:

''(i) payments by the Government to cover defaults and delinquencies, interest subsidies, or other payments; and

''(ii) payments to the Government including origination and other fees, penalties and recoveries;

including the effects of changes in loan terms resulting from the exercise by the guaranteed lender of an option included in the loan guarantee contract, or by the borrower of an option included in the guaranteed loan contract.''.

(4) In paragraph (5), amend subparagraph (D) to read as follows:

''(D) The cost of a modification is the difference between the current estimate of the net present value of the remaining cash flows under the terms of a direct loan or loan guarantee contract, and the current estimate of the net present value of the remaining cash flows under the terms of the contract, as modified.''.

(5) In paragraph (5)(E), insert ''the cash flows of'' after ''to''.

(6) In paragraph (5), by adding at the end the following:

''(F) When funds are obligated for a direct loan or loan guarantee, the estimated cost shall be based on the current assumptions, adjusted to incorporate the terms of the loan contract, for the fiscal year in which the funds are obligated.''.

(7) Redesignate paragraph (9) as paragraph (11) and after paragraph (8) add the following new paragraphs:

''(9) The term 'modification' means any Government action that alters the estimated cost of an outstanding direct loan (or direct loan obligation) or an outstanding loan guarantee (or loan guarantee commitment) from the current estimate of cash flows. This includes the sale of loan assets, with or without recourse, and the purchase of guaranteed loans. This also includes any action resulting from new legislation, or from the exercise of administrative discretion under existing law, that directly or indirectly alters the estimated cost of outstanding direct loans (or direct loan obligations) or loan guarantees (or loan guarantee commitments) such as a change in collection procedures.

''(10) The term 'current' has the same meaning as in section 250(c)(9) of the Balanced Budget and Emergency Deficit Control Act of 1985.''.

(b) SECTION 504.—Section 504 of the Federal Credit Reform Act of 1990 is amended as follows:

(1) Amend subsection (b)(1) to read as follows:

''(1) new budget authority to cover their costs is provided in advance in an appropriations Act;''.

(2) In subsection (b)(2), strike ''is enacted'' and insert ''has been provided in advance in an appropriations Act''.

(3) In subsection (c), strike ''Subsection (b)'' and insert ''Subsections (b) and (e)''.

(4) In subsection (d)(1), strike ''directly or indirectly alter the costs of outstanding direct loans and loan guarantees'' and insert ''modify outstanding direct loans (or direct loan obligations) or loan guarantees (or loan guarantee commitments)''.

(5) Amend subsection (e) to read as follows:

''(e) MODIFICATIONS.—An outstanding direct loan (or direct loan obligation) or loan guarantee (or loan guarantee commitment) shall not be modified in a manner that increases its costs unless budget authority for the additional cost has been provided in advance in an appropriations Act.''.

(c) SECTION 505.—Section 505 of the Federal Credit Reform Act of 1990 is amended as follows:

(1) In subsection (c), by inserting before the period at the end of the second sentence the following: '', except that the rate of interest charged by the Secretary on lending to financing accounts (including amounts treated as lending to financing accounts by the Federal Financing Bank (hereinafter in this subsection referred to as the 'Bank') pursuant to section 406(b)) and the rate of interest paid to financing accounts on uninvested balances in financing accounts shall be the same as the rate determined pursuant to section 502(5)(E). For guaranteed loans financed by the Bank and treated as direct loans by a Federal agency pursuant to section 406(b), any fee or interest surcharge (the amount by which the interest rate charged exceeds the rate determined pursuant to section 502(5)(E)) that the Bank charges to a private borrower pursuant to section 6(c) of the Federal Financing Bank Act of 1973 shall be considered a cash flow to the Government for the purposes of determining the cost of the direct loan pursuant to section 502(5). All such amounts shall be credited to the appropriate financing account. The Bank is authorized to require reimbursement from a Federal agency to cover the administrative expenses of the Bank that are attributable to the direct loans financed for that agency. All such payments by an agency shall be considered administrative expenses subject to section 504(g). This subsection shall apply to transactions related to direct loan obligations or loan guarantee commitments made on or after October 1, 1991''.

(2) In subsection (c), by striking ''supercede'' and inserting ''supersede''.

(3) By amending subsection (d) to read as follows:

''(d) AUTHORIZATION FOR LIQUIDATING ACCOUNTS.—(1) Amounts in liquidating accounts shall be available only for payments resulting from direct loan obligations or loan guarantee commitments made prior to October 1, 1991, for—

''(A) interest payments and principal repayments to the Treasury or the Federal Financing Bank for amounts borrowed;

''(B) disbursements of loans;

''(C) default and other guarantee claim payments;

''(D) interest supplement payments;

''(E) payments for the costs of foreclosing, managing, and selling collateral that are capitalized or routinely deducted from the proceeds of sales;

''(F) payments to financing accounts when required for modifications;

''(G) administrative expenses, if—

''(i) amounts credited to the liquidating account would have been available for administrative expenses under a provision of law in effect prior to October 1, 1991; and

''(ii) no direct loan obligation or loan guarantee commitment has been made, or any modification of a direct loan or loan guarantee has been made, since September 30, 1991; or

''(H) such other payments as are necessary for the liquidation of such direct loan obligations and loan guarantee commitments.

''(2) Amounts credited to liquidating accounts in any year shall be available only for payments required in that year. Any unobligated balances in liquidating accounts at the end of a fiscal year shall be transferred to miscellaneous receipts as soon as practicable after the end of the fiscal year.

''(3) If funds in liquidating accounts are insufficient to satisfy obligations and commitments of such accounts, there is hereby provided permanent, indefinite authority to make any payments required to be made on such obligations and commitments.''.

(d) SECTION 506.—Section 506 of the Federal Credit Reform Act of 1990 is amended—

(1) by striking ''(a) IN GENERAL.—'';

(2) by striking ''(1)'' and inserting the following:

''(a) IN GENERAL.—'';

(3) by striking ''(2) The'' and inserting the following:

''(b) STUDY.—The'';

(4) by striking ''(3)'' and inserting the following:

''(c) ACCESS TO DATA.—''; and

(5) in subsection (c) (as redesignated) by striking ''paragraph (2)'' and inserting ''subsection (b)''.

**SEC. 10118. REPEAL OF TITLE VI.**

(a) REPEALER.—Title VI of the Congressional Budget Act of 1974 is repealed.

(b) CONFORMING AMENDMENTS.—(1) The items relating to title VI of the table of contents set forth in section 1(b) of the Congressional Budget and Impoundment Control Act of 1974 are repealed.

(2) Clause 4(h) of rule X of the Rules of the House of Representatives is amended by striking ''section 302 or section 602 (in the case of fiscal years 1991 through 1995)'' and inserting ''section 302''.

**SEC. 10119. AMENDMENTS TO SECTION 904.**

(a) CONFORMING AMENDMENT.—Section 904(a) of the Congressional Budget Act of 1974 is amended by striking ''(except section 905)'' and by striking ''V, and VI (except section 601(a))'' and inserting ''and V''.

(b) WAIVERS.—Section 904(c) of the Congressional Budget Act of 1974 is amended to read as follows:

''(c) WAIVERS.—

''(1) PERMANENT.—Sections 305(b)(2), 305(c)(4), 306, 310(d)(2), 313, 904(c), and 904(d) of this Act may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn.

''(2) TEMPORARY.—Sections 301(i), 302(c), 302(f), 310(g), 311(a), 312(b), and 312(c) of this Act and sections 258(a)(4)(C), 258A(b)(3)(C)(I), 258B(f)(1), 258B(h)(1), 258(h)(3), 258C(a)(5), and 258C(b)(1) of the Balanced Budget and Emergency Deficit Control Act of 1985 may be waived or suspended in the Senate only by the affirmative vote of three-fifths of the Members, duly chosen and sworn.''.

(c) APPEALS.—Section 904(d) of the Congressional Budget Act of 1974 is amended to read as follows:

''(d) APPEALS.—

''(1) PROCEDURE.—Appeals in the Senate from the decisions of the Chair relating to any provision of title III or IV or section 1017 shall, except as otherwise provided therein, be limited to 1 hour, to be equally divided between, and controlled by, the mover and the manager of the resolution, concurrent resolution, reconciliation bill, or rescission bill, as the case may be.

''(2) PERMANENT.—An affirmative vote of three-fifths of the Members, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under sections 305(b)(2), 305(c)(4), 306, 310(d)(2), 313, 904(c), and 904(d) of this Act.

''(3) TEMPORARY.—An affirmative vote of three-fifths of the Members, duly chosen and sworn, shall be required in the Senate to sustain an appeal of the ruling of the Chair on a point of order raised under sections 301(i), 302(c), 302(f), 310(g), 311(a), 312(b), and 312(c) of this Act and sections 258(a)(4)(C), 258A(b)(3)(C)(I), 258B(f)(1), 258B(h)(1), 258(h)(3), 258C(a)(5), and 258C(b)(1) of the Balanced Budget and Emergency Deficit Control Act of 1985.''.

(d) EXPIRATION OF SUPERMAJORITY VOTING REQUIREMENTS.—Section 904 of the Congressional Budget Act of 1974 is amended by adding at the end the following:

''(e) EXPIRATION OF CERTAIN SUPERMAJORITY VOTING REQUIREMENTS.—Subsections (c)(2) and (d)(3) shall expire on September 30, 2002.''.

**SEC. 10120. REPEAL OF SECTIONS 905 AND 906.**

(a) REPEALER.—Sections 905 and 906 of the Congressional Budget Act of 1974 are repealed.

(b) CONFORMING AMENDMENTS.—The table of contents set forth in section 1(b) of the Congressional Budget and Impoundment Control Act of 1974 is amended by striking the items relating to sections 905 and 906.

**SEC. 10121. AMENDMENTS TO SECTIONS 1022 AND 1024.**

(a) SECTION 1022.—Section 1022(b)(1)(F) of the Congressional Budget and Impoundment Control Act of 1974 is amended by striking ''section 601'' and inserting ''section 251(c) of the Balanced Budget and Emergency Deficit Control Act of 1985''.

(b) SECTION 1024.—Section 1024(a)(1)(B) of the Congressional Budget and Impoundment Control Act of 1974 is amended by striking ''section 601(a)(2)'' and inserting ''section 251(c) of the Balanced Budget and Emergency Deficit Control Act of 1985''.

**SEC. 10122. AMENDMENT TO SECTION 1026.**

Section 1026(7)(A)(iv) of the Congressional Budget and Impoundment Control Act of 1974 is amended by striking ''; and'' and inserting ''; or''.

**SEC. 10123. SENATE TASK FORCE ON CONSIDERATION OF BUDGET MEASURES.**

(a) APPOINTMENT OF MEMBERS.—The Majority Leader and Minority Leader of the Senate shall each appoint 3 Senators to serve on a bipartisan task force to study the floor procedures for the consideration of budget resolutions and reconciliation bills in the Senate as provided in sections 305(b) and 310(e) of the Congressional Budget Act of 1974.

(b) REPORT OF THE TASK FORCE.—The task force shall submit its report to the Senate not later than October 8, 1997.

## Subtitle B—Amendments to the Balanced Budget and Emergency Deficit Control Act of 1985

**SEC. 10201. PURPOSE.**

The purpose of this subtitle is to extend discretionary spending limits and pay-as-you-go requirements.

**SEC. 10202. GENERAL STATEMENT AND DEFINITIONS.**

(a) GENERAL STATEMENT.—Section 250(b) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by striking the first 2 sentences and inserting the following: ''This part provides for budget enforcement as called for in House Concurrent Resolution 84 (105th Congress, 1st session).''.

(b) DEFINITIONS.—Section 250(c) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended—

(1) in paragraph (1)—

(A) by striking ''(but including'' through ''amount' ''; and

(B) by striking ''section 601 of that Act as adjusted under sections 251 and 253'' and inserting ''section 251'';

(2) by striking paragraph (4) and inserting the following:

''(4) The term 'category' means the subsets of discretionary appropriations in section 251(c). Discretionary appropriations in each of the categories shall be those designated in the joint explanatory statement accompanying the conference report on the Balanced Budget Act of 1997. New accounts or activities shall be categorized only after consultation with the committees on Appropriations and the Budget of the House of Representatives and the Senate and that consultation shall, to the extent practicable, include written communication to such committees that affords such committees the opportunity to comment before official action is taken with respect to new accounts or activities.'';

(3) by striking paragraph (6) and inserting the following:

''(6) The term 'budgetary resources' means new budget authority, unobligated balances, direct spending authority, and obligation limitations.'';

(4) in paragraph (9), by striking ''submission of the fiscal year 1992 budget that are not included with a budget submission'' and inserting ''that budget submission that are not included with it'';

(5) in paragraph (14), by inserting ''first 4'' before ''fiscal years'' and by striking ''through fiscal year 1995'';

(6) by striking paragraphs (17) and (20) and by redesignating paragraphs (18), (19), and (21) as paragraphs (17), (18), and (19), respectively;

(7) in paragraph (17) (as redesignated), by striking ''Omnibus Budget Reconciliation Act of 1990'' and inserting ''Balanced Budget Act of 1997'';

(8) in paragraph (18) (as redesignated), by striking all after ''expenses'' and inserting ''the Federal deposit insurance agencies, and other Federal agencies supervising insured depository institutions, resulting from full funding of, and continuation of, the deposit insurance guarantee commitment in effect under current estimates.''; and

(9) by striking paragraph (19) (as redesignated) and inserting the following:

''(19) The term 'asset sale' means the sale to the public of any asset (except for those assets covered by title V of the Congressional Budget Act of 1974), whether physical or financial, owned in whole or in part by the United States.''.

**SEC. 10203. ENFORCING DISCRETIONARY SPENDING LIMITS.**

(a) EXTENSION THROUGH FISCAL YEAR 2002.—Section 251 of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended—

(1) in the heading of subsection (a), by striking ''Fiscal Years 1991–1998'';

(2) in subsection (a)(3), by striking ''(h)'' both places it appears and inserting ''(f)'';

(3) by striking subsection (a)(7) and inserting the following:

''(7) ESTIMATES.—

''(A) CBO ESTIMATES.—As soon as practicable after Congress completes action on any discretionary appropriation, CBO, after consultation with the Committees on the Budget of the House of Representatives and the Senate, shall provide OMB with an estimate of the amount of discretionary new budget authority and outlays for the current year (if any) and the budget year provided by that legislation.

''(B) OMB ESTIMATES AND EXPLANATION OF DIFFERENCES.—Not later than 7 calendar days (excluding Saturdays, Sundays, and legal holidays) after the date of enactment of any discretionary appropriation, OMB shall transmit a report to the House of Representatives and to the Senate containing the CBO estimate of that legislation, an OMB estimate of the amount of discretionary new budget authority and outlays for the current year (if any) and the budget year provided by that legislation, and an explanation of any difference between the 2 estimates. If during the preparation of the report OMB determines that there is a significant difference between OMB and CBO, OMB shall consult with the Committees on the Budget of the House of Representatives and the Senate regarding that difference and that consultation shall include, to extent practicable, written communication to those committees that affords such committees the opportunity to comment before the issuance of the report.

''(C) ASSUMPTIONS AND GUIDELINES.—OMB estimates under this paragraph shall be made using current economic and technical assumptions. OMB shall use the OMB estimates transmitted to the Congress under this paragraph. OMB and CBO shall prepare estimates under this paragraph in conformance with scorekeeping guidelines determined after consultation among the House and Senate Committees on the Budget, CBO, and OMB.

''(D) ANNUAL APPROPRIATIONS.—For purposes of this paragraph, amounts provided by annual appropriations shall include any new budget authority and outlays for the current year (if any) and the budget year in accounts for which funding is provided in that legislation that result from previously enacted legislation.'';

(4) by striking subsection (b) and inserting the following:

''(b) ADJUSTMENTS TO DISCRETIONARY SPENDING LIMITS.—

''(1) PREVIEW REPORT.—When the President submits the budget under section 1105 of title 31, United States Code, OMB shall calculate and the budget shall include adjustments to discretionary spending limits (and those limits as cumulatively adjusted) for the budget year and each outyear to reflect changes in concepts and definitions. Such changes shall equal the baseline levels of new budget authority and outlays using up-to-date concepts and definitions minus those levels using the concepts and definitions in effect before such changes. Such changes may only be made after consultation with the committees on Appropriations and the Budget of the House of Representatives and the Senate and that consultation shall include written communication to such committees that affords such committees the opportunity to comment before official action is taken with respect to such changes.

''(2) SEQUESTRATION REPORTS.—When OMB submits a sequestration report under section 254(e), (f), or (g) for a fiscal year, OMB shall calculate, and the sequestration report and subsequent budgets submitted by the President under section 1105(a) of title 31, United States Code, shall include adjustments to discretionary spending limits (and those limits as adjusted) for the fiscal year and each succeeding year through 2002, as follows:

''(A) EMERGENCY APPROPRIATIONS.—If, for any fiscal year, appropriations for discretionary accounts are enacted that the President designates as emergency requirements and that the Congress so designates in statute, the adjustment shall be the total of such appropriations in discretionary accounts designated as emergency requirements and the outlays flowing in all fiscal years from such appropriations. This subparagraph shall not apply to appropriations to cover agricultural crop disaster assistance.

''(B) SPECIAL OUTLAY ALLOWANCE.—If, in any fiscal year, outlays for a category exceed the discretionary spending limit for that category but new budget authority does not exceed its limit for that category (after application of the first step of a sequestration described in subsection (a)(2), if necessary), the adjustment in outlays for a fiscal year is the amount of the excess but not to exceed 0.5 percent of the sum of the adjusted discretionary spending limits on outlays for that fiscal year.

''(C) CONTINUING DISABILITY REVIEWS.—(i) If a bill or joint resolution making appropriations for a fiscal year is enacted that specifies an amount for continuing disability reviews under the heading 'Limitation on Administrative Expenses' for the Social Security Administration, the adjustments for that fiscal year shall be the additional new budget authority provided in that Act for such reviews for that fiscal year and the additional outlays flowing from such amounts, but shall not exceed—

''(I) for fiscal year 1998, $290,000,000 in additional new budget authority and $338,000,000 in additional outlays;

''(II) for fiscal year 1999, $520,000,000 in additional new budget authority and $520,000,000 in additional outlays;

''(III) for fiscal year 2000, $520,000,000 in additional new budget authority and $520,000,000 in additional outlays;

''(IV) for fiscal year 2001, $520,000,000 in additional new budget authority and $520,000,000 in additional outlays; and

''(V) for fiscal year 2002, $520,000,000 in additional new budget authority and $520,000,000 in additional outlays.

''(ii) As used in this subparagraph—

''(I) the term 'continuing disability reviews' means reviews or redeterminations as defined under section 201(g)(1)(A) of the Social Security Act and reviews and redeterminations authorized under section 211 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996;

''(II) the term 'additional new budget authority' means the amount provided for a fiscal year, in excess of $200,000,000, in an appropriations Act and specified to pay for the costs of continuing disability reviews under the heading 'Limitation on Administrative Expenses' for the Social Security Administration; and

''(III) the term 'additional outlays' means outlays, in excess of $200,000,000 in a fiscal year, flowing from the amounts specified for continuing disability reviews under the heading 'Limitation on Administrative Expenses' for the Social Security Administration, including outlays in that fiscal year flowing from amounts specified in Acts enacted for prior fiscal years (but not before 1996).

''(D) ALLOWANCE FOR IMF.—If an appropriation bill or joint resolution is enacted for a fiscal year through 2002 that includes an appropriation with respect to clause (i) or (ii), the adjustment shall be the amount of budget authority in the measure that is the dollar equivalent of the Special Drawing Rights with respect to—

''(i) an increase in the United States quota as part of the International Monetary Fund Eleventh General Review of Quotas (United States Quota); or

''(ii) any increase in the maximum amount available to the Secretary of the Treasury pursuant to section 17 of the Bretton Woods Agreements Act, as amended from time to time (New Arrangements to Borrow).

''(E) ALLOWANCE FOR INTERNATIONAL ARREARAGES.—

''(i) ADJUSTMENTS.—If an appropriation bill or joint resolution is enacted for fiscal year 1998, 1999, or 2000 that includes an appropriation for arrearages for international organizations, international peacekeeping, and multilateral development banks for that fiscal year, the adjustment shall be the amount of budget authority in that measure and the outlays flowing in all fiscal years from that budget authority.

''(ii) LIMITATIONS.—The total amount of adjustments made pursuant to this subparagraph for the period of fiscal years 1998 through 2000 shall not exceed $1,884,000,000 in budget authority.

''(F) EITC COMPLIANCE INITIATIVE.—If an appropriation bill or joint resolution is enacted for a fiscal year that includes an appropriation for an earned income tax credit compliance initiative, the adjustment shall be the amount of budget authority in that measure for that initiative and the outlays flowing in all fiscal years from that budget authority, but not to exceed—

''(i) with respect to fiscal year 1998, $138,000,000 in new budget authority and $131,000,000 in outlays;

''(ii) with respect to fiscal year 1999, $143,000,000 in new budget authority and $143,000,000 in outlays;

''(iii) with respect to fiscal year 2000, $144,000,000 in new budget authority and $144,000,000 in outlays;

''(iv) with respect to fiscal year 2001, $145,000,000 in new budget authority and $145,000,000 in outlays; and

''(v) with respect to fiscal year 2002, $146,000,000 in new budget authority and $146,000,000 in outlays.''.

(b) SHIFTING OF DISCRETIONARY SPENDING LIMITS INTO THE BALANCED BUDGET AND EMERGENCY DEFICIT CONTROL ACT OF 1985.—Section 251 of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by adding at the end the following new subsection:

''(c) DISCRETIONARY SPENDING LIMIT.—As used in this part, the term 'discretionary spending limit' means—

''(1) with respect to fiscal year 1997, for the discretionary category, the current adjusted limits of new budget authority and outlays;

''(2) with respect to fiscal year 1998—

''(A) for the defense category: $269,000,000,000 in new budget authority and $266,823,000,000 in outlays;

''(B) for the nondefense category: $252,357,000,000 in new budget authority and $282,853,000,000 in outlays; and

''(C) for the violent crime reduction category: $5,500,000,000 in new budget authority and $3,592,000,000 in outlays;

''(3) with respect to fiscal year 1999—

''(A) for the defense category: $271,500,000,000 in new budget authority and $266,518,000,000 in outlays;

''(B) for the nondefense category: $255,699,000,000 in new budget authority and $287,850,000,000 in outlays; and

''(C) for the violent crime reduction category: $5,800,000,000 in new budget authority and $4,953,000,000 in outlays;

''(4) with respect to fiscal year 2000—

''(A) for the discretionary category: $532,693,000,000 in new budget authority and $558,711,000,000 in outlays; and

''(B) for the violent crime reduction category: $4,500,000,000 in new budget authority and $5,554,000,000 in outlays;

''(5) with respect to fiscal year 2001, for the discretionary category: $542,032,000,000 in new budget authority and $564,396,000,000 in outlays; and

''(6) with respect to fiscal year 2002, for the discretionary category: $551,074,000,000 in new budget authority and $560,799,000,000 in outlays;

as adjusted in strict conformance with subsection (b).''.

(c) REPEAL OF DUPLICATIVE PROVISIONS.—Sections 201, 202, 204(b), 206, and 211 of House Concurrent Resolution 84 (105th Congress) are repealed.

**SEC. 10204. VIOLENT CRIME REDUCTION SPENDING.**

(a) SEQUESTRATION REGARDING VIOLENT CRIME REDUCTION SPENDING.—

(1) REPEAL.—Section 251A of the Balanced Budget and Emergency Deficit Control Act of 1985 is repealed.

(2) TABLE OF CONTENTS.—The item relating to section 251A in the table contents set forth in section 250(a) of the Balanced Budget and Emergency Deficit Control Act of 1985 is repealed.

(b) CONFORMING AMENDMENT.—Section 310002 of Public Law 103–322 (42 U.S.C. 14212) is repealed.

**SEC. 10205. ENFORCING PAY-AS-YOU-GO.**

Section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended—

(1) by striking subsections (a) and (b) and inserting the following:

''(a) PURPOSE.—The purpose of this section is to assure that any legislation enacted before October 1, 2002, affecting direct spending or receipts that increases the deficit will trigger an offsetting sequestration.

''(b) SEQUESTRATION.—

''(1) TIMING.—Not later than 15 calendar days after the date Congress adjourns to end a session and on the same day as a sequestration (if any) under section 251 or 253, there shall be a sequestration to offset the amount of any net deficit increase caused by all direct spending and receipts legislation enacted before October 1, 2002, as calculated under paragraph (2).

''(2) CALCULATION OF DEFICIT INCREASE.—OMB shall calculate the amount of deficit increase or decrease by adding—

''(A) all OMB estimates for the budget year of direct spending and receipts legislation transmitted under subsection (d);

''(B) the estimated amount of savings in direct spending programs applicable to budget

year resulting from the prior year's sequestration under this section or section 253, if any, as published in OMB's final sequestration report for that prior year; and

''(C) any net deficit increase or decrease in the current year resulting from all OMB estimates for the current year of direct spending and receipts legislation transmitted under subsection (d) that were not reflected in the final OMB sequestration report for the current year.'';

(2) by amending subsection (c)(1)(B), by inserting ''and direct'' after ''guaranteed'';

(3) by amending subsection (d) to read as follows:

''(d) ESTIMATES.—

''(1) CBO ESTIMATES.—As soon as practicable after Congress completes action on any direct spending or receipts legislation, CBO shall provide an estimate to OMB of that legislation.

''(2) OMB ESTIMATES.—Not later than 7 calendar days (excluding Saturdays, Sundays, and legal holidays) after the date of enactment of any direct spending or receipts legislation, OMB shall transmit a report to the House of Representatives and to the Senate containing—

''(A) the CBO estimate of that legislation;

''(B) an OMB estimate of that legislation using current economic and technical assumptions; and

''(C) an explanation of any difference between the 2 estimates.

''(3) SIGNIFICANT DIFFERENCES.—If during the preparation of the report under paragraph (2) OMB determines that there is a significant difference between the OMB and CBO estimates, OMB shall consult with the Committees on the Budget of the House of Representatives and the Senate regarding that difference and that consultation, to the extent practicable, shall include written communication to such committees that affords such committees the opportunity to comment before the issuance of that report.

''(4) SCOPE OF ESTIMATES.—The estimates under this section shall include the amount of change in outlays or receipts for the current year (if applicable), the budget year, and each outyear excluding any amounts resulting from—

''(A) full funding of, and continuation of, the deposit insurance guarantee commitment in effect under current estimates; and

''(B) emergency provisions as designated under subsection (e).

''(5) SCOREKEEPING GUIDELINES.—OMB and CBO, after consultation with each other and the Committees on the Budget of the House of Representatives and the Senate, shall—

''(A) determine common scorekeeping guidelines; and

''(B) in conformance with such guidelines, prepare estimates under this section.''; and

(4) in subsection (e), by striking '', for any fiscal year from 1991 through 1998,'' and by striking ''through 1995''.

**SEC. 10206. REPORTS AND ORDERS.**

Section 254 of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended—

(1) by striking subsection (c) and redesignating subsections (d) through (k) as (c) through (j), respectively;

(2) in subsection (c) (as redesignated), by striking ''1998'' and inserting ''2002'';

(3) in subsection (d) (as redesignated), by striking ''(h)'' and inserting ''(f)'';

(4)(A) in subsection (f)(2)(A) (as redesignated), by striking ''1998'' and inserting ''2002'';

(B) in subsection (f)(3) (as redesignated), by striking ''through 1998''; and

(C) by striking subsection (f)(4) (as redesignated) and by redesignating paragraphs (5) and (6) of that subsection as paragraphs (4) and (5), respectively; and

(5) in subsection (g) (as redesignated), by striking ''(g)'' each place it appears and inserting ''(f)''.

**SEC. 10207. EXEMPT PROGRAMS AND ACTIVITIES.**

(a) VETERANS PROGRAMS.—Section 255(b) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended as follows:

(1) In the item relating to Veterans Insurance and Indemnity, strike ''Indemnity'' and insert ''Indemnities''.

(2) In the item relating to Veterans' Canteen Service Revolving Fund, strike ''Veterans'''.

(3) In the item relating to Benefits under chapter 21 of title 38, strike ''(36–0137–0–1–702)'' and insert ''(36–0120–0–1–701)''.

(4) In the item relating to Veterans' compensation, strike ''Veterans' compensation'' and insert ''Compensation''.

(5) In the item relating to Veterans' pensions, strike ''Veterans' pensions'' and insert ''Pensions''.

(6) After the last item, insert the following new items:

''Benefits under chapter 35 of title 38, United States Code, related to educational assistance for survivors and dependents of certain veterans with service-connected disabilities (36–0137–0–1–702);

''Assistance and services under chapter 31 of title 38, United States Code, relating to training and rehabilitation for certain veterans with service-connected disabilities (36–0137–0–1–702);

''Benefits under subchapters I, II, and III of chapter 37 of title 38, United States Code, relating to housing loans for certain veterans and for the spouses and surviving spouses of certain veterans Guaranty and Indemnity Program Account (36–1119–0–1–704);

''Loan Guaranty Program Account (36–1025–0–1–704); and

''Direct Loan Program Account (36–1024–0–1–704).''.

(b) CERTAIN PROGRAM BASES.—Section 255(f) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended to read as follows:

''(f) OPTIONAL EXEMPTION OF MILITARY PERSONNEL.—

''(1) IN GENERAL.—The President may, with respect to any military personnel account, exempt that account from sequestration or provide for a lower uniform percentage reduction than would otherwise apply.

''(2) LIMITATION.—The President may not use the authority provided by paragraph (1) unless the President notifies the Congress of the manner in which such authority will be exercised on or before the date specified in section 254(a) for the budget year.''.

