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H. R. 2425

IN THE SENATE OF THE UNITED STATES

OCTOBER 20 (legislative day, OCTOBER 18), 1995
Received; read twice and referred to the Committee on Finance

AN ACT

To amend title XVIII of the Social Security Act to preserve and reform the medicare program.

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

SECTION 1. PURPOSE.

The purpose of this Act is to reform the medicare program, in order to preserve and protect the financial stability of the program.

TITLE XV—MEDICARE

SEC. 15000. SHORT TITLE OF TITLE; AMENDMENTS AND REFERENCES TO OBRA; TABLE OF CONTENTS OF TITLE.

(a) SHORT TITLE.—This title may be cited as the ''Medicare Preservation Act of 1995''.

(b) 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.

(c) 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.

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

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Sec. 15002. MedicarePlus program.

''PART C—PROVISIONS RELATING TO MEDICAREPLUS

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''Sec. 1852. Requirements relating to benefits, provision of services, enrollment, and premiums.
''Sec. 1853. Patient protection standards.
''Sec. 1854. Provider-sponsored organizations.
''Sec. 1855. Payments to MedicarePlus organizations.
''Sec. 1856. Establishment of standards for MedicarePlus organizations and products.
''Sec. 1857. MedicarePlus certification.
''Sec. 1858. Contracts with MedicarePlus organizations.''
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Sec. 15004. Transitional rules for current medicare HMO program.

PART 2—SPECIAL RULES FOR MEDICAREPLUS MEDICAL SAVINGS ACCOUNTS

Sec. 15011. MedicarePlus MSA's.
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PART 3—SPECIAL ANTITRUST RULE FOR PROVIDER SERVICE NETWORKS

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Sec. 15032. Commission on the Effect of the Baby Boom Generation on the Medicare Program.
Sec. 15033. Change in appointment of Administrator of HCFA.

PART 5—TREATMENT OF HOSPITALS WHICH PARTICIPATE IN PROVIDER-SPONSORED ORGANIZATIONS

Sec. 15041. Treatment of hospitals which participate in provider-sponsored organizations.

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Sec. 15102. Beneficiary incentive programs.

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Sec. 15525. Treatment of items and services paid for under part B.
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Sec. 15527. Medical review process.
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Sec. 15602. Elimination of formula-driven overpayments for certain outpatient hospital services.
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PART 5—OTHER PROVISIONS RELATING TO PARTS A AND B

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Subtitle A—MedicarePlus Program

PART 1—INCREASING CHOICE UNDER THE MEDICARE PROGRAM

SEC. 15001. INCREASING CHOICE UNDER MEDICARE.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1804 the following new section:

''PROVIDING FOR CHOICE OF COVERAGE

''SEC. 1805. (a) CHOICE OF COVERAGE.—

''(1) IN GENERAL.—Subject to the provisions of this section, every individual who is entitled to benefits under part A and enrolled under part B shall elect to receive benefits under this title through one of the following:

''(A) THROUGH FEE-FOR-SERVICE SYSTEM.—Through the provisions of parts A and B.

''(B) THROUGH A MEDICAREPLUS PRODUCT.—Through a MedicarePlus product (as defined in paragraph (2)), which may be—

''(i) a high deductible/medisave product (and a contribution into a MedicarePlus medical savings account (MSA)),

''(ii) a product offered by a provider-sponsored organization,

''(iii) a product offered by an organization that is a union, Taft-Hartley plan, or association, or

''(iv) a product providing for benefits on a fee-for-service or other basis.

''(2) MEDICAREPLUS PRODUCT DEFINED.—For purposes this section and part C, the term 'MedicarePlus product' means health benefits coverage offered under a policy, contract, or plan by a MedicarePlus organization (as defined in section 1851(a)) pursuant to and in accordance with a contract under section 1858.

''(3) TERMINOLOGY RELATING TO OPTIONS.—For purposes of this section and part C—

''(A) NON-MEDICAREPLUS OPTION.—An individual who has made the election described

in paragraph (1)(A) is considered to have elected the 'Non-MedicarePlus option'.

''(B) MEDICAREPLUS OPTION.—An individual who has made the election described in paragraph (1)(B) to obtain coverage through a MedicarePlus product is considered to have elected the 'MedicarePlus option' for that product.

''(b) SPECIAL RULES.—

''(1) RESIDENCE REQUIREMENT.—Except as the Secretary may otherwise provide, an individual is eligible to elect a MedicarePlus product offered by a MedicarePlus organization only if the organization in relation to the product serves the geographic area in which the individual resides.

''(2) AFFILIATION REQUIREMENTS FOR CERTAIN PRODUCTS.—

''(A) IN GENERAL.—Subject to subparagraph (B), an individual is eligible to elect a MedicarePlus product offered by a limited enrollment MedicarePlus organization (as defined in section 1852(c)(4)(E)) only if—

''(i) the individual is eligible under section 1852(c)(4) to make such election, and

''(ii) in the case of a MedicarePlus organization that is a union sponsor or a Taft-Hartley sponsor (as defined in section 1852(c)(4)), the individual elected under this section a MedicarePlus product offered by the sponsor during the first enrollment period in which the individual was eligible to make such election with respect to such sponsor.

''(B) NO REELECTION AFTER DISENROLLMENT FOR CERTAIN PRODUCTS.—An individual is not eligible to elect a MedicarePlus product offered by a MedicarePlus organization that is a union sponsor or a Taft-Hartley sponsor if the individual previously had elected a MedicarePlus product offered by the organization and had subsequently discontinued to elect such a product offered by the organization.

''(3) SPECIAL RULE FOR CERTAIN ANNUITANTS.—An individual is not eligible to elect a high deductible/medisave product if the individual is entitled to benefits under chapter 89 of title 5, United States Code, as an annuitant or spouse of an annuitant.

''(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) EXPEDITED IMPLEMENTATION.—The Secretary shall establish the process of electing coverage under this section during the transition period (as defined in subsection (e)(1)(B)) in such an expedited manner as will permit such an election for MedicarePlus products in an area as soon as such products become available in that area.

''(3) COORDINATION THROUGH MEDICAREPLUS ORGANIZATIONS.—

''(A) ENROLLMENT.—Such process shall permit an individual who wishes to elect a MedicarePlus product offered by a MedicarePlus 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 MedicarePlus product offered by a MedicarePlus organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

''(4) 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 Non-MedicarePlus option.

''(ii) SEAMLESS CONTINUATION OF COVERAGE.—The Secretary shall establish procedures under which individuals who are enrolled with a MedicarePlus organization at the time of the initial election period and who fail to elect to receive coverage other than through the organization are deemed to have elected an appropriate MedicarePlus product offered by the organization.

''(B) CONTINUING PERIODS.—An individual who has made (or 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) a MedicarePlus product is discontinued, if the individual had elected such product at the time of the discontinuation.

''(5) AGREEMENTS WITH COMMISSIONER OF SOCIAL SECURITY TO PROMOTE EFFICIENT ADMINISTRATION.—In order to promote the efficient administration of this section and the MedicarePlus program under part C, the Secretary may enter into an agreement with the Commissioner of Social Security under which the Commissioner performs administrative responsibilities relating to enrollment and disenrollment in MedicarePlus products under this section.

''(d) PROVISION OF BENEFICIARY INFORMATION TO PROMOTE INFORMED CHOICE.—

''(1) IN GENERAL.—The Secretary shall provide for activities under this subsection to disseminate

broadly 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. Such information shall be made available on such a timely basis (such as 6 months before the date an individual would first attain eligibility for medicare on the basis of age) as to permit individuals to elect the MedicarePlus option during the initial election period described in subsection (e)(1).

''(2) USE OF NONFEDERAL ENTITIES.—The Secretary shall, to the maximum extent feasible, enter into contracts with appropriate non-Federal entities to carry out activities under this subsection.

''(3) SPECIFIC ACTIVITIES.—In carrying out this subsection, the Secretary shall provide for at least the following activities in all areas in which MedicarePlus products are offered:

''(A) INFORMATION BOOKLET.—

''(i) IN GENERAL.—The Secretary shall publish an information booklet and disseminate the booklet to all individuals eligible to elect the MedicarePlus option under this section during coverage election periods.

''(ii) INFORMATION INCLUDED.—The booklet shall include information presented in plain English and in a standardized format regarding—

''(I) the benefits (including cost-sharing) and premiums for the various MedicarePlus products in the areas involved;

''(II) the quality of such products, including consumer satisfaction information; and

''(III) rights and responsibilities of medicare beneficiaries under such products.

''(iii) PERIODIC UPDATING.—The booklet shall be updated on a regular basis (not less often than once every 12 months) to reflect changes in the availability of MedicarePlus products and the benefits and premiums for such products.

''(B) TOLL-FREE NUMBER.—The Secretary shall maintain a toll-free number for inquiries regarding MedicarePlus options and the operation of part C.

''(C) GENERAL INFORMATION IN MEDICARE HANDBOOK.—The Secretary shall include information about the MedicarePlus option provided under this section in the annual notice of medicare benefits under section 1804.

''(e) COVERAGE ELECTION PERIODS.—

''(1) INITIAL CHOICE UPON ELIGIBILITY TO MAKE ELECTION.—

''(A) IN GENERAL.—In the case of an individual who first becomes entitled to benefits under part A and enrolled under part B after the beginning of the transition period (as defined in subparagraph (B)), the individual shall make the election under this section during a period (of a duration and beginning at a time specified by the Secretary) at the first time the individual both is entitled to benefits under part A and enrolled under part B. Such period shall be specified in a manner so that, in the case of an individual who elects a MedicarePlus product during the period, coverage under the product becomes effective as of the first date on which the individual may receive such coverage.

''(B) TRANSITION PERIOD DEFINED.—In this subsection, the term 'transition period'

means, with respect to an individual in an area, the period beginning on the first day of the first month in which a MedicarePlus product is first made available to individuals in the area and ending with the month preceding the beginning of the first annual, coordinated election period under paragraph (3).

''(2) DURING TRANSITION PERIOD.—Subject to paragraph (6)—

''(A) CONTINUOUS OPEN ENROLLMENT INTO A MEDICARE-PLUS OPTION.—During the transition period, an individual who is eligible to make an election under this section and who has elected the non-MedicarePlus option may change such election to a MedicarePlus option at any time.

''(B) OPEN DISENROLLMENT BEFORE END OF TRANSITION PERIOD.—

''(i) IN GENERAL.—During the transition period, an individual who has elected a MedicarePlus option for a MedicarePlus product may change such election to another MedicarePlus product or to the non-MedicarePlus option.

''(ii) SPECIAL RULE.—During the transition period, an individual who has elected a high deductible/medisave product may not change such election to a MedicarePlus product that is not a high deductible/medisave product unless the individual has had such election in effect for 12 months.

''(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 annual, coordinated election periods.

''(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term 'annual, coordinated election period' means, with respect to a calendar year (beginning with 1998), the month of October before such year.

''(C) MEDICAREPLUS HEALTH FAIR DURING OCTOBER, 1996.—In the month of October, 1996, the Secretary shall provide for a nationally coordinated educational and publicity cam-

paign to inform individuals, who are eligible to elect MedicarePlus products, about such products and the election process provided under this section (including the annual, coordinated election periods that occur in subsequent years).

''(4) SPECIAL 90-DAY DISENROLLMENT OPTION.—

''(A) IN GENERAL.—In the case of the first time an individual elects a MedicarePlus option (other than a high deductible/medisave product) under this section, the individual may discontinue such election through the filing of an appropriate notice during the 90-day period beginning on the first day on which the individual's coverage under the MedicarePlus product under such option becomes effective.

''(B) EFFECT OF DISCONTINUATION OF ELECTION.—An individual who discontinues an election under this paragraph shall be deemed at the time of such discontinuation to have elected the Non-MedicarePlus option.

''(5) SPECIAL ELECTION PERIODS.—An individual may discontinue an election of a MedicarePlus product offered by a MedicarePlus organization other than during an annual, coordinated election

period and make a new election under this section if—

''(A) the organization's or product's certification under part C has been terminated or the organization has terminated or otherwise discontinued providing the product;

''(B) in the case of an individual who has elected a MedicarePlus product offered by a MedicarePlus organization, the individual is no longer eligible to elect the product 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 membership in a qualified association in the case of a product offered by a qualified association or termination of the individual's enrollment on the basis described in clause (i) or (ii) section 1852(c)(3)(B));

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

''(i) the organization offering the product substantially violated a material provision of the organization's contract

under part C in relation to the individual and the product; or

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

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

''(6) SPECIAL RULE FOR HIGH DEDUCTIBLE/MEDISAVE PRODUCTS.—Notwithstanding the previous provisions of this subsection, an individual may elect a high deductible/medisave product only during an annual, coordinated election period described in paragraph (3)(B) or during the month of October, 1996.

''(f) EFFECTIVENESS 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 TRANSITION; 90-DAY DISENROLLMENT OPTION.—An election of coverage made under subsection (e)(2) and an election to discontinue a MedicarePlus option under subsection (e)(4) at any time shall take effect with the first calendar month following the date on which the election is made.

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

''(4) OTHER PERIODS.—An election of coverage made during any other period under subsection (e)(5) 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) EFFECT OF ELECTION OF MEDICAREPLUS OPTION.—Subject to the provisions of section 1855(f), payments under a contract with a MedicarePlus organization under section 1858(a) with respect to an individual electing a MedicarePlus product 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.

''(h) ADMINISTRATION.—

''(1) IN GENERAL.—This part and sections 1805 and 1876 shall be administered through an operating division (A) that is established or identified by the Secretary in the Department of Health and Human Services, (B) that is separate from the Health Care Financing Administration, and (C) the primary function of which is the administration of this part and such sections. The director of such division shall be of equal pay and rank to that of the individual responsible for overall administration of parts A and B.

''(2) TRANSFER AUTHORITY.—The Secretary shall transfer such personnel, administrative support systems, assets, records, funds, and other resources in the Health Care Financing Administration to the operating division referred to in paragraph (1) as are used in the administration of section 1876 and as may be required to implement the provisions referred to in such paragraph promptly and efficiently.''.

SEC. 15002. MEDICAREPLUS PROGRAM.

(a) IN GENERAL.—Title XVIII is amended by redesignating part C as part D and by inserting after part B the following new part:

''PART C—PROVISIONS RELATING TO MEDICAREPLUS

''REQUIREMENTS FOR MEDICAREPLUS ORGANIZATIONS; HIGH DEDUCTIBLE/MEDISAVE PRODUCTS

''SEC. 1851. (a) MEDICAREPLUS ORGANIZATION DEFINED.—In this part, subject to the succeeding provisions of this section, the term 'MedicarePlus organization' means a public or private entity that is certified under section 1857 as meeting the requirements and standards of this part for such an organization.

''(b) ORGANIZED AND LICENSED UNDER STATE LAW.—

''(1) IN GENERAL.—A MedicarePlus organization shall be organized and licensed under State law to offer health insurance or health benefits coverage in each State in which it offers a MedicarePlus product.

''(2) EXCEPTION FOR UNION AND TAFT-HARTLEY SPONSORS.—Paragraph (1) shall not apply to an MedicarePlus organization that is a union sponsor or a Taft-Hartley sponsor (as defined in section 1852(c)(4)).

''(3) EXCEPTION FOR PROVIDER-SPONSORED ORGANIZATIONS.—Paragraph (1) shall not apply to a MedicarePlus organization that is a provider-sponsored organization (as defined in section 1854(a)) except to the extent provided under section 1857(c).

''(4) EXCEPTION FOR QUALIFIED ASSOCIATIONS.—Paragraph (1) shall not apply to a MedicarePlus organization that is a qualified association (as defined in section 1852(c)(4)(C)).

''(c) PREPAID PAYMENT.—A MedicarePlus organization shall be compensated (except for deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided to a member.

''(d) ASSUMPTION OF FULL FINANCIAL RISK.—The MedicarePlus organization shall assume full financial risk on a prospective basis for the provision of the health care services (other than hospice care) for which benefits are required to be provided under section 1852(a)(1), except that the organization—

''(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled

member such services the aggregate value of which exceeds $5,000 in any year,

''(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization,

''(3) may obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and

''(4) may make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

In the case of a MedicarePlus organization that is a union sponsor (as defined in section 1852(c)(4)(A)), Taft-Hartley sponsor (as defined in section 1852(c)(4)(B)), a qualified association (as defined in section 1852(c)(4)(C)), this subsection shall not apply with respect to MedicarePlus

products offered by such organization and issued by an organization to which subsection (b)(1) applies or by a provider-sponsored organization (as defined in section 1854(a)).

''(e) PROVISION AGAINST RISK OF INSOLVENCY.—

''(1) IN GENERAL.—Each MedicarePlus organization shall meet standards under section 1856 relating to the financial solvency and capital adequacy of the organization. Such standards shall take into account the nature and type of MedicarePlus products offered by the organization.

''(2) TREATMENT OF UNION AND TAFT-HARTLEY SPONSORS.—An entity that is a union sponsor or a Taft-Hartley sponsor is deemed to meet the requirement of paragraph (1).

''(3) TREATMENT OF CERTAIN QUALIFIED ASSOCIATIONS.—An entity that is a qualified association is deemed to meet the requirement of paragraph (1) with respect to MedicarePlus products offered by such association and issued by an organization to which subsection (b)(1) applies or by a provider-sponsored organization.

''(f) HIGH DEDUCTIBLE/MEDISAVE PRODUCT DEFINED.—

''(1) IN GENERAL.—In this part, the term 'high deductible/medisave product' means a MedicarePlus product that—

''(A) 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 product) equal to the amount of a deductible (described in paragraph (2));

''(B) counts as such expenses (for purposes of such deductible) at least all amounts that would have been payable under parts A and B or by the enrollee if the enrollee had elected to receive benefits through the provisions of such parts; and

''(C) provides, after such deductible is met for a year and for all subsequent expenses for benefits referred to in subparagraph (A) 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. Such term does not include the MedicarePlus MSA itself or any contribution into such account.

''(2) DEDUCTIBLE.—The amount of deductible under a high deductible/medisave product—

''(A) for contract year 1997 shall be not more than $10,000; and

''(B) for a subsequent contract year shall be not more than the maximum amount of such deductible for the previous contract year under this paragraph increased by the national average per capita growth rate under section 1855(c)(3) for the year.

If the amount of the deductible under subparagraph (B) is not a multiple of $50, the amount shall be rounded to the nearest multiple of $50.

''(g) ORGANIZATIONS TREATED AS MEDICAREPLUS ORGANIZATIONS DURING TRANSITION.—Any of the following organizations shall be considered to qualify as a MedicarePlus organization for contract years beginning before January 1, 1998:

''(1) HEALTH MAINTENANCE ORGANIZATIONS.—An organization that is organized under the

laws of any State and that is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act), an organization recognized under State law as a health maintenance organization, or a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

''(2) LICENSED INSURERS.—An organization that is organized under the laws of any State and—

''(A) is licensed by a State agency as an insurer for the offering of health benefit coverage, or

''(B) is licensed by a State agency as a service benefit plan,

but only for individuals residing in an area in which the organization is licensed to offer health insurance coverage.

''(3) CURRENT RISK-CONTRACTORS.—An organization that is an eligible organization (as defined in section 1876(b)) and that has a risk-sharing contract in effect under section 1876 as of the date of the enactment of this section.

''(h) MEDIGRANT DEMONSTRATION PROJECTS.—The Secretary shall provide, in at least 10 States, for dem-

onstration projects which would permit MediGrant programs under title XXI to be treated as MedicarePlus organizations under this part for individuals who are qualified to elect the MedicarePlus option and who eligible to receive medical assistance under the MediGrant program, for the purpose of demonstrating the delivery of primary, acute, and long-term care through an integrated delivery network which emphasizes noninstitutional care.

''REQUIREMENTS RELATING TO BENEFITS, PROVISION OF SERVICES, ENROLLMENT, AND PREMIUMS

''SEC. 1852. (a) BENEFITS COVERED.—

''(1) IN GENERAL.—Except as provided in section 1851(f)(1) with respect to high deductible/medisave products, each MedicarePlus product offered under this part shall provide benefits for at least the items and services for which benefits are available under parts A and B consistent with the standards for coverage of such items and services applicable under this title.

''(2) ORGANIZATION AS SECONDARY PAYER.—Notwithstanding any other provision of law, a MedicarePlus organization may (in the case of the provision of items and services to an individual under this part 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 such law or policy—

''(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.

''(3) SATISFACTION OF REQUIREMENT.—A MedicarePlus product (other than a high deductible/medisave product) offered by a MedicarePlus organization satisfies paragraph (1) with respect to benefits for items and services if the following requirements are met:

''(A) FEE FOR SERVICE PROVIDERS.—In the case of benefits furnished through a provider that does not have a contract with the organization, the product provides for at least the dollar amount of payment for such items and services as would otherwise be provided under parts A and B.

''(B) PARTICIPATING PROVIDERS.—In the case of benefits furnished through a provider that has such a contract, the individual's liabil-

ity for payment for such items and services does not exceed (after taking into account any deductible, which does not exceed any deductible under parts A and B) the lesser of the following:

''(i) NON-MEDICAREPLUS LIABILITY.—The amount of the liability that the individual would have had (based on the provider being a participating provider) if the individual had elected the non-MedicarePlus option.

''(ii) MEDICARE COINSURANCE APPLIED TO PRODUCT PAYMENT RATES.—The applicable coinsurance or copayment rate (that would have applied under the non-MedicarePlus option) of the payment rate provided under the contract.

''(b) ANTIDISCRIMINATION.—A MedicarePlus organization may not deny, limit, or condition the coverage or provision of benefits under this part based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual.

''(c) GUARANTEED ISSUE AND RENEWAL.—

''(1) IN GENERAL.—Except as provided in this subsection, a MedicarePlus organization shall pro-

vide that at any time during which elections are accepted under section 1805 with respect to a MedicarePlus product 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 MedicarePlus organization, in relation to a MedicarePlus product it offers, has a capacity limit and the number of eligible individuals who elect the product under section 1805 exceeds the capacity limit, the organization may limit the election of individuals of the product under such section but only if priority in election is provided—

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

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

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

''(A) IN GENERAL.—Subject to subparagraph (B), a MedicarePlus organization may not for any reason terminate the election of any

individual under section 1805 for a MedicarePlus product it offers.

''(B) BASIS FOR TERMINATION OF ELECTION.—A MedicarePlus organization may terminate an individual's election under section 1805 with respect to a MedicarePlus product it offers if—

''(i) any premiums required with respect to such product are not paid on a timely basis (consistent with standards under section 1856 that provide for a grace period for late payment of premiums),

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

''(iii) the product is terminated with respect to all individuals under this part.

Any individual whose election is so terminated is deemed to have elected the Non-MedicarePlus option (as defined in section 1805(a)(3)(A)).

''(C) ORGANIZATION OBLIGATION WITH RESPECT TO ELECTION FORMS.—Pursuant to a contract under section 1858, each MedicarePlus organization receiving an election form under section

1805(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.

''(4) SPECIAL RULES FOR LIMITED ENROLLMENT MEDICAREPLUS ORGANIZATIONS.—

''(A) UNIONS.—

''(i) IN GENERAL.—Subject to subparagraph (D), a union sponsor (as defined in clause (ii)) shall limit eligibility of enrollees under this part for MedicarePlus products it offers to individuals who are members of the sponsor and affiliated with the sponsor through an employment relationship with any employer or are the spouses of such members.

''(ii) UNION SPONSOR.—In this part and section 1805, the term 'union sponsor' means an employee organization in relation to a group health plan that is established or maintained by the organization other than pursuant to a collective bargaining agreement.

''(B) TAFT-HARTLEY SPONSORS.—

''(i) IN GENERAL.—Subject to subparagraph (D), a MedicarePlus organization that is a Taft-Hartley sponsor (as defined in clause (ii)) shall limit eligibility of enrollees under this part for MedicarePlus products it offers to individuals who are entitled to obtain benefits through such products under the terms of an applicable collective bargaining agreement.

''(ii) TAFT-HARTLEY SPONSOR.—In this part and section 1805, the term 'Taft-Hartley sponsor' means, in relation to a group health plan that is established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of parties who establish or maintain the plan.

''(C) QUALIFIED ASSOCIATIONS.—

''(i) IN GENERAL.—Subject to subparagraph (D), a MedicarePlus organization that is a qualified association (as defined in clause (iii)) shall limit eligibility of individuals under this part for products it

offers to individuals who are members of the association (or who are spouses of such individuals).

''(ii) LIMITATION ON TERMINATION OF COVERAGE.—Such a qualifying association offering a MedicarePlus product to an individual may not terminate coverage of the individual on the basis that the individual is no longer a member of the association except pursuant to a change of election during an open election period occurring on or after the date of the termination of membership.

''(iii) QUALIFIED ASSOCIATION.—In this part and section 1805, the term 'qualified association' means an association, religious fraternal organization, or other organization (which may be a trade, industry, or professional association, a chamber of commerce, or a public entity association) that the Secretary finds—

''(I) has been formed for purposes other than the sale of any health insurance and does not restrict membership based on the health sta-

tus, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual,

''(II) does not exist solely or principally for the purpose of selling insurance, and

''(III) has at least 1,000 individual members or 200 employer members.

Such term includes a subsidiary or corporation that is wholly owned by one or more qualified organizations.

''(D) LIMITATION.—Rules of eligibility to carry out the previous subparagraphs of this paragraph shall not have the effect of denying eligibility to individuals on the basis of health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability.

''(E) LIMITED ENROLLMENT MEDICAREPLUS ORGANIZATION.—In this part and section 1805, the term 'limited enrollment MedicarePlus organization' means a MedicarePlus organization that is a union spon-

sor, a Taft-Hartley sponsor, or a qualified association.

''(F) EMPLOYER, ETC.—In this paragraph, the terms 'employer', 'employee organization', and 'group health plan' have the meanings given such terms for purposes of part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

''(d) SUBMISSION AND CHARGING OF PREMIUMS.—

''(1) IN GENERAL.—Each MedicarePlus organization shall file with the Secretary each year, in a form and manner and at a time specified by the Secretary—

''(A) the amount of the monthly premiums for coverage under each MedicarePlus product it offers under this part in each payment area (as determined for purposes of section 1855) in which the product is being offered; and

''(B) the enrollment capacity in relation to the product in each such area.

''(2) AMOUNTS OF PREMIUMS CHARGED.—The amount of the monthly premium charged by a MedicarePlus organization for a MedicarePlus product offered in a payment area to an individual under

this part shall be equal to the amount (if any) by which—

''(A) the amount of the monthly premium for the product for the period involved, as established under paragraph (3) and submitted under paragraph (1), exceeds

''(B)(i) 1/12 of the annual MedicarePlus capitation rate specified in section 1855(b)(2) for the area and period involved, or (ii) in the case of a high deductible/medisave product, the monthly adjusted MedicarePlus capitation rate specified in section 1855(b)(1) for the individual and period involved.

''(3) UNIFORM PREMIUM.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the premiums charged by a MedicarePlus organization under this part may not vary among individuals who reside in the same payment area.

''(B) EXCEPTION FOR HIGH DEDUCTIBLE/MEDISAVE PRODUCTS.—A MedicarePlus organization shall establish premiums for any high deductible/medisave product it offers in a payment area based on each of the risk adjustment categories established for purposes of determining

the amount of the payment to MedicarePlus organizations under section 1855(b)(1) and using the identical demographic and other adjustments among such categories as are used for such purposes.

''(4) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each MedicarePlus organization shall permit the payment of monthly premiums on a monthly basis and may terminate election of individuals for a MedicarePlus product for failure to make premium payments only in accordance with subsection (c)(3)(B).

''(5) RELATION OF PREMIUMS AND COST-SHARING TO BENEFITS.—In no case may the portion of a MedicarePlus organization's premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (to the extent attributable to the minimum benefits described in subsection (a)(1) and not counting any amount attributable to balance billing) to individuals who are enrolled under this part with the organization exceed the actuarial value of the coinsurance and deductibles that would be applicable on the average to individuals enrolled under this part with the organization (or, if the Secretary finds that adequate data are not available to deter-

mine that actuarial value, the actuarial value of the coinsurance and deductibles applicable on the average to individuals in the area, in the State, or in the United States, eligible to enroll under this part with the organization, or other appropriate data) and entitled to benefits under part A and enrolled under part B if they were not members of a MedicarePlus organization.

''(e) REQUIREMENT FOR ADDITIONAL BENEFITS, PART B PREMIUM DISCOUNT REBATES, OR BOTH.—

''(1) REQUIREMENT.—

''(A) IN GENERAL.—Each MedicarePlus organization (in relation to a MedicarePlus product it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the product 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), a monetary rebate (paid on a monthly basis) of the part B monthly premium, or a combination thereof, in a total value which is at least equal to the adjusted excess amount (as defined in subparagraph (C)).

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

''(i) the average of the capitation payments made to the organization under this part for the product at the beginning of contract year, exceeds

''(ii) the actuarial value of the minimum benefits described in subsection (a)(1) under the product for individuals under this part, as determined based upon an adjusted community rate described in paragraph (5) (as reduced for the actuarial value of the coinsurance and deductibles under parts A and B).

''(C) ADJUSTED EXCESS AMOUNT.—For purposes of this paragraph, the 'adjusted excess amount', for an organization for a product, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (3).

''(D) NO APPLICATION TO HIGH DEDUCTIBLE/MEDISAVE PRODUCT.—Subparagraph (A)

shall not apply to a high deductible/medisave product.

''(E) UNIFORM APPLICATION.—This paragraph shall be applied uniformly for all enrollees for a product in a service area.

''(F) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a MedicarePlus organization from providing health care benefits that are in addition to the benefits otherwise required to be provided under this paragraph and from imposing a premium for such additional benefits.

''(2) LIMITATION ON AMOUNT OF PART B PREMIUM DISCOUNT REBATE.—In no case shall the amount of a part B premium discount rebate under paragraph (1)(A) exceed, with respect to a month, the amount of premiums imposed under part B (not taking into account section 1839(b) (relating to penalty for late enrollment) or 1839(h) (relating to affluence testing)), for the individual for the month. Except as provided in the previous sentence, a MedicarePlus organization is not authorized to provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

''(3) STABILIZATION FUND.—A MedicarePlus organization may provide that a part of the value of an excess actuarial 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 and rebates offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the MedicarePlus product in accordance with such paragraph prior to the end of such periods, shall revert for the use of such trust funds.

''(4) DETERMINATION BASED ON INSUFFICIENT DATA.—For purposes of this subsection, if the Secretary finds that there is insufficient enrollment experience (including no enrollment experience in the case of a provider-sponsored organization) to determine an average of the capitation payments to be made under this part at the beginning of a contract

period, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this part.

''(5) ADJUSTED COMMUNITY RATE.—

''(A) IN GENERAL.—For purposes of this subsection, subject to subparagraph (B), the term 'adjusted community rate' for a service or services means, at the election of a MedicarePlus organization, either—

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

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

but adjusted for differences between the utilization characteristics of the individuals electing coverage under this part and the utilization characteristics of the other enrollees with the organization (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 MedicarePlus coverage, or individuals in the area, in the State, or in the United States, eligible to elect MedicarePlus coverage under this part and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

''(B) SPECIAL RULE FOR PROVIDER-SPONSORED ORGANIZATIONS.—In the case of a MedicarePlus organization that is a provider-sponsored organization, the adjusted community rate under subparagraph (A) for a MedicarePlus product may be computed (in a manner specified by the Secretary) using data in the general commercial marketplace or (during a transition period) based on the costs incurred by the organization in providing such a product.

''(f) RULES REGARDING PHYSICIAN PARTICIPATION.—

''(1) PROCEDURES.—Each MedicarePlus organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under MedicarePlus products offered by the organization under this part. Such procedures shall include—

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

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

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

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

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

''(A) IN GENERAL.—Each MedicarePlus organization may not 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 individ-

uals enrolled with the organization who receive services from the physician or the physician 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 MedicarePlus organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect

to individuals enrolled with the organization under this part.

''(4) LIMITATION ON PROVIDER INDEMNIFICATION.—A MedicarePlus organization may not provide (directly or indirectly) for a provider (or group of providers) to indemnify the organization against any liability resulting from a civil action brought by or on behalf of an enrollee under this part for any damage caused to the enrollee by the organization's denial of medically necessary care.

''(5) EXCEPTION FOR CERTAIN FEE-FOR-SERVICE PLANS.—The previous provisions of this subsection shall not apply in the case of a MedicarePlus organization in relation to a MedicarePlus product if the organization does not have agreements between physicians and the organization for the provision of benefits under the product.

''(g) PROVISION OF INFORMATION.—A MedicarePlus organization shall provide the Secretary with such information on the organization and each MedicarePlus product it offers as may be required for the preparation of the information booklet described in section 1805(d)(3)(A).

''(h) COORDINATED ACUTE AND LONG-TERM CARE BENEFITS UNDER A MEDICAREPLUS PRODUCT.—Noth-

ing in this part shall be construed as preventing a State from coordinating benefits under its MediGrant program under title XXI with those provided under a MedicarePlus product 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 program.

''(i) TRANSITIONAL FILE AND USE FOR CERTAIN REQUIREMENTS.—

''(1) IN GENERAL.—In the case of a MedicarePlus product proposed to be offered before the end of the transition period (as defined in section 1805(e)(1)(B)), by a MedicarePlus organization described in section 1851(g)(3) or by a MedicarePlus organization with a contract in effect under section 1858, if the organization submits complete information to the Secretary regarding the product demonstrating that the product meets the requirements and standards under subsections (a), (d), and (e) (relating to benefits and premiums), the product shall be deemed as meeting such requirements and standards under such subsections unless the Secretary disapproves the product within 60 days after the date of submission of the complete information.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as waiving the requirement of a contract under section 1858 or waiving requirements and standards not referred to in paragraph (1).

''PATIENT PROTECTION STANDARDS

''SEC. 1853. (a) DISCLOSURE TO ENROLLEES.—A MedicarePlus organization shall disclose in clear, accurate, and standardized form, information regarding all of the following for each MedicarePlus product it offers:

''(1) Benefits under the MedicarePlus product offered, including exclusions from coverage and, if it is a high deductible/medisave product, a comparison of benefits under such a product with benefits under other MedicarePlus products.

''(2) Rules regarding prior authorization or other review requirements that could result in nonpayment.

''(3) Potential liability for cost-sharing for out-of-network services.

''(4) The number, mix, and distribution of participating providers.

''(5) The financial obligations of the enrollee, including premiums, deductibles, co-payments, and maximum limits on out-of-pocket losses for items and services (both in and out of network).

''(6) Statistics on enrollee satisfaction with the product and organization, including rates of reenrollment.

''(7) Enrollee rights and responsibilities, including the grievance process provided under subsection (f).

''(8) A statement that the use of the 911 emergency telephone number is appropriate in emergency situations and an explanation of what constitutes an emergency situation.

''(9) A description of the organization's quality assurance program under subsection (d).

Such information shall be disclosed to each enrollee under this part at the time of enrollment and at least annually thereafter.

''(b) ACCESS TO SERVICES.—

''(1) IN GENERAL.—A MedicarePlus organization offering a MedicarePlus product may restrict the providers from whom the benefits under the product are provided so long as—

''(A) the organization makes such benefits available and accessible to each individual electing the product within the product 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 product provides for reimbursement with respect to services which are covered under subparagraphs (A) and (B) and which are provided to such an individual other than through the organization, if—

''(i) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition, and

''(ii) it was not reasonable given the circumstances to obtain the services through the organization; and

''(D) coverage is provided for emergency services (as defined in paragraph (4)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization.

''(2) MINIMUM PAYMENT LEVELS WHERE PROVIDING POINT-OF-SERVICE COVERAGE.—If a MedicarePlus product provides benefits for items

and services (not described in paragraph (1)(C)) through a network of providers and also permits payment to be made under the product for such items and services not provided through such a network, the payment level under the product with respect to such items and services furnished outside the network shall be at least 70 percent (or, if the effective cost-sharing rate is 50 percent, at least 40 percent) of the lesser of—

''(A) the payment basis (determined without regard to deductibles and cost-sharing) that would have applied for such items and services under parts A and B, or

''(B) the amount charged by the entity furnishing such items and services.

''(3) PROTECTION OF ENROLLEES FOR CERTAIN EMERGENCY SERVICES.—

''(A) PARTICIPATING PROVIDERS.—In the case of emergency services described in subparagraph (C) which are furnished by a participating physician or provider of services to an individual enrolled with a MedicarePlus organization under this section, the applicable participation agreement is deemed to provide that the physician or provider of services will accept as

payment in full from the organization for such emergency services described in subparagraph (C) the amount that would be payable to the physician or provider of services under part B and from the individual under such part, if the individual were not enrolled with such an organization under this part.

''(B) NONPARTICIPATING PROVIDERS.—In the case of emergency services described in subparagraph (C) which are furnished by a nonparticipating physician, the limitations on actual charges for such services otherwise applicable under part B (to services furnished by individuals not enrolled with a MedicarePlus organization under this section) shall apply in the same manner as such limitations apply to services furnished to individuals not enrolled with such an organization.

''(C) EMERGENCY SERVICES DESCRIBED.—The emergency services described in this subparagraph are emergency services which are furnished to an enrollee of a MedicarePlus organization under this part by a physician or provider of services that is not under a contract with the organization.

''(D) EXCEPTION FOR CERTAIN FEE-FOR-SERVICE PLANS.—The previous provisions of this paragraph shall not apply in the case of a MedicarePlus organization in relation to a MedicarePlus product if the organization does not have agreements between physicians and the organization for the provision of benefits under the product.

''(4) DEFINITION OF EMERGENCY SERVICES.—In this subsection, the term 'emergency services' means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

''(A) are furnished by an appropriate source other than the organization,

''(B) are needed immediately because of an injury or sudden illness, and

''(C) are needed because the time required to reach the organization's providers or suppliers would have meant risk of serious damage to the patient's health.

''(c) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Each MedicarePlus organization shall establish procedures—

''(1) to safeguard the privacy of individually identifiable enrollee information, and

''(2) to maintain accurate and timely medical records for enrollees.

''(d) QUALITY ASSURANCE PROGRAM.—

''(1) IN GENERAL.—Each MedicarePlus organization must have arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for health care services it provides to such individuals.

''(2) ELEMENTS OF PROGRAM.—The quality assurance program shall—

''(A) stress health outcomes;

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

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

''(D) monitors and evaluates high volume and high risk services and the care of acute and chronic conditions;

''(E) evaluates the continuity and coordination of care that enrollees receive;

''(F) has mechanisms to detect both underutilization and overutilization of services;

''(G) after identifying areas for improvement, establishes or alters practice parameters;

''(H) takes action to improve quality and assesses the effectiveness of such action through systematic follow-up;

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

''(J) is evaluated on an ongoing basis as to its effectiveness; and

''(K) provide for external accreditation or review, by a utilization and quality control peer review organization under part B of title XI or other qualified independent review organization, of the quality of services furnished by the organization meets professionally recognized standards of health care (including providing adequate access of enrollees to services).

''(3) EXCEPTION FOR CERTAIN FEE-FOR-SERVICE PLANS.—Paragraph (1) and subsection (c)(2)

shall not apply in the case of a MedicarePlus organization in relation to a MedicarePlus product to the extent the organization provides for coverage of benefits without restrictions relating to utilization and without regard to whether the provider has a contract or other arrangement with the plan for the provision of such benefits.

''(4) TREATMENT OF ACCREDITATION.—The Secretary shall provide that a MedicarePlus organization is deemed to meet the requirements of paragraphs (1) and (2) of this subsection and subsection (c) if the organization is accredited (and periodically reaccredited) by a private organization under a process that the Secretary has determined assures that the organization meets standards that are no less stringent than the standards established under section 1856 to carry out this subsection and subsection (c).

''(e) COVERAGE DETERMINATIONS.—

''(1) DECISIONS ON NONEMERGENCY CARE.—A MedicarePlus organization shall make determinations regarding authorization requests for nonemergency care on a timely basis, depending on the urgency of the situation.

''(2) APPEALS.—

''(A) IN GENERAL.—Appeals from a determination of an organization denying coverage shall be decided within 30 days of the date of receipt of medical information, but not later than 60 days after the date of the decision.

''(B) PHYSICIAN DECISION ON CERTAIN APPEALS.—Appeal decisions relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician.

''(C) EMERGENCY CASES.—Appeals from such a determination involving a life-threatening or emergency situation shall be decided on an expedited basis.

''(f) GRIEVANCES AND APPEALS.—

''(1) GRIEVANCE MECHANISM.—Each MedicarePlus 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 under this part.

''(2) APPEALS.—An enrollee with an 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 sections 205(b) and 205(g) as provided in this subparagraph, and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

''(3) INDEPENDENT REVIEW OF CERTAIN COVERAGE DENIALS.—The Secretary shall contract with an independent, outside entity to review and resolve appeals of denials of coverage related to urgent or emergency services with respect to MedicarePlus products.

''(4) COORDINATION WITH SECRETARY OF LABOR.—The Secretary shall consult with the Secretary of Labor so as to ensure that the requirements of this subsection, as they apply in the case of grievances referred to in paragraph (1) to which section 503 of the Employee Retirement Income Security Act of 1974 applies, are applied in a manner consistent with the requirements of such section 503.

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

''(h) APPROVAL OF MARKETING MATERIALS.—

''(1) SUBMISSION.—Each MedicarePlus organization may not distribute marketing materials unless—

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

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

''(2) REVIEW.—The standards established under section 1856 shall include guidelines for the review of all such material submitted and under

such guidelines the Secretary shall disapprove such material if the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.

''(3) DEEMED APPROVAL (1-STOP SHOPPING).—In the case of material 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 materials under paragraph (1)(B) with respect to a MedicarePlus product in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the product and organization.

''(4) PROHIBITION OF CERTAIN MARKETING PRACTICES.—Each MedicarePlus organization shall conform to fair marketing standards in relation to MedicarePlus products offered under this part, included in the standards established under section 1856. Such standards shall include a prohibition against an organization (or agent of such an organization) completing any portion of any election form under section 1805 on behalf of any individual.

''PROVIDER-SPONSORED ORGANIZATIONS

''SEC. 1854. (a) PROVIDER-SPONSORED ORGANIZATION DEFINED.—

''(1) IN GENERAL.—In this part, the term 'provider-sponsored organization' means a public or private entity that (in accordance with standards established under subsection (b)) is a provider, or group of affiliated providers, that provides a substantial proportion (as defined by the Secretary under such standards) of the health care items and services under the contract under this part directly through the provider or affiliated group of providers.

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

''(A) shall take into account the need for such an organization to assume responsibility for a substantial proportion of services in order to assure financial stability and the practical difficulties in such an organization integrating a very wide range of service providers; and

''(B) may vary such proportion based upon relevant differences among 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) each provider is a participant in a lawful combination under which each provider shares, directly or indirectly, substantial financial risk in connection with their operations,

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

''(b) PROCESS FOR ESTABLISHING STANDARDS FOR PROVIDER-SPONSORED ORGANIZATIONS.—For process of establishing of standards for provider-sponsored organizations, see section 1856(c).

''(c) PROCESS FOR STATE CERTIFICATION OF PROVIDER-SPONSORED ORGANIZATIONS.—For process of

State certification of provider-sponsored organizations, see section 1857(c).

''(d) PREEMPTION OF STATE INSURANCE LICENSING REQUIREMENTS.—

''(1) IN GENERAL.—This section supersedes any State law which—

''(A) requires that a provider-sponsored organization meet requirements for insurers of health services or health maintenance organizations doing business in the State with respect to initial capitalization and establishment of financial reserves against insolvency, or

''(B) imposes requirements that would have the effect of prohibiting the organization from complying with the applicable requirements of this part,

insofar as such the law applies to individuals enrolled with the organization under this part.

''(2) EXCEPTION.—Paragraph (1) shall not apply with respect to any State law to the extent that such law provides standards or requirements, or provides for enforcement thereof, so as to meet the requirements of section 1857(c)(2) with respect to approval by the Secretary of State certification requirements thereunder.

''(3) CONSTRUCTION.—Nothing in this subsection shall be construed as affecting the operation of section 514 of the Employee Retirement Income Security Act of 1974.

''PAYMENTS TO MEDICAREPLUS ORGANIZATIONS

''SEC. 1855. (a) PAYMENTS.—

''(1) IN GENERAL.—Under a contract under section 1858 the Secretary shall pay to each MedicarePlus organization, with respect to coverage of an individual under this part in a payment area for a month, an amount equal to the monthly adjusted MedicarePlus capitation rate (as provided under subsection (b)) with respect to that individual for that area.

''(2) ANNUAL ANNOUNCEMENT.—The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than September 7 before the calendar year concerned—

''(A) the annual MedicarePlus capitation rate for each payment area for the year, and

''(B) the factors to be used in adjusting such rates under subsection (b) for payments for months in that year.

''(3) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the an-

nouncement under paragraph (2) for a year, the Secretary shall provide for notice to MedicarePlus organizations of proposed changes to be made in the methodology or benefit coverage assumptions from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

''(4) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (2) for a year, the Secretary shall include an explanation of the assumptions (including any benefit coverage assumptions) and changes in methodology used in the announcement in sufficient detail so that MedicarePlus organizations can compute monthly adjusted MedicarePlus capitation rates for classes of individuals located in each payment area which is in whole or in part within the service area of such an organization.

