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BUDGET RECONCILIATION RECOMMENDATIONS OF THE COMMITTEE ON FINANCE

AS SUBMITTED TO THE COMMITTEE ON THE BUDGET PURSUANT TO H. CON. RES. 67

COMMITTEE ON FINANCE
UNITED STATES SENATE

WILLIAM V. ROTH, JR., *Chairman*

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PREFACE

H.Con.Res. 67 sets forth the congressional budget for the United States Government for fiscal years 1996, 1997, 1998, 1999, 2000, 2001, and 2002. The resolution also instructs Senate and House committees to develop legislation that achieves the levels of deficit reduction established by the resolution. These "budget reconciliation" recommendations of the various committees are submitted to the Committees on the Budget and assembled into a bill which is considered by each House.

H.Con.Res. 67 instructs the Committee on Finance to report changes in laws within its jurisdiction sufficient to reduce outlays from direct spending programs by $15,328,000,000 in fiscal year 1996; $272,974,000,000 for the period of fiscal years 1996 through 2000; and by $530,359,000,000 for the period of fiscal years 1996 through 2002. The Committee on Finance is also instructed to report changes in laws to increase the statutory limit on the public debt to not more than $5,500,000,000,000.

On September 29, 1995, the Committee on Finance approved its budget reconciliation recommendations by a vote of 11–9. These recommendations reduce direct spending by $14,340,000,000 in fiscal year 1996, and $268,920,000,000 from fiscal year 1996 to fiscal year 2000 and by $530,377,000,000 for the period of fiscal years 1996 through 2002, and increase the statutory limit on the public debt to $5,500,000,000,000.

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(Secs. 7001–7007)

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MEDICARE HEALTH PLAN OPTIONS

Present Law

In lieu of the fee-for-service Medicare program, Medicare beneficiaries may enroll in a health maintenance organization (HMO) that has a contract with the Health Care Financing Administration (HCFA).

There are two types of contracts: cost and risk. Under cost contracts, Medicare arranges to reimburse the organization in a different way for Medicare covered services but essentially pays the same amount as it would under the Medicare fee-for-service program. The Committee is not proposing to change the Medicare HMO cost-contracting program. Therefore, the following description of current law for Medicare payments to HMOs refers only to Medicare risk contracts.

Organizations eligible to contract with HCFA on a risk basis must be organized under State laws and be either:

1. A federally qualified health maintenance organization (HMO) as defined by section 1310(d) of the Public Health Service Act; or

2. An organization called a "competitive medical plan" (CMP) that meets the following requirements:

   a. Provides at least the following services to its enrollees:

      (1) Physician services;

      (2) Inpatient hospital services;

      (3) Laboratory, x-ray, emergency, and preventive services; and

      (4) Out-of-area coverage.

   b. Is compensated on a periodic, capitated basis without regard to the volume of services provided to members.

   c. Physician services are provided by physicians on salary or through contracts with individual physicians or groups of physicians.

d. Assumes full financial risk on a prospective basis for the provision of health care services, except the organization may insure for:

(1) Services exceeding $5,000 per member per year;

(2) Services provided to members by providers outside the network;

(3) Not more than 90 percent of costs which exceed 115 percent of income in a fiscal year; and

(4) Make arrangements with other providers to accept all or part of the risk.

e. Meets solvency standards satisfactory to the Secretary.

For Medicare purposes, the requirements for HMOs and CMPs are essentially identical. For simplicity, the term "Medicare HMO" is used in this document to refer to both HMOs and CMPs that have Medicare risk contracts.

Eligibility

Any person entitled to coverage under Medicare Part A and enrolled under Medicare Part B, or enrolled under Medicare Part B only, except persons with end-stage renal disease, is eligible to enroll in a Medicare HMO that serves the geographic area in which the person resides. A Medicare beneficiary developing end-stage renal disease after having enrolled in a Medicare HMO may continue enrollment in that Medicare HMO.

Enrollment

Persons are automatically enrolled in the Medicare fee-for-service system when they first become eligible for Medicare. Once enrolled in the Medicare program, persons wishing to enroll in a Medicare HMO must do so directly through the Medicare HMO.

Each Medicare HMO is required to have at least a 30-day annual open enrollment period for Medicare beneficiaries. Open enrollment periods are not coordinated. Secretary may waive open enrollment under certain conditions. Medicare HMOs must accept persons on a first-come basis up to plan capacity.

Disenrollment

Medicare beneficiaries enrolled in Medicare HMOs may disenroll at any time and return to the regular Medicare program or switch to another Medicare HMO at the time of that Medicare HMO's open enrollment period.

Information

Information on Medicare HMOs must be obtained from the Medicare HMOs directly. The Health Care Financing Administration (HCFA) does not distribute any specific information on Medicare HMO options to Medicare beneficiaries.

Medicare HMOs are required to make available to enrollees at the time of enrollment, and at least annually thereafter, the following information:

1. The enrollee's rights to benefits from the organization;

2. The restrictions on Medicare payment for services furnished to the enrollee by other than the Medicare HMO's providers;
3. Out-of-area coverage provided by the Medicare HMO;
4. Coverage of emergency services and urgently needed care;
5. Appeal rights of enrollees; and
6. Notice that the Medicare HMO is authorized by law to terminate or refuse to renew its Medicare contract, and, therefore, may terminate or refuse to renew the enrollment of Medicare individuals.

Marketing

Medicare HMOs must submit any brochures, application forms, and promotional or informational material to the Secretary for approval 45 days before distribution of the material.

Benefits

Medicare HMOs are required to provide all services and items covered by Part A and Part B of the Medicare program. Beneficiaries must receive all Medicare covered services from the HMO's providers, except in emergencies.

Medicare HMOs may adopt cost-sharing requirements that are different from the cost-sharing requirements in the Medicare program. However, the average total amount of cost sharing per enrollee may not exceed the average total amount of cost sharing per enrollee in the fee-for-service Medicare program.

Medicare HMOs may offer additional benefits. The additional benefits may be included in the basic package of benefits offered by the HMO, subject to the approval of HCFA. Or, additional supplemental benefits may be offered for an additional, separate premium payment. The same supplemental benefit options must be offered to all of the HMO's Medicare enrollees and premiums for supplemental benefits may not exceed what the Medicare HMO would have charged for the same set of services in the private market.

Medicare HMOs are required to include additional benefits in their basic benefit package to the extent that the HMO achieves a "savings" from Medicare. The "savings" is the amount by which the capitated payment from Medicare exceeds the estimated rate the HMO would charge for coverage in the private market (called the adjusted community rate, or ACR). The additional benefits may be in the form of:

1. Reduced cost sharing;
2. Expanded scope of benefits; or
3. Reduction in the premium charged to the beneficiary by the Medicare HMO.

Instead of offering additional benefits up to the full value of their "savings," Medicare HMOs may elect to have a portion of their "savings" placed in a benefit stabilization fund. This fund enables Medicare HMOs to continue to offer the same benefit package from year to year without concern about the degree of annual fluctuation in the Medicare payment amount.

Health plan standards

Quality assurance—Medicare HMOs are required to have an ongoing quality assurance program. Medicare HMOs are also required to contract with Medicare Peer Review Organizations (PROs) for external quality oversight.

Capacity and enrollment—Medicare HMOs must have at least 5,000 enrollees, unless the HMO serves a primarily rural area (specified in regulation as 1,500 enrollees).

No more than 50 percent of a Medicare HMO's enrollment may be Medicare or Medicaid beneficiaries (called the "50/50" rule). Medicare HMOs serving areas where more than 50 percent of the population qualifies for Medicare or Medicaid may receive a waiver of this rule.

If a Medicare HMO terminates its Medicare contract, other Medicare HMOs serving the same service area must hold a 30-day open enrollment period for persons enrolled under the terminated contract.

Access—An HMO must make all Medicare covered services and all other services contracted for available and accessible within its service area, with reasonable promptness and in a manner that assures continuity of care. Urgent care must be available and accessible 24 hours a day and 7 days a week. Medicare HMOs must also pay for emergency services provided by nonaffiliated providers when it is not reasonable, given the circumstances, to obtain the services through the Medicare HMO.

Consumer protections—Medicare HMOs may not disenroll or refuse to re-enroll a beneficiary because of health status or need for health care services.

Medicare HMOs must have meaningful grievance procedures for the resolution of individual enrollee complaints. Any enrollee who is dissatisfied with the outcome of the grievance procedure has the right to a hearing before the Secretary if the amount involved is greater than $100. If the amount is greater than $1,000, either the enrollee or the Medicare HMO may seek judicial review.

A Medicare HMO may not adopt physician compensation policies that may directly or indirectly have the effect of reducing or limiting services to a specific enrollee.

A Medicare HMO terminating its contract with HCFA must arrange for supplementary coverage for its Medicare enrollees for the duration of any preexisting condition exclusion under the enrollee's successor coverage for the lesser of 6 months or the duration of the exclusion period.

Medicare payments

Medicare HMOs are paid a single monthly capitation payment issued by Medicare for each enrolled beneficiary. In order to determine appropriate payments to HMOs, two key numbers are calculated: the adjusted average per capita cost, or AAPCC, and the adjusted community rate, the ACR.

The AAPCC is Medicare's estimate of the average per capita amount it would spend for a given beneficiary (classified by certain demographic characteristics and county of residence) who obtained services on the usual fee-for-service basis. Separate AAPCCs are established for enrollees on the basis of age, disability status, and

other classes determined by the Secretary (which, by regulation, includes sex, whether they are in a nursing home or other institution, and whether they are also eligible for Medicaid) and the county of their residence. These AAPCC values are calculated in four basic steps:

1. Medicare national average calendar year per capita costs are projected for the future year under consideration. These numbers are known as the U.S. per capita costs (USPCCs). USPCCs are developed separately for Parts A and B of Medicare, and for costs incurred by the aged, disabled, and those with ESRD in those two parts of the program.

2. Geographic adjustment factors that reflect the historical relationship between each county's and the USPCC are used to convert the national average per capita costs to the county level.

3. Expected Medicare per capita costs for the county are adjusted to a fee-for-service basis by removing both reimbursement and enrollment attributable to Medicare beneficiaries in prepaid plans.

4. The recalculated county per capita cost is converted into rates that vary according to the demographic variables enumerated above: age, sex, institutional status, and Medicaid status.

For each Medicare beneficiary enrolled in a Medicare HMO, Medicare will pay the Medicare HMO 95 percent of the rate corresponding to the demographic class to which the beneficiary belongs.

The ACR is an estimate of what each Medicare HMO would charge comparable private enrollees for the set of benefits the Medicare HMO will be furnishing to Medicare beneficiaries under its contract. The starting point for this estimate is the community rate that the HMO actually charges its non-Medicare enrollees. This figure is then adjusted to reflect differences between the scope of benefits covered under Medicare and those offered under private contracts, as well as expected differences in the use of services by Medicare enrollees as compared to other HMO members. The ACR is an estimated market price for those services and may include allowances for reserve funds or profits.

The degree to which the average Medicare payment rate to a Medicare HMO exceeds the Medicare HMO's ACR is the "savings" amount available to provide additional benefits to Medicare enrollees, beyond the basic services covered by Medicare.

Administration and enforcement

Contracts with Medicare HMOs are for one year, and may be made automatically renewable. However, the contract may be terminated by the Secretary at any time (after reasonable notice and opportunity for a hearing) if the organization no longer meets the requirements for Medicare HMOs. The Secretary also has authority to impose certain lesser sanctions, including suspension of enrollment or payment and imposition of civil monetary penalties. These sanctions may be applied for denial of medically necessary services, overcharging, enrollment violations, misrepresentation, failure to pay promptly for services, or employment of providers barred from Medicare participation.

The Secretary transmits to each Medicare beneficiary's selected plan a payment amount equal to the pertinent Medicare payment amount for that individual in that payment area. Payments occur in advance and on a monthly basis.

Payments to plans shall be made with funds withdrawn from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The allocation from each fund determined each year by the Secretary, based on the relative weight that benefits from each fund contribute to the determination of the Medicare payment amounts.

Reasons for Change

The existing Medicare HMO risk contracting program has enjoyed only limited success for a number of reasons. First of all, there has been no assertive effort by the Health Care Financing Administration to inform Medicare beneficiaries of the option of enrolling in a Medicare HMO and encourage them to do so.

Second, the current Medicare risk-contracting program is limited to health maintenance organizations and does not allow Medicare beneficiaries a choice of the full range of health plan options currently available to the non-Medicare population.

The greatest impediment to increased enrollment in Medicare HMO plans is the existing methodology for computing the amount that the Medicare program pays for enrollees in Medicare HMOs. The payments, which are the direct result of per capita spending in an area by the traditional Medicare program, vary greatly from county to county.

For example, in 1995, average monthly payment amounts range across counties from $177 per month to $679 per month. Not surprisingly, most Medicare HMO activity is concentrated in high-payment areas.

Using the county as the geographic area also causes volatility of Medicare payment rates from year to year, especially in sparsely populated counties. Such unpredictable payment rates discourages HMOs from offering plans in many market areas.

Lastly, the Medicare program is not realizing the full financial benefits from the enrollment of Medicare beneficiaries in private health maintenance organizations. The Medicare risk contracting program is structured so that any savings achieved by enrollment in private health plans are returned to the beneficiaries in the form of additional benefits.

Committee Provision

A new "Medicare Choice" program is created. Medicare Choice builds on the existing Medicare program which allows health maintenance organizations (HMOs) to enter into risk contracts with the Health Care Financing Administration. Under Medicare Choice, Medicare beneficiaries will have the opportunity to choose from a variety of private health plan options the health care plan that best suits their needs and preferences.

Medicare Choice plan options

Medicare beneficiaries will be given the option of enrolling in the traditional fee-for-service Medicare program or enrolling in a Medicare Choice plan available in the area of their residence.

The types of health plans that may be available as Medicare Choice plans include (1) fee-for-service indemnity health plans which pay providers on the basis of a privately determined fee schedule; (2) coordinated care plans that arrange for the provision of health services through an integrated network of providers; (3) high-deductible health plans with a minimum annual deductible for insured medical services of $3,000 and which must be offered in conjunction with a Medicare Choice account; and (4) any other types of health plans that meet the standards required of Medicare Choice health plans.

The Secretary of Health and Human Services is to issue regulations, including standards for Medicare Choice sponsors and Medicare Choice plans, by April 30, 1996, or 120 days after passage of the Medicare Choice legislation. Medicare Choice health plans may be sponsored by insurers, health maintenance organizations, provider service networks, unions and Taft-Hartley multi-employer organizations, and associations.

Organizations eligible to contract with the Secretary to offer Medicare Choice plans must be organized and licensed under State laws applicable to entities bearing risk for the provision of health services, by each State in which they wish to enroll Medicare beneficiaries. Organizations that are exempt from State regulation, such as unions and associations, may apply for certification as a Medicare Choice plan sponsor directly to the Secretary.

In order to facilitate the availability of Medicare choice plans throughout the United States, a temporary Medicare Choice plan certification process is established.

Organizations unable to obtain State licensure within 90 days of submitting a completed application to the appropriate State licensing entity may apply for certification as a sponsor of a Medicare Choice plan directly to the Secretary. The Secretary shall review and consider the application only where it finds a state's review process and standards create unreasonable barriers to market entry.

The Secretary must approve or deny the application within 120 days. If the organization meets the quality, access, and solvency requirements of the Medicare Choice program, the Secretary shall grant the organization a certificate allowing the organization to offer Medicare Choice plans for a period of 36 months. If the sponsoring organization does not obtain a State license within the 36 month period, the organization must terminate its Medicare Choice plan offerings. In no case may an organization otherwise required to be State licensed sponsor a Medicare Choice plan after December 31, 2001, without having obtained the State license.