(c) OTHER PROGRAMS AND ACTIVITIES.—(1) Section 255(g)(1)(A) of the Balanced Budget Emergency Deficit Control Act of 1985 is amended as follows:

(A) After the first item, insert the following new item:

''Activities financed by voluntary payments to the Government for goods or services to be provided for such payments;''.

(B) Strike ''Thrift Savings Fund (26–8141–0–7–602);''.

(C) In the first item relating to the Bureau of Indian Affairs, insert ''Indian land and water claims settlements and'' after the comma.

(D) In the second item relating to the Bureau of Indian Affairs, strike ''miscellaneous'' and insert ''Miscellaneous'' and strike '', tribal trust funds''.

(E) Strike ''Claims, defense (97–0102–0–1–051);''.

(F) In the item relating to Claims, judgments, and relief acts, strike ''806'' and insert ''808''.

(G) Strike ''Coinage profit fund (20–5811–0–2–803);''.

(H) Insert ''Compact of Free Association (14–0415–0–1–808);'' after the item relating to the Claims, judgments, and relief acts.

(I) Insert ''Conservation Reserve Program (12–2319–0–1–302);'' after the item relating to the Compensation of the President.

(J) In the item relating to the Customs Service, strike ''852'' and insert ''806''.

(K) In the item relating to the Comptroller of the Currency, insert '', Assessment funds (20–8413–0–8–373)'' before the semicolon.

(L) Strike ''Director of the Office of Thrift Supervision;''.

(M) Strike ''Eastern Indian land claims settlement fund (14–2202–0–1–806);''.

(N) After the item relating to the Exchange stabilization fund, insert the following new items:

''Farm Credit Administration, Limitation on Administrative Expenses (78–4131–0–3–351);

''Farm Credit System Financial Assistance Corporation, interest payment (20–1850–0–1–908);''.

(O) Strike ''Federal Deposit Insurance Corporation;''.

(P) In the first item relating to the Federal Deposit Insurance Corporation, insert ''(51–4064–0–3–373)'' before the semicolon.

(Q) In the second item relating to the Federal Deposit Insurance Corporation, insert ''(51–4065–0–3–373)'' before the semicolon.

(R) In the third item relating to the Federal Deposit Insurance Corporation, insert ''(51–4066–0–3–373)'' before the semicolon.

(S) In the item relating to the Federal Housing Finance Board, insert ''(95–4039–0–3–371)'' before the semicolon.

(T) In the item relating to the Federal payment to the railroad retirement account, strike ''account'' and insert ''accounts''.

(U) In the item relating to the health professions graduate student loan insurance fund, insert ''program account'' after ''fund'' and strike ''(Health Education Assistance Loan Program) (75–4305–0–3–553)'' and insert ''(75–0340–0–1–552)''.

(V) In the item relating to Higher education facilities, strike ''and insurance''.

(W) In the item relating to Internal Revenue collections for Puerto Rico, strike ''852'' and insert ''806''.

(X) Amend the item relating to the Panama Canal Commission to read as follows:

''Panama Canal Commission, Panama Canal Revolving Fund (95–4061–0–3–403);''.

(Y) In the item relating to the Medical facilities guarantee and loan fund, strike ''(75–4430–0–3–551)'' and insert ''(75–9931–0–3–550)''.

(Z) In the first item relating to the National Credit Union Administration, insert ''operating fund (25–4056–0–3–373)'' before the semicolon.

(AA) In the second item relating to the National Credit Union Administration, strike ''central'' and insert ''Central'' and insert ''(25–4470–0–3–373)'' before the semicolon.

(BB) In the third item relating to the National Credit Union Administration, strike ''credit'' and insert ''Credit'' and insert ''(25–4468–0–3–373)'' before the semicolon.

(CC) After the third item relating to the National Credit Union Administration, insert the following new item:

''Office of Thrift Supervision (20–4108–0–3–373);''.

(DD) In the item relating to Payments to health care trust funds, strike ''572'' and insert ''571''.

(EE) Strike ''Compact of Free Association, economic assistance pursuant to Public Law 99–658 (14–0415–0–1–806);''.

(FF) In the item relating to Payments to social security trust funds, strike ''571'' and insert ''651''.

(GG) Strike ''Payments to state and local government fiscal assistance trust fund (20–2111–0–1–851);''.

(HH) In the item relating to Payments to the United States territories, strike ''852'' and insert ''806''.

(II) Strike ''Resolution Funding Corporation;''.

(JJ) In the item relating to the Resolution Trust Corporation, insert ''Revolving Fund (22–4055–0–3–373)'' before the semicolon.

(KK) After the item relating to the Tennessee Valley Authority funds, insert the following new items:

''Thrift Savings Fund;

''United States Enrichment Corporation (95–4054–0–3–271);

''Vaccine Injury Compensation (75–0320–0–1–551);

''Vaccine Injury Compensation Program Trust Fund (20–8175–0–7–551);''.

(2) Section 255(g)(1)(B) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended as follows:

(A) Strike ''The following budget'' and insert ''The following Federal retirement and disability''.

(B) In the item relating to Black lung benefits, strike ''lung benefits'' and insert ''Lung Disability Trust Fund''.

(C) In the item relating to the Court of Federal Claims Court Judges' Retirement Fund, strike ''Court of Federal''.

(D) In the item relating to Longshoremen's compensation benefits, insert ''Special workers compensation expenses,'' before ''Longshoremen's''.

(E) In the item relating to Railroad retirement tier II, strike ''retirement tier II'' and insert ''Industry Pension Fund''.

(3) Section 255(g)(2) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended as follows:

(A) Strike the following items:

''Agency for International Development, Housing, and other credit guarantee programs (72–4340–0–3–151);

''Agricultural credit insurance fund (12–4140–0–1–351);''.

(B) In the item relating to Check forgery, strike ''Check'' and insert ''United States Treasury check''.

(C) Strike ''Community development grant loan guarantees (86–0162–0–1–451);''.

(D) After the item relating to the United States Treasury Check forgery insurance fund, insert the following new item:

''Credit liquidating accounts;''.

(E) Strike the following items:

''Credit union share insurance fund (25–4468–0–3–371);''.

''Economic development revolving fund (13–4406–0–3–452);''.

''Export-Import Bank of the United States, Limitation of program activity (83–4027–0–3–155);''.

''Federal Deposit Insurance Corporation (51–8419–0–8–371);''.

''Federal Housing Administration fund (86–4070–0–3–371);''.

''Federal ship financing fund (69–4301–0–3–403);''.

''Federal ship financing fund, fishing vessels (13–4417–0–3–376);''.

''Government National Mortgage Association, Guarantees of mortgage-backed securities (86–4238–0–3–371);''.

''Health education loans (75–4307–0–3–553);''.

''Indian loan guarantee and insurance fund (14–4410–0–3–452);''.

''Railroad rehabilitation and improvement financing fund (69–4411–0–3–401);''.

''Rural development insurance fund (12–4155–0–3–452);''.

''Rural electric and telephone revolving fund (12–4230–8–3–271);''.

''Rural housing insurance fund (12–4141–0–3–371);''.

''Small Business Administration, Business loan and investment fund (73–4154–0–3–376);''.

''Small Business Administration, Lease guarantees revolving fund (73–4157–0–3–376);''.

''Small Business Administration, Pollution control equipment contract guarantee revolving fund (73–4147–0–3–376);''.

''Small Business Administration, Surety bond guarantees revolving fund (73–4156–0–3–376);''.

''Department of Veterans Affairs Loan guaranty revolving fund (36–4025–0–3–704);''.

(d) LOW-INCOME PROGRAMS.—Section 255(h) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended as follows:

(1) Amend the item relating to Child nutrition to read as follows:

''Child nutrition programs (with the exception of special milk programs) (12–3539–0–1–605);''.

(2) After the second item insert the following new items:

''Temporary assistance for needy families (75–1552–0–1–609);

''Contingency fund (75–1522–0–1–609);''

''Child care entitlement to States (75–1550–0–1–609);

(3) Amend the item relating to Women, infants, and children program to read as follows:

''Special supplemental nutrition program for women, infants, and children (WIC) (12–3510–0–1–605);''.

(4) After the last item add the following new item:

''Family support payments to States (75–1501–0–1–609);''.

(e) IDENTIFICATION OF PROGRAMS.—Section 255(i) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended to read as follows:

''(i) IDENTIFICATION OF PROGRAMS.—For purposes of subsections (b), (g), and (h), each account is identified by the designated budget account identification code number set forth in the Budget of the United States Government 1998–Appendix, and an activity within an account is designated by the name of the activity and the identification code number of the account.''.

(f) OPTIONAL EXEMPTION OF MILITARY PERSONNEL.—Section 255(h) of the Balanced Budget and Emergency Deficit Control Act of 1985 (relating to optional exemption of military personnel) is repealed.

**SEC. 10208. GENERAL AND SPECIAL SEQUESTRATION RULES.**

(a) HEADINGS.—

(1) SECTION.—The section heading of section 256 of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by striking ''**exceptions, limitations, and special rules**'' and inserting ''**general and special sequestration rules**''.

(2) TABLE OF CONTENTS.—The item relating to section 256 in the table contents set forth in section 250(a) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended to read as follows:

''SEC. 256. GENERAL AND SPECIAL SEQUESTRATION RULES.''.

(b) AUTOMATIC SPENDING INCREASES.—Section 256(a) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by striking paragraph (1) and redesignating paragraphs (2) and (3) as paragraphs (1) and (2), respectively.

(c) GUARANTEED AND DIRECT STUDENT LOAN PROGRAMS.—Section 256(b) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended to read as follows:

''(b) STUDENT LOANS.—For all student loans under part B or D of title IV of the Higher Education Act of 1965 made during the period when a sequestration order under section 254 is in effect as required by section 252 or 253, origination fees under sections 438(c)(2) and 455(c) of that Act shall each be increased by 0.50 percentage point.''.

(d) HEALTH CENTERS.—Section 256(e)(1) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by striking the dash and all that follows thereafter and inserting ''2 percent.''.

(e) TREATMENT OF FEDERAL ADMINISTRATIVE EXPENSES.—Section 256(h) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended—

(1) in paragraph (2), by striking ''joint resolution'' and inserting ''part''; and

(2) in paragraph (4), by striking subparagraphs (D) and (H), by redesignating subparagraphs (E), (F), (G), and (I), as subparagraphs (D), (E), (F), and (G), respectively, and by adding at the end the following new subparagraph:

''(H) Farm Credit Administration.''.

(f) COMMODITY CREDIT CORPORATION.—Section 256(j) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended by striking paragraphs (2) through (5) and inserting the following:

''(2) REDUCTION IN PAYMENTS MADE UNDER CONTRACTS.—(A) Loan eligibility under any contract entered into with a person by the Commodity Credit Corporation prior to the time an order has been issued under section 254 shall not be reduced by an order subsequently issued. Subject to subparagraph (B), after an order is issued under such section for a fiscal year, any cash payments for loans or loan deficiencies made by the Commodity Credit Corporation shall be subject to reduction under the order.

''(B) Each loan contract entered into with producers or producer cooperatives with respect to a particular crop of a commodity and subject to reduction under subparagraph (A) shall be reduced in accordance with the same terms and conditions. If some, but not all, contracts applicable to a crop of a commodity have been entered into prior to the issuance of an order under section 254, the order shall provide that the necessary reduction in payments under contracts applicable to the commodity be uniformly applied to all contracts for the next succeeding crop of the commodity, under the authority provided in paragraph (3).

''(3) DELAYED REDUCTION IN OUTLAYS PERMISSIBLE.—Notwithstanding any other provision of this title, if an order under section 254 is issued with respect to a fiscal year, any reduction under the order applicable to contracts described in paragraph (1) may provide for reductions in outlays for the account involved to occur in the fiscal year following the fiscal year to which the order applies.

''(4) UNIFORM PERCENTAGE RATE OF REDUCTION AND OTHER LIMITATIONS.—All reductions described in paragraph (2) which are required to be made in connection with an order issued under section 254 with respect to a fiscal year shall be made so as to ensure that outlays for each program, project, activity, or account involved are reduced by a percentage rate that is uniform for all such programs, projects, activities, and accounts, and may not be made so as to achieve a percentage rate of reduction in any such item exceeding the rate specified in the order.

''(5) DAIRY PROGRAM.—Notwithstanding any other provision of this subsection, as the sole means of achieving any reduction in outlays under the milk price support program, the Secretary of Agriculture shall provide for a reduction to be made in the price received by producers for all milk produced in the United States and marketed by producers for commercial use. That price reduction (measured in cents per hundred weight of milk marketed) shall occur under section 201(d)(2)(A) of the Agricultural Act of 1949 (7 U.S.C. 1446(d)(2)(A)), shall begin on the day any sequestration order is issued under section 254, and shall not exceed the aggregate amount of the reduction in outlays under the milk price support program that otherwise would have been achieved by reducing pay-

ments for the purchase of milk or the products of milk under this subsection during the applicable fiscal year.''.

(g) EFFECTS OF SEQUESTRATION.—Section 256(k) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended as follows:

(1) In paragraph (1), strike ''other than a trust or special fund account'' and insert '', except as provided in paragraph (5)'' before the period.

(2) Amend paragraph (6) to read as follows:

''(6) Budgetary resources sequestered in revolving, trust, and special fund accounts and offsetting collections sequestered in appropriation accounts shall not be available for obligation during the fiscal year in which the sequestration occurs, but shall be available in subsequent years to the extent otherwise provided in law.''.

**SEC. 10209. THE BASELINE.**

(a) IN GENERAL.—Section 257 of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended—

(1) in subsection (b)(2) by amending subparagraph (A) to read as follows:

''(A)(i) No program established by a law enacted on or before the date of enactment of the Balanced Budget Act of 1997 with estimated current year outlays greater than $50,000,000 shall be assumed to expire in the budget year or the outyears. The scoring of new programs with estimated outlays greater than $50,000,000 a year shall be based on scoring by the Committees on Budget or OMB, as applicable. OMB, CBO, and the Budget Committees shall consult on the scoring of such programs where there are differenes between CBO and OMB.

''(ii) On the expiration of the suspension of a provision of law that is suspended under section 171 of Public Law 104–127 and that authorizes a program with estimated fiscal year outlays that are greater than $50,000,000, for purposes of clause (i), the program shall be assumed to continue to operate in the same manner as the program operated immediately before the expiration of the suspension.'';

(2) by adding the end of subsection (b)(2) the following new subparagraph:

''(D) If any law expires before the budget year or any outyear, then any program with estimated current year outlays greater than $50,000,000 that operates under that law shall be assumed to continue to operate under that law as in effect immediately before its expiration.'';

(3) in the second sentence of subsection (c)(5), by striking ''national product fixed-weight price index'' and inserting ''domestic product chain-type price index''; and

(4) by striking subsection (e) and inserting the following:

''(e) ASSET SALES.—Amounts realized from the sale of an asset shall not be included in estimates under section 251, 252, or 253 if that sale would result in a financial cost to the Federal Government as determined pursuant to scorekeeping guidelines.''.

(b) PRESIDENT'S BUDGET.—Section 1105(a) of title 31, United States Code, is amended by adding at the end the following:

''(32) a statement of the levels of budget authority and outlays for each program assumed to be extended in the baseline as provided in section 257(b)(2)(A) and for excise taxes assumed to be extended under section 257(b)(2)(C) of the Balanced Budget and Emergency Deficit Control Act of 1985.''.

(c) BUDGETARY TREATMENT OF CERTAIN TRUST FUND OPERATIONS.—Section 710 of the Social Security Act (42 U.S.C. 911) is amended to read as follows:

''BUDGETARY TREATMENT OF TRUST FUND OPERATIONS

''SEC. 710. (a) The receipts and disbursements of the Federal Old-Age and Survivors Insurance Trust Fund and the Federal Disability Insurance Trust Fund and the taxes imposed under sections 1401 and 3101 of the Internal Revenue Code of 1986 shall not be included in the totals of the budget of the United States Government as submitted by the President or of the congressional budget and shall be exempt from any general budget limitation imposed by statute on expenditures and net lending (budget outlays) of the United States Government.

''(b) No provision of law enacted after the date of enactment of the Balanced Budget and Emergency Deficit Control Act of 1985 (other than a provision of an appropriation Act that appropriated funds authorized under the Social Security Act as in effect on the date of the enactment of the Balanced Budget and Emergency Deficit control Act of 1985) may provide for payments from the general fund of the Treasury to any Trust Fund specified in subsection (a) or for payments from any such Trust Fund to the general fund of the Treasury.''.

**SEC. 10210. TECHNICAL CORRECTION.**

Section 258 of the Balanced Budget and Emergency Deficit Control Act of 1985, entitled ''Modification of Presidential Order'', is repealed.

**SEC. 10211. JUDICIAL REVIEW.**

Section 274 of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended as follows:

(1) Strike ''252'' or ''252(b)'' each place it occurs and insert ''254''.

(2) In subsection (d)(1)(A), strike ''257(l) to the extent that'' and insert ''256(a) if'' and at the end insert ''or''.

(3) In subsection (d)(1)(B), strike ''new budget'' and all that follows through ''spending authority'' and insert ''budgetary resources'' and strike ''or'' after the comma.

(4) Strike subsection (d)(1)(C).

(5) Strike subsection (f) and redesignate subsections (g) and (h) as subsections (f) and (g), respectively.

(6) In subsection (g) (as redesignated), strike ''base levels of total revenues and total budget outlays, as'' and insert ''figures'', and strike ''251(a)(2)(B) or (c)(2),'' and insert ''254''.

**SEC. 10212. EFFECTIVE DATE.**

(a) EXPIRATION.—Section 275(b) of the Balanced Budget and Emergency Deficit Control Act of 1985 is amended—

(1) by striking ''Part C of this title, section'' and inserting ''Sections 251, 253, 258B, and'';

(2) by striking ''1995'' and inserting ''2002''; and

(3) by adding at the end the following new sentence: ''The remaining sections of part C of this title shall expire September 30, 2006.''.

(b) EXPIRATION.—Section 14002(c)(3) of the Omnibus Budget Reconciliation Act of 1993 (2 U.S.C. 900 note) is repealed.

**SEC. 10213. REDUCTION OF PREEXISTING BALANCES AND EXCLUSION OF EFFECTS OF THIS ACT FROM PAYGO SCORECARD.**

Upon the enactment of this Act, the Director of the Office of Management and Budget shall—

(1) reduce any balances of direct spending and receipts legislation for any fiscal year under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 to zero; and

(2) not make any estimates of changes in direct spending outlays and receipts under subsection (d) of that section for any fiscal year resulting from the enactment of this Act or of the Taxpayer Relief Act of 1997.

**TITLE XI—DISTRICT OF COLUMBIA REVITALIZATION**

**SECTION 11000. SHORT TITLE; TABLE OF CONTENTS.**

(a) SHORT TITLE.—This title may be cited as the ''National Capital Revitalization and Self-Government Improvement Act of 1997''.

(b) TABLE OF CONTENTS.—The table of contents of this title is as follows:

Sec. 11000. Short title; table of contents.

Subtitle A—District of Columbia Retirement Funds

CHAPTER 1—SHORT TITLE; FINDINGS; DEFINITIONS

Sec. 11001. Short title.
Sec. 11002. Findings and declaration of policy.
Sec. 11003. Definitions.

CHAPTER 2—FEDERAL BENEFIT PAYMENTS UNDER DISTRICT RETIREMENT PROGRAMS

Sec. 11011. Obligation of Federal government to make benefit payments.
Sec. 11012. Federal benefit payments described.
Sec. 11013. Establishment of single annual cost-of-living adjustment under District Retirement Program.

CHAPTER 3—DETERMINATIONS AND REVIEW OF ELIGIBILITY AND PAYMENTS; INFORMATION SHARING

Sec. 11021. Determination of eligibility for and amount of Federal benefit payments made by Trustee.
Sec. 11022. Procedures for resolving claims arising from denied benefit payments.
Sec. 11023. Transfer of and access to records of District Government.
Sec. 11024. Federal information sharing for verification of benefit determinations.

CHAPTER 4—DISTRICT OF COLUMBIA FEDERAL PENSION LIABILITY TRUST FUND

Sec. 11031. Creation of Trust Fund.
Sec. 11032. Uses of amounts in Trust Fund.
Sec. 11033. Transfer of assets and obligations of District Retirement Funds.
Sec. 11034. Treatment of Trust Fund under certain laws.
Sec. 11035. Administration through Trustee.

CHAPTER 5—RESPONSIBILITIES OF DISTRICT GOVERNMENT

Sec. 11041. Interim administration.
Sec. 11042. Replacement plan.

CHAPTER 6—FINANCING OF BENEFIT PAYMENTS AFTER DEPLETION OF TRUST FUND

Sec. 11051. Creation of Federal Supplemental Fund.
Sec. 11052. Uses of amounts in Fund.
Sec. 11053. Determination of annual payment into Federal Supplemental Fund.
Sec. 11054. Determination of methodology for making payments.
Sec. 11055. Special requirements upon discontinuation of Trust Fund.

CHAPTER 7—REPORTS

Sec. 11061. Annual valuations and reports by enrolled actuary.
Sec. 11062. Reports by Comptroller General.

CHAPTER 8—JUDICIAL ENFORCEMENT

Sec. 11071. Judicial review.
Sec. 11072. Jurisdiction and venue.
Sec. 11073. Statute of limitations.
Sec. 11074. Treatment of misappropriation of fund amounts as Federal crime.

CHAPTER 9—MISCELLANEOUS

Sec. 11081. Coordination between Secretary, Trustee, and District Government.
Sec. 11082. Study of alternatives for financing Federal obligations.
Sec. 11083. Issuance of regulations by Secretary.

Sec. 11084. Effect on Reform Act and other laws.
Sec. 11085. Reference to new Federal program for retirement of judges of District of Columbia courts.
Sec. 11086. Full faith and credit.
Sec. 11087. Severability of provisions.

Subtitle B—Management Reform Plans

Sec. 11101. Short title.
Sec. 11102. Management reform plans for District Government.
Sec. 11103. Procedures for development of plans.
Sec. 11104. Implementation of plans.
Sec. 11105. Reform of powers and duties of department heads.
Sec. 11106. No effect on powers of Financial Responsibility and Management Assistance Authority.

Subtitle C—Criminal Justice

CHAPTER 1—CORRECTIONS

Sec. 11201. Bureau of Prisons.
Sec. 11202. Corrections Trustee.
Sec. 11203. Priority consideration for employees of the District of Columbia.
Sec. 11204. Amendments related to persons with a mental disease or defect.
Sec. 11205. Liability for and litigation authority of Corrections Trustee.
Sec. 11206. Permitting expenditure of funds to carry out certain sewer agreement.

CHAPTER 2—SENTENCING

Sec. 11211. Truth-in-Sentencing Commission.
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Sec. 11213. Data collection.
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## Subtitle A—District of Columbia Retirement Funds

## CHAPTER 1—SHORT TITLE; FINDINGS; DEFINITIONS

**SEC. 11001. SHORT TITLE.**

This subtitle may be cited as the ''District of Columbia Retirement Protection Act of 1997''.

**SEC. 11002. FINDINGS AND DECLARATION OF POLICY.**

(a) FINDINGS.—The Congress finds that—

(1) State and municipal retirement programs should be funded on an actuarially sound basis;

(2) the retirement programs for the police officers and firefighters, teachers and judges of the District of Columbia had significant unfunded liabilities totaling approximately $1,900,000,000 when the Federal government transferred those programs to the District of Columbia, and those liabilities have since increased to nearly $4,800,000,000, an increase which is almost entirely attributable to the accumulation of interest on the value which existed at the time of transfer;

(3) the District of Columbia has fully met its financial obligations under the District of Columbia Retirement Reform Act of 1979 (Public Law 96–122);

(4) the growth of the unfunded liabilities of the three pension funds listed above did not occur because of any action taken or any failure to act that lay within the power of the District of Columbia government or the District of Columbia Retirement Board;

(5) the presence of the unfunded pension liability is having and will continue to have a negative impact on the District of Columbia's credit rating as it is a legal obligation and the total unfunded liability exceeds the total General Obligation debt of the District, and the costs associated with this liability are a contributing cause of the District's ongoing financial crisis;

(6) the obligations of the District associated with these pension programs in fiscal year 1997 represents nearly 10 percent of the District's revenue;

(7) the annual Federal contribution toward these costs under the District of Columbia Retirement Reform Act has remained $52,000,000;

(8) if the unfunded pension liability situation is not resolved, in 2004 the District of Columbia would be responsible for annual costs exceeding $800,000,000, a figure which would be impossible to meet without catastrophic impact on the District government's resources and programs;

(9) the financial resources of the District of Columbia are not adequate to discharge the unfunded liabilities of the retirement programs; and

(10) the level of benefits and funding of the current retirement programs were authorized by various Acts of Congress.

(b) POLICY.—It is the policy of this subtitle—

(1) to relieve the District of Columbia government of the responsibility for the unfunded pension liabilities transferred to it by the Federal government;

(2) for the Federal government to assume the legal responsibility for paying certain pension benefits (including certain unfunded pension liabilities which existed as of the day prior to introduction of this legislation) for the retirement plans of teachers, police, and firefighters;

(3) to provide for a responsible Federal system for payment of benefits accrued prior to the date of introduction of this legislation; and

(4) to require the establishment of replacement plans by the District of Columbia government for the current retirement plans for teachers, and police and firefighters.

**SEC. 11003. DEFINITIONS.**

For purposes of this subtitle, the following definitions shall apply:

(1) The term ''contract'' means the contract under section 11035 between the Secretary and the Trustee.

(2) The term ''covered District employee'' means a teacher of the District of Columbia public schools, or a member of the Metropolitan Police Force or the Fire Department of the District of Columbia, as defined under the District Retirement Program.

(3) The term ''District Government'' means any entity treated as part of the District government under section 305(5) of the District of Columbia Financial Responsibility and Management Assistance Act of 1995, including the District of Columbia Retirement Board (as defined in section 102(5) of the Reform Act).

(4) The term ''District Retirement Fund'' means the District of Columbia Police Officers and Fire Fighters Retirement Fund and the District of Columbia Teachers Retirement Fund, as defined in the Reform Act.

(5) The term ''District Retirement Program'' means any of the retirement programs for teachers and members of the Metropolitan Police Force and Fire Department, as described in section 102(7) of the Reform Act as in effect on the day before the freeze date (except as amended by section 11013).

(6) The term ''enrolled actuary'' means the enrolled actuary engaged by the Trustee under section 11061(a).

(7) The term ''Federal benefit payment'' means a payment described in section 11012.

(8) The term ''Federal Supplemental Fund'' means the Federal Supplemental District of Columbia Pension Fund created under section 11051.

(9) The term ''freeze date'' means June 30, 1997.

(10) The term ''person'' means an individual, partnership, joint venture, corporation, mutual company, joint-stock company, trust, estate, unincorporated organization, association, or employee organization.

(11) The term ''Reform Act'' means the District of Columbia Retirement Reform Act (Public Law 96–122).

(12) The term ''replacement plan'' means the plan described in section 11042.

(13) The term ''replacement plan adoption date'' means the date upon which the legislation establishing the replacement plan becomes effective, or the first day after the expiration of the 1-year period which begins on the date of the enactment of this Act, whichever occurs first.

(14) The term ''Trust Fund'' means the District of Columbia Federal Pension Liability Trust Fund established under section 11031.

(15) The term ''Secretary'' means the Secretary of the Treasury or the Secretary's designee.

(16) The term ''Trustee'' means the person or persons selected by the Secretary under section 11035.

## CHAPTER 2—FEDERAL BENEFIT PAYMENTS UNDER DISTRICT RETIREMENT PROGRAMS

**SEC. 11011. OBLIGATION OF FEDERAL GOVERNMENT TO MAKE BENEFIT PAYMENTS.**

(a) IN GENERAL.—In accordance with the provisions of this subtitle, the Federal Government shall make Federal benefit payments associated with the pension plans for police officers, firefighters, and teachers of the District of Columbia.

(b) NO REVERSION OF FEDERAL RESPONSIBILITY TO DISTRICT.—At no point after the effective date of this subtitle may the responsibility or any part thereof assigned to the Federal Government under subsection (a) for making Federal benefit payments revert to the District of Columbia.

**SEC. 11012. FEDERAL BENEFIT PAYMENTS DESCRIBED.**

(a) IN GENERAL.—Subject to the succeeding provisions of this subtitle, a ''Federal benefit payment'' is any benefit payment to which an individual is entitled under a District Retirement Program, in such amount and under such terms and conditions as may apply under such Program.

(b) TREATMENT OF SERVICE OCCURRING AFTER FREEZE DATE.—Service after the freeze date shall not be credited for purposes of determining the amount of any Federal benefit payment. Nothing in this subsection shall be construed to affect the crediting of such service for any other purpose under the District Retirement Program.

(c) SPECIAL RULE REGARDING DISABILITY BENEFITS.—To the extent that any portion of a benefit payment to which an individual is entitled under a District Retirement Program is based on a determination of disability made by the District of Columbia Retirement Board or the Trustee after the freeze date, the Federal benefit payment determined with respect to the individual shall be an amount equal to the deferred retirement benefit or normal retirement benefit the individual would receive if the individual left service on the day before the commencement of disability retirement benefits.

(d) SPECIAL RULE REGARDING CERTAIN DEATH BENEFITS.—

(1) IN GENERAL.—In the case of a benefit payment to which an individual is entitled under a District Retirement Program which is payable on the death of a covered District employee or former covered District employee and which is not determined by the length of service of the employee or former employee, the Federal benefit payment determined with respect to the individual shall be equal to the pre-freeze date percentage of the amount otherwise payable.