''(b) MONTHLY ADJUSTED MEDICAREPLUS CAPITATION RATE.—

''(1) IN GENERAL.—For purposes of this section, the 'monthly adjusted MedicarePlus capitation rate' under this subsection, for a month in a year for an individual in a payment area (specified under

paragraph (3)) and in a class (established under paragraph (4)), is 1/12 of the annual MedicarePlus capitation rate specified in paragraph (2) for that area for the year, adjusted to reflect the actuarial value of benefits under this title with respect to individuals in such class compared to the national average for individuals in all classes.

''(2) ANNUAL MEDICAREPLUS CAPITATION RATES.—For purposes of this section, the annual MedicarePlus capitation rate for a payment area for a year is equal to the annual MedicarePlus capitation rate for the area for the previous year (or, in the case of 1996, the average annual per capita rate of payment described in section 1876(a)(1)(C) for the area for 1995) increased by the per capita growth rate for that area and year (as determined under subsection (c)).

''(3) PAYMENT AREA DEFINED.—In this section, the term 'payment area' means a county (or equivalent area specified by the Secretary), except that in the case of the population group described in paragraph (5)(C), the payment area shall be each State.

''(4) CLASSES.—

''(A) IN GENERAL.—For purposes of this section, the Secretary shall define appropriate classes of enrollees, consistent with paragraph (5), based on age, gender, welfare status, institutionalization, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence.

''(B) RESEARCH.—The Secretary shall conduct such research as may be necessary to provide for greater accuracy in the adjustment of capitation rates under this subsection. Such research may include research into the addition or modification of classes under subparagraph (A). The Secretary shall submit to Congress a report on such research by not later than January 1, 1997.

''(5) DIVISION OF MEDICARE POPULATION.—In carrying out paragraph (4) and this section, the Secretary shall recognize the following separate population groups:

''(A) AGED.—Individuals 65 years of age or older who are not described in subparagraph (C).

''(B) DISABLED.—Disabled individuals who are under 65 years of age and not described in subparagraph (C).

''(C) INDIVIDUALS WITH END STAGE RENAL DISEASE.—Individuals who are determined to have end stage renal disease.

''(c) PER CAPITA GROWTH RATES.—

''(1) FOR 1996.—

''(A) IN GENERAL.—For purposes of this section and subject to subparagraph (B), the per capita growth rates for 1996, for a payment area assigned to a service utilization cohort under subsection (d), shall be the following:

''(i) LOWEST SERVICE UTILIZATION COHORT.—For areas assigned to the lowest service utilization cohort, 9.0 percent plus the additional percent provided under subparagraph (B)(ii).

''(ii) LOWER SERVICE UTILIZATION COHORT.—For areas assigned to the lower service utilization cohort, 8.0 percent.

''(iii) MEDIAN SERVICE UTILIZATION COHORT.—For areas assigned to the median service utilization cohort, 5.1 percent.

''(iv) HIGHER SERVICE UTILIZATION COHORT.—For areas assigned to the higher service utilization cohort, 4.7 percent.

''(v) HIGHEST SERVICE UTILIZATION COHORT.—For areas assigned to the highest service utilization cohort, 4.0 percent.

''(B) BUDGET NEUTRAL ADJUSTMENT.—In order to assure that the total capitation payments under this section during 1996 are the same as the amount such payments would have been if the per capita growth rate for all such areas for 1996 were equal to the national average per capita growth rate, specified in paragraph (3) for 1996, the Secretary shall adjust the per capita growth rates for payment areas as follows:

''(i) INCREASE UP TO FLOOR FOR LOWEST SERVICE UTILIZATION COHORT.—First, such additional percent increase as may be necessary to assure that the annual MedicarePlus capitation rate for each pay-

ment area is at least 12 times $300 for 1996.

''(ii) RESIDUAL INCREASE TO LOWEST SERVICE UTILIZATION COHORT.—Next, for payment areas assigned to the lowest service utilization cohort, such additional percent increase as will assure that the total capitation payments under this section during 1996 are the same as the amount such payments would have been if the per capita growth rate for all such areas for 1996 were equal to the national average per capita growth rate. The increase under this clause may apply to a payment area described in clause (i) and shall be applied after the increase provided under such clause.

''(2) FOR SUBSEQUENT YEARS.—

''(A) IN GENERAL.—For purposes of this section and subject to subparagraphs (B) and (C), the Secretary shall compute a per capita growth rate for each year after 1996, for each payment area as assigned to a service utilization cohort under subsection (d), consistent with the following rules:

''(i) MEDIAN SERVICE UTILIZATION COHORT SET AT NATIONAL AVERAGE PER CAPITA GROWTH RATE.—The per capita growth rate for areas assigned to the median service utilization cohort for the year shall be the national average per capita growth rate for the year (as specified under paragraph (3)), subject to subparagraph (C).

''(ii) HIGHEST SERVICE UTILIZATION COHORT SET AT 75 PERCENT OF NATIONAL AVERAGE PER CAPITA GROWTH RATE.—The per capita growth rate for areas assigned to the highest service utilization cohort for the year shall be 75 percent of the national average per capita growth rate for the year.

''(iii) LOWEST SERVICE UTILIZATION COHORT SET AT 187.5 PERCENT OF NATIONAL AVERAGE PER CAPITA GROWTH RATE.—The per capita growth rate for areas assigned to the lowest service utilization cohort for the year shall be 187.5 percent of the national average per capita

growth rate for the year, subject to subparagraph (C).

''(iv) LOWER SERVICE UTILIZATION COHORT SET AT 150 PERCENT OF NATIONAL AVERAGE PER CAPITA GROWTH RATE.—

''(I) IN GENERAL.—Subject to subclause (II), the per capita growth rate for areas assigned to the lower service utilization cohort for the year shall be 150 percent of the national average per capita growth rate for the year.

''(II) ADJUSTMENT.—If the Secretary has established under clause (v) the per capita growth rate for areas assigned to the higher service utilization cohort for the year at 75 percent of the national average per capita growth rate, the Secretary may provide for a reduced per capita growth rate under subclause (I) to the extent necessary to comply with subparagraph (B).

''(v) HIGHER SERVICE UTILIZATION COHORT.—The per capita growth rate for areas assigned to the higher service utilization cohort for the year shall be such percent (not less than 75 percent) of the national average per capita growth rate, as the Secretary may determine consistent with subparagraph (B).

''(B) AVERAGE PER CAPITA GROWTH RATE AT NATIONAL AVERAGE TO ASSURE BUDGET NEUTRALITY.—The Secretary shall compute per capita growth rates for a year under subparagraph (A) (before the application of subparagraph (C)) in a manner so that the weighted average per capita growth rate for all areas for the year (weighted to reflect the number of medicare beneficiaries in each area) is equal to the national average per capita growth rate under paragraph (3) for the year.

''(C) FINAL ADJUSTMENT OF GROWTH RATES.—After computing per capita growth rates under the previous provisions of this paragraph for a year, the Secretary shall—

''(i) reduce the per capita growth rate for areas assigned to the median service utilization cohort by the ratio of .1 to 5.3;

''(ii) if the year is 1997, increase per capita growth rates for payment areas to extent necessary to assure that the annual MedicarePlus capitation rate for each payment area for such year is at least 12 times $320; and

''(iii) adjust (consistent with clause (ii)) the per capita growth rate for areas assigned to the lowest service utilization cohort by such proportion as the Secretary determines will result in no net increase in outlays resulting from the application of this subparagraph for the year involved.

''(3) NATIONAL AVERAGE PER CAPITA GROWTH RATES.—In this subsection, the 'national average per capita growth rate' for—

''(A) 1996 is 5.3 percent,

''(B) 1997 is 3.8 percent,

''(C) 1998 is 4.6 percent,

''(D) 1999 is 4.3 percent,

''(E) 2000 is 3.8 percent,

''(F) 2001 is 5.5 percent,

''(G) 2002 is 5.6 percent, and

''(H) each subsequent year is 5.0 percent.

''(d) ASSIGNMENT OF PAYMENT AREAS TO SERVICE UTILIZATION COHORTS.—

''(1) IN GENERAL.—For purposes of determining per capita growth rates under subsection (c) for areas for a year, the Secretary shall assign each payment area to a service utilization cohort (based on the service utilization index value for that area determined under paragraph (2)) as follows:

''(A) LOWEST SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of less than .80 shall be assigned to the lowest service utilization cohort.

''(B) LOWER SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of at least .80 but less than .90 shall be assigned to the lower service utilization cohort.

''(C) MEDIAN SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of at least .90 but less than 1.10 shall be assigned to the median service utilization cohort.

''(D) HIGHER SERVICE UTILIZATION COHORT.—Areas with a service utilization index

value of at least 1.10 but less than 1.20 shall be assigned to the higher service utilization cohort.

''(E) HIGHEST SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of at least 1.20 shall be assigned to the highest service utilization cohort.

''(2) DETERMINATION OF SERVICE UTILIZATION INDEX VALUES.—In order to determine the per capita growth rate for a payment area for each year (beginning with 1996), the Secretary shall determine for such area and year a service utilization index value, which is equal to—

''(A) the annual MedicarePlus capitation rate under this section for the area for the year in which the determination is made (or, in the case of 1996, the average annual per capita rate of payment (described in section 1876(a)(1)(C)) for the area for 1995); divided by

''(B) the input-price-adjusted annual national MedicarePlus capitation rate (as determined under paragraph (3)) for that area for the year in which the determination is made.

''(3) DETERMINATION OF INPUT-PRICE-ADJUSTED RATES.—

''(A) IN GENERAL.—For purposes of paragraph (2), the 'input-price-adjusted annual national MedicarePlus capitation rate' for a 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—

''(i) the national standardized MedicarePlus 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 shall, 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 MEDICAREPLUS CAPITATION RATE.—In this paragraph, the 'national standardized MedicarePlus capitation rate' for a year is equal to—

''(i) the sum (for all payment areas) of the product of (I) the annual MedicarePlus capitation rate for that year for the area under subsection (b)(2), and (II) the average number of medicare beneficiaries residing in that area in the year; divided by

''(ii) the total average number of medicare beneficiaries residing in all the payment areas for that year.

''(C) SPECIAL RULES FOR 1996.—In applying this paragraph for 1996—

''(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) for such types of services shall be—

''(I) for part A services, the ratio (expressed as a percentage) of the av-

erage annual per capita rate of payment for the area for part A for 1995 to the total average annual per capita rate of payment for the area for parts A and B for 1995, and

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

''(iii) for the 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, 70

percent shall be adjusted by the index described in clause (iii);

''(v) the index values shall be computed based only on the beneficiary population described in subsection (b)(5)(A).

The Secretary may continue to apply the rules described in this subparagraph (or similar rules) for 1997.

''(e) PAYMENT PROCESS.—

''(1) IN GENERAL.—Subject to subsection (f), the Secretary shall make monthly payments under this section in advance and in accordance with the rate determined under subsection (a) to the plan for each individual enrolled with a MedicarePlus organization under this part.

''(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 MedicarePlus organization under a product 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 1853(a) at the time the individual enrolled with the organization.

''(f) SPECIAL RULES FOR INDIVIDUALS ELECTING HIGH DEDUCTIBLE/MEDISAVE PRODUCT.—

''(1) IN GENERAL.—In the case of an individual who has elected a high deductible/medisave product, notwithstanding the preceding provisions of this section—

''(A) the amount of the payment to the MedicarePlus organization offering the high deductible/medisave product shall not exceed the premium for the product, and

''(B) subject to paragraph (2), the difference between the amount of payment that would otherwise be made and the amount of payment to such organization shall be made directly into a MedicarePlus MSA established (and, if applicable, designated) by the individual under paragraph (2).

''(2) ESTABLISHMENT AND DESIGNATION OF MEDICAREPLUS MEDICAL SAVINGS ACCOUNT AS REQUIREMENT FOR PAYMENT OF CONTRIBUTION.—In the case of an individual who has elected coverage under a high deductible/medisave product, no payment shall be made under paragraph (1)(B) on be-

half 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 MedicarePlus MSA (as defined in section 137(b) of the Internal Revenue Code of 1986), and

''(B) if the individual has established more than one MedicarePlus MSA, has designated one of such accounts as the individual's MedicarePlus 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 a high deductible/medisave product effective beginning with a month in a year, the amount of the contribution to the MedicarePlus 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.

''(g) PAYMENTS FROM TRUST FUND.—The payment to a MedicarePlus organization under this section for individuals enrolled under this part with the organization, and payments to a MedicarePlus MSA under subsection (f)(1)(B), 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.

''(h) 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 MedicarePlus product offered by a MedicarePlus organization—

''(A) payment for such services until the date of the individual's discharge shall be made under this title through the MedicarePlus product or Non-MedicarePlus option (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 MedicarePlus 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 MedicarePlus 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.

''ESTABLISHMENT OF STANDARDS FOR MEDICARE-PLUS ORGANIZATIONS AND PRODUCTS

''SEC. 1856. (a) STANDARDS APPLICABLE TO STATE-REGULATED ORGANIZATIONS AND PRODUCTS.—

''(1) RECOMMENDATIONS OF NAIC.—The Secretary shall request the National Association of Insurance Commissioners to develop and submit to the Secretary, not later than 12 months after the date of the enactment of the Medicare Preservation Act of 1995, proposed standards consistent with the requirements of this part for MedicarePlus organizations (other than union sponsors, Taft-Hartley sponsors, and provider-sponsored organizations) and MedicarePlus products offered by such organizations, except that such proposed standards may relate to MedicarePlus organizations that are qualified associations only with respect to MedicarePlus products offered by them and only if such products are issued by organizations to which section 1851(b)(1) applies.

''(2) REVIEW.—If the Association submits such standards on a timely basis, the Secretary shall review such standards to determine if the standards meet the requirements of the part. The Secretary shall complete the review of the standards not later than 90 days after the date of their submission. The Secretary shall promulgate such proposed standards to apply to organizations and products described in paragraph (1) except to the extent that the Sec-

retary modifies such proposed standards because they do not meet such requirements.

''(3) FAILURE TO SUBMIT.—If the Association does not submit such standards on a timely basis, the Secretary shall promulgate such standards by not later than the date the Secretary would otherwise have been required to promulgate standards under paragraph (2).

''(4) USE OF INTERIM RULES.—For the period in which this part is in effect and standards are being developed and established under the preceding provisions of this subsection, the Secretary shall provide by not later than June 1, 1996, for the application of such interim standards (without regard to any requirements for notice and public comment) as may be appropriate to provide for the expedited implementation of this part. Such interim standards shall not apply after the date standards are established under the preceding provisions of this subsection.

''(b) UNION AND TAFT-HARTLEY SPONSORS, QUALIFIED ASSOCIATIONS, AND PRODUCTS.—

''(1) IN GENERAL.—The Secretary shall develop and promulgate by regulation standards consistent with the requirements of this part for union and

Taft-Hartley sponsors, for qualified associations, and for MedicarePlus products offered by such organizations (other than MedicarePlus products offered by qualified associations that are issued by organizations to which section 1851(b)(1) applies).

''(2) CONSULTATION WITH LABOR.—The Secretary shall consult with the Secretary of Labor with respect to such standards for such sponsors and products.

''(3) TIMING.—Standards under this subsection shall be promulgated at or about the time standards are promulgated under subsection (a).

''(c) ESTABLISHMENT OF STANDARDS FOR PROVIDER-SPONSORED ORGANIZATIONS.—

''(1) IN GENERAL.—The Secretary shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter 3 of chapter 5 of title 5, United States Code, standards that entities must meet to qualify as provider-sponsored organizations under this part.

''(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 represent-

ative 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 Medicare Preservation Act of 1995.

''(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 September 1, 1996.

''(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 June 1, 1996, regarding the committee's progress on achieving a concensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before one 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 one month before the target publication date.

''(8) INTERIM, FINAL EFFECT.—The Secretary shall publish a rule under this subsection in the Federal Register by not later than the target publication

date. 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 publication date.

''(10) PROCESS FOR APPROVAL OF APPLICATIONS FOR CERTIFICATION.—

''(A) IN GENERAL.—The Secretary shall establish a process for the receipt and approval of applications of entities for certification as provider-sponsored organizations under this part. Under such process, the Secretary shall act upon a complete application submitted within 60 days after the date it is received.

''(B) CIRCULATION OF PROPOSED APPLICATION FORM.—By March 1, 1996, the Sec-

retary, after consultation with the negotiated rulemaking committee, shall circulate a proposed application form that could be used by entities considering becoming certified as a provider-sponsored organization under this part.

''(d) COORDINATION AMONG FINAL STANDARDS.—In establishing standards (other than on an interim basis) under the previous provisions of this section, the Secretary shall seek to provide for consistency (as appropriate) across the different types of MedicarePlus organizations, in order to promote equitable treatment of different types of organizations and consistent protection for individuals who elect products offered by the different types of MedicarePlus organizations.

''(e) USE OF CURRENT STANDARDS FOR INTERIM STANDARDS.—To the extent practicable and consistent with the requirements of this part, standards established on an interim basis to carry out requirements of this part may be based on currently applicable standards, such as the rules established under section 1876 (as in effect as of the date of the enactment of this section) to carry out analogous provisions of such section or standards established or developed for application in the private health insurance market.

''(f) APPLICATION OF NEW STANDARDS TO ENTITIES WITH A CONTRACT.—In the case of a MedicarePlus organization with a contract in effect under this part at the time standards applicable to the organization under this section are changed, the organization may elect not to have such changes apply to the organization until the end of the current contract year (or, if there is less than 6 months remaining in the contract year, until 1 year after the end of the current contract year).

''(g) RELATION TO STATE LAWS.—The standards established under this section shall supersede any State law or regulation with respect to MedicarePlus products which are offered by MedicarePlus organizations and are issued by organizations to which section 1851(b)(1) applies, to the extent such law or regulation is inconsistent with such standards.

''MEDICARE-PLUS CERTIFICATION

''SEC. 1857. (a) STATE CERTIFICATION PROCESS FOR STATE-REGULATED ORGANIZATIONS.—

''(1) APPROVAL OF STATE PROCESS.—The Secretary shall approve a MedicarePlus certification and enforcement program established by a State for applying the standards established under section 1856 to MedicarePlus organizations (other than union sponsors, Taft-Hartley sponsors, and provider-sponsored organizations) and MedicarePlus products of-

fered by such organizations if the Secretary determines that the program effectively provides for the application and enforcement of such standards in the State with respect to such organizations and products. Such program shall provide for certification of compliance of MedicarePlus organizations and products with the applicable requirements of this part not less often than once every 3 years.

''(2) EFFECT OF CERTIFICATION UNDER STATE PROCESS.—A MedicarePlus organization and MedicarePlus product offered by such an organization that is certified under such program is considered to have been certified under this subsection with respect to the offering of the product to individuals residing in the State.

''(3) USER FEES.—The State may impose user fees on organizations seeking certification under this subsection in such amounts as the State deems sufficient to finance the costs of such certification. Nothing in this paragraph shall be construed as restricting a State's authority to impose premium taxes, other taxes, or other levies.

''(4) REVIEW.—The Secretary periodically shall review State programs approved under paragraph (1) to determine if they continue to provide for cer-

tification and enforcement described in such paragraph. If the Secretary finds that a State program no longer so provides, before making a final determination, the Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the State program to meet the requirements of paragraph (1). If the Secretary makes a final determination that the State program, after such an opportunity, fails to meet such requirements, the provisions of subsection (b) shall apply to MedicarePlus organizations and products in the State.

''(5) EFFECT OF NO STATE PROGRAM.—Beginning on the date standards are established under section 1856, in the case of organizations and products in States in which a certification program has not been approved and in operation under paragraph (1), the Secretary shall establish a process for the certification of MedicarePlus organizations (other than union sponsors, Taft-Hartley sponsors, and provider-sponsored organizations) and products of such organizations as meeting such standards.

''(6) PUBLICATION OF LIST OF APPROVED STATE PROGRAMS.—The Secretary shall publish (and periodically update) a list of those State pro-

grams which are approved for purposes of this subsection.

''(b) FEDERAL CERTIFICATION PROCESS FOR UNION SPONSORS, TAFT-HARTLEY SPONSORS, AND PROVIDER-SPONSORED ORGANIZATIONS.—

''(1) ESTABLISHMENT.—The Secretary shall establish a process for the certification of union sponsors, Taft-Hartley sponsors, and provider-sponsored organizations and MedicarePlus products offered by such sponsors and organizations as meeting the applicable standards established under section 1856.

''(2) INVOLVEMENT OF SECRETARY OF LABOR.—Such process shall be established and operated in cooperation with the Secretary of Labor with respect to union sponsors and Taft-Hartley sponsors.

''(3) USE OF STATE LICENSING AND PRIVATE ACCREDITATION PROCESSES.—

''(A) IN GENERAL.—The process under this subsection shall, to the maximum extent practicable, provide that MedicarePlus organizations and products that are licensed or certified through a qualified private accreditation process that the Secretary finds applies standards that are no less stringent than the require-

ments of this part are deemed to meet the corresponding requirements of this part for such an organization or product.

''(B) PERIODIC ACCREDITATION.—The use of an accreditation under subparagraph (A) shall be valid only for such period as the Secretary specifies.

''(4) USER FEES.—The Secretary may impose user fees on entities seeking certification under this subsection in such amounts as the Secretary deems sufficient to finance the costs of such certification.

''(c) CERTIFICATION OF PROVIDER-SPONSORED ORGANIZATIONS BY STATES.—

''(1) IN GENERAL.—The Secretary shall establish a process under which a State may propose to provide for certification of entities as meeting the requirements of this part to be provider-sponsored organizations.

''(2) CONDITIONS FOR APPROVAL.—The Secretary may not approve a State program for certification under paragraph (1) unless the Secretary determines that the certification program applies standards and requirements that are identical to the standards and requirements of this part and the applicable provisions for enforcement of such standards

and requirements do not result in a lower level or quality of enforcement than that which is otherwise applicable under this title.

''(d) NOTICE TO ENROLLEES IN CASE OF DECERTIFICATION.—If a MedicarePlus organization or product is decertified under this section, the organization shall notify each enrollee with the organization and product under this part of such decertification.

''(e) QUALIFIED ASSOCIATIONS.—In the case of MedicarePlus products offered by a MedicarePlus organization that is a qualified association (as defined in section 1854(c)(4)(C)) and issued by an organization to which section 1851(b)(1) applies or by a provider-sponsored organization (as defined in section 1854(a)), nothing in this section shall be construed as limiting the authority of States to regulate such products.

''CONTRACTS WITH MEDICAREPLUS ORGANIZATIONS

''SEC. 1858. (a) IN GENERAL.—The Secretary shall not permit the election under section 1805 of a MedicarePlus product offered by a MedicarePlus organization under this part, and no payment shall be made under section 1856 to an organization, unless the Secretary has entered into a contract under this section with an organization with respect to the offering of such product. Such a contract with an organization may cover more than one MedicarePlus product. 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 paragraphs (1) and (2), the Secretary may not enter into a contract under this section with a MedicarePlus organization (other than a union sponsor or Taft-Hartley sponsor) unless the organization has 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, except that the standards under section 1856 may permit the organization to have a lesser number of beneficiaries (but not less than 500 in the case of an organization that is a provider-sponsored organization) if the organization primarily serves individuals residing outside of urbanized areas.

''(2) EXCEPTION FOR HIGH DEDUCTIBLE/MEDISAVE PRODUCT.—Paragraph (1) shall not apply with respect to a contract that relates only to a high deductible/medisave product.

''(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 one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term.

''(2) TERMINATION AUTHORITY.—In accordance with procedures established under subsection (h), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in an applicable paragraph of subsection (g) on the MedicarePlus organization if the Secretary determines that the organization—

''(A) has failed substantially to carry out the contract;

''(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part;

''(C) is operating in a manner that is not in the best interests of the individuals covered under the contract; or

''(D) 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 a high deductible/medisave account be effective before January 1997 with respect to such coverage.

''(4) PREVIOUS TERMINATIONS.—The Secretary may not enter into a contract with a MedicarePlus organization if a previous contract with that organization under this section was terminated at the request of the organization within the preceding five-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

''(5) NO CONTRACTING AUTHORITY.—The authority vested in the Secretary by this part may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

''(d) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—

''(1) INSPECTION AND AUDIT.—Each contract under this section shall provide that the Secretary, or any person or organization designated by the Secretary—

''(A) shall have the right to inspect or otherwise evaluate (i) the quality, appropriateness, and timeliness of services performed under the contract and (ii) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

''(B) shall have the right to audit and inspect any books and records of the MedicarePlus organization that pertain (i) to the ability of the organization to bear the risk of potential financial losses, or (ii) to services performed or determinations of amounts payable under the contract.

''(2) ENROLLEE NOTICE AT TIME OF TERMINATION.—Each contract under this section shall require the organization to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining

benefits under this title, to each individual enrolled with the organization under this part.

''(3) DISCLOSURE.—

''(A) IN GENERAL.—Each MedicarePlus 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 MedicarePlus 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 MedicarePlus 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 MedicarePlus organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

''(4) LOAN INFORMATION.—The contract shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties.

''(e) ADDITIONAL CONTRACT TERMS.—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.

''(f) INTERMEDIATE SANCTIONS.—

''(1) IN GENERAL.—If the Secretary determines that a MedicarePlus 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 premiums permitted;

''(C) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this part;

''(D) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this part) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

''(E) misrepresents or falsifies information that is furnished—

''(i) to the Secretary under this part, or

''(ii) to an individual or to any other entity under this part;

''(F) fails to comply with the requirements of section 1852(f)(3); or

''(G) employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services;

the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2).

''(2) REMEDIES.—The remedies described in this paragraph are—

''(A) civil money penalties of not more than $25,000 for each determination under paragraph (1) or, with respect to a determination under subparagraph (D) or (E)(i) of such paragraph, of not more than $100,000 for each such determination, plus, with respect to a determination under paragraph (1)(B), double the

excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(D), $15,000 for each individual not enrolled as a result of the practice involved,

''(B) suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

''(C) suspension of payment to the organization under this part for individuals enrolled after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

''(3) OTHER INTERMEDIATE SANCTIONS.—In the case of a MedicarePlus organization for which the Secretary makes a determination under subsection (c)(2) the basis of which is not described in

paragraph (1), the Secretary may apply the following intermediate sanctions:

''(A) civil money penalties of not more than $25,000 for each determination under subsection (c)(2) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract;

''(B) civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under subsection (h) during which the deficiency that is the basis of a determination under subsection (c)(2) exists; and

''(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) PROCEDURES FOR IMPOSING SANCTIONS.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil

money penalty under paragraph (1) or (2) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

''(g) PROCEDURES FOR IMPOSING SANCTIONS.—The Secretary may terminate a contract with a MedicarePlus organization under this section or may impose the intermediate sanctions described in subsection (f) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

''(1) the Secretary provides the organization with the 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);

''(2) the Secretary shall impose more severe sanctions on organizations that have a history of deficiencies or that have not taken steps to correct deficiencies the Secretary has brought to their attention;

''(3) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

''(4) the Secretary provides the organization with reasonable notice and opportunity for hearing

(including the right to appeal an initial decision) before imposing any sanction or terminating the contract.''.

(b) 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).

(c) USE OF 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 promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

(d) ADVANCE DIRECTIVES.—Section 1866(f) (42 U.S.C. 1395cc(f)) is amended—

(1) in paragraph (1)—

(A) by inserting ''1853(g),'' after ''1833(s),'', and

(B) by inserting '', MedicarePlus organization,'' after ''provider of services'', and

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

''(4) Nothing in this subsection shall be construed to require the provision of information regarding assisted suicide, euthanasia, or mercy killing.''.

(e) CONFORMING AMENDMENT.—Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended by inserting before the semicolon at the end the following: ''and in the case of hospitals to accept as payment in full for inpatient hospital services that are emergency services (as defined in section 1853(b)(4)) that are covered under this title and are furnished to any individual enrolled under part C with a MedicarePlus organization which does not have a contract establishing payment amounts for services furnished to members of the organization the amounts that would be made as a payment in full under this title if the individuals were not so enrolled''.

SEC. 15003. DUPLICATION AND COORDINATION OF MEDICARE-RELATED PRODUCTS.

(a) TREATMENT OF CERTAIN HEALTH INSURANCE POLICIES AS NONDUPLICATIVE.—

(1) IN GENERAL.—Effective as if included in the enactment of section 4354 of the Omnibus Budget Reconciliation Act of 1990, section 1882(d)(3)(A) (42 U.S.C. 1395ss(d)(3)(A)) is amended—

(A) by amending clause (i) to read as follows:

''(i) It is unlawful for a person to sell or issue to an individual entitled to benefits under part A or enrolled under part B of this title or electing a MedicarePlus product under section 1805—

''(I) a health insurance policy (other than a medicare supplemental policy) with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this title or title XIX,

''(II) in the case of an individual not electing a MedicarePlus product, a medicare supplemental policy with knowledge that the individual is entitled to benefits under another medicare supplemental policy, or

''(III) in the case of an individual electing a MedicarePlus product, a medicare supplemental policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this title or under another medicare supplemental policy.'';

(B) in clause (iii), by striking ''clause (i)'' and inserting ''clause (i)(II)''; and

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

''(iv) For purposes of this subparagraph a health insurance policy shall be considered to 'duplicate' benefits under this title only when, under its terms, the policy provides specific reimbursement for identical items and services to the extent paid for under this title, and a health insurance policy providing for benefits which are payable to or on behalf of an individual without regard to other health benefit coverage of such individual is not considered to 'duplicate' any health benefits under this title.

''(v) For purposes of this subparagraph, a health insurance policy (or a rider to an insurance contract which is not a health insurance policy), including a policy (such as a long-term care insurance contract described in section 7702B(b) of the Internal Revenue Code of 1986, as added by the Contract with America Tax Relief Act of 1995 (H.R. 1215)) providing benefits for long-term care, nursing home care, home health care, or community-based care, that coordinates against or excludes items and services available or paid for under this title and (for policies sold or issued after January 1, 1996) that discloses such coordination or exclusion in the policy's outline of coverage, is not considered to 'duplicate' health benefits under this title. For purposes of this clause, the terms 'co-

ordinates' and 'coordination' mean, with respect to a policy in relation to health benefits under this title, that the policy under its terms is secondary to, or excludes from payment, items and services to the extent available or paid for under this title.

''(vi) Notwithstanding any other provision of law, no criminal or civil penalty may be imposed at any time under this subparagraph and no legal action may be brought or continued at any time in any Federal or State court if the penalty or action is based on an act or omission that occurred after November 5, 1991, and before the date of the enactment of this clause, and relates to the sale, issuance, or renewal of any health insurance policy during such period, if such policy meets the requirements of clause (iv) or (v).

''(vii) A State may not impose, with respect to the sale or issuance of a policy (or rider) that meets the requirements of this title pursuant to clause (iv) or (v) to an individual entitled to benefits under part A or enrolled under part B or enrolled under a MedicarePlus product under part C, any requirement based on the premise that such a policy or rider duplicates health benefits to which the individual is otherwise entitled under this title.''.

(2) CONFORMING AMENDMENTS.—Section 1882(d)(3) (42 U.S.C. 1395ss(d)(3)) is amended—

(A) in subparagraph (B), by inserting ''(including any MedicarePlus product)'' after ''health insurance policies'';

(B) in subparagraph (C)—

(i) by striking ''with respect to (i)'' and inserting ''with respect to'', and

(ii) by striking '', (ii) the sale'' and all that follows up to the period at the end; and

(C) by striking subparagraph (D).

(3) MEDICAREPLUS PRODUCTS NOT TREATED AS MEDICARE SUPPLEMENTARY POLICIES.—Section 1882(g) (42 U.S.C. 1395ss(g)) is amended by inserting ''a MedicarePlus product or'' after ''and does not include''

(4) REPORT ON DUPLICATION AND COORDINATION OF HEALTH INSURANCE POLICIES THAT ARE NOT MEDICARE SUPPLEMENTAL POLICIES.—Not later than 3 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall prepare and submit to Congress a report on the advisability and feasibility of restricting the sale to medicare beneficiaries of health insurance policies that duplicate (within the meaning of section 1882(d)(3)(A) of the Social Security Act) other

health insurance policies that such a beneficiary may have. In preparing such report, the Secretary shall seek the advice of the National Association of Insurance Commissioners and shall take into account the standards established under section 1807 of the Social Security Act for the electronic coordination of benefits.

(b) ADDITIONAL RULES RELATING TO INDIVIDUALS ENROLLED IN MEDICAREPLUS PRODUCTS.—Section 1882 (42 U.S.C. 1395ss) is further amended by adding at the end the following new subsection:

''(u)(1) Notwithstanding the previous provisions of this section, the following provisions shall not apply to a health insurance policy (other than a medicare supplemental policy) provided to an individual who has elected the MedicarePlus option under section 1805:

''(A) Subsections (o)(1), (o)(2), (p)(1)(A)(i), (p)(2), (p)(3), (p)(8), and (p)(9) (insofar as they relate to limitations on benefits or groups of benefits that may be offered).

''(B) Subsection (r) (relating to loss-ratios).

''(2)(A) It is unlawful for a person to sell or issue a policy described in subparagraph (B) to an individual with knowledge that the individual has in effect under sec-

tion 1805 an election of a high deductible/medisave product.

''(B) A policy described in this subparagraph is a health insurance policy that provides for coverage of expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under the high deductible/medisave product.''.

SEC. 15004. TRANSITIONAL RULES FOR CURRENT MEDICARE HMO PROGRAM.

(a) TRANSITION FROM CURRENT CONTRACTS.—

(1) LIMITATION ON NEW CONTRACTS.—

(A) NO NEW RISK-SHARING CONTRACTS AFTER NEW STANDARDS ESTABLISHED.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall not enter into any risk-sharing contract under section 1876 of the Social Security Act with an eligible organization for any contract year beginning on or after the date standards for MedicarePlus organizations and products are first established under section 1856(a) of such Act with respect to MedicarePlus organizations that are insurers or health maintenance organizations unless such a contract had been

in effect under section 1876 of such Act for the organization for the previous contract year.

(B) NO NEW COST REIMBURSEMENT CONTRACTS.—The Secretary shall not enter into any cost reimbursement contract under section 1876 of the Social Security Act beginning for any contract year beginning on or after the date of the enactment of this Act.

(2) TERMINATION OF CURRENT CONTRACTS.—

(A) RISK-SHARING CONTRACTS.—Notwithstanding any other provision of law, the Secretary shall not extend or continue any risk-sharing contract with an eligible organization under section 1876 of the Social Security Act (for which a contract was entered into consistent with paragraph (1)(A)) for any contract year beginning on or after 1 year after the date standards described in paragraph (1)(A) are established.

(B) COST REIMBURSEMENT CONTRACTS.—The Secretary shall not extend or continue any reasonable cost reimbursement contract with an eligible organization under section 1876 of the Social Security Act for any contract year beginning on or after January 1, 1998.

(b) CONFORMING PAYMENT RATES.—

(1) RISK-SHARING CONTRACTS.—Notwithstanding any other provision of law, the Secretary shall provide that payment amounts under risk-sharing contracts under section 1876(a) of the Social Security Act for months in a year (beginning with January 1996) shall be computed—

(A) with respect to individuals entitled to benefits under both parts A and B of title XVIII of such Act, by substituting payment rates under section 1855(a) of such Act for the payment rates otherwise established under section 1876(a) of such Act, and

(B) with respect to individuals only entitled to benefits under part B of such title, by substituting an appropriate proportion of such rates (reflecting the relative proportion of payments under such title attributable to such part) for the payment rates otherwise established under section 1876(a) of such Act.

For purposes of carrying out this paragraph for payment for months in 1996, the Secretary shall compute, announce, and apply the payment rates under section 1855(a) of such Act (notwithstanding any deadlines specified in such section) in as timely a

manner as possible and may (to the extent necessary) provide for retroactive adjustment in payments made not in accordance with such rates.

(2) COST CONTRACTS.—Notwithstanding any other provision of law, the Secretary shall provide that payment amounts under cost reimbursement contracts under section 1876(a) of the Social Security Act shall take into account adjustments in payment amounts made in parts A and B of title XVIII of such Act pursuant to the amendments made by this title.

(c) ELIMINATION OF 50:50 RULE.—

(1) IN GENERAL.—Section 1876 (42 U.S.C. 1395mm) is amended by striking subsection (f).

(2) CONFORMING AMENDMENTS.—Section 1876 is further amended—

(A) in subsection (c)(3)(A)(i), by striking ''would result in failure to meet the requirements of subsection (f) or'', and

(B) in subsection (i)(1)(C), by striking ''(e), and (f)'' and inserting ''and (e)''.

(3) EFFECTIVE DATE.—The amendments made by this section shall apply to contract years beginning on or after January 1, 1996.

PART 2—SPECIAL RULES FOR MEDICAREPLUS MEDICAL SAVINGS ACCOUNTS

SEC. 15011. MEDICAREPLUS MSA'S.

(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 137 as section 138 and by inserting after section 136 the following new section:

"SEC. 137. MEDICAREPLUS MSA'S.

''(a) EXCLUSION.—Gross income shall not include any payment to the MedicarePlus MSA of an individual by the Secretary of Health and Human Services under section 1855(f)(1)(B) of the Social Security Act.

''(b) MEDICAREPLUS MSA.—For purposes of this section—

''(1) MEDICAREPLUS MSA.—The term 'MedicarePlus MSA' means a trust created or organized in the United States exclusively for the purpose of paying the qualified medical expenses of the account holder, but only if the written governing instrument creating the trust meets the following requirements:

''(A) Except in the case of a trustee-to-trustee transfer described in subsection (d)(4), no contribution will be accepted unless it is made by the Secretary of Health and Human

Services under section 1855(f)(1)(B) of the Social Security Act.

''(B) The trustee is a bank (as defined in section 408(n)), an insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

''(C) No part of the trust assets will be invested in life insurance contracts.

''(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

''(E) The interest of an individual in the balance in his account is nonforfeitable.

''(F) Trustee-to-trustee transfers described in subsection (d)(4) may be made to and from the trust.

''(2) QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—The term 'qualified medical expenses' means, with respect to an account holder, amounts paid by such holder—

''(i) for medical care (as defined in section 213(d)) for the account holder, but only to the extent such amounts are not compensated for by insurance or otherwise, or

''(ii) for long-term care insurance for the account holder.

''(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—Subparagraph (A)(i) shall not apply to any payment for insurance.

''(3) ACCOUNT HOLDER.—The term 'account holder' means the individual on whose behalf the MedicarePlus MSA is maintained.

''(4) CERTAIN RULES TO APPLY.—Rules similar to the rules of subsections (g) and (h) of section 408 shall apply for purposes of this section.

''(c) TAX TREATMENT OF ACCOUNTS.—

''(1) IN GENERAL.—A MedicarePlus MSA is exempt from taxation under this subtitle unless such MSA has ceased to be a MedicarePlus MSA by reason of paragraph (2). Notwithstanding the preceding sentence, any such MSA is subject to the taxes imposed by section 511 (relating to imposition of tax

on unrelated business income of charitable, etc. organizations).

''(2) ACCOUNT ASSETS TREATED AS DISTRIBUTED IN THE CASE OF PROHIBITED TRANSACTIONS OR ACCOUNT PLEDGED AS SECURITY FOR LOAN.—Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to MedicarePlus MSA's, and any amount treated as distributed under such rules shall be treated as not used to pay qualified medical expenses.

''(d) TAX TREATMENT OF DISTRIBUTIONS.—

''(1) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—No amount shall be included in the gross income of the account holder by reason of a payment or distribution from a MedicarePlus MSA which is used exclusively to pay the qualified medical expenses of the account holder. Any amount paid or distributed from a MedicarePlus MSA which is not so used shall be included in the gross income of such holder.

''(2) PENALTY FOR DISTRIBUTIONS 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 MedicarePlus 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 the MedicarePlus 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 high deductible/medisave product covering the account holder as of January 1 of the calendar year in which the taxable year begins.

''(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 MedicarePlus MSA's 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.—Paragraphs (1) and (2) shall not apply to any payment or distribution from a MedicarePlus 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.—Paragraphs (1) and (2) shall not apply to any trustee-to-trustee transfer from a MedicarePlus MSA of an account holder to another MedicarePlus MSA of such account holder.

''(5) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of section 213, any pay-

ment or distribution out of a MedicarePlus MSA for qualified medical expenses shall not be treated as an expense paid for medical care.

''(e) TREATMENT OF ACCOUNT AFTER DEATH OF ACCOUNT HOLDER.—

''(1) TREATMENT IF DESIGNATED BENEFICIARY IS SPOUSE.—

''(A) IN GENERAL.—In the case of an account holder's interest in a MedicarePlus MSA which is payable to (or for the benefit of) such holder's spouse upon the death of such holder, such MedicarePlus MSA shall be treated as a MedicarePlus MSA of such spouse as of the date of such death.

''(B) SPECIAL RULES IF SPOUSE NOT MEDICARE ELIGIBLE.—If, as of the date of such death, such spouse is not entitled to benefits under title XVIII of the Social Security Act, then after the date of such death—

''(i) the Secretary of Health and Human Services may not make any payments to such MedicarePlus MSA, other than payments attributable to periods before such date,

''(ii) in applying subsection (b)(2) with respect to such MedicarePlus MSA, references to the account holder shall be treated as including references to any dependent (as defined in section 152) of such spouse and any subsequent spouse of such spouse, and

''(iii) in lieu of applying subsection (d)(2), the rules of section 220(f)(2) shall apply.

''(2) TREATMENT IF DESIGNATED BENEFICIARY IS NOT SPOUSE.—In the case of an account holder's interest in a MedicarePlus MSA which is payable to (or for the benefit of) any person other than such holder's spouse upon the death of such holder—

''(A) such account shall cease to be a MedicarePlus MSA as of the date of death, and

''(B) an amount equal to the fair market value of the assets in such account on such date shall be includible—

''(i) if such person is not the estate of such holder, in such person's gross income for the taxable year which includes such date, or

''(ii) if such person is the estate of such holder, in such holder's gross income for last taxable year of such holder.

''(f) REPORTS.—

''(1) IN GENERAL.—The trustee of a MedicarePlus MSA shall make such reports regarding such account to the Secretary and to the account holder with respect to—

''(A) the fair market value of the assets in such MedicarePlus MSA as of the close of each calendar year, and

''(B) contributions, distributions, and other matters,

as the Secretary may require by regulations.

''(2) TIME AND MANNER OF REPORTS.—The reports required by this subsection—

''(A) shall be filed at such time and in such manner as the Secretary prescribes in such regulations, and

''(B) shall be furnished to the account holder—

''(i) not later than January 31 of the calendar year following the calendar year to which such reports relate, and

''(ii) in such manner as the Secretary prescribes in such regulations.''

(b) EXCLUSION OF MEDICAREPLUS MSA'S FROM ESTATE TAX.—Part IV of subchapter A of chapter 11 of such Code is amended by adding at the end the following new section:

''SEC. 2057. MEDICAREPLUS MSA'S.

''For purposes of the tax imposed by section 2001, the value of the taxable estate shall be determined by deducting from the value of the gross estate an amount equal to the value of any MedicarePlus MSA (as defined in section 137(b)) included in the gross estate.''

(c) TAX ON PROHIBITED TRANSACTIONS.—

(1) Section 4975 of such Code (relating to tax on prohibited transactions) is amended by adding at the end of subsection (c) the following new paragraph:

''(4) SPECIAL RULE FOR MEDICAREPLUS MSA'S.—An individual for whose benefit a MedicarePlus MSA (within the meaning of section 137(b)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a

MedicarePlus MSA by reason of the application of section 137(c)(2) to such account.''

(2) Paragraph (1) of section 4975(e) of such Code is amended to read as follows:

''(1) PLAN.—For purposes of this section, the term 'plan' means—

''(A) a trust described in section 401(a) which forms a part of a plan, or a plan described in section 403(a), which trust or plan is exempt from tax under section 501(a),

''(B) an individual retirement account described in section 408(a),

''(C) an individual retirement annuity described in section 408(b),

''(D) a medical savings account described in section 220(d),

''(E) a MedicarePlus MSA described in section 137(b), or

''(F) a trust, plan, account, or annuity which, at any time, has been determined by the Secretary to be described in any preceding subparagraph of this paragraph.''

(d) FAILURE TO PROVIDE REPORTS ON MEDICAREPLUS MSA'S.—

(1) Subsection (a) of section 6693 of such Code (relating to failure to provide reports on individual retirement accounts or annuities) is amended to read as follows:

''(a) REPORTS.—

''(1) IN GENERAL.—If a person required to file a report under a provision referred to in paragraph (2) fails to file such report at the time and in the manner required by such provision, such person shall pay a penalty of $50 for each failure unless it is shown that such failure is due to reasonable cause.

''(2) PROVISIONS.—The provisions referred to in this paragraph are—

''(A) subsections (i) and (l) of section 408 (relating to individual retirement plans),

''(B) section 220(h) (relating to medical savings accounts), and

''(C) section 137(f) (relating to MedicarePlus MSA's).''

(2) The section heading for section 6693 of such Code is amended to read as follows:

"SEC. 6693. FAILURE TO FILE REPORTS ON INDIVIDUAL RETIREMENT PLANS AND CERTAIN OTHER TAX-FAVORED ACCOUNTS; PENALTIES RELATING TO DESIGNATED NONDEDUCTIBLE CONTRIBUTIONS."

(e) CLERICAL AMENDMENTS.—

(1) 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. 137. MedicarePlus MSA's.
''Sec. 138. Cross references to other Acts.''