The temporary certification process sunsets on December 31, 2000. The Secretary is required to report to Congress evaluating the temporary certification process by December 31, 1998. The report shall include an analysis of State efforts to adopt regulatory standards that take into account health plan sponsors that provide services directly to enrollees through affiliated providers.

Also by December 31, 1998, the Secretary shall report to Congress on the results of a demonstration project on alternative partial risk-sharing arrangements between the Secretary and health care providers. The report shall include an analysis of the administrative feasibility of partial capitation arrangements for the Medicare program and the information necessary to implement such arrangements.

All Medicare Choice plan sponsoring organizations must assume full financial risk on a prospective basis for the provision of health care services, except the organization may insure or make arrangements for: stop-loss coverage for costs exceeding $5,000 per member per year; services provided to members by providers outside of the organization; and for not more than 90 percent of costs which exceed 115 percent of income in a fiscal year. An organization may also make arrangements with providers to assume all or part of the risk on a prospective basis for the provision of basic health services.

Eligible Medicare Choice plan sponsoring organizations must meet solvency requirements satisfactory to the Secretary. Organizations licensed in States recognized by the Secretary as requiring solvency standards at least as stringent as those required by Medicare will be deemed to meet Medicare Choice plan solvency requirements.

In developing solvency requirements, the Secretary shall consult with State insurance commissioners, independent actuaries, providers, and insurers and shall take into account a Medicare Choice plan's delivery system assets and its ability to provide services directly to its enrollees through its affiliated providers. The Secretary shall also consider alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees from a financially strong party, organizational insurance coverage, partnership with a licensed entity, or other methods acceptable to the Secretary.

Eligibility

Any person entitled to coverage under Medicare Part A and enrolled in Medicare Part B is eligible to enroll in a Medicare Choice plan that serves the geographic area in which the person resides, except persons with end-stage renal disease (ESRD). However, a Medicare beneficiary developing end-stage renal disease after having enrolled in a Medicare Choice plan may continue enrollment in that Medicare Choice plan. The Secretary will report recommendations to Congress by December 31, 1999, on the enrollment of ESRD beneficiaries in Medicare Choice plans.

Eligibility for enrollment in union or association-sponsored Medicare Choice plans is limited to full-fledged members of the union or association and their spouses.

Enrollment

There will be an annual coordinated open enrollment period in November of each year during which the Secretary will provide every Medicare beneficiary with the opportunity to enroll in a Medicare Choice plan for the subsequent year.

The Secretary shall be responsible for enrolling individuals and shall provide for beneficiary enrollment, to the extent feasible, by telephone, through the mail, or in person at local Social Security offices.

Medicare beneficiaries will be enrolled in the Medicare Choice plan of their choice on a first-come basis up to the Medicare Choice plan's capacity. The Secretary will develop special rules governing the enrollment of Medicare beneficiaries in union and association-sponsored Medicare Choice plans.

Medicare beneficiaries who fail to notify the Secretary of their enrollment choice will continue to be enrolled in the same option as they were enrolled in during the previous year.

Persons newly Medicare eligible will have the opportunity to enroll in a Medicare Choice plan at the time of their initial enrollment in Medicare. The Secretary will be responsible for distributing Medicare Choice plan information and enrollment materials to persons newly eligible for Medicare within two months of their Medicare eligibility date.

Medicare beneficiaries who are also enrolled in Federal employees health benefits (FEHB) plans have their deductibles paid by the FEHB plan. For this reason, the Committee provision requires that persons enrolled in FEHB plans not enroll in a Medicare Choice high deductible plan until the Office of Personnel Management has adopted policies to ensure that enrollment in this option does not cause higher costs for Federal health plans.

Disenrollment

Medicare enrollees will be able to disenroll from a Medicare Choice plan and enroll in another Medicare Choice plan or revert to the traditional Medicare program annually, only during the open enrollment period, with the following exceptions: (1) Medicare enrollees will have the right to disenroll from a Medicare Choice plan and enroll in another Medicare Choice plan or enroll in the traditional Medicare program within ninety days of their initial enrollment in the Medicare Choice plan; (2) the Secretary shall identify qualifying events (such as change of residence) whereby a Medicare beneficiary may change health plan enrollment at times other than during the open enrollment period; and (3) Medicare Choice plan enrollees may disenroll from a Medicare Choice plan outside the open enrollment period for cause (to be defined in regulations by the Secretary).

There is a special disenrollment rule for beneficiaries choosing the high-deductible/Medicare Choice account plan. Individuals wishing to terminate enrollment in a high-deductible/Medicare Choice account plan must provide at least one year's notice, to be supplied during an annual open enrollment period, before being allowed to switch enrollment to another Medicare Choice plan or return to the traditional Medicare program.

Information

The Secretary is responsible for developing informational materials describing the Medicare Choice plans available in each area. The materials shall be mailed to each Medicare beneficiary no later than 30 days prior to the annual open enrollment period. The Sec-

retary may contract with public or private organizations to develop and distribute the informational materials.

The informational material shall be written in the most easily understandable manner possible, and include the information described in this section as well as any other information the Secretary determines is necessary to assist Medicare beneficiaries in the selection of a Medicare Choice plan.

The informational materials shall contain at a minimum: (1) the Medicare Part B premium rate for the upcoming calendar year; (2) a description of the covered items and the cost-sharing amounts applicable to the traditional Medicare program for the subsequent year; (3) the Medicare payment amount for Medicare enrollees in the Medicare payment area for the subsequent year; (4) information and instructions on how to enroll in a Medicare Choice plan; (5) the restriction on Medicare payments for services provided to beneficiaries enrolled in Medicare Choice plans; and (6) notice that Medicare Choice plan sponsors are authorized by law to terminate or refuse to renew their Medicare contracts, and, therefore, may terminate or refuse to renew the enrollment of Medicare individuals. The information materials shall also include comparative quality indicators for the traditional Medicare program and each of the Medicare Choice plans, including disenrollment rates for the previous two years (excluding disenrollment due to death or moving outside a plan's service area); and information on enrollee satisfaction and health outcomes.

The Committee is aware of the need for beneficiaries to receive full information about the scope of the services they might receive under Medicare Choice plans. To address such concerns by beneficiaries who might wish to select Medicare Choice plans, the Committee has included an amendment which requires that beneficiaries be advised of the extent to which they may select the provider of their choice, including providers both within the network and outside the network (if the plan allows out-of-network services). This provision is intended to provide beneficiaries with full information about the range of providers they may be able to utilize, as well as to provide assurances to providers, especially specialists, that beneficiaries will be aware of the extent to which the services they provide are covered under the various plans.

The information provided by the Secretary shall also include the following information for each Medicare Choice plan available in the Medicare payment area: (1) the plan's premium price and an indication of the difference between the premium price and the Medicare payment amount; (2) the enrollee's rights to benefits from the organization and an indication of the beneficiaries' exposure to balance billing; (3) the extent of the enrollee's rights to select a provider of their choice, including providers who do not belong to the plan's network and the restrictions on payment for services furnished to an enrollee by other than the Medicare Choice plan's participating providers; (4) out-of-area coverage provided by the Medicare Choice plan; (5) coverage of emergency services and urgently needed care; (6) the appeal rights of enrollees; (7) enrollees' rights to address grievances with the plan to the Secretary or the appropriate external review entity; (8) an indication of whether the plan sponsor is out-of-compliance with any Medicare Choice standards;

and (9) supplemental coverage available from the Medicare Choice plan and the premium prices for the supplemental coverage.

Marketing

Medicare Choice plans may prepare and distribute marketing materials and pursue marketing strategies so long as they accurately describe the benefits available from the plan in comparison to the traditional Medicare program. Marketing shall be pursued in a manner not intended to violate the anti-discrimination requirements. Marketing materials shall not contain false or materially misleading information, and shall conform to all other applicable fair marketing and advertising standards and requirements.

Medicare Choice plan sponsors must submit any brochures, application forms, and promotional or informational material to the Secretary for review. Materials not disapproved by the Secretary within 45 days may be distributed. Marketing materials reviewed and not disapproved in one HHS regional office shall be deemed approved for use in all other areas where the Medicare Choice plan is offered.

Benefits

All Medicare Choice plans must offer, at a minimum, coverage for the same items and services as the traditional Medicare program. Medicare Choice plans may require cost-sharing that is different from the cost-sharing requirements in the traditional Medicare program. However, the average total amount of cost-sharing per enrollee for Medicare covered items services in a Medicare Choice plan may not exceed the average total amount of cost-sharing per enrollee in the traditional Medicare program, except for the high-deductible/Medicare Choice Account plan. High deductible plans ($3,000 deductible) may not require annual out-of-pocket costs (deductibles, coinsurance, and copayments) for insured expenses in excess of $6,000 per year.

Medicare Choice plans may include additional benefits as part of their basic benefit package offered to Medicare enrollees and included in the basic premium price.

Medicare Choice plans may offer optional, supplemental benefits to Medicare Choice plan enrollees for an additional premium. The supplemental benefits may be marketed and sold by the Medicare Choice plan separate from the Medicare Choice enrollment process. However, if the supplemental benefits are offered only to enrollees in the sponsor's Medicare Choice plan(s) the same supplemental benefit options must be offered to all of the Medicare Choice plan sponsor's Medicare enrollees in each Medicare payment area for the same premium amount.

If the Secretary makes a determination on benefit coverage that will result in added costs for Medicare Choice plans, the Medicare Choice plans are not responsible for assuming responsibility for such coverage until the beginning of the next contract year. Medicare Choice plan enrollees may obtain such new benefits on fee-for-service basis until the new coverage requirement goes into effect at the beginning of the next contract year.

In the case of a Medicare beneficiary who is hospitalized at the time of enrollment or disenrollment from a Medicare Choice plan,

responsibility for payment for the hospitalization is determined by the status of coverage at the time of admission to the hospital.

Medicare Choice plans may recover payment for services provided to a plan enrollee which qualify for coverage under workers compensation, automobile, or other insurance policies of an enrollee.

Health plan standards

Each Medicare Choice plan sponsor must have arrangements for an ongoing quality assurance program. The program must (1) stress health outcomes; (2) provide written protocols for utilization review; (3) provide review by physicians and other health care professionals of the process followed in the provision of health services; (4) monitor and evaluate high-volume and high-risk services; (5) evaluate the continuity of care enrollees receive; (6) have mechanisms to identify underutilization and overutilization of services; (7) alter practice parameters after identifying areas for improvement; (8) take actions to improve quality; (9) and make available information on quality and outcomes to facilitate beneficiary comparisons.

Medicare Choice plan sponsors must also make arrangements with independent quality review and improvement organizations for external quality review of each Medicare Choice plan they offer. The organization will serve as an alternative means for addressing enrollee grievances; review health plan performance based on accepted quality criteria; promote and make health plans accountable for improved performance; integrate new standards into quality review developed specifically for the Medicare population; and report to the Secretary those Medicare Choice plans that are unable or unwilling to undertake necessary quality improvement activities.

Medicare Choice plan sponsors shall be accredited for meeting quality standards established by the Secretary. Medicare Choice plans accredited by external independent accrediting organizations, recognized by the Secretary as establishing standards at least as stringent as Medicare standards, shall be "deemed" accredited for Medicare purposes.

The Secretary shall create incentives for Medicare Choice plans to report to the Secretary aggregate encounter data, including data on physician visits, nursing home days, home health visits, hospital inpatient days, and rehabilitation services.

Medicare Choice plans must demonstrate the capacity to adequately serve their expected enrollment of Medicare beneficiaries.

Medicare Choice plans must make all Medicare covered services and all other services contracted for available and accessible within service areas, with reasonable promptness and in a manner that assures continuity of care. All Medicare Choice plans must provide access to the appropriate providers, including specialists credentialed by the Medicare Choice plan sponsor, for all medically necessary treatment and services.

The Committee anticipates that Medicare Choice plans will include centers of specialized care, such as teaching hospitals, academic health centers, cancer centers, children's hospitals and other pediatric facilities, in establishing arrangements to provide the full range of specialized care for enrollees.

If a Medicare Choice plan restricts coverage to services provided by a network of providers, primary care services in rural areas must be available within 30 minutes or 30 miles from an enrollee's place of residence. The Secretary may make exceptions to this standard on a case-by-case basis.

Urgent care must be available and accessible 24 hours a day and 7 days a week. Medicare Choice plans must also pay for emergency services provided by nonaffiliated providers when it is not reasonable, given the circumstances, to obtain the services through the Medicare Choice plan.

Medicare Choice plan service areas must correspond to Medicare payment areas. The Secretary may waive this requirement and approve service areas that are smaller than Medicare payment areas if the Secretary determines that the service areas are not defined so as to discriminate against any population.

Medicare Choice plan sponsors may not discriminate against individuals on the basis of health status or anticipated need for health services in the enrollment, disenrollment, or provision of services.

Medicare Choice plan sponsors may not cancel or refuse to renew a beneficiary except in cases of fraud or non-payment of premium amounts due the plan.

Medicare Choice plan sponsors must have meaningful grievance procedures for the resolution of individual enrollee complaints. An enrollee who is dissatisfied with the outcome of the grievance procedure has the right to a hearing before the Secretary if the amount involved is greater than $100. If the amount is greater than $1,000, either the enrollee or the Medicare Choice plan sponsor may seek judicial review.

The Secretary shall review in an expedited manner any denial of service by a Medicare Choice plan in cases where denial of care could result in significant harm.

A Medicare Choice plan sponsor terminating its contract with the Secretary must arrange for supplementary coverage for its Medicare enrollees for the duration of any preexisting condition exclusion under the enrollee's successor coverage for the lesser of 6 months or the duration of the exclusion period.

Medicare Choice plan sponsors must make adequate provision against the risk of insolvency, including provisions to prevent the plan's enrollees from being held liable to any person or entity for the plan sponsor's debts in the event of the plan sponsor's insolvency.

Each Medicare Choice plans must submit to the Secretary a table of its rates for all actuarial categories of beneficiaries prior to contract approval by the Secretary.

Medicare Choice plan sponsors must provide prompt payment for covered items and services to providers who are not under contract with the plan. If the Medicare Choice plan sponsor does not provide prompt payment, the Secretary may pay such providers directly and deduct the payment amount from the payments made to the Medicare Choice plan.

A Medicare Choice plan must maintain written policies and procedures respecting advance directives. Nothing in this section shall

be construed to require the provision of information regarding assisted suicide, euthanasia, or mercy killing.

Medicare payments

A Medicare payment amount will be established for each Medicare payment area within the United States. The Medicare payment amount will be the same for every Medicare beneficiary eligible for coverage within a Medicare payment area. The Medicare payment amount for each Medicare payment area will be the standardized, or average, amount for the area.

In making payments to Medicare Choice plans on behalf of Medicare beneficiaries, the Medicare payment amount will be adjusted by the Secretary to reflect demographic and health status factors applicable to the beneficiary.

The Medicare payment amounts will be based on the current Medicare HMO payment methods with adjustments made so that the Medicare payment amounts are fair and so that the variation in Medicare payment amounts across geographic areas are reasonable.

A base Medicare payment amount will be established for each Medicare payment area. The link between traditional Medicare fee-for-service spending and the Medicare payment amounts will be broken. After 1996, Medicare payment amounts will be updated annually by the nominal per capita growth in the gross domestic product (GDP).