(2) PRE-FREEZE DATE PERCENTAGE DEFINED.—In paragraph (1), the ''pre-freeze date percentage'' with respect to a covered District employee or former covered District employee is the amount (expressed as a percentage) equal to the quotient of—

(A) the number of months of the covered District employee's or former covered District employee's service prior to the freeze date; divided by

(B) the total number of months of the covered District employee's or former covered District employee's service.

**SEC. 11013. ESTABLISHMENT OF SINGLE ANNUAL COST-OF-LIVING ADJUSTMENT UNDER DISTRICT RETIREMENT PROGRAM.**

(a) PROGRAM FOR POLICE AND FIRE FIGHTERS.—Subsection (m) of the Policemen and Firemen's Retirement and Disability Act (DC Code, sec. 4–624) is amended—

(1) in paragraph (2), by striking ''the Mayor shall'' and all that follows and inserting the following: ''on January 1 of each year (or within a reasonable time thereafter), the Mayor shall determine the per centum change in the price index for the preceding year by determining the difference between the index published for December of the preceding year and the index published for December of the second preceding year.''; and

(2) by amending paragraph (3) to read as follows:

''(3)(A) If (in accordance with paragraph (2)) the Mayor determines in a year (beginning with 1999) that the per centum change in the price index for the preceding year indicates a rise in the price index, each annuity having a commencing date on or before March 1 of the year shall, effective March 1 of the year, be increased by an amount equal to—

''(i) in the case of an annuity having a commencing date on or before March 1 of such preceding year, the per centum change computed under paragraph (1), adjusted to the nearest 1/10 of 1 per centum; or

''(ii) in the case of an annuity having a commencing date after March 1 of such preceding year, a pro rata increase equal to the product of—

''(I) 1/12 of the per centum change computed under paragraph (1), multiplied by

''(II) the number of months (not to exceed 12 months, counting any portion of a month as an entire month) for which the annuity was payable before the effective date of the increase,

adjusted to the nearest 1/10 of 1 per centum.

''(B) On January 1, 1998 (or within a reasonable time thereafter), the Mayor shall determine the per centum change in the price index published for December 1997 over the price index published for June 1997. If such per centum change indicates a rise in the price index, effective March 1, 1998—

''(i) each annuity having a commencing date on or before September 1, 1997, shall be increased by an amount equal to such per centum change, adjusted to the nearest 1/10 of 1 per centum; and

''(ii) each annuity having a commencing date after September 1, 1997, and on or before March 1, 1998, shall be increased by a pro rata increase equal to the product of—

''(I) 1/6 of such per centum change, multiplied by

''(II) the number of months (not to exceed 6 months, counting any portion of a month as an entire month) for which the annuity was payable before the effective date of the increase,

adjusted to the nearest 1/10 of 1 per centum.''.

(b) PROGRAM FOR TEACHERS.—Section 21(b) of the Act entitled ''An Act for the retirement of public-school teachers in the District of Columbia'', approved August 7, 1946 (DC Code, sec. 31–1241(b)) is amended—

(1) in paragraph (1), by striking ''The Mayor shall—'' and all that follows and inserting the following: ''On January 1 of each year (or within a reasonable time thereafter), the Mayor shall determine the per centum change in the price index for the preceding year by determining the difference between the index published for December of the preceding year and the index published for December of the second preceding year.''; and

(2) by amending paragraph (2) to read as follows:

''(2)(A) If (in accordance with paragraph (1)) the Mayor determines in a year (begin-

ning with 1999) that the per centum change in the price index for the preceding year indicates a rise in the price index, each annuity having a commencing date on or before March 1 of the year shall, effective March 1 of the year, be increased by an amount equal to—

''(i) in the case of an annuity having a commencing date on or before March 1 of such preceding year, the per centum change computed under paragraph (1), adjusted to the nearest 1/10 of 1 per centum; or

''(ii) in the case of an annuity having a commencing date after March 1 of such preceding year, a pro rata increase equal to the product of—

''(I) 1/12 of the per centum change computed under paragraph (1), multiplied by

''(II) the number of months (not to exceed 12 months, counting any portion of a month as an entire month) for which the annuity was payable before the effective date of the increase,

adjusted to the nearest 1/10 of 1 per centum.

''(B) On January 1, 1998 (or within a reasonable time thereafter), the Mayor shall determine the per centum change in the price index published for December 1997 over the price index published for June 1997. If such per centum change indicates a rise in the price index, effective March 1, 1998—

''(i) each annuity having a commencing date on or before September 1, 1997, shall be increased by an amount equal to such per centum change, adjusted to the nearest 1/10 of 1 per centum; and

''(ii) each annuity having a commencing date after September 1, 1997, and on or before March 1, 1998, shall be increased by a pro rata increase equal to the product of—

''(I) 1/6 of such per centum change, multiplied by

''(II) the number of months (not to exceed 6 months, counting any portion of a month as an entire month) for which the annuity was payable before the effective date of the increase,

adjusted to the nearest 1/10 of 1 per centum.''.

## CHAPTER 3—DETERMINATIONS AND REVIEW OF ELIGIBILITY AND PAYMENTS; INFORMATION SHARING

### SEC. 11021. DETERMINATION OF ELIGIBILITY FOR AND AMOUNT OF FEDERAL BENEFIT PAYMENTS MADE BY TRUSTEE.

Notwithstanding any provision of a District Retirement Program or any other law, rule, or regulation, the Trustee—

(1) shall determine whether an individual is eligible to receive a Federal benefit payment under this subtitle;

(2) shall determine the amount and form of an individual's Federal benefit payment under this subtitle; and

(3) may recoup or recover any amounts paid under this subtitle as a result of errors or omissions by the Trustee, the District Government, or any other person.

### SEC. 11022. PROCEDURES FOR RESOLVING CLAIMS ARISING FROM DENIED BENEFIT PAYMENTS.

(a) REQUIRING NOTICE AND OPPORTUNITY FOR REVIEW.—In accordance with procedures approved by the Secretary, the Trustee shall provide to any individual whose claim for a Federal benefit payment under this subtitle has been denied in whole or in part—

(1) adequate written notice of such denial, setting forth the specific reasons for the denial in a manner calculated to be understood by the average participant in the District Retirement Program; and

(2) a reasonable opportunity for a full and fair review of the decision denying such claim.

(b) STANDARD FOR REVIEW.—Any factual determination made by the Trustee shall be presumed correct unless rebutted by clear and convincing evidence. The Trustee's interpretation and construction of the benefit provisions of the District Retirement Program and this subtitle shall be entitled to great deference.

### SEC. 11023. TRANSFER OF AND ACCESS TO RECORDS OF DISTRICT GOVERNMENT.

(a) IN GENERAL.—Within 30 days after the Secretary or the Trustee requests, the District Government shall furnish copies of all records, documents, information, or data the Secretary or the Trustee deems necessary to carry out responsibilities under this subtitle and the contract. Upon request, the District Government shall grant the Secretary or the Trustee direct access to such information systems, records, documents, information or data as the Secretary or Trustee requires to carry out responsibilities under this subtitle or the contract.

(b) REPAYMENT BY DISTRICT GOVERNMENT.—The District Government shall reimburse the Trust Fund for all costs, including benefit costs, that are attributable to errors or omissions in the transferred records that are identified within 3 years after such records are transferred.

### SEC. 11024. FEDERAL INFORMATION SHARING FOR VERIFICATION OF BENEFIT DETERMINATIONS.

(a) IN GENERAL.—Except with respect to taxpayer returns and return information subject to section 6103 of the Internal Revenue Code of 1986, the Secretary may—

(1) secure directly from any department or agency of the United States information necessary to enable the Secretary to verify or confirm benefit determinations under this subtitle; and

(2) by regulation authorize the Trustee to review such information for purposes of administering this subtitle and the contract.

(b) AMENDMENTS TO INTERNAL REVENUE CODE.—The Internal Revenue Code of 1986 is amended as follows:

(1) In section 6103(l), as amended by section 1206(a) of the Taxpayer Bill of Rights 2, by adding at the end the following new paragraph:

''(16) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF ADMINISTERING THE DISTRICT OF COLUMBIA RETIREMENT PROTECTION ACT OF 1997.—

''(A) IN GENERAL.—Upon written request available return information (including such information disclosed to the Social Security Administration under paragraph (1) or (5) of this subsection), relating to the amount of wage income (as defined in section 3121(a) or 3401(a)), the name, address, and identifying number assigned under section 6109, of payors of wage income, taxpayer identity (as defined in subsection 6103(b)(6)), and the occupational status reflected on any return filed by, or with respect to, any individual with respect to whom eligibility for, or the correct amount of, benefits under the District of Columbia Retirement Protection Act of 1997, is sought to be determined, shall be disclosed by the Commissioner of Social Security, or to the extent not available from the Social Security Administration, by the Secretary, to any duly authorized officer or employee of the Department of the Treasury, or a Trustee or any designated officer or employee of a Trustee (as defined in the District of Columbia Retirement Protection Act of 1997), or any actuary engaged by a Trustee under the terms of the District of Columbia Retirement Protection Act of 1997, whose official duties require such disclosure, solely for the purpose of, and to the extent necessary in, determining an individual's eligibility for, or the correct amount of, benefits under the District of Columbia Retirement Protection Act of 1997.

''(B) DISCLOSURE FOR USE IN JUDICIAL OR ADMINISTRATIVE PROCEEDINGS.—Return information disclosed to any person under this paragraph may be disclosed in a judicial or administrative proceeding relating to the determination of an individual's eligibility for, or the correct amount of, benefits under the District of Columbia Retirement Protection Act of 1997.''.

(2) In section 6103(a)(3), by striking ''(6) or (12)'' and inserting ''(6), (12), or (16)'';

(3) In section 6103(i)(7)(B)(i), by inserting after ''(other than an agency referred to in subparagraph (A))'' and before the word ''for'' the words ''or by a Trustee as defined in the District of Columbia Retirement Protection Act of 1997,''.

(4) In section 6103(p)(3)(A), by striking ''or (15)'' and inserting ''(15), or (16)''.

(5) In section 6103(p)(4) in the matter preceding subparagraph (A), by striking ''or (12)'' and inserting ''(12), or (16), or any other person described in subsection (l)(16)''.

(6) In section 6103(p)(4)(F)(i), by striking ''or (9),'' and inserting ''(9), or (16), or any other person described in subsection (1)(16)''.

(7) In section 6103(p)(4)(F) in the matter following clause (iii)—

(A) by inserting after ''any such agency, body or commission'' and before the words ''for the General Accounting Office'' the words '', including an agency or any other person described in subsection (l)(16),'';

(B) by striking ''to such agency, body, or commission'' and inserting ''to such agency, body, or commission, including an agency or any other person described in subsection (l)(16),'';

(C) by striking ''or (12)(B)'' and inserting '', (12)(B), or (16)'';

(D) by inserting after the words ''any agent,'' and before the words ''this paragraph shall'' the words ''or any person including an agent described in subsection (l)(16),'';

(E) by inserting after the words ''such agent'' and before ''(except that'' the words ''or other person''; and

(F) by inserting after the words ''an agent,'' and before the words ''any report'' the words ''or any person including an agent described in subsection (l)(16),''.

(8) In section 7213(a)(2), by striking ''or (15),'' and inserting ''(15), or (16)''.

(c) CONFIDENTIALITY.—The Secretary may issue regulations governing the confidentiality of the information obtained pursuant to subsection (a) and the provisions of law amended by subsection (b).

## CHAPTER 4—DISTRICT OF COLUMBIA FEDERAL PENSION LIABILITY TRUST FUND

### SEC. 11031. CREATION OF TRUST FUND.

(a) ESTABLISHMENT.—There is established on the books of the Treasury the District of Columbia Federal Pension Liability Trust Fund, consisting of the assets transferred pursuant to section 11033 and any income earned on the investment of such assets pursuant to subsection (b).

(b) INVESTMENT OF ASSETS.—The Trustee may invest the assets of the Trust Fund in private securities and any other form of investment deemed appropriate by the Secretary.

### SEC. 11032. USES OF AMOUNTS IN TRUST FUND.

(a) IN GENERAL.—Amounts in the Trust Fund shall be used—

(1) to make Federal benefit payments under this subtitle;

(2) subject to subsection (b), to cover the reasonable and necessary expenses of administering the Trust Fund under the contract entered into pursuant to section 11035(b); and

(3) for such other purposes as are specified in this subtitle.

(b) SPECIAL RULES REGARDING ADMINISTRATIVE EXPENSES.—

(1) BUDGETING; CERTIFICATION AND APPROVAL.—The administrative expenses of the Trust Fund shall be paid in accordance with an annual budget set forth by the Trustee

which shall be subject to certification and approval by the Secretary.

(2) USE OF DISTRICT RETIREMENT FUND FOR INTERIM ADMINISTRATION.—The Secretary is authorized to requisition from the District Retirement Fund such sums as are necessary to administer the Trust Fund until assets are transferred to the Trust Fund pursuant to section 11033.

**SEC. 11033. TRANSFER OF ASSETS AND OBLIGATIONS OF DISTRICT RETIREMENT FUNDS.**

(a) IN GENERAL.—As of the replacement plan adoption date, all obligations to make Federal benefit payments and all assets of the District Retirement Fund as of the replacement plan adoption date (except as provided in subsections (b) and (c)) shall be transferred to the Trust Fund.

(b) DESIGNATION OF ASSETS TO BE RETAINED BY DISTRICT RETIREMENT FUND.—The Secretary shall designate assets with a value of $1.275 billion that shall not be transferred from the District Retirement Fund under subsection (a). The Secretary's designation and valuation of the assets shall be final and binding.

(c) EXCEPTION FOR CERTAIN EMPLOYEE CONTRIBUTIONS.—

(1) IN GENERAL.—Subsection (a) shall not apply to assets consisting of the District Retirement Fund consisting of any employee contributions deducted and withheld after the freeze date or any interest thereon (computed at a rate and in a manner determined by the Secretary).

(2) EMPLOYEE CONTRIBUTIONS DEFINED.—In paragraph (1), the term ''employee contributions'' means amounts deducted and withheld from the salaries of covered District employees and paid to the District Retirement Fund (and, in the case of teachers, amounts of additional deposits paid to the District Retirement Fund), pursuant to the District Retirement Program.

(d) RESPONSIBILITIES OF DISTRICT GOVERNMENT.—

(1) IN GENERAL.—The transfer of assets from the District Retirement Fund under this section shall be made in accordance with the direction of the Secretary. The District Government shall promptly take all steps, and execute all documents, that the Secretary deems necessary to effect the transfer.

(2) FINAL RECONCILIATION OF ACCOUNTS.—As soon as practicable after the replacement plan adoption date, the District Government shall furnish the Trustee a final reconciliation of accounts in connection with the transfer of assets and obligations to the Trust Fund. The allocation of assets under this section shall be adjusted in accordance with this reconciliation.

**SEC. 11034. TREATMENT OF TRUST FUND UNDER CERTAIN LAWS.**

(a) INTERNAL REVENUE CODE.—For purposes of the Internal Revenue Code of 1986—

(1) the Trust Fund shall be treated as a trust described in section 401(a) of the Code which is exempt from taxation under section 501(a) of the Code;

(2) any transfer to or distribution from the Trust Fund shall be treated in the same manner as a transfer to or distribution from a trust described in section 401(a) of the Code; and

(3) the benefits provided by the Trust Fund shall be treated as benefits provided under a governmental plan maintained by the District of Columbia.

(b) ERISA.—For purposes of the Employee Retirement Income Security Act of 1974, the benefits provided by the Trust Fund shall be treated as benefits provided under a governmental plan maintained by the District of Columbia.

(c) APPLICATION OF CERTAIN FUTURE AMENDMENTS TO INTERNAL REVENUE CODE.—To the extent that any provision of subpart A of part I of subchapter D of chapter 1 of the Internal Revenue Code of 1986 (26 U.S.C. 401 et seq.) is amended after the date of the enactment of this Act, such provision as amended shall apply to the Trust Fund only to the extent the Secretary determines that application of the provision as amended is consistent with the administration of this subtitle.

**SEC. 11035. ADMINISTRATION THROUGH TRUSTEE.**

(a) IN GENERAL.—As soon as practicable after the enactment of this subtitle, the Secretary shall select a Trustee to administer the Trust Fund and otherwise carry out the responsibilities and duties specified in this subtitle in accordance with the contract described in subsection (b).

(b) CONTRACT.—The Secretary shall enter into a contract with the Trustee to provide for the management, investment, control and auditing of Trust Fund assets, the making of Federal benefit payments under this subtitle from the Trust Fund, and such other matters as the Secretary deems appropriate. The Secretary shall enforce the provisions of the contract and otherwise monitor the administration of the Trust Fund.

(c) REPORTS.—The Trustee shall report to the Secretary, in a form and manner and at such intervals as the Secretary may prescribe, on any matters or transactions relating to the Trust Fund, including financial matters, as the Secretary may require.

## CHAPTER 5—RESPONSIBILITIES OF DISTRICT GOVERNMENT

**SEC. 11041. INTERIM ADMINISTRATION.**

(a) ADMINISTRATION OF BENEFITS UNTIL APPOINTMENT OF TRUSTEE.—Notwithstanding chapter 2, after the enactment of this subtitle the District Government shall continue to discharge its duties and responsibilities under the District Retirement Program and the District Retirement Fund (as such duties and responsibilities are modified by this subtitle), including the responsibility for Federal benefit payments, until such time as the Secretary notifies the District Government that the Secretary has directed the Trustee to carry out the duties and responsibilities required under the contract.

(b) REIMBURSEMENT FROM TRUST FUND.—The Trustee shall reimburse the District Government for any administrative expenses incurred by the District Government in carrying out subsection (a)—

(1) if the Trustee finds such expenses to be reasonable and necessary; and

(2) to the extent that the District Government is not reimbursed for such expenses from other sources.

(c) MAKING DISTRICT RETIREMENT FUND WHOLE.—The District Government shall reimburse the District Retirement Fund for any benefits paid inconsistent with this subtitle from the District Retirement Fund between the freeze date and the replacement plan adoption date.

**SEC. 11042. REPLACEMENT PLAN.**

(a) ADOPTION BY DISTRICT GOVERNMENT.—Not later than one year after the date of the enactment of this subtitle, the District Government shall adopt a replacement plan for pension benefits for covered District employees, effective as of the freeze date.

(b) REPLACEMENT PLAN IMPOSED IF DISTRICT GOVERNMENT FAILS TO ADOPT PLAN.—If the District Government fails to adopt a replacement plan within the period prescribed in subsection (a), the retirement program applicable to police, firefighters, and teachers under the laws of the District of Columbia in effect as of June 1, 1997 (except as otherwise amended by this Act), including all requirements of the program regarding benefits, contributions, and cost-of-living adjustments, shall be treated as the replacement plan for purposes of this subtitle.

(c) NO PAYMENT OF AMOUNTS PAID AS FEDERAL BENEFIT PAYMENT.—Notwithstanding any provision of the Reform Act or any other law, rule, or regulation, the District Government is not required to pay any amount under any replacement plan under this subtitle if the amount is paid as a Federal benefit payment under this subtitle.

## CHAPTER 6—FINANCING OF BENEFIT PAYMENTS AFTER DEPLETION OF TRUST FUND

**SEC. 11051. CREATION OF FEDERAL SUPPLEMENTAL FUND.**

(a) ESTABLISHMENT.—There is established on the books of the Treasury the Federal Supplemental District of Columbia Pension Fund, which shall be administered by the Secretary and shall consist of the following assets:

(1) Amounts deposited into such Fund under the provisions of this subtitle.

(2) Any amount otherwise appropriated to such Fund.

(3) Any income earned on the investment of the assets of such Fund pursuant to subsection (b).

(b) INVESTMENT OF ASSETS.—The Secretary shall invest such portion of the Federal Supplemental Fund as is not in the judgment of the Secretary required to meet current withdrawals. Such investments shall be in public debt securities with maturities suitable to the needs of the Federal Supplemental Fund, as determined by the Secretary, and bearing interest at rates determined by the Secretary, taking into consideration current market yields on outstanding marketable obligations of the United States of comparable maturities.

(c) RECORDKEEPING FOR ACTUARIAL STATUS.—The Secretary shall provide for the keeping of such records as are necessary for determining the actuarial status of the Federal Supplemental Fund.

**SEC. 11052. USES OF AMOUNTS IN FUND.**

Amounts in the Federal Supplemental Fund shall be used for the accumulation of funds in order to finance obligations of the Federal Government for benefits and necessary administrative expenses under the provisions of this subtitle, in accordance with the methodology selected by the Secretary under section 11054(b), except that payments from the Fund for administrative expenses may be made only the extent and in such amounts as are provided in advance in appropriations acts.

**SEC. 11053. DETERMINATION OF ANNUAL PAYMENT INTO FEDERAL SUPPLEMENTAL FUND.**

(a) IN GENERAL.—At the end of each applicable fiscal year the Secretary shall promptly pay into the Federal Supplemental Fund from the General Fund of the Treasury an amount equal to the sum of—

(1) the annual amortization amount for the year (which may not be less than zero); and

(2) the covered administrative expenses for the year.

(b) DETERMINATION OF AMOUNTS.—For purposes of this section:

(1) The ''original unfunded liability'' is the amount that is the present value as of the freeze date of future benefits payable from the Federal Supplemental Fund.

(2) The ''annual amortization amount'' is the amount determined by the enrolled actuary to be necessary to amortize in equal annual installments (until fully amortized)—

(A) the original unfunded liability over a 30-year period;

(B) a net experience gain or loss over a 10-year period; and

(C) any other changes in actuarial liability over a 20-year period.

(3) The ''covered administrative expenses'' are the expenses determined by the Secretary (on an annual basis) to be necessary

to administer the Federal Supplemental Fund.

(c) TIMING.—The first applicable fiscal year under subsection (a) is the first fiscal year that ends more than six months after the replacement plan adoption date.

**SEC. 11054. DETERMINATION OF METHODOLOGY FOR MAKING PAYMENTS.**

(a) NOTICE TO PRESIDENT AND CONGRESS.—Not later than 18 months before the time that assets remaining in the Trust Fund are projected to be insufficient for making Federal benefit payments and covering necessary administrative expenses when due, the Secretary shall so advise the President and the Congress.

(b) SELECTION OF METHODOLOGY.—Before all available assets of the Trust Fund have been depleted, the Secretary shall determine whether Federal benefit payments and necessary administrative expenses under this subtitle shall be made by one of the following methods:

(1) Continuation of the Trust Fund using payments from the Federal Supplemental Fund.

(2) Discontinuation of the Trust Fund, with payments made—

(A) by direct payment by the Secretary from the Federal Supplemental Fund; or

(B) from the Federal Supplemental Fund through another department or agency of the United States.

(c) ARRANGEMENTS BY SECRETARY.—The Secretary shall make appropriate arrangements to implement the determinations made in this subsection.

**SEC. 11055. SPECIAL REQUIREMENTS UPON DISCONTINUATION OF TRUST FUND.**

(a) SUCCESSOR TO TRUSTEE.—If the Secretary determines that the Trust Fund shall be discontinued after it has been depleted of assets, the Secretary shall appoint a successor to the Trustee to administer the requirements of this subtitle, with the same powers and subject to the same conditions as were applicable to the Trustee.

(b) CONTINUING APPLICATION OF TERMS AND CONDITIONS.—The methodology selected by the Secretary under section 11054(b), and the payment of benefits pursuant to such methodology, shall be subject to the same arrangements, terms, and conditions as were applicable under this subtitle to the Trust Fund and the benefits paid under the Trust Fund (including provisions relating to the treatment of the Trust Fund under certain laws).

## CHAPTER 7—REPORTS

**SEC. 11061. ANNUAL VALUATIONS AND REPORTS BY ENROLLED ACTUARY.**

(a) DETERMINATION OF ACTUARIAL VALUATIONS.—The Trustee shall engage an enrolled actuary (as defined in section 7701(a)(35) of the Internal Revenue Code of 1986) who is a member of the American Academy of Actuaries to perform an annual actuarial valuation (in a manner and form determined by the Secretary) of the Trust Fund and the Federal Supplemental Fund for obligations assumed by the Federal Government under this subtitle.

(b) ANNUAL REPORT ON STATUS OF FUNDS.—The enrolled actuary shall prepare and submit to the Secretary and the Trustee an annual report on the actuarial status of the Trust Fund and the Federal Supplemental Fund, and shall include in the report—

(1) a projection of when assets in the Trust Fund will be insufficient to pay benefits and necessary administrative expenses when due; and

(2) a determination of the annual payment to the Federal Supplemental Fund under section 11053.

**SEC. 11062. REPORTS BY COMPTROLLER GENERAL.**

(a) IN GENERAL.—The Comptroller General is authorized to conduct evaluations of the administration of this subtitle to ensure that the Trust Fund and Federal Supplemental Fund are being properly administered and shall report the findings of such evaluations to the Secretary and the Congress.

(b) ACCESS TO INFORMATION.—For the purpose of evaluations under subsection (a) the Comptroller General, subject to section 6103 of the Internal Revenue Code of 1986, shall have access to and the right to copy any books, accounts, records, correspondence or other pertinent documents that are in the possession of the Secretary or the Trustee, or any contractor or subcontractor of the Secretary or the Trustee.

## CHAPTER 8—JUDICIAL ENFORCEMENT

**SEC. 11071. JUDICIAL REVIEW.**

(a) IN GENERAL.—A civil action may be brought—

(1) by a participant or beneficiary to enforce or clarify rights to benefits from the Trust Fund or Federal Supplemental Fund under this subtitle;

(2) by the Trustee—

(A) to enforce any claim arising (in whole or in part) under this subtitle or the contract; or

(B) to recover benefits improperly paid from the Trust Fund or Federal Supplemental Fund or to clarify a participant's or beneficiary's rights to benefits from the Trust Fund or Federal Supplemental Fund; and

(3) by the Secretary to enforce any provision of this subtitle or the contract.

(b) TREATMENT OF TRUST FUND.—The Trust Fund may sue and be sued as an entity.

(c) EXCLUSIVE REMEDY.—This chapter shall be the exclusive means for bringing actions against the Trust Fund, the Trustee or the Secretary under this subtitle.

**SEC. 11072. JURISDICTION AND VENUE.**

(a) IN GENERAL.—The United States District Court for the District of Columbia shall have exclusive jurisdiction and venue, regardless of the amount in controversy, of—

(1) civil actions brought by participants or beneficiaries pursuant to this subtitle, and

(2) any other action otherwise arising (in whole or part) under this subtitle or the contract.

(b) REVIEW BY COURT OF APPEALS.—Notwithstanding any other provision of law, any order of the United States District Court for the District of Columbia issued pursuant to an action described in subsection (a) that concerns the validity or enforceability of any provision of this subtitle or seeks injunctive relief against the Secretary or Trustee under this subtitle shall be reviewable only pursuant to a notice of appeal to the United States Court of Appeals for the District of Columbia Circuit.

(c) REVIEW BY SUPREME COURT.—Notwithstanding any other provision of law, review by the Supreme Court of the United States of a decision of the Court of Appeals that is issued pursuant to subsection (b) may be had only if the petition for relief is filed within 20 calendar days after the entry of such decision.

(d) RESTRICTIONS ON DECLARATORY OR INJUNCTIVE RELIEF.—No order of any court granting declaratory or injunctive relief against the Secretary or the Trustee shall take effect during the pendency of the action before such court, during the time an appeal may be taken, or (if an appeal is taken or petition for certiorari filed) during the period before the court has entered its final order disposing of the action.

**SEC. 11073. STATUTE OF LIMITATIONS.**

(a) ACTION FOR BENEFITS.—Any civil action by an individual with respect to a Federal benefit payment under this subtitle shall be commenced within 180 days of a final benefit determination.

(b) ACTION FOR BREACH OF CONTRACT OR OTHER VIOLATIONS.—Except as provided in subsection (c), any civil action for breach of the contract or any other violation of this subtitle shall be commenced within the later of—

(1) six years after the last act that constituted the alleged breach or violation or, in the case of an omission, six years after the last date on which the alleged breach or violation could have been cured; or

(2) three years after the earliest date on which the plaintiff knew or could have reasonably been expected to have known of the act or omission on which the action is based.

(c) SPECIAL RULE FOR ACTIONS AGAINST SECRETARY.—Notwithstanding subsection (b), any action against the Secretary arising (in whole or part) under this subtitle or the contract shall be commenced within one year of the events giving rise to the cause of action.

**SEC. 11074. TREATMENT OF MISAPPROPRIATION OF FUND AMOUNTS AS FEDERAL CRIME.**

The provisions of section 664 of title 18, United States Code (relating to theft or embezzlement from employee benefit plans), shall apply to the Trust Fund and the Federal Supplemental Fund.

## CHAPTER 9—MISCELLANEOUS

**SEC. 11081. COORDINATION BETWEEN SECRETARY, TRUSTEE, AND DISTRICT GOVERNMENT.**

The Secretary, Trustee, and District Government shall carry out responsibilities under this subtitle and under the contract in a manner which promotes the cost-effective and efficient administration of benefit payments under the District Retirement Programs, and in a manner which avoids unnecessary interruptions and delays in paying individuals the full benefits to which they are entitled under such Programs.

**SEC. 11082. STUDY OF ALTERNATIVES FOR FINANCING FEDERAL OBLIGATIONS.**

(a) IN GENERAL.—As soon as practicable after the date of the enactment of this subtitle, the Secretary shall enter into a contract with an independent consultant to conduct a study of actuarial alternatives for financing the federal obligations assumed under this subtitle, together with an analysis of the impact of each alternative on the federal budget. The Secretary and the District Government shall cooperate with the consultant and shall provide direct access to such information systems, records, documents, information, or data as will enable the consultant to conduct the study.