(2) The table of sections for part 1 of subchapter B of chapter 68 of such Code is amended by striking the item relating to section 6693 and inserting the following new item:

''Sec. 6693. Failure to file reports on individual retirement plans and certain other tax-favored accounts; penalties relating to designated nondeductible contributions.''

(3) The table of sections for part IV of subchapter A of chapter 11 of such Code is amended by adding at the end the following new item:

''Sec. 2057. MedicarePlus MSA's.''

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1996.

SEC. 15012. CERTAIN REBATES EXCLUDED FROM GROSS INCOME.

(a) IN GENERAL.—Section 105 of the Internal Revenue Code of 1986 (relating to amounts received under accident and health plans) is amended by adding at the end the following new subsection:

''(j) CERTAIN REBATES UNDER SOCIAL SECURITY ACT.—Gross income does not include any rebate received under section 1852(e)(1)(A) of the Social Security Act during the taxable year.''

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

PART 3—SPECIAL ANTITRUST RULE FOR PROVIDER SERVICE NETWORKS

SEC. 15021. APPLICATION OF ANTITRUST RULE OF REASON TO PROVIDER SERVICE NETWORKS.

(a) RULE OF REASON STANDARD.—In any action under the antitrust laws, or under any State law similar to the antitrust laws—

(1) the conduct of a provider service network in negotiating, making, or performing a contract (including the establishment and modification of a fee schedule and the development of a panel of physicians), to the extent such contract is for the purpose

of providing health care services to individuals under the terms of a MedicarePlus PSO product, and

(2) the conduct of any member of such network for the purpose of providing such health care services under such contract to such extent,

shall not be deemed illegal per se. Such conduct shall be judged on the basis of its reasonableness, taking into account all relevant factors affecting competition, including the effects on competition in properly defined markets.

(b) DEFINITIONS.—For purposes of subsection (a):

(1) ANTITRUST LAWS.—The term ''antitrust laws'' has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section 5 applies to unfair methods of competition.

(2) HEALTH CARE PROVIDER.—The term ''health care provider'' means any individual or entity that is engaged in the delivery of health care services in a State and that 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.

(3) HEALTH CARE SERVICE.—The term ''health care service'' means any service for which payment may be made under a MedicarePlus PSO product including services related to the delivery or administration of such service.

(4) MEDICAREPLUS PROGRAM.—The term ''MedicarePlus program'' means the program under part C of title XVIII of the Social Security Act.

(5) MEDICAREPLUS PSO PRODUCT.—The term ''MedicarePlus PSO product'' means a MedicarePlus product offered by a provider-sponsored organization under part C of title XVIII of the Social Security Act.

(6) PROVIDER SERVICE NETWORK.—The term ''provider service network'' means an organization that—

(A) is organized by, operated by, and composed of members who are health care providers and for purposes that include providing health care services,

(B) is funded in part by capital contributions made by the members of such organization,

(C) with respect to each contract made by such organization for the purpose of providing

a type of health care service to individuals under the terms of a MedicarePlus PSO product—

(i) requires all members of such organization who engage in providing such type of health care service to agree to provide health care services of such type under such contract,

(ii) receives the compensation paid for the health care services of such type provided under such contract by such members, and

(iii) provides for the distribution of such compensation,

(D) has established, consistent with the requirements of the MedicarePlus program for provider-sponsored organizations, a program to review, pursuant to written guidelines, the quality, efficiency, and appropriateness of treatment methods and setting of services for all health care providers and all patients participating in such product, along with internal procedures to correct identified deficiencies relating to such methods and such services,

(E) has established, consistent with the requirements of the MedicarePlus program for provider-sponsored organizations, a program to monitor and control utilization of health care services provided under such product, for the purpose of improving efficient, appropriate care and eliminating the provision of unnecessary health care services,

(F) has established a management program to coordinate the delivery of health care services for all health care providers and all patients participating in such product, for the purpose of achieving efficiencies and enhancing the quality of health care services provided, and

(G) has established, consistent with the requirements of the MedicarePlus program for provider-sponsored organizations, a grievance and appeal process for such organization designed to review and promptly resolve beneficiary or patient grievances and complaints.

Such term may include a provider-sponsored organization.

(7) PROVIDER-SPONSORED ORGANIZATION.—The term ''provider-sponsored organization'' means a MedicarePlus organization under the MedicarePlus

program that is a provider-sponsored organization (as defined in section ____ of the Social Security Act).

(8) STATE.—The term ''State'' has the meaning given it in section 4G(2) of the Clayton Act (15 U.S.C. 15g(2)).

(c) ISSUANCE OF GUIDELINES.—Not later than 120 days after the date of the enactment of this Act, the Attorney General and the Federal Trade Commission shall issue jointly guidelines specifying the enforcement policies and analytical principles that will be applied by the Department of Justice and the Commission with respect to the operation of subsection (a).

PART 4—COMMISSIONS

SEC. 15031. MEDICARE PAYMENT REVIEW COMMISSION.

(a) IN GENERAL.—Title XVIII, as amended by section 15001(a), is amended by inserting after section 1805 the following new section:

''MEDICARE PAYMENT REVIEW COMMISSION

''SEC. 1806. (a) ESTABLISHMENT.—There is hereby established the Medicare Payment Review Commission (in this section referred to as the 'Commission').

''(b) DUTIES.—

''(1) GENERAL DUTIES AND REPORTS.—

''(A) IN GENERAL.—The Commission shall review, and make recommendations to Congress concerning, payment policies under this title.

''(B) ANNUAL REPORTS.—By not later than June 1 of each year, the Commission shall 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.

''(C) ADDITIONAL REPORTS.—The Commission may submit to Congress from time to time such other reports as the Commission deems appropriate. By not later than May 1, 1997, the Commission shall submit to Congress a report on the matter described in paragraph (2)(G).

''(D) SECRETARIAL RESPONSE IN RULEMAKING.—The Secretary shall respond to recommendations of the Commission in notices of rulemaking proceedings under this title.

''(2) SPECIFIC DUTIES RELATING TO MEDICAREPLUS PROGRAM.—Specifically, the Com-

mission shall review, with respect to the MedicarePlus program under part C—

''(A) the appropriateness of 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);

''(B) the appropriateness of the mechanisms used to adjust payments for risk and the need to adjust such mechanisms to take into account health status of beneficiaries;

''(C) the implications of risk selection both among MedicarePlus organizations and between the MedicarePlus option and the non-MedicarePlus option;

''(D) in relation to payment under part C, the development and implementation of mechanisms to assure the quality of care for those enrolled with MedicarePlus organizations;

''(E) the impact of the MedicarePlus program on access to care for medicare beneficiaries;

''(F) the feasibility and desirability of extending the rules for open enrollment that apply during the transition period to apply in each

county during the first 2 years in which MedicarePlus products are made available to individuals residing in the county; and

''(G) other major issues in implementation and further development of the MedicarePlus program.

''(3) SPECIFIC DUTIES RELATING TO THE FAILSAFE BUDGET MECHANISM.—Specifically, the Commission shall review, with respect to the failsafe budget mechanism described in section 1895—

''(A) the appropriateness of the expenditure projections by the Secretary under section 1895(c) for each medicare sector;

''(B) the appropriateness of the growth factors for each sector and the ability to take into account substitution across sectors;

''(C) the appropriateness of the mechanisms for implementing reductions in payment amounts for different sectors, including any adjustments to reflect changes in volume or intensity resulting for any payment reductions;

''(D) the impact of the mechanism on provider participation in parts A and B and in the MedicarePlus program; and

''(E) the appropriateness of the medicare benefit budget (under section 1895(c)(2)(C) of the Social Security Act), particularly for fiscal years after fiscal year 2002.

''(4) SPECIFIC DUTIES RELATING TO THE FEE-FOR-SERVICE SYSTEM.—Specifically, the Commission shall review payment policies under parts A and B, including—

''(A) the factors affecting expenditures for services in different sectors, including the process for updating hospital, physician, and other fees,

''(B) payment methodologies; and

''(C) the impact of payment policies on access and quality of care for medicare beneficiaries.

''(5) SPECIFIC DUTIES RELATING TO INTERACTION OF 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 under this title and assess the implications of changes in the health services market on the medicare program.

''(c) MEMBERSHIP.—

''(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members appointed by the Comptroller General.

''(2) QUALIFICATIONS.—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 services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives, including physicians and other health professionals, employers, third party payors, 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.

''(3) CONSIDERATIONS IN INITIAL APPOINTMENT.—To the extent possible, in first appointing members to the Commission the Comptroller General shall consider appointing individuals who (as of

the date of the enactment of this section) were serving on the Prospective Payment Assessment Commission or the Physician Payment Review Commission.

''(4) 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.

''(5) 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 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.

''(6) 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.

''(7) 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 collect and assess information to—

''(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 data of the Commission, immediately upon request.

''(4) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the General Accounting Office.

''(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. 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.''.

(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 Review Commission''.

(2) PPRC.—

(A) IN GENERAL.—Title XVIII is amended by striking section 1845 (42 U.S.C. 1395w–1).

(B) CONFORMING AMENDMENTS.—

(i) Section 1834(b)(2) (42 U.S.C. 1395m(b)(2)) is amended by striking ''Physician Payment Review Commission'' and inserting ''Medicare Payment Review Commission''.

(ii) Section 1842(b) (42 U.S.C. 1395u(b)) is amended by striking ''Physician Payment Review Commission'' each place it appears in paragraphs (9)(D) and (14)(C)(i) and inserting ''Medicare Payment Review Commission''.

(iii) Section 1848 (42 U.S.C. 1395w–4) is amended by striking ''Physician Payment Review Commission'' and inserting ''Medicare Payment Review Commission'' each place it appears in paragraph (2)(A)(ii), (2)(B)(iii), and (5) of subsection (c), subsection (d)(2)(F), paragraphs (1)(B), (3), and (4)(A) of subsection (f), and paragraphs (6)(C) and (7)(C) of subsection (g).

(c) EFFECTIVE DATE; TRANSITION.—

(1) IN GENERAL.—The Comptroller General shall first provide for appointment of members to the Medicare Payment Review Commission (in this subsection referred to as ''MPRC'') by not later than March 31, 1996.

(2) TRANSITION.—Effective on a date (not later than 30 days after the date a majority of members of the MPRC have first been appointed, 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''), and amendments made by subsection (b), are terminated. The Comptroller General, to the maximum extent feasible, shall pro-

vide for the transfer to the MPRC of assets and staff of ProPAC and PPRC, without any loss of benefits or seniority by virtue of such transfers. Fund balances available to the ProPAC or PPRC for any period shall be available to the MPRC for such period for like purposes.

(3) CONTINUING RESPONSIBILITY FOR REPORTS.—The MPRC 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 MPRC) by the ProPAC and PPRC, and, for this purpose, any reference in law to either such Commission is deemed, after the appointment of the MPRC, to refer to the MPRC.

SEC. 15032. COMMISSION ON THE EFFECT OF THE BABY BOOM GENERATION ON THE MEDICARE PROGRAM.

(a) ESTABLISHMENT.—There is established a commission to be known as the Commission on the Effect of the Baby Boom Generation on the Medicare Program (in this section referred to as the ''Commission'').

(b) DUTIES.—

(1) IN GENERAL.—The Commission shall—

(A) examine 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) make specific recommendations to the Congress respecting a comprehensive approach to preserve the medicare program for the period during which such individuals are eligible for medicare.

(2) CONSIDERATIONS IN MAKING RECOMMENDATIONS.—In making its recommendations, the Commission shall consider the following:

(A) The amount and sources of Federal funds to finance the medicare program, including the potential use of innovative financing methods.

(B) The most efficient and effective manner of administering the program, including the appropriateness of continuing the application of the failsafe budget mechanism under section 1895 of the Social Security Act for fiscal years after fiscal year 2002 and the appropriate long-term growth rates for contributions electing

coverage under MedicarePlus under part C of title XVIII of such Act.

(C) Methods used by other nations to respond to comparable demographic patterns in eligibility for health care benefits for elderly and disabled individuals.

(D) Modifying age-based eligibility to correspond to changes in age-based eligibility under the OASDI program.

(E) Trends in employment-related health care for retirees, including the use of medical savings accounts and similar financing devices.

(c) MEMBERSHIP.—

(1) APPOINTMENT.—The Commission shall be composed of 15 members appointed as follows:

(A) The President shall appoint 3 members.

(B) The Majority Leader of the Senate shall appoint, after consultation with the minority leader of the Senate, 6 members, of whom not more than 4 may be of the same political party.

(C) The Speaker of the House of Representatives shall appoint, after consultation with the minority leader of the House of Rep-

resentatives, 6 members, of whom not more than 4 may be of the same political party.

(2) CHAIRMAN AND VICE CHAIRMAN.—The Commission shall elect a Chairman and Vice Chairman from among its members.

(3) VACANCIES.—Any vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made and shall not affect the power of the remaining members to execute the duties of the Commission.

(4) QUORUM.—A quorum shall consist of 8 members of the Commission, except that 4 members may conduct a hearing under subsection (e).

(5) MEETINGS.—The Commission shall meet at the call of its Chairman or a majority of its members.

(6) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—Members of the Commission are not entitled to receive compensation for service on the Commission. Members may be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Commission.

(d) STAFF AND CONSULTANTS.—

(1) STAFF.—The Commission may appoint and determine the compensation of such staff as may be

necessary to carry out the duties of the Commission. Such appointments and compensation may be made without regard to the provisions of title 5, United States Code, that govern appointments in the competitive services, and the provisions of chapter 51 and subchapter III of chapter 53 of such title that relate to classifications and the General Schedule pay rates.

(2) CONSULTANTS.—The Commission may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code, as the Commission determines to be necessary to carry out the duties of the Commission.

(e) POWERS.—

(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.—

(A) Upon the request of the Commission, the Director of the Congressional Budget Office shall provide to the Commission such cost estimates as the Commission determines to be necessary to carry out its duties.

(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) ACCEPTANCE OF DONATIONS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

(10) PRINTING.—For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Of-

fice, the Commission shall be deemed to be a committee of the Congress.

(f) REPORT.—Not later than May 1, 1997, the Commission shall submit to Congress a report containing its findings and recommendations regarding how to protect and preserve the medicare program in a financially solvent manner until 2030 (or, if later, throughout the period of projected solvency of the Federal Old-Age and Survivors Insurance Trust Fund). The report shall include detailed recommendations for appropriate legislative initiatives respecting how to accomplish this objective.

(g) TERMINATION.—The Commission shall terminate 60 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. Amounts appropriated to carry out this section shall remain available until expended.

SEC. 15033. CHANGE IN APPOINTMENT OF ADMINISTRATOR OF HCFA.

(a) IN GENERAL.—Section 1117 (42 U.S.C. 1317) is amended by striking ''President by and with the advice and consent of the Senate'' and inserting ''Secretary of Health and Human Services''.

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

PART 5—TREATMENT OF HOSPITALS WHICH PARTICIPATE IN PROVIDER-SPONSORED ORGANIZATIONS

SEC. 15041. 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 (n) as subsection (o) and by inserting after subsection (m) the following new subsection:

''(n) 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 1854(a)(1) 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—Preventing Fraud and Abuse

PART 1—GENERAL PROVISIONS

SEC. 15101. INCREASING AWARENESS OF FRAUD AND ABUSE.

(a) BENEFICIARY OUTREACH EFFORTS.—The Secretary of Health and Human Services (acting through the Administrator of the Health Care Financing Administration and the Inspector General of the Department of Health and Human Services) shall make ongoing efforts (through public service announcements, publications, and other appropriate methods) to alert individuals entitled to benefits under the medicare program of the existence of fraud and abuse committed against the program and the costs to the program of such fraud and abuse, and of the existence of the toll-free telephone line operated by the Secretary to receive information on fraud and abuse committed against the program.

(b) CLARIFICATION OF REQUIREMENT TO PROVIDE EXPLANATION OF MEDICARE BENEFITS.—The Secretary shall provide an explanation of benefits under the medicare program with respect to each item or service for which payment may be made under the program which is furnished to an individual, without regard to whether or not a deductible or coinsurance may be imposed against the individual with respect to the item or service.

(c) PROVIDER OUTREACH EFFORTS; PUBLICATION OF FRAUD ALERTS.—

(1) SPECIAL FRAUD ALERTS.—

(A) IN GENERAL.—

(i) REQUEST FOR SPECIAL FRAUD ALERTS.—Any person may present, at any time, a request to the Secretary to issue and publish a special fraud alert.

(ii) SPECIAL FRAUD ALERT DEFINED.—In this section, a ''special fraud alert'' is a notice which informs the public of practices which the Secretary considers to be suspect or of particular concern under the medicare program or a State health care program (as defined in section 1128(h) of the Social Security Act).

(B) ISSUANCE AND PUBLICATION OF SPECIAL FRAUD ALERTS.—

(i) INVESTIGATION.—Upon receipt of a request for a special fraud alert under subparagraph (A), the Secretary shall investigate the subject matter of the request to determine whether a special fraud alert should be issued. If appropriate, the Secretary (in consultation with the Attorney General) shall issue a special fraud alert in response to the request. All special fraud alerts issued pursuant to this subparagraph shall be published in the Federal Register.

(ii) CRITERIA FOR ISSUANCE.—In determining whether to issue a special fraud alert upon a request under subparagraph (A), the Secretary may consider—

(I) whether and to what extent the practices that would be identified in the special fraud alert may result in any of the consequences described in 15214(b); and

(II) the extent and frequency of the conduct that would be identified in the special fraud alert.

(2) PUBLICATION OF ALL HCFA FRAUD ALERTS IN FEDERAL REGISTER.—Each notice issued by the Health Care Financing Administration which informs the public of practices which the Secretary considers to be suspect or of particular concern under the medicare program or a State health care program (as defined in section 1128(h) of the Social Security Act) shall be published in the Federal Register, without regard to whether or not the notice is issued by a regional office of the Health Care Financing Administration.

SEC. 15102. BENEFICIARY INCENTIVE PROGRAMS.

(a) PROGRAM TO COLLECT INFORMATION ON FRAUD AND ABUSE.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary of Health and Human Services (hereinafter in this subtitle referred to as the ''Secretary'') shall establish a program under which the Secretary shall encourage individuals to report to the Secretary information on individuals and entities who are engaging or who have engaged in acts

or omissions which constitute grounds for the imposition of a sanction under section 1128, section 1128A, or section 1128B of the Social Security Act, or who have otherwise engaged in fraud and abuse against the medicare program for which there is a sanction provided under law. The program shall discourage provision of, and not consider, information which is frivolous or otherwise not relevant or material to the imposition of such a sanction.

(2) PAYMENT OF PORTION OF AMOUNTS COLLECTED.—If an individual reports information to the Secretary under the program established under paragraph (1) which serves as the basis for the collection by the Secretary or the Attorney General of any amount of at least $100 (other than any amount paid as a penalty under section 1128B of the Social Security Act), the Secretary may pay a portion of the amount collected to the individual (under procedures similar to those applicable under section 7623 of the Internal Revenue Code of 1986 to payments to individuals providing information on violations of such Code).

(b) PROGRAM TO COLLECT INFORMATION ON PROGRAM EFFICIENCY.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary shall establish a program under which the Secretary shall encourage individuals to submit to the Secretary suggestions on methods to improve the efficiency of the medicare program.

(2) PAYMENT OF PORTION OF PROGRAM SAVINGS.—If an individual submits a suggestion to the Secretary under the program established under paragraph (1) which is adopted by the Secretary and which results in savings to the program, the Secretary may make a payment to the individual of such amount as the Secretary considers appropriate.

SEC. 15103. INTERMEDIATE SANCTIONS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

(a) APPLICATION OF INTERMEDIATE SANCTIONS FOR ANY PROGRAM VIOLATIONS.—

(1) IN GENERAL.—Section 1876(i)(1) (42 U.S.C. 1395mm(i)(1)) is amended by striking ''the Secretary may terminate'' and all that follows and inserting the following: ''in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in para-

graph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—

''(A) has failed substantially to carry out the contract;

''(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section;

''(C) is operating in a manner that is not in the best interests of the individuals covered under the contract; or

''(D) no longer substantially meets the applicable conditions of subsections (b), (c), and (e).''.

(2) OTHER INTERMEDIATE SANCTIONS FOR MISCELLANEOUS PROGRAM VIOLATIONS.—Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is amended by adding at the end the following new subparagraph:

''(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1) the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

''(i) civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determina-

tion has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract;

''(ii) civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists; and

''(iii) suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) 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.''.

(3) PROCEDURES FOR IMPOSING SANCTIONS.—Section 1876(i) (42 U.S.C. 1395mm(i)) is amended by adding at the end the following new paragraph:

''(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

''(A) the Secretary provides the organization with the opportunity to develop and implement a

corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1);

''(B) the Secretary shall impose more severe sanctions on organizations that have a history of deficiencies or that have not taken steps to correct deficiencies the Secretary has brought to their attention;

''(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

''(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.''.

(4) CONFORMING AMENDMENTS.—(A) Section 1876(i)(6)(B) (42 U.S.C. 1395mm(i)(6)(B)) is amended by striking the second sentence.

(B) Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is further amended by adding at the end the following new subparagraph:

''(D) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (A) or (B) in the same manner

as they apply to a civil money penalty or proceeding under section 1128A(a).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contract years beginning on or after January 1, 1996.

SEC. 15104. VOLUNTARY DISCLOSURE PROGRAM.

Title XI (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128B the following new section:

''VOLUNTARY DISCLOSURE OF ACTS OR OMISSIONS

''SEC. 1129. (a) ESTABLISHMENT OF VOLUNTARY DISCLOSURE PROGRAM.—Not later than 3 months after the date of the enactment of this section, the Secretary shall establish a program to encourage individuals and entities to voluntarily disclose to the Secretary information on acts or omissions of the individual or entity which constitute grounds for the imposition of a sanction described in section 1128, 1128A, or 1128B.

''(b) EFFECT OF VOLUNTARY DISCLOSURE.—If an individual or entity voluntarily discloses information with respect to an act or omission to the Secretary under subsection (a), the following rules shall apply:

''(1) The Secretary may waive, reduce, or otherwise mitigate any sanction which would otherwise be applicable to the individual or entity under section 1128, 1128A, or 1128B as a result of the act or omission involved.

''(2) No qui tam action may be brought pursuant to chapter 37 of title 31, United States Code, against the individual or entity with respect to the act or omission involved.''.

SEC. 15105. REVISIONS TO CURRENT SANCTIONS.

(a) DOUBLING THE AMOUNT OF CIVIL MONETARY PENALTIES.—The maximum amount of civil monetary penalties specified in section 1128A of the Social Security Act or under title XVIII of such Act (as in effect on the day before the date of the enactment of this Act) shall, effective for violations occurring after the date of the enactment of this Act, be double the amount otherwise provided as of such date.

(b) ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION.—Section 1128(c)(3) (42 U.S.C. 1320a–7(c)(3)) is amended by adding at the end the following new subparagraphs:

''(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

''(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

''(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to acts or omissions occurring on or after January 1, 1996.

SEC. 15106. DIRECT SPENDING FOR ANTI-FRAUD ACTIVITIES UNDER MEDICARE.

(a) ESTABLISHMENT OF MEDICARE INTEGRITY PROGRAM.—Title XVIII is amended by adding at the end the following new section:

''MEDICARE INTEGRITY PROGRAM

''SEC. 1893. (a) ESTABLISHMENT OF PROGRAM.—There is hereby established the Medicare Integrity Program (hereafter in this section referred to as the 'Program') under which the Secretary shall promote the integrity of the medicare program by entering into contracts in accordance with this section with eligible private entities to carry out the activities described in subsection (b).

''(b) ACTIVITIES DESCRIBED.—The activities described in this subsection are as follows:

''(1) Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass the capability of the equipment and technologies used in the review of claims under this title as of the date of the enactment of this section).

''(2) Audit of cost reports.

''(3) Determinations as to whether payment should not be, or should not have been, made under this title by reason of section 1862(b), and recovery of payments that should not have been made.

''(4) Education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.

''(c) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if—

''(1) the entity has demonstrated capability to carry out such activities;

''(2) in carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General of the United States, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this title and in other cases arising out of such activities;

''(3) the entity's financial holdings, interests, or relationships will not interfere with its ability to perform the functions to be required by the contract in an effective and impartial manner; and

''(4) the entity meets such other requirements as the Secretary may impose.

''(d) PROCESS FOR ENTERING INTO CONTRACTS.—The Secretary shall enter into contracts under the Program in accordance with such procedures as the Secretary may by regulation establish, except that such procedures shall include the following:

''(1) The Secretary shall determine the appropriate number of separate contracts which are necessary to carry out the Program and the appropriate

times at which the Secretary shall enter into such contracts.

''(2) The provisions of section 1153(e)(1) shall apply to contracts and contracting authority under this section, except that competitive procedures must be used when entering into new contracts under this section, or at any other time considered appropriate by the Secretary.

''(3) A contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

''(e) LIMITATION ON CONTRACTOR LIABILITY.—The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1157.

''(f) TRANSFER OF AMOUNTS TO MEDICARE ANTI-FRAUD AND ABUSE TRUST FUND.—For each fiscal year, the Secretary shall transfer from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to the Medicare Anti-Fraud

and Abuse Trust Fund under subsection (g) such amounts as are necessary to carry out the activities described in subsection (b). Such transfer shall be in an allocation as reasonably reflects the proportion of such expenditures associated with part A and part B.

''(g) MEDICARE ANTI-FRAUD AND ABUSE TRUST FUND.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—There is hereby established in the Treasury of the United States the Anti-Fraud and Abuse Trust Fund (hereafter in this subsection referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in subparagraph (B) and such amounts as may be deposited in the Trust Fund as provided in subsection (f), paragraph (3), and title XI.

''(B) AUTHORIZATION TO ACCEPT GIFTS AND BEQUESTS.—The Trust Fund is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Trust Fund, for the benefit of the Trust Fund or any activity financed through the Trust Fund.

''(2) INVESTMENT.—

''(A) IN GENERAL.—The Secretary of the Treasury shall invest such amounts of the Fund as such Secretary determines are not required to meet current withdrawals from the Fund in government account serial securities.

''(B) USE OF INCOME.—Any interest derived from investments under subparagraph (A) shall be credited to the Fund.

''(3) AMOUNTS DEPOSITED INTO TRUST FUND.—In addition to amounts transferred under subsection (f), there shall be deposited in the Trust Fund—

''(A) that portion of amounts recovered in relation to section 1128A arising out of a claim under title XVIII as remains after application of subsection (f)(2) (relating to repayment of the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Trust Fund) of that section, as may be applicable,

''(B) fines imposed under section 1128B arising out of a claim under this title, and

''(C) penalties and damages imposed (other than funds awarded to a relator or for restitution) under sections 3729 through 3732 of title

31, United States Code (pertaining to false claims) in cases involving claims relating to programs under title XVIII, XIX, or XXI.

''(4) DIRECT APPROPRIATION OF FUNDS TO CARRY OUT PROGRAM.—

''(A) IN GENERAL.—There are appropriated from the Trust Fund for each fiscal year such amounts as are necessary to carry out the Medicare Integrity Program under this section, subject to subparagraph (B).

''(B) AMOUNTS SPECIFIED.—The amount appropriated under subparagraph (A) for a fiscal year is as follows:

''(i) For fiscal year 1996, such amount shall be not less than $430,000,000 and not more than $440,000,000.

''(ii) For fiscal year 1997, such amount shall be not less than $490,000,000 and not more than $500,000,000.

''(iii) For fiscal year 1998, such amount shall be not less than $550,000,000 and not more than $560,000,000.

''(iv) For fiscal year 1999, such amount shall be not less than $620,000,000 and not more than $630,000,000.

''(v) For fiscal year 2000, such amount shall be not less than $670,000,000 and not more than $680,000,000.

''(vi) For fiscal year 2001, such amount shall be not less than $690,000,000 and not more than $700,000,000.

''(vii) For fiscal year 2002, such amount shall be not less than $710,000,000 and not more than $720,000,000.

''(5) ANNUAL REPORT.—The Secretary shall submit an annual report to Congress on the amount of revenue which is generated and disbursed by the Trust Fund in each fiscal year.''.

(b) ELIMINATION OF FI AND CARRIER RESPONSIBILITY FOR CARRYING OUT ACTIVITIES SUBJECT TO PROGRAM.—

(1) RESPONSIBILITIES OF FISCAL INTERMEDIARIES UNDER PART A.—Section 1816

(42 U.S.C. 1395h) is amended by adding at the end the following new subsection:

''(l) No agency or organization may carry out (or receive payment for carrying out) any activity pursuant to an agreement under this section to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893.''.

(2) RESPONSIBILITIES OF CARRIERS UNDER PART B.—Section 1842(c) (42 U.S.C. 1395u(c)) is amended by adding at the end the following new paragraph:

''(6) No carrier may carry out (or receive payment for carrying out) any activity pursuant to a contract under this subsection to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893.''.

(c) CONFORMING AMENDMENT.—Section 1128A(f)(3) (42 U.S.C. 1320a–7a(f)(3)) is amended by striking ''as miscellaneous receipts of the Treasury of the United States'' and inserting ''in the Anti-Fraud and Abuse Trust Fund established under section 1893(g)''.

(d) DIRECT SPENDING FOR MEDICARE-RELATED ACTIVITIES OF INSPECTOR GENERAL.—Section 1893, as added by subsection (a), is amended by adding at the end the following new subsection:

''(h) DIRECT SPENDING FOR MEDICARE-RELATED ACTIVITIES OF INSPECTOR GENERAL.—

''(1) IN GENERAL.—There are appropriated from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to the Inspector General of the Department of Health and Human Services for each fiscal year such amounts as are necessary to enable the Inspector General to carry out activities relating to the medicare program (as described in paragraph (2)), subject to paragraph (3).

''(2) ACTIVITIES DESCRIBED.—The activities described in this paragraph are as follows:

''(A) Prosecuting medicare-related matters through criminal, civil, and administrative proceedings.

''(B) Conducting investigations relating to the medicare program.

''(C) Performing financial and performance audits of programs and operations relating to the medicare program.

''(D) Performing inspections and other evaluations relating to the medicare program.

''(E) Conducting provider and conumer education activities regarding the requirements of this title.

''(3) AMOUNTS SPECIFIED.—The amount appropriated under paragraph (1) for a fiscal year is as follows:

''(A) For fiscal year 1996, such amount shall be $130,000,000.

''(B) For fiscal year 1997, such amount shall be $181,000,000.

''(C) For fiscal year 1998, such amount shall be $204,000,000.

''(D) For each subsequent fiscal year, the amount appropriated for the previous fiscal year, increased by the percentage increase in aggregate expenditures under this title for the fiscal year involved over the previous fiscal year.

''(4) ALLOCATION OF PAYMENTS AMONG TRUST FUNDS.—The appropriations made under paragraph (1) shall be in an allocation as reasonably reflects the proportion of such expenditures associated with part A and part B.''.

SEC. 15107. PERMITTING CARRIERS TO CARRY OUT PRIOR AUTHORIZATION FOR CERTAIN ITEMS OF DURABLE MEDICAL EQUIPMENT.

(a) IN GENERAL.—Section 1834(a)(15) (42 U.S.C. 1395m(a)(15)), as amended by section 135(b) of the Social Security Act Amendments of 1994, is amended by adding at the end the following new subparagraphs:

''(D) APPLICATION BY CARRIERS.—A carrier may develop (and periodically update) a list of items under subparagraph (A) and a list of suppliers under subparagraph (B) in the same manner as the Secretary may develop (and periodically update) such lists.

''(E) WAIVER OF PUBLICATION REQUIREMENT.—A carrier may make an advance determination under subparagraph (C) with respect to an item or supplier on a list developed by the Secretary or the carrier without regard to whether or not the Secretary has promulgated a regulation with respect to the list, except that the carrier may not make such an advance determination with respect to an item or supplier on a list until the expiration of the 30-day period beginning on the date the Secretary or the carrier places the item or supplier on the list.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enactment of the Social Security Act Amendments of 1994.

SEC. 15108. NATIONAL HEALTH CARE ANTI-FRAUD TASK FORCE.

(a) ESTABLISHMENT.—The Attorney General, in consultation with the Secretary of Health and Human Services, shall establish a national health care anti-fraud task force (in this section referred to as the ''task force''). The Attorney General shall establish the task force within 120 days after the date of the enactment of this Act.

(b) COMPOSITION.—The task force shall include representatives of Federal agencies involved in the investigation and prosecution of persons violating laws relating to health care fraud and abuse, including at least one representative from each of the following agencies:

(1) The Department of Justice and the Federal Bureau of Investigation.

(2) The Department of Health and Human Services and the Office of the Inspector General within the Department.

(3) The office in the Department of Defense responsible for administration of the CHAMPUS program.

(4) The Department of Veterans' Affairs.

(5) The United States Postal Inspection Service.

(6) The Internal Revenue Service.

The Attorney General (or the designee of the Attorney General) shall serve as chair of the task force.

(c) DUTIES.—The task force shall coordinate Federal law enforcement activities relating to health care fraud and abuse in order to better control fraud and abuse in the delivery of health care in the United States. Specifically, the task force shall coordinate activities—

(1) in order to assure the effective targeting and investigation of persons who organize, direct, finance, or otherwise knowingly engage in health care fraud, and

(2) in order to assure full and effective cooperation between Federal and State agencies involved in health care fraud investigations.

(d) STAFF.—Each member of the task force who represents an agency shall be responsible for providing for the detail (from the agency) of at least one full-time staff person to staff the task force. Such detail shall be without change in salary, compensation, benefits, and other employment-related matters.

SEC. 15109. STUDY OF ADEQUACY OF PRIVATE QUALITY ASSURANCE PROGRAMS.

(a) IN GENERAL.—The Administrator of the Health Care Financing Administration (acting through the Director of the Office of Research and Demonstrations) shall enter into an agreement with a private entity to conduct a study during the 5-year period beginning on the date of the enactment of this Act of the adequacy of the quality assurance programs and consumer protections used by the MedicarePlus program under part C of title XVIII of the Social Security Act (as inserted by section 15002(a)), and shall include in the study an analysis of the effectiveness of such programs in protecting plan enrollees against the risk of insufficient provision of benefits which may result from utilization controls.

(b) REPORT.—Not later than 6 months after the conclusion of the 5-year period described in subsection (a), the Administrator shall submit a report to Congress on the study conducted under subsection (a).

SEC. 15110. PENALTY FOR FALSE CERTIFICATION FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1128A(b) (42 U.S.C. 1320a–7a(b)) is amended by adding at the end the following new paragraph:

''(3)(A) Any physician who executes a document described in subparagraph (B) with respect to an individual

knowing that all of the requirements referred to in such subparagraph are not met with respect to the individual shall be subject to a civil monetary penalty of not more than the greater of—

''(i) $5,000, or

''(ii) three times the amount of the payments under title XVIII for home health services which are made pursuant to such certification.

''(B) A document described in this subparagraph is any document that certifies, for purposes of title XVIII, that an individual meets the requirements of section 1814(a)(2)(C) or 1835(a)(2)(A) in the case of home health services furnished to the individual.''.

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

SEC. 15111. PILOT PROJECTS.

The Secretary of Health and Human Services shall establish and operate 5 pilot projects (in various geographic regions of the United States) under which the Secretary shall implement innovative approaches to monitor payment claims under the medicare program to detect those claims that are wasteful or fraudulent.

PART 2—REVISIONS TO CRIMINAL LAW

SEC. 15121. DEFINITION OF FEDERAL HEALTH CARE OFFENSE.

(a) IN GENERAL.—Chapter 2 of title 18, United States Code, is amended by adding at the end the following:

"§ 24. Definition of Federal health care offense

''(a) As used in this title, the term 'Federal health care offense' means—

''(1) a violation of, or criminal conspiracy to violate section 226, 227, 669, 1035, 1347, or 1518 of this title;

''(2) a violation of, or criminal conspiracy to violate section 1128B of the Social Security Act (42 U.S.C. 1320a–7b);

''(3) a violation of, or criminal conspiracy to violate section 201, 287, 371, 664, 666, 1001, 1027, 1341, 1343, or 1954 of this title, if the violation or conspiracy relates to a health care benefit program;

''(4) a violation of, or criminal conspiracy to violate section 501 or 511 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1131 or 29 U.S.C. 1141), if the violation or conspiracy relates to a health care benefit program;

''(5) the commission of, or attempt to commit, an act which constitutes grounds for the imposition

of a penalty under section 303 of the Federal Food, Drug, and Cosmetic Act, if the act or attempt relates to a health care benefit program; or

''(6) a violation of, or criminal conspiracy to violate, section 3 of the Anti-Kickback Act of 1986 (41 U.S.C. 53), if the violation or conspiracy relates to a health care benefit program.

''(b) As used in this title, the term 'health care benefit program' has the meaning given such term in section 1347(b) of this title.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 2 of title 18, United States Code, is amended by inserting after the item relating to section 23 the following new item:

''24. Definition relating to Federal health care offense defined.''.

SEC. 15122. HEALTH CARE FRAUD.

(a) IN GENERAL.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

''§ 1347. Health care fraud

''(a) Whoever, having devised or intending to devise a scheme or artifice, commits or attempts to commit an act in furtherance of or for the purpose of executing such scheme or artifice—

''(1) to defraud any health care benefit program; or

''(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health care benefit program,

shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365 of this title), such person shall be fined under this title or imprisoned not more than 20 years, or both; and if the violation results in death, such person shall be fined under this title, or imprisoned for any term of years or for life, or both.

''(b) As used in this section, the term 'health care benefit program' means any public or private plan or contract under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following:

''1347. Health care fraud.''.

SEC. 15123. THEFT OR EMBEZZLEMENT.

(a) IN GENERAL.—Chapter 31 of title 18, United States Code, is amended by adding at the end the following:

''§ 669. Theft or embezzlement in connection with health care

''(a) Whoever embezzles, steals, or otherwise without authority willfully and unlawfully converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of a health care benefit program, shall be fined under this title or imprisoned not more than 10 years, or both.

''(b) As used in this section, the term 'health care benefit program' has the meaning given such term in section 1347(b) of this title.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 31 of title 18, United States Code, is amended by adding at the end the following:

''669. Theft or embezzlement in connection with health care.''.

SEC. 15124. FALSE STATEMENTS.

(a) IN GENERAL.—Chapter 47 of title 18, United States Code, is amended by adding at the end the following:

''§ 1035. False statements relating to health care matters

''(a) Whoever, in any matter involving a health care benefit program, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious, or fraudulent state-

ments or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry, shall be fined under this title or imprisoned not more than 5 years, or both.

''(b) As used in this section, the term 'health care benefit program' has the meaning given such term in section 1347(b) of this title.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 47 of title 18, United States Code, is amended by adding at the end the following new item:

''1035. False statements relating to health care matters.''.

SEC. 15125. BRIBERY AND GRAFT.

(a) IN GENERAL.—Chapter 11 of title 18, United States Code, is amended by adding at the end the following:

''§ 226. Bribery and graft in connection with health care

''(a) Whoever—

''(1) directly or indirectly, corruptly gives, offers, or promises anything of value to a health care official, or offers or promises to give anything of value to any other person, or attempts to violate this subsection, with intent—

''(A) to influence any of the health care official's actions, decisions, or duties relating to a health care benefit program;

''(B) to influence such an official to commit or aid in the committing, or collude in or allow, any fraud, or make opportunity for the commission of any fraud, on a health care benefit program; or

''(C) to induce such an official to engage in any conduct in violation of the lawful duty of such official; or

''(2) being a health care official, directly or indirectly, corruptly demands, seeks, receives, accepts, or agrees to accept anything of value personally or for any other person or entity, the giving of which violates paragraph (1) of this subsection, or attempts to violate this subsection,

shall be fined under this title or imprisoned not more than 15 years, or both.

''(b) Whoever—

''(1) otherwise than as provided by law for the proper discharge of any duty, directly or indirectly gives, offers, or promises anything of value to a health care official, for or because of any of the health care official's actions, decisions, or duties re-

lating to a health care benefit program, or attempts to violate this subsection; or

''(2) being a health care official, otherwise than as provided by law for the proper discharge of any duty, directly or indirectly, demands, seeks, receives, accepts or agrees to accept anything of value personally or for any other person or entity, the giving of which violates paragraph (1) of this subsection, or attempts to violate this subsection,

shall be fined under this title, or imprisoned not more than 2 years, or both.

''(c) As used in this section—

''(1) the term 'health care official' means—

''(A) an administrator, officer, trustee, fiduciary, custodian, counsel, agent, or employee of any health care benefit program;

''(B) an officer, counsel, agent, or employee, of an organization that provides services under contract to any health care benefit program; or

''(C) an official, employee, or agent of an entity having regulatory authority over any health care benefit program; and

''(2) the term 'health care benefit program' has the meaning given such term in section 1347(b) of this title.''.

(b) CLERICAL AMENDMENT.—The table of chapters at the beginning of chapter 11 of title 18, United States Code, is amended by adding at the end the following new item:

''226. Bribery and graft in connection with health care.''.

SEC. 15126. ILLEGAL REMUNERATION WITH RESPECT TO HEALTH CARE BENEFIT PROGRAMS.

(a) IN GENERAL.—Chapter 11 of title 18, United States Code, is amended by adding at the end the following:

"§ 227. Illegal remuneration with respect to health care benefit programs

''(a) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

''(1) in return for referring any individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part by any health care benefit program; or

''(2) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leas-

ing, or ordering any good, facility, service, or item for which payment may be made in whole or in part by any health care benefit program, or attempting to do so,

shall be fined under this title or imprisoned for not more than 5 years, or both.

''(b) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly, or covertly, in cash or in kind to any person to induce such person—

''(1) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part by any health benefit program; or

''(2) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part by any health benefit program or attempts to do so,

shall be fined under this title or imprisoned for not more than 5 years, or both.

''(c) Subsections (a) and (b) shall not apply to—

''(1) a discount or other reduction in price obtained by a provider of services or other entity under a health care benefit program if the reduction in

price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under a health care benefit program;

''(2) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services if the amount of the remuneration under the arrangement is consistent with the fair market value of the services and is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals;

''(3) any amount paid by a vendor of goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities who are furnishing services reimbursed under a health care benefit program if—

''(A) the person has a written contract, with each such individual or entity, which specifies the amount to be paid the person, which amount may be a fixed amount or a percentage of the value of the purchases made by each such individual or entity under the contract, and

''(B) in the case of an entity that is a provider of services (as defined in section 1861(u) of the Social Security Act, the person discloses (in such form and manner as the Secretary of Health and Human Services requires) to the entity and, upon request, to the Secretary the amount received from each such vendor with respect to purchases made by or on behalf of the entity;

''(4) a waiver of any coinsurance under part B of title XVIII of the Social Security Act by a federally qualified health care center with respect to an individual who qualifies for subsidized services under a provision of the Public Health Service Act; and

''(5) any payment practice specified by the Secretary of Health and Human Services in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987.

''(d) Any person injured in his business or property by reason of a violation of this section or section 226 of this title may sue therefor in any appropriate United States district court and shall recover threefold the damages such person sustains and the cost of the suit, including a reasonable attorney's fee.

''(e) As used in this section, 'health care benefit program' has the meaning given such term in section 1347(b) of this title.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 11 of title 18, United States Code, is amended by adding at the end the following:

''227. Illegal remuneration with respect to health care benefit programs.''.

(c) CONFORMING AMENDMENT.—Section 1128B of the Social Security Act (42 U.S.C. 1320a–7b) is amended by striking subsection (b).

SEC. 15127. OBSTRUCTION OF CRIMINAL INVESTIGATIONS OF HEALTH CARE OFFENSES.

(a) IN GENERAL.—Chapter 73 of title 18, United States Code, is amended by adding at the end the following:

''§ 1518. Obstruction of criminal investigations of health care offenses

''(a) Whoever willfully prevents, obstructs, misleads, delays or attempts to prevent, obstruct, mislead, or delay the communication of information or records relating to a violation of a health care offense to a criminal investigator shall be fined under this title or imprisoned not more than 5 years, or both.

''(b) As used in this section the term 'health care offense' has the meaning given such term in section 24 of this title.

''(c) As used in this section the term 'criminal investigator' means any individual duly authorized by a department, agency, or armed force of the United States to conduct or engage in investigations for prosecutions for violations of health care offenses.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 of title 18, United States Code, is amended by adding at the end the following new item:

''1518. Obstruction of criminal investigations of health care offenses.''.

SEC. 15128. CIVIL PENALTIES FOR VIOLATIONS OF FEDERAL HEALTH CARE OFFENSES.

(a) IN GENERAL.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

"§ 1348. Civil penalties for violations of Federal health care offenses

''The Attorney General may bring a civil action in the appropriate United States district court against any person who engages in conduct constituting a violation of Federal health care offense, as that term is defined in section 24 of this title and, upon proof of such conduct by a preponderance of the evidence, such person shall be subject to a civil penalty of not more than $50,000 for each violation or the amount of compensation or proceeds which the person received or offered for the prohibited conduct,

whichever amount is greater. The imposition of a civil penalty under this section does not preclude any other criminal or civil statutory, common law, or administrative remedy, which is available by law to the United States or any other person.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 63 of title 18, United States Code, is amended by adding at the end the following item:

''1348. Civil penalties for violations of Federal health care offenses.''.

SEC. 15129. INJUNCTIVE RELIEF RELATING TO HEALTH CARE OFFENSES.