The base Medicare payment amounts will be phased-in over a three-year period as follows:

1996:

1995 Medicare per capita rates of payment for each county for Medicare HMO risk contract plans will be updated by the projected percentage increase in Medicare spending for calendar year 1996 over 1995. 1996 Medicare per capita payment rates for each county will then be computed by blending the county rate (75%) with a national rate (25%). The national rate will be adjusted for each geographic area to account for differences in local input prices. Input price indices are to be developed by the Secretary, using the most recent Medicare fee-for-service price indices for Medicare Part A and Part B services.

In no case will the average per capita rate of payment for a county in 1996 be less than it was in 1995.

1997:

Three adjustments will be made to the 1996 Medicare per capita rates of payment, in addition to applying the update based on the percentage increase in the gross domestic product per capita.

First, Medicare per capita rates of payment for counties will be aggregated into new Medicare payment areas consisting of each Metropolitan Statistical Area (MSA) within a state, (Primary MSAs in the case of Consolidated MSAs), and all areas outside of MSAs will be aggregated into one area for Medicare payment rate purposes. States may apply to the Secretary for adjustments in these area definitions.

Second, the per capita rates of payment will be a blend of the local area rate (50%) and the price-adjusted national rate for the payment area (50%).

Third, one-half of the Medicare payments for medical education and disproportionate share (DSH) that were included as part of Medicare spending that served as the base for calculating the per capita rates of payment will be removed. Hospitals will be allowed to receive payment from the Medicare program for each Medicare Choice plan admission equal to one-half of the amount of medical education and DSH payments they would otherwise receive for a patient enrolled in traditional Medicare.

1998:

The remaining Medicare medical education and DSH amounts will be removed from the per capita rates of payment. Hospitals will be allowed to submit a Medicare claim for each Medicare Choice plan admission and receive the total amount of medical education and DSH payments they would otherwise receive for a patient enrolled in traditional Medicare.

Adjustments after 1998

Unless Congress acts otherwise, beginning January 1, 2000, the Secretary shall make annual differential adjustments in Medicare payment amounts in different Medicare Choice payment areas so as to achieve by 2002 an appropriate, and equitable, variation in Medicare payment amounts across geographic areas which is reasonable and justifiable in measurable terms.

These annual differential adjustments shall be based on an analysis conducted by the Secretary. Because Congress is not certain what constitutes an appropriate and equitable variation in Medicare payment amounts in different Medicare payment areas, the analysis conducted by the Secretary shall take into consideration measurable input cost differences such as wage differentials and/or such other measurable variables. The Secretary should consult interested parties in making these analyses.

In the event the Secretary determines that the Medicare payments amounts resulting from the transition diverge from the appropriate and equitable Medicare payment amounts as determined by her analysis, the Secretary shall make differential annual adjustments in the Medicare payment amounts in different Medicare Choice payment areas so as to achieve such appropriate and equitable variation in Medicare payment amounts across geographic areas, by 2002.

The Secretary shall also describe the degree to which Medicare beneficiaries, including beneficiaries in rural and underserved areas, have access to more health plan choices at the end of the transition period for the Medicare Choice program and the extent to which available payment amounts have limited or enhanced choices in those areas.

Any payment adjustments made by the Secretary shall not cause total Medicare spending to increase.

The Secretary shall restrict recommendations to adjustments in the Medicare payment amounts to be made after 1999.

The Secretary shall report to the appropriate Committees of the Congress, and the public, the findings on appropriate and equitable Medicare payment amounts, and on the payment adjustments proposed to be made annually to 2002, not later than March 1, 1999.

The annual adjustments in per capita payment amounts proposed by the Secretary for the Medicare Choice payment areas shall be made by the Secretary effective January 1, 2000, unless the Congress proposes an alternative plan for those annual adjustments.

Differentials

Payment for any premium amount in excess of the Medicare payment amount that is due to a Medicare Choice plan shall be paid as mutually arranged between the Medicare beneficiary and the Medicare Choice plan sponsor.

If the premium price of a Medicare Choice plan is less than the Medicare payment amount, the beneficiary may instruct the Secretary to: (1) deposit the excess amount in a Medicare medical savings account; (2) apply the excess towards the cost of supplemental benefits offered by the Medicare Choice plan sponsor; or (3) get a cash rebate equal to 75 percent of the excess amount at the end of the calendar year.

Administration and enforcement

The Secretary shall enter into a contract with every organization eligible to offer a Medicare Choice plan and certified by the Secretary as meeting Medicare Choice plan standards. The contracts may be made automatically renewable.

The Secretary shall transmit to each Medicare beneficiary's selected Medicare Choice plan a payment amount equal to the pertinent risk adjusted Medicare payment amount for that individual in that Medicare payment area. Payments shall occur in advance and on a monthly basis.

Payments to plans shall be made with funds withdrawn from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The allocation from each fund shall be determined each year by the Secretary, based on the relative weight that benefits from each fund contribute to the determination of the Medicare payment amounts.

The contract shall provide that the Secretary, or the Secretary's designee, shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the contract; the facilities of the plan's sponsor; and the books and records of the plan sponsor that pertain to the ability of the sponsor to bear responsibility for potential financial losses. The Secretary shall also require a Medicare Choice plan sponsor to provide notice to enrollees in the event of termination of the plan's contract and include in the notice a description of each enrollee's options for obtaining benefits.

Prior to terminating a contract or imposing intermediate sanctions for non-compliance on a Medicare Choice plan sponsor, the Secretary shall provide the Medicare Choice plan sponsor with the opportunity to develop and implement a corrective action plan. The Secretary must also provide the Medicare Choice plan sponsor with

the opportunity for a hearing, including the opportunity to appeal an initial decision, before imposing any sanction or terminating the contract.

The Secretary of HHS may impose certain lesser sanctions, including suspension of enrollment or payment and imposition of civil monetary penalties. These sanctions may be applied for denial of medically necessary services, overcharging, enrollment violations, misrepresentation, failure to pay promptly for services, or employment of providers barred from Medicare participation.

A contract may be terminated by the Secretary of HHS at any time (after reasonable notice and opportunity for a hearing) if the organization no longer meets the Medicare Choice plan requirements.

The Secretary may not enter into a contract with a Medicare Choice plan sponsor if a previous contract with the plan sponsor was terminated within the previous five years, except in circumstances that warrant special consideration.

Transition rules for 1996

Existing Medicare HMO risk-contract plans are automatically grandfathered as Medicare Choice plans and have up to three years to meet any new or different standards.

Medicare Part B-only risk-contract plan enrollees are grandfathered subject to regulations adopted by the Secretary. Persons enrolled in Medicare Part B only will not be allowed to enroll in Medicare Choice plans. HHS will adopt regulations for the grandfathered Part B only enrollees.

Effective date

Effective with respect to contracts effective on or after January 1, 1997.

SUBCHAPTER B—TAX PROVISIONS RELATING TO MEDICARE CHOICE PLANS

DESCRIPTION OF TAXATION OF MEDICARE CHOICE ACCOUNTS (Sec. 7006)

Present Law

Under present law, the value of Medicare coverage and benefits is not taxable.

An individual may deduct unreimbursed medical expenses (including expenses for his or her spouse and dependents) to the extent such expenses exceed 7.5 percent of the individual's adjusted gross income. Medical expenses for this purpose include amounts paid for medical insurance, including Medicare part B premiums.

There are no specific tax provisions for Medicare Choice Accounts under current law.

Reasons for Change

The Committee believes the cornerstone to providing America's senior citizens with greater power over their health care is to bring private sector ideas and improvements into the Medicare system.

The Medicare Choice Account does this by offering seniors a new option other than the traditional Medicare program and rewarding those who choose a lower cost health insurance option. The Medicare Choice Account further provides seniors with control over their own health care expenses.

Committee Provision

Under the provision, individuals who are eligible for Medicare can choose between enrolling in the traditional Medicare program and enrolling in a Medicare Choice plan. Medicare Choice plans include traditional fee-for-service plans, coordinated health care plans, a high-deductible plan combined with a Medicare Choice Account, and union- or association-sponsored health plans. A high-deductible health plan must have a minimum deductible of $3,000 and limit the insured's maximum annual out-of-pocket expense to no more than $6,000.

If an individual chooses the high-deductible plan/Medicare Choice Account option, the difference between the Medicare payment amount for the individual and the cost of the high-deductible plan is deposited by the Secretary of Health and Human Services in the insured's Medicare Choice Account. If the insured chooses another Medicare Choice plan option, the individual may direct the Secretary of Health and Human Services to deposit the difference between the Medicare payment amount and the cost of the Medicare Choice plan into the insured's Medicare Choice Account. Only the Secretary of Health and Human Services can make contributions to a Medicare Choice Account. Contributions to a Medicare Choice Account are not taxable.[1] Earnings on amounts in a Medicare Choice Account are not taxable. Withdrawals from a Medicare Choice Account are not taxable if used for qualified medical expenses.

Definition of Medicare Choice Accounts

A Medicare Choice Account is a tax-exempt trust (or a custodial account) created for the purpose of paying the insured's qualified medical expenses. A Medicare Choice Account is subject to certain rules applicable to individual retirement arrangements ("IRAs").[2] The trustee of a Medicare Choice Account could be a bank, insurance company, or other person approved by the Secretary of the Treasury.

A Medicare Choice Account trustee is required to prepare and file such reports as may be required by the Secretary of the Treasury. A $50 penalty is imposed for each failure to file without reasonable cause.

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[1] An individual does not have taxable income merely because the individual can choose among various Medicare Choice options and the traditional Medicare program or between payment of a cash rebate and other options.

[2] For example, no Medicare Choice Account assets can be invested in life insurance contracts, Medicare Choice Account assets can not be commingled with other property except in a common trust fund or common investment fund, and an account holder's interest in a Medicare Choice Account is nonforfeitable. In addition, if an account holder engages in a prohibited transaction with respect to a Medicare Choice Account or pledges assets in a Medicare Choice Account, rules similar to those for IRAs apply, and any amounts treated as distributed to the account holder under such rules are treated as not used for qualified medical expenses.

TAXATION OF DISTRIBUTIONS FROM A MEDICARE CHOICE ACCOUNT

Distributions from a Medicare Choice Account that are used to pay qualified medical expenses of the insured (and the insured's spouse, if the spouse is eligible for Medicare) are not taxable. Qualified medical expenses include medical expenses defined under section 213(d) and long-term care services. Qualified medical expenses do not include any insurance premiums other than premiums for long-term care insurance.[3]

Distributions from a Medicare Choice Account that are not used for qualified medical expenses are taxable, and subject to a 10-percent penalty. The 10-percent penalty does not apply to distributions due to death or disability.

Tax-free transfers are permitted between Medicare Choice Accounts.

Erroneous contributions to the Medicare Choice Accounts can be returned to the Secretary of Health and Human Services without tax or penalty.

TREATMENT OF MEDICARE CHOICE ACCOUNT AT DEATH

Upon the death of the Medicare Choice Account beneficiary, no estate tax applies, and the following income tax rules apply.

A surviving spouse who is Medicare eligible can inherit the deceased spouse's Medicare Choice Account. If the surviving spouse is not Medicare eligible, the surviving spouse can continue the Medicare Choice Account for the purpose of paying the qualified medical expenses of dependents and a subsequent spouse. Additional contributions are not permitted to the inherited Medicare Choice Account and earnings are not taxable. Withdrawals for nonqualified medical expenses are taxable and subject to a 10-percent excise tax unless the distribution is made after the surviving spouse dies or becomes disabled.

If the beneficiary of an inherited Medicare Choice Account is not the spouse, the value of the Medicare Choice Account is taxable to the beneficiary. If there is no beneficiary of the Medicare Choice Account, the deceased account holder is taxed on the value of the account.

REVENUE EFFECT OF MEDICARE CHOICE ACCOUNTS

Under the proposed changes to the Medicare program, the Medicare Choice Account option will result in a reallocation of Medicare funds. This reallocation generally will move some funds from Medicare service providers to Medicare recipient accounts. The reallocation of outlays from service providers to recipient accounts would not be scored for budget purposes because the overall level of income would remain the same as projected in the Congressional Budget Office revenue baseline.

Balances in the Medicare Choice Accounts would be used for Medicare-covered expenses, non-Medicare covered medical expenses, or for nonmedical expenses. To the extent the Medicare Choice Account participant does not spend the entire Medicare

[3] Distributions from a Medicare Choice Account that are not taxable cannot be taken into account for purposes of the itemized deduction for medical expenses.

Choice contribution, there will be a balance in the Medicare Choice Account at the end of the year and there will be earnings on that account balance that will not be subject to Federal income taxation. To the extent that these earnings represent amounts that would have been taxable if held in another form of savings instrument, there would be a net decrease in Federal revenues.

It is assumed that, at least as an initial matter, the demographics of the potential population of Medicare Choice participants, the estimated premium differentials, and estimated low participation rates will cause Medicare Choice Accounts to have relatively small end of year account balances. For these reasons, it is likely that Medicare Choice Accounts will have a negligible effect on Federal fiscal year budget receipts.

Effective Date

The provision is effective for taxable years beginning after December 31, 1996.

DESCRIPTION OF TAX TREATMENT OF CASH REBATES

Present Law

Present law does not provide for cash payments to individuals under Medicare.

Reasons for Change

The Committee believes it is important to provide America's senior citizens with greater power over their health care spending decisions. The Medicare Choice Plan with its cash rebate option provides seniors with control over their own health care expenses and rewards them for cost-effective decision making.

Committee Provision

Under the provision, certain individuals would be entitled to cash rebates under the Medicare Choice program. These rebates are taxable.

Effective Date

The provision applies to rebates received after the date of enactment.

Chapter 2—Provisions Relating to Part A

SUBCHAPTER A—GENERAL PROVISIONS RELATING TO PART A

PPS HOSPITAL PAYMENT UPDATE

(Sec. 7011)

Present Law

Since 1983, Medicare has paid hospitals for most inpatient services with a fixed, predetermined amount according to patient diag-

nosis. The payment system is called the Medicare Prospective Payment System (called PPS).

Medicare's PPS payments are updated each year for inflation. The inflation update is based on the projected increase in the "market basket index" (MBI), which estimates the prices of the goods and services hospitals buy to provide care.

Since fiscal year (FY) 1986, Congress has repeatedly set the update factor at a level below the MBI. In OBRA 1993, the update was set at:

1. FY 1994—
   Rural hospitals: MBI minus 1.0 percentage point.
   Urban hospitals: MBI minus 2.5 percentage points.
2. FY 1995—
   Rural hospitals: inflation update necessary to eliminate the rural/urban differential.
   Urban hospitals: MBI minus 2.5 percentage points.
3. FY 1996—
   MBI minus 2 percentage points.
4. FY 1997—
   MBI minus 0.5 percentage point.
5. FY 1998 and later years—
   Equal to the MBI with no reductions.

Reasons for Change

Hospitals' cost growth has slowed in recent years. For example, in 1995, hospitals' costs are growing 1.4 percent per year as estimated by the Prospective Payment Assessment Commission (ProPAC). The Congressional Budget Office estimates that the hospital market basket increase will be slightly less than 4 percent from 1996–2002, more than two percentage points higher than hospitals' cost growth.

Committee Provision

The provision sets the annual market basket update for hospitals to equal MBI minus 2.5 percentage points for each year, 1996–2002. In addition, the annual inflation update for hospitals will not be less than 1.3 percent in fiscal year 1996; 1.2 percent in fiscal year 1997; and 1.1 percent from fiscal years 1998–2002.

Effective Date

For cost reporting periods beginning on or after October 1, 1995.