(b) DEADLINE.—The contract entered into under subsection (a) shall require the consultant to report the results of the study not later than 12 months after the date of enactment of this Act.

(c) NO EFFECT ON FEDERAL OBLIGATIONS.—Nothing in this section may be construed to affect any obligation of the Federal Government to make payments under this subtitle.

**SEC. 11083. ISSUANCE OF REGULATIONS BY SECRETARY.**

The Secretary is authorized to issue regulations to implement, interpret, administer and carry out the purposes of this subtitle, and, in the Secretary's discretion, those regulations may have retroactive effect.

**SEC. 11084. EFFECT ON REFORM ACT AND OTHER LAWS.**

(a) REFORM ACT.—

(1) IN GENERAL.—This subtitle supersedes any provision of the Reform Act inconsistent with this subtitle and the regulations thereunder.

(2) TERMINATION OF PAYMENTS TO DISTRICT RETIREMENT FUNDS.—Section 144 of the Reform Act (DC Code, sec. 1–724) is amended by adding at the end the following new subsection:

''(f) Notwithstanding any other provision of this Act, no Federal payments may be made to any Fund established by this title for any fiscal year after fiscal year 1997.''.

(b) NO EFFECT ON TAX TREATMENT OF BENEFITS.—Except as otherwise specifically provided, nothing in this subtitle may be construed to affect the application of any provision of the Internal Revenue Code of 1986 to any annuity or other benefit provided to or on behalf of any individual, including any disability benefit or any portion of a retirement benefit attributable to an individual's disability status.

(c) NO EFFECT ON BENEFITS FOR PARK POLICE AND SECRET SERVICE.—Nothing in this subtitle shall be deemed to alter or amend in any way the provisions of existing law (including the Reform Act) relating to the program of annuities, other retirement benefits, or medical benefits for members and officers, retired members and officers, and survivors thereof, of the United States Park Police force, the United States Secret Service, or the United States Secret Service Uniformed Division.

**SEC. 11085. REFERENCE TO NEW FEDERAL PROGRAM FOR RETIREMENT OF JUDGES OF DISTRICT OF COLUMBIA COURTS.**

For provisions describing the retirement program for judges and judicial personnel of the District of Columbia, see subchapter B of chapter 4 of subtitle C.

**SEC. 11086. FULL FAITH AND CREDIT.**

Federal obligations for benefits under this subtitle are backed by the full faith and credit of the United States.

**SEC. 11087. SEVERABILITY OF PROVISIONS.**

If any provision of this subtitle, or the application of such provision to any person or circumstances, shall be held invalid, the remainder of this subtitle, or the application of such provision to persons or circumstances other than those as to which it is held invalid, shall not be affected thereby.

**Subtitle B—Management Reform Plans**

**SEC. 11101. SHORT TITLE.**

This subtitle may be cited as the ''District of Columbia Management Reform Act of 1997''.

**SEC. 11102. MANAGEMENT REFORM PLANS FOR DISTRICT GOVERNMENT.**

(a) IN GENERAL.—In accordance with the provisions of this subtitle, the District of Columbia Financial Responsibility and Management Assistance Authority (hereafter in this subtitle referred to as the ''Authority'') and the government of the District of Columbia shall develop and implement management reform plans—

(1) for each of the departments of the government of the District of Columbia described in paragraph (1) of subsection (b); and

(2) for all entities of the government of the District of Columbia with respect to the items described in paragraph (2) of subsection (b).

(b) DEPARTMENTS AND ITEMS SUBJECT TO PLANS.—

(1) DEPARTMENTS DESCRIBED.—The departments referred to in this paragraph are as follows:

(A) The Department of Administrative Services.

(B) The Department of Consumer and Regulatory Affairs.

(C) The Department of Corrections.

(D) The Department of Employment Services.

(E) The Department of Fire and Emergency Medical Services.

(F) The Department of Housing and Community Development.

(G) The Department of Human Services.

(H) The Department of Public Works.

(I) The Public Health Department.

(2) ITEMS DESCRIBED.—The items referred to in this paragraph are as follows:

(A) Asset management.

(B) Information resources management.

(C) Personnel.

(D) Procurement.

**SEC. 11103. PROCEDURES FOR DEVELOPMENT OF PLANS.**

(a) CONTRACTS WITH CONSULTANTS.—Not later than 30 days after the date of the enactment of this Act (or, at the option of the Authority and upon notification to Congress, not later than 60 days after such date), the Authority shall enter into contracts with consultants to develop the management reform plans under this subtitle.

(b) DEADLINE FOR SUBMISSION OF PLANS.—Under a contract entered into with the Authority under subsection (a), a consultant shall submit a completed management reform plan for the department or item involved within 90 days (or, at the option of the Authority, within 120 days).

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Authority such sums as may be necessary to carry out the contracts entered into under this section.

**SEC. 11104. IMPLEMENTATION OF PLANS.**

(a) ESTABLISHMENT OF MANAGEMENT REFORM TEAMS.—With respect to each management reform plan developed under this subtitle, there shall be a management reform team consisting of the following:

(1) The Chair of the Authority (or the Chair's designee).

(2) The Chair of the Council of the District of Columbia (or the Chair's designee).

(3) The Mayor of the District of Columbia (or the Mayor's designee).

(4) In the case of a management reform plan for a department of the government of the District of Columbia, the head of the department involved.

(b) RESPONSIBILITY FOR IMPLEMENTATION OF PLANS.—

(1) PLANS FOR SPECIFIC DEPARTMENTS.—In the case of a management reform plan for a department of the government of the District of Columbia, the head of the department involved shall take any and all steps within his or her authority to implement the terms of the plan, in consultation and coordination with the other members of the management reform team.

(2) PLANS FOR ITEMS COVERING ENTIRE DISTRICT GOVERNMENT.—In the case of a management reform plan for an item described in section 11102(b)(2), each member of the management reform team shall take any and all steps within the member's authority to implement the terms of the plan, under the direction and subject to the instructions of the Chair of the Authority (or the Chair's designee).

(3) REPORT TO AUTHORITY.—In carrying out any of the management reform plans under this section, the member of the management reform team described in subsection (a)(4) shall report to the Authority.

**SEC. 11105. REFORM OF POWERS AND DUTIES OF DEPARTMENT HEADS.**

(a) APPOINTMENT AND REMOVAL.—

(1) APPOINTMENT.—

(A) IN GENERAL.—During a control year, the head of each department of the government of the District of Columbia described in section 11102(b)(1) shall be appointed by the Mayor as follows:

(i) Prior to appointment, the Authority may submit recommendations for the appointment to the Mayor.

(ii) In consultation with the Authority and the Council, the Mayor shall nominate an individual for appointment and notify the Council of the nomination.

(iii) After the expiration of the 7-day period which begins on the date the Mayor notifies the Council of the nomination under clause (ii), the Mayor shall notify the Authority of the nomination.

(iv) The nomination shall be effective subject to approval by a majority vote of the Authority.

(B) APPOINTMENT BY AUTHORITY IF NO NOMINATION MADE WITHIN 30 DAYS.—During a control year, if the Mayor fails to nominate an individual to fill a vacancy in the position of the head of any of the departments described in section 11102(b)(1) during the 30-day period which begins on the date the vacancy begins (or during such longer period as the Authority may establish, upon notification to Congress), the Authority shall appoint an individual to fill the vacancy.

(C) POSITIONS DEEMED VACANT UPON ENACTMENT.—For purposes of this paragraph, a vacancy shall be deemed to exist in the position of the head of each of the departments described in section 11102(b)(1) upon the date of the enactment of this Act. Nothing in this subparagraph shall be deemed to affect any of the powers and duties of any individual serving as the head of such a department as of such date.

(2) REMOVAL.—During a control year, the head of any of the departments of the government of the District of Columbia described in section 11102(b)(1) may be removed by the Authority or by the Mayor with the approval of the Authority.

(3) CONTROL YEAR DEFINED.—In this subsection, the term ''control year'' has the meaning given such term in section 305(4) of the District of Columbia Financial Responsibility and Management Assistance Act of 1995.

(b) CONTROL OVER PERSONNEL.—

(1) IN GENERAL.—Notwithstanding any other provision of law and except as provided in paragraph (3), all personnel of the departments of the government of the District of Columbia described in section 11102(b)(1) shall be appointed by and shall act under the direction and control of the head of the department involved.

(2) REASSIGNMENT OF PERSONNEL.—The head of each of the departments described in section 11102(b)(1) may reassign any personnel of the department in such manner as the head considers appropriate.

(3) REQUIREMENTS FOR ADVERSE ACTIONS.—The head of each of the departments described in section 11102(b)(1) may take corrective or adverse action against any personnel of the department pursuant to rules (promulgated consistent with the publication and comment provisions of the District of Columbia Administrative Procedure Act) which—

(A) provide that adverse actions may only be taken for cause;

(B) define the causes for which a corrective or adverse action may be taken;

(C) require prior written notice of the grounds on which the action is proposed to be taken;

(D) require an opportunity to be heard (which may be in writing only) before the action becomes effective, unless the head of the department finds that taking action prior to the exercise of such opportunity is necessary to protect the integrity of government operations, in which case a hearing shall be afforded within a reasonable time after the action becomes effective; and

(E) provide that the head of the department shall be the final administrative authority with respect to the action, subject to judicial review of the record of the administrative proceeding in an action against the District of Columbia to be brought only in the Superior Court for the District of Columbia.

**SEC. 11106. NO EFFECT ON POWERS OF FINANCIAL RESPONSIBILITY AND MANAGEMENT ASSISTANCE AUTHORITY.**

Nothing in this subtitle may be construed to affect the authority of the District of Columbia Financial Responsibility and Man-

agement Assistance Authority to carry out any of its powers under the District of Columbia Financial Responsibility and Management Assistance Act of 1995.

**Subtitle C—Criminal Justice**

**CHAPTER 1—CORRECTIONS**

**SEC. 11201. BUREAU OF PRISONS.**

(a) FELONS SENTENCED PURSUANT TO THE TRUTH-IN-SENTENCING REQUIREMENTS.—Not later than October 1, 2001, any person who has been sentenced to incarceration pursuant to the District of Columbia Code or the truth-in-sentencing system as described in section 11211 shall be designated by the Bureau of Prisons to a penal or correctional facility operated or contracted for by the Bureau of Prisons, for such term of imprisonment as the court may direct. Such persons shall be subject to any law or regulation applicable to persons committed for violations of laws of the United States consistent with the sentence imposed.

(b) FELONS SENTENCED PURSUANT TO THE D.C. CODE.—Notwithstanding any other provision of law, not later than December 31, 2001, the Lorton Correctional Complex shall be closed and the felony population sentenced pursuant to the District of Columbia Code residing at the Lorton Correctional Complex shall be transferred to a penal or correctional facility operated or contracted for by the Bureau of Prisons. Such persons shall be subject to any law or regulation applicable to persons committed for violations of laws of the United States consistent with the sentence imposed, and the Bureau of Prisons shall be responsible for the custody, care, subsistence, education, treatment and training of such persons.

(c) PRIVATIZATION.—

(1) TRANSITION OF INMATES FROM LORTON.—The Bureau of Prisons shall house, in private contract facilities—

(A) at least 2000 District of Columbia sentenced felons by December 31, 1999; and

(B) at least 50 percent of the District of Columbia sentenced felony population by September 30, 2003.

(2) DUTIES OF DEPUTY ATTORNEY GENERAL.—The Deputy Attorney General shall—

(A) be responsible for overseeing Bureau of Prisons privatization activities; and

(B) submit a report to Congress on October 1 of each year detailing the progress and status of compliance with privatization requirements.

(3) DUTIES OF ATTORNEY GENERAL.—The Attorney General shall—

(A) conduct a study of correctional privatization, including a review of relevant research and related legal issues, and comparative analysis of the cost effectiveness and feasibility of private sector and Federal, State, and local governmental operation of prisons and corrections programs at all security levels; and

(B) submit a report to Congress no later than one year after the date of enactment of this Act.

(d) SITE ACQUISITION AND CONSTRUCTION.—In order to house the District of Columbia felony inmate population the Bureau of Prisons shall acquire land, construct and build new facilities at sites selected by the Bureau of Prisons, or contract for appropriate bed space, but no facilities may be built on the grounds of the Lorton Reservation.

(e) NATIONAL CAPITAL PLANNING.—Notwithstanding any other provision of law, the requirements of the National Capital Planning Act of 1952 (40 U.S.C. 71 et seq.) shall not apply to any actions taken by the Bureau of Prisons or its agents or employees.

(f) DEPARTMENT OF CORRECTIONS AUTHORITY.—The District of Columbia Department of Corrections shall remain responsible for the custody, care, subsistence, education, treatment, and training of any person convicted of a felony offense pursuant to the District of Columbia Code and housed at the Lorton Correctional Complex until December 31, 2001, or the date on which the last inmate housed at the Lorton Correctional Complex is designated by the Bureau of Prisons, whichever is earlier.

(g) LORTON CORRECTIONAL COMPLEX.—

(1) TRANSFER OF FUNCTIONS.—Notwithstanding any other provision of law, to the extent the Bureau of Prisons assumes functions of the Department of Corrections under this subtitle, the Department is no longer responsible for such functions and the provisions of ''An Act to create a Department of Corrections in the District of Columbia'', approved June 27, 1946 (D.C. Code 24–441, 442), that apply with respect to such functions are no longer applicable. Except as provided in paragraph (2), any property on which the Lorton Correctional Complex is located shall be transferred to the Department of the Interior.

(2) TRANSFER OF LAND.—

(A) IN GENERAL.—

(i) FAIRFAX COUNTY WATER AUTHORITY.—150 acres of parcel 106–4–001–54 located west of Ox Road (State Route 123) on which the Lorton Correctional Complex is located shall be transferred, without consideration, to the Fairfax County Water Authority of Fairfax, Virginia.

(ii) FAIRFAX COUNTY DEPARTMENT OF PARKS AND RECREATION.—Any acres of parcel 106–4–001–54 located west of Ox Road (State Route 123) on which the Lorton Correctional Complex is located not transferred under clause (i) shall be assigned to the Department of the Interior, National Park Service, for conveyance to the Fairfax County Department of Parks and Recreation for recreational purposes pursuant to the section 203(k)(2) of the Federal Property and Administrative Services Act of 1949 (40 U.S.C. 484(k)(2)).

(B) CONDITION OF TRANSFER.—

(i) WATER SERVICES.—The United States Government shall not transfer any parcels under this paragraph unless the Fairfax County Water Authority certifies that it will continue to provide water services to the Lorton Correctional Complex at the rate it provided water services prior to the transfer.

(ii) RESTRICTION ON TRANSFER.—No Federal agency may transfer the property under this paragraph until the prospective recipient of the property provides to such agency—

(I) a land description survey suitable for transferring property under Virginia law; and

(II) any necessary surveys to determine the presence of any hazardous substances, contaminants or pollutants.

(iii) LORTON CORRECTIONAL COMPLEX.—The Lorton Correctional Complex shall remain available for the District of Columbia Department of Corrections to house District of Columbia felony inmates until the last inmate at the Complex has been designated by the Bureau of Prisons or until December 31, 2003, whichever is earlier.

(C) AUTHORIZATION.—The General Services Administration and the National Park Service is authorized to expend any funds necessary to ensure that the transfer or conveyance under subparagraph (A) complies with all applicable environmental and historic preservation laws.

(3) WATER MAINS.—Any water mains located on or across the Lorton Correctional Complex on the date of the transfers under paragraph (2), that are owned by the Fairfax County Water Authority and provide water to the public, shall be permitted to remain in place, and shall be operated, maintained, repaired, and replaced by the Fairfax County Water Authority or a successor agency furnishing water to the public in Fairfax County or adjacent jurisdictions, but shall not interfere with operations of the Lorton Correctional Complex.

(g) DISTRICT OF COLUMBIA CORRECTIONS INFORMATION COUNCIL.—

(1) ESTABLISHMENT.—There is established a council to be known as the District of Columbia Correction Information Council (hereafter referred to as ''Council'').

(2) MEMBERSHIP.—The Council shall be composed of 3 members appointed as follows:

(A) 2 individuals appointed by the mayor of the District of Columbia.

(B) 1 individual appointed by the Council of the District of Columbia.

(3) COMPENSATION.—Members of the Council may not receive pay, allowances, or benefits by reason of their service on the Council.

(4) DUTIES.—The Council shall report to the Director of the Bureau of Prisons with advice and information regarding matters affecting the District of Columbia sentenced felon population.

(h) TIMING OF INMATE TRANSFERS.—As soon as practicable after the date of the enactment of this Act, the Director of the Bureau of Prisons shall begin the transferring of inmates to Bureau of Prison or private contract facilities required by this section.

**SEC. 11202. CORRECTIONS TRUSTEE.**

(a) APPOINTMENT AND REMOVAL OF TRUSTEE.—

(1) APPOINTMENT.—Pursuant to the Federal Government's assumption of responsibility for persons convicted of a felony offense under the District of Columbia Code, the Attorney General, in consultation with the Chairman of the District of Columbia Financial Responsibility and Management Assistance Authority (hereafter in this chapter referred to as the ''D.C. Control Board''), the Mayor of the District of Columbia, the District of Columbia Council, and the District of Columbia judiciary, shall select a Corrections Trustee, who shall be an independent officer of the government of the District of Columbia, to oversee financial operations of the District of Columbia Department of Corrections until the Bureau of Prisons has designated all felony offenders sentenced under the District of Columbia Code to a penal or correctional facility operated or contracted for by the Bureau of Prisons under section 11201.

(2) REMOVAL.—The Corrections Trustee may be removed by the Mayor with the concurrence of the Attorney General. The Attorney General shall have the authority to remove the Corrections Trustee for misfeasance or malfeasance in office. At the request of the Corrections Trustee, the District of Columbia Financial Responsibility and Management Assistance Authority may exercise any of its powers and authorities on behalf of the Corrections Trustee.

(b) DUTIES OF TRUSTEE.—Beginning on the date of appointment and continuing until the felony population sentenced pursuant to the District of Columbia Code residing at the Lorton Correctional Complex is transferred to a penal or correctional facility operated or contracted for by the Bureau of Prisons, the Corrections Trustee shall carry out the following responsibilities (notwithstanding any law of the District of Columbia to the contrary):

(1) Exercise financial oversight over the District of Columbia Department of Corrections and allocate funds as enacted in law or as otherwise allocated, including funds for short term improvements which are necessary for the safety and security of staff, inmates and the community.

(2) Purchase any necessary goods or services on behalf of the District of Columbia Department of Corrections consistent with Federal procurement regulations as they apply to the Bureau of Prisons.

(c) FUNDING.—

(1) IN GENERAL.—Funds available for the Corrections Trustee, staff and all necessary and appropriate operations shall be made available to the extent provided in appropriations acts to the Corrections Trustee. Funding requests shall be proposed by the Corrections Trustee to the President and Congress for each Fiscal Year.

(2) REIMBURSEMENT TO BUREAU OF PRISONS.—Upon receipt of Federal funds, the Corrections Trustee shall immediately provide an advance reimbursement to the Bureau of Prisons of all funds identified by the Congress for construction of new prisons and major renovations, which shall remain available until expended. The Bureau of Prisons shall be responsible and accountable for determining how these funds shall be used for renovation and construction, including type, security level, and location of new facilities.

(3) ACCOUNTABILITY AND REPORTS.—The District of Columbia Department of Corrections and the Bureau of Prisons shall maintain accountability for funds reimbursed from the Corrections Trustee, and shall provide expense reports by project at the request of the Corrections Trustee.

(d) COMPENSATION AND DETAILEES.—The Corrections Trustee shall be compensated at a rate not to exceed the basic pay payable for Level IV of the Executive Schedule. The Corrections Trustee may appoint and fix the pay of additional staff without regard to the provisions of the District of Columbia Code governing appointments and salaries, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and without regard to the provisions of chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification and General Schedule pay rates. Upon request of the Corrections Trustee, the head of any Federal department or agency may, on a reimbursable or non reimbursable basis, provide services and detail any personnel of that department or agency to the Corrections Trustee to assist in carrying out his duties.

(e) PROCUREMENT AND JUDICIAL REVIEW.—The provisions of the District of Columbia Code governing procurement shall not apply to the Corrections Trustee. The Corrections Trustee may seek judicial enforcement of his authority to carry out his duties.

(f) PRESERVATION OF RETIREMENT AND CERTAIN OTHER RIGHTS OF FEDERAL EMPLOYEES WHO BECOME EMPLOYED BY THE CORRECTIONS TRUSTEE.—

(1) IN GENERAL.—A Federal employee who, within 3 days after separating from the Federal Government, is appointed Corrections Trustee or becomes employed by the Corrections Trustee—

(A) shall be treated as an employee of the Federal Government for purposes of chapters 83, 84, 87, and 89 of title 5 of the United States Code; and

(B) if, after serving with the Trustee, such employee becomes reemployed by the Federal Government, shall be entitled to credit for the full period of such individual's service with the Trustee, for purposes of determining the applicable leave accrual rate.

(2) REGULATIONS.—The Office of Personnel Management shall prescribe such regulations as may be necessary to carry out this subsection.

**SEC. 11203. PRIORITY CONSIDERATION FOR EMPLOYEES OF THE DISTRICT OF COLUMBIA.**

(a) ESTABLISHMENT.—As soon as practicable after appointment, the Bureau of Prisons, working with the Corrections Trustee, shall establish a priority consideration program to facilitate employment placement for employees of the District of Columbia Department of Corrections who are scheduled to be separated from service as a result of closing the Lorton Correctional Complex.

(b) PROVISIONS.—The priority consideration program shall include provisions under which a vacant federal correctional institution position established as a result of this Act and identified for external hiring shall not be filled by the appointment of any individual from outside of the District of Columbia Department of Corrections if there is available any interested applicant within the District of Columbia Department of Corrections who meets all qualification and suitability requirements for Bureau of Prisons law enforcement positions, including those related to criminal history, educational experience and level of functions, drug use, and work-related misconduct. The priority consideration program shall also include provisions under which an employee described in subsection (a) who does not meet the qualification and suitability requirements for Bureau of Prisons law enforcement positions shall receive priority consideration for other Federal positions, and any such employee who is found to be well qualified for such a position may be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service. Such program shall terminate one year after the closing of the Lorton Correctional Complex.

**SEC. 11204. AMENDMENTS RELATED TO PERSONS WITH A MENTAL DISEASE OR DEFECT.**

Title 18, United States Code, is amended as follows:

(1) Section 4246 is amended—

(A) in subsection (a) by inserting ''in the custody of the Bureau of Prisons'' after ''certifies that a person''; and

(B) by adding at the end the following new subsection:

''(h) DEFINITION.—As used in this chapter the term ''State'' includes the District of Columbia.''.

(2) Section 4247(a) is amended—

(A) in paragraph (1)(D) by striking ''and'' after the semi-colon;

(B) in paragraph (2) by striking the period and inserting ''; and''; and

(C) by adding at the end the following new paragraph:

''(3) 'State' includes the District of Columbia.''.

(3) Section 4247(j) of title 18, United States Code, is amended by striking ''This chapter does'' and inserting ''Sections 4241, 4242, 4243, and 4244 do'.

**SEC. 11205. LIABILITY FOR AND LITIGATION AUTHORITY OF CORRECTIONS TRUSTEE.**

(a) LIABILITY.—The District of Columbia shall defend any civil action or proceeding brought in any court or other official Federal, state, or municipal forum against the Corrections Trustee, or against the District of Columbia or it officers, employees, or agents, and shall assume any liability resulting from such an action or proceeding, if the action or proceeding arises from—

(1) an inmate's confinement with the District of Columbia Department of Corrections;

(2) the District of Columbia's operation or management of the buildings, facilities, or lands comprising the Lorton property; or

(3) the District of Columbia's operations or activities occurring on any property not specifically transferred to the administrative control of the Federal Government pursuant to this Act.

(b) LITIGATION.—

(1) CORPORATION COUNSEL.—Subject to paragraph (2), the Corporation Counsel of the District of Columbia shall provide litigation services to the Corrections Trustee, except that the Trustee may instead elect, either generally or in relation to particular cases or classes of cases, to hire necessary staff and personnel or enter into contracts for the provision of litigation services at the Trustee's expense.

(2) ATTORNEY GENERAL.—

(A) IN GENERAL.—Notwithstanding paragraph (1), with respect to any litigation involving the Corrections Trustee, the Attorney General may—

(i) direct the litigation of the Trustee, and of the District of Columbia on behalf of the Trustee; and

(ii) provide on a reimbursable or non-reimbursable basis litigation services for the Trustee at the Trustee's request or on the Attorney General's own initiative.

(B) APPROVAL OF SETTLEMENT.—With respect to any litigation involving the Corrections Trustee, the Trustee may not agree to any settlement involving any form of equitable relief without the approval of the Attorney General. The Trustee shall provide to the Attorney General such notice and reports concerning litigation as the Attorney General may direct.

(C) DISCRETION.—Any decision to exercise any authority of the Attorney General under this subsection shall be in the sole discretion of the Attorney General and shall not be reviewable in any court.

(c) LIMITATIONS.—Nothing in this section shall be construed—

(1) as a waiver of sovereign immunity, or as limiting any other defense or immunity that would otherwise be available to the United States, the District of Columbia, their agencies, officers, employees, or agents; or

(2) to obligate the District of Columbia to represent or indemnify the Corrections Trustee or any officer, employee, or agent where the Trustee (or any person employed by or acting under the authority of the Trustee) acts beyond the scope of his authority.

**SEC. 11206. PERMITTING EXPENDITURE OF FUNDS TO CARRY OUT CERTAIN SEWER AGREEMENT.**

Notwithstanding the fourth sentence of section 446 of the District of Columbia Self-Government and Governmental Reorganization Act, the District of Columbia is authorized to obligate or expend such funds as may be necessary during a fiscal year (beginning with fiscal year 1997) to carry out the Sewage Delivery System and Capacity Purchase Agreement between Fairfax County and the District of Columbia with respect to Project Number K00301, without regard to the amount appropriated for such purpose in the budget of the District of Columbia for the fiscal year.

## CHAPTER 2—SENTENCING

**SEC. 11211. TRUTH IN SENTENCING COMMISSION.**

(a) ESTABLISHMENT.—There is established as an independent agency of the District of Columbia a District of Columbia Truth in Sentencing Commission (hereafter in this chapter referred to as ''the Commission''), which shall consist of 7 voting members. The Attorney General, or the Attorney General's designee, shall be the chairperson of the Commission and shall have the duty to convene meetings of the Commission to ensure that it fulfills its responsibilities under this Act. The members shall serve for the life of the Commission and shall be subject to removal only for neglect of duty, malfeasance in office, or other good cause shown.

(b) MEMBERSHIP.—The members of the Commission shall have knowledge and responsibility with respect to criminal justice matters. Two members of the Commission shall be judges of the Superior Court of the District of Columbia, and shall be appointed by the chief judge of that court; one member shall be a representative of the District of Columbia Council and shall be appointed by the chairperson or chairperson pro temp of the Council; one member shall be a rep-

resentative of the executive branch of the District of Columbia government with official responsibilities for criminal justice matters in the District of Columbia and shall be appointed by the Mayor of the District of Columbia; one member shall be a representative of the District of Columbia Public Defender Service and shall be appointed by the Director of such Service; and one member shall be a representative of the United States Attorney for the District of Columbia and shall be appointed by the United States Attorney. A representative of the Federal Bureau of Prisons and a representative of the office of Corporation Counsel of the District of Columbia shall each serve as a non-voting, ex officio member.

(c) VACANCY.—Any vacancy in the Commission shall be filled in the same manner as the original appointment. Members of the Commission shall receive no compensation for their services, but shall be reimbursed for travel, subsistence, and other necessary expenses incurred in the performance of duties vested in the Commission, but not in excess of the maximum amounts authorized under section 456 of title 28, United States Code.

**SEC. 11212. GENERAL DUTIES, POWERS, AND GOALS OF COMMISSION.**

(a) RECOMMENDATIONS.—The Commission shall, within 180 days after the enactment of this Act, make recommendations to the District of Columbia Council for amendments to the District of Columbia Code with respect to the sentences to be imposed for all felonies committed on or after 3 years after the date of enactment of this Act.

(b) CONTENTS OF RECOMMENDATIONS.—Such recommendations shall—

(1) as to all felonies described in paragraph (h), meet the truth in sentencing standards of 20104(a)(1) of the Violent Crime Control and Law Enforcement Act of 1994;

(2) as to all felonies ensure that—

(A) an offender will have a sentence imposed that—

(i) reflects the seriousness of the offense and the criminal history of the offender; and

(ii) provides for just punishment, affords adequate deterrence to potential future criminal conduct of the offender and others, and provides the offender with needed educational or vocational training, medical care, and other correctional treatment;

(B) good time shall be calculated pursuant to section 3624 of title 18, United States Code; and

(C) an adequate period of supervision will be imposed to follow release from the imprisonment.

(c) DEATH PENALTY.—The Commission shall not have the power to recommend a sentence of death for any offense nor for any offense a term of imprisonment less than that prescribed by the D.C. Code as a mandatory minimum sentence.

(d) OTHER FEATURES OF RECOMMENDATIONS.—The Commission shall ensure that its recommendations—

(1) will be neutral as to the race, sex, marital status, ethnic origin, religious affiliation, national origin, creed, socioeconomic status, and sexual orientation of offenders;

(2) will include provisions designed to maximize the effectiveness of the drug court of the Superior Court of the District of Columbia; and

(3) will be fully consistent with all other provisions of this Act, including provisions relating to the administration of probation, parole, and supervised release for District of Columbia Code offenders.