Section 1345(a)(1) of title 18, United States Code, is amended—

(1) by striking ''or'' at the end of subparagraph (A);

(2) by inserting ''or'' at the end of subparagraph (B); and

(3) by adding at the end the following:

''(C) committing or about to commit a Federal health care offense (as defined in section 24 of this title).''.

SEC. 15130. AUTHORIZED INVESTIGATIVE DEMAND PROCEDURES.

(a) IN GENERAL.—Chapter 233 of title 18, United States Code, is amended by adding after section 3485 the following:

"§ 3486. Authorized investigative demand procedures

''(a) AUTHORIZATION.—(1) In any investigation relating to functions set forth in paragraph (2), the Attorney General or the Director of the Federal Bureau of Investigation or their designees may issue in writing and cause to be served a summons compelling the attendance and testimony of witnesses and requiring the production of any records (including any books, papers, documents, electronic media, or other objects or tangible things), which may be relevant to an authorized law enforcement inquiry, that a person or legal entity may possess or have care, custody, or control. The attendance of witnesses and the production of records may be required from any place in any State or in any territory or other place subject to the jurisdiction of the United States at any designated place of hearing; except that a witness shall not be required to appear at any hearing more than 500 miles distant from the place where he was served with a subpoena. Witnesses summoned under this section shall be paid the same fees and mileage that are paid witnesses in the courts of the United States. A summons requiring the production of records shall describe the objects required to be produced and prescribe a return date within a reasonable period of time within which the objects can be assembled and made available.

''(2) Investigative demands utilizing an administrative summons are authorized for:

''(A) Any investigation with respect to any act or activity constituting an offense involving a Federal health care offense as that term is defined in section 24 of title 18, United States Code.

''(B) Any investigation, with respect to violations of sections 1073 and 1074 of title 18, United States Code, or in which an individual has been lawfully charged with a Federal offense and such individual is avoiding prosecution or custody or confinement after conviction of such offense or attempt.

''(b) SERVICE.—A subpoena issued under this section may be served by any person designated in the subpoena to serve it. Service upon a natural person may be made by personal delivery of the subpoena to him. Service may be made upon a domestic or foreign corporation or upon a partnership or other unincorporated association which is subject to suit under a common name, by delivering the subpoena to an officer, to a managing or general agent, or to any other agent authorized by appointment or by law to receive service of process. The affidavit of the person serving the subpoena entered on a true copy thereof by the person serving it shall be proof of service.

''(c) ENFORCEMENT.—In the case of contumacy by or refusal to obey a subpoena issued to any person, the Attorney General may invoke the aid of any court of the United States within the jurisdiction of which the investigation is carried on or of which the subpoenaed person is an inhabitant, or in which he carries on business or may be found, to compel compliance with the subpoena. The court may issue an order requiring the subpoenaed person to appear before the Attorney General to produce records, if so ordered, or to give testimony touching the matter under investigation. Any failure to obey the order of the court may be punished by the court as a contempt thereof. All process in any such case may be served in any judicial district in which such person may be found.

''(d) IMMUNITY FROM CIVIL LIABILITY.—Notwithstanding any Federal, State, or local law, any person, including officers, agents, and employees, receiving a summons under this section, who complies in good faith with the summons and thus produces the materials sought, shall not be liable in any court of any State or the United States to any customer or other person for such production or for nondisclosure of that production to the customer.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 223 of title 18, United States

Code, is amended by inserting after the item relating to section 3485 the following new item:

''3486. Authorized investigative demand procedures.''.

(c) CONFORMING AMENDMENT.—Section 1510(b)(3)(B) of title 18, United States Code, is amended by inserting ''or a Federal Bureau of Investigation summons (issued under section 3486 of title 18),'' after ''subpoena''.

SEC. 15131. GRAND JURY DISCLOSURE.

Section 3322 of title 18, United States Code, is amended—

(1) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(2) by inserting after subsection (b) the following:

''(c) A person who is privy to grand jury information concerning a health care offense—

''(1) received in the course of duty as an attorney for the Government; or

''(2) disclosed under rule 6(e)(3)(A)(ii) of the Federal Rules of Criminal Procedure;

may disclose that information to an attorney for the Government to use in any civil investigation or proceeding related to a Federal health care offense (as defined in section 24 of this title).''.

SEC. 15132. MISCELLANEOUS AMENDMENTS TO TITLE 18, UNITED STATES CODE.

(a) LAUNDERING OF MONETARY INSTRUMENTS.—Section 1956(c)(7) of title 18, United States Code, is amended by adding at the end thereof the following:

''(F) Any act or activity constituting an offense involving a Federal health care offense as that term is defined in section 24 of title 18, United States Code.''.

(b) ENHANCED PENALTIES.—Section 2326(2) of title 18, United States Code, is amended by striking ''sections that—'' and inserting ''or in the case of a Federal health care offense as that term is defined in section 24 of this title, that—''.

(c) AUTHORIZATION FOR INTERCEPTION OF WIRE, ORAL, OR ELECTRONIC COMMUNICATIONS.—Section 2516(1)(c) of title 18, United States Code, is amended—

(1) by inserting ''section 226 (bribery and graft in connection with health care), section 227 (illegal remunerations)'' after ''section 224 (bribery in sporting contests),''; and

(2) by inserting ''section 1347 (health care fraud)'' after ''section 1344 (relating to bank fraud),'' .

(d) DEFINITIONS.—Section 1961(1) of title 18, United States Code, is amended—

(1) by inserting ''sections 226 and 227 (relating to bribery and graft, and illegal remuneration in connection with health care)'' after ''section 224 (relating to sports bribery),'';

(2) by inserting ''section 669 (relating to theft or embezzlement in connection with health care)'' after ''section 664 (relating to embezzlement from pension and welfare funds),''; and

(3) by inserting ''section 1347 (relating to health care fraud)'' after ''section 1344 (relating to financial institution fraud),''.

(e) CRIMINAL FORFEITURE.—Section 982(a) of title 18, United States Code, is amended by adding at the end the following new paragraph:

''(6) The court in imposing sentence on a person convicted of a Federal health care offense as defined in section 24 of this title, shall order that the offender forfeit to the United States any real or personal property constituting or derived from proceeds that the offender obtained directly or indirectly as the result of the offense.''.

(f) REWARDS FOR INFORMATION LEADING TO PROSECUTION AND CONVICTION.—Section 3059(c)(1) of title 18, United States Code, is amended by inserting ''or furnishes information unknown to the Government relating

to a possible prosecution of a Federal health care offense as defined in section 24 of this title, which results in a conviction'' before the period at the end.

Subtitle C—Regulatory Relief

PART 1—PHYSICIAN OWNERSHIP REFERRAL REFORM

SEC. 15201. REPEAL OF PROHIBITIONS BASED ON COMPENSATION ARRANGEMENTS.

(a) IN GENERAL.—Section 1877(a)(2) (42 U.S.C. 1395nn(a)(2)) is amended by striking ''is—'' and all that follows through ''equity,'' and inserting the following: ''is (except as provided in subsection (c)) an ownership or investment interest in the entity through equity,''.

(b) CONFORMING AMENDMENTS.—Section 1877 (42 U.S.C. 1395nn) is amended as follows:

(1) In subsection (b)—

(A) in the heading, by striking ''TO BOTH OWNERSHIP AND COMPENSATION ARRANGEMENT PROHIBITIONS'' and inserting ''WHERE FINANCIAL RELATIONSHIP EXISTS''; and

(B) by redesignating paragraph (4) as paragraph (7).

(2) In subsection (c)—

(A) by amending the heading to read as follows: ''EXCEPTION FOR OWNERSHIP OR IN-

VESTMENT INTEREST IN PUBLICLY TRADED SECURITIES AND MUTUAL FUNDS''; and

(B) in the matter preceding paragraph (1), by striking ''subsection (a)(2)(A)'' and inserting ''subsection (a)(2)''.

(3) In subsection (d)—

(A) by striking the matter preceding paragraph (1);

(B) in paragraph (3), by striking ''paragraph (1)'' and inserting ''paragraph (4)''; and

(C) by redesignating paragraphs (1), (2), and (3) as paragraphs (4), (5), and (6), and by transferring and inserting such paragraphs after paragraph (3) of subsection (b).

(4) By striking subsection (e).

(5) In subsection (f)(2)—

(A) in the matter preceding paragraph (1), by striking ''ownership, investment, and compensation'' and inserting ''ownership and investment'';

(B) in paragraph (2), by striking ''subsection (a)(2)(A)'' and all that follows through ''subsection (a)(2)(B)),'' and inserting ''subsection (a)(2),''; and

(C) in paragraph (2), by striking ''or who have such a compensation relationship with the entity''.

(6) In subsection (h)—

(A) by striking paragraphs (1), (2), and (3);

(B) in paragraph (4)(A), by striking clauses (iv) and (vi);

(C) in paragraph (4)(B), by striking ''RULES.—'' and all that follows through ''(ii) FACULTY'' and inserting ''RULES FOR FACULTY''; and

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

''(C) MEMBER OF A GROUP.—A physician is a 'member' of a group if the physician is an owner or a bona fide employee, or both, of the group.''.

SEC. 15202. REVISION OF DESIGNATED HEALTH SERVICES SUBJECT TO PROHIBITION.

(a) IN GENERAL.—Section 1877(h)(6) (42 U.S.C. 1395nn(h)(6)) is amended by striking subparagraphs (B) through (K) and inserting the following:

''(B) Parenteral and enteral nutrients, equipment, and supplies.

''(C) Magnetic resonance imaging and computerized tomography services.

''(D) Outpatient physical or occupational therapy services.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1877(b)(2) (42 U.S.C. 1395nn(b)(2)) is amended in the matter preceding subparagraph (A) by striking ''services'' and all that follows through ''supplies)—'' and inserting ''services—''.

(2) Section 1877(h)(5)(C) (42 U.S.C. 1395nn(h)(5)(C)) is amended—

(A) by striking '', a request by a radiologist for diagnostic radiology services, and a request by a radiation oncologist for radiation therapy,'' and inserting ''and a request by a radiologist for magnetic resonance imaging or for computerized tomography'', and

(B) by striking ''radiologist, or radiation oncologist'' and inserting ''or radiologist''.

SEC. 15203. DELAY IN IMPLEMENTATION UNTIL PROMULGATION OF REGULATIONS.

(a) IN GENERAL.—Section 13562(b) of OBRA–1993 (42 U.S.C. 1395nn note) is amended—

(1) in paragraph (1), by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (3)''; and

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

''(3) PROMULGATION OF REGULATIONS.—Notwithstanding paragraphs (1) and (2), the amendments made by this section shall not apply to any referrals made before the effective date of final regulations promulgated by the Secretary of Health and Human Services to carry out such amendments.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect as if included in the enactment of OBRA–1993.

SEC. 15204. EXCEPTIONS TO PROHIBITION.

(a) REVISIONS TO EXCEPTION FOR IN-OFFICE ANCILLARY SERVICES.—

(1) REPEAL OF SITE-OF-SERVICE REQUIREMENT.—Section 1877 (42 U.S.C. 1395nn) is amended—

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

''(A) that are furnished personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individ-

uals who are under the general supervision of the physician or of another physician in the group practice, and'', and

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

''(7) GENERAL SUPERVISION.—An individual is considered to be under the 'general supervision' of a physician if the physician (or group practice of which the physician is a member) is legally responsible for the services performed by the individual and for ensuring that the individual meets licensure and certification requirements, if any, applicable under other provisions of law, regardless of whether or not the physician is physically present when the individual furnishes an item or service.''.

(2) CLARIFICATION OF TREATMENT OF PHYSICIAN OWNERS OF GROUP PRACTICE.—Section 1877(b)(2)(B) (42 U.S.C. 1395nn(b)(2)(B)) is amended by striking ''physician or such group practice'' and inserting ''physician, such group practice, or the physician owners of such group practice''.

(3) CONFORMING AMENDMENT.—Section 1877(b)(2) (42 U.S.C. 1395nn(b)(2)) is amended by amending the heading to read as follows: ''ANCIL-

LARY SERVICES FURNISHED PERSONALLY OR THROUGH GROUP PRACTICE.—''.

(b) CLARIFICATION OF EXCEPTION FOR SERVICES FURNISHED IN A RURAL AREA.—Paragraph (5) of section 1877(b) (42 U.S.C. 1395nn(b)), as transferred by section 15201(b)(3)(C), is amended by striking ''substantially all'' and inserting ''not less than 75 percent''.

(c) REVISION OF EXCEPTION FOR CERTAIN MANAGED CARE ARRANGEMENTS.—Section 1877(b)(3) (42 U.S.C. 1395nn(b)(3)) is amended—

(1) in the heading by inserting ''MANAGED CARE ARRANGEMENTS'' after ''PREPAID PLANS'';

(2) in the matter preceding subparagraph (A), by striking ''organization—'' and inserting ''organization, directly or through contractual arrangements with other entities, to individuals enrolled with the organization—'';

(3) in subparagraph (A), by inserting ''or part C'' after ''section 1876'';

(4) by striking ''or'' at the end of subparagraph (C);

(5) by striking the period at the end of subparagraph (D) and inserting a comma; and

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

''(E) with a contract with a State to provide services under the State plan under title XIX (in accordance with section 1903(m)) or a State MediGrant plan under title XXI; or

''(F) which is a MedicarePlus organization under part C or which provides or arranges for the provision of health care items or services pursuant to a written agreement between the organization and an individual or entity if the written agreement places the individual or entity at substantial financial risk for the cost or utilization of the items or services which the individual or entity is obligated to provide, whether through a withhold, capitation, incentive pool, per diem payment, or any other similar risk arrangement which places the individual or entity at substantial financial risk.''.

(d) NEW EXCEPTION FOR SHARED FACILITY SERVICES.—

(1) IN GENERAL.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15201(b)(3)(C), is amended—

(A) by redesignating paragraphs (4) through (7) as paragraphs (5) through (8); and

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

''(4) SHARED FACILITY SERVICES.—In the case of a designated health service consisting of a shared facility service of a shared facility—

''(A) that is furnished—

''(i) personally by the referring physician who is a shared facility physician or personally by an individual directly employed or under the general supervision of such a physician,

''(ii) by a shared facility in a building in which the referring physician furnishes substantially all of the services of the physician that are unrelated to the furnishing of shared facility services, and

''(iii) to a patient of a shared facility physician; and

''(B) that is billed by the referring physician or a group practice of which the physician is a member.''.

(2) DEFINITIONS.—Section 1877(h) (42 U.S.C. 1395nn(h)), as amended by section 15201(b)(6), is amended by inserting before paragraph (4) the following new paragraph:

''(1) SHARED FACILITY RELATED DEFINITIONS.—

''(A) SHARED FACILITY SERVICE.—The term 'shared facility service' means, with respect to a shared facility, a designated health service furnished by the facility to patients of shared facility physicians.

''(B) SHARED FACILITY.—The term 'shared facility' means an entity that furnishes shared facility services under a shared facility arrangement.

''(C) SHARED FACILITY PHYSICIAN.—The term 'shared facility physician' means, with respect to a shared facility, a physician (or a group practice of which the physician is a member) who has a financial relationship under a shared facility arrangement with the facility.

''(D) SHARED FACILITY ARRANGEMENT.—The term 'shared facility arrangement' means, with respect to the provision of shared facility services in a building, a financial arrangement—

''(i) which is only between physicians who are providing services (unrelated to

shared facility services) in the same building,

''(ii) in which the overhead expenses of the facility are shared, in accordance with methods previously determined by the physicians in the arrangement, among the physicians in the arrangement, and

''(iii) which, in the case of a corporation, is wholly owned and controlled by shared facility physicians.''.

(e) NEW EXCEPTION FOR SERVICES FURNISHED IN COMMUNITIES WITH NO ALTERNATIVE PROVIDERS.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15201(b)(3)(C) and subsection (d)(1), is amended—

(1) by redesignating paragraphs (5) through (8) as paragraphs (6) through (9); and

(2) by inserting after paragraph (4) the following new paragraph:

''(5) NO ALTERNATIVE PROVIDERS IN AREA.—In the case of a designated health service furnished in any area with respect to which the Secretary determines that individuals residing in the area do not have reasonable access to such a designated health service for which subsection (a)(1) does not apply.''.

(f) NEW EXCEPTION FOR SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15201(b)(3)(C), subsection (d)(1), and subsection (e)(1), is amended—

(1) by redesignating paragraphs (6) through (9) as paragraphs (7) through (10); and

(2) by inserting after paragraph (5) the following new paragraph:

''(6) SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.—In the case of a designated health service furnished in an ambulatory surgical center described in section 1832(a)(2)(F)(i).''.

(g) NEW EXCEPTION FOR SERVICES FURNISHED IN RENAL DIALYSIS FACILITIES.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15201(b)(3)(C), subsection (d)(1), subsection (e)(1), and subsection (f), is amended—

(1) by redesignating paragraphs (7) through (10) as paragraphs (8) through (11); and

(2) by inserting after paragraph (6) the following new paragraph:

''(7) SERVICES FURNISHED IN RENAL DIALYSIS FACILITIES.—In the case of a designated health

service furnished in a renal dialysis facility under section 1881.''.

(h) NEW EXCEPTION FOR SERVICES FURNISHED IN A HOSPICE.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15201(b)(3)(C), subsection (d)(1), subsection (e)(1), subsection (f), and subsection (g), is amended—

(1) by redesignating paragraphs (8) through (11) as paragraphs (9) through (12); and

(2) by inserting after paragraph (7) the following new paragraph:

''(8) SERVICES FURNISHED BY A HOSPICE PROGRAM.—In the case of a designated health service furnished by a hospice program under section 1861(dd)(2).''.

(i) NEW EXCEPTION FOR SERVICES FURNISHED IN A COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15201(b)(3)(C), subsection (d)(1), subsection (e)(1), subsection (f), subsection (g), and subsection (h), is amended—

(1) by redesignating paragraphs (9) through (12) as paragraphs (10) through (13); and

(2) by inserting after paragraph (8) the following new paragraph:

''(9) SERVICES FURNISHED IN A COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY.—In the case of a designated health service furnished in a comprehensive outpatient rehabilitation facility (as defined in section 1861(cc)(2)).''.

(i) DEFINITION OF REFERRAL.—Section 1877(h)(5)(A) (42 U.S.C. 1395nn(h)(5)(A)) is amended—

(1) by striking ''an item or service'' and inserting ''a designated health service'', and

(2) by striking ''the item or service'' and inserting ''the designated health service''.

SEC. 15205. REPEAL OF REPORTING REQUIREMENTS.

Section 1877 (42 U.S.C. 1395nn) is amended—

(1) by striking subsection (f); and

(2) by striking subsection (g)(5).

SEC. 15206. PREEMPTION OF STATE LAW.

Section 1877 (42 U.S.C. 1395nn) is amended by adding at the end the following new subsection:

''(i) PREEMPTION OF STATE LAW.—This section preempts State law to the extent State law is inconsistent with this section.''.

SEC. 15207. EFFECTIVE DATE.

Except as provided in section 15203(b), the amendments made by this part shall apply to referrals made on

or after August 14, 1995, regardless of whether or not regulations are promulgated to carry out such amendments.

PART 2—OTHER MEDICARE REGULATORY RELIEF

SEC. 15211. REPEAL OF MEDICARE AND MEDICAID COVERAGE DATA BANK.

(a) IN GENERAL.—Section 1144 (42 U.S.C. 1320b–14) is repealed.

(b) CONFORMING AMENDMENTS.—

(1) MEDICARE.—Section 1862(b)(5) (42 U.S.C. 1395y(b)(5)) is amended—

(A) in subparagraph (B), by striking ''under—'' and all that follows through the end and inserting ''subparagraph (A) for purposes of carrying out this subsection.'', and

(B) in subparagraph (C)(i), by striking ''subparagraph (B)(i)'' and inserting ''subparagraph (B)''.

(2) MEDICAID.—Section 1902(a)(25)(A)(i) (42 U.S.C. 1396a(a)(25)(A)(i)) is amended by striking ''including the use of'' and all that follows through ''any additional measures''.

(3) ERISA.—Section 101(f) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021(f)) is repealed.

(4) DATA MATCHES.—Section 552a(a)(8)(B) of title 5, United States Code, is amended—

(A) by adding ‘‘; or’’ at the end of clause (v),

(B) by striking ‘‘or’’ at the end of clause (vi), and

(C) by striking clause (vii).

SEC. 15212. CLARIFICATION OF LEVEL OF INTENT REQUIRED FOR IMPOSITION OF SANCTIONS.

(a) CLARIFICATION OF LEVEL OF KNOWLEDGE REQUIRED FOR IMPOSITION OF CIVIL MONETARY PENALTIES.—

(1) IN GENERAL.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(A) in paragraphs (1) and (2), by inserting ‘‘knowingly’’ before ‘‘presents’’ each place it appears; and

(B) in paragraph (3), by striking ‘‘gives’’ and inserting ‘‘knowingly gives or causes to be given’’.

(2) DEFINITION OF STANDARD.—Section 1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by adding at the end the following new paragraph:

''(6) The term 'should know' means that a person, with respect to information—

''(A) acts in deliberate ignorance of the truth or falsity of the information; or

''(B) acts in reckless disregard of the truth or falsity of the information,

and no proof of specific intent to defraud is required.''.

(b) CLARIFICATION OF EFFECT AND APPLICATION OF SAFE HARBOR EXCEPTIONS.—For purposes of section 1128B(b)(3) of the Social Security Act, the specification of any payment practice in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid Program and Patient Protection Act of 1987 is—

(1) solely for the purpose of adding additional exceptions to the types of conduct which are not subject to an anti-kickback penalty under such section and not for the purpose of limiting the scope of such exceptions; and

(2) for the purpose of prescribing criteria for qualifying for such an exception notwithstanding the intent of the party involved.

(c) LIMITING IMPOSITION OF ANTI-KICKBACK PENALTIES TO ACTIONS WITH SIGNIFICANT PURPOSE TO INDUCE REFERRALS.—Section 1128B(b)(2) (42 U.S.C. 1320a–7b(b)(2)) is amended in the matter preceding subparagraph (A) by striking ''to induce'' and inserting ''for the significant purpose of inducing''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to acts or omissions occurring on or after January 1, 1996.

SEC. 15213. ADDITIONAL EXCEPTION TO ANTI-KICKBACK PENALTIES FOR MANAGED CARE ARRANGEMENTS.

(a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

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

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

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

''(F) any remuneration between an organization and an individual or entity providing services pursuant to a written agreement between the organization and the individual or entity if the organization is a MedicarePlus organization under part C of title

XVIII or if the written agreement places the individual or entity at substantial financial risk for the cost or utilization of the items or services which the individual or entity is obligated to provide, whether through a withhold, capitation, incentive pool, per diem payment, or any other similar risk arrangement which places the individual or entity at substantial financial risk.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to acts or omissions occurring on or after January 1, 1996.

SEC. 15214. SOLICITATION AND PUBLICATION OF MODIFICATIONS TO EXISTING SAFE HARBORS AND NEW SAFE HARBORS.

(a) IN GENERAL.—

(1) SOLICITATIONS.—Not later than January 1, 1996, and not less than annually thereafter, the Secretary of Health and Human Services shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for—

(A) modifications to existing safe harbors issued pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987;

(B) additional safe harbors specifying payment practices that shall not be treated as a criminal offense under section 1128B(b) of the Social Security Act and shall not serve as the basis for an exclusion under section 1128(b)(7) of such Act; and

(C) special fraud alerts to be issued pursuant to section 15101(c).

(2) PUBLICATION OF PROPOSED MODIFICATIONS AND PROPOSED ADDITIONAL SAFE HARBORS.—Not later than 120 days after receiving the proposals described in subparagraphs (A) and (B) of paragraph (1), the Secretary, after considering such proposals in consultation with the Attorney General, shall publish in the Federal Register proposed modifications to existing safe harbors and proposed additional safe harbors, if appropriate, with a 60-day comment period. After considering any public comments received during this period, the Secretary shall issue final rules modifying the existing safe harbors and establishing new safe harbors, as appropriate.

(3) REPORT.—The Inspector General shall, in an annual report to Congress or as part of the year-end semiannual report required by section 5 of the

Inspector General Act of 1978, describe the proposals received under subparagraphs (A) and (B) of paragraph (1) and explain which proposals were included in the publication described in paragraph (2), which proposals were not included in that publication, and the reasons for the rejection of the proposals that were not included.

(b) CRITERIA FOR MODIFYING AND ESTABLISHING SAFE HARBORS.—In modifying and establishing safe harbors under subsection (a)(2), the Secretary may consider the extent to which providing a safe harbor for the specified payment practice may result in any of the following:

(1) An increase or decrease in access to health care services.

(2) An increase or decrease in the quality of health care services.

(3) An increase or decrease in patient freedom of choice among health care providers.

(4) An increase or decrease in competition among health care providers.

(5) An increase or decrease in the cost to health care programs of the Federal Government.

(6) An increase or decrease in the potential overutilization of health care services.

(7) Any other factors the Secretary deems appropriate in the interest of preventing fraud and abuse in health care programs of the Federal Government.

SEC. 15215. ISSUANCE OF ADVISORY OPINIONS UNDER TITLE XI.

(a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.), as amended by section 15104(a), is amended by inserting after section 1129 the following new section:

''ADVISORY OPINIONS

''SEC. 1130. (a) ISSUANCE OF ADVISORY OPINIONS.—The Secretary shall issue written advisory opinions as provided in this section.

''(b) MATTERS SUBJECT TO ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as to the following matters:

''(1) What constitutes prohibited remuneration within the meaning of section 1128B(b).

''(2) Whether an arrangement or proposed arrangement satisfies the criteria set forth in section 1128B(b)(3) for activities which do not result in prohibited remuneration.

''(3) Whether an arrangement or proposed arrangement satisfies the criteria which the Secretary has established, or shall establish by regulation for

activities which do not result in prohibited remuneration.

''(4) What constitutes an inducement to reduce or limit services to individuals entitled to benefits under title XVIII or title XIX or title XXI within the meaning of section 1128B(b).

''(5) Whether any activity or proposed activity constitutes grounds for the imposition of a sanction under section 1128, 1128A, or 1128B.

''(c) MATTERS NOT SUBJECT TO ADVISORY OPINIONS.—Such advisory opinions shall not address the following matters:

''(1) Whether the fair market value shall be, or was paid or received for any goods, services or property.

''(2) Whether an individual is a bona fide employee within the requirements of section 3121(d)(2) of the Internal Revenue Code of 1986.

''(d) EFFECT OF ADVISORY OPINIONS.—

''(1) BINDING AS TO SECRETARY AND PARTIES INVOLVED.—Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

''(2) FAILURE TO SEEK OPINION.—The failure of a party to seek an advisory opinion may not be

introduced into evidence to prove that the party intended to violate the provisions of sections 1128, 1128A, or 1128B.

''(e) REGULATIONS.—

''(1) IN GENERAL.—Not later than 180 days after the date of the enactment of this section, the Secretary shall issue regulations to carry out this section. Such regulations shall provide for—

''(A) the procedure to be followed by a party applying for an advisory opinion;

''(B) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

''(C) the interval in which the Secretary shall respond;

''(D) the reasonable fee to be charged to the party requesting an advisory opinion; and

''(E) the manner in which advisory opinions will be made available to the public.

''(2) SPECIFIC CONTENTS.—Under the regulations promulgated pursuant to paragraph (1)—

''(A) the Secretary shall be required to respond to a party requesting an advisory opinion by not later than 30 days after the request is received; and

''(B) the fee charged to the party requesting an advisory opinion shall be equal to the costs incurred by the Secretary in responding to the request.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to requests for advisory opinions made on or after January 1, 1996.

SEC. 15216. PRIOR NOTICE OF CHANGES IN BILLING AND CLAIMS PROCESSING REQUIREMENTS FOR PHYSICIANS' SERVICES.

Except as may be specifically provided by Congress, the Secretary of Health and Human Services may not implement any change in the requirements imposed on the billing and processing of claims for payment for physicians' services under part B of the medicare program unless the Secretary notifies the individuals furnishing such services of the change not later than 120 days before the effective date of the change.

PART 3—PROMOTING PHYSICIAN SELF-POLICING

SEC. 15221. EXEMPTION FROM ANTITRUST LAWS FOR CERTAIN ACTIVITIES OF MEDICAL SELF-REGULATORY ENTITIES.

(a) EXEMPTION DESCRIBED.—An activity relating to the provision of health care services shall be exempt from the antitrust laws, and any State law similar to the anti-

trust laws, if the activity is within the safe harbor described in subsection (b).

(b) SAFE HARBOR FOR ACTIVITIES OF MEDICAL SELF-REGULATORY ENTITIES.—

(1) IN GENERAL.—The safe harbor referred to in subsection (a) is, subject to paragraph (2), any activity of a medical self-regulatory entity relating to standard setting or standard enforcement activities that are designed to promote the quality of health care services provided to patients.

(2) EXCEPTION.—No activity of a medical self-regulatory entity may be deemed to fall under the safe harbor established under paragraph (1) if the activity—

(A) is conducted for purposes of financial gain, or

(B) interferes with the provision of health care services by any health care provider who is not a member of the specific profession which is subject to the authority of the medical self-regulatory entity.

(c) DEFINITIONS.—For purposes of this section:

(1) ANTITRUST LAWS.—The term ''antitrust laws'' has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C.

12(a)), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition.

(2) HEALTH BENEFIT PLAN.—The term ''health benefit plan'' means—

(A) a hospital or medical expense incurred policy or certificate,

(B) a hospital or medical service plan contract,

(C) a health maintenance subscriber contract,

(D) a multiple employer welfare arrangement or employee benefit plan (as defined under the Employee Retirement Income Security Act of 1974), or

(E) a MedicarePlus product (offered under part C of title XVIII of the Social Security Act),

that provides benefits with respect to health care services.

(3) HEALTH CARE SERVICE.—The term ''health care service'' means any service for which payment may be made under a health benefit plan including

services related to the delivery or administration of such service.

(4) MEDICAL SELF-REGULATORY ENTITY.—The term ''medical self-regulatory entity'' means a medical society or association, a specialty board, a recognized accrediting agency, or a hospital medical staff, and includes the members, officers, employees, consultants, and volunteers or committees of such an entity.

(5) HEALTH CARE PROVIDER.—The term ''health care provider'' means any individual or entity that is engaged in the delivery of health care services in a State and that 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.

(6) STANDARD SETTING OR STANDARD ENFORCEMENT ACTIVITIES.—The term ''standard setting or standard enforcement activities'' means—

(A) accreditation of health care practitioners, health care providers, medical education institutions, or medical education programs,

(B) technology assessment and risk management activities,

(C) the development and implementation of practice guidelines or practice parameters, or

(D) official peer review proceedings undertaken by a hospital medical staff (or committee thereof) or a medical society or association for purposes of evaluating the professional conduct or quality of health care provided by a medical professional.

Subtitle D—Medical Liability Reform

PART 1—GENERAL PROVISIONS

SEC. 15301. FEDERAL REFORM OF HEALTH CARE LIABILITY ACTIONS.

(a) APPLICABILITY.—This subtitle shall apply with respect to any health care liability action brought in any State or Federal court, except that this subtitle shall not apply to—

(1) an action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the action, or

(2) an action under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.).

(b) PREEMPTION.—This subtitle shall preempt any State law to the extent such law is inconsistent with the limitations contained in this subtitle. This subtitle shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained in this subtitle or otherwise imposes greater restrictions than those provided in this subtitle.

(c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in subsection (b) shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

(d) AMOUNT IN CONTROVERSY.—In an action to which this subtitle applies and which is brought under section 1332 of title 28, United States Code, the amount of noneconomic damages or punitive damages, and attorneys' fees or costs, shall not be included in determining whether the matter in controversy exceeds the sum or value of $50,000.

(e) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this subtitle shall be construed to establish any jurisdiction in the district courts of the United States over health care liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. 15302. DEFINITIONS.

As used in this subtitle:

(1) ACTUAL DAMAGES.—The term ''actual damages'' means damages awarded to pay for economic loss.

(2) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term ''alternative dispute resolution system'' or ''ADR'' means a system established under Federal or State law that provides for the resolution of health care liability claims in a manner other than through health care liability actions.

(3) CLAIMANT.—The term ''claimant'' means any person who brings a health care liability action and any person on whose behalf such an action is brought. If such action is brought through or on behalf of an estate, the term includes the claimant's decedent. If such action is brought through or on behalf of a minor or incompetent, the term includes the claimant's legal guardian.

(4) CLEAR AND CONVINCING EVIDENCE.—The term ''clear and convincing evidence'' is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established. Such measure or degree of proof is more than that required under preponderance of the evidence but less than that required for proof beyond a reasonable doubt.

(5) COLLATERAL SOURCE PAYMENTS.—The term ''collateral source payments'' means any amount paid or reasonably likely to be paid in the future to or on behalf of a claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of a claimant, as a result of an injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident or workers' compensation Act;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(6) DRUG.—The term ''drug'' has the meaning given such term in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)).

(7) ECONOMIC LOSS.—The term ''economic loss'' means any pecuniary loss resulting from injury (including the loss of earnings or other benefits related to employment, medical expense loss, replacement services loss, loss due to death, burial costs, and loss of business or employment opportunities), to the extent recovery for such loss is allowed under applicable State law.

(8) HARM.—The term ''harm'' means any legally cognizable wrong or injury for which punitive damages may be imposed.

(9) HEALTH BENEFIT PLAN.—The term ''health benefit plan'' means—

(A) a hospital or medical expense incurred policy or certificate,

(B) a hospital or medical service plan contract,

(C) a health maintenance subscriber contract, or

(D) a MedicarePlus product (offered under part C of title XVIII of the Social Security Act),

that provides benefits with respect to health care services.

(10) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action brought in a State or Federal court against a health care provider, an entity which is obligated to provide or pay for health benefits under any health benefit plan (including any person or entity acting under a contract or arrangement to provide or administer any health benefit), or the manufacturer, distributor, supplier, marketer, promoter, or seller of

a medical product, in which the claimant alleges a claim (including third party claims, cross claims, counter claims, or distribution claims) based upon the provision of (or the failure to provide or pay for) health care services or the use of a medical product, regardless of the theory of liability on which the claim is based or the number of plaintiffs, defendants, or causes of action.

(11) HEALTH CARE LIABILITY CLAIM.—The term ''health care liability claim'' means a claim in which the claimant alleges that injury was caused by the provision of (or the failure to provide) health care services.

(12) HEALTH CARE PROVIDER.—The term ''health care provider'' means any person that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(13) HEALTH CARE SERVICE.—The term ''health care service'' means any service for which payment may be made under a health benefit plan including services related to the delivery or administration of such service.

(14) MEDICAL DEVICE.—The term ''medical device'' has the meaning given such term in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)).

(15) NONECONOMIC DAMAGES.—The term ''noneconomic damages'' means damages paid to an individual for pain and suffering, inconvenience, emotional distress, mental anguish, loss of consortium, injury to reputation, humiliation, and other nonpecuniary losses.

(16) PERSON.—The term ''person'' means any individual, corporation, company, association, firm, partnership, society, joint stock company, or any other entity, including any governmental entity.

(17) PRODUCT SELLER.—

(A) IN GENERAL.—Subject to subparagraph (B), the term ''product seller'' means a person who, in the course of a business conducted for that purpose—

(i) sells, distributes, rents, leases, prepares, blends, packages, labels, or is otherwise involved in placing, a product in the stream of commerce, or

(ii) installs, repairs, or maintains the harm-causing aspect of a product.

(B) EXCLUSION.—Such term does not include—

(i) a seller or lessor of real property;

(ii) a provider of professional services in any case in which the sale or use of a product is incidental to the transaction and the essence of the transaction is the furnishing of judgment, skill, or services; or

(iii) any person who—

(I) acts in only a financial capacity with respect to the sale of a product; or

(II) leases a product under a lease arrangement in which the selection, possession, maintenance, and operation of the product are controlled by a person other than the lessor.

(18) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded against any person not to compensate for actual injury suffered, but to punish or deter such person or others from engaging in similar behavior in the future.

(19) STATE.—The term ''State'' means each of the several States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa,

the Northern Mariana Islands, and any other territory or possession of the United States.

SEC. 15303. EFFECTIVE DATE.

This subtitle will apply to any health care liability action brought in a Federal or State court and to any health care liability claim subject to an alternative dispute resolution system, that is initiated on or after the date of enactment of this subtitle, except that any health care liability claim or action arising from an injury occurring prior to the date of enactment of this subtitle shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

PART 2—UNIFORM STANDARDS FOR HEALTH CARE LIABILITY ACTIONS

SEC. 15311. STATUTE OF LIMITATIONS.

A health care liability action may not be brought after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject of the action was discovered or should reasonably have been discovered, but in no case after the expiration of the 5-year period that begins on the date the alleged injury occurred.

SEC. 15312. CALCULATION AND PAYMENT OF DAMAGES.

(a) TREATMENT OF NONECONOMIC DAMAGES.—

(1) LIMITATION ON NONECONOMIC DAMAGES.—The total amount of noneconomic damages that may be awarded to a claimant for losses resulting from the injury which is the subject of a health care liability action may not exceed $250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury.

(2) JOINT AND SEVERAL LIABILITY.—In any health care liability action brought in State or Federal court, a defendant shall be liable only for the amount of noneconomic damages attributable to such defendant in direct proportion to such defendant's share of fault or responsibility for the claimant's actual damages, as determined by the trier of fact. In all such cases, the liability of a defendant for noneconomic damages shall be several and not joint.

(b) TREATMENT OF PUNITIVE DAMAGES.—

(1) GENERAL RULE.—Punitive damages may, to the extent permitted by applicable State law, be awarded in any health care liability action for harm in any Federal or State court against a defendant if the claimant establishes by clear and convincing evi-

dence that the harm suffered was the result of conduct—

(A) specifically intended to cause harm, or

(B) conduct manifesting a conscious, flagrant indifference to the rights or safety of others.

(2) PROPORTIONAL AWARDS.—The amount of punitive damages that may be awarded in any health care liability action subject to this subtitle shall not exceed 3 times the amount of damages awarded to the claimant for economic loss, or $250,000, whichever is greater. This paragraph shall be applied by the court and shall not be disclosed to the jury.

(3) APPLICABILITY.—This subsection shall apply to any health care liability action brought in any Federal or State court on any theory where punitive damages are sought. This subsection does not create a cause of action for punitive damages. This subsection does not preempt or supersede any State or Federal law to the extent that such law would further limit the award of punitive damages.

(4) BIFURCATION.—At the request of any party, the trier of fact shall consider in a separate proceeding whether punitive damages are to be awarded and the amount of such award. If a sepa-

rate proceeding is requested, evidence relevant only to the claim of punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether actual damages are to be awarded.

(5) DRUGS AND DEVICES.—

(A) IN GENERAL.—(i) Punitive damages shall not be awarded against a manufacturer or product seller of a drug or medical device which caused the claimant's harm where—

(I) such drug or device was subject to premarket approval by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such drug or device which caused the claimant's harm, or the adequacy of the packaging or labeling of such drug or device which caused the harm, and such drug, device, packaging, or labeling was approved by the Food and Drug Administration; or

(II) the drug is generally recognized as safe and effective pursuant to conditions established by the Food and Drug Admin-

istration and applicable regulations, including packaging and labeling regulations.

(ii) Clause (i) shall not apply in any case in which the defendant, before or after premarket approval of a drug or device—

(I) intentionally and wrongfully withheld from or misrepresented to the Food and Drug Administration information concerning such drug or device required to be submitted under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and relevant to the harm suffered by the claimant, or

(II) made an illegal payment to an official or employee of the Food and Drug Administration for the purpose of securing or maintaining approval of such drug or device.

(B) PACKAGING.—In a health care liability action for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of

Health and Human Services (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the court by clear and convincing evidence to be substantially out of compliance with such regulations.

(c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

(1) GENERAL RULE.—In any health care liability action in which the damages awarded for future economic and noneconomic loss exceeds $50,000, a person shall not be required to pay such damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based on when the damages are found likely to occur, as such payments are determined by the court.

(2) FINALITY OF JUDGMENT.—The judgment of the court awarding periodic payments under this subsection may not, in the absence of fraud, be reopened at any time to contest, amend, or modify the schedule or amount of the payments.

(3) LUMP-SUM SETTLEMENTS.—This subsection shall not be construed to preclude a settlement providing for a single, lump-sum payment.

(d) TREATMENT OF COLLATERAL SOURCE PAYMENTS.—

(1) INTRODUCTION INTO EVIDENCE.—In any health care liability action, any defendant may introduce evidence of collateral source payments. If any defendant elects to introduce such evidence, the claimant may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the claimant to secure the right to such collateral source payments.

(2) NO SUBROGATION.—No provider of collateral source payments shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated the right of the claimant in a health care liability action.

(3) APPLICATION TO SETTLEMENTS.—This subsection shall apply to an action that is settled as well as an action that is resolved by a fact finder.

SEC. 15313. ALTERNATIVE DISPUTE RESOLUTION.

Any ADR used to resolve a health care liability action or claim shall contain provisions relating to statute of limitations, non-economic damages, joint and several liability, punitive damages, collateral source rule, and periodic pay-

ments which are identical to the provisions relating to such matters in this subtitle.

Subtitle E—Teaching Hospitals and Graduate Medical Education

PART 1—TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND

SEC. 15401. ESTABLISHMENT OF FUND; PAYMENTS TO TEACHING HOSPITALS.

The Social Security Act (42 U.S.C. 300 et seq.) is amended by adding after title XXI the following title:

''TITLE XXII—TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND

''PART A—ESTABLISHMENT OF FUND

''SEC. 2201. ESTABLISHMENT OF FUND.

''(a) IN GENERAL.—There is established in the Treasury of the United States a fund to be known as the Teaching Hospital and Graduate Medical Education Trust Fund (in this title referred to as the 'Fund'), consisting of amounts appropriated to the Fund in subsection (d) and subsection (e)(3), amounts transferred to the Fund under section 1886(j), and such gifts and bequests as may be deposited in the Fund pursuant to subsection (f). Amounts in the Fund are available until expended.

''(b) EXPENDITURES FROM FUND.—Amounts in the Fund are available to the Secretary for making payments under section 2211.

''(c) ACCOUNTS IN FUND.—There are established within the Fund the following accounts:

''(1) The Indirect-Costs Medical Education Account.

''(2) The Medicare Direct-Costs Medical Education Account.

''(3) The General Direct-Costs Medical Education Account.

''(d) GENERAL TRANSFERS TO FUND.—

''(1) IN GENERAL.—For fiscal year 1997 and each subsequent fiscal year, there are appropriated to the Fund (effective on the applicable date under paragraph (2)), out of any money in the Treasury not otherwise appropriated, the following amounts (as applicable to the fiscal year involved):

''(A) For fiscal year 1997, $1,300,000,000.

''(B) For fiscal year 1998, $1,500,000,000.

''(C) For fiscal year 1999, $2,300,000,000.

''(D) For fiscal year 2000, $3,100,000,000.

''(E) For fiscal year 2001, $3,600,000,000.

''(F) For fiscal year 2002, $4,000,000,000.

''(G) For fiscal year 2003 and each subsequent fiscal year, the greater of the amount appropriated for the preceding fiscal year or an amount equal to the product of—

''(i) the amount appropriated for the preceding fiscal year; and

''(ii) 1 plus the percentage increase in the nominal gross domestic product for the one-year period ending upon July 1 of such preceding fiscal year.

''(2) EFFECTIVE DATE FOR ANNUAL APPROPRIATION.—For purposes of paragraph (1) (and for purposes of section 2221(a)(1), and subsections (b)(1)(A) and (c)(1)(A) of section 2231)), the applicable date for a fiscal year is the first day of the fiscal year, exclusive of Saturdays, Sundays, and Federal holidays.

''(3) ALLOCATION AMONG CERTAIN ACCOUNTS.—Of the amount appropriated in paragraph (1) for a fiscal year—

''(A) there shall be allocated to the Indirect-Costs Medical Education Account the percentage determined under paragraph (4)(B); and

''(B) there shall be allocated to the General Direct-Costs Medical Education Account the percentage determined under paragraph (4)(C).

''(4) DETERMINATION OF PERCENTAGES.—The Secretary of Health and Human Services, acting through the Administrator of the Health Care Financing Administration, shall determine the following:

''(A) The total amount of payments that were made under subsections (d)(5)(B) and (h) of section 1886 for fiscal year 1994.

''(B) The percentage of such total that was constituted by payments under subsection (d)(5)(B) of such section.

''(C) The percentage of such total that was constituted by payments under subsection (h) of such section.

''(e) INVESTMENT.—

''(1) IN GENERAL.—The Secretary of the Treasury shall invest such amounts of the Fund as

such Secretary determines are not required to meet current withdrawals from the Fund. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

''(2) SALE OF OBLIGATIONS.—Any obligation acquired by the Fund may be sold by the Secretary of the Treasury at the market price.

''(3) AVAILABILITY OF INCOME.—Any interest derived from obligations acquired by the Fund, and proceeds from any sale or redemption of such obligations, are hereby appropriated to the Fund.

''(f) ACCEPTANCE OF GIFTS AND BEQUESTS.—The Fund may accept on behalf of the United States money gifts and bequests made unconditionally to the Fund for the benefit of the Fund or any activity financed through the Fund.

''PART B—PAYMENTS TO TEACHING HOSPITALS

''Subpart 1—Requirement of Payments

''SEC. 2211. FORMULA PAYMENTS TO TEACHING HOSPITALS.