PPS-Exempt Hospital Payments

(Sec. 7012)

Present Law

Certain types of hospitals are excluded by law from Medicare's Prospective Payment System (PPS-exempt) and are paid on the basis of reasonable costs, subject to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) rate of increase limits. The rate of increase limits are called TEFRA limits.

OBRA 93 provided for an update factor to the TEFRA limits of market basket minus 1.0 percentage point for fiscal years 1994–1997. A hospital with operating costs in FY 1990 that exceeded the TEFRA limits by 10 percent or more are exempt from the update reduction, with partial reductions applied to hospitals near the threshold.

PPS-exempt hospitals are paid for the reasonable costs of capital.

Committee Provision

The update factor to the cost limits of PPS-exempt hospitals will be set to equal market basket minus 2.5 percentage points for 1996–2002.

The update adjustment will vary for hospitals above and below TEFRA limits. For hospitals with costs that exceed the TEFRA limits in fiscal year 1995 by 10 percent or more, the update will equal the market basket. Hospitals near the cost limit threshold will receive partial reductions to the market basket. Hospitals with costs times 150 percent equaling or exceeding their TEFRA limits will receive no inflation updates.

The Secretary shall adjust, for hospitals receiving updates, the inflation update to be no less than 1.4 percent in fiscal year 1996; 1.3 percent in fiscal year 1997; and 1.1 percent for fiscal years 1998–2002.

The Committee provision adjusts the TEFRA limits for new and existing PPS-exempt hospitals. PPS-exempt hospitals and units (for rehabilitation hospitals and units and long-term care hospitals only) that began receiving PPS-exempt payments on or after October 1, 1995 will have TEFRA limits not to exceed 130 percent of the national average TEFRA limits using 1991 cost report data (means are calculated by type of hospital/unit) of PPS-exempt hospitals and units. By type of hospital/unit, the PPS-exempt hospitals and units (for rehabilitation hospital/units and long-term care hospitals only) that received PPS-exempt payments before October 1, 1995 will be paid TEFRA limits that are no less than 50 percent of the national average TEFRA limits. The Secretary, prior to implementing the provision, will determine if a separate TEFRA limit should be calculated for certain types of long-term care hospitals as categorized by patient diagnostic related groups and case mix.

PPS-exempt hospitals' capital payments will be reduced by 15 percent for fiscal years 1996–2002.

The Secretary is directed to report on a prospective payment system for PPS-exempt hospitals no later than June 1, 1996.

Effective Date

Cost reports beginning on or after October 1, 1995.

CAPITAL PAYMENTS FOR PPS HOSPITALS

(Sec. 7013)

Present Law

Hospital capital expenses (the costs of building or acquiring facilities and major equipment) are paid for under the Prospective Payment System (PPS).

Until fiscal year 1992, Medicare payments for capital costs were based on each hospital's actual expenses, subject to statutory percentage reductions. Since fiscal year 1992, Medicare instead pays for capital on a prospective per-case basis, with each hospital's payment rate based on a blend of its own actual costs (called the hospital specific rate) and a standard Federal rate.

Under current law, capital payment rates for fiscal year 1994 and fiscal year 1995 are to be adjusted to produce an aggregate 10 percent savings relative to what would have been paid on a full reasonable cost basis. In addition, for discharges occurring in fiscal year 1994 or later, the standard Federal rate is reduced by 7.4 percent. The Secretary is authorized to determine annual updates for capital payment rates.

The Secretary implements the capital provisions by regulation. Currently, there is no separate payment for property tax-related capital. There is a special exceptions process for certain major capital projects in regulation currently.

Reasons for Change

Hospital inpatient capital payments are expected to grow per discharge over 20 percent in fiscal year 1996 due to expiring statutory provisions according to ProPAC. The hospital market basket increase, according to the Congressional Budget Office, is estimated at slightly less than 4.0 percent for fiscal years 1996–2002. If changes are not made in current law, hospitals will be significantly overpaid by Medicare for capital costs beginning in fiscal year 1996.

Committee Provision

The Committee provision would adjust Medicare payments for inpatient capital payments as follows:

For cost reports starting on or after October 1, 1995:

1. Reduce the standard Federal rate 7.47 percent;
2. Reduce the hospital specific rate 8.27 percent; and
3. Extend the original OBRA 1990 budget neutrality requirement (extended in OBRA 1993 for fiscal years 1994 and 1995) with an additional 5 percent reduction through fiscal years 1996–2002 so that aggregate capital payments each year equal 85 percent of what payments would be under reasonable cost payment.

The Committee provision also makes several adjustments to the current regulations for capital payments to hospitals, on a budget neutral basis:

1. The Secretary is directed to provide a hospital-specific add-on capital payment for the property tax related capital costs for hospitals incurring such costs (including costs for payments in lieu of taxes for private not-for-profit organizations); and
2. The special exceptions process is modified in law to add several criteria and rules for such special exceptions. The additional amount of special exceptions payments is limited to a total over seven years to not exceed $50 million per year.

Effective Date

Cost reports starting on or after October 1, 1995.

DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

(Sec. 7014)

Present Law

Under Medicare's Prospective Payment System (PPS), an extra payment is made for certain hospitals that serve a disproportionate share of low-income patients.

The extra DSH payment is intended to compensate only hospitals that treat large proportions of low-income patients. Such hospitals are thought to have higher costs than otherwise similar hospitals for a variety of reasons. For example, low-income patients may be more severely ill at the time of admission, and experience a longer hospital stay due to difficulties in post hospital placement.

The amount of the extra DSH payment for each hospital is based on a formula that considers certain hospital and patient factors. The factors considered in determining whether a hospital qualifies for extra DSH payments include number of beds, patient days, and hospital location.

Reasons for Change

Medicare's Disproportionate Share payments have grown from 2.0 percent to 6.0 percent of Medicare's PPS payments from 1988–1995 according to ProPAC annual reports. ProPAC estimates that hospital losses from uncompensated care have been stable at slightly less than 5.0 percent of costs since 1984.

Committee Provision

The Committee provision phases down Medicare Disproportionate Share Hospital (DSH) payments to equal 25 percent less than current law projections of spending in fiscal year 2000. In order to accomplish the phase-down, DSH payments will be reduced 5 percent from current law estimates each fiscal year from 1996–2000. In fiscal years 2001 and 2002, the amounts will continue at about 25 percent less than current law projections of spending.

As a result of this phase-down, DSH payments will average 5.0 percent of base PPS payments between 1996–2002 (i.e., all PPS operating payments minus DSH and Medicare Indirect Medical education payments). The proposal assumes a reduction in PPS hospitals' annual inflation update at market basket minus 2.5 percentage points for 1996–2002.

Effective Date

Cost reporting periods beginning on or after October 1, 1995.

INDIRECT MEDICAL EDUCATION PAYMENTS
(Sec. 7015)

Present Law

Medicare makes additional payments to teaching hospitals for the indirect costs associated with approved residency programs. These indirect costs may be due to a variety of factors, such as extra demands placed on hospital staff due to teaching activity, additional tests and procedures ordered by residents, or more severely ill patients treated at teaching hospitals.

The payment adjustment is currently based on a formula that increases the diagnosis-related group (DRG) payment by approximately 7.7 percent for each 10-percent increase in the ratio of interns and residents to beds.

Reason for Change

The Prospective Payment Assessment Commission (ProPAC) has advised Congress that Medicare is paying more than Medicare's share of hospitals' costs for indirect medical education.

Committee Provision

The Committee provision reduces the additional payment adjustment for Medicare Indirect Medical Education (IME) from 7.7 percent for each 10 percent increase in the ratio of interns and residents to beds to:

1. Fiscal year 1996: 6.7 percent
2. Fiscal year 1997: 5.6 percent
3. Fiscal years 1998–2002: 4.5 percent

for each 10 percent increase in the ratio of interns/residents to beds.

Effective Date

Cost reporting periods beginning on or after October 1, 1995.

GRADUATE MEDICAL EDUCATION AND DISPROPORTIONATE SHARE PAYMENT ADJUSTMENTS FOR MEDICARE CHOICE
(Sec. 7016)

Present Law

Medicare's HMO payment amount includes the costs of graduate medical education (Direct Medical Education and Indirect Medical Education) in an area. Hospitals incurring graduate medical education and disproportionate share costs associated with Medicare HMO patients do not receive a direct payment from Medicare for such costs. The current formulas used to calculate a hospital's IME and DME payment amounts do not account for Medicare HMO patients.

Reasons for Change

As the number of Medicare beneficiaries choosing Medicare Choice plans increases, it will become important to account for

these patients in Medicare's calculation of a hospital's associated DME, IME, and DSH costs so that hospitals are fairly paid for such costs. Certain changes in Medicare's current calculations and a new process for hospital payment is required related to Medicare Choice patients.

Committee Provision

The Committee provision changes Medicare's current formulas for teaching (Direct Medical Education and Indirect Medical Education) and care for the poor (Disproportionate Share Hospital) payments to count Medicare Choice patients in determining Medicare's hospital payments. In addition, the Committee provision removes area hospitals' costs for teaching and care for the poor from the calculation of Medicare Choice payments. Hospitals that care for Medicare Choice patients will bill Medicare and receive an additional Medicare payment for the appropriate teaching and care for the poor adjustment.

Effective Date

Phased in beginning January 1, 1997.

PAYMENTS FOR HOSPICE SERVICES

(Sec. 7017)

Present Law

Medicare covers hospice care for terminally ill beneficiaries with a life expectancy of 6 months or less.

Hospice rates are updated annually by the hospital market basket index (MBI). OBRA 93 set the update for the prospective payment rates as follows: (1) fiscal year (FY) 1996—MBI minus 1.0 percentage point, and (2) FY 1997—MBI minus 0.5 percentage point. Beginning with FY 1998, the full market basket percentage update will again apply.

Reasons for Change

Medicare's payments for hospice services is one of the fastest growing areas in the Medicare program. The Congressional Budget Office projects that hospice payments will grow 40 percent between 1994–1995. This level of cost growth is unsustainable.

Committee Provision

The Committee provision sets the update for hospice services at MBI minus 2.5 percentage points each year for fiscal years 1996–2002. In addition, the annual inflation update for hospice services will not be less than 1.3 percent in fiscal year 1996; 1.2 percent in fiscal year 1997; and 1.1 percent from fiscal years 1998–2002.

Effective Date

Cost reporting periods beginning on or after October 1, 1995.

EXTENDING MEDICARE COVERAGE OF, AND APPLICATION OF HOSPITALS INSURANCE TAX TO, ALL STATE AND LOCAL GOVERNMENT EMPLOYEES

(Sec. 7018)

Present Law

Under current law, State and local government employees hired after March 31, 1986, must pay the Hospital Insurance tax (HI tax) and qualify for Medicare Part A coverage. State and local government employees hired before April 1, 1986, do not pay the HI tax and do not directly qualify for Medicare unless their government employer elects to extend Medicare Part A coverage to them.

The total HI tax rate for Medicare-covered employees is 2.9 percent of wages. One-half of the HI tax is imposed on the employee and one-half on the employer.

Reasons for Change

There are several million State and local government retirees that will be eligible to receive Medicare coverage but are exempt from paying the HI tax. In fairness to the Medicare beneficiaries that pay the HI tax, exempt State and local government employees that will receive Medicare coverage should be required to pay the HI tax.

According to the Congressional Research Service, in 1992 about 98 percent of State and local pensioners aged 65 and older were eligible for Medicare coverage. Most exempt State and local government employees will receive Medicare coverage through their spouses or from prior non-government employment.

Committee Provision

Medicare coverage is extended to State and local government employees not otherwise covered under current law. These employees and their employers would become liable for the HI tax and the employees would earn credit toward Medicare eligibility. In addition, the service of State and local government employees prior to January 1, 1996, would be considered covered employment for purposes of determining eligibility for Medicare coverage.

The Department of Treasury would be required to reimburse the Federal Hospital Insurance Trust Fund for additional payments made, administrative expenses incurred, and any interest losses which occur as a result of the provision.

Effective Date

This provision would apply to services performed by State and local government employees after December 31, 1995.

SUBCHAPTER B—PAYMENTS TO SKILLED NURSING FACILITIES

PAYMENTS TO NURSING HOMES

(Secs. 7031–7038)

Present Law

Medicare pays skilled nursing facilities (SNFs) on a per day basis for reasonable costs, subject to per day cost limits. The limits are applied to the per day routine service costs only (nursing, room and board, administrative, and other overhead) of a facility. Each year, the cost limits for routine per day costs are updated for inflation.

Non-routine costs, such as therapy services (e.g., physical therapy, occupational therapy, and speech therapy services) are paid according to reasonable costs. There are no cost limits for non-routine costs. Medicare pays, under Part A and Part B, a variety of providers (i.e., nursing homes for facility-based therapists, independent therapists, therapy companies) for non-routine services.

Freestanding SNF cost limits are set at 112 percent of the mean per day routine costs. Hospital-based SNF cost limits are set at the limit for freestanding SNFs, plus 50 percent of the difference between the freestanding limit and 112 percent of the mean per day routine service costs of hospital-based SNFs.

Routine cost limits are updated annually by the skilled nursing home market basket. OBRA 93 eliminated the annual market basket update for SNF limits for cost reporting periods beginning in FY 1994 and FY 1995 (called a freeze).

Low-volume SNFs (less than 1500 SNF days per year) may choose to be paid on a prospective payment basis at 105 percent of the mean. The prospective rate is updated for inflation each year. Low volume SNFs did not receive inflation updates for 1994 and 1995 prospective rates.

SNFs' costs of capital (land and equipment) are paid on a reasonable cost basis.

Reasons for Change

Medicare payments for skilled nursing facilities (SNFs) is projected to grow over 28 percent for 1994–1995 according to CBO. Spending growth of nursing home care is unsustainable in the Medicare program. Providers are paid based on costs subject to certain limits for routine services, with no limits for non-routine services. Providers have no incentives to keep the cost growth of non-routine services low.

Committee Provision

The proposal would extend the OBRA 1993 savings on routine cost limits for one year and change how SNFs' non-routine costs and other costs would be paid:

1. The cost savings effects of the OBRA 1993 cost limit provisions will be extended for cost reporting periods beginning in fiscal year 1996. National cost limits shall not be less than 100 percent of the mean costs used to calculate the current limits for fiscal year 1996.

2. A new routine cost limit amount will be calculated for fiscal year 1997 by the Secretary (using complete cost reports ending September 30, 1994 and including the cost saving effects of the OBRA 1993 cost limit provisions) with an expanded definition of routine costs. Routine costs are all items used in the current law definition—nursing, room and board, administration, and other overhead, plus all ancillaries, supplies and equipment except those specified in non-routine costs under (3).

3. Non-routine services will include (1) therapies (speech, occupational, respiratory and physical therapy services); (2) prescription drugs; (3) complex medical equipment; (4) intravenous therapy and solutions including enteral and parenteral nutrients, associated supplies and equipment; (5) and diagnostic services (including laboratory, pulmonary, and radiology services including tomography and imaging).

4. For cost-reporting periods beginning in fiscal year 1997, all services not subject to routine cost limits—including therapy services, prescription drugs, complex medical equipment, intravenous therapy, and diagnostic services—would be subject to new limits.

5. New limits will be established by the Secretary using cost-reporting periods ending September 30, 1994 inflated forward to fiscal year 1997 by the SNF market basket. The national mean limit amount (calculated separately for free-standing and hospital-based facilities) and the facility-specific limit amounts for non-routine services per stay will be updated by the SNF market basket minus 2.5 percentage points for future years (fiscal years 1997–2002). Annual inflation updates shall not be less than 1.2 percent in fiscal year 1997 and 1.1 percent each year for fiscal years 1998–2002.