(e) VOTE; TERMINATION.—The recommendations of the Commission required under subsections (a)–(d) shall be adopted by a vote of not less than 6 of the members and when made shall be transmitted forthwith to the District of Columbia Council. The Commission shall cease to exist 90 days after the transmittal of recommendations to the Council or on the last date on which timely recommendations may be made if the Commission is unable to agree on such recommendations.

(f) RECOMMENDATIONS FOR IMPLEMENTATION.—In fulfilling its responsibilities, the Commission may adopt by a vote of not less than 6 of the members and transmit to the Superior Court of the District of Columbia recommended rules and principles for determining the sentence to be imposed, including—

(1) whether to impose a sentence of probation, a term of imprisonment and/or a fine, and the amount or length thereof, and including intermediate sanctions in appropriate cases; and

(2) whether multiple sentences of terms of imprisonment should run concurrently or consecutively.

(g) POWERS.—The Commission is authorized—

(1) to hold hearings and call witnesses that might assist the Commission in the exercise of its powers;

(2) to perform such other functions as may be necessary to carry out the purposes of this section; and

(3) except as otherwise provided, to conduct business, exercise powers, and fulfill duties by the vote of a majority of the members present at any meeting.

(h) FELONIES DESCRIBED.—The felonies described in this subsection are violations of any of the following provisions of law:

(1) The following provisions relating to arson:

(A) Section 820 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–401).

(B) Section 821 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–402).

(2) The following provisions relating to felony assault:

(A) Section 803 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–501).

(B) Section 804 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–502).

(C) Section 805 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–503).

(D) Section 806a of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–504.1).

(E) Section 432 of the Revised Statutes, relating to the District of Columbia (DC Code, sec. 22–505).

(F) Section 807 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–506).

(3) Section 502 of the District of Columbia Theft and White Collar Crimes Act of 1982 (DC Code, sec. 22–722) (relating to obstruction of justice).

(4) Section 3 of the Act of February 13, 1885 (chapter 58; 23 Stat. 303) (DC Code, sec. 22–901) (relating to cruelty to children).

(5) Section 823 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–1801) (relating to first degree burglary).

(6) Section 812 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–2101) (relating to kidnapping).

(7) The following provisions relating to murder and manslaughter:

(A) Section 798 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–2401).

(B) Section 799 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–2402).

(C) Section 800 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–2403).

(D) Section 801 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–2404).

(E) Section 802 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–2405).

(F) Section 802a of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22-2406).

(8) Section 8 of the Act of July 15, 1932 (chapter 492; 47 Stat. 698) (DC Code, sec. 22–2601) (relating to prison breach).

(9) The Act entitled ''An Act to prohibit the introduction of contraband into the District of Columbia penal institutions,'' approved December 15, 1941 (DC Code, sec. 22–2603).

(10) Section 810 of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–2901) (relating to robbery).

(11) Section 811a of the Act entitled ''An Act to establish a code of law for the District of Columbia,'' approved March 3, 1901 (DC Code, sec. 22–2903) (relating to carjacking).

(12) The Dangerous Weapons Act (DC Code, sec. 22-3201 et seq.).

(13) The following provisions relating to sex offenses:

(A) Section 201 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4102).

(B) Section 202 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4103).

(C) Section 203 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4104).

(D) Section 204 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4105).

(E) Section 207 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4108).

(F) Section 208 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4109).

(G) Section 209 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4110).

(H) Section 212 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4113).

(I) Section 213 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4114).

(J) Section 214 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4115).

(K) Section 215 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4116).

(L) Section 217 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4118).

(M) Section 219 of the Anti-Sexual Abuse Act of 1994 (DC Code, sec. 22–4120).

(14) Section 401 of the District of Columbia Uniform Controlled Substances Act of 1981 (D.C. Code, sec. 33-541) (relating to recidivist drug offenders), but only in the case of a second or subsequent violation.

**SEC. 11213. DATA COLLECTION.**

(a) DATA FOR ATTORNEY GENERAL.—The Commission, the Superior Court of the District of Columbia, the District of Columbia Department of Corrections, and other agencies as necessary shall provide to the Attorney General such data as are requested in furtherance of this Act.

(b) SUPERIOR COURT.—The Superior Court of the District of Columbia, in connection with defendants sentenced in such Court,

shall provide to the Commission and the Attorney General such data as are requested for planning, statistical analysis or projecting future prison population levels.

**SEC. 11214. ENACTMENT OF AMENDMENTS TO DISTRICT OF COLUMBIA CODE.**

If, within 270 days after the date of the enactment of this Act, the Council of the District of Columbia has failed to amend the District of Columbia Code to enact in whole the recommendations of the Commission under this chapter, or if the Commission fails to make such recommendations within the deadline established under such section, the Attorney General (after consultation with the Commission) shall promulgate within 90 days amendments to the District of Columbia Code with respect to the sentences to be imposed for all offenses committed on or after 3 years after the date of the enactment of this Act. Such amendments shall be consistent with the standards of subsections (a) through (d) of section 11212. Such amendments shall take effect 30 days after the Attorney General transmits the recommendations to Congress.

**CHAPTER 3—OFFENDER SUPERVISION AND PAROLE**

**SEC. 11231. PAROLE.**

(a) PAROLING JURISDICTION.—

(1) JURISDICTION OF PAROLE COMMISSION TO GRANT OR DENY PAROLE AND TO IMPOSE CONDITIONS.—Not later than one year after date of the enactment of this Act, the United States Parole Commission shall assume the jurisdiction and authority of the Board of Parole of the District of Columbia to grant and deny parole, and to impose conditions upon an order of parole, in the case of any imprisoned felon who is eligible for parole or reparole under the District of Columbia Code. The Parole Commission shall have exclusive authority to amend or supplement any regulation interpreting or implementing the parole laws of the District of Columbia with respect to felons, provided that the Commission adheres to the rulemaking procedures set forth in section 4218 of title 18, United States Code.

(2) JURISDICTION OF PAROLE COMMISSION TO REVOKE PAROLE OR MODIFY CONDITIONS.—On the date in which the District of Columbia Offender Supervision, Defender, and Courts Services Agency is established under section 11233, the United States Parole Commission shall assume any remaining powers, duties, and jurisdiction of the Board of Parole of the District of Columbia, including jurisdiction to revoke parole and to modify the conditions of parole, with respect to felons.

(3) JURISDICTION OF SUPERIOR COURT.—On the date on which the District of Columbia Offender Supervision, Defender, and Courts Services Agency is established under section 11233, the Superior Court of the District of Columbia shall assume the jurisdiction and authority of the Board of Parole of the District of Columbia to grant, deny, and revoke parole, and to impose and modify conditions of parole, with respect to misdemeanants.

(b) ABOLITION OF THE BOARD OF PAROLE.—On the date on which the District of Columbia Offender Supervision, Defender, and Courts Services Agency is established under section 11233, the Board of Parole established in the District of Columbia Board of Parole Amendment Act of 1987 shall be abolished.

(c) RULEMAKING AND LEGISLATIVE RESPONSIBILITY FOR PAROLE MATTERS.—The Parole Commission shall exercise the authority vested in it by this section pursuant to the parole laws and regulations of the District of Columbia, except that the Council of the District of Columbia and the Board of Parole of the District of Columbia may not revise any such laws or regulations (as in effect on the date of the enactment of this Act) without the concurrence of the Attorney General.

(d) INCREASE IN THE AUTHORIZED NUMBER OF UNITED STATES PAROLE COMMISSIONERS.—Section 2(c) of the Parole Commission Phaseout Act of 1996 (Public Law 104–232) is amended to read as follows:

''(c) The United States Parole Commission shall have no more than five members.''.

**SEC. 11232. PRETRIAL SERVICES, DEFENSE SERVICES, PAROLE, ADULT PROBATION AND OFFENDER SUPERVISION TRUSTEE.**

(a) APPOINTMENT AND REMOVAL.—

(1) APPOINTMENT.—The Attorney General, in consultation with the Chairman of the District of Columbia Financial Responsibility and Management Assistance Authority (hereafter in this section referred to as the ''D.C. Control Board'') and the Mayor of the District of Columbia, shall appoint a Pretrial Services, Defense Services, Parole, Adult Probation and Offender Supervision Trustee, who shall be an independent officer of the government of the District of Columbia, to effectuate the reorganization and transition of functions and funding relating to pretrial services, defense services, parole, adult probation and offender supervision.

(2) REMOVAL.—The Trustee may be removed by the Mayor with the concurrence of the Attorney General. The Attorney General shall have the authority to remove the Trustee for misfeasance or malfeasance in office. At the request of the Trustee, the District of Columbia Financial Responsibility and Management Assistance Authority may exercise any of its powers and authorities on behalf of the Trustee.

(b) AUTHORITY.—Beginning on the date of appointment, and continuing until the District of Columbia Offender Supervision, Defender, and Courts Services Agency is established under section 11233, the Trustee shall—

(1) have the authority to exercise all powers and functions authorized for the Director of the District of Columbia Offender Supervision, Defender and Courts Services Agency;

(2) have the authority to direct the actions of all agencies of the District of Columbia whose functions will be assumed by or within the District of Columbia Offender Supervision, Defender and Courts Services Agency, and of the Board of Parole of the District of Columbia, including the authority to discharge or replace any officers or employees of these agencies, except that the Trustee may not direct the conduct of particular cases by the District of Columbia Public Defender Service;

(3) exercise financial oversight over all agencies of the District of Columbia whose functions will be assumed by or within the District of Columbia Offender Supervision, Defender and Courts Services Agency, and over the Board of Parole of the District of Columbia, and allocate funds to these agencies as appropriated by Congress and allocated by the President;

(4) receive and transmit to the District of Columbia Pretrial Services Agency all funds appropriated for such agency; and

(5) receive and transmit to the District of Columbia Public Defender Service all funds appropriated for such agency.

(c) COMPENSATION.—The Trustee shall be compensated at a rate not to exceed the basic pay payable for Level IV of the Executive Schedule. The Trustee may appoint and fix the pay of additional staff without regard to the provisions of the District of Columbia Code governing appointments and salaries, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and without regard to the provisions of chapter 51 and subchapter III of Chapter 53 of title 5, United States Code, relating to classification and General Schedule pay rates. Upon request of the Trustee, the head of any Federal department or agency may, on a reimbursable or non-reimbursable basis, provide services and/or detail any personnel of that department or agency to the Trusteeship to assist in carrying out its duties.

(d) PROCUREMENT AND JUDICIAL REVIEW.—The provisions of the District of Columbia Code governing procurement shall not apply to the Trustee. The Trustee may enter into such contracts as the Trustee considers appropriate to carry out the Trustee's duties. The Trustee may seek judicial enforcement of the Trustee's authority to carry out the Trustee's duties.

(e) PRESERVATION OF RETIREMENT AND CERTAIN OTHER RIGHTS OF FEDERAL EMPLOYEE WHO BECOMES THE TRUSTEE OR FEDERAL EMPLOYEES WHO BECOME EMPLOYED BY THE TRUSTEE.—

(1) IN GENERAL.—A Federal employee who, within 3 days after separating from the Federal Government, is appointed Trustee or becomes employed by the Trustee—

(A) shall be treated as an employee of the Federal Government for purposes of chapters 83, 84, 87, and 89 of title 5 of the United States Code; and

(B) if, after serving with the Trustee, such employee becomes reemployed by the Federal Government, shall be entitled to credit for the full period of such individual's service with the Trustee, for purposes of determining the applicable leave accrual rate.

(2) REGULATIONS.—The Office of Personnel Management shall prescribe such regulations as may be necessary to carry out this subsection.

(f) FUNDING.—Funds available for operations of the Trustee shall be made available to the extent provided in appropriations acts to the Trustee, through the State Justice Institute. Funding requests shall be proposed by the Trustee to the President and Congress for each Fiscal Year.

(g) LIABILITY AND LITIGATION AUTHORITY.—

(1) LIABILITY.—The District of Columbia shall defend any civil action or proceeding brought in any court or other official Federal, state, or municipal forum against the Trustee, or against the District of Columbia or its officers, employees, or agents, and shall assume any liability resulting from such an action or proceeding, if the action or proceeding arises from the—

(A) supervision of offenders on probation, parole, or supervised release;

(B) provision of pretrial services by the District of Columbia; or

(C) activities of the District of Columbia Board of Parole.

(2) LITIGATION.—

(A) CORPORATION COUNSEL.—Subject to subparagraph (B), the Corporation Counsel of the District of Columbia shall provide litigation services to the Trustee, except that the Trustee may instead elect, either generally or in relation to particular cases or classes of cases, to hire necessary staff and personnel or enter into contracts for the provision of litigation services at the Trustee's expense.

(B) ATTORNEY GENERAL.—

(i) IN GENERAL.—Notwithstanding subparagraph (A), with respect to any litigation involving the Trustee, the Attorney General may—

(I) direct the litigation of the Trustee, and of the District of Columbia on behalf of the Trustee; and

(II) provide on a reimbursable or non-reimbursable basis litigation services for the Trustee at the Trustee's request or on the Attorney General's own initiative.

(ii) APPROVAL OF SETTLEMENT.—With respect to any litigation involving the Trustee, the Trustee may not agree to any settlement involving any form of equitable relief without the approval of the Attorney General. The Trustee shall provide to the Attorney

General such notice and reports concerning litigation as the Attorney General may direct.

(iii) DISCRETION.—Any decision to exercise any authority of the Attorney General under this paragraph shall be in the sole discretion of the Attorney General and shall not be reviewable in any court.

(3) LIMITATIONS.—Nothing in this section shall be construed—

(1) as a waiver of sovereign immunity, or as limiting any other defense or immunity that would otherwise be available to the United States, the District of Columbia, their agencies, officers, employees, or agents; or

(2) to obligate the District of Columbia to represent or indemnify the Corrections Trustee or any officer, employee, or agent where the Trustee (or any person employed by or acting under the authority of the Trustee) acts beyond the scope of his authority.

(h) CERTIFICATION.—The District of Columbia Offender Supervision, Defender, and Courts Services Agency shall assume its duties pursuant to section 11233 when, within the period beginning one year after the date of the enactment of this subtitle and ending three years after the date of the enactment of this subtitle, the Trustee certifies to the Attorney General and the Attorney General concurs that the Agency can carry out the functions described in section 11233 and the United States Parole Commission can carry out the functions described in section 11231.

**SEC. 11233. OFFENDER SUPERVISION, DEFENDER AND COURTS SERVICES AGENCY.**

(a) ESTABLISHMENT.—There is established within the executive branch of the Federal Government the District of Columbia Offender Supervision, Defender, and Courts Services Agency (hereafter in this section referred to as the ''Agency'') which shall assume its duties not less than one year or more than three years after the enactment of this Act.

(b) DIRECTOR.—

(1) APPOINTMENT AND COMPENSATION.—The Agency shall be headed by a Director appointed by the President, by and with the advice and consent of the Senate, for a term of six years. The Director shall be compensated at the rate prescribed for Level IV of the Executive Schedule, and may be removed from office prior to the expiration of term only for neglect of duty, malfeasance in office, or other good cause shown.

(2) POWERS AND DUTIES OF DIRECTOR.—The Director shall—

(A) submit annual appropriation requests for the Agency to the Office of Management and Budget;

(B) determine, in consultation with the Chief Judge of the United States District Court for the District of Columbia, the Chief Judge of the Superior Court of the District of Columbia, and the Chairman of the United States Parole Commission, uniform supervision and reporting practices for the Agency;

(C) hire and supervise supervision officers and support staff for the Agency;

(D) direct the use of funds made available to the Agency;

(E) enter into such contracts, leases, and cooperative agreements as may be necessary for the performance of the Agency's functions, including contracts for substance abuse and other treatment and rehabilitative programs;

(F) develop and operate intermediate sanctions programs for sentenced offenders; and

(G) arrange for the supervision of District of Columbia paroled offenders in jurisdictions outside the District of Columbia.

(c) FUNCTIONS.—

(1) IN GENERAL.—The Agency shall provide supervision, through qualified supervision officers, for offenders on probation, parole, and supervised release pursuant to the District of Columbia Code. The Agency shall carry out its responsibilities on behalf of the court or agency having jurisdiction over the offender being supervised.

(2) SUPERVISION OF RELEASED OFFENDERS.—The Agency shall supervise any offender who is released from imprisonment for any term of supervised release imposed by the Superior Court of the District of Columbia. Such offender shall be subject to the authority of the United States Parole Commission until completion of the term of supervised release. The United States Parole Commission shall have and exercise the same authority as is vested in the United States district courts by paragraphs (d) through (i) of section 3583 of title 18, United States Code, except that—

(A) the procedures followed by the Commission in exercising such authority shall be those set forth in chapter 311 of title 18, United States Code; and

(B) an extension of a term of supervised release under subsection (e)(2) of section 3583 may only be ordered by the Superior Court upon motion from the Commission.

(3) SUPERVISION OF PROBATIONERS.—Subject to appropriations and program availability, the Agency shall supervise all offenders placed on probation by the Superior Court of the District of Columbia. The Agency shall carry out the conditions of release imposed by the Superior Court (including conditions that probationers undergo training, education, therapy, counseling, drug testing, or drug treatment), and shall make such reports to the Superior Court with respect to an individual on probation as the Superior Court may require.

(4) SUPERVISION OF DISTRICT OF COLUMBIA PAROLEES.—The Agency shall supervise all individuals on parole pursuant to the District of Columbia Code. The Agency shall carry out the conditions of release imposed by the United States Parole Commission or, with respect to a misdemeanant, by the Superior Court of the District of Columbia, and shall make such reports to the Commission or Court with respect to an individual on parole supervision as the Commission or Court may require.

(d) AUTHORITY OF OFFICERS.—The supervision officers of the Agency shall have and exercise the same powers and authority as are granted by law to United States Probation and Pretrial Officers.

(e) PRETRIAL SERVICES AGENCY AND PUBLIC DEFENDER SERVICE.—

(1) INDEPENDENT ENTITIES.—The District of Columbia Pretrial Services Agency established by subchapter I of chapter 13 title 23, District of Columbia Code, and the District of Columbia Public Defender Service established by title III of the District of Columbia Court Reform and Criminal Procedure Act of 1970 (D.C. Code, sec. 1–2701 et seq.) shall function as independent entities within the Agency.

(2) SUBMISSION ON BEHALF OF PRETRIAL SERVICES.—The Director of the Agency shall submit, on behalf of the District of Columbia Pretrial Services Agency and with the approval of the Director of the Pretrial Services Agency, an annual appropriation request to the Office of Management and Budget. Such request shall be separate from the request submitted for the Agency.

(3) SUBMISSION ON BEHALF OF PUBLIC DEFENDER SERVICE.—The Director of the Agency shall submit, on behalf of the District of Columbia Public Defender Service and with the approval of the Director of the Public Defender Service, an annual appropriation request to the Office of Management and Budget. Such request shall be separate from that submitted for the Agency.

(4) LIABILITY OF DISTRICT OF COLUMBIA.—The District of Columbia shall defend any civil action or proceeding brought in any court or other official Federal, state, or municipal forum against the District of Columbia Pretrial Services Agency, the District of Columbia Public Defender Service, or the District of Columbia or its officers, employees, or agents, and shall assume any liability resulting from such an action or proceeding, if the action or proceeding arises from the activities of the District of Columbia Pretrial Services Agency or the District of Columbia Public Defender Service prior to the date on which the Offender Supervision, Defender and Courts Services Agency assumes its duties.

(5) LITIGATION.—

(A) CORPORATION COUNSEL.—Subject to subparagraph (B), the Corporation Counsel of the District of Columbia shall provide litigation services to the District of Columbia Pretrial Services Agency and the District of Columbia Public Defender Service, except that the District of Columbia Pretrial Services Agency and the District of Columbia Public Defender Service may instead elect, either generally or in relation to particular cases or classes of cases, to hire necessary staff and personnel or enter into contracts for the provision of litigation services at such agency's expense.

(B) ATTORNEY GENERAL.—

(i) IN GENERAL.—Notwithstanding subparagraph (A), with respect to any litigation involving the District of Columbia Pretrial Services Agency, the Attorney General may—

(I) direct the litigation of the agency, and of the District of Columbia on behalf of the agency; and

(II) provide on a reimbursable or non-reimbursable basis litigation services for the agency at the agency's request or on the Attorney General's own initiative.

(ii) APPROVAL OF SETTLEMENT.—With respect to any litigation involving the District of Columbia Pretrial Services Agency, the agency may not agree to any settlement involving any form of equitable relief without the approval of the Attorney General. The agency shall provide to the Attorney General such notice and reports concerning litigation as the Attorney General may direct.

(iii) DISCRETION.—Any decision to exercise any authority of the Attorney General under this paragraph shall be in the sole discretion of the Attorney General and shall not be reviewable in any court.

**SEC. 11234. AUTHORIZATION OF APPROPRIATIONS.**

There are authorized to be appropriated through the State Justice Institute in each fiscal year such sums as may be necessary for the following:

(1) District of Columbia Pretrial Services Agency.

(2) District of Columbia Public Defender Service.

(3) Supervision of offenders on probation, parole, or supervised release for offenses under the District of Columbia Code.

(4) Operation of the parole system for offenders convicted of offenses under the District of Columbia Code.

(5) Operation of the Trusteeship described in section 11232.

## CHAPTER 4—DISTRICT OF COLUMBIA COURTS

### Subchapter A—Transfer of Administration and Financing of Courts to Federal Government

**SEC. 11241. AUTHORIZATION OF APPROPRIATIONS.**

(a) AUTHORIZATIONS.—There are authorized to be appropriated through the State Justice Institute in each fiscal year such sums as may be necessary for the following:

(1) The Superior Court of the District of Columbia.

(2) The District of Columbia Court of Appeals.

(3) The District of Columbia Court System.

(b) SUBMISSION TO OMB.—The Joint Committee on Judicial Administration in the District of Columbia shall include in its submissions to the Office of Management and Budget and the Congress, the budget and appropriations requests of the Superior Court for the District of Columbia, the District of Columbia Court of Appeals, and the District of Columbia Court System.

**SEC. 11242. ADMINISTRATION OF COURTS UNDER DISTRICT OF COLUMBIA CODE.**

(a) SUBMISSION OF ANNUAL BUDGET REQUESTS BY JOINT COMMITTEE ON JUDICIAL ADMINISTRATION.—Section 11–1701(b)(4), District of Columbia Code, is amended to read as follows:

''(4) Submission of the annual budget requests of the District of Columbia Court of Appeals, the Superior Court of the District of Columbia, and the District of Columbia Court System as the integrated budget of the District of Columbia courts, except that such requests may be modified upon the concurrence of four of the five members of the Joint Committee.''.

(b) AUDIT OF ACCOUNTS OF COURTS.—Section 11–1723(a)(3), District of Columbia Code, is amended to read as follows:

''(3) The Fiscal Officer shall be responsible for the approval of vouchers and the internal auditing of the accounts of the courts and shall arrange for an annual independent audit of the accounts of the courts.''.

(c) APPOINTMENT AND REMOVAL OF COURT PERSONNEL.—Section 11–1725(b) of the District of Columbia Code is amended to read as follows:

''(b) The Executive Officer shall appoint, and may remove, the Director of Social Services, the clerks of the courts, the Auditor-Master, and all other nonjudicial personnel for the courts (other than the Register of Wills and personal law clerks and secretaries of the judges) as may be necessary, subject to—

''(1) regulations approved by the Joint Committee; and

''(2) the approval of the chief judge of the court to which the personnel are or will be assigned.

''Appointments and removals of court personnel shall not be subject to the laws, rules, and limitations applicable to District of Columbia employees.''.

(d) PROCUREMENT OF EQUIPMENT AND SUPPLIES.—Section 11–1742(b), District of Columbia Code, is amended to read as follows:

''(b) The Executive Officer shall be responsible for the procurement of necessary equipment, supplies, and services for the courts and shall have power, subject to applicable law, to reimburse the District of Columbia government for services provided and to contract for such equipment, supplies, and services as may be necessary.''.

(e) BUDGET AND EXPENDITURES.—

(1) IN GENERAL.—Section 11–1743, District of Columbia Code, is amended to read as follows:

**''§ 11–1743. Annual Budget and Expenditures.**

''(a) The Joint Committee shall prepare and submit to the Mayor and the Council of the District of Columbia annual estimates of the expenditures and appropriations necessary for the maintenance and operations of the District of Columbia courts, and shall submit such estimates to Congress and the Director of the Office of Management and Budget after submitting them to the Mayor and the Council. All such estimates shall be included in the budget without revision by the President but subject to the President's recommendations.

''(b) The District of Columbia Courts may make such expenditures as may be necessary to execute efficiently the functions vested in the Courts.

''(c) All expenditures of the Courts shall be allowed and paid upon presentation of itemized vouchers signed by the certifying officer designated by the Joint Committee. All such expenditures shall be paid out of moneys appropriated for purposes of the Courts.''.

(2) CLERICAL AMENDMENT.—The item relating to section 11–1743 in the table of sections for subchapter III of chapter 17 of title 11, District of Columbia Code, is amended to read as follows:

''11–1743. Annual budget and expenditures.''.

**SEC. 11243. BUDGETING AND FINANCING REQUIREMENTS FOR COURTS UNDER HOME RULE ACT.**

(a) BUDGET OF COURTS.—Section 445 of the District of Columbia Self-Government and Governmental Reorganization Act (DC Code, Title 11 App.) is amended to read as follows:

''SEC. 445. The District of Columbia courts shall prepare and annually submit to the Director of the Office of Management and Budget, for inclusion in the annual budget, annual estimates of the expenditures and appropriations necessary for the maintenance and operation of the District of Columbia court system. The courts shall submit as part of their budgets both a multiyear plan and a multiyear capital improvements plan and shall submit a statement presenting qualitative and quantitative descriptions of court activities and the status of efforts to comply with reports of the Comptroller General of the United States.''.

(b) FINANCIAL DUTIES OF THE MAYOR.—Section 448(a)(6) of such Act (DC Code, sec. 47–310(a)(6)) is amended to read as follows:

''(6) supervise and be responsible for the levying and collection of all taxes, special assessments, license fees, and other revenues of the District, as required by law, and receive all moneys receivable by the District from the Federal Government or from any agency or instrumentality of the District, except that this paragraph shall not apply to moneys from the District of Columbia Courts.''.

(c) FUNDS OF THE DISTRICT.—Section 450 of such Act (DC Code, sec. 47–130) is amended to read as follows:

''SEC. 450. The General Fund of the District shall be composed of those District revenues which on the effective date of this title are paid into the Treasury of the United States and credited either to the General Fund of the District or its miscellaneous receipts, but shall not include any revenues which are applied by law to any special fund existing on the date of enactment of this title. The Council may from time to time establish such additional special funds as may be necessary for the efficient operation of the government of the District. All money received by any agency, officer, or employee of the District in its or his official capacity shall belong to the District government and shall be paid promptly to the Mayor for deposit in the appropriate fund, except that all money received by the District of Columbia Courts shall be deposited in the Treasury of the United States or the Crime Victims Fund.''.

(d) REDUCTIONS IN BUDGETS OF INDEPENDENT AGENCIES.—Section 453(c) of such Act (DC Code, sec. 47–304.1(c)) is amended to read as follows:

''(c) Subsection (a) shall not apply to amounts appropriated or otherwise made available to the Council or to the District of Columbia Financial Responsibility and Management Assistance Authority established under section 101(a) of the District of Columbia Financial Responsibility and Management Assistance Act of 1995.''.

(e) TREATMENT OF COURT FEES IN CALCULATION OF LIMITS ON DISTRICT BORROWING.—Section 603 of such Act (DC Code, sec. 47–313) is amended—

(1) in subsection (b)—

(A) in paragraph (1)—

(i) in the first sentence, by striking ''less court fees, any fees'' and inserting ''less any fees''; and

(ii) in the second sentence, by striking ''section 2501, title 47 of the District of Columbia Code, as amended'' and inserting ''title VI of the District of Columbia Revenue Act of 1939'';

(B) in paragraph (3)(A), by striking ''less court fees, any fees'' and inserting ''less any fees''; and

(2) in subsection (c), by striking the last sentence (relating to budget estimates of the District of Columbia courts).

**SEC. 11244. AUDITING OF ACCOUNTS OF COURT SYSTEM.**

(a) POWERS OF DISTRICT OF COLUMBIA AUDITOR.—Section 455 of the District of Columbia Self-Government and Governmental Reorganization Act (DC Code, sec. 47–117) is amended by adding at the end the following new subsection:

''(g) This section shall not apply to the District of Columbia Courts or the accounts and operations thereof.''

(b) SUBMISSION OF GAO AUDIT REPORTS TO MAYOR AND COUNCIL.—Section 715(b) of title 31, United States Code (DC Code, sec. 47–118.1(b)), is amended by striking ''and the Mayor'' and inserting ''and (other than the audit reports of the District of Columbia Courts) the Mayor''.

(c) INDEPENDENT ANNUAL AUDIT.—Section 4 of Public Law 94–399 (DC Code, sec. 47–119) is amended by adding at the end the following new subsection:

''(d) This section shall not apply to the District of Columbia Courts or the financial operations thereof.''

**SEC. 11245. MISCELLANEOUS BUDGETING AND FINANCING REQUIREMENTS FOR COURTS UNDER DISTRICT LAW.**

(a) DEPOSIT OF PUBLIC FUNDS.—Section 2(21) of the District of Columbia Depository Act of 1977 (DC Code, sec. 47–341(21)) is amended by striking ''a court, agency'' and inserting ''an agency''.

(b) REPROGRAMMING OF BUDGET AMOUNTS.—Section 4(h) of D.C. Law 3–100 (DC Code, sec. 47–363(h)) is amended by striking ''the District of Columbia courts,''.