''(a) IN GENERAL.—Subject to subsection (d), in the case of each teaching hospital that in accordance with sub-

section (b) submits to the Secretary a payment document for fiscal year 1997 or any subsequent fiscal year, the Secretary shall make payments for the year to the teaching hospital for the costs of operating approved medical residency training programs. Such payments shall be made from the Fund, and the total of the payments to the hospital for the fiscal year shall equal the sum of the following:

''(1) An amount determined under section 2221 (relating to the indirect costs of graduate medical education).

''(2) An amount determined under section 2231 (relating to the direct costs of graduate medical education).

''(b) PAYMENT DOCUMENT.—For purposes of subsection (a), a payment document is a document containing such information as may be necessary for the Secretary to make payments under such subsection to a teaching hospital for a fiscal year. The document is submitted in accordance with this subsection if the document is submitted not later than the date specified by the Secretary, and the document is in such form and is made in such manner as the Secretary may require. The Secretary may require that information under this subsection be submitted to the Secretary in periodic reports.

''(c) ADMINISTRATOR OF PROGRAMS.—This part, and the subsequent parts of this title, shall be carried out by the Secretary acting through the Administrator of the Health Care Financing Administration.

''(d) SPECIAL RULES.—

''(1) AUTHORITY REGARDING PAYMENTS TO CONSORTIA OF PROVIDERS.—In the case of payments under subsection (a) that are determined under section 2231:

''(A) The requirement under such subsection to make the payments to teaching hospitals is subject to the authority of the Secretary under section 2233(a) to make payments to qualifying consortia.

''(B) If the Secretary authorizes such a consortium for purposes of section 2233(a), subsections (a) and (b) of this section apply to the consortium to the same extent and in the same manner as the subsections apply to teaching hospitals.

''(2) CERTAIN HOSPITALS.—Paragraph (1) of subsection (a) is subject to sections 2222 and 2223 of subpart 2. Paragraph (2) of subsection (a) is subject to sections 2232 through 2234 of subpart 3.

''(e) APPROVED MEDICAL RESIDENCY TRAINING PROGRAM.—For purposes of this title, the term 'approved medical residency training program' has the meaning given such term in section 1886(h)(5)(A).

''Subpart 2—Amount Relating to Indirect Costs of Graduate Medical Education

"SEC. 2221. DETERMINATION OF AMOUNT RELATING TO INDIRECT COSTS.

''(a) IN GENERAL.—For purposes of section 2211(a)(1), the amount determined under this section for a teaching hospital for a fiscal year is the product of—

''(1) the amount in the Indirect-Costs Medical Education Account on the applicable date under section 2201(d) (once the appropriation under such section is made); and

''(2) the percentage determined for the hospital under subsection (b).

''(b) HOSPITAL-SPECIFIC PERCENTAGE.—

''(1) IN GENERAL.—For purposes of subsection (a)(2), the percentage determined under this subsection for a teaching hospital is the mean average of the respective percentages determined under paragraph (3) for each fiscal year of the applicable period (as defined in paragraph (2)), adjusted by the Secretary (upward or downward, as the case may

be) on a pro rata basis to the extent necessary to ensure that the sum of the percentages determined under this paragraph for all teaching hospitals is equal to 100 percent. The preceding sentence is subject to sections 2222 and 2223.

''(2) APPLICABLE PERIOD REGARDING RELEVANT DATA; FISCAL YEARS 1992 THROUGH 1994.—For purposes of this part, the term 'applicable period' means the period beginning on the first day of fiscal year 1992 and continuing through the end of fiscal year 1994.

''(3) RESPECTIVE DETERMINATIONS FOR FISCAL YEARS OF APPLICABLE PERIOD.—For purposes of paragraph (1), the percentage determined under this paragraph for a teaching hospital for a fiscal year of the applicable period is the percentage constituted by the ratio of—

''(A) the total amount of payments received by the hospital under section 1886(d)(5)(B) for discharges occurring during the fiscal year involved; to

''(B) the sum of the respective amounts determined under subparagraph (A) for the fiscal year for all teaching hospitals.

''(c) AVAILABILITY OF DATA.—If a teaching hospital received the payments specified in subsection (b)(3)(A) during the applicable period but a complete set of the relevant data is not available to the Secretary for purposes of determining an amount under such subsection for the fiscal year involved, the Secretary shall for purposes of such subsection make an estimate on the basis of such data as are available to the Secretary for the applicable period.

"SEC. 2222. INDIRECT COSTS; SPECIAL RULES REGARDING DETERMINATION OF HOSPITAL-SPECIFIC PERCENTAGE.

''(a) SPECIAL RULE REGARDING FISCAL YEARS 1995 AND 1996.—

''(1) IN GENERAL.—In the case of a teaching hospital whose first payments under section 1886(d)(5)(B) were for discharges occurring in fiscal year 1995 or in fiscal year 1996 (referred to in this subsection individually as a 'first payment year'), the percentage determined under paragraph (2) for the hospital is deemed to be the percentage applicable under section 2221(b) to the hospital, except that the percentage under paragraph (2) shall be adjusted in accordance with section 2221(b)(1) to the extent determined by the Secretary to be nec-

essary with respect to a sum that equals 100 percent.

''(2) DETERMINATION OF PERCENTAGE.—For purposes of paragraph (1), the percentage determined under this paragraph for a teaching hospital is the percentage constituted by the ratio of the amount determined under subparagraph (A) to the amount determined under subparagraph (B), as follows:

''(A)(i) If the first payment year for the hospital is fiscal year 1995, the amount determined under this subparagraph is the total amount of payments received by the hospital under section 1886(d)(5)(B) for discharges occurring during fiscal year 1995.

''(ii) If the first payment year for the hospital is fiscal year 1996, the amount determined under this subparagraph is an amount equal to an estimate by the Secretary of the total amount of payments that would have been paid to the hospital under section 1886(d)(5)(B) for discharges occurring during fiscal year 1995 if such section, as in effect for fiscal year 1996, had applied to the hospital for discharges occurring during fiscal year 1995.

''(B)(i) If the first payment year for the hospital is fiscal year 1995, the amount determined under this subparagraph is the aggregate total of the payments received by teaching hospitals under section 1886(d)(5)(B) for discharges occurring during fiscal year 1995.

''(ii) If the first payment year for the hospital is fiscal year 1996—

''(I) the Secretary shall make an estimate in accordance with subparagraph (A)(ii) for all teaching hospitals; and

''(II) the amount determined under this subparagraph is the sum of the estimates made by the Secretary under subclause (I).

''(b) NEW TEACHING HOSPITALS.—

''(1) IN GENERAL.—Subject to paragraph (4), in the case of a teaching hospital that did not receive payments under section 1886(d)(5)(B) for any of the fiscal years 1992 through 1996, the percentage determined under paragraph (3) for the hospital is deemed to be the percentage applicable under section 2221(b) to the hospital, except that the percentage under paragraph (3) shall be adjusted in accordance with section 2221(b)(1) to the extent deter-

mined by the Secretary to be necessary with respect to a sum that equals 100 percent.

''(2) DESIGNATED FISCAL YEAR REGARDING DATA.—The determination under paragraph (3) of a percentage for a teaching hospital described in paragraph (1) shall be made for the most recent fiscal year for which the Secretary has sufficient data to make the determination (referred to in this subsection as the 'designated fiscal year').

''(3) DETERMINATION OF PERCENTAGE.—For purposes of paragraph (1), the percentage determined under this paragraph for the teaching hospital involved is the percentage constituted by the ratio of the amount determined under subparagraph (A) to the amount determined under subparagraph (B), as follows:

''(A) The amount determined under this subparagraph is an amount equal to an estimate by the Secretary of the total amount of payments that would have been paid to the hospital under section 1886(d)(5)(B) for the designated fiscal year if such section, as in effect for the first fiscal year for which payments pursuant to this subsection are to be made to the

hospital, had applied to the hospital for the designated fiscal year.

''(B) The Secretary shall make an estimate in accordance with subparagraph (A) for all teaching hospitals. The amount determined under this subparagraph is the sum of the estimates made by the Secretary under the preceding sentence.

''(4) LIMITATION.—This subsection does not apply to a teaching hospital described in paragraph (1) if the hospital is in a State for which a demonstration project under section 1814(b)(3) is in effect.

''(c) CONSOLIDATIONS AND MERGERS.—In the case of two or more teaching hospitals that have each received payments pursuant to section 2221 for one or more fiscal years and that undergo a consolidation or merger, the percentage applicable to the resulting teaching hospital for purposes of section 2221(b) is the sum of the respective percentages that would have applied pursuant to such section if the hospitals had not undergone the consolidation or merger.

"SEC. 2223. INDIRECT COSTS; ALTERNATIVE PAYMENTS REGARDING TEACHING HOSPITALS IN CERTAIN STATES.

''(a) IN GENERAL.—In the case of a teaching hospital in a State for which a demonstration project under section 1814(b)(3) is in effect, this section applies in lieu of section 2221. For purposes of section 2211(a)(1), the amount determined for such a teaching hospital for a fiscal year is the product of—

''(1) the amount in the Indirect-Costs Medical Education Account for the fiscal year pursuant to the allocation under section 2201(d)(3)(A) for the year; and

''(2) the percentage determined under subsection (b) for the hospital.

''(b) DETERMINATION OF PERCENTAGE.—For purposes of subsection (a)(2):

''(1) The Secretary shall make an estimate of the total amount of payments that would have been received under section 1886(d)(5)(B) by the hospital involved with respect to each of the fiscal years of the applicable period if such section (as in effect for such fiscal years) had applied to the hospital for such years.

''(2) The percentage determined under this subsection for the hospital for a fiscal year is a mean

average percentage determined for the hospital in accordance with the methodology of section 2221(b)(1), except that the estimate made by the Secretary under paragraph (1) of this subsection for a fiscal year of the applicable period is deemed to be the amount that applies for purposes of section 2221(b)(3)(A) for such year.

''(c) RULE REGARDING PAYMENTS FROM CERTAIN AMOUNTS.—In the case of a teaching hospital described in subsection (a), this section does not authorize any payment to the hospital from amounts transferred to the Fund under section 1886(j).

''(d) ADJUSTMENT REGARDING PAYMENTS TO OTHER HOSPITALS.—In the case of a fiscal year for which payments pursuant to subsection (a) are made to one or more teaching hospitals, the following applies:

''(1) The Secretary shall determine a percentage equal to the sum of the respective percentages determined for the hospitals under subsection (b).

''(2) The Secretary shall determine an amount equal to the product of—

''(A) the percentage determined under paragraph (1); and

''(B) the amount in the Indirect-Costs Medical Education Account for the fiscal year

pursuant to the transfer under section 1886(j)(1).

''(3) The Secretary shall, for each hospital (other than hospitals described in subsection (a)), make payments to the hospital in amounts whose sum for the fiscal year is equal to the product of—

''(A) the amount determined under paragraph (2); and

''(B) the percentage that applies to the hospital for purposes of section 2221(b), except that such percentage shall be adjusted in accordance with the methodology of section 2221(b)(1) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent.

''Subpart 3—Amount Relating to Direct Costs of Graduate Medical Education

''SEC. 2231. DETERMINATION OF AMOUNT RELATING TO DIRECT COSTS.

''(a) IN GENERAL.—For purposes of section 2211(a)(2), the amount determined under this section for a teaching hospital for a fiscal year is the sum of—

''(1) the amount determined under subsection (b) (relating to the General Direct-Costs Medical Education Account); and

''(2) the amount determined under subsection (c) (relating to the Medicare Direct-Costs Medical Education Account).

''(b) PAYMENT FROM GENERAL ACCOUNT.—

''(1) IN GENERAL.—For purposes of subsection (a)(1), the amount determined under this subsection for a teaching hospital for a fiscal year is the product of—

''(A) the amount in the General Direct-Costs Medical Education Account on the applicable date under section 2201(d) (once the appropriation under such section is made); and

''(B) the percentage determined for the hospital under paragraph (2).

''(2) HOSPITAL-SPECIFIC PERCENTAGE.—

''(A) IN GENERAL.—For purposes of paragraph (1)(B), the percentage determined under this paragraph for a teaching hospital is the mean average of the respective percentages determined under subparagraph (B) for each fiscal year of the applicable period (as defined in section 2221(b)(2)), adjusted by the Secretary (upward or downward, as the case may be) on a pro rata basis to the extent necessary to ensure that the sum of the percentages deter-

mined under this subparagraph for all teaching hospitals is equal to 100 percent. The preceding sentence is subject to sections 2232 through 2234.

''(B) RESPECTIVE DETERMINATIONS FOR FISCAL YEARS OF APPLICABLE PERIOD.—For purposes of subparagraph (A), the percentage determined under this subparagraph for a teaching hospital for a fiscal year of the applicable period is the percentage constituted by the ratio of—

''(i) the total amount of payments received by the hospital under section 1886(h) for cost reporting periods beginning during the fiscal year involved; to

''(ii) the sum of the respective amounts determined under clause (i) for the fiscal year for all teaching hospitals.

''(3) AVAILABILITY OF DATA.—If a teaching hospital received the payments specified in paragraph (2)(B)(i) during the applicable period but a complete set of the relevant data is not available to the Secretary for purposes of determining an amount under such paragraph for the fiscal year involved, the Secretary shall for purposes of such

paragraph make an estimate on the basis of such data as are available to the Secretary for the applicable period.

''(c) PAYMENT FROM MEDICARE ACCOUNT.—

''(1) IN GENERAL.—For purposes of subsection (a)(2), the amount determined under this subsection for a teaching hospital for a fiscal year is the product of—

''(A) the amount in the Medicare Direct-Costs Medical Education Account on the applicable date under section 2201(d) (once the appropriation under such section is made); and

''(B) the percentage determined for the hospital under paragraph (2) for the fiscal year.

''(2) HOSPITAL-SPECIFIC PERCENTAGE.—For purposes of paragraph (1)(B), the percentage determined under this subsection for a teaching hospital for a fiscal year is the percentage constituted by the ratio of—

''(A) the estimate made by the Secretary for the hospital for the fiscal year under section 1886(j)(2)(B); to

''(B) the sum of the respective estimates referred to in subparagraph (A) for all teaching hospitals.

"SEC. 2232. DIRECT COSTS; SPECIAL RULES REGARDING DETERMINATION OF HOSPITAL-SPECIFIC PERCENTAGE.

''(a) SPECIAL RULE REGARDING FISCAL YEARS 1995 AND 1996.—

''(1) IN GENERAL.—In the case of a teaching hospital whose first payments under section 1886(h) were for the cost reporting period beginning in fiscal year 1995 or in fiscal year 1996 (referred to in this subsection individually as a 'first payment year'), the percentage determined under paragraph (2) for the hospital is deemed to be the percentage applicable under section 2231(b)(2) to the hospital, except that the percentage under paragraph (2) shall be adjusted in accordance with section 2231(b)(2)(A) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent.

''(2) DETERMINATION OF PERCENTAGE.—For purposes of paragraph (1), the percentage determined under this paragraph for a teaching hospital is the percentage constituted by the ratio of the amount determined under subparagraph (A) to the amount determined under subparagraph (B), as follows:

''(A)(i) If the first payment year for the hospital is fiscal year 1995, the amount determined under this subparagraph is the total amount of payments received by the hospital under section 1886(h) for cost reporting periods beginning in fiscal year 1995.

''(ii) If the first payment year for the hospital is fiscal year 1996, the amount determined under this subparagraph is an amount equal to an estimate by the Secretary of the total amount of payments that would have been paid to the hospital under section 1886(h) for cost reporting periods beginning in fiscal year 1995 if such section, as in effect for fiscal year 1996, had applied to the hospital for fiscal year 1995.

''(B)(i) If the first payment year for the hospital is fiscal year 1995, the amount determined under this subparagraph is the aggregate total of the payments received by teaching hospitals under section 1886(h) for cost reporting periods beginning in fiscal year 1995.

''(ii) If the first payment year for the hospital is fiscal year 1996—

''(I) the Secretary shall make an estimate in accordance with subparagraph (A)(ii) for all teaching hospitals; and

''(II) the amount determined under this subparagraph is the sum of the estimates made by the Secretary under subclause (I).

''(b) NEW TEACHING HOSPITALS.—

''(1) IN GENERAL.—Subject to paragraph (4), in the case of a teaching hospital that did not receive payments under section 1886(h) for any of the fiscal years 1992 through 1996, the percentage determined under paragraph (3) for the hospital is deemed to be the percentage applicable under section 2231(b)(2) to the hospital, except that the percentage under paragraph (3) shall be adjusted in accordance with section 2231(b)(2)(A) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent.

''(2) DESIGNATED FISCAL YEAR REGARDING DATA.—The determination under paragraph (3) of a percentage for a teaching hospital described in paragraph (1) shall be made for the most recent fiscal year for which the Secretary has sufficient data to

make the determination (referred to in this subsection as the 'designated fiscal year').

''(3) DETERMINATION OF PERCENTAGE.—For purposes of paragraph (1), the percentage determined under this paragraph for the teaching hospital involved is the percentage constituted by the ratio of the amount determined under subparagraph (A) to the amount determined under subparagraph (B), as follows:

''(A) The amount determined under this subparagraph is an amount equal to an estimate by the Secretary of the total amount of payments that would have been paid to the hospital under section 1886(h) for the designated fiscal year if such section, as in effect for the first fiscal year for which payments pursuant to this subsection are to be made to the hospital, had applied to the hospital for cost reporting periods beginning in the designated fiscal year.

''(B) The Secretary shall make an estimate in accordance with subparagraph (A) for all teaching hospitals. The amount determined under this subparagraph is the sum of the estimates made by the Secretary under the preceding sentence.

''(4) LIMITATION.—This subsection does not apply to a teaching hospital described in paragraph (1) if the hospital is in a State for which a demonstration project under section 1814(b)(3) is in effect.

''(c) CONSOLIDATIONS AND MERGERS.—In the case of two or more teaching hospitals that have each received payments pursuant to section 2231 for one or more fiscal years and that undergo a consolidation or merger, the percentage applicable to the resulting teaching hospital for purposes of section 2231(b) is the sum of the respective percentages that would have applied pursuant to such section if the hospitals had not undergone the consolidation or merger.

"SEC. 2233. DIRECT COSTS; AUTHORITY FOR PAYMENTS TO CONSORTIA OF PROVIDERS.

''(a) IN GENERAL.—In lieu of making payments to teaching hospitals pursuant to section 2231, the Secretary may make payments under this section to consortia that meet the requirements of subsection (b).

''(b) QUALIFYING CONSORTIUM.—For purposes of subsection (a), a consortium meets the requirements of this subsection if the consortium is in compliance with the following:

''(1) The consortium consists of an approved medical residency training program and one or more of the following entities:

''(A) Schools of allopathic medicine or osteopathic medicine.

''(B) Teaching hospitals.

''(C) Other approved medical residency training programs.

''(D) Federally qualified health centers.

''(E) Medical group practices.

''(F) Managed care entities.

''(G) Entities furnishing outpatient services.

''(H) Such other entities 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) PAYMENTS FROM ACCOUNTS.—

''(1) IN GENERAL.—Subject to subsection (d), the total of payments to a qualifying consortium for a fiscal year pursuant to subsection (a) shall be the sum of—

''(1) the aggregate amount determined for the teaching hospitals of the consortium pursuant to paragraph (1) of section 2231(a); and

''(2) an amount determined in accordance with the methodology that applies pursuant to paragraph (2) of such section, except that the estimate used for purposes of subsection (c)(2)(A) of such section shall be the estimate made for the consortium under section 1886(j)(2)(C)(ii).

''(d) LIMITATION ON AGGREGATE TOTAL OF PAYMENTS TO CONSORTIA.—The aggregate total of the amounts paid under subsection (c)(2) to qualifying consortia for a fiscal year may not exceed the sum of—

''(1) the aggregate total of the amounts that would have been paid under section 2231(c) for the fiscal year to the teaching hospitals of the consortia if the hospitals had not been participants in the consortia; and

''(2) an amount equal to 1 percent of the amount that applies under section 2231(c)(1)(A) for

the fiscal year (relating to the Medicare Direct-Costs Medical Education Account).

''(e) DEFINITION.—For purposes of this title, the term 'qualifying consortium' means a consortium that meets the requirements of subsection (b).

"SEC. 2234. DIRECT COSTS; ALTERNATIVE PAYMENTS REGARDING TEACHING HOSPITALS IN CERTAIN STATES.

''(a) IN GENERAL.—In the case of a teaching hospital in a State for which a demonstration project under section 1814(b)(3) is in effect, this section applies in lieu of section 2231. For purposes of section 2211(a)(2), the amount determined for a teaching hospital for a fiscal year is the product of—

''(1) the amount in the General Direct-Costs Medical Education Account on the applicable date under section 2201(d) (once the appropriation under such section is made); and

''(2) the percentage determined under subsection (b) for the hospital.

''(b) DETERMINATION OF PERCENTAGE.—For purposes of subsection (a)(2):

''(1) The Secretary shall make an estimate of the total amount of payments that would have been received under section 1886(h) by the hospital in-

volved with respect to each of the fiscal years of the applicable period if such section (as in effect for such fiscal years) had applied to the hospital for such years.

''(2) The percentage determined under this subsection for the hospital for a fiscal year is a mean average percentage determined for the hospital in accordance with the methodology of section 2231(b)(2)(A), except that the estimate made by the Secretary under paragraph (1) of this subsection for a fiscal year of the applicable period is deemed to be the amount that applies for purposes of section 2231(b)(2)(B)(i) for such year.

''(c) RULE REGARDING PAYMENTS FROM CERTAIN AMOUNTS.—In the case of a teaching hospital described in subsection (a), this section does not authorize any payment to the hospital from amounts transferred to the Fund under section 1886(j).

''Subpart 4—General Provisions

"SEC. 2241. ADJUSTMENTS IN PAYMENT AMOUNTS.

''(a) COLLECTION OF DATA ON ACCURACY OF ESTIMATES.—The Secretary shall collect data on whether the estimates made by the Secretary under section 1886(j) for a fiscal year were substantially accurate.

''(b) ADJUSTMENTS.—If the Secretary determines under subsection (a) that an estimate for a fiscal year was not substantially accurate, the Secretary shall, for the first fiscal year beginning after the Secretary makes the determination—

''(1) make adjustments accordingly in transfers to the Fund under section 1886(j); and

''(2) make adjustments accordingly in the amount of payments to teaching hospitals pursuant to 2231(c) (or, as applicable, to qualifying consortia pursuant to section 2233(c)(2)).''.

PART 2—AMENDMENTS TO MEDICARE PROGRAM

SEC. 15411. TRANSFERS TO TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND.

Section 1886 (42 U.S.C. 1395ww) is amended—

(1) in subsection (d)(5)(B), in the matter preceding clause (i), by striking ''The Secretary shall provide'' and inserting the following: ''For discharges occurring on or before September 30, 1996, the Secretary shall provide'';

(2) in subsection (h)—

(A) in paragraph (1), in the first sentence, by striking ''the Secretary shall provide'' and

inserting ''the Secretary shall, subject to paragraph (6), provide''; and

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

''(6) LIMITATION.—

''(A) IN GENERAL.—The authority to make payments under this subsection applies only with respect to cost reporting periods ending on or before September 30, 1996, except as provided in subparagraph (B).

''(B) RULE REGARDING PORTION OF LAST COST REPORTING PERIOD.—In the case of a cost reporting period that extends beyond September 30, 1996, payments under this subsection shall be made with respect to such portion of the period as has lapsed as of such date.

''(C) RULE OF CONSTRUCTION.—This paragraph may not be construed as authorizing any payment under section 1861(v) with respect to graduate medical education.''; and

(3) by adding at the end the following subsection:

''(j) TRANSFERS TO TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND.—

''(1) INDIRECT COSTS OF MEDICAL EDUCATION.—

''(A) IN GENERAL.—From the Federal Hospital Insurance Trust Fund, the Secretary shall, for fiscal year 1997 and each subsequent fiscal year, transfer to the Indirect-Costs Medical Education Account (under section 2201) an amount determined by the Secretary in accordance with subparagraph (B).

''(B) DETERMINATION OF AMOUNTS.—The Secretary shall make an estimate for the fiscal year involved of the nationwide total of the amounts that would have been paid under subsection (d)(5)(B) to hospitals during the fiscal year if such payments had not been terminated for discharges occurring after September 30, 1996. For purposes of subparagraph (A), the amount determined under this subparagraph for the fiscal year is the estimate made by the Secretary under the preceding sentence.

''(2) DIRECT COSTS OF MEDICAL EDUCATION.—

''(A) IN GENERAL.—From the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, the Secretary shall, for fiscal year 1997

and each subsequent fiscal year, transfer to the Medicare Direct-Costs Medical Education Account (under section 2201) the sum of—

''(i) an amount determined by the Secretary in accordance with subparagraph (B); and

''(ii) as applicable, an amount determined by the Secretary in accordance with subparagraph (C)(ii).

''(B) DETERMINATION OF AMOUNTS.—For each hospital (other than a hospital that is a member of a qualifying consortium referred to in subparagraph (C)), the Secretary shall make an estimate for the fiscal year involved of the amount that would have been paid under subsection (h) to the hospital during the fiscal year if such payments had not been terminated for cost reporting periods ending on or before September 30, 1996. For purposes of subparagraph (A)(i), the amount determined under this subparagraph for the fiscal year is the sum of all estimates made by the Secretary under the preceding sentence.

''(C) ESTIMATES REGARDING QUALIFYING CONSORTIA.—If the Secretary elects to author-

ize one or more qualifying consortia for purposes of section 2233(a), the Secretary shall carry out the following:

''(i) The Secretary shall establish a methodology for making payments to qualifying consortia with respect to the reasonable direct costs of such consortia in carrying out programs of graduate medical education. The methodology shall be the methodology established in subsection (h), modified to the extent necessary to take into account the participation in such programs of entities other than hospitals.

''(ii) For each qualifying consortium, the Secretary shall make an estimate for the fiscal year involved of the amount that would have been paid to the consortium during the fiscal year if, using the methodology under clause (i), payments had been made to the consortium for the fiscal year as reimbursements with respect to cost reporting periods. For purposes of subparagraph (A)(ii), the amount determined under this clause for the fiscal year

is the sum of all estimates made by the Secretary under the preceding sentence.

''(D) ALLOCATION BETWEEN FUNDS.—In providing for a transfer under subparagraph (A) for a fiscal year, the Secretary shall provide for an allocation of the amounts involved between part A and part B (and the trust funds established under the respective parts) as reasonably reflects the proportion of direct graduate medical education costs of hospitals associated with the provision of services under each respective part.

''(3) APPLICABILITY OF CERTAIN AMENDMENTS.—Amendments made to subsection (d)(5)(B) and subsection (h) that are effective on or after October 1, 1996, apply only for purposes of estimates under paragraphs (1) and (2) and for purposes of determining the amount of payments under 2211. Such amendments do not require any adjustment to amounts paid under subsection (d)(5)(B) or (h) with respect to fiscal year 1996 or any prior fiscal year.

''(4) RELATIONSHIP TO CERTAIN DEMONSTRATION PROJECTS.—In the case of a State for which a demonstration project under section 1814(b)(3) is in effect, the Secretary, in making determinations of

the rates of increase under such section, shall include all amounts transferred under this subsection. Such amounts shall be so included to the same extent and in the same manner as amounts determined under subsections (d)(5)(B) and (h) were included in such determination under the provisions of this title in effect on September 30, 1996.''.

SEC. 15412. MODIFICATION IN PAYMENT POLICIES REGARDING GRADUATE MEDICAL EDUCATION.

(a) INDIRECT COSTS OF MEDICAL EDUCATION; APPLICABLE PERCENTAGE.—

(1) MODIFICATION REGARDING 5.6 PERCENT.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(A) by striking ''on or after October 1, 1988,'' and inserting ''on or after October 1, 1999,''; and

(B) by striking ''1.89'' and inserting ''1.38''.

(2) SPECIAL RULE REGARDING FISCAL YEARS 1996 THROUGH 1998; MODIFICATION REGARDING 6 PERCENT.—Section 1886(d)(5)(B)(ii), as amended by paragraph (1), is amended by adding at the end the following: ''In the case of discharges occurring on or after October 1, 1995, and before October 1,

1999, the preceding sentence applies to the same extent and in the same manner as the sentence applies to discharges occurring on or after October 1, 1999, except that the term '1.38' is deemed to be '1.48'.''.

(3) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNTS.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by striking ''1985'' and inserting the following: ''1985, but (for discharges occurring after September 30, 1995) not taking into account any reductions in such costs resulting from the amendments made by section 15412(a) of the Medicare Preservation Act of 1995''.

(b) DIRECT COSTS OF MEDICAL EDUCATION.—

(1) LIMITATION ON NUMBER OF FULL-TIME-EQUIVALENT RESIDENTS.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended by adding at the end the following new subparagraph:

''(F) LIMITATION ON NUMBER OF RESIDENTS FOR CERTAIN FISCAL YEARS.—

''(i) IN GENERAL.—Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1995, and on or before September 30,

2002, the number of full-time-equivalent residents determined under this paragraph with respect to an approved medical residency training program may not exceed the number of full-time-equivalent residents with respect to the program as of August 1, 1995 (except that this subparagraph applies only to approved medical residency training programs in the fields of allopathic medicine and osteopathic medicine).

''(ii) DISPOSITION OF UNUSED RESIDENCY POSITIONS.—In the case of a cost reporting period to which the limitation under clause (i) applies, if for such a period the number of full-time-equivalent residents determined under this paragraph with respect to an approved medical residency training program is less than the maximum number applicable to the program under such clause, the Secretary may authorize for one or more other approved medical residency training programs offsetting increases in the respective maximum numbers that otherwise would be applica-

ble under such clause to the programs. In authorizing such increases with respect to a cost reporting period, the Secretary shall ensure that the national total of the respective maximum numbers determined under such clause with respect to approved medical residency training programs is not exceeded.''.

(2) EXCLUSION OF RESIDENTS AFTER INITIAL RESIDENCY PERIOD.—Section 1886(h)(4)(C) (42 U.S.C. 1395ww(h)(4)(C)) is amended to read as follows:

''(C) WEIGHTING FACTORS FOR RESIDENTS.—Effective for cost reporting periods beginning on or after October 1, 1997, such rules shall provide that, in the calculation of the number of full-time-equivalent residents in an approved residency program, the weighting factor for a resident who is in the initial residency period (as defined in paragraph (5)(F)) is 1.0 and the weighting factor for a resident who has completed such period is 0.0. (In the case of cost reporting periods beginning before October 1, 1997, the weighting factors that apply in such calculation are the weighting factors that

were applicable under this subparagraph on the day before the date of the enactment of the Medicare Preservation Act of 1995.)''.

(3) REDUCTIONS IN PAYMENTS FOR ALIEN RESIDENTS.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)), as amended by paragraph (1), is amended by adding at the end the following new subparagraph:

''(G) SPECIAL RULES FOR ALIEN RESIDENTS.—In the case of individuals who are not citizens or nationals of the United States, aliens lawfully admitted to the United States for permanent residence, aliens admitted to the United States as refugees, or citizens of Canada, in the calculation of the number of full-time-equivalent residents in an approved medical residency program, the following rules shall apply with respect to such individuals who are residents in the program:

''(i) For a cost reporting period beginning during fiscal year 1996, for each such individual the Secretary shall apply a weighting factor of .75.

''(ii) For a cost reporting period beginning during fiscal year 1997, for each

such individual the Secretary shall apply a weighting factor of .50.

''(iii) For a cost reporting period beginning during fiscal year 1998 or any subsequent fiscal year, for each such individual the Secretary shall apply a weighting factor of .25.''.

(4) EFFECTIVE DATE.—Except as provided otherwise in this subsection (or in the amendments made by this subsection), the amendments made by this subsection apply to hospital cost reporting periods beginning on or after October 1, 1995.

PART 3—REFORM OF FEDERAL POLICIES REGARDING TEACHING HOSPITALS AND GRADUATE MEDICAL EDUCATION

SEC. 15421. ESTABLISHMENT OF ADVISORY PANEL FOR RECOMMENDING POLICIES.

Title XXII of the Social Security Act, as added by section 15401, is amended by adding at the end the following part:

''PART C—OTHER MATTERS

"SEC. 2251. ADVISORY PANEL ON REFORM IN FINANCING OF TEACHING HOSPITALS AND GRADUATE MEDICAL EDUCATION.

''(a) ESTABLISHMENT.—The Chair of the Medicare Payment Review Commission under section 1806 shall establish a temporary advisory panel to be known as the Advisory Panel on Financing for Teaching Hospitals and Graduate Medical Education (in this section referred to as the 'Panel').

''(b) DUTIES.—The Panel shall develop recommendations on whether and to what extent Federal policies regarding teaching hospitals and graduate medical education should be reformed, including recommendations regarding the following:

''(1) The financing of graduate medical education, including consideration of alternative broad-based sources of funding for such education.

''(2) The financing of teaching hospitals, including consideration of the difficulties encountered by such hospitals as competition among health care entities increases. Matters considered under this paragraph shall include consideration of the effects on teaching hospitals of the method of financing

used for the MedicarePlus program under part C of title XVIII.

''(3) The methodology for making payments for graduate medical education, and the selection of entities to receive the payments. Matters considered under this paragraph shall include the following:

''(A) The methodology under part B for making payments from the Fund, including the use of data from the fiscal years 1992 through 1994, and including the methodology that applies with respect to consolidations and mergers of participants in the program under such part and with respect to the inclusion of additional participants in the program.

''(B) Issues regarding children's hospitals, and approved medical residency training programs in pediatrics.

''(C) Whether and to what extent payments are being made (or should be made) for graduate training in the various nonphysician health professions.

''(4) Federal policies regarding international medical graduates.

''(5) The dependence of schools of medicine on service-generated income.

''(6) The effects of the amendments made by section 15412 of the Medicare Preservation Act of 1995, including adverse effects on teaching hospitals that result from modifications in policies regarding international medical graduates.

''(7) Whether and to what extent the needs of the United States regarding the supply of physicians will change during the 10-year period beginning on October 1, 1995, and whether and to what extent any such changes will have significant financial effects on teaching hospitals.

''(8) The appropriate number and mix of residents.

''(c) COMPOSITION.—Not later than three months after being designated as the initial chair of the Medicare Payment Review Commission, the Chair of the Commission shall appoint to the Panel 19 individuals who are not members of the Commission, who are not officers or employees of the United States, and who possess expertise on matters on which the Panel is to make recommendations under subsection (b). Such individuals shall include the following:

''(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 each of the fields of advanced practice nursing, physician assistants, and podiatric medicine.

''(5) Individuals with substantial experience in the study of issues regarding the composition of the health care workforce of the United States.

''(6) Individuals with expertise on the financing of health care.

''(7) Representatives from health insurance organizations and health plan organizations.

''(d) RELATIONSHIP OF PANEL TO MEDICARE PAYMENT REVIEW COMMISSION.—From amounts appropriated under subsection (n), the Medicare Payment Review Commission shall provide for the Panel such staff and administrative support (including quarters for the

Panel) as may be necessary for the Panel to carry out the duties under subsection (b).

''(e) CHAIR.—The Panel shall designate a member of the Panel to serve as the Chair of the Panel.

''(f) MEETINGS.—The Panel shall meet at the call of the Chair or a majority of the members, except that the first meeting of the Panel shall be held not later than three months after the date on which appointments under subsection (c) are completed.

''(g) TERMS.—The term of a member of the Panel is the duration of the Panel.

''(h) VACANCIES.—

''(1) IN GENERAL.—A vacancy in the membership of the Panel does not affect the power of the remaining members to carry out the duties under subsection (b). A vacancy in the membership of the Panel shall be filled in the manner in which the original appointment was made.

''(2) INCOMPLETE TERM.—If a member of the Panel does not serve the full term applicable to the member, the individual appointed to fill the resulting vacancy shall be appointed for the remainder of the term of the predecessor of the individual.

''(i) COMPENSATION; REIMBURSEMENT OF EXPENSES.—

''(1) COMPENSATION.—Members of the Panel shall receive compensation for each day (including traveltime) engaged in carrying out the duties of the Committee. Such compensation may not be in an amount in excess of the daily equivalent of the annual maximum rate of basic pay payable under the General Schedule (under title 5, United States Code) for positions above GS–15.

''(2) REIMBURSEMENT.—Members of the Panel may, in accordance with chapter 57 of title 5, United States Code, be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Panel.

''(j) CONSULTANTS.—The Panel may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code, as the Panel may determine to be useful in carrying out the duties under subsection (b). The Panel may not procure services under this subsection at any rate in excess of the daily equivalent of the maximum annual rate of basic pay payable under the General Schedule for positions above GS–15. Consultants under this subsection may, in accordance with chapter 57 of title 5, United States Code, be reimbursed for travel, subsistence, and other necessary ex-

penses incurred for activities carried out on behalf of the Panel pursuant to subsection (b).

''(k) POWERS.—

''(1) IN GENERAL.—For the purpose of carrying out the duties of the Panel under subsection (b), the Panel may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Panel considers appropriate.

''(2) OBTAINING OFFICIAL INFORMATION.—Upon the request of the Panel, the heads of Federal agencies shall furnish directly to the Panel information necessary for the Panel to carry out the duties under subsection (b).±

''(3) USE OF MAILS.—The Panel may use the United States mails in the same manner and under the same conditions as Federal agencies.

''(l) REPORTS.—

''(1) FIRST INTERIM REPORT.—Not later than one year after the date of the enactment of the Medicare Preservation Act of 1995, the Panel shall submit to the Congress a report providing the recommendations of the Panel regarding the matters specified in paragraphs (1) through (4) of subsection (b).

''(2) SECOND INTERIM REPORT.—Not later than 2 years after the date of enactment specified in paragraph (1), the Panel shall submit to the Congress a report providing the recommendations of the Panel regarding the matters specified in paragraphs (5) and (6) of subsection (b).

''(3) FINAL REPORT.—Not later than 3 years after the date of enactment specified in paragraph (1), the Panel shall submit to the Congress a final report providing the recommendations of the Panel under subsection (b).

''(m) DURATION.—The Panel terminates upon the expiration of the 180-day period beginning on the date on which the final report under subsection (l)(3) is submitted to the Congress.

''(n) AUTHORIZATION OF APPROPRIATIONS.—

''(1) IN GENERAL.—Subject to paragraph (2), for the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 1996 through 1999.

''(2) LIMITATION.—The authorization of appropriations established in paragraph (1) is effective only with respect to appropriations made from allo-

cations under section 302(b) of the Congressional Budget Act of 1974—

''(A) for the Subcommittee on Labor, Health and Human Services, and Education, Committee on Appropriations of the House of Representatives, in the case of any bill, resolution, or amendment considered in the House; and

''(B) for the Subcommittee on Labor, Health and Human Services, and Education, Committee on Appropriations of the Senate, in the case of any bill, resolution, or amendment considered in the Senate.''.

Subtitle F—Provisions Relating to Medicare Part A

PART 1—HOSPITALS

Subpart A—General Provisions Relating to Hospitals

SEC. 15501. REDUCTIONS IN INFLATION UPDATES FOR PPS HOSPITALS.

Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended by striking subclauses (XI), (XII), and (XIII) and inserting the following:

''(XI) for fiscal year 1996, the market basket percentage increase minus 2.5 percentage points for hospitals in all areas,

''(XII) for each of the fiscal years 1997 through 2002, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas, and

''(XIII) for fiscal year 2003 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.''.

SEC. 15502. REDUCTIONS IN DISPROPORTIONATE SHARE PAYMENT ADJUSTMENTS.

(a) IN GENERAL.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(1) in clause (ii), by striking ''The amount'' and inserting ''Subject to clause (ix), the amount''; and

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

''(ix) In the case of discharges occurring on or after October 1, 1995, the additional payment amount otherwise determined under clause (ii) shall be reduced as follows:

''(I) For discharges occurring on or after October 1, 1995, and on or before September 30, 1996, by 20 percent.

''(II) For discharges occurring on or after October 1, 1996, and on or before September 30, 1997, by 25 percent.

''(III) For discharges occurring on or after October 1, 1997, by 30 percent.''.

(b) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNTS.—Section 1886(d)(2)(C)(iv) (42 U.S.C. 1395ww(d)(2)(C)(iv)) is amended by striking the period at the end and inserting the following: '', and the Secretary shall not take into account any reductions in the amount of such additional payments resulting from the amendments made by section 15502(a) of the Medicare Preservation Act of 1995.''.

SEC. 15503. PAYMENTS FOR CAPITAL-RELATED COSTS FOR INPATIENT HOSPITAL SERVICES.

(a) REDUCTION IN PAYMENTS FOR PPS HOSPITALS.—

(1) CONTINUATION OF CURRENT REDUCTIONS.—Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended in the second sentence—

(A) by striking ''through 1995'' and inserting ''through 2002''; and

(B) by inserting after ''10 percent reduction'' the following: ''(or a 15 percent reduction in the case of payments during fiscal years 1996 through 2002)''.

(2) REDUCTION IN BASE PAYMENT RATES.—Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended by adding at the end the following new sentence: ''In addition to the reduction described in the preceding sentence, for discharges occurring after September 30, 1995, the Secretary shall reduce by 7.47 percent the unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on the date of the enactment of the Medicare Preservation Act of 1995) and shall reduce by 8.27 percent the unadjusted hospital-specific rate (as described in 42 CFR 412.328(e)(1), as in effect on such date of enactment).''.

(b) REDUCTION IN PAYMENTS FOR PPS-EXEMPT HOSPITALS.—Section 1886(g) (42 U.S.C. 1395ww(g)) is amended by adding at the end the following new paragraph:

''(4)(A) Except as provided in subparagraph (B), in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of inpatient hospital services furnished during fiscal years 1996 through 2002 of a hospital which is not a subsection (d) hospital or a subsection (d) Puerto Rico hospital, the Secretary shall reduce the amounts of such payments otherwise determined under this title by 15 percent.

''(B) Subparagraph (A) shall not apply to payments with respect to the capital-related costs of any hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii) or a rural primary care hospital (as defined in section 1861(mm)(1)).''.

(c) HOSPITAL-SPECIFIC ADJUSTMENT FOR CAPITAL-RELATED TAX COSTS.—Section 1886(g)(1) (42 U.S.C. 1395ww(g)(1)) is amended—

(1) by redesignating subparagraph (C) as subparagraph (D), and

(2) by inserting after subparagraph (B) the following:

''(C)(i) For discharges occurring after September 30, 1995, such system shall provide for an adjustment in an amount equal to the amount determined under clause (iv) for capital-related tax costs for each hospital that is eligible for such adjustment.

''(ii) Subject to clause (iii), a hospital is eligible for an adjustment under this subparagraph, with respect to discharges occurring in a fiscal year, if the hospital—

''(I) is a hospital that may otherwise receive payments under this subsection,

''(II) is not a public hospital, and

''(III) incurs capital-related tax costs for the fiscal year.

''(iii)(I) In the case of a hospital that first incurs capital-related tax costs in a fiscal year after fiscal year 1992 because of a change from nonproprietary to proprietary status or because the hospital commenced operation after such fiscal year, the first fiscal year for which the hospital shall be eligible for such adjustment is the second full fiscal year following the fiscal year in which the hospital first incurs such costs.

''(II) In the case of a hospital that first incurs capital-related tax costs in a fiscal year after fiscal year 1992 because of a change in State or local tax laws, the first fiscal year for which the hospital shall be eligible for such adjustment is the fourth full fiscal year following the fiscal year in which the hospital first incurs such costs.

''(iv) The per discharge adjustment under this clause shall be equal to the hospital-specific capital-related tax costs per discharge of a hospital for fiscal year 1992 (or, in the case of a hospital that first incurs capital-related tax costs for a fiscal year after fiscal year 1992, for the first full fiscal year for which such costs are incurred), updated to the fiscal year to which the adjustment applies. Such per discharge adjustment shall be added to the Federal capital rate, after such rate has been adjusted as described in 42 CFR 412.312 (as in effect on the date of the enactment of the Medicare Preservation Act of 1995),

and before such rate is multiplied by the applicable Federal rate percentage.

''(v) For purposes of this subparagraph, capital-related tax costs include—

''(I) the costs of taxes on land and depreciable assets owned by a hospital (or related organization) and used for patient care,

''(II) payments in lieu of such taxes (made by hospitals that are exempt from taxation), and

''(III) the costs of taxes paid by a hospital (or related organization) as lessee of land, buildings, or fixed equipment from a lessor that is unrelated to the hospital (or related organization) under the terms of a lease that requires the lessee to pay all expenses (including mortgage, interest, and amortization) and leaves the lessor with an amount free of all claims (sometimes referred to as a 'net net net' or 'triple net' lease).

In determining the adjustment required under clause (i), the Secretary shall not take into account any capital-related tax costs of a hospital to the extent that such costs are based on tax rates and assessments that exceed those for similar commercial properties.

''(vi) The system shall provide that the Federal capital rate for any fiscal year after September 30, 1995,

shall be reduced by a percentage sufficient to ensure that the adjustments required to be paid under clause (i) for a fiscal year neither increase nor decrease the total amount that would have been paid under this system but for the payment of such adjustments for such fiscal year.''.