6. Non-routine services must be billed to Medicare by SNFs, and paid through Part A only while a patient is eligible for the Medicare Part A SNF benefit.

7. Medicare payments for non-routine services will be according to whichever amount is less:

a. A blended (50%/50%) payment limit that averages facility-specific limit amounts of non-routine services per stay and the wage-adjusted national average limit amounts of non-routine services per stay. (National average limit amounts would be calculated separately for free-standing nursing homes and hospital-based units); or

b. Facility-specific costs of non-routine services per stay.

c. However, SNFs that have aggregate non-routine costs per stay below the blended payment limit would keep 50 percent of the savings. Shared savings may not exceed 5 percent of the aggregate Medicare payments to the SNF each year.

8. SNFs will be required to bill Medicare for all Part B services used by SNF Medicare patients subsequent to the Part A benefit expiring for a patient or for SNF Medicare patients not qualifying for Part A benefits. SNFs must use the available fee schedule, if that has been the practice for Part B nursing home billings for the service in the past, or on a lesser of costs or

charges basis. The operating cost portion of Part B billings will be reduced by 5.8 percent for fiscal years 1996–2002.

9. SNF capital costs will be reduced by 15 percent beginning in fiscal year 1996.

10. New SNF units and facilities without fiscal year 1997 cost reports will be subject to the lesser of their costs or routine cost limits in the region as well as the new limited payment system for non-routine services established in this act, which would equal 100 percent of the national amount.

11. The Secretary will make routine cost limit exceptions payments at an annual level no higher than the 1994 aggregate payments for exceptions, inflated by the nursing home market basket each year. The Secretary must make any exceptions to the non-routine payment limits on a budget neutral basis. Exceptions for non-routine payment limits cannot exceed 5 percent of total non-routine payments each year and must be budget neutral.

12. Low Medicare volume SNFs will be subject to the cost savings from the OBRA 1993 provisions for fiscal year 1996. Beginning fiscal 1997, the Secretary should conform payments to low Medicare volume nursing homes with the policies in these provisions.

13. The Secretary, in consultation with ProPAC and nursing home experts, will recommend to Congress a separate payment limit for patients with intensive nursing and therapy needs by June 1997. In developing the separate payment limit, the Secretary may give consideration to performance measures, such as length of stay and discharge rates, to assure the delivery of medically necessary services.

14. ProPAC is required to report to Congress on the new payment system within one year of its operation with special attention to whether free-standing and hospital-based limits should be calculated separately, quality of services issues and recommendations, and whether the Medicare physician fee schedule should be used to calculate resource use of non-routine services.

Effective Date

The routine cost limit savings extension is effective for fiscal year 1996. The new payment system for non-routine services will be effective in fiscal year 1997.

Chapter 3—Provisions Relating to Part B

PAYMENTS FOR PHYSICIANS' SERVICES

(Sec. 7041)

Present Law

The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) provided for establishment of a fee schedule for payments for physicians' services beginning in 1992. Under the fee schedule (a resource-based relative value scale or RBRVS), each physician service is assigned relative value units (RVUs) that reflect physician work,

practice costs, and malpractice costs. The RVUs for each physician service are adjusted for geographic variations in the costs of practicing medicine.

To determine the Medicare fee payment for a physician service, the adjusted RVUs for the service are multiplied by a dollar amount called a "conversion factor." There are currently three conversion factors, for (1) surgical services; (2) primary care services; and (3) other nonsurgical services.

Each year, unless Congress otherwise provides, a default formula is used to determine an update, or a percentage increase or decrease, to each conversion factor. The default update is the sum of the Medicare Economic Index (MEI) (a measure of changes in physician practice costs) and a performance adjustment.

The performance adjustment is a comparison of actual physician spending in a base period with an expenditure goal known as the Medicare Volume Performance Standard (MVPS). The MVPS is calculated from estimates of several factors (changes in fees, non-HMO enrollment, volume and intensity of physician services, and laws and regulations), based on data from the second-preceding fiscal year (e.g., fiscal year 1993 data would be used to determine the calendar year 1995 update). The MVPS derived from this calculation is subject to a reduction known as the "performance standard factor." The MVPS has a lower limit of MEI minus five percentage points.

Reasons for Change

The Committee provision provides for a single conversion factor. A single conversion factor restores the integrity of the RBRVS. When the Medicare fee system was established by Congress, it was intended that each RVU should be worth the same amount across all physicians' services, and not by the category of physician service (i.e., surgical services, primary care services, and other nonsurgical services). However, under current law, physician services assigned the same number of RVUs may be paid differing amounts. The Committee provision corrects this distortion of the physician fee schedule. A single conversion factor has been recommended by the Physician Payment Review Commission.

The Committee provision also revises the default update formula, for two reasons. First, the current default update formula has resulted in highly volatile updates. In 1994 and 1995, the default update formula allowed for an aggregate update for surgical services of 22.2 percent; for primary care services, 15.8 percent; and for nonsurgical physicians' services, 10.5 percent. These updates are in excess of inflation and improvements in medical science or medical technology. Furthermore, if Congress had not mandated reductions in 1993 in the updates for surgical services and other nonsurgical services, the updates for surgical services and nonsurgical services would have been even higher.

The revision to the conversion factor and the default update formula will also reduce the rate of growth of physician expenditures to a sustainable level. Nonetheless, total spending for physician services will grow substantially over the next seven years. The Committee will examine carefully the impact of these changes on

both payments to physicians, to ensure their adequacy, and on access to physician services by Medicare beneficiaries.

Committee Provision

The Committee bill would amend Sec. 1848(d)(1) of the Social Security Act to provide for the establishment of a single conversion factor, rather than three conversion factors, effective January 1, 1996. The conversion factor for 1996 would be set at $35.42.

The Committee bill would amend Sec. 1848 to modify the calculation of the default update, effective for calendar year 1997. The MVPS would be repealed, and the performance adjustment would be replaced with an update adjustment factor. The update would equal the product of MEI and the update adjustment factor. The update adjustment factor would match spending on physician services to a cumulative sustainable growth rate.

The update adjustment factor for the succeeding year will be determined by the Secretary in October of each year and is to be calculated on the basis of a comparison between cumulative target spending (cumulated from annual sustainable growth rate calculations) and cumulative actual spending from a base year of July 1994 to June 1995.

The annual sustainable growth rate is calculated with the same factors as the current Medicare Volume Performance Standard (MVPS), except the factor of growth in historical volume and intensity of physician services is replaced with projected annual growth in real Gross Domestic Product (GDP) per capita plus two percentage points and the performance standard factor is eliminated.

The update would be subject to upper and lower bounds, of no more than 103 percent of the MEI or less than 93 percent of the MEI expressed as a growth rate. In other words, the update could be no greater than approximately MEI plus three percentage points, or less than MEI minus seven percentage points.

OBRA 89 authorized direct Medicare payments to clinical psychologists and social workers. The Committee is aware that the Secretary has initiated a rulemaking to establish a fee schedule for the services of psychologists and social workers, and recommends the Secretary act expeditiously in this matter.

In response to a Congressional mandate, the Health Care Financing Administration (HCFA) has undertaken a revision of the practice expense component of the RBRVS to reflect resources actually used, rather than past physicians' charges. To this end, HCFA has commissioned a study of practice expenses. The Committee requests the Secretary to consider analyzing the codes for portable x-ray/EKGs and transportation separately in this cost study to ensure fair and accurate evaluation of such resource-based practice expenses.

Effective Date

January 1, 1996.

ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS FOR CERTAIN OUTPATIENT HOSPITAL SERVICES

(Sec. 7042)

Present Law

Medicare payments for hospital outpatient departments are not paid under the Prospective Payment System (PPS). Medicare payments for hospital outpatient ambulatory surgery, radiology, and other diagnostic services are based on a formula that equals the lesser of:

1. The lower of a hospital's reasonable costs or its customary charges, net of coinsurance amounts; or
2. A blended formula amount comprised of a cost portion (with a reduction in the formula for the beneficiary coinsurance amounts) and a portion calculated using rates that would apply in other settings.

Reasons for Change

There is a flaw in the current payment formula causing Medicare to overpay hospital outpatient departments. The flaw relates to how beneficiary coinsurance amounts are accounted for in the formula.

Committee Provision

The Committee provision adjusts the current Medicare formula for hospital outpatient departments to eliminate Medicare's overpayments due to the formula flaw.

Using the current blend formula percentages, the payment formula would be changed by calculating the total blended payment amount prior to subtracting the beneficiary coinsurance amount.

Medicare's payment amount would be calculated based on the lesser of (1) the lower of the hospital's reasonable costs or customary charges, or (2) the blended payment amount. Medicare would then pay the lesser of (1) 80 percent of the lowest amount, or (2) the lowest amount less the beneficiary cost-sharing amounts.

Effective Date

Cost reporting periods starting on or after October 1, 1995.

PAYMENTS FOR CLINICAL LABORATORY DIAGNOSTIC SERVICES

(Sec. 7043)

Present Law

Since 1984, Medicare payments for clinical laboratory services have been made on the basis of local fee schedules established in areas designated by the Secretary. Beginning in 1986, the fee for each laboratory service has been limited by a national cap amount, which is based on the median of all local fees established for that laboratory test during a base year. The Omnibus Budget Reconciliation Act of 1993 mandated a reduction in the national cap

amounts in 1996 to 76 percent of the median fee amount paid for each service in a base year.

Current law provides that fee schedule amounts for laboratory services are updated each January 1 by the decrease or increase in the consumer price index for urban consumers (CPI–U). OBRA 93 eliminated this update for 1994 and 1995.

Reasons for Change

The Committee provision would reduce expenditures on laboratory tests to a more sustainable level, although the Committee notes that spending on laboratory services will continue to rank among the areas of highest Medicare expenditure growth. The Committee has provided for a study to ensure that the fees paid by the traditional Medicare program for laboratory services are consistent with the fees paid by other high-volume purchasers of laboratory services.

Committee Provision

The Committee provision would amend Sec. 1833 of the Social Security Act to reduce the national cap for each laboratory service to 65 percent of the national median fee during the base year for that service, effective January 1, 1997; and eliminate all CPI–U updates from 1996 through 2002.

The Committee provision would also direct the Secretary to compare the fees paid by Medicare for laboratory services with other high-volume purchasers of laboratory services, and to recommend any changes in fee schedule amounts and payment methodology in this regard.

The Committee also requests the Secretary to consult with providers of clinical laboratory services and to carefully consider any proposals to simplify and make uniform administrative and payment policies.

Effective Date

January 1, 1996.

DURABLE MEDICAL EQUIPMENT

(Sec. 7044)

Present Law

The Omnibus Budget Reconciliation Act of 1987 established six categories of durable medical for purposes of determining fee schedules and making payments. Among these categories are home oxygen equipment, which is reimbursed on a regionally adjusted monthly payment amount. Fee schedule amounts for durable medical equipment are updated annually by the consumer price index for urban consumers (CPI–U).

Under current law, when an item of durable medical equipment is deemed medically necessary and reasonable, the beneficiary may purchase an approved standard item from a supplier. The supplier collects a co-payment of 20 percent of the purchase price from the beneficiary and bills Medicare for the remaining 80 percent. How-

ever, if a beneficiary wishes to purchase a more expensive or enhanced item, the beneficiary must make full payment to the supplier, and submit a claim to Medicare for reimbursement of the amount of the approved standard item.

Reasons for Change

Although the Committee bill would reduce the growth in expenditures on durable medical equipment, spending in this area is expected to remain among the fastest growing areas in the Medicare program. In the category of home oxygen equipment, the Committee was aware of substantial evidence that the amounts paid for such equipment are excessive, and have reduced the payment rate accordingly.

The Committee bill also provides for a simpler, less cumbersome procedure for beneficiaries who wish to purchase enhanced items of medically necessary and reasonable durable medical equipment by allowing the supplier to collect not only the co-payment amount directly from the beneficiary but an additional amount for the enhanced features. However, the Committee is concerned that this provision has the potential for abuse, and has provided the Secretary with broad authority to provide for consumer protection.

Committee Provision

The Committee provision would amend Sec. 1834 of the Social Security Act to provide for the monthly payment amount for home oxygen equipment at 60 percent of the current amounts; and eliminate CPI–U updates for all categories of DME from 1996 through 2002.

The Committee also requests the Secretary to report to the Committee within nine months after the new payments rates for home oxygen equipment are implemented on the access and availability to such equipment by Medicare beneficiaries, and to make such recommendations as appropriate to the Committee.

The Committee bill amends Sec. 1834 to permit suppliers to receive a payment for an enhanced item of durable medical equipment in addition to the co-payment specified by law. The Committee bill provides for the promulgation by the Secretary of consumer protection regulations, at which time this provision becomes effective.

Effective Date

January 1, 1996.

UPDATES FOR ORTHOTICS AND PROSTHETICS

(Sec. 7045)

Present Law

Prosthetics and orthotics are reimbursed on the basis of a fee schedule. Fee schedule amounts are updated annually by the consumer price index for urban consumers (CPI–U). The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) eliminated updates for 1994 and 1995.

Committee Provision

The Committee bill would amend Sec. 1834 of the Social Security Act to eliminate the annual updates for payments made under the orthotics and prosthetics fee schedule from 1996 through 2002.

The Committee requests the Secretary to review the scientific literature on the clinical and cost effectiveness, and the impact on quality of life, of integrated clinical programs of drug therapy, diet modification, and nutritional counseling as a treatment and cure for dependence on total parenteral nutrition, and to advise the Committee whether payments for such treatment should be authorized by the traditional Medicare program. The Secretary may also wish to consider establishing a demonstration project to further test the effectiveness of such treatment.

The Committee further requests the Secretary to study whether a specific authorization in law should be established for parenteral and enteral nutrition (including home infusion therapy), and to make such recommendations as appropriate to the Committee, including the scope of such authorization and any additional projected cost. In this regard, the Secretary should consider what payments related to parenteral and enteral nutrition are currently made under the durable medical equipment benefit, and the feasibility and desirability of combining such payments in a specific authorization.

Effective Date

January 1, 1996.

PAYMENTS FOR CAPITAL-RELATED COSTS OF OUTPATIENT HOSPITAL SERVICES

(Sec. 7046)

Present Law

Medicare pays hospital outpatient departments for capital-related costs (e.g., buildings and land) on the basis of hospital-specific reasonable costs. OBRA 1993 provided for an annual 10-percent reduction in capital-related costs through FY 1998.

Reasons for Change

Medicare payments based on costs continue to grow at an unsustainable rate.

Committee Provision

The Committee proposal would reduce hospital outpatient departments' capital-related costs an additional (to OBRA 1993's 10-percent reduction) 5 percent each year, fiscal years 1996–1998. Therefore capital-related costs for hospital outpatient departments would be reduced a total of 15 percent for each year, fiscal years 1996–1998. From 1998–2002, hospital outpatient departments' capital-related costs would be reduced each year by 15 percent.

Effective Date

Cost reporting periods beginning on or after October 1, 1995.

PAYMENTS FOR NON-CAPITAL COSTS OF OUTPATIENT HOSPITAL SERVICES

(Sec. 7047)

Present Law

OBRA 1993 required the Secretary to reduce the payments made to hospital outpatient departments made on a reasonable cost basis and to the cost portion of the hospital outpatient blended formula by 5.8 percent each year for services provided during fiscal years 1994–1998.

Reasons for Change

Medicare's payments for hospital outpatient departments have been growing at an unsustainable rate. The Congressional Budget Office projects hospital outpatient departments' spending growth to exceed an annual rate of 14 percent.