(c) CONTROL OF GRANT FUNDS.—(1) Section 3(1) of D.C. Law 3–104 (DC Code, sec. 47–382(1)) is amended to read as follows:

''(1) 'Agency' means the highest organizational structure of the District at which budgeting data is aggregated, but shall not include the District of Columbia Courts.''

(2) Section 4(b) of D.C. Law 3–104 (DC Code, sec. 47–383(b)) is amended to read at follows:

''(b) The Trustees of the University of the District of Columbia, the Board of Education, and the D.C. General Hospital Commission shall submit to the Mayor two copies of the application and completed approval form, as an advisory notice, concurrent with submitting the application and completed approval form to a grant-making agency in accordance with rules and regulations issued pursuant to subsection (c) of this section.''.

**SEC. 11246. OTHER PROVISIONS RELATING TO ADMINISTRATION OF DISTRICT OF COLUMBIA COURTS.**

(a) JUROR FEES.—Section 11–1912(a), District of Columbia Code, is amended to read as follows:

''(a) Notwithstanding section 602(a) of the District of Columbia Self-Government and Governmental Reorganization Act, grand and petit jurors serving in the Superior Court shall receive fees and expenses at rates established by the Board of Judges of the Superior Court'', except that such fees and ex-

penses may not exceed the respective rates paid to such jurors in the Federal system.''.

(b) COMPENSATION AND BENEFITS FOR COURT PERSONNEL.—

(1) IN GENERAL.—Section 11–1726, District of Columbia Code, is amended to read as follows:

**''§ 11–1726. Compensation and benefits for court personnel.**

''(a) In the case of nonjudicial employees of the District of Columbia courts whose compensation is not otherwise fixed by this title, the Executive Officer shall fix the rates of compensation of such employees without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code. Any rates so established shall be subject to the limitation on pay fixed by administrative action in section 5373 of such title. In fixing the rates of compensation of nonjudicial employees under this section, the Executive Officer may be guided by the rates of compensation fixed for employees in the executive and judicial branches of the Federal Government or State or local governments occupying the same or similar positions or occupying positions of similar responsibility, duty, and difficulty.

''(b)(1) Nonjudicial employees of the District of Columbia courts shall be treated as employees of the Federal Government solely for purposes of any of the following provisions of title 5, United States Code:

''(A) Subchapter 1 of chapter 81 (relating to compensation for work injuries).

''(B) Chapter 83 (relating to retirement).

''(C) Chapter 84 (relating to the Federal Employees' Retirement System).

''(D) Chapter 87 (relating to life insurance).

''(E) Chapter 89 (relating to health insurance).

''(2) The employing agency shall make contributions under the provisions referred to paragraph (1) at the same rates applicable to agencies of the Federal Government.

''(3) An individual who is a nonjudicial employee of the District of Columbia courts on the date of the enactment of the Balanced Budget Act of 1997 may make, within 60 days after such date, an election under section 8351 or section 8432 of title 5, United States Code, to participate in the Thrift Savings Plan for Federal employees.

''(c)(1) Judicial employees of the District of Columbia courts shall be treated as employees of the Federal Government for purposes of any of the following provisions of title 5, United States Code:

''(A) Subchapter 1 of chapter 81 (relating to compensation for work injuries).

''(B) Chapter 87 (relating to life insurance).

''(C) Chapter 89 (relating to health insurance).

''(2) The employing agency shall make contributions under the provisions referred to paragraph (1) at the same rates applicable to agencies of the Federal Government.

''(3) For purposes of section 8706(b) and section 8901(3)(B) of title 5, United States Code, benefits paid from the retirement system for judicial employees of the District of Columbia courts or from the system providing benefits to survivors of such employees shall be considered an annuity.

''(4) For purposes of section 8901(3)(A) of title 5, United States Code, the retirement system for judicial employees of the District of Columbia courts shall be considered a retirement system for employees of the Government.''.

(2) CLERICAL AMENDMENT.—The table of sections for subchapter II of chapter 15 of title 11, District of Columbia Code, is amended by amending the item relating to section 11–1726 to read as follows:

''11–1726. Compensation and benefits for court personnel.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to all months beginning after the date on which the Director of the Office of Personnel Management issues regulations to carry out section 11–1726, District of Columbia Code (as amended by paragraph (1)).

(c) RETIREMENT PERIOD FOR EXECUTIVE OFFICER.—Section 11–1703(d), District of Columbia Code, is amended by striking the period at the end and inserting the following: '', except that the Executive Officer (if initially hired after October 1, 1997) shall be eligible for retirement under subchapter III of chapter 15 when the Executive Officer has completed 7 years of service as Executive Officer, whether continuous or not.''.

**Subchapter B—Judicial Retirement Program**

**SEC. 11251. JUDICIAL RETIREMENT AND SURVIVORS ANNUITY FUND.**

(a) ESTABLISHMENT OF FUND.—Section 11–1570, District of Columbia Code, is amended to read as follows:

**''§ 11–1570. The District of Columbia Judicial Retirement and Survivors Annuity Fund.**

''(a) There is established in the Treasury a fund known as the District of Columbia Judicial Retirement and Survivors Annuity Fund (hereafter in this section referred to as the 'Fund'), which shall consist of the following assets:

''(1) Amounts deposited by, or deducted and withheld from the salary and retired pay of, a judge under section 1563 or 1567 of this title, which shall be credited to an individual account of the judge.

''(2) Amounts transferred from the District of Columbia Judges' Retirement Fund under section 124(c)(1) of the District of Columbia Retirement Reform Act, as amended by section 11252 of the Balanced Budget Act of 1997.

''(3) Amounts deposited under subsection (d).

''(4) Any return on investment of the assets of the Fund.

''(b)(1) The Secretary of the Treasury (hereafter in this section referred to as the 'Secretary') shall be responsible for the administration of the Fund. The Secretary may carry out such responsibilities through an agreement with a Trustee or contractor (who may be the Trustee or contractor appointed to carry out responsibilities relating to Federal benefit payments under title I of the National Capital Revitalization and Self-Government Improvement Act of 1997) and an enrolled actuary (as defined in section 7701(a)(35) of the Internal Revenue Code of 1986) who is a member of the American Academy of Actuaries (who may be the enrolled actuary engaged under such Act).

''(2) The chief judges of the District of Columbia Court of Appeals and Superior Court of the District of Columbia shall submit to the President and the Secretary an annual estimate of the expenditures and appropriations necessary for the maintenance and operation of the Fund, and such supplemental and deficiency estimates as may be required from time to time for the same purposes, according to law.

''(3) The Secretary may cause periodic examinations of the Fund to be made by an enrolled actuary (as defined in section 7701(a)(35) of the Internal Revenue Code of 1986) who is a member of the American Academy of Actuaries.

''(c)(1) Amounts in the Fund are available for the payment of judges' retirement pay, annuities, refunds, and allowances under this subchapter.

''(2) Notwithstanding any other provision of District law or any other law, rule, or regulation, the Secretary may review benefit determinations under this subchapter made prior to the date of the enactment of the National Capital Revitalization and Self-Government Improvement Act of 1997, and shall make initial benefit determinations after such date.

''(d)(1) Subject to the availability of appropriations, there shall be deposited in the Fund, not later than the close of each fiscal year (beginning with the first fiscal year which ends more than 6 months after the replacement plan adoption date described in section 103(13) of the National Capital Revitalization and Self-Government Improvement Act of 1997), an amount equal to the sum of—

''(A) the normal cost for the year;

''(B) the annual amortization amount for the year (which may not be less than zero); and

''(C) the covered administrative expenses for the year.

''(2) For purposes of this subsection:

''(A) The 'original unfunded liability' is the amount that is the present value as of June 30, 1997, of future benefits payable from the Fund (net the sum of future normal cost and plan assets as of such date).

''(B) The 'annual amortization amount' is the amount determined by the enrolled actuary to be necessary to amortize in equal annual installments (until fully amortized)—

''(i) the original unfunded liability over a 30-year period;

''(ii) a net experience gain or loss over a 10-year period; and

''(iii) any other changes in actuarial liability over a 20-year period.

''(C) The 'covered administrative expenses' are the expenses determined by the Secretary (on an annual basis) to be necessary to administer the Fund.

''(3) Deposits made under this subsection shall be taken from sums available for that fiscal year for the payment of the expenses of the Court, and shall not be credited to the account of any individual.

''(e) The Secretary shall invest such portion of the Fund as is not in the judgment of the Secretary required to meet current withdrawals. Such investments shall be in public debt securities with maturities suitable to the needs of the Fund, as determined by the Secretary, and bearing interest at rates determined by the Secretary, taking into consideration current market yields on outstanding marketable obligations of the United States of comparable maturities.

''(f) None of the moneys mentioned in this subchapter shall be assignable, either in law or in equity, or be subject to execution, levy, attachment, garnishment, or other legal process (except to the extent permitted pursuant to the District of Columbia Spouse Equity Act of 1988).

''(g) Notwithstanding any other provision of District law, rule, or regulation, any civil action brought—

''(1) by an individual to enforce or clarify rights to benefits from the Fund; or

''(2) by the Secretary—

''(A) to enforce any claim arising (in whole or in part) under this section or any contract entered into to carry out this section,

''(B) to recover benefits improperly paid from the Fund or to clarify an individual's rights to benefits from the Fund, or

''(C) to enforce any provision of this section or any contract entered into to carry out this section,

shall be brought in the United States District Court for the District of Columbia.''.

(b) CLERICAL AMENDMENT.—The table of sections for subchapter III of chapter 15 of title 11, District of Columbia Code, is amended by amending the item relating to section 11–1570 to read as follows:

''11–1570. The District of Columbia Judicial Retirement and Survivors Annuity Fund.''.

**SEC. 11252. TERMINATION OF CURRENT FUND AND PROGRAM.**

(a) TERMINATION OF JUDGES' RETIREMENT FUND.—Section 124 of the District of Colum-

bia Retirement Reform Act (DC Code, sec. 1–714) is amended by striking subsection (c) and inserting the following:

''(c)(1) Notwithstanding any other provision of this Act or the amendments made by this Act, upon the date the assets of the Retirement Fund described in title I of the National Capital Revitalization and Self-Government Improvement Act of 1997 are transferred, the assets of the District of Columbia Judges' Retirement Fund established under subsection (a) shall be transferred to the District of Columbia Judicial Retirement and Survivors Annuity Fund under section 11–1570, District of Columbia Code, and no amounts shall be deposited into the District of Columbia Judges' Retirement Fund after the date on which the assets are so transferred.

''(2) The District of Columbia Judges' Retirement Fund established under subsection (a) shall be continued in the Treasury and appropriated for the purposes provided in this Act until such time as all amounts in such Fund have been expended or transferred to the District of Columbia Judicial Retirement and Survivors Annuity Fund pursuant to paragraph (1). Thereafter any payments of retirement pay, annuities, refunds, and allowances for judicial personnel of the District of Columbia shall be paid from the District of Columbia Judicial Retirement and Survivors Annuity Fund in accordance with subchapter III of chapter 15 of title 11, District of Columbia Code.''.

(b) REMOVAL OF JUDGES FROM RETIREMENT BOARD.—Section 121(b)(1)(A) of the District of Columbia Retirement Reform Act (DC Code, sec. 1–711(b)(1)(A)) is amended—

(1) in the matter preceding clause (i), by striking ''13'' and inserting ''11'';

(2) by striking clause (vii); and

(3) by redesignating clauses (viii) and (ix) as clauses (vii) and (viii).

**SEC. 11253. CONFORMING AMENDMENTS.**

(a) TRANSFER OF AUTHORITY OVER FUND TO SECRETARY OF THE TREASURY.—Title 11, District of Columbia Code, is amended as follows:

(1) In sections 11–1561(8)(C), 11–1562(c), 11–1563(b), 11–1563(c), 11–1564(d)(6), 11–1564(d)(7), 11–1566(a), and 11–1570(c), by striking ''Commissioner [Mayor]'' each place it appears and inserting ''Secretary of the Treasury''.

(2) In sections 11–1566(b)(2), 11–1567(a), 11–1567(b), by striking ''Mayor'' each place it appears and inserting ''Secretary of the Treasury''.

(3) In sections 11–1564(d)(2)(A) and 11–1568.1(1)(B), by striking ''Mayor of the District of Columbia'' each place it appears and inserting ''Secretary of the Treasury''.

(4) In section 11–1563(a), by striking ''paid to the Custodian of Retirement Funds (as defined in section 102(6) of the District of Columbia Retirement Reform Act)'' and inserting ''paid to the Secretary of the Treasury''.

(b) DEFINITION OF FUND.—Section 11–1561(4), District of Columbia Code, is amended to read as follows:

''(4) The term 'fund' means the District of Columbia Judicial Retirement and Survivors Annuity Fund established by sections 11–1570.''.

(c) TREATMENT OF FEDERAL SERVICE OF JUDGES.—Section 11–1564(d)(4), District of Columbia Code, is amended by striking ''Judges' Retirement Fund established by section 124(a) of the District of Columbia Retirement Reform Act'' and inserting ''Judicial Retirement and Survivors Annuity Fund under section 11–1570''.

**Subchapter C—Miscellaneous Conforming and Administrative Provisions**

**SEC. 11261. TREATMENT OF COURTS UNDER MISCELLANEOUS DISTRICT LAWS.**

(a) FINANCIAL RESPONSIBILITY AND MANAGEMENT ASSISTANCE ACT.—Paragraph (5) of section 305 of the District of Columbia Financial Responsibility and Management Assistance Act of 1995 (DC Code, sec. 47–393(5)) is amended to read as follows:

''(5) The term 'District government' means the government of the District of Columbia, including any department, agency or instrumentality of the government of the District of Columbia; any independent agency of the District of Columbia established under part F of title IV of the District of Columbia Self-Government and Governmental Reorganization Act or any other agency, board, or commission established by the Mayor or the Council; the Council of the District of Columbia; and any other agency, public authority, or public benefit corporation which has the authority to receive monies directly or indirectly from the District of Columbia (other than monies received from the sale of goods, the provision of services, or the loaning of funds to the District of Columbia), except that such term does not include the Authority.''.

(b) MERIT PERSONNEL ACT.—(1) Section 201 of the District of Columbia Comprehensive Merit Personnel Act of 1978 (DC Code, sec. 1–602.1) is amended—

(A) by striking ''(a) Except as provided in subsection (b) or unless'' and inserting ''Unless''; and

(B) by striking subsection (b).

(2) Section 301(13) of the District of Columbia Comprehensive Merit Personnel Act of 1978 (DC Code, sec. 1–603.1(13)) is amended by striking '', the Superior Court of the District of Columbia, and the District of Columbia Court of Appeals shall be considered independent agencies'' and inserting ''shall be considered an independent agency''.

**SEC. 11262. REPRESENTATION OF INDIGENTS IN CRIMINAL CASES.**

(a) BUDGET.—Section 11–2607, District of Columbia Code, is amended to read as follows:

**''§ 11–2607. Preparation of Budget**

''The joint committee shall prepare and include in its annual budget requests for the District of Columbia court system estimates of the expenditures and appropriations necessary for furnishing representation by private attorneys to persons entitled to representation in accordance with section 2601 of this title.''.

(b) AUTHORIZATION OF APPROPRIATIONS.—Section 11–2608 of the District of Columbia Code is amended to read as follows:

**''§ 11–2608. Authorization of appropriations**

''There are authorized to be appropriated through the State Justice Institute such sums as may be necessary to pay for representation by private attorneys and related services under this chapter. When so specified in appropriation Acts, such appropriations shall remain available until expended.''.

(c) REPEAL AUTHORITY OF COUNCIL.—

(1) IN GENERAL.—Section 11–2609, District of Columbia Code, is repealed.

(2) CLERICAL AMENDMENT.—The table of sections for chapter 26 of title 11, District of Columbia Code, is amended by striking the item relating to section 11–2609.

**CHAPTER 5—PRETRIAL SERVICES AGENCY AND PUBLIC DEFENDER SERVICE**

**SEC. 11271. AMENDMENTS AFFECTING PRETRIAL SERVICES AGENCY.**

(a) IN GENERAL.—Sections 23–1304 through 23–1308 of the District of Columbia Code are amended to read as follows:

**''§ 23–1304. Executive committee; composition; appointment and qualifications of Director**

''(a) The agency shall be advised by an executive committee of seven members, of which four members shall constitute a quorum. The Executive Committee shall be composed of the following persons or their designees: the Chief Judge of the United States Court of Appeals for the District of Columbia Circuit, the Chief Judge of the United States District Court for the District of Columbia, the Chief Judge of the District of the Columbia Court of Appeals, the Chief Judge of the Superior Court of the District of Columbia, the United States Attorney for the District of Columbia, the Director of the District of Columbia Public Defender Service, and the Director of the District of Columbia Offender Supervision, Defender and Courts Services Agency.

''(b) The Chief Judge of the United States Court of Appeals for the District of Columbia Circuit and the Chief Judge of the United States District Court for the District of Columbia, in consultation with the other members of the executive committee, shall appoint a Director of the agency who shall be a member of the bar of the District of Columbia.

**''§ 23–1305. Duties of director; compensation**

''(a) The Director of the agency shall be responsible for the supervision and execution of the duties of the agency. The Director shall be compensated as a member of the Senior Executive Service pursuant to subchapter VIII of chapter 53 of title 5, United States Code.

**''§ 23–1306. Chief assistant and other agency personnel; compensation**

''The Director shall employ a chief assistant who shall be compensated as a member of the Senior Executive Service pursuant to section 5382 of title 5, United States Code. The Director shall employ such agency personnel as may be necessary properly to conduct the business of the agency. All employees other than the chief assistant shall receive compensation that is comparable to levels of compensation established for Federal pretrial services agencies.

**''§ 23–1307. Annual reports**

''(a) The Director shall each year submit to the executive committee and to the Director of the District of Columbia Offender Supervision, Defender and Courts Services Agency a report as to the Pretrial Services Agency's administration of its responsibilities for the previous fiscal year. The Director shall include in the report a statement of financial condition, revenues, and expenses for the past fiscal year.

**''§ 23–1308. Appropriation; budget**

''There are authorized to be appropriated through the State Justice Institute in each fiscal year such sums as may be necessary to carry out the provisions of this subchapter. Funds appropriated by Congress for the District of Columbia Pretrial Services Agency shall be received by the Director of the District of Columbia Offender Supervision, Defender and Courts Services Agency, and shall be disbursed by that Director to and on behalf of the District of Columbia Pretrial Services Agency. The District of Columbia Pretrial Services Agency shall submit to the Director of the District of Columbia Offender Supervision, Defender and Courts Services Agency at the time and in the form prescribed by that Director, reports of its activities and financial position and its proposed budget.''.

(b) CLERICAL AMENDMENT.—The table of sections for subchapter I of chapter 13 of title 23, District of Columbia Code, is amended by striking the items relating to sections 23–1304 through 23–1308 and inserting the following:

''23–1304. Executive committee; composition; appointment and qualifications of Director.
''23–1305. Duties of director; compensation.
''23–1306. Chief assistant and other agency personnel; compensation.

''23–1307. Annual reports.

''23–1308. Appropriation; budget.''

**SEC. 11272. AMENDMENTS AFFECTING PUBLIC DEFENDER SERVICE.**

(a) BOARD OF TRUSTEES.—Section 303(a) of the District of Columbia Court Reform and Criminal Procedure Act of 1970 (DC Code, sec. 1–2703(a)) is amended to read as follows:

''(a) The Service shall be advised on matters of general policy by a Board of Trustees.''.

(b) APPOINTMENT OF DIRECTOR AND DEPUTY DIRECTOR.—Section 304 of such Act (DC Code, sec. 1–2704) is amended to read as follows:

**''SEC. 304. DIRECTOR AND DEPUTY DIRECTOR; APPOINTMENT; DUTIES; MEMBERSHIP IN BAR REQUIRED.**

''The Chief Judge of the United States Court of Appeals for the District of Columbia Circuit and the Chief Judge of the United States District Court for the District of Columbia, in consultation with the persons described in subparagraphs (B) through (D) of section 303(b)(1) and the Board of Trustees, shall appoint a Director and Deputy Director of the Service. The Director shall be responsible for the supervision and execution of the duties of the Service. The Deputy Director shall assist the Director and shall perform such duties as the Director may prescribe. The Director and Deputy Director shall be members of the bar of the District of Columbia. The Director of the District of Columbia Offender Supervision, Defender and Courts Services Agency shall fix the compensation of the Director and the Deputy Director, but the compensation of the Director shall not exceed the compensation received by the United States Attorney for the District of Columbia.''.

(c) ANNUAL REPORT AND AUDIT.—Section 306 of such Act (DC Code, sec. 1–2706) is amended—

(1) in subsection (a)—

(A) by striking ''Board of Trustees'' and inserting ''Director'', and

(B) by striking ''and to the Mayor of the District of Columbia'' and inserting ''to the Director of the District of Columbia Offender Supervision, Defender and Courts Services Agency, and to the Office of Management and Budget''; and

(2) in subsection (b)—

(A) by striking ''Board of Trustees'' and inserting ''Director''; and

(B) by striking ''the Administrative Office of the United States Courts'' and inserting ''the Director of the District of Columbia Offender Supervision, Defender and Courts Services Agency''.

(d) APPROPRIATIONS.—Section 307 of such Act (DC Code, sec. 1–2707) is amended—

(1) by amending subsection (a) to read as follows:

''(a) There are authorized to be appropriated through the State Justice Institute in each fiscal year such sums as may be necessary to carry out the provisions of this chapter. Funds appropriated by Congress for the District of Columbia Public Defender Service shall be received by the Director of the District of Columbia Offender Supervision, Defender and Courts Services Agency, and shall be disbursed by that Director to and on behalf of the Service. The Service shall submit to the Director of the District of Columbia Offender Supervision, Defender and Courts Services Agency, at the time and in the form prescribed by that Director, reports of its activities and financial position and its proposed budget.''; and

(2) in subsection (b), by striking ''Upon approval of the Board of Trustees, the'' and inserting ''The'' .

**CHAPTER 6—MISCELLANEOUS PROVISIONS**

**SEC. 11281. TECHNICAL ASSISTANCE AND RESEARCH.**

There are authorized to be appropriated to the National Institute of Justice in each fiscal year (beginning with fiscal year 1998) such sums as may be necessary for the following activities:

(1) Research and demonstration projects, evaluations, and technical assistance to assess and analyze the crime problem in the District of Columbia, and to improve the ability of the criminal justice and other systems and entities in the District of Columbia to prevent, solve, and punish crimes.

(2) The establishment of a locally-based corporation or institute in the District of Columbia supporting research and demonstration projects relating to the prevention, solution, or punishment of crimes in the District of Columbia, including the provision of related technical assistance.

**SEC. 11282. EXEMPTION FROM PERSONNEL AND BUDGET CEILINGS FOR TRUSTEES AND RELATED AGENCIES.**

The Trustees described in sections 11202 and 11232 and the activities and personnel of, and the funds allocated or otherwise available to, the Trustees and the agencies over which the Trustees exercise financial oversight pursuant to those sections, shall not be subject to any general personnel or budget limitations which otherwise apply to the District of Columbia government or its agencies in any appropriations act.

**Subtitle D—Privatization of Tax Collection and Administration**

**SEC. 11301. FINDINGS.**

Congress finds as follows:

(1) The District of Columbia government has historically had a poor record of determining and collecting all revenue it is due under its revenue code.

(2) The impact on the District's financial condition of poor administration and collection is significant and has contributed both to the size of its accumulated operating deficit and to the difficulty in balancing the budget going forward.

(3) More complete collection of taxes would not only increase District of Columbia revenues, but would give residents and businesses a sense of equity and that all were paying their fair share.

(4) Once District tax processing and collection is competently managed it will be possible for the District government to accurately assess the true value of its many taxes and determine that some may be reduced or eliminated without a significant negative impact on revenues.

(5) Any reduction or elimination of nonproductive or counterproductive taxes or taxes which cost more to administer than they produce in revenue would significantly improve the negative atmosphere surrounding the District of Columbia tax system and its enforcement.

**SEC. 11302. AUTHORIZING CHIEF FINANCIAL OFFICER TO PRIVATIZE TAX ADMINISTRATION AND COLLECTION.**

The Chief Financial Officer of the District of Columbia may enter into contracts with a private entity for the administration and collection of taxes of the District of Columbia.

**Subtitle E—Financing of District of Columbia Accumulated Deficit**

**SEC. 11401. FINDINGS.**

Congress finds as follows:

(1) The District of Columbia government sold accumulated deficit financing bonds in 1991.

(2) Between 1991 and the end of fiscal year 1997 the District of Columbia government is expected to accumulate an operating deficit in excess of $500,000,000.

(3) Requiring the District of Columbia budget for fiscal year 1998 to be balanced will ensure that no further addition is made to the accumulated operating deficit.

(4) In every other example of an American city in financial crisis, a vital and necessary component of recovery was to finance the accumulated operating deficit.

(5) Carrying forward an accumualted operating deficit of more than $500,000,000 has a significant negative impact on the District of Columbia's cash flow and financial condition and on its ability to improve its credit rating.

(6) It is not feasible to carry forward such a debt with an expectation of paying it off gradually from future budget surpluses.

(7) Financing the accumulated deficit would improve the District's cash management position and allow more normal cash management techniques.

**SEC. 11402. AUTHORIZATION FOR INTERMEDIATE-TERM ADVANCES OF FUNDS BY THE SECRETARY OF THE TREASURY TO LIQUIDATE THE ACCUMULATED GENERAL FUND DEFICIT OF THE DISTRICT OF COLUMBIA.**

Title VI of the District of Columbia Revenue Act of 1939 (DC Code, sec. 47–3401 et seq.) is amended—

(1) by redesignating sections 602 through 605 as sections 603 through 606, respectively; and

(2) by inserting after section 601 the following:

**''SEC. 602. INTERMEDIATE-TERM ADVANCES FOR LIQUIDATION OF DEFICIT.**

''(a) IN GENERAL.—If the conditions in subsection (b) are satisfied, the Secretary shall make an advance of funds from time to time, out of any money in the Treasury not otherwise appropriated and to the extent provided in advance in annual appropriations Acts, for the purpose of assisting the District government in liquidating the outstanding accumulated operating deficit of the general fund of the District government existing as of September 30, 1997.

''(b) CONDITIONS TO MAKING ANY INTERMEDIATE-TERM ADVANCE.—The Secretary shall make an advance under this section if—

''(1) the Mayor delivers to the Secretary the following instruments, in form and substance satisfactory to the Secretary—

''(A) a financing agreement in which the Mayor agrees to procedures for requisitioning advances;

''(B) a requisition for an advance under this section; and

''(C) a promissory note evidencing the District government's obligation to reimburse the Treasury for the requisitioned advance, which note may be a general obligation bond issued under section 461(a) of the District of Columbia Self-Government and Governmental Reorganization Act by the District government to the Secretary if the Secretary determines that such a bond is satisfactory;

''(2) the date on which the requisitioned advance is requested to be made is not later than 3 years from the date of enactment of the Balanced Budget Act of 1997;

''(3) the District government delivers to the Secretary—

''(A) evidence demonstrating to the satisfaction of the Secretary that, at the time of the Mayor's requisition for an advance, the District government is effectively unable to obtain credit in the public credit markets or elsewhere in sufficient amounts and on sufficiently reasonable terms to meet the District government's need for financing to accomplish the purpose described in subsection (a); and

''(B) a schedule setting out the anticipated timing and amounts of requisitions for advances under this section;

''(4) the Authority certifies to the Secretary that—

''(A) there is an approved financial plan and budget in effect under the District of Columbia Financial Responsibility and Management Assistance Act of 1995 for the fiscal year in which the requisition is to be made;

''(B) at the time that the Mayor's requisition for an advance is delivered to the Secretary, the District government is in compliance with the approved financial plan and budget;

''(C) both the receipt of funds from such advance and the reimbursement of Treasury for such advance are consistent with the approved financial plan and budget for the year;

''(D) such advance will not adversely affect the financial stability of the District government; and

''(E) at the time that the Mayor's requisition for an advance is delivered to the Secretary, the District government is effectively unable to obtain credit in the public credit markets or elsewhere in sufficient amounts and on sufficiently reasonable terms to meet the District government's need for financing to accomplish the purpose described in subsection (a);

''(5) the Inspector General of the District of Columbia certifies to the Secretary the information described in subparagraphs (A) through (D) of paragraph (4), and in making this certification, the Inspector General may rely upon an audit conducted by an outside auditor engaged by the Inspector General under section 208(a)(4) of the District of Columbia Procurement Practices Act of 1985 if, after reasonable inquiry, the Inspector General concurs in the findings of such audit;

''(6) the Secretary determines that—

''(A) there is reasonable assurance of reimbursement for the requisitioned advance; and

''(B) the debt owed by the District government to the Treasury on account of the requisitioned advance will not be subordinate to any other debt owed by the District or to any other claims against the District; and

''(7) the Secretary receives from such persons as the Secretary determines to be appropriate such additional certifications and opinions relating to such matters as the Secretary determines to be appropriate.

''(c) AMOUNT OF ANY INTERMEDIATE-TERM ADVANCE.—

''(1) IN GENERAL.—Except as provided in paragraph (3), if the conditions in paragraph (2) are satisfied, each advance made under this section shall be in the amount designated by the Mayor in the Mayor's requisition for such advance.

''(2) CONDITIONS APPLICABLE TO DESIGNATED AMOUNT.—Paragraph (1) applies if—

''(A) the Mayor certifies that the amount designated in the Mayor's requisition for such advance is needed to accomplish the purpose described in subsection (a) within 30 days of the time that the Mayor's requisition is delivered to the Secretary; and

''(B) the Authority concurs in the Mayor's certification under subparagraph (A).