(d) REVISION OF EXCEPTIONS PROCESS UNDER PROSPECTIVE PAYMENT SYSTEM FOR CERTAIN PROJECTS.—

(1) IN GENERAL.—Section 1886(g)(1) (42 U.S.C. 1395ww(g)(1)), as amended by subsection (c), is amended—

(A) by redesignating subparagraph (D) as subparagraph (E), and

(B) by inserting after subparagraph (C) the following:

''(D) The exceptions under the system provided by the Secretary under subparagraph (B)(iii) shall include the provision of exception payments under the special exceptions process provided under 42 CFR 412.348(g) (as in effect on September 1, 1995), except that the Secretary shall revise such process as follows:

''(i) A hospital with at least 100 beds which is located in an urban area shall be eligible under such process without regard to its disproportionate patient percentage under subsection (d)(5)(F) or

whether it qualifies for additional payment amounts under such subsection.

''(ii) The minimum payment level for qualifying hospitals shall be 85 percent.

''(iii) A hospital shall be considered to meet the requirement that it completes the project involved no later than the end of the hospital's last cost reporting period beginning after October 1, 2001, if—

''(I) the hospital has obtained a certificate of need for the project approved by the State or a local planning authority, and

''(II) by September 1, 1995, the hospital has expended on the project at least $750,000 or 10 percent of the estimated cost of the project.

''(iv) The amount of the exception payment made shall not be reduced by any offsetting amounts.''.

(2) CONFORMING AMENDMENT.—Section 1886(g)(1)(B)(iii) (42 U.S.C. 1395ww(g)(1)(B)(iii)) is amended by striking ''may provide'' and inserting ''shall provide (in accordance with subparagraph (D))''.

SEC. 15504. REDUCTION IN ADJUSTMENT FOR INDIRECT MEDICAL EDUCATION.

For provisions modifying medicare payment policies regarding graduate medical education, see part 2 of subtitle E.

SEC. 15505. TREATMENT OF PPS-EXEMPT HOSPITALS.

(a) UPDATES.—Section 1886(b)(3)(B)(ii)(V) (42 U.S.C. 1395ww(b)(3)(B)(ii)(V)) is amended by striking ''thorugh 1997'' and inserting ''through 2002''.

(b) REBASING FOR CERTAIN LONG-TERM CARE HOSPITALS.—

(1) IN GENERAL.—Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)) is amended—

(A) in subparagraph (A), by striking ''and (E)'' and inserting ''(E), and (F)'';

(B) in subparagraph (B)(ii), by striking ''(A) and (E)'' and inserting ''(A), (E), and (F)''; and

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

''(F)(i) In the case of a qualified long-term care hospital (as defined in clause (ii)), the term 'target amount' means—

''(I) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital, the allowable operating costs of inpa-

tient 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 1991; or

''(II) with respect to a later cost reporting period, the target amount for the preceding cost reporting period, increase by the applicable percentage increase under subparagraph (B)(ii) for that later cost reporting period.

''(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 fiscal year 1995 for which the hospital's allowable operating costs of inpatient hospital services recognized under this title for each of the two most recent previous 12-month cost reporting periods exceeded the hospital's target amount determined under this paragraph for such cost reporting periods, if the hospital—

''(I) has a disproportionate patient percentage during such cost reporting period (as determined by the Secretary under subsection (d)(5)(F)(vi) as if the hospital were a subsection (d) hospital) of at least 25 percent, or

''(II) is located in a State for which no payment is made under the State plan under title XIX for

days of inpatient hospital services furnished to any individual in excess of the limit on the number of days of such services furnished to the individual for which payment may be made under this title.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to discharges occurring during cost reporting periods beginning on or after October 1, 1995.

(c) TREATMENT OF CERTAIN LONG-TERM CARE HOSPITALS LOCATED WITHIN OTHER HOSPITALS.—

(1) IN GENERAL.—Section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) is amended in the matter following clause (v) by striking the period and inserting the following: '', or a hospital classified by the Secretary as a long-term care hospital on or before September 30, 1995, and located in the same building as, or on the same campus as, another hospital.''.

(2) STUDY BY REVIEW COMMISSION.—Not later than 12 months after the date a majority of the members of the Medicare Payment Review Commission are first appointed, the Commission shall submit a report to Congress containing recommendations for appropriate revisions in the treatment of long-term care hospitals located in the same building

as or on the same campus as another hospital for purposes of section 1886 of the Social Security Act.

(3) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to discharges occurring on or after October 1, 1995.

(d) STUDY OF PROSPECTIVE PAYMENT SYSTEM FOR REHABILITATION HOSPITALS AND UNITS.—

(1) IN GENERAL.—After consultation with the Prospective Payment Assessment Commission, providers of rehabilitation services, and other appropriate parties, the Secretary of Health and Human Services shall submit to Congress, by not later than June 1, 1996, a report on the advisability and feasibility of providing for payment based on a prospective payment system for inpatient services of rehabilitation hospitals and units under the medicare program.

(2) ITEMS INCLUDED.—The report shall include the following:

(A) The available and preferred systems of classifying rehabilitation patients relative to duration and intensity of inpatient services, including the use of functional-related groups (FRGs).

(B) The means of calculating medicare program payments to reflect such patient requirements.

(C) Other appropriate adjustments which should be made, such as for geographic variations in wages and other costs and outliers.

(D) A timetable under which such a system might be introduced.

(E) Whether such a system should be applied to other types of providers of inpatient rehabilitation services.

SEC. 15506. REDUCTION IN PAYMENTS TO HOSPITALS FOR ENROLLEES' BAD DEBTS.

(a) IN GENERAL.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

''(T)(i) In determining such reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs which are attributable to the deductibles and coinsurance amounts under this title shall be reduced by—

''(I) 75 percent for cost reporting periods beginning during fiscal year 1996,

''(II) 60 percent for cost reporting periods beginning during fiscal year 1997, and

''(III) 50 percent for subsequent cost reporting periods.

''(ii) Clause (i) shall not apply with respect to bad debt of a hospital described in section 1886(d)(1)(B)(iv) if the debt is attributable to uncollectable deductible and coinsurance payments owed by individuals enrolled in a State plan under title XIX or under the MediGrant program under title XXI.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to hospital cost reporting periods beginning on or after October 1, 1995.

SEC. 15507. PERMANENT EXTENSION OF HEMOPHILIA PASS-THROUGH.

Effective as if included in the enactment of OBRA–1989, section 6011(d) of such Act (as amended by section 13505 of OBRA–1993) is amended by striking ''and shall expire September 30, 1994''.

SEC. 15508. CONFORMING AMENDMENT TO CERTIFICATION OF CHRISTIAN SCIENCE PROVIDERS.

(a) HOSPITALS.—Section 1861(e) (42 U.S.C. 1395x(e)) is amended in the sixth sentence by inserting after ''Massachusetts,'' the following: ''or by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.,''.

(b) SKILLED NURSING FACILITIES.—Section 1861(y)(1) is amended by inserting after ''Massachusetts,'' the following: ''or by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.,''.

Subpart B—Provisions Relating to Rural Hospitals

SEC. 15511. SOLE COMMUNITY HOSPITALS.

(a) UPDATE.—Section 1886(b)(3)(B)(iv) (42 U.S.C. 1395ww(b)(3)(B)(iv)) is amended—

(A) in subclause (III), by striking ''and'' at the end; and

(B) by striking subclause (IV) and inserting the following:

''(IV) for each of the fiscal years 1996 through 2000, the market basket percentage increase minus 1 percentage points, and

''(V) for fiscal year 2001 and each subsequent fiscal year, the applicable percentage increase under clause (i).''.

(b) STUDY OF IMPACT OF SOLE COMMUNITY HOSPITAL DESIGNATIONS.—

(1) STUDY.—The Medicare Payment Review Commission shall conduct a study of the impact of the designation of hospitals as sole community hospitals under the medicare program on the delivery of

health care services to individuals in rural areas, and shall include in the study an analysis of the characteristics of the hospitals designated as such sole community hospitals under the program.

(2) REPORT.—Not later than 12 months after the date a majority of the members of the Commission are first appointed, the Commission shall submit to Congress a report on the study conducted under paragraph (1).

SEC. 15512. CLARIFICATION OF TREATMENT OF EAC AND RPC HOSPITALS.

Paragraphs (1)(A)(i) and (2)(A)(i) of section 1820(i) (42 U.S.C. 1395i–4(i)) are each amended by striking the semicolon at the end and inserting the following: ‘‘, or in a State which the Secretary finds would receive a grant under such subsection during a fiscal year if funds were appropriated for grants under such subsection for the fiscal year;’’.

SEC. 15513. ESTABLISHMENT OF RURAL EMERGENCY ACCESS CARE HOSPITALS.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Rural Emergency Access Care Hospital; Rural Emergency Access Care Hospital Services

''(oo)(1) The term 'rural emergency access care hospital' means, for a fiscal year, a facility with respect to which the Secretary finds the following:

''(A) The facility is located in a rural area (as defined in section 1886(d)(2)(D)).

''(B) The facility was a hospital under this title at any time during the 5-year period that ends on the date of the enactment of this subsection.

''(C) The facility is in danger of closing due to low inpatient utilization rates and operating losses, and the closure of the facility would limit the access to emergency services of individuals residing in the facility's service area.

''(D) The facility has entered into (or plans to enter into) an agreement with a hospital with a participation agreement in effect under section 1866(a), and under such agreement the hospital shall accept patients transferred to the hospital from the facility and receive data from and transmit data to the facility.

''(E) There is a practitioner who is qualified to provide advanced cardiac life support services (as de-

termined by the State in which the facility is located) on-site at the facility on a 24-hour basis.

''(F) A physician is available on-call to provide emergency medical services on a 24-hour basis.

''(G) The facility 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, except insofar as the facility is required to provide emergency care on a 24-hour basis under subparagraphs (E) and (F); and

''(ii) the facility may provide any services otherwise required to be provided by a full-time, on-site dietitian, pharmacist, laboratory technician, medical technologist, or radiological technologist on a part-time, off-site basis.

''(H) The facility meets the requirements applicable to clinics and facilities under subparagraphs (C) through (J) of paragraph (2) of section 1861(aa) and of clauses (ii) and (iv) of the second sentence of such paragraph (or, in the case of the requirements of subparagraph (E), (F), or (J) of

such paragraph, would meet the requirements if any reference in such subparagraph to a 'nurse practitioner' or to 'nurse practitioners' were deemed to be a reference to a 'nurse practitioner or nurse' or to 'nurse practitioners or nurses'); except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).

''(2) The term 'rural emergency access care hospital services' means the following services provided by a rural emergency access care hospital and furnished to an individual over a continuous period not to exceed 24 hours (except that such services may be furnished over a longer period in the case of an individual who is unable to leave the hospital because of inclement weather):

''(A) An appropriate medical screening examination (as described in section 1867(a)).

''(B) Necessary stabilizing examination and treatment services for an emergency medical condition and labor (as described in section 1867(b)).''.

(b) REQUIRING RURAL EMERGENCY ACCESS CARE HOSPITALS TO MEET HOSPITAL ANTI-DUMPING REQUIREMENTS.—Section 1867(e)(5) (42 U.S.C.

1395dd(e)(5)) is amended by striking ''1861(mm)(1))'' and inserting ''1861(mm)(1)) and a rural emergency access care hospital (as defined in section 1861(oo)(1))''.

(c) REFERENCE TO PAYMENT PROVISIONS UNDER PART B.—For provisions relating to payment for rural emergency access care hospital services under part B, see section 15607.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to fiscal years beginning on or after October 1, 1995.

SEC. 15514. CLASSIFICATION OF RURAL REFERRAL CENTERS.

(a) PROHIBITING DENIAL OF REQUEST FOR RECLASSIFICATION ON BASIS OF COMPARABILITY OF WAGES.—

(1) IN GENERAL.—Section 1886(d)(10)(D) (42 U.S.C. 1395ww(d)(10)(D)) is amended—

(A) by redesignating clause (iii) as clause (iv); and

(B) 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 is 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.''.

(2) EFFECTIVE DATE.—Notwithstanding section 1886(d)(10)(C)(ii) of the Social Security Act, a hospital may submit an application to the Medicare Geographic Classification Review Board during the 30-day period beginning on the date of the enactment of this Act requesting a change in its classification for purposes of determining the area wage index applicable to the hospital under section 1886(d)(3)(D) of such Act for fiscal year 1997, if the hospital would be eligible for such a change in its classification under the standards described in section 1886(d)(10)(D) (as amended by paragraph (1)) but for its failure to meet the deadline for applications under section 1886(d)(10)(C)(ii).

(b) CONTINUING TREATMENT OF PREVIOUSLY DESIGNATED CENTERS.—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 1994 shall be classified as such a rural referral center for fiscal year 1996 and each subsequent fiscal year.

SEC. 15515. FLOOR ON AREA WAGE INDEX.

(a) IN GENERAL.—For purposes of section 1886(d)(3)(E) of the Social Security Act for discharges occurring on or after October 1, 1995, 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) may not be less than the average of the area wage indices applicable under such section to hospitals located in rural areas in the State in which the hospital is located.

(b) BUDGET-NEUTRALITY IN IMPLEMENTATION.—The Secretary of Health and Human Services shall adjust the area wage indices referred to in subsection (a) for hospitals not described in such subsection in a manner which assures that the aggregate payments made under section 1886(d) of the Social Security Act 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.

PART 2—PAYMENTS TO SKILLED NURSING FACILITIES

SEC. 15521. PAYMENTS FOR ROUTINE SERVICE COSTS.

(a) CLARIFICATION OF DEFINITION OF ROUTINE SERVICE COSTS.—Section 1888 (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

''(e) For purposes of this section, the 'routine service costs' of a skilled nursing facility are all costs which are attributable to nursing services, room and board, administrative costs, other overhead costs, and all other ancillary services (including supplies and equipment), excluding costs attributable to covered non-routine services subject to payment limits under section 1888A.''.

(b) CONFORMING AMENDMENT.—Section 1888 (42 U.S.C. 1395yy) is amended in the heading by inserting ''AND CERTAIN ANCILLARY'' after ''SERVICE''.

SEC. 15522. INCENTIVES FOR COST EFFECTIVE MANAGEMENT OF COVERED NON-ROUTINE SERVICES.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1888 the following new section:

''INCENTIVES FOR COST-EFFECTIVE MANAGEMENT OF COVERED NON-ROUTINE SERVICES OF SKILLED NURSING FACILITIES

''SEC. 1888A. (a) DEFINITIONS.—For purposes of this section:

''(1) COVERED NON-ROUTINE SERVICES.—The term 'covered non-routine services' means post-hospital extended care services consisting of any of the following:

''(A) Physical or occupational therapy or speech-language pathology services, or res-

piratory therapy, including supplies and support services incident to such services and therapy.

''(B) Prescription drugs.

''(C) Complex medical equipment.

''(D) Intravenous therapy and solutions (including enteral and parenteral nutrients, supplies, and equipment).

''(E) Radiation therapy.

''(F) Diagnostic services, including laboratory, radiology (including computerized tomography services and imaging services), and pulmonary services.

''(2) SNF MARKET BASKET PERCENTAGE INCREASE.—The term 'SNF market basket percentage increase' for a fiscal year means a percentage equal to the percentage increase in routine service cost limits for the year under section 1888(a).

''(3) STAY.—The term 'stay' means, with respect to an individual who is a resident of a skilled nursing facility, a period of continuous days during which the facility provides extended care services for which payment may be made under this title with respect to the individual during the individual's spell of illness.

''(b) NEW PAYMENT METHOD FOR COVERED NON-ROUTINE SERVICES.—

''(1) IN GENERAL.—Subject to subsection (c), a skilled nursing facility shall receive interim payments under this title for covered non-routine services furnished to an individual during a cost reporting period beginning during a fiscal year (after fiscal year 1996) in an amount equal to the reasonable cost of providing such services in accordance with section 1861(v). The Secretary may adjust such payments if the Secretary determines (on the basis of such estimated information as the Secretary considers appropriate) that payments to the facility under this paragraph for a cost reporting period would substantially exceed the cost reporting period limit determined under subsection (c)(1)(B).

''(2) RESPONSIBILITY OF SKILLED NURSING FACILITY TO MANAGE BILLINGS.—

''(A) CLARIFICATION RELATING TO PART A BILLING.—In the case of a covered non-routine service furnished to an individual who (at the time the service is furnished) is a resident of a skilled nursing facility who is entitled to coverage under section 1812(a)(2) for such service, the skilled nursing facility shall submit a claim

for payment under this title for such service under part A (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).

''(B) PART B BILLING.—In the case of a covered non-routine service (other than a portable X-ray or portable electrocardiogram treated as a physician's service for purposes of section 1848(j)(3)) furnished to an individual who (at the time the service is furnished) is a resident of a skilled nursing facility who is not entitled to coverage under section 1812(a)(2) for such service but is entitled to coverage under part B for such service, the skilled nursing facility shall submit a claim for payment under this title for such service under part B (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).

''(C) MAINTAINING RECORDS ON SERVICES FURNISHED TO RESIDENTS.—Each skilled nurs-

ing facility receiving payments for extended care services under this title shall document on the facility's cost report all covered non-routine services furnished to all residents of the facility to whom the facility provided extended care services for which payment was made under part A during a fiscal year (beginning with fiscal year 1996) (without regard to whether or not the services were furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise).

''(c) RECONCILIATION OF AMOUNTS.—

''(1) LIMIT BASED ON PER STAY LIMIT AND NUMBER OF STAYS.—

''(A) IN GENERAL.—If a skilled nursing facility has received aggregate payments under subsection (b) for covered non-routine services during a cost reporting period beginning during a fiscal year in excess of an amount equal to the cost reporting period limit determined under subparagraph (B), the Secretary shall reduce the payments made to the facility with respect to such services for cost reporting periods beginning during the following fiscal year in an

amount equal to such excess. The Secretary shall reduce payments under this subparagraph at such times and in such manner during a fiscal year as the Secretary finds necessary to meet the requirement of this subparagraph.

''(B) COST REPORTING PERIOD LIMIT.—The cost reporting period limit determined under this subparagraph is an amount equal to the product of—

''(i) the per stay limit applicable to the facility under subsection (d) for the period; and

''(ii) the number of stays beginning during the period for which payment was made to the facility for such services.

''(C) PROSPECTIVE REDUCTION IN PAYMENTS.—In addition to the process for reducing payments described in subparagraph (A), the Secretary may reduce payments made to a facility under this section during a cost reporting period if the Secretary determines (on the basis of such estimated information as the Secretary considers appropriate) that payments to the facility under this section for the period will substantially exceed the cost reporting period

limit for the period determined under this paragraph.

''(2) INCENTIVE PAYMENTS.—

''(A) IN GENERAL.—If a skilled nursing facility has received aggregate payments under subsection (b) for covered non-routine services during a cost reporting period beginning during a fiscal year in an amount that is less than the amount determined under paragraph (1)(B), the Secretary shall pay the skilled nursing facility in the following fiscal year an incentive payment equal to 50 percent of the difference between such amounts, except that the incentive payment may not exceed 5 percent of the aggregate payments made to the facility under subsection (b) for the previous fiscal year (without regard to subparagraph (B)).

''(B) INSTALLMENT INCENTIVE PAYMENTS.—The Secretary may make installment payments during a fiscal year to a skilled nursing facility based on the estimated incentive payment that the facility would be eligible to receive with respect to such fiscal year.

''(d) DETERMINATION OF FACILITY PER STAY LIMIT.—

''(1) LIMIT FOR FISCAL YEAR 1997.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the Secretary shall establish separate per stay limits for hospital-based and freestanding skilled nursing facilities for the 12-month cost reporting period beginning during fiscal year 1997 that are equal to the sum of—

''(i) 50 percent of the facility-specific stay amount for the facility (as determined under subsection (e)) for the last 12-month cost reporting period ending on or before September 30, 1994, increased (in a compounded manner) by the SNF market basket percentage increase for fiscal years 1995 through 1997; and

''(ii) 50 percent of the average of all facility-specific stay amounts for all hospital-based facilities or all freestanding facilities (whichever is applicable) during the cost reporting period described in clause (i), increased (in a compounded manner) by the SNF market basket percentage increase for fiscal years 1995 through 1997.

''(B) FACILITIES NOT HAVING 1994 COST REPORTING PERIOD.—In the case of a skilled

nursing facility for which payments were not made under this title for covered non-routine services for the last 12-month cost reporting period ending on or before September 30, 1994, the per stay limit for the 12-month cost reporting period beginning during fiscal year 1997 shall be twice the amount determined under subparagraph (A)(ii).

''(2) LIMIT FOR SUBSEQUENT FISCAL YEARS.—The per stay limit for a skilled nursing facility for a 12-month cost reporting period beginning during a fiscal year after fiscal year 1997 is equal to the per stay limit established under this subsection for the 12-month cost reporting period beginning during the previous fiscal year, increased by the SNF market basket percentage increase for such subsequent fiscal year minus 2 percentage points.

''(3) REBASING OF AMOUNTS.—

''(A) IN GENERAL.—The Secretary shall provide for an update to the facility-specific amounts used to determine the per stay limits under this subsection for cost reporting periods beginning on or after October 1, 1999, and every 2 years thereafter.

''(B) TREATMENT OF FACILITIES NOT HAVING REBASED COST REPORTING PERIODS.—Paragraph (1)(B) shall apply with respect to a skilled nursing facility for which payments were not made under this title for covered non-routine services for the 12-month cost reporting period used by the Secretary to update facility-specific amounts under subparagraph (A) in the same manner as such paragraph applies with respect to a facility for which payments were not made under this title for covered non-routine services for the last 12-month cost reporting period ending on or before September 30, 1994.

''(e) DETERMINATION OF FACILITY-SPECIFIC STAY AMOUNTS.—The 'facility-specific stay amount' for a skilled nursing facility for a cost reporting period is the sum of—

''(1) the average amount of payments made to the facility under part A during the period which are attributable to covered non-routine services furnished during a stay; and

''(2) the Secretary's best estimate of the average amount of payments made under part B during the period for covered non-routine services furnished

to all residents of the facility to whom the facility provided extended care services for which payment was made under part A during the period (without regard to whether or not the services were furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise), as estimated by the Secretary.

''(f) INTENSIVE NURSING OR THERAPY NEEDS.—

''(1) IN GENERAL.—In applying subsection (b) to covered non-routine services furnished during a stay beginning during a cost reporting period beginning during a fiscal year to a resident of a skilled nursing facility who requires intensive nursing or therapy services, the per stay limit determined for the fiscal year under the methodology for such resident shall be the per stay limit developed under paragraph (2) instead of the per stay limit determined under subsection (d)(1)(A).

''(2) PER STAY LIMIT FOR INTENSIVE NEED RESIDENTS.—Not later than June 30, 1996, the Secretary, after consultation with the Medicare Payment Review Commission and skilled nursing facility experts, shall develop and publish a methodology for determining on an annual basis a per stay limit for

residents of a skilled nursing facility who require intensive nursing or therapy services.

''(3) BUDGET NEUTRALITY.—The Secretary shall adjust payments under subsection (b) in a manner that ensures that total payments for covered non-routine services under this section are not greater or less than total payments for such services would have been but for the application of paragraph (1).

''(g) SPECIAL TREATMENT FOR MEDICARE LOW VOLUME SKILLED NURSING FACILITIES.—This section shall not apply with respect to a skilled nursing facility for which payment is made for routine service costs during a cost reporting period on the basis of prospective payments under section 1888(d).

''(h) EXCEPTIONS AND ADJUSTMENTS TO LIMITS.—

''(1) IN GENERAL.—The Secretary may make exceptions and adjustments to the cost reporting limits applicable to a skilled nursing facility under subsection (c)(1)(B) for a cost reporting period, except that the total amount of any additional payments made under this section for covered non-routine services during the cost reporting period as a result of such exceptions and adjustments may not exceed 5 percent of the aggregate payments made to

all skilled nursing facilities for covered non-routine services during the cost reporting period (determined without regard to this paragraph).

''(2) BUDGET NEUTRALITY.—The Secretary shall adjust payments under subsection (b) in a manner that ensures that total payments for covered non-routine services under this section are not greater or less than total payments for such services would have been but for the application of paragraph (1).

''(i) SPECIAL RULE FOR X-RAY SERVICES.—Before furnishing a covered non-routine service consisting of an X-ray service for which payment may be made under part A or part B to a resident, a skilled nursing facility shall consider whether furnishing the service through a provider of portable X-ray service services would be appropriate, taking into account the cost effectiveness of the service and the convenience to the resident.''.

(b) CONFORMING AMENDMENT.—Section 1814(b) (42 U.S.C. 1395f(b)) is amended in the matter preceding paragraph (1) by striking ''1813 and 1886'' and inserting ''1813, 1886, 1888, and 1888A''.

SEC. 15523. PAYMENTS FOR ROUTINE SERVICE COSTS.

(a) MAINTAINING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES.—

(1) BASING UPDATES TO PER DIEM COST LIMITS ON LIMITS FOR FISCAL YEAR 1993.—

(A) IN GENERAL.—The last sentence of section 1888(a) (42 U.S.C. 1395yy(a)) is amended by inserting before the period at the end the following: ''(except that such updates may not take into account any changes in the routine service costs of skilled nursing facilities occurring during cost reporting periods which began during fiscal year 1994 or fiscal year 1995)''.

(B) NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.—The Secretary of Health and Human Services shall not consider the amendment made by subparagraph (A) in making any adjustments pursuant to section 1888(c) of the Social Security Act.

(2) PAYMENTS DETERMINED ON PROSPECTIVE BASIS.—Any change made by the Secretary of Health and Human Services in the amount of any prospective payment paid to a skilled nursing facility under section 1888(d) of the Social Security Act for cost reporting periods beginning on or after October 1, 1995, may not take into account any changes in the costs of services occurring during cost reporting

periods which began during fiscal year 1994 or fiscal year 1995.

(b) ESTABLISHMENT OF SCHEDULE FOR MAKING ADJUSTMENTS TO LIMITS.—Section 1888(c) (42 U.S.C. 1395yy(c)) is amended by striking the period at the end of the second sentence and inserting ‘‘, and may only make adjustments under this subsection with respect to a facility which applies for an adjustment during an annual application period established by the Secretary.’’.

(c) LIMITATION ON AGGREGATE INCREASE IN PAYMENTS RESULTING FROM ADJUSTMENTS TO LIMITS.—Section 1888(c) (42 U.S.C. 1395yy(c)) is amended—

(1) by striking ‘‘(c) The Secretary’’ and inserting ‘‘(c)(1) Subject to paragraph (2), the Secretary’’; and

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

‘‘(2) The Secretary may not make any adjustments under this subsection in the limits set forth in subsection (a) for a cost reporting period beginning during a fiscal year to the extent that the total amount of the additional payments made under this title as a result of such adjustments is greater than an amount equal to—

‘‘(A) for cost reporting periods beginning during fiscal year 1997, the total amount of the addi-

tional payments made under this title as a result of adjustments under this subsection for cost reporting periods beginning during fiscal year 1996 increased by the SNF market basket percentage increase (as defined in section 1888A(e)(3)) for fiscal year 1997; and

''(B) for cost reporting periods beginning during a subsequent fiscal year, the amount determined under this paragraph for the previous fiscal year increased by the SNF market basket percentage increase for such subsequent fiscal year.''.

(d) IMPOSITION OF LIMITS FOR ALL COST REPORTING PERIODS.—Section 1888(a) (42 U.S.C. 1395yy(a)) is amended in the matter preceding paragraph (1) by inserting after ''extended care services'' the following: ''(for any cost reporting period for which payment is made under this title to the skilled nursing facility for such services)''.

SEC. 15524. REDUCTIONS IN PAYMENT FOR CAPITAL-RELATED COSTS.

Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)), as amended by section 15506, is amended by adding at the end the following new subparagraph:

''(U) Such regulations shall provide that, in determining the amount of the payments that may be made under this title with respect to all the capital-related costs

of skilled nursing facilities, the Secretary shall reduce the amounts of such payments otherwise established under this title by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1996 through 2002.''.

SEC. 15525. TREATMENT OF ITEMS AND SERVICES PAID FOR UNDER PART B.

(a) REQUIRING PAYMENT FOR ALL ITEMS AND SERVICES TO BE MADE TO FACILITY.—

(1) IN GENERAL.—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 physicians' services and other than a portable X-ray or portable electrocardiogram treated as a physician's service for purposes of section 1848(j)(3)) furnished to an individual who (at the time the item or service is furnished) is a resident of a skilled nursing facility, payment shall be made to the facility (without regard to whether or not the item or service was furnished by the facility, by others under arrange-

ment with them made by the facility, or otherwise).''.

(2) EXCLUSION FOR ITEMS AND SERVICES NOT BILLED BY FACILITY.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(A) by striking ''or'' at the end of paragraph (14);

(B) by striking the period at the end of paragraph (15) and inserting ''; or''; and

(C) by inserting after paragraph (15) the following new paragraph:

''(16) where such expenses are for covered non-routine services (as defined in section 1888A(a)(1)) (other than a portable X-ray or portable electrocardiogram treated as a physician's service for purposes of section 1848(j)(3)) furnished to an individual who is a resident of a skilled nursing facility and for which the claim for payment under this title is not submitted by the facility.''.

(3) CONFORMING AMENDMENT.—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);''.

(b) REDUCTION IN PAYMENTS FOR ITEMS AND SERVICES FURNISHED BY OR UNDER ARRANGEMENTS WITH

FACILITIES.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)), as amended by sections 15506 and 15524, is amended by adding at the end the following new subparagraph:

''(V) In the case of an item or service furnished by a skilled nursing facility (or by others under arrangement with them made by a skilled nursing facility) for which payment is made under part B in an amount determined in accordance with section 1833(a)(2)(B), the Secretary shall reduce the reasonable cost for such item or service otherwise determined under clause (i)(I) of such section by 5.8 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1996 through 2002.''.

SEC. 15526. CERTIFICATION OF FACILITIES MEETING REVISED NURSING HOME REFORM STANDARDS.

(a) IN GENERAL.—Section 1819(a)(3) (42 U.S.C. 1395i–3(a)(3)) is amended to read as follows:

''(3)(A) is certified by the Secretary as meeting the standards established under subsection (b), or (B) is a State-certified facility (as defined in subsection (d)).''.

(b) REQUIREMENTS DESCRIBED.—Section 1819 (42 U.S.C. 1395i–3) is amended by striking subsections (b) through (i) and inserting the following:

''(b) STANDARDS FOR AND CERTIFICATION OF FACILITIES.—

''(1) STANDARDS FOR FACILITIES.—

''(A) IN GENERAL.—The Secretary shall provide for the establishment and maintenance of standards consistent with the contents described in subparagraph (B) for skilled nursing facilities which furnish services for which payment may be made under this title.

''(B) CONTENTS OF STANDARDS.—The standards established for facilities under this paragraph shall contain provisions relating to the following items:

''(i) The treatment of resident medical records.

''(ii) Policies, procedures, and bylaws for operation.

''(iii) Quality assurance systems.

''(iv) Resident assessment procedures, including care planning and outcome evaluation.

''(v) The assurance of a safe and adequate physical plant for the facility.

''(vi) Qualifications for staff sufficient to provide adequate care.

''(vii) Utilization review.

''(viii) The protection and enforcement of resident rights described in subparagraph (C).

''(C) RESIDENT RIGHTS DESCRIBED.—The resident rights described in this subparagraph are the rights of residents to the following:

''(i) To exercise the individual's rights as a resident of the facility and as a citizen or resident of the United States.

''(ii) To receive notice of rights and services.

''(iii) To be protected against the misuse of resident funds.

''(iv) To be provided privacy and confidentiality.

''(v) To voice grievances.

''(vi) To examine the results of inspections under the certification program.

''(vii) To refuse to perform services for the facility.

''(viii) To be provided privacy in communications and to receive mail.

''(ix) To have the facility provide immediate access to any resident by any rep-

resentative of the certification program, the resident's individual physician, the State long term care ombudsman, and any person the resident has designated as a visitor.

''(x) To retain and use personal property.

''(xi) To be free from abuse, including verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion.

''(xii) To be provided with prior written notice of a pending transfer or discharge.

''(D) REQUIRING NOTICE AND COMMENT.—The standards established for facilities under this paragraph may only take effect after the Secretary has provided the public with notice and an opportunity for comment.

''(2) CERTIFICATION PROGRAM.—

''(A) IN GENERAL.—The Secretary shall provide for the establishment and operation of a program consistent with the requirements of subparagraph (B) for the certification of skilled nursing facilities which meet the standards es-

tablished under paragraph (1) and the decertification of facilities which fail to meet such standards.

''(B) REQUIREMENTS FOR PROGRAM.—In addition to any other requirements the Secretary may impose, in establishing and operating the certification program under subparagraph (A), the Secretary shall ensure the following:

''(i) The Secretary shall ensure public access (as defined by the Secretary) to the certification program's evaluations of participating facilities, including compliance records and enforcement actions and other reports by the Secretary regarding the ownership, compliance histories, and services provided by certified facilities.

''(ii) Not less often than every 4 years, the Secretary shall audit its expenditures under the program, through an entity designated by the Secretary which is not affiliated with the program, as designated by the Secretary.

''(c) INTERMEDIATE SANCTION AUTHORITY.—

''(1) AUTHORITY.—In addition to any other authority, where the Secretary determines that a nursing facility which is certified for participation under this title (whether certified by the Secretary as meeting the standards established under subsection (b) or a State-ceritified facility) no longer or does not substantially meet the requirements for such a facility under this title as specified under subsection (b) and further determines that the facility's deficiencies—

''(A) immediately jeopardize the health and safety of its residents, the Secretary shall at least provide for the termination of the facility's certification for participation under this title, or

''(B) do not immediately jeopardize the health and safety of its residents, the Secretary may, in lieu of providing for terminating the facility's certification for participation under the plan, provide lesser sanctions including one that provides that no payment will be made under this title with respect to any individual admitted to such facility after a date specified by the Secretary.

''(2) NOTICE.—The Secretary shall not make such a decision with respect to a facility until the fa-

cility has had a reasonable opportunity, following the initial determination that it no longer or does not substantially meet the requirements for such a facility under this title, to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

''(3) EFFECTIVENESS.—The Secretary's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the Secretary, and its effectiveness shall terminate (A) when the Secretary finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the requirements for such a facility under this title, or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the Secretary shall terminate such facility's certification for participation under this title effective with the first day of the first month following the month specified in such clause.

''(d) STATE-CERTIFIED FACILITY DEFINED.—In subsection (a), a 'State-certified facility' means a facility licensed or certified as a skilled nursing facility by the State in which it is located, or a facility which otherwise meets the requirements applicable to providers of nursing facility services under the State plan under title XIX or the MediGrant program under title XXI.''.

(c) CONFORMING AMENDMENTS.—(1) Section 1861(v)(1)(E) (42 U.S.C. 1395x(v)(1)(E)) is amended by striking the second sentence.

(2) Section 1864 (42 U.S.C. 1395aa) is amended by striking subsection (d).

(3) Section 1866(f)(1) (42 U.S.C. 1395cc(f)(1)) is amended by striking ''1819(c)(2)(E),''.

(4) Section 1883(f) (42 U.S.C. 1395tt(f)) is amended—

(A) in the second sentence, by striking ''such a hospital'' and inserting ''a hospital which enters into an agreement with the Secretary under this section''; and

(B) by striking the first sentence.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to cost reporting periods beginning on or after October 1, 1995.

SEC. 15527. MEDICAL REVIEW PROCESS.

In order to ensure that medicare beneficiaries are furnished appropriate extended care services, 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 part on the quality of extended care 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 for which payment is made under section 1888A of the Social Security Act.

SEC. 15528. REPORT BY MEDICARE PAYMENT REVIEW COMMISSION.

Not later than October 1, 1997, the Medicare Payment Review Commission shall submit to Congress a report on the system under which payment is made under the medicare program for extended care services furnished by skilled nursing facilities, and shall include in the report the following:

(1) An analysis of the effect of the methodology established under section 1888A of the Social Security Act (as added by section 15522) on the payments for, and the quality of, extended care services under the medicare program.

(2) An analysis of the advisability of determining the amount of payment for covered non-routine

services of facilities (as described in such section) on the basis of the amounts paid for such services when furnished by suppliers under part B of the medicare program.

(3) An analysis of the desirability of maintaining separate limits for hospital-based and freestanding facilities in the costs of extended care services recognized as reasonable under the medicare program.

(4) An analysis of the quality of services furnished by skilled nursing facilities.

(5) An analysis of the adequacy of the process and standards used to provide exceptions to the limits described in paragraph (3).

SEC. 15529. EFFECTIVE DATE.

Except as otherwise provided in this part, the amendments made by this part shall apply to services furnished during cost reporting periods (or portions of cost reporting periods) beginning on or after October 1, 1996.

PART 3—CLARIFICATION OF CREDITS TO PART A TRUST FUND

SEC. 15531. CLARIFICATION OF AMOUNT OF TAXES CREDITED TO FEDERAL HOSPITAL INSURANCE TRUST FUND.

Section 121(e)(1)(B) of the Social Security Amendments of 1983 (Public Law 98–21) is amended by adding at the end the following: ''The Secretary of the Treasury shall carry out this subparagraph without regard to any amendments to this subsection or to section 86 of the Internal Revenue Code of 1986 which take effect on or after January 1, 1994.''.

Subtitle G—Provisions Relating to Medicare Part B

PART 1—PAYMENT REFORMS

SEC. 15601. PAYMENTS FOR PHYSICIANS' SERVICES.

(a) REPLACEMENT OF VOLUME PERFORMANCE STANDARD WITH SUSTAINABLE GROWTH RATE.—Section 1848(f) (42 U.S.C. 1395w–4(f)) is amended to read as follows:

''(f) SUSTAINABLE GROWTH RATE.—

''(1) SPECIFICATION OF GROWTH RATE.—

''(A) FISCAL YEAR 1996.—The sustainable growth rate for all physicians' services for fiscal year 1996 shall be equal to the product of—

''(i) 1 plus the Secretary's estimate of the percentage change in the medicare economic index for 1996 (described in the fourth sentence of section 1842(b)(3)) (divided by 100),

''(ii) 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 private plan enrollees) from fiscal year 1995 to fiscal year 1996,

''(iii) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from fiscal year 1995 to fiscal year 1996, plus 2 percentage points, and

''(iv) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in fiscal year 1996 (compared with fiscal year 1995) which will result from changes in law, determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians' services or changes in ex-

penditures resulting from changes in the update to the conversion factor under subsection (d),

minus 1 and multiplied by 100.

''(B) SUBSEQUENT FISCAL YEARS.—The sustainable growth rate for all physicians' services for fiscal year 1997 and each subsequent fiscal year shall be equal to the product of—

''(i) 1 plus the Secretary's estimate of the percentage change in the medicare economic index for the fiscal year involved (described in the fourth sentence of section 1842(b)(3)) (divided by 100),

''(ii) 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 private plan enrollees) from the previous fiscal year to the fiscal year involved,

''(iii) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from the previous fiscal year to the fiscal year involved, plus 2 percentage points, and

''(iv) 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 (including changes made by the Secretary in response to section 1895), determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians' services or changes in expenditures resulting from changes in the update to the conversion factor under subsection (d)(3),

minus 1 and multiplied by 100.

''(2) EXCLUSION OF SERVICES FURNISHED TO PRIVATE PLAN ENROLLEES.—In this subsection, the term 'physicians' services' with respect to a fiscal year does not include services furnished to an individual enrolled under this part who has elected to receive benefits under this title for the fiscal year through a MedicarePlus product offered under part C or through enrollment with an eligible organization with a risk-sharing contract under section 1876.''.

(b) ESTABLISHING UPDATE TO CONVERSION FACTOR TO MATCH SPENDING UNDER SUSTAINABLE GROWTH RATE.—

(1) IN GENERAL.—Section 1848(d) (42 U.S.C. 1395w–4(d)) is amended—

(A) by striking paragraph (2);

(B) by amending paragraph (3) to read as follows:

''(3) UPDATE.—

''(A) IN GENERAL.—Subject to subparagraph (E), for purposes of this section the update for a year (beginning with 1997) is equal to the product of—

''(i) 1 plus the Secretary's estimate of the percentage increase in the medicare economic index (described in the fourth sentence of section 1842(b)(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.—The 'update adjustment factor' for a year is equal to the quotient of—

''(i) the difference between (I) the sum of the allowed expenditures for physicians' services furnished during each of the years 1995 through the year involved and (II) the sum of the amount of actual expenditures for physicians' services furnished during each of the years 1995 through the previous year; divided by

''(ii) the Secretary's estimate of allowed expenditures for physicians' services furnished during the year.

''(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of subparagraph (B), allowed expenditures for physicians' services shall be determined as follows (as estimated by the Secretary):

''(i) In the case of allowed expenditures for 1995, such expenditures shall be equal to actual expenditures for services furnished during the 12-month period ending with June of 1995.

''(ii) In the case of allowed expenditures for 1996 and each subsequent year, such expenditures shall be equal to allowed expenditures for the previous year, in-

creased by the sustainable growth rate under subsection (f) for the fiscal year which begins during the year.

''(D) DETERMINATION OF ACTUAL EXPENDITURES.—For purposes of subparagraph (B), the amount of actual expenditures for physicians' services furnished during a year shall be equal to the amount of expenditures for such services during the 12-month period ending with June of the previous year.

''(E) RESTRICTION ON VARIATION FROM MEDICARE ECONOMIC INDEX.—

''(i) IN GENERAL.—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 103 percent of 1 plus the Secretary's estimate of the percentage increase in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for the year (divided by 100); or

''(II) less than the applicable percentage limit of 1 plus the Secretary's estimate of the percentage increase in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for the year (divided by 100).

''(ii) APPLICABLE PERCENTAGE LIMIT.—In clause (i)(II), the 'applicable percentage limit' for a year is—

''(I) for 1997, 93 percent;

''(II) for 1998, 92.25 percent; and

''(III) for 1999 and each succeeding year, 92 percent.''; and

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

''(4) REPORTING REQUIREMENTS.—

''(A) IN GENERAL.—Not later than November 1 of each year (beginning with 1996), the Secretary shall transmit to the Congress a report that describes the update in the conversion factor for physicians' services (as defined in subsection (f)(3)(A)) in the following year.

''(B) COMMISSION REVIEW.—The Medicare Payment Review Commission shall review the report submitted under subparagraph (A) for a year and shall submit to the Congress, by not later than December 1 of the year, a report containing its analysis of the conversion factor for the following year.''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to physicians' services furnished on or after January 1, 1996.

(c) ESTABLISHMENT OF SINGLE CONVERSION FACTOR FOR 1996.—

(1) IN GENERAL.—Section 1848(d)(1) (42 U.S.C. 1395w–4(d)(1)) is amended—

(A) by redesignating subparagraph (C) as subparagraph (D); and

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

''(C) SPECIAL RULE FOR 1996.—For 1996, the conversion factor under this subsection shall be $35.42 for all physicians' services.''.

(2) CONFORMING AMENDMENTS.—Section 1848 (42 U.S.C. 1395w–4), as amended by paragraph (1), is amended—

(A) by striking ''(or factors)'' each place it appears in subsection (d)(1)(A) and (d)(1)(D)(ii);

(B) in subsection (d)(1)(A), by striking ''or updates'';

(C) in subsection (d)(1)(D)(ii), by striking ''(or updates)''; and

(D) in subsection (i)(1)(C), by striking ''conversion factors'' and inserting ''the conversion factor''.

SEC. 15602. ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS FOR CERTAIN OUTPATIENT HOSPITAL SERVICES.

(a) 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) RADIOLOGY SERVICES AND DIAGNOSTIC PROCEDURES.—Section 1833(n)(1)(B)(i)(II) (42 U.S.C. 1395l(n)(1)(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).’’.

(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, 1995.

SEC. 15603. 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) by striking ‘‘and’’ at the end of subparagraph (A);

(B) in subparagraph (B)—

(i) by striking ‘‘a subsequent year’’ and inserting ‘‘1993, 1994, and 1995’’, and

(ii) by striking the period at the end and inserting a semicolon; and

(C) by adding at the end the following:

''(C) for each of the years 1996 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) by striking ''and'' at the end of clause (iii);

(B) by redesignating clause (iv) as clause (v); and

(C) by inserting after clause (iii) the following new clause:

''(iv) for each of the years 1996 through 2002, 1 percent, and''.

(b) OXYGEN AND OXYGEN EQUIPMENT.—Section 1834(a)(9)(C) (42 U.S.C. 1395m(a)(9)(C)) is amended—

(1) by striking ''and'' at the end of clause (iii);

(2) in clause (iv)—

(A) by striking ''a subsequent year'' and inserting ''1993, 1994, and 1995'', and

(B) by striking the period at the end and inserting a semicolon; and

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

''(v) in 1996, is 80 percent of the national limited monthly payment rate computed under subparagraph (B) for the item for the year; and

''(vi) in a subsequent year, is the national limited monthly payment rate computed under subparagraph (B) for the item for the year.''.

(c) PAYMENT FOR UPGRADED DURABLE MEDICAL EQUIPMENT.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended by inserting after paragraph (15) the following new paragraph:

''(16) PAYMENT FOR CERTAIN UPGRADED ITEMS.—

''(A) INDIVIDUAL'S RIGHT TO CHOOSE UPGRADED ITEM.—Notwithstanding any other provision of this title, effective on the date on which the Secretary issues regulations under subparagraph (C), payment may be made under this part for an upgraded item of durable medical equipment in the same manner as payment

may be made for a standard item of durable medical equipment.

''(B) PAYMENTS TO SUPPLIER.—In the case of the purchase or rental of an upgraded item under subparagraph (A)—

''(i) the supplier shall receive payment under this subsection with respect to such item as if such item were a standard item; and

''(ii) the individual purchasing or renting the item shall pay the supplier an amount equal to the difference between the supplier's charge and the amount under clause (i).