Committee Provision

The Committee provision would extend the current annual 5.8 percent reduction through the year 2002.

Effective Date

Cost reports beginning on or after October 1, 1998.

UPDATES FOR AMBULATORY SURGICAL SERVICES

(Sec. 7048)

Present Law

Under current law, payments to ambulatory surgical centers are made on the basis of prospectively determined rates, determined by the Secretary for each covered procedure. Payments are updated annually by the consumer price index for urban consumers (CPI–U). The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) eliminated updates for fiscal years 1994 and 1995.

Committee Provision

The Committee bill would eliminate updates for payments to ambulatory surgical centers for 1996 through 2002.

Effective Date

January 1, 1996.

PAYMENTS FOR AMBULANCE SERVICES
(Sec. 7049)

Present Law

Medicare provides payment for ambulance services where such services are deemed medically necessary and reasonable. Annual updates in payments for ambulances services are provided in regulation.

Committee Provision

The Committee provision instructs the Secretary to eliminate any updates for ambulance service payments from 1996 through 2002.

The Committee is also aware of allegations that Medicare reimburses inappropriately for ambulance services. The Committee requests the Secretary to examine payment policies for ambulance services, and, if indicated, to modify Medicare payment policies to: (1) ensure that ambulance services are reimbursed at the lowest rate for ambulance service that is consistent with an individual's medical need, not by the level of ambulance service provided (e.g., basic life support versus advanced life support); and (2) establish a separate, lower payment for scheduled, routine transportation versus unscheduled, emergency transportation. The Committee requests the Secretary to report in a timely fashion on the results of the examination of Medicare ambulance payment policies and proposed changes to those policies.

Effective Date

January 1, 1996.

PHYSICIAN SUPERVISION OF NURSE ANESTHETISTS
(Sec. 7050)

Present Law

Current Medicare regulations governing participation in the Medicare program by hospitals and ambulatory surgical centers require that a certified registered nurse anesthetist (CRNA) practicing in such facilities be under the supervision of the operating practitioner or of an anesthesiologist who is immediately available.

Committee Provision

The Committee bill would direct the Secretary to revise the Medicare regulations governing the supervision of nurse anesthetists to defer to State law in determining when to condition Medicare reimbursement to CRNAs on physician supervision.

Effective Date

January 1, 1996

PART B DEDUCTIBLE

(Sec. 7051)

Present Law

Part B of Medicare is a voluntary program. Beneficiaries enrolled in Part B must pay the first $100 each year of the costs of Part B covered services. The deductible amount has been increased only three times since the inception of the Medicare program: from 1966 to 1972, the deductible amount was $50; from 1973 to 1981, $60; and from 1982 to 1990, $75.

Reasons for Change

This small increase in the beneficiary deductible will help reduce the substantial taxpayer subsidy of the Part B program and the contribution of Part B expenditures to the deficit. By spreading the increased beneficiary contribution over the entire beneficiary base, few beneficiaries should experience a significant burden. A similar provision to increase the Part B deductible to $150 was included in the Senate-passed version of the Omnibus Budget Reconciliation Act of 1990 (OBRA 90). The Senate, however, receded in conference. If the Part B deductible amount had been automatically adjusted for the change in the consumer price index (CPI) since 1966, the deductible today would be approximately $242.

Committee Provision

The Committee provision would amend Sec. 1833(b) of the Social Security Act and raise the annual Part B deductible to $150, effective January 1, 1996, and increase the deductible amount by $10 each January 1 thereafter through 2002.

Effective Date

January 1, 1996.

PART B PREMIUM

(Sec. 7052)

Present Law

Part B of Medicare is a voluntary program for which enrollees pay a monthly premium. When Medicare was established in 1965, the Part B monthly premium was set at an amount to cover one-half of the Part B program costs, with the remainder of funding from general revenues.

Under current law, Part B monthly premiums are required to cover 25 percent of Part B program costs. However, the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) placed in law the actual premium amounts for 1991 through 1995. According to the 1995 SMI (Part B) Trustees Report, the Part B monthly premium specified in OBRA 90 for 1995 ($46.10) actually covers 31.5 percent of Part B spending.

Reasons for Change

The Committee provision would establish the policy that Part B premiums cover Part B spending at the rate at which 1995 premiums cover such spending. This policy would further help insure that beneficiary contributions cover a fair share of Part B program spending and reduce the substantial taxpayer subsidy of Part B spending and the contribution of Part B expenditures to the deficit. Again, by spreading the increased beneficiary contribution over the entire beneficiary base, few beneficiaries should experience a significant burden. The provision also continues the practice established by OBRA 90 of specifying the actual premiums in law, which provides beneficiaries with certainty about future premium amounts.

Committee Provision

The Committee provision would amend Sec. 1833(i)(2)(3) of the Social Security Act and establish Part B monthly premiums in law at the following amounts: for 1996, $53.00; 1997, $57.00; 1998, $61.00; 1999, $66.00; 2000, $74.00; 2001, $80.00; and 2002, $89.00.

Effective Date

January 1, 1996.

ELIMINATE THE TAXPAYER SUBSIDY OF THE MEDICARE PART B PREMIUM FOR HIGH INCOME INDIVIDUALS

(Sec. 7053)

Present Law

Medicare Part B is a voluntary program. Persons electing to enroll in Medicare Part B pay a monthly premium which covers 31.5 percent of Medicare Part B costs. All beneficiaries regardless of income pay the same Part B premium. The remaining 68.5 percent of Medicare Part B costs is subsidized from general Federal revenues. In 1995 the Medicare Part B premium is $46.10. The Medicare Part B premium is deducted from Social Security checks.

Reasons for change

Costs in the Medicare Part B program are projected to increase about 12 percent annually. Because Medicare Part B is heavily subsidized from general Federal revenues, all taxpayers end up paying for the ever increasing Federal share of this program. The Committee believes that taxpayers should not subsidize the costs of Medicare Part B for high-income seniors who have the ability to pay a greater portion of the cost of their health care insurance.

Committee Provision

The Federal subsidy for the Medicare Part B premium is reduced for Medicare enrollees with incomes above $50,000 for singles ($75,000 for couples). The subsidy phases-down ratably from the income thresholds over $50,000 of income for singles ($75,000 for couples). This means the subsidy is completely eliminated at income

of $100,000 for singles ($150,000 for couples). Income includes adjusted gross income plus other items such as tax-exempt interest. This income is already reported to the Internal Revenue Service for purposes of determining the taxability of Social Security benefits.

Medicare enrollees will declare during the Medicare open enrollment period whether their estimated income for the upcoming year will exceed the income thresholds. If enrollees are unsure of their income for the upcoming year, they may use their modified income reported on the previous year's Federal income tax return. The Secretary of Health and Human Services will notify the Social Security Administration of the amount of premium to deduct from each enrollee's Social Security check based upon the beneficiary's declaration of income. The amount of the Medicare Part B premium payment will be reconciled with actual income in conjunction with the annual income tax filing process. A separate form, to be filed with the Secretary, will be included in enrollees' Federal income tax return forms package. Underpayments and overpayments will be will be handled directly through the Secretary of Health and Human Services. The Secretary and the Internal Revenue Service (IRS) will share certain tax return information to permit verification of declared income with actual income reported to the IRS.

Effective Date

This provision will be effective for calendar years beginning on or after January 1, 1997.

Chapter 4—Provisions Relating to Parts A and B

SUBCHAPTER A—GENERAL PROVISIONS RELATING TO PARTS A AND B

SECONDARY PAYER PROVISIONS

(Sec. 7055)

Present Law

(a) Generally, Medicare is the "primary payer," that is, Medicare pays medical claims first, with an individual's private or other public insurance only responsible for claims not covered by Medicare. For certain Medicare beneficiaries, however, the beneficiary's employer's health insurance plan pays medical bills first (so-called "primary payer"), with Medicare paying for any gaps in coverage within Medicare's coverage limits (Medicare is the "secondary payer"). Medicare is the secondary payer to certain employer group health plans for: (1) aged beneficiaries (age 65 and over); (2) disabled beneficiaries, and (3) beneficiaries with end-stage renal disease (ESRD) during the first 18 months of a beneficiary's entitlement to Medicare on the basis of ESRD.

The Medicare secondary payer provision regarding aged beneficiaries is permanent law. The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) extended the law making Medicare the secondary payer for disabled and ESRD beneficiaries through October 1, 1998.

(b) The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) authorized a "data match" program to identify potential secondary payer situations. Medicare beneficiaries are matched against data collected by Internal Revenue Service and the Social Security Administration to identify cases in which a working beneficiary (or working spouse) may have employer-based health insurance coverage. Cases of incorrect Medicare payments are identified and recoveries of payments are sought. The authority for this program expires on September 30, 1998.

(c) The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) provided for a new secondary payer provision regarding ESRD beneficiaries. The Health Care Financing Administration (HCFA) subsequently issued regulations in June 1994 to make Medicare the secondary payer for ESRD beneficiaries for 18 months, even if a beneficiary was otherwise eligible for Medicare because of age or disability. In April 1995, HCFA issued an instruction reversing this regulation, and dialysis facilities were required to make refunds to private payers and to file claims with Medicare. Dialysis facilities subsequently obtained a temporary injunction in Federal court against this requirement.

Committee Provision

The Committee bill will:

(a) Make permanent law that Medicare is the secondary payer for disabled beneficiaries who have employer-provided health insurance; and make permanent law and extend to 30 months the period of time employer health insurance is the primary payer for ESRD beneficiaries.

(b) Make the data match program authority permanent law; and

(c) Prohibit a retroactive requirement for making refunds to private payers and filing corresponding claims with Medicare for ESRD beneficiaries. In the event that age-based or disability-based Medicare entitlement precedes ESRD-based eligibility, Medicare will be the secondary payer to an employer group health plan (subject to such conditions as specified in law) for the period August 10, 1993, through April 24, 1995. This construction would be consistent with the original guidance provided by the Health Care Financing Administration in July 1994.

Effective Date

On enactment.

TREATMENT OF ASSISTED SUICIDE

(Sec. 7056)

Present Law

There is no prohibition on Medicare payment for services related to assisted suicide, euthanasia, or mercy killing. Providers are required to provide written information to a Medicare beneficiary regarding the individual's rights under State law to make decisions regarding their medical care, including the right to accept or refuse treatment.

Committee Provision

Medicare payment for expenses related to services for the purpose of causing, or assisting in causing, death, suicide, euthanasia, or mercy killing is prohibited. Health care providers, or employees of providers, may not be required to inform or counsel a patient regarding assisted suicide or other services which purposefully cause the death of a person.

Effective Date

Upon enactment.

ADMINISTRATIVE PROVISIONS

(Sec. 7057)

Present Law

Indian Health Service facilities are eligible for Medicare payments. The First Church of Christ, Scientist, Boston, Massachusetts is a certifying agency for the purposes of Medicare eligible related organizations.

Reasons for Change

Clarifications are necessary to assure that eligible organizations continue to receive Medicare payments.

Committee Provision

Nothing in the Committee provisions shall be interpreted as meaning any change in Medicare payment to eligible Indian Health Services facilities. Further, the certifying authority for Christian Science health facilities for the purposes of Medicare payment provisions is changed from "the First Church of Christ, Scientist, Boston, Massachusetts" to "the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.".

Effective Date

The Indian Health Service Facility provision continues as under current law. The Christian Science name clarification is effective January 1, 1997.

SUBCHAPTER B—PAYMENTS FOR HOME HEALTH SERVICES

PAYMENTS FOR HOME HEALTH SERVICES

(Secs. 7061–7063)

Present Law

Home health care agencies are currently reimbursed on the basis of reasonable costs, up to specified cost limits. Cost limits for the individual services are set at 112 percent of the mean labor-related and nonlabor per visit costs for freestanding agencies. Cost limits are updated annually by applying a market basket index to base year data derived from home health agency cost reports. The labor-

related portion of a cost limit is adjusted by the current hospital wage index.

The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) required that there be no changes in home health cost limits (including no adjustments for changes in the wage index or other updates of data) for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996.

In legislation passed in 1983, 1987, and 1990, Congress required the Secretary to develop alternative methods for paying for home health care on a prospective basis. In 1994, the Office of Research and Demonstration in the Health Care Financing Administration (HCFA) completed a demonstration project that tested prospective payment for home health care on a per visit basis. Preliminary analysis indicates that the per visit prospective payment methodology had no effect on cost per visit or volume of visits. HCFA has just begun a second project, referred to as Phase II, to test prospective payment on a per episode basis. This project is not scheduled to be completed until December 1998.

Reasons for Change

Medicare home health service utilization and costs are growing at an unsustainable rate for the Medicare program. ProPAC reports that from 1980–1994, persons using the home care benefit grew from 26 to 88 persons per 1,000 Medicare enrollees and 23 to 65 visits per 1,000 for those persons using the home care benefit. From 1994–1995 alone, the Congressional Budget Office estimated Medicare's payments for home health services to grow over 20 percent.

Medicare's current cost-based payment system for home care provides few incentives for providers or patients to be cost conscious.

Committee Provision

The provision would establish a prospective payment system for home health services. The system would be based on prospectively determined national average per visit rates (adjusted for regional differences in workers' wages). Aggregate payments would be subject to an episode limit, adjusted to reflect each agency's mix of patients. Agencies capable of keeping costs below the regionally established per episode limits would share in Medicare savings. The new prospective system would be established as follows:

1. Using the 1994 home health cost report data, the Secretary would be required to establish national average per visit rates for each of the home health service disciplines covered under Medicare—skilled nursing care, physical therapy, speech pathology, occupational therapy, medical social services, and home health aide services. The per visit rates would be set so as to assure budget neutrality with respect to the OBRA 1993 changes in effect for cost reporting periods ending June 30, 1996. To reflect regional differences in the costs of providing services, the labor-related portion of the per visit rates would be adjusted by the hospital wage index. This wage index is currently used to adjust home health cost limits. The adjusted per visit rates would be the amounts that home health care agen-

cies would receive for each of the particular mix of visits provided to a given home health care beneficiary.

2. Per visit rates would be subject to a per episode limit. The Secretary would calculate separate per episode limits for each of 18 different case categories of home health care. These 18 categories would be the same as those being used in HCFA's Phase II demonstration, and would serve as a substitute for a true case-mix adjustment not yet available.

3. The per episode limit would be calculated as follows. For a base year, using the best available 1994 home health agency data, the Secretary would calculate for each of the 18 categories the number of visits by type times the per visit national rate established by discipline incurred by agencies for care delivered during a period of 120 days following the initial admission of the beneficiary to home health. This would become the target per episode limit.

4. Calculation of per episode limits would be done on a regional basis; for these purposes region would be defined by the same metropolitan statistical area (MSA)/rural classification system used for the hospital wage index.

5. Each agency would be paid per visit payments throughout the year. At the end of the year, an agency's aggregate limit would be calculated by multiplying the Secretary's regional target per episode limit for each of the 18 categories times the agency's number of episodes in each of the 18 categories. The sum of these products becomes the per agency aggregate limit.

6. For the purposes of calculating the agency-specific per episode limit, 165 days of care per episode would be used. Agencies that received aggregate per visit payments below their regional target limit would share 50 percent of the savings. The shared savings cannot exceed 5 percent of an agency's aggregate Medicare payments in a year. Agencies would not be allowed to keep aggregate payments that are over the limit.

7. If a beneficiary continues to need home health visits after a period of 165 days, then an agency may request that additional payments be made on a per visit basis. In order for fiscal intermediaries to approve such requests, agencies would be required to submit a physician's certification of the continuing need for skilled care as well as information about utilization of services in the previous period and expected use of services in the upcoming period.