''(3) MAXIMUM AMOUNT.—Notwithstanding paragraph (1), the aggregate amount of all advances made under this section shall not be greater than $300,000,000.

''(d) MATURITY OF ANY INTERMEDIATE-TERM ADVANCE.—

''(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), each advance made under this section shall mature on the date designated by the Mayor in the Mayor's requisition for such advance.

''(2) LATEST PERMISSIBLE MATURITY DATE.—Notwithstanding paragraph (1), the maturity date for any advance made under this section shall not be later than 10 years from the date on which the first advance under this section is made.

''(4) SECRETARY'S RIGHT TO REQUIRE EARLY REIMBURSEMENT.—Notwithstanding paragraph (1), if the Secretary determines, at any time while any advance made under this section has not been fully reimbursed, that the District is able to obtain credit in the public credit markets or elsewhere in sufficient amounts and on sufficiently reasonable terms, in the judgment of the Secretary, to refinance all or a portion of the unpaid balance of such advance in the public credit markets or elsewhere without adversely affecting the financial stability of the District government, the Secretary may require reimbursement for all or a portion of the unpaid balance of such advance at any time after the Secretary makes the determination.

''(e) INTEREST RATE.—Each advance made under this section shall bear interest at an annual rate equal to a rate determined by the Secretary at the time that the Secretary makes such advance taking into consideration the prevailing yield on outstanding marketable obligations of the United States with remaining periods to maturity comparable to the repayment schedule of such advance, plus ⅛ of 1 percent.

''(f) OTHER TERMS AND CONDITIONS.—Each advance made under this section shall be on such other terms and conditions, including repayment schedule, as the Secretary determines to be appropriate.

''(g) DEPOSIT OF ADVANCES.—As provided in section 204(b) of the District of Columbia Financial Responsibility and Management Assistance Act of 1995, advances made under this section for the account of the District government shall be deposited by the Secretary into an escrow account held by the Authority.''.

**SEC. 11403. CONFORMING AMENDMENTS.**

(a) AMENDMENT TO SECTION 601.—Section 601 of the District of Columbia Revenue Act of 1939 (DC Code, sec. 47–3401) is amended—

(1) in subsection (c)(2)(B)(i)(IV), by striking ''602(b)'' and inserting ''603(b)''; and

(2) in subsection (d)(2)(B)(iii), by striking ''602(b)'' and inserting ''603(b)''.

(b) AMENDMENT TO SECTION 604.—Section 604 of the District of Columbia Revenue Act of 1939 (DC Code, sec. 47–3401.3) is amended—

(1) in subsection (a)(2)(A)(i), by striking ''602'' and inserting ''603''; and

(2) in subsection (a)(2)(B)(i), by striking ''602'' and inserting ''603''.

**SEC. 11404. TECHNICAL CORRECTIONS.**

Section 601 of the District of Columbia Revenue Act of 1939 (DC Code, sec. 47–3401) is amended—

(1) in subsection (a)(3)(D), by striking ''September 30, 1995'' and inserting ''September 30, 1996'';

(2) in subsection (b)(2)(E), by striking ''September 30, 1996'' and inserting ''September 30, 1997'';

(3) in subsection (c)(2)(B)(i), by striking ''October 1, 1995'' and inserting ''September 30, 1995'';

(4) in subsection (d)(2)(B)(i)(II), by striking ''September 30, 1997'' and inserting ''September 30, 1998'';

(5) in subsection (d)(2)(B)(ii)—

(A) by striking ''September 30, 1995'' and inserting ''October 1, 1995''; and

(B) by striking ''September 30, 1997'' and inserting ''October 1, 1997''; and

(6) in subsection (d)(2)(C)(iv), by striking ''September 30, 1997'' and inserting ''September 30, 1998''.

**SEC. 11405. AUTHORIZATION FOR ISSUANCE OF GENERAL OBLIGATION BONDS BY THE DISTRICT OF COLUMBIA TO FINANCE OR REFUND ITS ACCUMULATED GENERAL FUND DEFICIT.**

Section 461(a) of the District of Columbia Self-Government and Governmental Reorganization Act (DC Code, sec. 47–321(a)) is amended—

(1) in paragraph (1), by inserting ''to finance or refund the outstanding accumulated operating deficit of the general fund of the District of $500,000,000, existing as of September 30, 1997,'' after ''existing as of September 30, 1990,''; and

(2) in paragraph (2), by inserting ''existing as of September 30, 1990'' after ''operating deficit''.

**Subtitle F—District of Columbia Bond Financing Improvements**

**SEC. 11501. SHORT TITLE.**

This subtitle may be cited as the ''District of Columbia Bond Financing Improvements Act of 1997''.

**SEC. 11502. FINDINGS.**

Congress finds as follows:

(1) The bond authorization provision of the District of Columbia Self-Government and Governmental Reorganization Act (commonly known as the ''Home Rule Act'') have not been updated to conform with changes in the municipal securities marketplace.

(2) The Home Rule Act unduly limits the ability of the District to take advantage of cost savings, investment opportunities, and other efficiencies generally available to municipal securities issuers.

(3) Section 461 of the Home Rule Act limits the ability of the District government to implement cost-effective capital planning to the extent that it does not permit the District access to interim capital financing in anticipation of its periodic long-term borrowings.

(4) Section 462 of the Home Rule Act prevents the reprogramming of unused bond proceeds from dormant projects to other pending, authorized, and viable projects.

(5) Section 466 of the Home Rule Act requires that the District undertake competitive bond sales even under circumstances in which greater efficiencies can be achieved through negotiated sales.

(6) Section 490 of the Home Rule Act does not permit the issuance and sale of taxable and tax-exempt bonds for the full range of economic development and governmental purposes permitted the States and their political subdivisions.

**SEC. 11503. AMENDMENT TO SECTION 462 (RELATING TO CONTENTS OF BORROWING LEGISLATION AND ELECTIONS ON ISSUING GENERAL OBLIGATION BONDS).**

Section 462(a) of the District of Columbia Self-Government and Governmental Reorganization Act (DC Code, sec. 47–322(a)) is amended to read as follows:

''(a) The Council may by act authorize the issuance of general obligation bonds for the purposes specified in section 461. Such an Act shall contain, at least, provisions—

''(1) briefly describing the projects or categories of projects to be financed by the Act;

''(2) identifying the act authorizing each such project or category of projects;

''(3) setting forth the maximum amount of the principal of the indebtedness which may be incurred for the projects to be financed;

''(4) setting forth the maximum rate of interest to be paid on such indebtedness;

''(5) setting forth the maximum allowable maturity for the issue and the maximum debt service payable in any year; and

''(6) setting forth, in the event that the Council determines in its discretion to submit the question of issuing such bonds to a vote of the qualified voters of the District, the manner of holding such election, the date of such election, the manner of voting for or against the incurring of such indebtedness, and the form of ballot to be used at such election.''.

**SEC. 11504. AMENDMENT TO SECTION 466 (RELATING TO PUBLIC OR NEGOTIATED SALE OF GENERAL OBLIGATION BONDS).**

Section 466 of the District of Columbia Self-Government and Governmental Reorganization Act (DC Code, sec. 47–326) is amended by striking all after the heading and inserting the following:

''SEC. 466. General obligation bonds issued under this part may be sold at a private sale on a negotiated basis (in such manner as the Mayor may determine to be in the public interest), or may be sold at public sale upon sealed proposals after publication of a notice of such public sale at least once not less than 10 days prior to the date fixed for sale in a daily newspaper carrying municipal bond notices and devoted primarily to financial news or to the subject of State and municipal bonds published in the city of New York, New York, and in 1 or more newspapers of general circulation published in the District. Such notice of public sale shall state, among other things, that no proposal shall be considered unless there is deposited with the District as a down payment a certified check, cashier's check, or surety for an amount equal to at least 2 percent of the par amount of general obligation bonds bid for, and the Mayor shall reserve the right to reject any and all bids.''

**SEC. 11505. AMENDMENT TO SECTION 467 (RELATING TO AUTHORITY TO CREATE SECURITY INTERESTS IN DISTRICT REVENUES).**

Section 467 of the District of Columbia Self-Government and Governmental Reorganization Act (D.C. Code Sec. 47–326.1.) is amended by striking all after the heading and inserting the following:

''SEC. 467. (a) IN GENERAL.—An act of the Council authorizing the issuance of general obligation bonds or notes under section 461(a), section 471(a), section 472(a), or section 475(a) may create a security interest in any District revenues as additional security for the payment of the bonds or notes authorized by such act.

''(b) CONTENTS OF ACTS.—Any such act creating a security interest in District revenues may contain provisions (which may be part of the contract with the holders of such bonds or notes)—

''(1) describing the particular District revenues which are subject to such security interest;

''(2) creating a reasonably required debt service reserve fund or any other special fund;

''(3) authorizing the Mayor of the District to execute a trust indenture securing the bonds or notes;

''(4) vesting in the trustee under such a trust indenture such properties, rights, powers, and duties in trust as may be necessary, convenient, or desirable;

''(5) authorizing the Mayor of the District to enter into and amend agreements concerning—

''(A) the custody, collection, use, disposition, security, investment, and payment of the proceeds of the bonds or notes and the District revenues which are subject to such security interest; and

''(B) the doing of any act (or the refraining from doing any act) that the District would have the right to do in the absence of such an agreement;

''(6) prescribing the remedies of the holders of the bonds or notes in the event of a default; and

''(7) authorizing the Mayor to take any other actions in connection with the issuance, sale, delivery, security, and payment of the bonds or notes.

''(c) TIMING AND PERFECTION OF SECURITY INTERESTS.—Notwithstanding article 9 of title 28 of the District of Columbia Code, any security interest in District revenues created under subsection (a) shall be valid, binding, and perfected from the time such security interest is created, with or without the physical delivery of any funds or any other property and with or without any further action. Such security interest shall be valid, binding, and perfected whether or not any statement, document, or instrument relating to such security interest is recorded or filed. The lien created by such security interest is valid, binding, and perfected with respect to any individual or legal entity having claims against the District, whether or not such individual or legal entity has notice of such lien.

''(d) OBLIGATIONS AND EXPENDITURES NOT SUBJECT TO APPROPRIATION.—The fourth sentence of section 446 shall not apply to any obligation or expenditure of any District revenues to secure any general obligation bond or note under subsection (a).''.

**SEC. 11506. AMENDMENT TO SECTION 472 (RELATING TO BORROWING IN ANTICIPATION OF REVENUES).**

Section 472 of the District of Columbia Self-Government and Governmental Reorganization Act (DC Code, sec. 47-328) is amended by striking all after the heading and inserting the following:

''SEC. 472. (a) IN GENERAL.—In anticipation of the collection or receipt of revenues for a fiscal year, the Council may by act authorize the issuance of general obligation notes for such fiscal year, to be known as revenue anticipation notes.

''(b) LIMIT ON AGGREGATE NOTES OUTSTANDING.—The total amount of all revenue anticipation notes issued under subsection (a) outstanding at any time during a fiscal year shall not exceed 20 percent of the total anticipated revenue of the District for such fiscal year, as certified by the Mayor under this subsection. The Mayor shall certify, as of a date which occurs not more than 15 days before each original issuance of such revenue anticipation notes, the total anticipated revenue of the District for such fiscal year.

''(c) PERMITTED OUTSTANDING DURATION.—Any revenue anticipation note issued under subsection (a) may be renewed. Any such note, including any renewal note, shall be due and payable not later than the last day of the fiscal year during which the note was originally issued.

''(d) EFFECTIVE DATE OF AUTHORIZATION ACTS; PAYMENTS NOT SUBJECT TO APPROPRIATION.—

''(1) EFFECTIVE DATE.—Notwithstanding section 602(c)(1), any act of the Council authorizing the issuance of revenue anticipation notes under subsection (a) shall take effect—

''(A) if such act is enacted during a control year (as defined in section 305(4) of the District of Columbia Financial Responsibility and Management Assistance Act of 1995), on the date of approval by the District of Columbia Financial Responsibility and Management Assistance Authority; or

''(B) if such act is enacted during any other year, on the date of enactment of such act.

''(2) PAYMENTS NOT SUBJECT TO APPROPRIATION.—The fourth sentence of section 446 shall not apply to any amount obligated or expended by the District for the payment of the principal of, interest on, or redemption premium for any revenue anticipation note issued under subsection (a).''.

**SEC. 11507. ADDITION OF NEW SECTION 475 (RELATING TO GENERAL OBLIGATION BOND ANTICIPATION NOTES).**

(a) IN GENERAL.—Subpart 2 of part E of title IV of the District of Columbia Self-Government and Governmental Reorganization Act is amended by adding at the end the following new section:

''BOND ANTICIPATION NOTES

''SEC. 475. (a) AUTHORIZING ISSUANCE.—

''(1) IN GENERAL.—In anticipation of the issuance of general obligation bonds, the Council may by act authorize the issuance of general obligation notes to be known as bond anticipation notes in accordance with this section.

''(2) PURPOSES; PERMITTING ISSUANCE OF GENERAL OBLIGATION BONDS TO COVER INDEBTEDNESS.—The proceeds of bond anticipation notes issued under this section shall be used for the purposes for which general obligation bonds may be issued under section 461, and such notes shall constitute indebtedness which may be refunded through the issuance of general obligation bonds under such section.

''(b) MAXIMUM ANNUAL DEBT SERVICE AMOUNT.—The Act of the Council authorizing the issuance of bond anticipation notes shall set forth for the bonds anticipated by such notes an estimated maximum annual debt service amount based on an estimated schedule of annual principal payments and an estimated schedule of annual interest payments (based on an estimated maximum average annual interest rate for such bonds over a period of 30 years from the earlier of the date of issuance of the notes or the date of original issuance of prior notes in anticipation of those bonds). Such estimated maximum annual debt service amount as estimated at the time of issuance of the original bond anticipation notes shall be included in the calculation required by section 603(b) while such notes or renewal notes are outstanding.

''(c) PERMITTED OUTSTANDING DURATION.—Any bond anticipation note, including any renewal note, shall be due and payable not later than the last day of the third fiscal year following the fiscal year during which the note was originally issued.

''(d) GENERAL AUTHORITY OF COUNCIL.—If provided for in Act of the Council authorizing such an issue of bond anticipation notes, bond anticipation notes may be issued in succession, in such amounts, at such times, and bearing interest rates within the permitted maximum authorized by such Act.

''(e) EFFECTIVE DATE OF AUTHORIZATION ACTS; PAYMENTS NOT SUBJECT TO APPROPRIATION.—

''(1) EFFECTIVE DATE.—Notwithstanding section 602(c)(1), any act of the Council authorizing the renewal of bond anticipation notes under subsection (c) or the issuance of general obligation bonds under section 461(a) to refund any bond anticipation notes shall take effect—

''(A) if such act is enacted during a control year (as defined in section 305(4) of the District of Columbia Financial Responsibility and Management Assistance Act of 1995), on the date of approval by the District of Columbia Financial Responsibility and Management Assistance Authority; or

''(B) if such act is enacted during any other year, on the date of enactment of such act.

''(2) PAYMENT NOT SUBJECT TO APPROPRIATION.—The fourth sentence of 446 shall not apply to any amount obligated or expended by the District for the payment of the principal of, interest on, or redemption premium for any bond anticipation note issued under this section.''.

(b) CLERICAL AMENDMENT.—The table of contents for the District of Columbia Self-Government and Governmental Reorganization Act is amended by adding at the end of the items relating to subpart 2 of part E of title IV the following new item:

''Sec. 475. Bond anticipation notes.''.

**SEC. 11508. AMENDMENT TO SECTION 490 (RELATING TO REVENUE BONDS AND OTHER OBLIGATIONS).**

Section 490 of the District of Columbia Self-Government and Governmental Reorganization Act (DC Code, sec. 47–334), as

amended by section 2 of the District of Columbia Water and Sewer Authority Act of 1996, is amended—

(1) in subsection (a)—

(A) by amending paragraphs (1) through (3) to read as follows:

''(a)(1) Subject to paragraph (2), the Council may by act or by resolution authorize the issuance of taxable and tax-exempt revenue bonds, notes, or other obligations to borrow money to finance, refinance, or reimburse and to assist in the financing, refinancing, or reimbursing of or for capital projects and other undertakings by the District or by any District instrumentality, or on behalf of any qualified applicant, including capital projects or undertakings in the areas of housing; health facilities; transit and utility facilities; manufacturing; sports, convention, and entertainment facilities; recreation, tourism and hospitality facilities; facilities to house and equip operations of the District government or its instrumentalities; public infrastructure development and redevelopment; elementary, secondary and college and university facilities; educational programs which provide loans for the payment of educational expenses for or on behalf of students; facilities used to house and equip operations related to the study, development, application, or production of innovative commercial or industrial technologies and social services; water and sewer facilities (as defined in paragraph (5)); pollution control facilities; solid and hazardous waste disposal facilities; parking facilities, industrial and commercial development; authorized capital expenditures of the District; and any other property or project that will, as determined by the Council, contribute to the health, education, safety, or welfare, of, or the creation or preservation of jobs for, residents of the District, or to economic development of the District, and any facilities or property, real or personal, used in connection with or supplementing any of the foregoing; lease-purchase financing of any of the foregoing facilities or property; and any costs related to the issuance, carrying, security, liquidity or credit enhancement of or for revenue bonds, notes, or other obligations, including, capitalized interest and reserves, and the costs of bond insurance, letters of credit, and guaranteed investment, forward purchase, remarketing, auction, and swap agreements. Any such financing, refinancing, or reimbursement may be effected by loans made directly or indirectly to any individual or legal entity, by the purchase of any mortgage, note, or other security, or by the purchase, lease, or sale of any property.

''(2) Any revenue bond, note, or other obligation issued under paragraph (1) shall be a special obligation of the District and shall be a negotiable instrument, whether or not such revenue bond, note, or other obligation is a security as defined in section 28:8-102(1)(a) of title 28 of the District of Columbia Code.

''(3) Any revenue bond, note, or other obligation issued under paragraph (1) shall be paid and secured (as to principal, interest, and any premium) as provided by the act or resolution of the Council authorizing the issuance of such revenue bond, note, or other obligation. Any act or resolution of the Council, or any delegation of Council authority under subsection (a)(6), authorizing the issuance of revenue bonds, notes, or other obligations may provide for (A) the payment of such revenue bonds, notes, or other obligations from any available revenues, assets, property (including water and sewer enterprise fund revenues, assets, or other property in the case of bonds, notes, or obligations issued with respect to water and sewer facilities), and (B) the securing of such revenue bond, note, or other obligation by the mortgage of real property or the creation of a security interest in available revenues, assets, or other property (including water and sewer enterprise fund revenues, assets, or other property in the case of bonds, notes, or obligations issued with respect to water and sewer facilities).'',

(B) by amending paragraph (4)(A) to read as follows:

''(4)(A) In authorizing the issuance of any revenue bond, note, or other obligation under paragraph (1), the Council may enter into, or authorize the Mayor to enter into, any agreement concerning the acquisition, use, or disposition of any available revenues, assets, or property. Any such agreement may create a security interest in any available revenues, assets, or property, may provide for the custody, collection, security, investment, and payment of any available revenues (including any funds held in trust) for the payment of such revenue bond, note, or other obligation, may mortgage any property, may provide for the acquisition, construction, maintenance, and disposition of the undertaking financed or refinanced using the proceeds of such revenue bond, note, or other obligation, and may provide for the doing of any act (or the refraining from doing of any act) which the District has the right to do in the absence of such agreement. Any such agreement may be assigned for the benefit of, or made a part of any contract with, any holder of such revenue bond, note, or other obligation issued under paragraph (1).'', and

(C) by adding at the end the following new paragraph:

''(6)(A) The Council may by act delegate to any District instrumentality the authority of the Council under subsection (a)(1) to issue taxable or tax-exempt revenue bonds, notes, or other obligations to borrow money for the purposes specified in this subsection. For purposes of this paragraph, the Council shall specify for what undertakings revenue bonds, notes, or other obligations may be issued under each delegation made pursuant to this paragraph. Any District instrumentality may exercise the authority and the powers incident thereto delegated to it by the Council as described in the first sentence of this paragraph only in accordance with this paragraph and shall be consistent with this paragraph and the terms of the delegation.

''(B) Revenue bonds, notes, or other obligations issued by a District instrumentality under a delegation of authority described in subparagraph (A) shall be issued by resolution of that instrumentality, and any such resolution shall not be considered to be an act of the Council.

''(C) Nothing in this paragraph shall be construed as restricting, impairing, or superseding the authority otherwise vested by law in any District instrumentality.'';

(2) by amending subsection (b) to read as follows:

''(b) No property owned by the United States may be mortgaged or made subject to any security interest to secure any revenue bond, note, or other obligation issued under subsection (a)(1).'';

(3) by amending subsection (c) to read as follows:

''(c) Any and all such revenue bonds, notes, or other obligations issued under subsection (a)(1) shall not be general obligations of the District, shall not be a pledge of or involve the faith and credit or taxing power of the District (other than with respect to any dedicated taxes) and shall not constitute a debt of the District, and shall not constitute lending of the public credit for private undertakings for purposes of section 602(a)(2).'';

(4) by amending subsection (f) to read as follows:

''(f) The fourth sentence of section 446 shall not apply to—

''(1) any amount (including the amount of any accrued interest or premium) obligated or expended from the proceeds of the sale of any revenue bond, note, or other obligations issued under subsection (a)(1);

''(2) any amount obligated or expended for the payment of the principal of, interest on, or any premium for any revenue bond, note, or other obligation issued under subsection (a)(1);

''(3) any amount obligated or expended pursuant to provisions made to secure any revenue bond, note, or other obligations issued under subsection (a)(1); and

''(4) any amount obligated or expended pursuant to commitments made in connection with the issuance of revenue bonds, notes, or other obligations for repair, maintenance, and capital improvements relating to undertakings financed through any revenue bond, note, or other obligation issued under subsection (a)(1).''; and

(5) by adding at the end the following new subsections:

''(i) The revenue bonds, notes, or other obligations issued under subsection (a)(1) are not general obligation bonds of the District government and shall not be included in determining the aggregate amount of all outstanding obligations subject to the limitation specified in section 603(b).

''(j) The issuance of revenue bonds, notes, or other obligations by the District where the ultimate obligation to repay such revenue bonds, notes, or other obligations is that of one or more non-governmental persons or entities may be authorized by resolution of the Council. The issuance of all other revenue bonds, notes, or other obligations by the District shall be authorized by act of the Council.

''(k) During any control period (as defined in section 209 of the District of Columbia Financial Responsibility and Management Assistance Act of 1995), any act or resolution of the Council authorizing the issuance of revenue bonds, notes, or other obligations under subsection (a)(1) shall be submitted to the District of Columbia Financial Responsibility and Management Assistance Authority for certification in accordance with section 204 of that Act. Any certification issued by the Authority during a control period shall be effective for purposes of this subsection for revenue bonds, notes, or other obligations issued pursuant to such act or resolution of the Council whether the revenue bonds, notes, or other obligations are issued during or subsequent to that control period.

''(l) The following provisions of law shall not apply with respect to property acquired, held, and disposed of by the District in accordance with the terms of any lease-purchase financing authorized pursuant to subsection (a)(1):

''(1) The Act entitled 'An Act authorizing the sale of certain real estate in the District of Columbia no longer required for public purposes', approved August 5, 1939 (53 Stat. 1211; DC Code sec. 9–401 et seq.).

''(2) Subchapter III of chapter 13 of title 16, District of Columbia Code.

''(3) Any other provision of District of Columbia law that prohibits or restricts lease-purchase financing.

''(m) For purposes of this section, the following definitions shall apply:

''(1) The term 'revenue bonds, notes, or other obligations' means special fund bonds, notes, or other obligations (including refunding bonds, notes, or other obligations) used to borrow money to finance, assist in financing, refinance, or repay, restore or reimburse moneys used for purposes referred to in subsection (a)(1) the principal of and interest, if any, on which are to be paid and secured in the manner described in this section and which are special obligations and to which

the full faith and credit of the District of Columbia is not pledged.

''(2) The term 'District instrumentality' means any agency or instrumentality (including an independent agency or instrumentality), authority, commission, board, department, division, office, body, or officer of the District of Columbia government duly established by an act of the Council or by the laws of the United States, whether established before or after the date of enactment of the District of Columbia Bond Financing Improvements Act of 1997.

''(3) The term 'available revenues' means gross revenues and receipts, other than general fund tax receipts, lawfully available for the purpose and not otherwise exclusively committed to another purpose, including enterprise funds, grants, subsidies, contributions, fees, dedicated taxes and fees, investment income and proceeds of revenue bonds, notes, or other obligations issued under this section.

''(4) The term 'enterprise fund' means a fund or account for operations that are financed or operated in a manner similar to private business enterprises, or established so that separate determinations may more readily be made periodically of revenues earned, expenses incurred, or net income for management control, accountability, capital maintenance, public policy, or other purposes.

''(5) The term 'dedicated taxes and fees' means taxes and surtaxes, portions thereof, tax increments, or payments in lieu of taxes, and fees that are dedicated pursuant to law to the payment of the debt service on revenue bonds, notes, or other obligations authorized under this section, the provision and maintenance of reserves for that purpose, or the provision of working capital for or the maintenance, repair, reconstruction or improvement of the undertaking to which the revenue bonds, notes, or other obligations relate.

''(6) The term 'tax increments' means taxes, other than the special tax provided for in section 481 and pledged to the payment of general obligation indebtedness of the District, allocable to the increase in taxable value of real property or the increase in sales tax receipts, each from a certain date or dates, in prescribed areas, to the extent that such increases are not otherwise exclusively committed to another purpose and as further provided for pursuant to an act of the Council.''.

**SEC. 11509. CONFORMING AMENDMENT.**

The fourth sentence of section 446 of the District of Columbia Self-Government and Governmental Reorganization Act (DC Code, sec. 47–304) is amended to read as follows: ''Except as provided in section 467(d), section 471(c), section 472(d)(2), section 475(e)(2), section 483(d), and section 490(f), (g), and (h)(3), no amount may be obligated or expended by any officer or employee of the District of Columbia government unless such amount has been approved by Act of Congress, and then only according to such Act.''.

## Subtitle G—District of Columbia Government Budget

**SEC. 11601. ELIMINATION OF THE ANNUAL FEDERAL PAYMENT TO THE DISTRICT OF COLUMBIA.**

(a) ELIMINATION OF PAYMENT.—

(1) IN GENERAL.—Title V of the District of Columbia Self-Government and Governmental Reorganization Act (DC Code, sec. 47–3406 et seq.) is hereby repealed.

(2) CLERICAL AMENDMENT.—The table of contents of such Act is amended by striking the items relating to title V.

(b) CONFORMING AMENDMENTS.—

(1) HOME RULE ACT.—The District of Columbia Self-Government and Governmental Reorganization Act is amended as follows:

(A) In section 103(10) (DC Code, sec. 1–202(10)), by striking ''the annual Federal payment to the District authorized under title V,''.

(B) In section 483 (DC Code, sec. 47–331.2), by striking subsection (c).

(C) In section 603(c) (DC Code, sec. 47–313(c)), by striking the fourth sentence.

(D) In section 603(f)(1) (DC Code, sec. 47–313(f)(1)), by striking ''(other than the fourth sentence)''.

(2) FINANCIAL RESPONSIBILITY AND MANAGEMENT ASSISTANCE ACT.—The District of Columbia Financial Responsibility and Management Assistance Act of 1995 is amended—

(A) by striking section 205 (DC Code, sec. 47–392.5); and

(B) in the table of contents for such Act, by striking the item relating to section 205.

(3) PROCUREMENT PRACTICES ACT.—Section 208(a)(2) of the District of Columbia Procurement Practices Act of 1985 (DC Code, sec. 1–1182.8(a)(2)) is amended—

(1) by striking subparagraph (B);

(2) by redesignating subparagraph (C) as subparagraph (B); and

(3) in subparagraph (B), as so redesignated, by striking ''Amounts deposited in the dedicated fund described in subparagraph (B)'' and inserting ''Amounts appropriated for the Inspector General''.

(4) DISTRICT OF COLUMBIA REVENUE ACT OF 1939.—The District of Columbia Revenue Act of 1939 (DC Code, sec. 47–3401 et seq.) is amended as follows:

(A) In section 603(b) (as redesignated by section 11402)—

(i) in paragraph (5), by adding ''and'' at the end;

(ii) in paragraph (6), by striking ''; and'' and inserting a period; and

(iii) by striking paragraph (7).

(B) In section 603(c) (as redesignated by section 11402), by amending subparagraph (C) to read as follows:

''(C) APPLICABLE LIMIT DEFINED.—In this paragraph, the 'applicable limit' for a fiscal year is equal to 15 percent of the total anticipated revenues of the District government for such fiscal year, as certified by the Mayor at the time of the Mayor's requisition for an advance.''.

(C) In section 605(b) (as redesignated by section 11402)—

(i) by striking paragraph (1) and redesignating paragraphs (2) through (4) as paragraphs (1) through (3);

(ii) in paragraph (1) (as so redesignated), by striking ''OTHER'' in the heading;

(iii) in paragraph (1) (as so redesignated), by striking ''If, after'' and all that follows through ''the Secretary'' and inserting ''The Secretary'';

(iv) in paragraph (1) (as so redesignated), by striking ''to individuals,'' and inserting ''to individuals (including any Federal contribution authorized to be appropriated pursuant to section 11601(c)(2) of the Balanced Budget Act of 1997),'';

(v) in paragraph (2) (as so redesignated), by striking ''paragraphs (1) and (2)'' and inserting ''paragraph (1)''; and

(vi) in paragraph (3) (as so redesignated), by striking ''(1) through (3)'' and inserting ''(1) and (2)''.