In no event may the supplier's charge for an upgraded item exceed the applicable fee schedule amount (if any) for such item.

''(C) CONSUMER PROTECTION SAFEGUARDS.—The Secretary shall issue regulations providing for consumer protection standards with respect to the furnishing of upgraded equipment under subparagraph (A). Such regulations shall provide for—

''(i) full disclosure by the supplier 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;

''(ii) conditions of participation for suppliers of upgraded items, including conditions relating to billing procedures;

''(iii) sanctions (including exclusion) of suppliers who are determined to have engaged in coercive or abusive practices; and

''(iv) such other safeguards as the Secretary determines are necessary.''.

(d) 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 1996 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 1993.

SEC. 15604. REDUCTION IN UPDATES TO PAYMENT AMOUNTS FOR CLINICAL DIAGNOSTIC 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 striking ''1994 and 1995'' and inserting ''1994 through 2002''.

(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, 1997,'' 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, 1996, is equal to 65 percent of such median.''.

SEC. 15605. 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 2002''.

(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 2002''.

SEC. 15606. FREEZE IN PAYMENTS FOR AMBULATORY SURGICAL CENTER SERVICES.

The Secretary of Health and Human Services shall not provide for any inflation update in the payment amounts under subparagraphs (A) and (B) of section 1833(i)(2) of the Social Security Act for any of the fiscal years 1996 through 2002.

SEC. 15607. RURAL EMERGENCY ACCESS CARE HOSPITALS.

(a) COVERAGE UNDER PART B.—Section 1832(a)(2) (42 U.S.C. 1395k(a)(2)) is amended—

(1) by striking ''and'' at the end of subparagraph (I);

(2) by striking the period at the end of subparagraph (J) and inserting ''; and''; and

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

''(K) rural emergency access care hospital services (as defined in section 1861(oo)(2)).''.

(b) PAYMENT BASED ON PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

(1) IN GENERAL.—Section 1833(a)(6) (42 U.S.C. 1395l(a)(6)) is amended by striking ''services,'' and inserting ''services and rural emergency access care hospital services,''.

(2) PAYMENT METHODOLOGY DESCRIBED.—Section 1834(g) (42 U.S.C. 1395m(g)) is amended—

(A) in the heading, by striking ''SERVICES'' and inserting ''SERVICES AND RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES''; and

(B) by adding at the end the following new sentence: ''The amount of payment for rural emergency access care hospital services provided during a year shall be determined using the applicable method provided under this subsection for determining payment for outpatient rural primary care hospital services during the year.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 1995.

SEC. 15608. ENSURING PAYMENT FOR PHYSICIAN AND NURSE FOR JOINTLY FURNISHED ANESTHESIA SERVICES.

(a) PAYMENT FOR JOINTLY FURNISHED SINGLE CASE.—

(1) PAYMENT TO PHYSICIAN.—Section 1848(a)(4) (42 U.S.C. 1395w–4(a)(4)) is amended by adding at the end the following new subparagraph:

''(C) PAYMENT FOR SINGLE CASE.—Notwithstanding section 1862(a)(1)(A), with respect to physicians' services consisting of the furnishing of anesthesia services for a single case that are furnished jointly with a certified registered nurse anesthetist, if the carrier determines that the use of both the physician and the nurse anesthetist to furnish the anesthesia service was not medically necessary, the fee schedule amount for the physicians' services shall be equal to 50 percent (or 55 percent, in the case of services furnished during 1996 or 1997) of the fee schedule amount applicable under this section for anesthesia services personally performed by the physician alone (without regard to this subparagraph). Nothing in this subparagraph may be construed to affect

the application of any provision of law regarding balance billing.''.

(2) PAYMENT TO CRNA.—Section 1833(l)(4)(B) (42 U.S.C. 1395l(l)(4)(B)) is amended by adding at the end the following new clause:

''(iv) Notwithstanding section 1862(a)(1)(A), in the case of services of a certified registered nurse anesthetist consisting of the furnishing of anesthesia services for a single case that are furnished jointly with a physician, if the carrier determines that the use of both the physician and the nurse anesthetist to furnish the anesthesia service was not medically necessary, the fee schedule amount for the services furnished by the certified registered nurse anesthetist shall be equal to 50 percent (or 40 percent, in the case of services furnished during 1996 or 1997) of the fee schedule amount applicable under section 1848 for anesthesia services personally performed by the physician alone (without regard to this clause).''.

(b) EFFECTIVE DATE.—The amendments made by subsections (a) shall apply to services furnished on or after July 1, 1996.

SEC. 15609. STATEWIDE FEE SCHEDULE AREA FOR PHYSICIANS' SERVICES.

(a) IN GENERAL.—Notwithstanding section 1848(j)(2) of the Social Security Act, in the case of the

State of Wisconsin, the Secretary of Health and Human Services shall treat the State as a single fee schedule area for purposes of determining the fee schedule amount (as referred to in section 1848(a) of such Act) for physicians' services (as defined in section 1848(j)(3) of such Act) under part B of the medicare program.

(b) BUDGET-NEUTRALITY.—Notwithstanding any provision of part B of title XVIII of the Social Security Act, the Secretary shall carry out subsection (a) in a manner that ensures that total payments for physicians' services (as so defined) furnished by physicians in Wisconsin during a year are not greater or less than total payments for such services would have been but for this section.

(c) CONSTRUCTION.—Nothing in this section shall be construed as limiting the availability (to the Secretary, the appropriate agency or organization with a contract under section 1842 of such Act, or physicians in the State of Wisconsin) of otherwise applicable administrative procedures for modifying the fee schedule area or areas in the State after implementation of subsection (a).

(d) EFFECTIVE DATE.—This section shall apply with respect to physicians' services furnished on or after January 1, 1997.

SEC. 15609A. ESTABLISHMENT OF FEE SCHEDULE FOR AMBULANCE SERVICES.

(a) PAYMENT IN ACCORDANCE WITH FEE SCHEDULE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(1) by striking ''and (P)'' and inserting ''(P)''; and

(2) by striking the semicolon at the end and inserting the following: '', and (Q) with respect to ambulance service, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph (in accordance with section 15608(b) of the Medicare Preservation Act);''.

(b) REQUIREMENTS FOR ESTABLISHMENT OF FEE SCHEDULE.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall establish the fee schedule for ambulance services under section 1833(a)(1)(Q) of the Social Security Act (as added by subsection (a)) 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 the fee schedule for ambulance services, the Secretary shall—

(A) establish mechanisms to control increases in expenditures for ambulance services under part B of the medicare program which fairly reflect the changing nature of the ambulance service industry;

(B) establish definitions for ambulance services which promote efficiency and link payments (including fees for assessment and treatment services) to the type of service provided;

(C) take into account regional differences which affect cost and productivity, including differences in the costs of resources and the costs of uncompensated care;

(D) apply dynamic adjustments to payment rates to account for inflation, demographic changes in the population of medicare beneficiaries, and changes in the number of providers of ambulance services participating in the medicare program; and

(E) phase in the application of the payment rates under the fee schedule in an efficient and fair manner.

(3) SAVINGS.—In establishing the fee schedule for ambulance services, the Secretary shall—

(A) ensure that the aggregate amount of payments made for ambulance services under part B of the medicare program during 1998 does not exceed the aggregate amount of payments which would have been made for such services under part B of the program during 1998 if the amendments made by this section were not in effect; and

(B) set the payment amounts provided under the fee schedule for services furnished in 1999 and each subsequent year at amounts equal to the payment amounts under the fee schedule for service furnished during the previous year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

(4) CONSULTATION.—In establishing the fee schedule for ambulance services, the Secretary shall consult regularly with the American Ambulance Association, the National Association of State Medical Directors, and other national organizations representing individuals and entities who furnish or reg-

ulate ambulance services, and shall share with such associations and organizations the data and data analysis used in establishing the fee schedule, including data on variations in payments for ambulance services under part B of the medicare program for years prior to 1998 among geographic areas and types of ambulance service providers.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) and the fee schedule described in subsection (b) shall apply to ambulance services furnished on or after January 1, 1998.

SEC. 15609B. STANDARDS FOR PHYSICAL THERAPY SERVICES FURNISHED BY PHYSICIANS.

(a) APPLICATION OF STANDARDS FOR OTHER PROVIDERS OF PHYSICAL THERAPY SERVICES TO SERVICES FURNISHED BY PHYSICIANS.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 15525(a)(2), 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) in the case of physicians' services under section 1848(j)(3) consisting of outpatient physical therapy services or outpatient occupational therapy services, which are furnished by a physician who does not meet the requirements applicable under section 1861(p) to a clinic or rehabilitation agency furnishing such services.''.

(b) CONFORMING AMENDMENT.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(subject to section 1862(a)(17))'' after ''(2)(D)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1996.

PART 2—PART B PREMIUM

SEC. 15611. EXTENSION OF PART B PREMIUM.

(a) IN GENERAL.—Section 1839(e)(1) (42 U.S.C. 1395r(e)(1)) is amended—

(1) in subparagraph (A)—

(A) by striking ''and prior to January 1999'', and

(B) by inserting ''(or, if higher, the percent described in subparagraph (C))'' after ''50 percent''; and

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

''(C) For purposes of subparagraph (A), the percent described in this subparagraph is the ratio (expressed as a percentage) of the monthly premium established under this section for months in 1995 to the monthly actuarial rate for enrollees age 65 and over applicable to such months (as specified in the most recent report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund published prior to the date of the enactment of the Medicare Preservation Act of 1995).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to premiums for months beginning with January 1996.

SEC. 15612. INCOME-RELATED REDUCTION IN MEDICARE SUBSIDY.

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

''(h)(1) Notwithstanding the previous subsections of this section, in the case of an individual whose modified adjusted gross income for a taxable year ending with or within a calendar year (as initially determined by the Secretary in accordance with paragraph (3)) exceeds the threshold amount described in paragraph (5)(B), the Secretary shall increase the amount of the monthly premium for months in the calendar year by an amount equal to the difference between—

''(A) 200 percent of the monthly actuarial rate for enrollees age 65 and over as determined under subsection (a)(1) for that calendar year; and

''(B) the total of the monthly premiums paid by the individual under this section (determined without regard to subsection (b)) during such calendar year.

''(2) In the case of an individual described in paragraph (1) whose modified adjusted gross income exceeds the threshold amount by less than $25,000, the amount of the increase in the monthly premium applicable under paragraph (1) shall be an amount which bears the same ratio to the amount of the increase described in paragraph (1) (determined without regard to this paragraph) as such excess bears to $25,000. In the case of a joint return filed under section 6013 of the Internal Revenue Code of 1986 by spouses both of whom are enrolled under this part, the previous sentence shall be applied by substituting '$50,000' for '$25,000'. The preceding provisions of this paragraph shall not apply to any individual whose threshold amount is zero.

''(3) The Secretary shall make an initial determination of the amount of an individual's modified adjusted gross income for a taxable year ending with or within a calendar year for purposes of this subsection as follows:

''(A) Not later than October 1 of the year preceding the year, the Secretary shall provide notice to each individual whom the Secretary finds (on the basis of the individual's actual modified adjusted gross income for the most recent taxable year for which such information is available or other information provided to the Secretary by the Secretary of the Treasury) will be subject to an increase under this subsection that the individual will be subject to such an increase, and shall include in such notice the Secretary's estimate of the individual's modified adjusted gross income for the year.

''(B) If, during the 30-day period beginning on the date notice is provided to an individual under subparagraph (A), the individual provides the Secretary with information on the individual's anticipated modified adjusted gross income for the year, the amount initially determined by the Secretary under this paragraph with respect to the individual shall be based on the information provided by the individual.

''(C) If an individual does not provide the Secretary with information under subparagraph (B), the amount initially determined by the Secretary under this paragraph with respect to the individual shall be

the amount included in the notice provided to the individual under subparagraph (A).

''(4)(A) If the Secretary determines (on the basis of final information provided by the Secretary of the Treasury) that the amount of an individual's actual modified adjusted gross income for a taxable year ending with or within a calendar year is less than or greater than the amount initially determined by the Secretary under paragraph (3), the Secretary shall increase or decrease the amount of the individual's monthly premium under this section (as the case may be) for months during the following calendar year by an amount equal to 1/12 of the difference between—

''(i) the total amount of all monthly premiums paid by the individual under this section during the previous calendar year; and

''(ii) the total amount of all such premiums which would have been paid by the individual during the previous calendar year if the amount of the individual's modified adjusted gross income initially determined under paragraph (3) were equal to the actual amount of the individual's modified adjusted gross income determined under this paragraph.

''(B) In the case of an individual who is not enrolled under this part for any calendar year for which the indi-

vidual's monthly premium under this section for months during the year would be increased pursuant to subparagraph (A) if the individual were enrolled under this part for the year, the Secretary may take such steps as the Secretary considers appropriate to recover from the individual the total amount by which the individual's monthly premium for months during the year would have been increased under subparagraph (A) if the individual were enrolled under this part for the year.

''(C) In the case of a deceased individual for whom the amount of the monthly premium under this section for months in a year would have been decreased pursuant to subparagraph (A) if the individual were not deceased, the Secretary shall make a payment to the individual's surviving spouse (or, in the case of an individual who does not have a surviving spouse, to the individual's estate) in an amount equal to the difference between—

''(i) the total amount by which the individual's premium would have been decreased for all months during the year pursuant to subparagraph (A); and

''(ii) the amount (if any) by which the individual's premium was decreased for months during the year pursuant to subparagraph (A).

''(5) In this subsection, the following definitions apply:

''(A) The term 'modified adjusted gross income' means adjusted gross income (as defined in section 62 of the Internal Revenue Code of 1986)—

''(i) determined without regard to sections 135, 911, 931, and 933 of such Code, and

''(ii) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax under such Code.

''(B) The term 'threshold amount' means—

''(i) except as otherwise provided in this paragraph, $75,000,

''(ii) $125,000, in the case of a joint return (as defined in section 7701(a)(38) of such Code), and

''(iii) zero in the case of a taxpayer who—

''(I) is married at the close of the taxable year but does not file a joint return (as so defined) for such year, and

''(II) does not live apart from his spouse at all times during the taxable year.''.

(b) CONFORMING AMENDMENT.—Section 1839(f) (42 U.S.C. 1395r(f)) is amended by striking ''if an individual'' and inserting the following: ''if an individual

(other than an individual subject to an increase in the monthly premium under this section pursuant to subsection (h))''.

(c) REPORTING REQUIREMENTS FOR SECRETARY OF THE TREASURY.—

(1) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating to confidentiality and disclosure of returns and return information) is amended by adding at the end the following new paragraph:

''(15) DISCLOSURE OF RETURN INFORMATION TO CARRY OUT INCOME-RELATED REDUCTION IN MEDICARE PART B PREMIUM.—

''(A) IN GENERAL.—The Secretary may, upon written request from the Secretary of Health and Human Services, disclose to officers and employees of the Health Care Financing Administration return information with respect to a taxpayer who is required to pay a monthly premium under section 1839 of the Social Security Act. Such return information shall be limited to—

''(i) taxpayer identity information with respect to such taxpayer,

''(ii) the filing status of such taxpayer,

''(iii) the adjusted gross income of such taxpayer,

''(iv) the amounts excluded from such taxpayer's gross income under sections 135 and 911,

''(v) the interest received or accrued during the taxable year which is exempt from the tax imposed by chapter 1 to the extent such information is available, and

''(vi) the amounts excluded from such taxpayer's gross income by sections 931 and 933 to the extent such information is available.

''(B) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Health Care Financing Administration only for the purposes of, and to the extent necessary in, establishing the appropriate monthly premium under section 1839 of the Social Security Act.''

(2) CONFORMING AMENDMENT.—Paragraphs (3)(A) and (4) of section 6103(p) of such Code are

each amended by striking ''or (14)'' each place it appears and inserting ''(14), or (15)''.

(d) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to the monthly premium under section 1839 of the Social Security Act for months beginning with January 1997.

PART 3—ADMINISTRATION AND BILLING OF LABORATORY SERVICES

SEC. 15621. ADMINISTRATIVE SIMPLIFICATION FOR LABORATORY SERVICES.

(a) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services (in accordance with the process described in subsection (b)) shall adopt uniform coverage, administration, and payment policies for clinical diagnostic laboratory tests under part B of the medicare program.

(b) PROCESS FOR ADOPTION OF POLICIES.—The Secretary shall adopt uniform policies under subsection (a) in accordance with the following process:

(1) The Secretary shall select from carriers with whom the Secretary has a contract under part B during 1995 15 medical directors, who will meet and develop recommendations for such uniform policies. The medical directors selected shall represent

various geographic areas and have a varied range of experience in relevant medical fields, including pathology and clinical laboratory practice.

(2) The medical directors selected under paragraph (1) shall consult with independent experts in each major discipline of clinical laboratory medicine, including clinical laboratory personnel, bioanalysts, pathologists, and practicing physicians. The medical directors shall also solicit comments from other individuals and groups who wish to participate, including consumers and other affected parties. This process shall be conducted as a negotiated rulemaking under title 5, United States Code.

(3) Under the negotiated rulemaking, the recommendations for uniform policies shall be designed to simplify and reduce unnecessary administrative burdens in connection with the following:

(A) Beneficiary information required to be submitted with each claim.

(B) Physicians' obligations regarding documentation requirements and recordkeeping.

(C) Procedures for filing claims and for providing remittances by electronic media.

(D) The performance of post-payment review of test claims.

(E) The prohibition of the documentation of medical necessity except when determined to be appropriate after identification of aberrant utilization pattern through focused medical review.

(F) Beneficiary responsibility for payment.

(4) During the pendency of the adoption by the Secretary of the uniform policies, fiscal intermediaries and carriers under the medicare program may not implement any new requirement relating to the submission of a claim for clinical diagnostic laboratory tests retroactive to January 1, 1995, and carriers may not initiate any new coverage, administrative, or payment policy unless the policy promotes the goal of administrative simplification of requirements imposed on clinical laboratories in accordance with the Secretary's promulgation of the negotiated rulemaking.

(5) Not later than 6 months after the date of the enactment of this Act, the medical directors shall submit their recommendations to the Secretary, and the Secretary shall publish the recommendations and solicit public comment using negotiated rulemaking in accordance with title 5, United States Code. The Secretary shall publish final uniform policies for cov-

erage, administration, and payment of claims for clinical diagnostic laboratory tests, effective after the expiration of the 180-day period which begins on the date of publication.

(6) After the publication of the final uniform policies, the Secretary shall implement identical uniform documentation and processing policies for all clinical diagnostic laboratory tests paid under the medicare program through fiscal intermediaries or carriers.

(c) OPTIONAL SELECTION OF SINGLE CARRIER.—Effective for claims submitted after the expiration of the 90-day period which begins on the date of the enactment of this Act, an independent laboratory may select a single carrier for the processing of all of its claims for payment under part B of the medicare program, without regard to the location where the laboratory or the patient or provider involved resides or conducts business. Such election of a single carrier shall be made by the clinical laboratory and an agreement made between the carrier and the laboratory shall be forwarded to the Secretary of Health and Human Services. Nothing in this subsection shall be construed to require a laboratory to select a single carrier under this subsection.

SEC. 15622. RESTRICTIONS ON DIRECT BILLING FOR LABORATORY SERVICES.

(a) REQUIREMENT FOR DIRECT BILLING.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following new paragraph:

''(7)(A) Effective for services furnished on or October 1, 1996, an individual or entity that performs clinical laboratory diagnostic tests shall not present or cause to be presented a claim, bill, or demand for payment to any person, other than the individual receiving such services or the health plan designated by such person, except that (i) in the case of a test performed by one laboratory at the request of another laboratory, which meets the requirements of clause (i), (ii), or (iii) of paragraph (5)(A), payment may be made to the requesting laboratory, and (ii) the Secretary may by regulation establish appropriate exceptions to the requirement of this subparagraph.

''(B)(i) Any person that collects any amounts that were billed in violation of paragraph (7)(A) above shall be liable for such amounts to the person from whom such amounts were collected.

''(ii) Any person that furnishes clinical laboratory services for which payment is made under paragraph (1)(D)(i) or paragraph (2)(D)(i) that knowingly violates subparagraph (A) is subject to a civil money penalty of not more than $10,000 for each such violation. The provi-

sions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this paragraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1128A(a).

''(iii)(I) Any individual or entity that the Secretary determines has repeatedly violated subparagraph (A) may be excluded from participation in any Federal health care program. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to an exclusion under this paragraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1128A(a).

''(II) The provisions of section 1128(e) of the Social Security Act shall apply to any exclusion under clause (iii)(I) in the same manner as such provisions apply to a proceeding under section 1128.

''(iv) If the Secretary finds, after a reasonable notice and opportunity for a hearing, that a laboratory which holds a certificate pursuant to section 353 of the Public Health Service Act has on a repeated basis violated subparagraph (A), the Secretary may suspend, revoke, or limit such certification in accordance with the procedures established in section 353(k) of Public Health Service Act.

''(C) For purposes of this paragraph, the following definitions shall apply:

''(i) The term 'Federal health care program' means—

''(I) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded, in whole or in part, by the United States Government; or

''(II) any State health care program, as defined in section 1128(h).

''(ii) The term 'health plan' means any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by an insurer, except that such term does not include any of the following:

''(I) Coverage only for accident, dental, vision, disability income, or long-term care insurance, or any combination thereof.

''(II) Medicare supplemental health insurance.

''(III) Coverage issued as a supplement to liability insurance.

''(IV) Liability insurance, including general liability insurance and automobile liability insurance.

''(V) Worker's compensation or similar insurance.

''(VI) Automobile medical-payment insurance.

''(VII) Coverage for a specified disease or illness.

''(VIII) A hospital or fixed indemnity policy.

(b) LOOK BACK PROVISIONS TO ASSURE SAVINGS.—

(1) IN GENERAL.—Section 1833(h)(4)(B) (42 U.S.C. 1395l(h)(4)(B)), as amended by section 15604(b), is amended—

(A) in clause (vii), by striking ''and'' at the end;

(B) in clause (viii)—

(i) by inserting ''and before January 1, 2000,'' after ''1996,'', and

(ii) by striking the period at the end and inserting '', and''; and

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

''(ix) after December 31, 1999, is equal to such percentage of such median as the Secretary establishes under paragraph (8)(B), or, if the Secretary does not act under paragraph (8)(B), is equal to 65 percent of such median.''.

(2) PROCESS FOR REDUCTIONS.—Section 1833(h) (42 U.S.C. 1395l(h)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

''(8)(A) On July 31, 1999, the Secretary shall estimate—

''(i) the amount of expenditures under this section for clinical diagnostic laboratory tests which will be made in the period from January 1, 1997, through September 30, 2002, and

''(ii) the amount of expenditures which would have been made under this section for clinical diagnostic laboratory tests in the period from January 1, 1997, through September 30, 2002, if paragraph (7) had not been enacted.

''(B) If the amount estimated under subparagraph (A)(i) is greater than 97 percent of the amount estimated under subparagraph (A)(ii), the Secretary shall establish a limitation amount under paragraph (4)(B)(ix) such that, when such limitation amount is considered, the amount estimated under subparagraph (A)(i) is 97 percent of the amount estimated under subparagraph (A)(ii).

''(C) The Director of the Congressional Budget Office (hereafter in this subparagraph referred to as the 'Director') shall—

''(i) independently estimate the amounts specified in subparagraph (A) and compute any limitation amount required under subparagraph (B), and

''(ii) submit a report on such estimates and computation to Congress not later than August 31, 1999.

The Secretary shall provide the Director with such data as the Director reasonably requires to prepare such estimates and computation.''.

PART 4—QUALITY STANDARDS FOR DURABLE MEDICAL EQUIPMENT

SEC. 15631. RECOMMENDATIONS FOR QUALITY STANDARDS FOR DURABLE MEDICARE EQUIPMENT.

(a) APPOINTMENT OF TASK FORCE BY SECRETARY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall establish a broadly based task force to develop recommendations for quality standards for durable medical equipment under part B of the medicare program.

(2) COMPOSITION.—The task force shall include individuals selected by the Secretary from representatives of suppliers of items of durable medical equipment under part B, consumers, and other users of such equipment. In appointing members, the Sec-

retary shall assure representation from various geographic regions of the United States.

(3) NO COMPENSATION FOR SERVICE.—Members of the task force shall not receive any compensation for service on the task force.

(4) TERMINATION.—The task force shall terminate 30 days after it submits the report described in subsection (b).

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the task force established under subsection (a) shall submit to the Secretary its recommendations for quality standards for durable medicare equipment under part B of the medicare program.

Subtitle H—Provisions Relating to Medicare Parts A and B

PART 1—PAYMENTS FOR HOME HEALTH SERVICES

SEC. 15701. PAYMENT FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 15106, is amended by adding at the end the following new section:

''PAYMENT FOR HOME HEALTH SERVICES

''SEC. 1894. (a) IN GENERAL.—

''(1) PER VISIT PAYMENTS.—Subject to subsection (c), the Secretary shall make per visit payments beginning with fiscal year 1997 to a home

health agency in accordance with this section for each type of home health service described in paragraph (2) furnished to an individual who at the time the service is furnished is under a plan of care by the home health agency under this title (without regard to whether or not the item or service was furnished by the agency or by others under arrangement with them made by the agency, or otherwise).

''(2) TYPES OF SERVICES.—The types of home health services described in this paragraph are the following:

''(A) Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse.

''(B) Physical therapy.

''(C) Occupational therapy.

''(D) Speech-language pathology services.

''(E) Medical social services under the direction of a physician.

''(F) To the extent permitted in regulations, part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary.

''(b) ESTABLISHMENT OF PER VISIT RATE FOR EACH TYPE OF SERVICES.—

''(1) IN GENERAL.—The Secretary shall, subject to paragraph (3), establish a per visit payment rate for a home health agency in an area for each type of home health service described in subsection (a)(2). Such rate shall be equal to the national per visit payment rate determined under paragraph (2) for each such type, except that the labor-related portion of such rate shall be adjusted by the area wage index applicable under section 1886(d)(3)(E) for the area in which the agency is located (as determined without regard to any reclassification of the area under section 1886(d)(8)(B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under section 1886(d)(10) for cost reporting periods beginning after October 1, 1995).

''(2) NATIONAL PER VISIT PAYMENT RATE.—The national per visit payment rate for each type of service described in subsection (a)(2)—

''(A) for fiscal year 1997, is an amount equal to the national average amount paid per visit under this title to home health agencies for such type of service during the most recent 12-month cost reporting period ending on or before

June 30, 1994, increased (in a compounded manner) by the home health market basket percentage increase for fiscal years 1995, 1996, and 1997; and

''(B) for each subsequent fiscal year, is an amount equal to the national per visit payment rate in effect for the preceding fiscal year, increased by the home health market basket percentage increase for such subsequent fiscal year minus 2 percentage points.

''(3) REBASING OF RATES.—The Secretary shall provide for an update to the national per visit payment rates under this subsection for cost reporting periods beginning not later than the first day of the fifth fiscal year which begins after fiscal year 1997, and not later than every 5 years thereafter, to reflect the most recent available data.

''(4) 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 types of home health services described in subsection (a)(2) in the same

manner as the market basket percentage increase under section 1886(b)(3)(B)(iii) is determined and applied to inpatient hospital services for the fiscal year.

''(c) PER EPISODE LIMIT.—

''(1) AGGREGATE LIMIT.—

''(A) IN GENERAL.—Except as provided in paragraph (2), a home health agency may not receive aggregate per visit payments under subsection (a) for a fiscal year in excess of an amount equal to the sum of the following products determined for each case-mix category for which the agency receives payments:

''(i) The number of episodes of each case-mix category during the fiscal year; multiplied by

''(ii) the per episode limit determined for such case-mix category for such fiscal year.

''(B) ESTABLISHMENT OF PER EPISODE LIMITS.—

''(i) IN GENERAL.—The per episode limit for a fiscal year for any case-mix category for the area in which a home health agency is located is equal to—

''(I) the mean number of visits for each type of home health service described in subsection (a)(2) furnished during an episode of such case-mix category in such area during fiscal year 1994, adjusted by the case-mix adjustment factor determined in clause (ii) for the fiscal year involved; multiplied by

''(II) the per visit payment rate established under subsection (b) for such type of home health service for the fiscal year for which the determination is being made.

''(ii) CASE MIX ADJUSTMENT FACTOR.—For purposes of clause (i), the case-mix adjustment factor for a year is the factor determined by the Secretary to assure that aggregate payments for home health services under this section during the year will not exceed the payment for such services during the previous year as a result of changes in the number and type of home health visits within case-mix categories over the previous year.

''(iii) REBASING OF PER EPISODE AMOUNTS.—Beginning with fiscal year 1999 and every 2 years thereafter, the Secretary shall revise the mean number of home health visits determined under clause (i)(I) for each type of home health service visit described in subsection (a)(2) furnished during an episode in a case-mix category to reflect the most recently available data on the number of visits.

''(iv) DETERMINATION OF APPLICABLE AREA.—For purposes of determining per episode limits under this subparagraph, the area in which a home health agency is considered to be located shall be such area as the Secretary finds appropriate for purposes of this subparagraph.

''(C) CASE-MIX CATEGORY.—For purposes of this paragraph, the term 'case-mix category' means each of the 18 case-mix categories established under the Phase II Home Health Agency Prospective Payment Demonstration Project conducted by the Health Care Financing Administration. The Secretary may develop an al-

ternate methodology for determining case-mix categories.

''(D) EPISODE.—

''(i) IN GENERAL.—For purposes of this paragraph, the term 'episode' means the continuous 120-day period that—

''(I) begins on the date of an individual's first visit for a type of home health service described in subsection (a)(2) for a case-mix category, and

''(II) is immediately preceded by a 60-day period in which the individual did not receive visits for a type of home health service described in subsection (a)(2).

''(ii) TREATMENT OF EPISODES SPANNING COST REPORTING PERIODS.—The Secretary shall provide for such rules as the Secretary considers appropriate regarding the treatment of episodes under this paragraph which begin during a cost reporting period and end in a subsequent cost reporting period.

''(E) EXEMPTIONS AND EXCEPTIONS.—The Secretary may provide for exemptions and

exceptions to the limits established under this paragraph for a fiscal year as the Secretary deems appropriate, to the extent such exemptions and exceptions do not result in greater payments under this section than the exemptions and exceptions provided under section 1861(v)(1)(L)(ii) in fiscal year 1994, increased by the home health market basket percentage increase for the fiscal year involved (as defined in subsection (b)(4)).

''(2) RECONCILIATION OF AMOUNTS.—

''(A) OVERPAYMENTS TO HOME HEALTH AGENCIES.—Subject to subparagraph (B), if a home health agency has received aggregate per visit payments under subsection (a) for a fiscal year in excess of the amount determined under paragraph (1) with respect to such home health agency for such fiscal year, the Secretary shall reduce payments under this section to the home health agency in the following fiscal year in such manner as the Secretary considers appropriate (including on an installment basis) to recapture the amount of such excess.

''(B) EXCEPTION FOR HOME HEALTH SERVICES FURNISHED OVER A PERIOD GREATER THAN 165 DAYS.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the amount of aggregate per visit payments determined under subsection (a) shall not include payments for home health visits furnished to an individual on or after a continuous period of more than 165 days after an individual begins an episode described in subsection (c)(1)(D) (if such period is not interrupted by the beginning of a new episode).

''(ii) REQUIREMENT OF CERTIFICATION.—Clause (i) shall not apply if the agency has not obtained a physician's certification with respect to the individual requiring such visits that includes a statement that the individual requires such continued visits, the reason for the need for such visits, and a description of such services furnished during such visits.

''(C) SHARE OF SAVINGS.—

''(i) BONUS PAYMENTS.—If a home health agency has received aggregate per

visit payments under subsection (a) for a fiscal year in an amount less than the amount determined under paragraph (1) with respect to such home health agency for such fiscal year, the Secretary shall pay such home health agency a bonus payment equal to 50 percent of the difference between such amounts in the following fiscal year, except that the bonus payment may not exceed 5 percent of the aggregate per visit payments made to the agency for the year.

''(ii) INSTALLMENT BONUS PAYMENTS.—The Secretary may make installment payments during a fiscal year to a home health agency based on the estimated bonus payment that the agency would be eligible to receive with respect to such fiscal year.

''(d) MEDICAL REVIEW PROCESS.—The Secretary shall implement a medical review process (with a particular emphasis on fiscal years 1997 and 1998) for the system of payments described in this section that shall provide an assessment of the pattern of care furnished to individuals receiving home health services for which pay-

ments are made under this section to ensure that such individuals receive appropriate home health services. Such review process shall focus on low-cost cases described in subsection (e)(3) and cases described in subsection (c)(2)(B) and shall require recertification by intermediaries at 30, 60, 90, 120, and 165 days into an episode described in subsection (c)(1)(D).

''(e) ADJUSTMENT OF PAYMENTS TO AVOID CIRCUMVENTION OF LIMITS.—

''(1) IN GENERAL.—The Secretary shall provide for appropriate adjustments to payments to home health agencies under this section to ensure that agencies do not circumvent the purpose of this section by—

''(A) discharging patients to another home health agency or similar provider;

''(B) altering corporate structure or name to avoid being subject to this section or for the purpose of increasing payments under this title; or

''(C) undertaking other actions considered unnecessary for effective patient care and intended to achieve maximum payments under this title.

''(2) TRACKING OF PATIENTS THAT SWITCH HOME HEALTH AGENCIES DURING EPISODE.—

''(A) DEVELOPMENT OF SYSTEM.—The Secretary shall develop a system that tracks home health patients that receive home health services described in subsection (a)(2) from more than 1 home health agency during an episode described in subsection (c)(1)(D).

''(B) ADJUSTMENT OF PAYMENTS.—The Secretary shall adjust payments under this section to each home health agency that furnishes an individual with a type of home health service described in subsection (a)(2) to ensure that aggregate payments on behalf of such individual during such episode do not exceed the amount that would be paid under this section if the individual received such services from a single home health agency.

''(3) LOW-COST CASES.—The Secretary shall develop a system designed to adjust payments to a home health agency for a fiscal year to eliminate any increase in growth of the percentage of low-cost episodes for which home health services are furnished by the agency over such percentage determined for the agency for the 12-month cost reporting period

ending on June 30, 1994. The Secretary shall define a low-cost episode in a manner that provides that a home health agency has an incentive to be cost efficient in delivering home health services and that the volume of such services does not increase as a result of factors other than patient needs.

''(f) REPORT BY MEDICARE PAYMENT REVIEW COMMISSION.—During the first 3 years in which payments are made under this section, the Medicare Payment Review Commission shall annually submit a report to Congress on the effectiveness of the payment methodology established under this section that shall include recommendations regarding the following:

''(1) Case-mix and volume increases.

''(2) Quality monitoring of home health agency practices.

''(3) Whether a capitated payment for home care patients receiving care during a continuous period exceeding 165 days is warranted.

''(4) Whether public providers of service are adequately reimbursed.

''(5) The adequacy of the exemptions and exceptions to the limits provided under subsection (c)(1)(E).

''(6) The appropriateness of the methods provided under this section to adjust the per episode limits and annual payment updates to reflect changes in the mix of services, number of visits, and assignment to case categories to reflect changing patterns of home health care.

''(7) The geographic areas used to determine the per episode limits.

''(g) NO EFFECT ON NON-MEDICARE SERVICES.—Nothing in this section may be construed to affect the provision of or payment for home health services for which payment is not made under this title.''.

(b) PAYMENT FOR PROSTHETICS AND ORTHOTICS UNDER PART A.—Section 1814(k) (42 U.S.C. 1395f(k)) is amended—

(1) by inserting ''and prosthetics and orthotics'' after ''durable medical equipment''; and

(2) by inserting ''and 1834(h), respectively'' after ''1834(a)(1)''.

(c) CONFORMING AMENDMENTS.—

(1) PAYMENTS UNDER PART A.—Section 1814(b) (42 U.S.C. 1395f(b)), as amended by section 15522(b), is amended in the matter preceding paragraph (1) by striking ''1888 and 1888A'' and inserting ''1888, 1888A, and 1894''.

(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—

''(i) that are a type of home health service described in section 1894(a)(2), and which are 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, the amount determined under section 1894; or

''(ii) that are not described in clause (i) (other than a covered osteoporosis drug) (as defined in section 1861(kk)), 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;''.

(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 15525(a)(1), 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 types of home health services described in section 1894(a)(2) 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 otherwise).''.

(ii) CONFORMING AMENDMENT.—Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)), as amended by section 15525(a)(3), is amended by striking ''section 1842(b)(6)(E);'' and inserting ''subpara-

graphs (E) and (F) of section 1842(b)(6);''.

(C) EXCLUSIONS FROM COVERAGE.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 15525(a)(2) and section 15609B(a), is amended—

(i) by striking ''or'' at the end of paragraph (16);

(ii) by striking the period at the end of paragraph (17) and inserting ''; or''; and

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

''(18) where such expenses are for home health services furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency.''.

(3) SUNSET OF REASONABLE COST LIMITATIONS.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)) is amended by adding at the end the following new clause:

''(iv) This subparagraph shall apply only to services furnished by home health agencies during cost reporting periods ending on or before September 30, 1996.''.

(d) LIMITATION ON PART A COVERAGE.—

(1) IN GENERAL.—Section 1812(a)(3) (42 U.S.C. 1395d(a)(3)) is amended by striking the semicolon and inserting ''for up to 165 days during any spell of illness;''.

(2) CONFORMING AMENDMENT.—Section 1812(b) (42 U.S.C. 1395d(b)) is amended—

(A) by striking ''or'' at the end of paragraph (2),

(B) by striking the period at the end of paragraph (3) and inserting ''; or'', and

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

''(4) home health services furnished to the individual during such spell after such services have been furnished to the individual for 165 days during such spell.''.

(3) EXCLUSION OF ADDITIONAL PART B COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.—Section 1839(a) (42 U.S.C. 1395r(a)) is amended—

(A) in the second sentence of paragraph (1), by striking ''enrollees.'' and inserting ''enrollees (except as provided in paragraph (5)).''; and

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

''(5) In estimating the benefits and administrative costs which will be payable from the Federal Supplementary Medical Insurance Trust Fund for a year (beginning with 1996), the Secretary shall exclude an estimate of any benefits and costs attributable to home health services for which payment would have been made under part A during the year but for paragraph (4) of section 1812(b).''.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to spells of illness beginning on or after October 1, 1995.

(e) EFFECTIVE DATE.—Except as provided in subsection (d)(4), the amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 1996.

SEC. 15702. MAINTAINING 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)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by adding at the end the following sentence: ''In establishing limits under this subparagraph, the Secretary

may not take into account any changes in the costs of the provision of services furnished by home health agencies 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.

SEC. 15703. EXTENSION OF WAIVER OF PRESUMPTION OF LACK OF KNOWLEDGE OF EXCLUSION FROM COVERAGE FOR HOME HEALTH AGENCIES.

Section 9305(g)(3) of OBRA–1986, as amended by section 426(d) of the Medicare Catastrophic Coverage Act of 1988 and section 4207(b)(3) of OBRA–1990 (as renumbered by section 160(d)(4) of the Social Security Act Amendments of 1994), is amended by striking ''December 31, 1995'' and inserting ''September 30, 1996''.

SEC. 15704. REPORT ON RECOMMENDATIONS FOR PAYMENTS AND CERTIFICATION FOR HOME HEALTH SERVICES OF CHRISTIAN SCIENCE PROVIDERS.

Not later than July 1, 1996, the Secretary of Health and Human Services shall submit recommendations to Congress regarding an appropriate methodology for mak-

ing payments under the medicare program for home health services furnished by Christian Science providers who meet applicable requirements of the First Church of Christ, Scientist, Boston, Massachusetts, and appropriate criteria for the certification of such providers for purposes of the medicare program.

SEC. 15705. EXTENSION OF PERIOD OF HOME HEALTH AGENCY CERTIFICATION.

Section 1891(c)(2)(A) (42 U.S.C. 1395bbb(c)(2)(A)) is amended—

(1) by striking ''15 months'' and inserting ''36 months''; and

(2) by striking the second sentence and inserting the following: ''The Secretary shall establish a frequency for surveys of home health agencies within this 36-month interval commensurate with the need to assure the delivery of quality home health services.''.

PART 2—MEDICARE SECONDARY PAYER IMPROVEMENTS

SEC. 15711. EXTENSION AND EXPANSION OF EXISTING REQUIREMENTS.

(a) DATA MATCH.—

(1) Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

(b) APPLICATION TO DISABLED INDIVIDUALS IN LARGE GROUP HEALTH PLANS.—

(1) IN GENERAL.—Section 1862(b)(1)(B) (42 U.S.C. 1395y(b)(1)(B)) is amended—

(A) in clause (i), by striking ''clause (iv)'' and inserting ''clause (iii)'',

(B) by striking clause (iii), and

(C) by redesignating clause (iv) as clause (iii).

(2) CONFORMING AMENDMENTS.—Paragraphs (1) through (3) of section 1837(i) (42 U.S.C. 1395p(i)) and the second sentence of section 1839(b) (42 U.S.C. 1395r(b)) are each amended by striking ''1862(b)(1)(B)(iv)'' each place it appears and inserting ''1862(b)(1)(B)(iii)''.

(c) EXPANSION OF PERIOD OF APPLICATION TO INDIVIDUALS WITH END STAGE RENAL DISEASE.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the first sentence, by striking ''12-month'' each place it appears and inserting ''24-month'', and

(2) by striking the second sentence.

SEC. 15712. IMPROVEMENTS IN RECOVERY OF PAYMENTS.

(a) PERMITTING RECOVERY AGAINST THIRD PARTY ADMINISTRATORS OF PRIMARY PLANS.—Section 1862(b)(2)(B)(ii) (42 U.S.C. 1395y(b)(2)(B)(ii)) is amended—

(1) by striking ''under this subsection to pay'' and inserting ''(directly, as a third-party administrator, or otherwise) to make payment'', and

(2) by adding at the end the following: ''The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.''.

(b) EXTENSION OF CLAIMS FILING PERIOD.—Section 1862(b)(2)(B) (42 U.S.C. 1395y(b)(2)(B)) is amended by adding at the end the following 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.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after the date of the enactment of this Act.

SEC. 15713. PROHIBITING RETROACTIVE APPLICATION OF POLICY REGARDING ESRD BENEFICIARIES ENROLLED IN PRIMARY PLANS.

For purposes of carrying out section 1862(b)(1)(C) of the Social Security Act, the Secretary of Health and Human Services shall apply the policy directive issued by the Administrator of the Health Care Financing Administration on April 24, 1995, only with respect to items and services furnished on or after such date.

PART 3—FAILSAFE

SEC. 15721. FAILSAFE BUDGET MECHANISM.

(a) IN GENERAL.—Title XVIII, as amended by sections 15106(a) and 15701(a), is amended by adding at the end the following new section:

''FAILSAFE BUDGET MECHANISM

''SEC. 1895. (a) REQUIREMENT OF PAYMENT ADJUSTMENTS TO ACHIEVE MEDICARE BUDGET TAR-

GETS.—If the Secretary determines under subsection (e)(3)(C) before a fiscal year (beginning with fiscal year 1998) that—

''(1) the fee-for-service expenditures (as defined in subsection (f)) for a sector of medicare services (as defined in subsection (b)) for the fiscal year, will exceed

''(2) the allotment specified under subsection (c)(2) for such fiscal year (taking into account any adjustment in the allotment under subsection (h) for that fiscal year),

then, notwithstanding any other provision of this title, there shall be an adjustment (consistent with subsection (d)) in applicable payment rates or payments for items and services included in the sector in the fiscal year so that such expenditures for the sector for the year will be reduced by 133⅓ percent of the amount of such excess.

''(b) SECTORS OF MEDICARE SERVICES DESCRIBED.—

''(1) IN GENERAL.—For purposes of this section, items and services included under each of the following subparagraphs shall be considered to be a separate 'sector' of medicare services:

''(A) Inpatient hospital services.

''(B) Home health services.

''(C) Extended care services (for inpatients of skilled nursing facilities).

''(D) Hospice care.

''(E) Physicians' services (including services and supplies described in section 1861(s)(2)(A)) and services of other health care professionals (including certified registered nurse anesthetists, nurse practitioners, physician assistants, and clinical psychologists) for which separate payment is made under this title.

''(F) Outpatient hospital services and ambulatory facility services.

''(G) Durable medical equipment and supplies, including prosthetic devices and orthotics.

''(H) Diagnostic tests (including clinical laboratory services and x-ray services).

''(I) Other items and services.

''(2) CLASSIFICATION OF ITEMS AND SERVICES.—The Secretary shall classify each type of items and services covered and paid for separately under this title into one of the sectors specified in paragraph (1). After publication of such classification under subsection (e)(1), the Secretary is not au-

thorized to make substantive changes in such classification.

''(c) ALLOTMENT.—

''(1) ALLOTMENTS FOR EACH SECTOR.—For purposes of this section, subject to subsection (h)(1), the allotment for a sector of medicare services for a fiscal year is equal to the product of—

''(A) the total allotment for the fiscal year established under paragraph (2), and

''(B) the allotment proportion (specified under paragraph (3)) for the sector and fiscal year involved.

''(2) TOTAL ALLOTMENT.—

''(A) IN GENERAL.—For purposes of this section, the total allotment for a fiscal year is equal to—

''(i) the medicare benefit budget for the fiscal year (as specified under subparagraph (B)), reduced by

''(ii) the amount of payments the Secretary estimates will be made in the fiscal year under the MedicarePlus program under part C.