8. A new episode is defined as a new home health admission after a 60 day gap in home health services.

9. Per visit and per episode limits would be adjusted annually for fiscal years 1997 and future years by the home health market basket minus 2.5 percentage points (the market basket is the one currently used to update cost limits). The annual inflation update will not be less than 1.2 percent for fiscal year 1997 and not less than 1.1 percent for fiscal years 1998–2002 however. The Secretary will rebase the per episode cap every 2 years to refine the episode system to adjust for changes in the trends in the number of and mix of visits per episode.

10. The Secretary shall adjust payments to remove the effects for case mix increases due to reporting improvements

rather than real changes in patients' resource use every year for the first three years, and then every two years thereafter.

11. Low cost episodes will be examined by the Secretary to assure that agencies have an incentive to be cost efficient in delivering home health services, but that the volume of these episodes does not increase for reasons other than patient needs. Then, in each year, the Secretary will adjust payments to reflect growth in the proportionate distribution of low cost episodes by agency.

12. Separate Part B billings would be prohibited for any services covered under the per episode limit while the beneficiary is receiving home health services.

13. Agencies would be required to bill prosthetics and orthotics furnished as part of a home health visit under Part B's prosthetics and orthotics fee schedule, just as durable medical equipment (DME) furnished by an agency as part of home health must now be billed under fee schedules for DME.

14. Exceptions payments cannot exceed 1995 exceptions payments inflated to the home health market basket in 1996.

15. The limited waiver of liability for home health agencies is due to expire on December 31, 1995. The waiver shall be extended to September 30, 1996.

16. The Secretary is directed to implement a thorough medical review process for the new payment system, with particularly careful focus for fiscal years 1997–1998. The goal of the medical review process is to adequately assess the appropriate pattern of care provided to beneficiaries to be sure appropriate services per episode are provided:

a. Medical reviews will focus on short stay cases and cases over 165 days.

b. Recertification by intermediaries shall be done at 30, 60, 120, and 165 days of home health care.

17. The Secretary may deem private organizations to conduct medical reviews.

18. Secretary is required to investigate and make adjustments to payments to home health agencies to account for irregularities intended to circumvent the application of the policies of the home health prospective payment system such as:

a. Discharging patients to another home health agency or similar provider;

b. Altering corporate structure or name to avoid being subject to home health payment limits or for the purposes of increasing Medicare payments; and

c. Other actions considered unnecessary for patient care and instead intended by the home health agency to achieve maximum Medicare payments.

19. The Secretary is directed to develop a system to track home health patients that switch home health agencies during an episode. The Secretary shall adjust the payment to the home health agencies to result in no higher per episode payment than would have been otherwise if the patient had completed an episode in one single agency.

20. New agencies will be paid by the new payment system defined in this proposal.

21. ProPAC is directed to complete yearly assessments of how well the new prospective payment system for home care is working during the first three years of the new payment system. ProPAC will include recommendations at least once a year in its report to Congress. ProPAC will include recommendations on: (1) case mix and volume increases, (2) quality monitoring of home health agency practices, and (3) whether a capitated payment for home care patients using over 165 days of service is warranted.

Effective Date

The new prospective payment system would be in effect for cost reporting periods beginning on or after July 1, 1996.

Chapter 5—Rural Areas

(Secs. 7071–7077)

Present Law

The Medicare program includes a number of provisions to help rural seniors receive health services and for Medicare to pay fairly in rural areas.

Medicare begin paying rural hospitals, under the Prospective Payment System, a standardized amount that is equal to the "other urban" amount for the first time in 1995.

In addition, the Medicare program has a special designation for hospitals in remote areas that are the sole hospital in an area, called "Sole Community Hospitals." A second special designation, Medicare Dependent Hospitals, expired July 30, 1994, which included rural hospitals that are not Sole Community Hospitals, with 100 or fewer beds and at least 60 percent Medicare patient discharges or days. Medicare Dependent Hospitals receive special Medicare payments.

Medicare restricts payments to limited service hospitals with the exception of a seven-State program called the Essential Access Community Access Hospital and Rural Primary Care Hospital program (EACH/PCH). Montana also has a limited hospital program called the Medical Assistance Facility (MAF).

Physicians who treat patients residing in Health Personnel Shortage Areas (HPSA) receive bonus payments of 10 percent. The HPSA definition requires a physician to population ratio of 3,500 to 1 (or 3,000 to 1 in certain circumstances), and adjoining areas must have provider resources that are overused, or more than 30 travel miles away, or otherwise inaccessible.

Physician assistants (PA) and nurse practitioners (NP) are reimbursed under Medicare Part B if they are working in settings specified in law. The reimbursement rate for those services varies with the setting. In all settings not specified by law, services provided by N.P.s. and P.A.s are reimbursed at 100 percent of the physician RBRVS reimbursement rate if they are provided "incident to" a physician service.

Certain grants for telemedicine have been available through the Office of Rural Health Policy's Rural Telemedicine Grant Program to demonstrate and collect information on the feasibility, cost, appropriateness, and acceptability of telemedicine consultations for improving access to health services for rural residents and reducing the isolation of rural practitioners.

ProPAC will make recommendations on updates and assuring access related to hospitals that have a high proportion of Medicare patients and patient days.

Reasons for Change

Rural providers are often very financially dependent on Medicare payments. The provisions assist rural areas to continue to provide high quality, cost effective access to health services.

Committee Provision

The Medicare Dependent Hospital program will be re-instituted effective for cost reporting periods on or after September 1, 1995. The same program with the expired provisions setting out the criteria of rural hospitals with 100 or less beds and 60 percent of discharges or patient days will be used to identify eligible hospitals. Medicare Dependent Hospitals will receive Medicare payment based on the expiring provisions payment arrangement.

A new limited service hospital program will be available to all the States. Certain grants will be available for hospitals seeking to become limited service hospitals through the Secretary of Health and Human Services. Criteria for the limited service hospitals include an average length of stay of 72 hours and 6 beds. Hospitals participating in the swing bed program may use 12 beds. Medicare will pay for the limited service hospitals on a reasonable cost basis.

The Medical Assistance Program will be continued for all qualifying facilities in Montana. Hospitals paid under the EACH/PCH program will continue on the same payment basis in future years.

A new program for Rural Emergency Access Hospitals (REACH) is designated for converted rural hospitals that will operate to serve patients that stay only up to 24 hours, with an exception for severe weather conditions. The purpose of these facilities is to stabilize patients until transfer to a full-service hospitals. Medicare Part B payments will be based on reasonable costs.

Rural, primary care physicians' (practicing in Health Personnel Shortage Areas [HPSAs]) bonus payments will be increased from 10 percent to 20 percent.

Physician Assistants (P.A.s) and Nurse Practitioners (N.P.s) will be paid at 85 percent of the RBRVS fee schedule (physician fee schedule) for outpatient settings.

A new telemedicine grant program will be available through the Office of Rural Health Policy's Rural Telemedicine Grant Program.

ProPAC is directed to make recommendations on hospitals that have a high number of Medicare patients and patient days each year.

Effective Date

All provisions are effective in fiscal year 1996. The Medicare Dependent Hospital program expires on September 30, 2000.

Chapter 6—Health Care Fraud and Abuse Prevention

(Secs. 7101–7151)

Present Law

Medicare law includes a number of provisions that give the Secretary administrative, civil, and criminal remedies to combat fraud and abuse against the Medicare and Medicaid programs.

There are no provisions of law in the criminal code specific to health care fraud and abuse.

Committee Provision

1. Coordinated anti-fraud program

The Secretary of Health and Human Services (acting through the Office of the Inspector General) and the Attorney General are directed to jointly establish a program to coordinate Federal, State, and local law enforcement efforts to combat fraud and abuse in the delivery of and payment for health care in the United States.

2. Health care fraud and abuse account

A new health care anti-fraud and abuse mandatory spending account is established. There are appropriated from the Federal Hospital Insurance (HI) Trust Fund in the amount of such sums as may be necessary, not to exceed: $200 million in fiscal year 1996; increased by 15 percent each year through 2002; frozen in nominal dollars at the 2002 level thereafter.

These appropriated funds will be used to cover the costs of the administration and operation of the coordinated anti-health care fraud and abuse program for the Inspector General, the FBI, the State Fraud Control Units, and the Department of Justice prosecutors.

All monies from any and all civil money penalties, fines, forfeitures and damages assessed in criminal, civil or administrative health care cases, along with any gifts or bequests would be considered income to the Medicare Hospital Insurance Trust Fund.

3. Health care fraud and abuse guidelines

a. *Safe harbors.*—The Secretary shall publish an annual notice in the Federal Register soliciting proposals for modifications to existing safe harbors, new safe harbors, interpretive rulings and special fraud alerts. After receiving comments, the Secretary, in consultation with the Attorney General, will issue final rules modifying existing safe harbors and establishing new safe harbors.

b. *Interpretative rulings.*—Interpretive rulings related to Medicare and Medicaid anti-fraud and abuse laws may be requested, at any time, by any person, and shall be issued by the Inspector General, in consultation with the Attorney General, no later than 90 days after receiving such a request. The interpretive rulings will be

published in the Federal Register, but will not have the force of law.

c. *Special fraud alerts.*—Any person may request the Inspector General to investigate and issue a special fraud alert informing the public of practices which are suspect or of concern relating fraud and abuse against the Medicare and Medicaid programs.

4. Revisions to the current sanctions for Medicare and Medicaid fraud and abuse

Under current law, the Secretary of Health and Human Services has the authority to exclude certain individuals and entities (like a health plan) from receiving Medicare and Medicaid payments under certain circumstances (e.g., for convictions of criminal offenses).

The proposal makes it mandatory for the Secretary to exclude individuals from receiving payment from Medicare and Medicaid when convicted of felonies relating to health care fraud. In addition, the Secretary has the right to exclude persons convicted of a criminal misdemeanor related to health care fraud offense. The proposal also sets certain minimum periods for exclusion from Medicare and Medicaid payments.

The Secretary may also exclude an individual who has a direct or indirect ownership or control interest of 5 percent or more in an entity or is an officer or managing employee if the entity is already excluded from Medicare and Medicaid or has been convicted of a criminal offense relating to health care fraud.

5. Intermediate sanctions

The Secretary may terminate a contract with a Medicare HMO if the HMO as failed to carry out the contract. Other penalties include civil money penalties ranging from $10,000 to $100,000. Suspension of continued enrollment or payments can also be used as sanctions.

Before the Secretary imposes the HMO penalties, the Secretary must follow certain procedures to allow the organization to develop and implement a corrective action plan.

HMOs must also have a written agreement with a PRO or similar organization to perform quality review functions.

6. Data collection program

The Secretary of Health and Human Services is required to establish a national health care fraud and abuse data collection program for reporting final adverse actions against health care providers, suppliers, or practitioners.

The information in the database is required to be available to Federal and a State government agencies and health plans according to the procedures that the Secretary will set by regulation.

7. Civil monetary penalties

There are a number of current civil money penalties for certain fraudulent claims for reimbursement under Medicare and Medicaid.

The proposal requires that civil money penalties and assessments will be used to pay the Medicare and Medicaid programs

back, with the remaining dollars deposited in the health care fraud account.

Civil monetary penalties are increased (from $2,000–$5,000) to $10,000 for a number of current law fraud and abuse activities.

New prohibited practices are added to the current law for which civil money penalties can be assessed: (1) incorrect coding; (2) medically unnecessary services; and (3) persons offering remuneration (including waiving coinsurance and deductible amounts) to induce the individual to order from a particular provider or supplier receiving Medicare or State health care funds.

The Secretary can impose intermediate civil money penalties of not more than $10,000 per violation for criminal anti-kickback violations. In addition, the person shall not be assessed an intermediate sanction that is more than twice the total amount of the remuneration offered, paid, solicited, or received in the prohibited activity.

8. Criminal law provisions

A health care fraud section is added to the criminal code. Currently, criminal penalties for health care fraud violations are imposed using the Federal mail and wire fraud statutes, the False Claims Act, the false statement statutes, money laundering statutes, racketeering, and other related laws.

The amendments to criminal law include:

a. Forfeiture of property that is obtained from the proceeds traceable to health care fraud;

b. Injunctive relief may be imposed on activities related to health care fraud;

c. Grand jury disclosure allowed for health care fraud proceedings;

d. Criminal penalties for false statements;

e. Criminal penalties for the obstruction of criminal investigation;

f. Criminal penalties would be imposed for theft or embezzlement;

g. Criminal penalties for laundering of money used in health care fraud offenses; and

h. Subpoena authority is given to the Attorney General for health care fraud cases.

9. State Health Care Fraud Control Units

Currently, States investigate fraud against the Medicaid program by State Health Care Fraud Control Units.

The proposal extends the authority of the Units by (1) allowing the Units to investigate other Federal fraud abuses; and (2) allowing investigation and prosecution in the case of patient abuse in non-Medicaid board and care facilities.

10. Clarifications to the anti-kickback provisions

Certain clarifications to the anti-kickback provisions in current law are made in the areas of discounting and managed care related to Medicare Choice plans. The Secretary is directed to study the benefits of volume and combination discounts to the Medicare program and report such findings to the Congress. The Secretary shall

develop regulations based on the findings of the study that are budget neutral basis.

Effective Date

Fiscal year 1996.

Chapter 7—Other Provisions for Trust Fund Solvency

SUBCHAPTER A—GENERAL PROVISIONS

CONFORMING AGE FOR ELIGIBILITY UNDER MEDICARE TO RETIREMENT AGE FOR SOCIAL SECURITY BENEFITS

(Sec. 7171)

Present Law

In 1983, Congress raised the eligibility age for Social Security old-age cash benefits from age 65 to age 67, to be phased in over a transition period from 2003 to 2027. However, under current law, the age of entitlement for Medicare remains unchanged at age 65.

Reasons for Change

The Committee provision will establish a consistent national policy on eligibility for both Social Security old-age pension benefits and Medicare. Although this provision will not produce any savings that apply to the Committee's reconciliation instructions, this provision will improve the long-term solvency of the Hospital Insurance (Part A) Trust Fund.

Committee Provision

The Committee provision amends the relevant sections of the Social Security Act to raise the age of eligibility for Medicare benefits from age 65 to age 67 over the years 2003 to 2027 in the same steps as for Social Security old-age pensions as detailed in section 216(*l*)(1)) of the Social Security Act.

Effective Date

January 1, 2003.

TRANSFERS OF CERTAIN PART B SAVINGS TO HOSPITAL INSURANCE TRUST FUND

(Sec. 7173)

Present Law

Under current law, Medicare enrollee payments for Part B premiums go into the Federal Supplementary Trust Fund.

Reason for change

The Committee wishes to assure Medicare beneficiaries that savings resulting from changes in Part B premiums and the Part B annual deductible will only be used to strengthen the financial status of the Medicare program.

Committee Provision

Under the Committee provision, the Secretary of the Treasury, who serves as the managing Trustee of the Medicare Trust Funds, will annually estimate the amount of savings to the Federal Government resulting from the changes in this legislation to the Part B premium and to the annual Part B deductible. Each year, the amount of savings to the Federal Government resulting from these provisions will be transferred from the general fund of the Treasury to the Federal Hospital Insurance Trust Fund in the form of public-debt obligations issued exclusively to the Federal Hospital Insurance Trust Fund. Money from the Federal Hospital Insurance Trust Fund may only be used for Medicare expenditures.

Effective Date

January 1, 1996.