(c) FEDERAL CONTRIBUTION TO OPERATIONS OF GOVERNMENT OF NATION'S CAPITAL.—

(1) FINDINGS.—Congress finds as follows:

(A) Congress has restricted the overall size of the District of Columbia's economy by limiting the height of buildings in the District and imposing other limitations relating to the Federal presence in the District.

(B) Congress has imposed limitations on the District's ability to tax income earned in the District of Columbia.

(C) The unique status of the District of Columbia as the seat of the government of the United States imposes unusual costs and requirements which are not imposed on other jurisdictions and many of which are not directly reimbursed by the Federal government.

(D) These factors play a significant role in causing the relative tax burden on District residents to be greater than the burden on residents in other jurisdictions in the Washington, D.C. metropolitan area and in other cities of comparable size.

(2) FEDERAL CONTRIBUTION.—There is authorized to be appropriated a Federal contribution towards the costs of the operation of the government of the Nation's capital—

(A) for fiscal year 1998, $190,000,000; and

(B) for each subsequent fiscal year, such amount as may be necessary for such contribution.

In determining the amount appropriated pursuant to the authorization under this paragraph, Congress shall take into account the findings described in paragraph (1).

**SEC. 11602. REQUIREMENT THAT THE DISTRICT OF COLUMBIA BALANCE ITS BUDGET IN FY 1998.**

(a) IN GENERAL.—Section 201(c)(1) of the District of Columbia Financial Responsibility and Management Assistance Act of 1995 is amended—

(1) in subparagraph (A), by striking ''1999'' and inserting ''1998''; and

(2) in subparagraph (B), by striking ''1996, 1997, and 1998,'' and inserting ''1996 and 1997,''.

(b) CONFORMING AMENDMENT.—Section 603(f) of the District of Columbia Self-Government and Governmental Reorganization Act (DC Code, sec. 47–313(f)) is amended by striking ''Act of 1995)—'' and all that follows through ''(2) the Council'' and inserting ''Act of 1995), the Council''.

**SEC. 11603. PERMITTING EXPEDITED SUBMISSION AND APPROVAL OF CONSENSUS BUDGET AND FINANCIAL PLAN.**

(a) FINDINGS.—Congress finds the following:

(1) The District of Columbia Financial Responsibility and Management Assistance Act (hereafter in this subsection referred to as the ''Act'') was structured as to preserve the maximum prerogatives of each branch of elected self-government consistent with returning the District of Columbia to full financial stability and health.

(2) The Act was intended to eliminate unnecessary bureaucratic barriers and procedures throughout the District government, including the budget process.

(3) Preservation of home rule and self-government are consistent with cooperation between elected officials and the Authority in drawing the annual budget and other matters affecting the District of Columbia government, and are preferable to achieve greater efficiency, communication among the parties, and avoidance of conflict and delay.

(b) IN GENERAL.—Section 202 of the District of Columbia Financial Responsibility and Management Assistance Act of 1995 is amended by adding at the end the following new subsection:

''(i) EXPEDITED SUBMISSION AND APPROVAL OF CONSENSUS BUDGET AND FINANCIAL PLAN.—Notwithstanding any other provision of this section, if the Mayor, the Council, and the Authority jointly develop a financial plan and budget for the fiscal year which meets the requirements applicable under section 201 and which the Mayor, Council, and Authority certify reflects a consensus among them—

''(1) such financial plan and budget shall serve as the budget of the District government for the fiscal year adopted by the Council under section 446 of the District of Columbia Self-Government and Governmental Reorganization Act; and

''(2) the Mayor shall transmit the financial plan and budget to the President and Congress under such section.''.

(c) EFFECTIVE DATE.—The amendment made by subsection (b) shall apply with respect to fiscal years beginning with fiscal year 1998.

**SEC. 11604. INCREASE IN MAXIMUM AMOUNT OF PERMITTED DISTRICT BORROWING.**

Section 603(b) of the District of Columbia Self-Government and Governmental Reorganization Act (DC Code, sec. 47–313(b)) is amended by striking ''14 per centum'' each place it appears in paragraph (1) and paragraph (3) and inserting ''17 percent''.

**Subtitle H—Miscellaneous Provisions**

**CHAPTER 1—REGULATORY REFORM IN THE DISTRICT OF COLUMBIA**

**SEC. 11701. REVIEW AND REVISION OF REGULATIONS AND PERMIT AND APPLICATION PROCESSES.**

(a) REVIEW OF CURRENT REGULATIONS BY AUTHORITY.—

(1) IN GENERAL.—Not later than 6 months after the date of the enactment of this title, the District of Columbia Financial Responsibility and Management Assistance Authority shall complete a review of regulations of the District of Columbia in effect as of the date of the enactment of this title and analyze the extent to which such regulations unnecessarily and inappropriately impair economic development in the District of Columbia and the financial stability and management efficiency of the District of Columbia government. To the greatest extent possible, such review shall take into account the work and recommendations of the Business Regulatory Reform Commission pursuant to the Business Regulatory Reform Commission Act of 1994 (DC Code, sec. 2–4101 et seq.) and other existing and ongoing public and private regulatory reform efforts. The Authority shall transmit the findings of its review to the Mayor, Council, and Congress.

(2) REVISION.—Based on the review conducted under paragraph (1) and taking into account actions by the Council and the Executive Branch of the District of Columbia government, the Authority shall take such additional actions as it considers appropriate to repeal or revise the regulations of the District of Columbia, in accordance with (and subject to the terms and conditions described in) section 207 of the District of Columbia Financial Responsibility and Management Assistance Act of 1995.

(b) SURVEY AND REVISION OF PERMIT AND APPLICATION PROCESSES.—

(1) IN GENERAL.—Not later than 6 months after the date of the enactment of this title, the Authority shall complete a review of the current processes of the District of Columbia for obtaining permits and applications of all types and analyze the extent to which such processes and their completion times vary from the processes applicable in other jurisdictions. To the greatest extent possible, such review shall take into account the work and recommendations of the Business Regulatory Reform Commission pursuant to the Business Regulatory Reform Commission Act of 1994 (DC Code, sec. 2–4101 et seq.) and other existing and ongoing public and private regulatory reform efforts. The Authority shall transmit the findings of its review to the Mayor, Council, and Congress.

(2) REVISION.—Based on the review conducted under paragraph (1) and taking into account actions by the Council and the Executive Branch of the District of Columbia government, the Authority shall take such additional actions as it considers appropriate to repeal or revise the permit and application processes (and their completion times) of the District of Columbia, in accordance with (and subject to the terms and conditions described in) section 207 of the District of Columbia Financial Responsibility and Management Assistance Act of 1995. In carrying out such repeals or revisions, the Authority shall seek to ensure that the average time required to obtain a permit or application from the District of Columbia is consistent with the average time for other similar jurisdictions in the United States.

(c) REPORTS TO CONGRESS.—Upon the expiration of the 6-month period which begins on the date of the enactment of this title and on a quarterly basis thereafter, the Authority shall submit a report to Congress describing the steps taken to carry out the requirements of this section and the effectiveness of the regulatory, permit, and application processes of the District of Columbia.

**SEC. 11702. REPEAL OF CLEAN AIR COMPLIANCE FEE ACT OF 1994.**

(a) REPEAL.—

(1) IN GENERAL.—Effective March 21, 1995, the Clean Air Compliance Fee Act of 1994 is hereby repealed (DC Code, sec. 47–2731 et seq.), except as provided in subsection (b).

(2) CONFORMING AMENDMENT.—Section 2(b)(2) of the Stable and Reliable Source of Revenues for WMATA Act of 1982 (DC Code, sec. 1–2466(b)(2)) is amended by striking subparagraph (H).

(b) EXCEPTION FOR PROVISIONS EXEMPTING DELIVERY OF NEWSPAPERS FROM APPLICATION OF CERTAIN TAXES.—Subsection (a) shall not apply to section 14 of the Clean Air Compliance Fee Act of 1994.

**SEC. 11703. REPEAL REQUIREMENT FOR CONGRESSIONAL AUTHORIZATION OF CERTAIN MERGERS INVOLVING DISTRICT OF COLUMBIA PUBLIC UTILITY CORPORATIONS.**

Section 11 of the Act of March 4, 1913 (37 Stat. 1006; DC Code, sec. 43–802) is hereby repealed.

**SEC. 11704. EXEMPTION OF CERTAIN CONTRACTS FROM COUNCIL REVIEW.**

(a) IN GENERAL.—Section 451 of the District of Columbia Self-Government and Governmental Reorganization Act (sec. 1–1130, D.C. Code) is amended by adding at the end the following new subsection:

''(d) EXEMPTION FOR CERTAIN CONTRACTS.—The requirements of this section shall not apply with respect to any of the following contracts:

''(1) Any contract entered into by the Washington Convention Center Authority for preconstruction activities, project management, design, or construction.

''(2) Any contract entered into by the District of Columbia Water and Sewer Authority established pursuant to the Water and Sewer Authority Establishment and Department of Public Works Reorganization Act of 1996, other than contracts for the sale or lease of the Blue Plains Wastewater Treatment Plant.

''(3) At the option of the Council, any contract for a highway improvement project carried out under title 23, United States Code.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to contracts entered into on or after the date of the enactment of this title.

**CHAPTER 2—OTHER MISCELLANEOUS PROVISIONS**

**SEC. 11711. REVISIONS TO FINANCIAL RESPONSIBILITY AND MANAGEMENT ASSISTANCE ACT.**

(a) USE OF INTEREST ON ACCOUNTS OF AUTHORITY FOR BENEFIT OF DISTRICT.—Section 106 of the District of Columbia Financial Responsibility and Management Assistance Act of 1995 (DC Code, sec. 47–391.6) is amended by adding at the end the following new subsection:

''(d) USE OF INTEREST ON ACCOUNTS FOR DISTRICT.—

''(1) IN GENERAL.—Notwithstanding any other provision of this Act, the Authority may transfer or otherwise expend any amounts derived from interest earned on accounts held by the Authority on behalf of the District of Columbia for such purposes as it considers appropriate to promote the economic stability and management efficiency of the District government.

''(2) SPENDING NOT SUBJECT TO APPROPRIATION BY CONGRESS.—Notwithstanding subsection (a)(3), any amounts transferred or otherwise expended pursuant to paragraph (1) may be obligated or expended without approval by Act of Congress.''.

(b) APPOINTMENT OF INSPECTOR GENERAL.—Section 303(e)(1) of such Act (DC Code, sec. 1–1182.8 note) is amended by striking ''the Authority'' and inserting ''the Mayor''.

**SEC. 11712. COOPERATIVE AGREEMENTS BETWEEN FEDERAL AGENCIES AND METROPOLITAN POLICE DEPARTMENT.**

(a) AGREEMENTS.—Each covered Federal law enforcement agency may enter into a cooperative agreement with the Metropolitan Police Department of the District of Columbia to assist the Department in carrying out crime prevention and law enforcement activities in the District of Columbia, including taking appropriate action to enforce subsection (e) (except that nothing in such an agreement may be construed to grant authority to the United States to prosecute violations of subsection (e)).

(b) CONTENTS OF AGREEMENT.—An agreement entered into between a covered Federal law enforcement agency and the Metropolitan Police Department pursuant to this section may include agreements relating to—

(1) sending personnel of the agency on patrol in areas of the District of Columbia which immediately surround the area of the agency's jurisdiction, and granting personnel of the agency the power to arrest in such areas;

(2) sharing and donating equipment and supplies with the Metropolitan Police Department;

(3) operating on shared radio frequencies with the Metropolitan Police Department;

(4) permitting personnel of the agency to carry out processing and papering of suspects they arrest in the District of Columbia; and

(5) such other items as the agency and the Metropolitan Police Department may agree to include in the agreement.

(c) COORDINATION WITH U.S. ATTORNEY'S OFFICE.—Agreements entered into pursuant to this section shall be coordinated in advance with the United States Attorney for the District of Columbia.

(d) COVERED FEDERAL LAW ENFORCEMENT AGENCIES DESCRIBED.—In this section, the term ''covered Federal law enforcement agency'' means any of the following:

(1) United States Capitol Police.

(2) United States Marshals Service.

(3) Library of Congress Police.

(4) Bureau of Engraving and Printing Police Force.

(5) Supreme Court Police.

(6) Amtrak Police Department.

(7) Department of Protective Services, United States Holocaust Museum.

(8) Government Printing Office Police.

(9) United States Park Police.

(10) Bureau of Alcohol, Tobacco, and Firearms.

(11) Drug Enforcement Administration.

(12) Federal Bureau of Investigation.

(13) Criminal Investigation Division, Internal Revenue Service.

(14) Department of the Navy Police Division, Naval District Washington.

(15) Naval Criminal Investigative Service.

(16) 11th Security Police Squadron, Bolling Air Force Base.

(17) United States Army Military District of Washington.

(18) United States Customs Service.

(19) Immigration and Naturalization Service.

(20) Postal Inspection Service, United States Postal Service.

(21) Uniformed Division, United States Secret Service.

(22) United States Secret Service.

(23) National Zoological Park Police.

(24) Federal Protective Service, General Services Administration, National Capital Region.

(25) Defense Protective Service, Department of Defense Washington Headquarters Services.

(26) Office of Protective Services, Smithsonian Institution.

(27) Office of Protective Services, National Gallery of Art.

(28) United States Army Criminal Investigation Command, Department of the Army Washington District, 3rd Military Police Group.

(29) Marine Corps Law Enforcement.

(30) Department of State Diplomatic Security.

(31) United States Coast Guard.

(32) United States Postal Police.

(e) CERTAIN PROHIBITED ACTIVITY.—Effective with respect to conduct occurring on or after the date of the enactment of this title, whoever in the District of Columbia knowingly and willfully obstructs any bridge connecting the District of Columbia and the Commonwealth of Virginia—

(1) shall be fined not less than $1,000 and not more than $5,000, and in addition may be imprisoned not more than 30 days; or

(2) if applicable, shall be subject to prosecution by the District of Columbia under the provisions of District law and regulation amended by the Safe Streets Anti-Prostitution Amendment Act of 1996 (D.C. Law 11–130).

**SEC. 11713. PERMITTING GARNISHMENT OF WAGES OF OFFICERS AND EMPLOYEES OF DISTRICT OF COLUMBIA GOVERNMENT.**

Section 2 of D.C. Law 2–14 (DC Code, sec. 1–516) is amended—

(1) by striking ''After July 25'' and inserting ''(a) After July 25''; and

(2) by adding at the end the following new subsection:

''(b) After October 1, 1997, wages salaries, annuities, retirement and disability benefits, and other remuneration based upon employment, or other income owed by, due from, and payable by the government of the District of Columbia to any individual shall be subject to attachment, garnishment, assignment, or withholding in accordance with subchapter III of chapter 5 of title 16 of the District of Columbia Code in the same manner and to the same extent as if the government of the District of Columbia were a private person.''.

**SEC. 11714. PERMITTING EXCESS APPROPRIATIONS BY WATER AND SEWER AUTHORITY FOR CAPITAL PROJECTS.**

(a) IN GENERAL.—Section 445A of the District of Columbia Self-Government and Governmental Reorganization Act (DC Code, sec. 43–1691), as added by section 4(a) of the District of Columbia Water and Sewer Authority Act of 1996, is amended—

(1) by striking ''The District'' and inserting ''(a) IN GENERAL.—The District''; and

(2) by adding at the end the following new subsection:

''(b) PERMITTING EXPENDITURE OF EXCESS REVENUES FOR CAPITAL PROJECTS IN EXCESS OF BUDGET.—Notwithstanding the amount appropriated for the District of Columbia Water and Sewer Authority for capital projects for a fiscal year, if the revenues of the Authority for the year exceed the estimated revenues of the Authority provided in the annual budget of the District of Columbia for the fiscal year, the Authority may obligate or expend an additional amount for capital projects during the year equal to the amount of such excess revenues.''.

(b) CONFORMING AMENDMENT.—The fourth sentence of section 446 of such Act (DC Code, sec. 47–304), as amended by section 2(c)(2) of the District of Columbia Water and Sewer Authority Act of 1996, is amended by striking ''in section 467(d)'' and inserting ''in section 445A(b), section 467(d)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to fiscal years beginning on or after October 1, 1996.

**SEC. 11715. REQUIRING CERTAIN FEDERAL OFFICIALS TO PROVIDE NOTICE BEFORE CARRYING OUT ACTIVITIES AFFECTING REAL PROPERTY LOCATED IN DISTRICT OF COLUMBIA.**

(a) HEADS OF FEDERAL AGENCIES.—

(1) IN GENERAL.—Except as provided in subsection (d), the head of any Federal agency may not carry out any activity that affects real property located in the District of Columbia unless—

(A) not later than 60 days before carrying out such activity, the head of the agency provides a notice describing such activity and the property affected to the Administrator of General Services and the Administrator of General Services transmits such notice to the individuals described in subsection (c); and

(B) the head of the agency provides the individuals described in subsection (c) with the opportunity to present oral or written comments on the activity to a representative of the head of the agency before the head of the agency carries out the activity.

(2) FEDERAL AGENCY DEFINED.—In subsection (a), the term ''Federal agency'' means an executive department (as defined in section 101 of title 5, United States Code).

(b) ARCHITECT OF THE CAPITOL.—Except as provided in subsection (d), the Architect of the Capitol may not carry out any activity that affects real property located in the District of Columbia unless—

(1) not later than 60 days before carrying out such activity, the Architect provides a notice describing such activity and the property affected to the Committee on Transportation and Infrastructure of the House of Representatives and the Committee on Environment and Public Works of the Senate and such Committees transmit such notice to the individuals described in subsection (c); and

(2) the Architect provides the individuals described in subsection (c) with the opportunity to present oral or written comments on the activity to a representative of the Architect before the Architect carries out the activity.

(c) INDIVIDUALS DESCRIBED.—The individuals described in this paragraph (with respect to the activity and the real property involved) are the Mayor of the District of Columbia, the Chair of the Council of the District of Columbia, and the Chair of the Advisory Neighborhood Commission (as established pursuant to section 738 of the District of Columbia Self-Government and Governmental Reorganization Act) in whose neighborhood such property is located.

(d) EXCEPTION FOR EMERGENCIES.—The head of a Federal agency or the Architect of the Capitol may waive the requirements of subsection (a) if the head of the agency or the Architect finds that compliance with the requirements would jeopardize the public safety or the national security interests of the United States, but only if the head of the agency or the Architect—

(1) certifies such finding and the reasons for such finding to the individuals described in subsection (c) and to Congress; and

(2) at the earliest time practicable, provides such individuals with the notice described in paragraph (1) of subsection (a) or (b) (whichever is applicable) and the opportunity to present comments described in paragraph (2) of subsection (a) or (b).

(e) EFFECTIVE DATE.—Section 1 shall apply to activities carried out after the expiration of the 60-day period that begins on the date of the enactment of this title.

**SEC. 11716. REPEAL TERM OF DEED OF CONVEYANCE TO CERTAIN HOSPITAL.**

Secton 2 of the Act of June 6, 1952 (chapter 486; 66 Stat. 288) (DC Code, sec. 32–121) is hereby repealed.

**SEC. 11717. SHORT TITLE OF HOME RULE ACT.**

(a) IN GENERAL.—Section 101 of the District of Columbia Self-Government and Governmental Reorganization Act is amended by striking ''District of Columbia Self-Government and Governmental Reorganization Act'' and inserting ''District of Columbia Home Rule Act''.

(b) REFERENCES IN LAW.—Any reference in law or regulation to the District of Columbia Self-Government and Governmental Reorganization Act shall be deemed to be a reference to the District of Columbia Home Rule Act.

## CHAPTER 3—EFFECTIVE DATE; GENERAL PROVISIONS

**SEC. 11721. EFFECTIVE DATE.**

Except as otherwise provided in this title, the provisions of this title shall take effect on the later of October 1, 1997, or the day the District of Columbia Financial Responsibility and Management Assistance Authority certifies that the financial plan and budget for the District government for fiscal year 1998 meet the requirements of section 201(c)(1) of the District of Columbia Financial Responsibility and Management Assistance Act of 1995, as amended by this title.

**SEC. 11722. TECHNICAL ASSISTANCE**

Any Federal agency (as defined in section 101 of title 31, United States Code) may provide, at the discretion of the head of the agency, technical assistance to, and training for, personnel of the Government of the District of Columbia. Such assistance shall be limited to assistance that does not interfere with the mission of the agency. The authority provided by this section shall expire three years from the date of enactment of this statute.

**SEC. 11723. LIABILITY.**

(a) DISTRICT OF COLUMBIA.—The District of Columbia shall defend any civil action or proceeding pending on the effective date of this title in any court or other official municipal, state, or federal forum against the District of Columbia or its officers, employees, or agents, and shall assume any liability resulting from such an action or proceeding.

(b) STATE JUSTICE INSTITUTE.—The State Justice Institute shall not be liable for damages or equitable relief on the basis of the activities or operations of any federal or District of Columbia agency which receives funds through the State Justice Institute pursuant to this title.

(c) UNITED STATES.—The United States, its officers, employees, and agents, and its agencies shall not—

(1) be responsible for the payment of any judgments, liabilities or costs resulting from any action or proceeding against the District of Columbia or its agencies, officers, employees, or agents;

(2) be subject to liability in any case on the basis of the activities of the District of Columbia or its agencies, officers, employees, or agents; or

(3) be subject to liability in any case under section 1979 of the Revised Statutes (42 U.S.C. 1983).

(d) LIMITATIONS.—Nothing in this section shall be construed as a waiver of sovereign immunity, or as limiting any other defense

or immunity that would otherwise be available to the United States, the District of Columbia, their agencies, officers, employees, or agents.

And the Senate agree to the same.

For consideration of the House bill, and the Senate amendment, and modifications committed to conference:

JOHN R. KASICH,
DAVID L. HOBSON,
RICHARD K. ARMEY,
TOM DELAY,
J. DENNIS HASTERT,
JOHN M. SPRATT, JR.,
DAVID E. BONIOR,
VIC FAZIO.

As additional conferees from the Committee on Agriculture, for consideration of title I of the House bill, and title I of the Senate amendment, and modifications committed to conference:

ROBERT SMITH,
BOB GOODLATTE,
CHARLES W. STENHOLM.

As additional conferees from the Committee on Banking and Financial Services, for consideration of title II of the House bill, and title II of the Senate amendment, and modifications committed to conference:

JAMES A. LEACH,
RICK LAZIO.

As additional conferees from the Committee on Commerce, for consideration of subtitles A–C of title III of the House bill, and title IV of the Senate amendment, and modifications committed to conference:

TOM BLILEY,
DAN SCHAEFER,
JOHN D. DINGELL.

As additional conferees from the Committee on Commerce, for consideration of subtitle D of title III of the House bill, and subtitle A of title III of the Senate amendment, and modifications committed to conference:

TOM BLILEY,
BILLY TAUZIN.

As additional conferees from the Committee on Commerce, for consideration of subtitles E and F of title III, titles IV and X of the House bill, and divisions 1 and 2 of title V of the Senate amendment, and modifications committed to conference:

TOM BLILEY,
MICHAEL BILIRAKIS.

As additional conferees from the Committee on Education and the Workforce, for consideration of subtitle A of title V and subtitle A of title IX of the House bill, and chapter 2 of division 3 of title V of the Senate amendment, and modifications committed to conference:

BILL GOODLING,
JIM TALENT.

As additional conferees from the Committee on Education and the Workforce, for consideration of subtitles B and C of title V of the House bill, and title VII of the Senate amendment, and modifications committed to conference:

BILL GOODLING,
HOWARD ''BUCK'' MCKEON,
DALE E. KILDEE.

As additional conferees from the Committee on Education and the Workforce, for consideration of subtitle D of title V of the House bill, and chapter 7 of division 4 of title V of the Senate amendment, and modifications committed to conference:

DONALD M. PAYNE.

As additional conferees from the Committee on Government Reform and Oversight, for consideration of title VI of the House bill, and subtitle A of title VI of the Senate amendment, and modifications committed to conference:

DAN BURTON,
JOHN L. MICA.

As additional conferees from the Committee on Transportation and Infrastructure, for consideration of title VII of the House bill, and subtitle B of title III and subtitle B of title VI of the Senate amendment, and modifications committed to conference:

BUD SHUSTER,
WAYNE T. GILCHREST,
JAMES L. OBERSTAR.

As additional conferees from the Committee on Veterans' Affairs, for consideration of title VIII of the House bill, and title VIII of the Senate amendment, and modifications committed to conference:

BOB STUMP,
CHRISTOPHER H. SMITH,
LANE EVANS.

As additional conferees from the Committee on Ways and Means, for consideration of subtitle A of title V and title IX of the House bill, and divisions 3 and 4 of title V of the Senate amendment, and modifications committed to conference:

BILL ARCHER,
E. CLAY SHAW, JR.,
DAVE CAMP,
CHARLES B. RANGEL,
SANDER M. LEVIN.

As additional conferees from the Committee on Ways and Means, for consideration of titles IV and X of the House bill, and division 1 of title V of the Senate amendment, and modifications committed to conference:

BILL ARCHER,
WILLIAM THOMAS.

*Managers on the part of the House.*

From the Committee on the Budget:

PETE DOMENICI,
CHUCK GRASSLEY,
DON NICKLES,
PHIL GRAMM,
FRANK LAUTENBERG.

From the Committee on Agriculture, Nutrition, and Forestry:

DICK LUGAR.

From the Committee on Banking, Housing, and Urban Affairs:

ALFONSE D'AMATO,
RICHARD SHELBY,
PAUL SARBANES.

From the Committee on Commerce, Science and Transportation:

JOHN MCCAIN,
TED STEVENS,
(Except for provisions in universal service fund).

From the Committee on Energy and Natural Resources:

FRANK H. MURKOWSKI,
LARRY E. CRAIG.

From the Committee on Finance:

BILL ROTH,
TRENT LOTT,
DANIEL P. MOYNIHAN.

From the Committee on Governmental Affairs:

FRED THOMPSON,
MS. SUSAN COLLINS.

From the Committee on Veterans' Affairs:

ARLEN SPECTER,
STROM THURMOND,
JOHN ROCKEFELLER.

*Managers on the part of the Senate.*

When said conference report was considered.

After debate,

¶90.14 CALL OF THE HOUSE

On motion of Mr. SHAYS, by unanimous consent, a call of the House was ordered.

The call was taken by electronic device, and the following-named Members responded—

¶90.15 [Roll No. 344]

Abercrombie
Ackerman
Aderholt
Allen
Andrews
Armey
Bachus
Baesler
Baker
Baldacci
Ballenger
Barcia
Barr
Barrett (NE)
Barrett (WI)
Bartlett
Barton
Bass
Bateman
Becerra
Bentsen
Bereuter
Berman
Berry
Bilbray
Bilirakis
Bishop
Blagojevich
Bliley
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Borski
Boswell
Boyd
Brady
Brown (CA)
Brown (FL)
Brown (OH)
Bryant
Bunning
Burr
Burton
Buyer
Callahan
Calvert
Camp
Campbell
Canady
Cannon
Capps
Cardin
Carson
Castle
Chabot
Chambliss
Chenoweth
Christensen
Clay
Clement
Clyburn
Coble
Coburn
Collins
Combest
Condit
Conyers
Cook
Cooksey
Costello
Cox
Coyne
Cramer
Crane
Crapo
Cubin
Cummings
Cunningham
Danner
Davis (FL)
Davis (IL)
Davis (VA)
Deal
DeFazio
DeGette
Delahunt
DeLauro
DeLay
Dellums
Deutsch
Dickey
Dicks
Dingell
Dixon
Doggett
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Ehrlich
Emerson
Engel
English
Ensign
Eshoo
Etheridge
Evans
Everett
Ewing
Farr
Fattah
Fazio
Filner
Flake
Foglietta
Foley
Ford
Fowler
Fox
Franks (NJ)
Frelinghuysen
Furse
Gallegly
Ganske
Gejdenson
Gibbons
Gilchrest
Gillmor
Gilman
Goode
Goodlatte
Goodling
Gordon
Goss
Graham
Granger
Green
Greenwood
Gutierrez
Gutknecht
Hall (OH)
Hall (TX)
Hamilton
Hansen
Harman
Hastert
Hastings (FL)
Hastings (WA)
Hayworth
Hefley
Hefner
Herger
Hill
Hilleary
Hilliard
Hinchey
Hinojosa
Hobson
Hoekstra
Holden
Hooley
Horn
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hutchinson
Hyde
Inglis
Istook
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Jenkins
John
Johnson (CT)
Johnson (WI)
Johnson, E. B.
Jones
Kanjorski
Kaptur
Kasich
Kelly
Kennedy (MA)
Kennedy (RI)
Kennelly
Kildee
Kilpatrick
Kim
Kind (WI)
King (NY)
Kingston
Kleczka
Klink
Klug
Knollenberg
Kolbe
Kucinich
LaFalce
LaHood
Lampson
Lantos
Largent
Latham
LaTourette
Lazio
Leach
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
Livingston
LoBiondo
Lofgren
Lowey
Lucas
Luther
Maloney (CT)
Maloney (NY)
Manton
Markey
Martinez
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCrery
McDade
McDermott
McGovern
McHale
McHugh
McInnis
McIntosh
McIntyre
McKeon
McKinney
McNulty
Meehan
Meek
Menendez
Metcalf
Mica
Millender-McDonald
Miller (CA)
Miller (FL)
Minge
Mink
Moakley
Molinari
Mollohan
Moran (KS)
Moran (VA)
Morella
Murtha
Myrick
Nadler
Neal
Nethercutt
Neumann
Ney
Northup
Norwood
Nussle
Oberstar
Obey
Olver
Ortiz
Oxley
Packard
Pallone
Pappas
Parker
Pascrell
Pastor
Paul
Paxon
Payne
Pease
Pelosi
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pickett
Pitts