In making the estimate under clause (ii), the Secretary shall take into account estimated en-

rollment and demographic profile of individuals electing MedicarePlus products.

''(B) MEDICARE BENEFIT BUDGET.—For purposes of this subsection, subject to subparagraph (C), the 'medicare benefit budget'—

''(i) for fiscal year 1997 is $208.0 billion;

''(ii) for fiscal year 1998 is $217.1 billion;

''(iii) for fiscal year 1999 is $228.4 billion;

''(iv) for fiscal year 2000 is $246.4 billion;

''(v) for fiscal year 2001 is $265.5 billion;

''(vi) for fiscal year 2002 is $288.0 billion; and

''(vii) for a subsequent fiscal year is equal to the medicare benefit budget under this subparagraph for the preceding fiscal year increased by the product of (I) 1.05, and (II) 1 plus the annual percentage increase in the average number of medicare beneficiaries from the previous fiscal year to the fiscal year involved.

''(3) MEDICARE ALLOTMENT PROPORTION DEFINED.—

''(A) IN GENERAL.—For purposes of this section and with respect to a sector of medicare services for a fiscal year, the term 'medicare allotment proportion' means the ratio of—

''(i) the baseline-projected medicare expenditures (as determined under subparagraph (B)) for the sector for the fiscal year, to

''(ii) the sum of such baseline expenditures for all such sectors for the fiscal year.

''(B) BASELINE-PROJECTED MEDICARE EXPENDITURES.—In this paragraph, the 'baseline, projected medicare expenditures' for a sector of medicare services—

''(i) for fiscal year 1996 is equal to fee-for-service expenditures for such sector during fiscal year 1995, increased by the baseline annual growth rate for such sector of medicare services for fiscal year 1996 (as specified in table in subparagraph (C)); and

''(ii) for a subsequent fiscal year is equal to the baseline-projected medicare expenditures under this subparagraph for the sector for the previous fiscal year increased by the baseline annual growth rate for such sector for the fiscal year involved (as specified in such table).

''(C) BASELINE ANNUAL GROWTH RATES.—The following table specifies the baseline annual growth rates for each of the sectors for different fiscal years:

''For the following sector—	Baseline annual growth rates for fiscal year—						
	1996	1997	1998	1999	2000	2001	2002 and thereafter
(A) Inpatient hospital services	5.7%	5.6%	6.0%	6.1%	5.7%	5.5%	5.2%
(B) Home health services	17.2%	15.1%	11.7%	9.1%	8.4%	8.1%	7.9%
(C) Extended care services	19.7%	12.3%	9.3%	8.7%	8.6%	8.4%	8.0%
(D) Hospice care	32.0%	24.0%	18.0%	15.0%	12.0%	10.0%	9.0%
(E) Physicians' services	12.4%	9.7%	8.7%	9.0%	9.3%	9.6%	10.1%
(F) Outpatient hospital services	14.7%	13.9%	14.5%	15.0%	14.1%	13.9%	14.0%
(G) Durable medical equipment and supplies	16.1%	15.5%	13.7%	12.4%	13.2%	13.9%	14.5%
(H) Diagnostic tests	13.1%	11.3%	11.0%	11.4%	11.4%	11.5%	11.9%
(I) Other items and services	11.2%	10.2%	10.9%	12.0%	11.6%	11.6%	11.8%

''(d) MANNER OF PAYMENT ADJUSTMENT.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall apply a payment reduction for a sector for a fiscal year in such a manner as to—

''(A) make a change in payment rates (to the maximum extent practicable) at the time

payment rates are otherwise changed or subject to change for that fiscal year; and

''(B) provide for the full appropriate adjustment so that the fee-for-service expenditures for the sector for the fiscal year will approximate (and not exceed) the allotment for the sector for the fiscal year.

''(2) TAKING INTO ACCOUNT VOLUME AND CASH FLOW.—In providing for an adjustment in payments under this subsection for a sector for a fiscal year, the Secretary shall take into account (in a manner consistent with actuarial projections)—

''(A) the impact of such an adjustment on the volume or type of services provided in such sector (and other sectors), and

''(B) the fact that an adjustment may apply to items and services furnished in a fiscal year (payment for which may occur in a subsequent fiscal year),

in a manner that is consistent with assuring that total fee-for-services expenditures for each sector for the fiscal year will not exceed the allotment under subsection (c)(1) for such sector for such year.

''(3) PROPORTIONALITY OF REDUCTIONS WITHIN A SECTOR.—In making adjustments under this

subsection in payment for items and services included within a sector of medicare services for a fiscal year, the Secretary shall provide for such an adjustment that results (to the maximum extent feasible) in the same percentage reductions in aggregate Federal payments under parts A and B for the different classes of items and services included within the sector for the fiscal year.

''(4) APPLICATION TO PAYMENTS MADE BASED ON PROSPECTIVE PAYMENT RATES DETERMINED ON A FISCAL YEAR BASIS.—

''(A) IN GENERAL.—In applying subsection (a) with respect to items and services for which payment is made under part A or B on the basis of rates that are established on a prospective basis for (and in advance of) a fiscal year, the Secretary shall provide for the payment adjustment under such subsection through an appropriate reduction in such rates established for items and services furnished (or, in the case of payment for operating costs of inpatient hospital services of subsection (d) hospitals and subsection (d) Puerto Rico hospitals (as defined in paragraphs (1)(B) and (9)(A) of section

1886(d)), discharges occurring) during such year.

''(B) DESCRIPTION OF APPLICATION TO SPECIFIC SERVICES.—The payment adjustment described in subparagraph (A) applies for a fiscal year to at least the following:

''(i) UPDATE FACTOR FOR PAYMENT FOR OPERATING COSTS OF INPATIENT HOSPITAL SERVICES OF PPS HOSPITALS.—To the computation of the applicable percentage increase specified in section 1886(d)(3)(B)(i) for discharges occurring in the fiscal year.

''(ii) HOME HEALTH SERVICES.—To the extent payment amounts for home health services are based on per visit payment rates under section 1894, to the computation of the increase in the national per visit payment rates established for the year under section 1894(b)(2)(B).

''(iii) HOSPICE CARE.—To the update of payment rates for hospice care under section 1814(i) for services furnished during the fiscal year.

''(iv) UPDATE FACTOR FOR PAYMENT OF OPERATING COSTS OF INPATIENT HOSPITAL SERVICES OF PPS-EXEMPT HOSPITALS.—To the computation of the target amount under section 1886(b)(3) for discharges occurring during the fiscal year.

''(v) COVERED NON-ROUTINE SERVICES OF SKILLED NURSING FACILITIES.—To the computation of the facility per stay limits for the year under section 1888A(d) for covered non-routine services of a skilled nursing facility (as described in such section).

''(5) APPLICATION TO PAYMENTS MADE BASED ON PROSPECTIVE PAYMENT RATES DETERMINED ON A CALENDAR YEAR BASIS.—

''(A) IN GENERAL.—In applying subsection (a) for a fiscal year with respect to items and services for which payment is made under part A or B on the basis of rates that are established on a prospective basis for (and in advance of) a calendar year, the Secretary shall provide for the payment adjustment under such subsection through an appropriate reduction in such rates established for items and services

furnished at any time during such calendar year as follows:

''(i) For fiscal year 1997, the reduction shall be made for payment rates during calendar year 1997 in a manner so as to achieve the necessary payment reductions for such fiscal year for items and services furnished during the first 3 quarters of calendar year 1997.

''(ii) For a subsequent fiscal year, the reduction shall be made for payment rates during the calendar year in which the fiscal year ends in a manner so as to achieve the necessary payment reductions for such fiscal year for items and services furnished during the first 3 quarters of the calendar year, but also taking into account the payment reductions made in the first quarter of the fiscal year resulting from payment reductions made under this paragraph for the previous calendar year.

''(iii) Payment rate reductions effected under this subparagraph for a calendar year and applicable to the last 3 quarters of the fiscal year in which the cal-

endar year ends shall continue to apply during the first quarter of the succeeding fiscal year.

''(B) APPLICATION IN SPECIFIC CASES.—The payment adjustment described in subparagraph (A) applies for a fiscal year to at least the following:

''(i) UPDATE IN CONVERSION FACTOR FOR PHYSICIANS' SERVICES.—To the computation of the conversion factor under subsection (d) of section 1848 used in the fee schedule established under subsection (b) of such section, for items and services furnished during the calendar year in which the fiscal year ends.

''(ii) PAYMENT RATES FOR OTHER HEALTH CARE PROFESSIONALS.—To the computation of payments for professional services of certified registered nurse anesthetists under section 1833(l), nurse midwives, physician assistants, nurse practitioners and clinical nurse specialists under section 1833(r), clinical psychologists, clinical social workers, physical or occupational therapists, and any other health profes-

sionals for which payment rates are based (in whole or in part) on payments for physicians' services, for services furnished during the calendar year in which the fiscal year ends.

''(iii) UPDATE IN LAB FEE SCHEDULE.—To the computation of the fee schedule amount under section 1833(h)(2) for clinical diagnostic laboratory services furnished during the calendar year in which the fiscal year ends.

''(iv) UPDATE IN REASONABLE CHARGES FOR VACCINES.—To the computation of the reasonable charge for vaccines described in section 1861(s)(10) for vaccines furnished during the calendar year in which the fiscal year ends.

''(v) DURABLE MEDICAL EQUIPMENT-RELATED ITEMS.—To the computation of the payment basis under section 1834(a)(1)(B) for covered items described in section 1834(a)(13), for items furnished during the calendar year in which the fiscal year ends.

''(vi) RADIOLOGIST SERVICES.—To the computation of conversion factors for radiologist services under section 1834(b), for services furnished during the calendar year in which the fiscal year ends.

''(vii) SCREENING MAMMOGRAPHY.—To the computation of payment rates for screening mammography under section 1834(c)(1)(C)(ii), for screening mammography performed during the calendar year in which the fiscal year ends.

''(viii) PROSTHETICS AND ORTHOTICS.—To the computation of the amount to be recognized under section 1834(h) for payment for prosthetic devices and orthotics and prosthetics, for items furnished during the calendar year in which the fiscal year ends.

''(ix) SURGICAL DRESSINGS.—To the computation of the payment amount referred to in section 1834(i)(1)(B) for surgical dressings, for items furnished during the calendar year in which the fiscal year ends.

''(x) PARENTERAL AND ENTERAL NUTRITION.—To the computation of reasonable charge screens for payment for parenteral and enteral nutrition under section 1834(h), for nutrients furnished during the calendar year in which the fiscal year ends.

''(xi) AMBULANCE SERVICES.—To the computation of limits on reasonable charges for ambulance services, for services furnished during the calendar year in which the fiscal year ends.

''(6) APPLICATION TO PAYMENTS MADE BASED ON COSTS DURING A COST REPORTING PERIOD.—

''(A) IN GENERAL.—In applying subsection (a) for a fiscal year with respect to items and services for which payment is made under part A or B on the basis of costs incurred for items and services in a cost reporting period, the Secretary shall provide for the payment adjustment under such subsection for a fiscal year through an appropriate proportional reduction in the payment for costs for such items and services incurred at any time during each cost reporting period any part of which occurs during the fiscal year involved, but only (for each such cost

reporting period) in the same proportion as the fraction of the cost reporting period that occurs during the fiscal year involved.

''(B) APPLICATION IN SPECIFIC CASES.—The payment adjustment described in subparagraph (A) applies for a fiscal year to at least the following:

''(i) CAPITAL-RELATED COSTS OF HOSPITAL SERVICES.—To the computation of payment amounts for inpatient and outpatient hospital services under sections 1886(g) and 1861(v) for portions of cost reporting periods occurring during the fiscal year.

''(ii) OPERATING COSTS FOR PPS-EXEMPT HOSPITALS.—To the computation of payment amounts under section 1886(b) for operating costs of inpatient hospital services of PPS-exempt hospitals for portions of cost reporting periods occurring during the fiscal year.

''(iii) DIRECT GRADUATE MEDICAL EDUCATION.—To the computation of payment amounts under section 1886(h) for reasonable costs of direct graduate medical

education costs for portions of cost reporting periods occurring during the fiscal year.

''(iv) INPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—To the computation of payment amounts under section 1814(j) for inpatient rural primary care hospital services for portions of cost reporting periods occurring during the fiscal year.

''(v) EXTENDED CARE SERVICES OF A SKILLED NURSING FACILITY.—To the computation of payment amounts under section 1861(v) for post-hospital extended care services of a skilled nursing facility (other than covered non-routine services subject to section 1888A) for portions of cost reporting periods occurring during the fiscal year.

''(vi) REASONABLE COST CONTRACTS.—To the computation of payment amounts under section 1833(a)(1)(A) for organizations for portions of cost reporting periods occurring during the fiscal year.

''(vii) HOME HEALTH SERVICES.—Subject to paragraph (4)(B)(ii), for payment amounts for home health services, for portions of cost reporting periods occurring during such fiscal year.

''(7) OTHER.—In applying subsection (a) for a fiscal year with respect to items and services for which payment is made under part A or B on a basis not described in a previous paragraph of this subsection, the Secretary shall provide for the payment adjustment under such subsection through an appropriate proportional reduction in the payments (or payment bases for items and services furnished) during the fiscal year.

''(8) ADJUSTMENT OF PAYMENT LIMITS.—The Secretary shall provide for such proportional adjustment in any limits on payment established under part A or B for payment for items and services within a sector as may be appropriate based on (and in order to properly carry out) the adjustment on the amount of payment under this subsection in the sector.

''(9) REFERENCES TO PAYMENT RATES.—Except as the Secretary may provide, any reference in this title (other than this section) to a payment rate

is deemed a reference to such a rate as adjusted under this subsection.

''(e) PUBLICATION OF DETERMINATIONS; JUDICIAL REVIEW.—

''(1) ONE-TIME PUBLICATION OF SECTORS AND GENERAL PAYMENT ADJUSTMENT METHODOLOGY.—Not later than October 1, 1996, the Secretary shall publish in the Federal Register the classification of medicare items and services into the sectors of medicare services under subsection (b) and the general methodology to be used in applying payment adjustments to the different classes of items and services within the sectors.

''(2) INCLUSION OF INFORMATION IN PRESIDENT'S BUDGET.—

''(A) IN GENERAL.—With respect to fiscal years beginning with fiscal year 1999, the President shall include in the budget submitted under section 1105 of title 31, United States Code, information on—

''(i) the fee-for-service expenditures, within each sector, for the second previous fiscal year, and how such expenditures compare to the adjusted sector allotment for that sector for that fiscal year; and

''(ii) actual annual growth rates for fee-for-service expenditures in the different sectors in the second previous fiscal year.

''(B) RECOMMENDATIONS REGARDING GROWTH FACTORS.—The President may include in such budget for a fiscal year (beginning with fiscal year 1998) recommendations regarding percentages that should be applied (for one or more fiscal years beginning with that fiscal year) instead of the baseline annual growth rates under subsection (c)(3)(C). Such recommendations shall take into account medically appropriate practice patterns.

''(3) DETERMINATIONS CONCERNING PAYMENT ADJUSTMENTS.—

''(A) RECOMMENDATIONS OF COMMISSION.—By not later than March 1 of each year (beginning with 1997), the Medicare Payment Review Commission shall submit to the Secretary and the Congress a report that analyzes the previous operation (if any) of this section and that includes recommendations concerning the manner in which this section should be applied for the following fiscal year.

''(B) PRELIMINARY NOTICE BY SECRETARY.—Not later than May 15 preceding the beginning of each fiscal year (beginning with fiscal year 1998), the Secretary shall publish in the Federal Register a notice containing the Secretary's preliminary determination, for each sector of medicare services, concerning the following:

''(i) The projected allotment under subsection (c) for such sector for the fiscal year.

''(ii) Whether there will be a payment adjustment for items and services included in such sector for the fiscal year under subsection (a).

''(iii) If there will be such an adjustment, the size of such adjustment and the methodology to be used in making such a payment adjustment for classes of items and services included in such sector.

''(iv) Beginning with fiscal year 1999, the fee-for-service expenditures for such sector for the second preceding fiscal year.

Such notice shall include an explanation of the basis for such determination. Determinations

under this subparagraph and subparagraph (C) shall be based on the best data available at the time of such determinations.

''(C) FINAL DETERMINATION.—Not later than September 1 preceding the beginning of each fiscal year (beginning with fiscal year 1998), the Secretary shall publish in the Federal Register a final determination, for each sector of medicare services, concerning the matters described in subparagraph (B) and an explanation of the reasons for any differences between such determination and the preliminary determination for such fiscal year published under subparagraph (B).

''(4) LIMITATION ON ADMINISTRATIVE OR JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1878 or otherwise of—

''(A) the classification of items and services among the sectors of medicare services under subsection (b),

''(B) the determination of the amounts of allotments for the different sectors of medicare services under subsection (c),

''(C) the determination of the amount (or method of application) of any payment adjustment under subsection (d), or

''(D) any adjustment in an allotment effected under subsection (h).

''(f) FEE-FOR-SERVICE EXPENDITURES DEFINED.—In this section, the term 'fee-for-service expenditures', for items and services within a sector of medicare services in a fiscal year, means amounts payable for such items and services which are furnished during the fiscal year, and—

''(1) includes types of expenses otherwise reimbursable under parts A and B (including administrative costs incurred by organizations described in sections 1816 and 1842) with respect to such items and services, and

''(2) does not include amounts paid under part C.

''(g) EXPEDITED PROCESS FOR ADJUSTMENT OF SECTOR GROWTH RATES.—

''(1) OPTIONAL INCLUSION OF LEGISLATIVE PROPOSAL.—The President may include in recommendations under subsection (e)(2)(B) submitted with respect to a fiscal year a specific legislative proposal that provides only for the substitution of percentages specified in the proposal for one or more of

the baseline annual growth rates (specified in the table in subsection (c)(3)(C) or in a previous legislative proposal under this subsection) for that fiscal year or any subsequent fiscal year.

''(2) CONGRESSIONAL CONSIDERATION.—

''(A) IN GENERAL.—The percentages contained in a legislative proposal submitted under paragraph (1) shall apply under this section if a joint resolution (described in subparagraph (B)) approving such proposal is enacted, in accordance with the provisions of subparagraph (C), before the end of the 60-day period beginning on the date on which such proposal was submitted. For purposes of applying the preceding sentence and subparagraphs (B) and (C), the days on which either House of Congress is not in session because of an adjournment of more than three days to a day certain shall be excluded in the computation of a period.

''(B) JOINT RESOLUTION OF APPROVAL.—A joint resolution described in this subparagraph means only a joint resolution which is introduced within the 10-day period beginning on the date on which the President submits a proposal under paragraph (1) and—

''(i) which does not have a preamble;

''(ii) the matter after the resolving clause of which is as follows: 'That Congress approves the proposal of the President providing for substitution of percentages for certain baseline annual growth rates under section 1895 of the Social Security Act, as submitted by the President on _____.', the blank space being filled in with the appropriate date; and

''(iii) the title of which is as follows: 'Joint resolution approving Presidential proposal to substitute certain specified percentages for baseline annual growth rates under section 1895 of the Social Security Act, as submitted by the President on _____.', the blank space being filled in with the appropriate date.

''(C) PROCEDURES FOR CONSIDERATION OF RESOLUTION OF APPROVAL.—Subject to subparagraph (D), the provisions of section 2908 (other than subsection (a)) of the Defense Base Closure and Realignment Act of 1990 shall apply to the consideration of a joint reso-

lution described in subparagraph (B) in the same manner as such provisions apply to a joint resolution described in section 2908(a) of such Act.

''(D) SPECIAL RULES.—For purposes of applying subparagraph (C) with respect to such provisions—

''(i) any reference to the Committee on Armed Services of the House of Representatives shall be deemed a reference to an appropriate Committee of the House of Representatives (specified by the Speaker of the House of Representatives at the time of submission of a legislative proposal under paragraph (1)) and any reference to the Committee on Armed Services of the Senate shall be deemed a reference to the Committee on Finance of the Senate;

''(ii) any reference to a resolution of which a committee shall be discharged from further consideration shall be deemed to be a reference to the first such resolution introduced; and

''(iii) any reference to the date on which the President transmits a report

shall be deemed a reference to the date on which the President submits the legislative proposal under paragraph (1).

''(h) LOOK-BACK ADJUSTMENT IN ALLOTMENTS TO REFLECT ACTUAL EXPENDITURES.—

''(1) IN GENERAL.—If the Secretary determines under subsection (e)(3)(B) with respect to a particular fiscal year (beginning with fiscal year 1999) that the fee-for-service expenditures for a sector of medicare services for the second preceding fiscal year—

''(A) exceeded the adjusted allotment for such sector for such year (as defined in paragraph (2)), then the allotment for the sector for the particular fiscal year shall be reduced by 133⅓ percent of the amount of such excess, or

''(B) was less than the adjusted allotment for such sector for such year, then the allotment for the sector for the particular fiscal year shall be increased by the amount of such deficit.

''(2) ADJUSTED ALLOTMENT.—The adjusted allotment under this paragraph for a sector for a fiscal year is—

''(A) the amount that would be computed as the allotment under subsection (c) for the

sector for the fiscal year if the actual amount of payments made in the fiscal year under the MedicarePlus program under part C in the fiscal year were substituted for the amount described in subsection (c)(2)(A)(ii) for that fiscal year,

''(B) adjusted to take into account the amount of any adjustment under paragraph (1) for that fiscal year (based on expenditures in the second previous fiscal year).

''(i) PROSPECTIVE APPLICATION OF CERTAIN NATIONAL COVERAGE DETERMINATIONS.—In the case of a national coverage determination that the Secretary projects will result in significant additional expenditures under this title (taking into account any substitution for existing procedures or technologies), such determination shall not become effective before the beginning of the fiscal year that begins after the date of such determination and shall apply to contracts under part C entered into (or renewed) after the date of such determination.''.

(b) REPORT OF TRUSTEES ON GROWTH RATE IN PART A EXPENDITURES.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

''(k) Each annual report provided in subsection (b)(2) shall include information regarding the annual rate of growth in program expenditures that would be required to maintain the financial solvency of the Trust Fund and the extent to which the provisions of section 1895 restrain the rate of growth of expenditures under this part in order to achieve such solvency.''.

PART 4—ADMINISTRATIVE SIMPLIFICATION

SEC. 15731. STANDARDS FOR MEDICARE INFORMATION TRANSACTIONS AND DATA ELEMENTS.

Title XVIII, as amended by section 15031, is amended by inserting after section 1806 the following new section:

''STANDARDS FOR MEDICARE INFORMATION TRANSACTIONS AND DATA ELEMENTS

''SEC. 1807. (a) ADOPTION OF STANDARDS FOR DATA ELEMENTS.—

''(1) IN GENERAL.—Pursuant to subsection (b), the Secretary shall adopt standards for information transactions and data elements of medicare information and modifications to the standards under this section that are—

''(A) consistent with the objective of reducing the administrative costs of providing and paying for health care; and

''(B) developed or modified by a standard setting organization (as defined in subsection (h)(8)).

''(2) SPECIAL RULE RELATING TO DATA ELEMENTS.—The Secretary may adopt or modify a standard relating to data elements that is different from the standard developed by a standard setting organization, if—

''(A) the different standard or modification will substantially reduce administrative costs to health care providers and health plans compared to the alternative; and

''(B) the standard or modification is promulgated in accordance with the rulemaking procedures of subchapter III of chapter 5 of title 5, United States Code.

''(3) SECURITY STANDARDS FOR HEALTH INFORMATION NETWORK.—

''(A) IN GENERAL.—Each person, who maintains or transmits medicare information or data elements of medicare information and is subject to this section, shall maintain reasonable and appropriate administrative, technical, and physical safeguards—

''(i) to ensure the integrity and confidentiality of the information;

''(ii) to protect against any reasonably anticipated—

''(I) threats or hazards to the security or integrity of the information; and

''(II) unauthorized uses or disclosures of the information; and

''(iii) to otherwise ensure compliance with this section by the officers and employees of such person.

''(B) SECURITY STANDARDS.—The Secretary shall establish security standards and modifications to such standards with respect to medicare information network services, health plans, and health care providers that—

''(i) take into account—

''(I) the technical capabilities of record systems used to maintain medicare information;

''(II) the costs of security measures;

''(III) the need for training persons who have access to medicare information; and

''(IV) the value of audit trails in computerized record systems; and

''(ii) ensure that a medicare information network service, if it is part of a larger organization, has policies and security procedures which isolate the activities of such service with respect to processing information in a manner that prevents unauthorized access to such information by such larger organization.

The security standards established by the Secretary shall be based on the standards developed or modified by standard setting organizations. If such standards do not exist, the Secretary shall rely on the recommendations of the Medicare Information Advisory Committee (established under subsection (g)) and shall consult with appropriate government agencies and private organizations in accordance with paragraph (5).

''(4) IMPLEMENTATION SPECIFICATIONS.—The Secretary shall establish specifications for imple-

menting each of the standards and the modifications to the standards adopted pursuant to paragraph (1) or (3).

''(5) ASSISTANCE TO THE SECRETARY.—In complying with the requirements of this section, the Secretary shall rely on recommendations of the Medicare Information Advisory Committee established under subsection (g) and shall consult with appropriate Federal and State agencies and private organizations. The Secretary shall publish in the Federal Register the recommendations of the Medicare Information Advisory Committee regarding the adoption of a standard under this section.

''(b) STANDARDS FOR INFORMATION TRANSACTIONS AND DATA ELEMENTS.—

''(1) IN GENERAL.—The Secretary shall adopt standards for transactions and data elements to make medicare information uniformly available to be exchanged electronically, that is—

''(A) appropriate for the following financial and administrative transactions: claims (including coordination of benefits) or equivalent encounter information, enrollment and disenrollment, eligibility, premium payments, and referral certification and authorization; and

''(B) related to other financial and administrative transactions determined appropriate by the Secretary consistent with the goals of improving the operation of the health care system and reducing administrative costs.

''(2) UNIQUE HEALTH IDENTIFIERS.—

''(A) ADOPTION OF STANDARDS.—The Secretary shall adopt standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the medicare information system. In developing unique health identifiers for each health plan and health care provider, the Secretary shall take into account multiple uses for identifiers and multiple locations and specialty classifications for health care providers.

''(B) PENALTY FOR IMPROPER DISCLOSURE.—A person who knowingly uses or causes to be used a unique health identifier under subparagraph (A) for a purpose that is not authorized by the Secretary shall—

''(i) be fined not more than $50,000, imprisoned not more than 1 year, or both; or

''(ii) if the offense is committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both.

''(3) CODE SETS.—

''(A) IN GENERAL.—The Secretary, in consultation with the Medicare Information Advisory Committee, experts from the private sector, and Federal and State agencies, shall—

''(i) select code sets for appropriate data elements from among the code sets that have been developed by private and public entities; or

''(ii) establish code sets for such data elements if no code sets for the data elements have been developed.

''(B) DISTRIBUTION.—The Secretary shall establish efficient and low-cost procedures for distribution (including electronic distribution) of code sets and modifications made to such code sets under subsection (c)(2).

''(4) ELECTRONIC SIGNATURE.—

''(A) IN GENERAL.—The Secretary, after consultation with the Medicare Information Advisory Committee, shall promulgate regulations

specifying procedures for the electronic transmission and authentication of signatures, compliance with which will be deemed to satisfy Federal and State statutory requirements for written signatures with respect to information transactions required by this section and written signatures on enrollment and disenrollment forms.

''(B) PAYMENTS FOR SERVICES AND PREMIUMS.—Nothing in this section shall be construed to prohibit the payment of health care services or health plan premiums by debit, credit, payment card or numbers, or other electronic means.

''(5) TRANSFER OF INFORMATION BETWEEN HEALTH PLANS.—The Secretary shall develop rules and procedures—

''(A) for determining the financial liability of health plans when health care benefits are payable under two or more health plans; and

''(B) for transferring among health plans appropriate standard data elements needed for the coordination of benefits, the sequential processing of claims, and other data elements

for individuals who have more than one health plan.

''(6) COORDINATION OF BENEFITS.—If, at the end of the 5-year period beginning on the date of the enactment of this section, the Secretary determines that additional transaction standards for coordinating benefits are necessary to reduce administrative costs or duplicative (or inappropriate) payment of claims, the Secretary shall establish further transaction standards for the coordination of benefits between health plans.

''(7) PROTECTION OF TRADE SECRETS.—Except as otherwise required by law, the standards adopted under this section shall not require disclosure of trade secrets or confidential commercial information by an entity operating a medicare information network.

''(c) TIMETABLES FOR ADOPTION OF STANDARDS.—

''(1) INITIAL STANDARDS.—Not later than 18 months after the date of the enactment of this section, the Secretary shall adopt standards relating to the information transactions, data elements of medicare information and security described in subsections (a) and (b).

''(2) ADDITIONS AND MODIFICATIONS TO STANDARDS.—

''(A) IN GENERAL.—The Secretary shall review the standards adopted under this section and shall adopt additional or modified standards, that have been developed or modified by a standard setting organization, as determined appropriate, but not more frequently than once every 12 months. Any addition or modification to such standards shall be completed in a manner which minimizes the disruption and cost of compliance.

''(B) ADDITIONS AND MODIFICATIONS TO CODE SETS.—

''(i) IN GENERAL.—The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets.

''(ii) ADDITIONAL RULES.—If a code set is modified under this paragraph, the modified code set shall include instructions on how data elements of medicare information that were encoded prior to the modification may be converted or translated so as to preserve the informational value of

the data elements that existed before the modification. Any modification to a code set under this paragraph shall be implemented in a manner that minimizes the disruption and cost of complying with such modification.

''(d) REQUIREMENTS FOR HEALTH PLANS.—

''(1) IN GENERAL.—If a person desires to conduct any of the information transactions described in subsection (b)(1) with a health plan as a standard transaction, the health plan shall conduct such standard transaction in a timely manner and the information transmitted or received in connection with such transaction shall be in the form of standard data elements of medicare information.

''(2) SATISFACTION OF REQUIREMENTS.—A health plan may satisfy the requirement imposed on such plan under paragraph (1) by directly transmitting standard data elements of medicare information or submitting nonstandard data elements to a medicare information network service for processing into standard data elements and transmission.

''(3) TIMETABLES FOR COMPLIANCE WITH REQUIREMENTS.—Not later than 24 months after the date on which standards are adopted under sub-

sections (a) and (b) with respect to any type of information transaction or data element of medicare information or with respect to security, a health plan shall comply with the requirements of this section with respect to such transaction or data element.

''(4) COMPLIANCE WITH MODIFIED STANDARDS.—If the Secretary adopts a modified standard under subsection (a) or (b), a health plan shall be required to comply with the modified standard at such time as the Secretary determines appropriate taking into account the time needed to comply due to the nature and extent of the modification. However, the time determined appropriate under the preceding sentence shall be not earlier than the last day of the 180-day period beginning on the date such modified standard is adopted. The Secretary may extend the time for compliance for small health plans, if the Secretary determines such extension is appropriate.

''(e) GENERAL PENALTY FOR FAILURE TO COMPLY WITH REQUIREMENTS AND STANDARDS.—

''(1) GENERAL PENALTY.—

''(A) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall impose on

any person that violates a requirement or standard—

''(i) with respect to medicare information transactions, data elements of medicare information, or security imposed under subsection (a) or (b); or

''(ii) with respect to health plans imposed under subsection (d);

a penalty of not more than $100 for each such violation of a specific standard or requirement, but the total amount imposed for all such violations of a specific standard or requirement during the calendar year shall not exceed $25,000.

''(B) PROCEDURES.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil money penalty under this paragraph in the same manner as such provisions apply to the imposition of a penalty under such section 1128A.

''(C) DENIAL OF PAYMENT.—Except as provided in paragraph (2), the Secretary may deny payment under this title for an item or service furnished by a person if the person fails to comply with an applicable requirement or

standard for medicare information relating to that item or service.

''(2) LIMITATIONS.—

''(A) NONCOMPLIANCE NOT DISCOVERED.—A penalty may not be imposed under paragraph (1) if it is established to the satisfaction of the Secretary that the person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person failed to comply with the requirement or standard described in paragraph (1).

''(B) FAILURES DUE TO REASONABLE CAUSE.—

''(i) IN GENERAL.—Except as provided in clause (ii), a penalty may not be imposed under paragraph (1) if—

''(I) the failure to comply was due to reasonable cause and not to willful neglect; and

''(II) the failure to comply is corrected during the 30-day period beginning on the first date the person liable for the penalty knew, or by exercising reasonable diligence would have

known, that the failure to comply occurred.

''(ii) EXTENSION OF PERIOD.—

''(I) NO PENALTY.—The period referred to in clause (i)(II) may be extended as determined appropriate by the Secretary based on the nature and extent of the failure to comply.

''(II) ASSISTANCE.—If the Secretary determines that a health plan failed to comply because such plan was unable to comply, the Secretary may provide technical assistance to such plan during the period described in clause (i)(II). Such assistance shall be provided in any manner determined appropriate by the Secretary.

''(C) REDUCTION.—In the case of a failure to comply which is due to reasonable cause and not to willful neglect, any penalty under paragraph (1) that is not entirely waived under subparagraph (B) may be waived to the extent that the payment of such penalty would be excessive relative to the compliance failure involved.

''(f) EFFECT ON STATE LAW.—

''(1) GENERAL EFFECT.—

''(A) GENERAL RULE.—Except as provided in subparagraph (B), a provision, requirement, or standard under this section shall supersede any contrary provision of State law, including a provision of State law that requires medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form.

''(B) EXCEPTIONS.—A provision, requirement, or standard under this section shall not supersede a contrary provision of State law if the Secretary determines that the provision of State law should be continued for any reason, including for reasons relating to prevention of fraud and abuse or regulation of controlled substances.

''(2) PUBLIC HEALTH REPORTING.—Nothing in this section shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.

''(g) MEDICARE INFORMATION ADVISORY COMMITTEE.—

''(1) ESTABLISHMENT.—There is established a committee to be known as the Medicare Information Advisory Committee (in this subsection referred to as the 'committee').

''(2) DUTIES.—The committee shall—

''(A) advise the Secretary in the development of standards under this section; and

''(B) be generally responsible for advising the Secretary and the Congress on the status and the future of the medicare information network.

''(3) MEMBERSHIP.—

''(A) IN GENERAL.—The committee shall consist of 9 members of whom—

''(i) 3 shall be appointed by the President;

''(ii) 3 shall be appointed by the Speaker of the House of Representatives after consultation with the minority leader of the House of Representatives; and

''(iii) 3 shall be appointed by the President pro tempore of the Senate after

consultation with the minority leader of the Senate.

The appointments of the members shall be made not later than 60 days after the date of the enactment of this section. The President shall designate 1 member as the Chair.

''(B) EXPERTISE.—The membership of the committee shall consist of individuals who are of recognized standing and distinction in the areas of information systems, information networking and integration, consumer health, or health care financial management, and who possess the demonstrated capacity to discharge the duties imposed on the committee.

''(C) TERMS.—Each member of the committee shall be appointed for a term of 5 years, except that the members first appointed shall serve staggered terms such that the terms of not more than 3 members expire at one time.

''(D) INITIAL MEETING.—Not later than 30 days after the date on which a majority of the members have been appointed, the committee shall hold its first meeting.

''(4) REPORTS.—Not later than 1 year after the date of the enactment of this section, and annually

thereafter, the committee shall submit to Congress and the Secretary a report regarding—

''(A) the extent to which entities using the medicare information network are meeting the standards adopted under this section and working together to form an integrated network that meets the needs of its users;

''(B) the extent to which such entities are meeting the security standards established pursuant to this section and the types of penalties assessed for noncompliance with such standards;

''(C) any problems that exist with respect to implementation of the medicare information network; and

''(D) the extent to which timetables under this section are being met.

Reports made under this subsection shall be made available to health care providers, health plans, and other entities that use the medicare information network to exchange medicare information.

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

''(1) CODE SET.—The term 'code set' means any set of codes used for encoding data elements,

such as tables of terms, enrollment information, and encounter data.

''(2) COORDINATION OF BENEFITS.—The term 'coordination of benefits' means determining and coordinating the financial obligations of health plans when health care benefits are payable under such a plan and under this title (including under a MedicarePlus product).

''(3) MEDICARE INFORMATION.—The term 'medicare information' means any information that relates to the enrollment of individuals under this title (including information relating to elections of MedicarePlus products under section 1805) and the provision of health benefits (including benefits provided under such products) under this title.

''(4) MEDICARE INFORMATION NETWORK.—The term 'medicare information network' means the medicare information system that is formed through the application of the requirements and standards established under this section.

''(5) MEDICARE INFORMATION NETWORK SERVICE.—The term 'medicare information network service' means a public or private entity that—

''(A) processes or facilitates the processing of nonstandard data elements of medicare information into standard data elements;

''(B) provides the means by which persons may meet the requirements of this section; or

''(C) provides specific information processing services.

''(6) HEALTH PLAN.—The term 'health plan' means a plan which provides, or pays the cost of, health benefits. Such term includes the following, or any combination thereof:

''(A) Part A or part B of this title, and includes a MedicarePlus product.

''(B) The medicaid program under title XIX and the MediGrant program under title XXI.

''(C) A medicare supplemental policy (as defined in section 1882(g)(1)).

''(D) Worker's compensation or similar insurance.

''(E) Automobile or automobile medical-payment insurance.

''(F) A long-term care policy, other than a fixed indemnity policy.

''(G) The Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code.

''(H) An employee welfare benefit plan, as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(1)), but only to the extent the plan is established or maintained for the purpose of providing health benefits.

''(7) INDIVIDUALLY IDENTIFIABLE MEDICARE INFORMATION.—The term 'individually identifiable medicare information' means medicare enrollment information, including demographic information collected from an individual, that—

''(A) is created or received by a health care provider, health plan, employer, or medicare information network service, and

''(B) identifies an individual.

''(8) STANDARD SETTING ORGANIZATION.—The term 'standard setting organization' means a standard setting organization accredited by the American National Standards Institute.

''(9) STANDARD TRANSACTION.—The term 'standard transaction' means, when referring to an information transaction or to data elements of medi-

care information, any transaction that meets the requirements and implementation specifications adopted by the Secretary under subsections (a) and (b).''.

PART 5—OTHER PROVISIONS RELATING TO PARTS A AND B

SEC. 15741. CLARIFICATION OF MEDICARE COVERAGE OF ITEMS AND SERVICES ASSOCIATED WITH CERTAIN MEDICAL DEVICES APPROVED FOR INVESTIGATIONAL USE.

(a) COVERAGE.—Nothing in title XVIII of the Social Security Act may be construed to prohibit coverage under part A or part B of the medicare program of items and services associated with the use of a medical device in the furnishing of inpatient hospital services (as defined for purposes of part A of the medicare program) solely on the grounds that the device is not an approved device, if—

(1) the device is an investigational device; and

(2) the device is used instead of an approved device.

(b) CLARIFICATION OF PAYMENT AMOUNT.—Notwithstanding any other provision of title XVIII of the Social Security Act, the amount of payment made under the medicare program for any item or service associated with the use of an investigational device in the furnishing of inpatient hospital services (as defined for purposes of part

A of the medicare program) may not exceed the amount of the payment which would have been made under the program for the item or service if the item or service were associated with the use of an approved device.

(c) DEFINITIONS.—In this section—

(1) the term ''approved device'' means a medical device which has been approved for marketing under pre-market approval under the Federal Food, Drug, and Cosmetic Act or cleared for marketing under a 510(k) notice under such Act; and

(2) the term ''investigational device'' means a medical device (other than a device described in paragraph (1)) which is approved for investigational use under section 520(g) of the Federal Food, Drug, and Cosmetic Act.

SEC. 15742. ADDITIONAL EXCLUSION FROM COVERAGE.

(a) IN GENERAL.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 15525(a)(2), section 15609B(a), and section 15701(c)(2)(C), is amended—

(1) by striking ''or'' at the end of paragraph (17),

(2) by striking the period at the end of paragraph (18) and inserting ''; or'', and

(3) by inserting after paragraph (18) the following new paragraph:

''(19) where such expenses are for items or services, or to assist in the purchase, in whole or in part, of health benefit coverage that includes items or services, for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payment for items and services furnished on or after the date of the enactment of this Act.

SEC. 15743. COMPETITIVE BIDDING FOR CERTAIN ITEMS AND SERVICES.

(a) ESTABLISHMENT OF DEMONSTRATION.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall establish and operate over a 2-year period a demonstration project in 2 geographic regions selected by the Secretary under which (notwithstanding any provision of title XVIII of the Social Security Act to the contrary) the amount of payment made under the medicare program for a selected item or service (other than clinical diagnostic laboratory tests) furnished in the region shall be equal to the price determined pursuant to a competitive bidding process which meets the requirements of subsection (b).

(b) REQUIREMENTS FOR COMPETITIVE BIDDING PROCESS.—The competitive bidding process used under the demonstration project under this section shall meet such requirements as the Secretary may impose to ensure the cost-effective delivery to medicare beneficiaries in the project region of items and services of high quality.

(c) DETERMINATION OF SELECTED ITEMS OR SERVICES.—The Secretary shall select items and services to be subject to the demonstration project under this section if the Secretary determines that the use of competitive bidding with respect to the item or service under the project will be appropriate and cost-effective. In determining the items or services to be selected, the Secretary shall consult with an advisory taskforce which includes representatives of providers and suppliers of items and services (including small business providers and suppliers) in each geographic region in which the project will be effective.

SEC. 15744. DISCLOSURE OF CRIMINAL CONVICTIONS RELATING TO PROVISION OF HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1891 (42 U.S.C. 1395bbb) is amended by adding at the end the following new subsection:

''(g) The Secretary, and each State or local survey agency or other State agency responsible for monitoring

compliance of home health agencies with requirements, shall make available, upon request of any person, information the Secretary or agency has on individuals who have been convicted of felonies relating to the provision of home health services.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 15745. REQUIRING RENAL DIALYSIS FACILITIES TO MAKE SERVICES AVAILABLE ON A 24-HOUR BASIS.

(a) IN GENERAL.—Section 1881(b)(1) (42 U.S.C. 1395rr(b)(1)) is amended by striking the period at the end and inserting the following: '', together with a requirement (in the case of a renal dialysis facility) that the facility make institutional dialysis services and supplies available on a 24-hour basis (either directly or through arrangements with providers of services or other renal dialysis facilities that meet the requirements of such subparagraph) and that the facility provide notice informing its patients of the other providers of services or renal dialysis facilities (if any) with whom the facility has made such arrangements.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items and services furnished on or after January 1, 1996.

Subtitle I—Clinical Laboratories

SEC. 15801. EXEMPTION OF PHYSICIAN OFFICE LABORATORIES.

Section 353(d) of the Public Health Service Act (42 U.S.C. 263a(d)) is amended—

(1) by redesignating paragraphs (2), (3), and (4) as paragraphs (3), (4), and (5) and by adding after paragraph (1) the following:

''(2) EXEMPTION OF PHYSICIAN OFFICE LABORATORIES.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), a clinical laboratory in a physician's office (including an office of a group of physicians) which is directed by a physician and in which examinations and procedures are either performed by a physician or by individuals supervised by a physician solely as an adjunct to other services provided by the physician's office is exempt from this section.

''(B) EXCEPTION.—A clinical laboratory described in subparagraph (A) is not exempt

from this section when it performs a pap smear (Papanicolaou Smear) analysis.

''(C) DEFINITION.—For purposes of subparagraph (A), the term 'physician' has the same meaning as is prescribed for such term by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).'';

(2) in paragraph (3) (as so redesignated) by striking ''(3)'' and inserting ''(4)''; and

(3) in paragraphs (4) and (5) (as so redesignated) by striking ''(2)'' and inserting ''(3)''.

Subtitle J—Lock-Box Provisions for Medicare Part B Savings from Growth Reductions

SEC. 15901. ESTABLISHMENT OF MEDICARE GROWTH REDUCTION TRUST FUND FOR PART B SAVINGS.

Part B of title XVIII is amended by inserting after section 1841 the following new section:

''MEDICARE GROWTH REDUCTION TRUST FUND

''SEC. 1841A. (a)(1) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Medicare Growth Reduction Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1) and amounts appropriated under paragraph (2).

''(2) There are hereby appropriated to the Trust Fund, out of any amounts in the Treasury not otherwise appropriated, amounts equivalent to 100 percent of the Secretary's estimate of the reductions in outlays under this part that are attributable to the Medicare Preservation Act of 1995. The amounts appropriated by the preceding sentence shall be transferred from time to time (not less frequently than monthly) from the general fund in the Treasury to the Trust Fund.

''(3)(A) Subject to subparagraph (B), with respect to monies transferred to the Trust Fund, no transfers, authorizations of appropriations, or appropriations are permitted.

''(B) Beginning with fiscal year 2003, the Secretary may expend funds in the Trust Fund to carry out this title, but only to the extent provided by Congress in advance through a specific amendment to this section.

''(b) The provisions of subsections (b) through (e) of section 1841 shall apply to the Trust Fund in the same manner as they apply to the Federal Supplementary Medical Insurance Trust Fund, except that the Board of Trustees and Managing Trustee of the Trust Fund shall be composed of the members of the Board of Trustees and

the Managing Trustee, respectively, of the Federal Supplementary Medical Insurance Trust Fund.''.

Passed the House of Representatives October 19, 1995.

Attest: ROBIN H. CARLE,
Clerk.

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