BUDGET EXPENDITURE LIMITING TOOL

(Sec. 7175)

Present Law

Under current law, Medicare is an open-ended, entitlement program. As a result, there is no constraint on annual Medicare program spending.

A provision in the Omnibus Budget Reconciliation Act of 1990 requires that legislation providing for increased entitlement spending or decreases in revenue be offset by entitlement decreases and/or revenue increases on a pay-as-you-go (PAYGO) basis. A violation of PAYGO rules can trigger a sequestration, a process by which most Federal spending programs are reduced by a percentage of total spending necessary to make up a spending overrun or revenue shortfall. Under PAYGO, Medicare spending can not be reduced by more than 4 percent. PAYGO rules apply through FY 1998.

The automatic spending reductions under PAYGO rules have never occurred. Sequestration has occurred under a similar statute (the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987) in FY 1988. Payment rates for medical services were reduced by 2 percent to achieve the necessary savings.

Reasons for change

Congress has not been very successful in controlling spending growth in the Medicare program. Providers have historically been able to continue increasing the amount of reimbursements or the volume of services even while Congress has been enacting changes to curb the growth of Medicare spending. The Committee believes that legislation is needed to provide a back-stop to curb unforeseen spending growth.

Committee provision

A new provision to Title XVIII of the Social Security Act is added to assure that actual Medicare spending does not exceed projected Medicare spending during each fiscal year within the period FY 1996–2002.

Under the provision, Medicare spending under Parts A and B would automatically be reduced by a annual Medicare budget expenditure limit tool (BELT) by a percentage to bring spending within the budget targets.

Under the Medicare BELT provision total mandatory Medicare outlay targets are:

Fiscal Year	Annual Target (billions)
1996	$193.3
1997	$206.5
1998	$219.7
1999	$233.5
2000	$249.6
2001	$266.9
2002	$285.6

Beginning for fiscal year 1996 and each year thereafter through 2002, the Congressional Budget Office (CBO) and the Office of Management and Budget (OMB) will issue reports by August 15th to Congress on estimated Medicare outlays for the fiscal year in comparison to baseline Medicare outlays (as defined by this Act) for the fiscal year. These will serve as notice of estimated actual Medicare spending in relation to Medicare spending targets and, therefore, alert Congress to the potential need for a BELT adjustment to Medicare provider payments in the subsequent fiscal year.

A Presidential order to bring spending within the annual target for the fiscal year shall be issued on October 15 based upon a final OMB report on Medicare spending. The order will specify the reduction in payment amounts for provider services which are necessary to meet the annual spending target. OMB will be required for purposes of this title to use CBO economic assumptions for purposes of reports required by this title.

Under a BELT compliance order, each payment amount for covered services (as determined under Medicare law and regulations) would be reduced by a specified percentage which when applied proportionally to all payments will equal the amount of reductions needed to bring the previous or current fiscal year in compliance with the BELT targets. The provision describes the various situations when a payment for services has occurred for purposes of BELT.

The percentage reductions would also affect the coinsurance, or premium amounts payable by Medicare beneficiaries.

The reduction would take effect as of the beginning of the fiscal year. Where this date is not at the beginning of a provider's cost reporting year, the reduction would be prorated evenly over the months of the two cost reporting years to which it is applicable. Because final determination of the BELT tightening amount will be made after the beginning of a fiscal year, if payments made after October 1 differ from the final order, the Secretary of HHS shall recover any overpayments made. Spending at a level below the target for a fiscal year shall not be available to offset additional spending above the targeted amount in any other fiscal year.

Unless Congress provides otherwise, beginning on October 1, 1999, The Secretary may adjust the amount of percentage reductions under a BELT compliance order to reflect variation in per capita spending growth across Medicare payment areas. The Secretary shall report to Congress one year prior to the effective date of this section regarding the types of measurable variables which would be used to determine variations in spending growth. The Secretary shall also provide an analysis of how these variations would impact a BELT compliance order in different regions of the country.

It is anticipated that Congress, based upon the initial OMB snapshot in August, will enact legislative changes to bring spending within the target and avoid the issuance of a BELT compliance order. If, Congress has not acted and the President issues a BELT compliance order, Congress can alter the way the across the board cuts are applied to the various Medicare payments for services through an expediated process similar to the procedure in Section 258A of the Balanced Budget and Emergency Deficit Control Act of 1985. This procedure permits Congress to respond quickly without filibusters or extraneous matters delaying legislation to bring spending under control. This procedure can only be used to change how the spending reductions are made. The procedure is not available to reduce the amount of the cuts necessary to bring spending within the targeted amount. If Congress wants to delay or eliminate spending reductions required under BELT, Congress will need three-fifths of the Senate and House to approve such changes. In addition, a point of order will apply against any provision which causes spending to exceed the annual target.

Effective Date

This provision is effective for fiscal years 1996 through 2002.

SUBTITLE B—TRANSFORMATION OF THE MEDICAID PROGRAM

Overview

Present Law

The current Medicaid program (Title XIX of the Social Security Act) is an open-ended individual entitlement program which pays for health care and long-term care items and services on behalf of low-income persons who are aged, blind, disabled, or members of families with pregnant women or children. Each State designs and administers its Medicaid program within Federal guidelines. However, current law includes requirements that States must meet with respect to eligibility, covered services, provider payments and delivery systems.

Reasons for Change

Adopted 30 years ago as a relatively simple and lean health care program to supplement cash assistance programs, the Medicaid program has expanded beyond recognition to cover a vast array of population groups and services. As it has grown in coverage, so has it grown in complexity and in the degree of prescriptive Federal regulation and intervention. The statute defining the program has become incomprehensible even to its most experienced students. Federal regulations based on the statute fill a thick volume and include a minefield of prohibitions, limitations, and complicated requirements that are increasingly used to withhold Federal funds even for the most minor or technical infractions. Shelves of manuals, interpretive bulletins and similar material have been created by the Federal bureaucracy weaving an ever tightening straitjacket around State administration and attempts to operate efficient programs.

The result of 30 years of expanding Federal control has produced a dizzying array of more than 70 arbitrary eligibility categories that compel coverage for some whose needs are no greater and often are less than others for whom coverage is prohibited. It has built a system that constantly favors the most expensive institutional care while discouraging innovative service delivery and the development of more efficient means of meeting beneficiaries' needs. It purports to offer opportunities for States to experiment with new approaches under waivers, but surrounds the waiver processes with so many limitations and procedural hoops that the opportunity for real reform is more illusory than real.

The Committee believes that the many problems now burdening this program cannot be rectified by minor amendments which, in the hands of an aggressive Federal bureaucracy, will be used as further opportunity to write Federal rules and extend Federal con-

trol. Real reform is needed, and that can only be accomplished by repealing the existing program and turning to a clean slate to design a sensible program that will meet today's needs and allow States to adjust to the changing needs of tomorrow.

The Committee recognizes the need for preserving a health care safety net for the most vulnerable segments of our society, for a commitment to high-quality service paid for by public funds, and for continued contribution of State funds to accompany the Federal dollars that will be used to pay for health services under the new program. The Committee has developed a reform plan which contemplates a public role in developing a State's plan, and emphasizes quality assurance, but does not hamper those policy goals with the kind of Federal bureaucratic management that has produced the hopeless labyrinth that is today's program.

Under the Committee's provision, the current Medicaid program will be completely replaced by a new, simplified program to provide payment for health and long-term care services on behalf of low-income Americans. States will be given much broader flexibility to determine how best to meet the needs of their low-income residents. The Federal Government will remain a partner in financing States' efforts to address these needs.

Description of Provision

The following describes the major components of the provision.

ELIGIBILITY

Present Law

Medicaid is a means-tested entitlement program. Applicants' income and resources must be within program financial standards that vary among States. Medicaid recipients are poor and either aged, blind, disabled, or are specified members of families with dependent children. Persons who do not meet the categorical requirements (e.g., single adults, childless couples) cannot qualify for Medicaid regardless of poverty status.

Medicaid statute defines over 50 distinct population groups that may qualify under the program. Federal law requires States to cover certain population groups. Others may be covered at States' option. Most of those individuals who are potentially eligible fall into 5 basic groups:

1. Families, pregnant women and children

States must provide Medicaid to:

a. Families receiving benefits under the Aid to Families with Dependent Children (AFDC) program and to AFDC-related groups not actually receiving cash payments. For example, States must provide Medicaid for 12 months to certain families who have lost AFDC because of increased earnings or hours of work. States are permitted to provide coverage to additional AFDC-related groups.

b. Pregnant women and children under age 6 in families with household incomes under 133 percent of the Federal poverty level. At their option, States may extend coverage to preg-

nant women and infants up to age 1 in families with incomes below 185 percent of the Federal poverty level.

c. Children (under age 19) born after Sept. 30, 1983 with incomes under the Federal poverty level.

2. Aged and disabled persons

States are generally required to cover aged and disabled persons who receive benefits under the Supplemental Security Income (SSI) program. However, 12 States are permitted to use more restrictive eligibility standards for Medicaid than those for SSI if the State's standards were in use on January 1, 1972. States using more restrictive income standards must allow applicants to deduct incurred medical expenses from income before determining eligibility. This process is known as "spend-down."

States must continue Medicaid coverage for certain groups of individuals who have lost SSI eligibility. The "qualified severely impaired" are disabled persons who have returned to work and have lost eligibility as a result of employment earnings, but still have the condition that originally rendered them disabled and meet all non-disability criteria for SSI except income. Medicaid must be continued if such an individual needs continued medical assistance to continue employment and the individual's earnings are not sufficient to provide the equivalent of SSI, Medicaid, and attendant care benefits the individual would qualify for in the absence of earnings. States must continue Medicaid coverage for persons who have lost SSI because of a cost-of-living adjustment in their Social Security benefits.

3. Medically needy persons

States are permitted to provide Medicaid coverage to "medically needy" persons. These are people who meet the categorical standards for Medicaid (i.e., pregnant women, children, aged, blind, or disabled individuals) but do not meet the applicable income and resource requirements. Individuals may qualify for Medicaid by incurring medical expenses to "spend down" to a State's medically needy standard. A State may set its medically needy standard at any income level up to 133 percent of the maximum payment for a similar family under the State's AFDC program.

4. Medicare beneficiaries

States must cover:

a. "Qualified Medicare Beneficiaries" (QMBs). These are aged and disabled Medicare beneficiaries with incomes below 100 percent of the Federal poverty level and resources not more than twice the amount allowable under the SSI program. States must pay Medicare premiums and cost-sharing charges for these individuals.

b. "Specified Low-Income Medicare Beneficiaries" (SLMBs). These are aged and disabled Medicare beneficiaries with incomes between 100 percent of the Federal poverty level and 120 percent of the Federal poverty level and resources not more than twice the amount allowable under the SSI program. States must pay Medicare Part B premiums (but not deductible or co-insurance charges) for these individuals.

c. "Qualified Disabled and Working Individuals" (QDWIs). These are persons who have lost eligibility for Social Security disability benefits and Medicare but may continue to receive Medicare in return for payment of the Part A premium and have incomes under 200 percent of the Federal poverty level and resources not more than twice the amount allowable under the SSI program. States must pay Medicare Part A premiums for these individuals.

At their option, States may provide full Medicaid benefits, rather than just paying Medicare premiums and cost-sharing, to Medicare beneficiaries who meet a State-established income standard that is no higher than the poverty level.

5. Persons receiving long-term care

States may provide Medicaid for persons receiving long-term care in a nursing home or in a community-based program if they meet a special income standard no higher than 300 percent of the basic SSI benefit that would be payable to a person living at home. At their option, States may also provide Medicaid to certain other groups of persons who are in nursing homes or other institutions, or who would require institutional care if they were not receiving alternative services at home or in the community. Current law requires that people spend their income and assets down to eligibility standards before becoming eligible for Medicaid.

Reasons for Change

From its inception in 1965, Medicaid has become a complex program with a bewildering set of categorical boxes for eligibility. Today, Title XIX contains over 70 separate definitions of who is eligible to receive services. Potential Medicaid beneficiaries must fill out mind-boggling forms, and States must expend considerable resources on staff who make eligibility determinations.

A recitation of just some of the over 70 categories of eligibility would reveal the myriad opportunities for difficulty in eligibility determinations. Yet, there is no existing statutory authority to waive these complex eligibility categories. Although States have been permitted to expand eligibility to individuals not now eligible to be served by Medicaid, the Health Care Financing Administration (HCFA) does not have the authority to permit States to restrict existing mandatory eligibility categories, nor will the agency permit States to reduce their eligibility categories once a State has elected to expand coverage to optional groups. In fact, even though States have attempted to streamline the eligibility process through waivers and expand coverage to individuals based on income alone, HCFA still requires States to continue to make categorical eligibility determinations so that people can be "counted and tracked" in their proper boxes. It is clearly time to eliminate these costly eligibility categories and allow States to operate sensible health care programs for their low-income residents.

Proposed Change

The Medicaid program will remain a health care program for low-income individuals. States will be given much greater flexibil-

ity to determine who is eligible under their new programs. States will be permitted to cover any individuals or families with income below 250 percent of the Federal poverty level ($31,475 for a family of 3 in 1995). States will be required to cover two specific groups of individuals:

1. Pregnant women and children aged 12 and younger living in families with income below the Federal poverty level; and,
2. Disabled individuals (as determined by the State).

States will be required to meet minimum spending obligations for each of three specific groups of beneficiaries:

1. Families with income below 185 percent of poverty with a pregnant woman or child;
2. Elderly individuals; and
3. Disabled individuals.

For each group, States must spend at least 85 percent of the amount spent in FY 1995 on mandatory services (including nursing facility services) for members of the group States were required to cover under current Medicaid law during FY 1995.

The Committee has included a provision requiring that State Medicaid plans include a description of their goals and objectives related to standards of care and access to services for children with special health care needs in that State. Children with special health care needs, those with serious chronic conditions or disabilities such as cerebral palsy, cystic fibrosis, cancer, or heart conditions, represent approximately two percent of all children, but will need special attention to make sure their needs are met. While managed care can offer all children and their families better access to care and better coordination of services, some plans have not developed the expertise to treat children with special health care needs. Accordingly, the Committee intends that States outline in their plans how they will provide care to children with special health care needs. The Secretary HHS will be asked to fund the refinement and validation of a classification system and regional demonstration projects for children with special health care needs.

Current law protections against impoverishment for spouses of nursing home residents who remain in the community will also be retained. In addition, States will be prohibited from imposing a lien against a family farm or a home of moderate value as a condition of receiving nursing home or other long term care benefits under the Medicaid plan. The definition of a "home of moderate value" is intended to mean a home which is less than or equal to 150 percent of the median value of a home in a State (as defined by HUD and reported by the Bureau of the Census).

The Congressional Budget Office will be required to prepare and submit an annual report which analyzes the effects of changes in the Medicaid program on the health insurance status of children, the elderly and the disabled.

Effective Date

Date of enactment.

BENEFITS

Present Law

States are required to provide the following services to the "categorical" eligibility groups (i.e., those individuals which States are required to cover):

- inpatient and outpatient hospital services;
- nursing facility services for individuals 21 or older;
- physicians' services;
- laboratory and X-ray services;
- early and periodic screening, diagnostic and treatment (EPSDT) services for individuals under age 21;
- family planning services;
- home health services for an individual entitled to care in a nursing facility;
- rural health clinic (RHC) services and services at federally qualified health centers (FQHCs);
- services of nurse-midwives, certified pediatric nurse practitioners, and certified family nurse practitioners to the extend these individuals are authorized to practice under State law; and
- Medicare premiums, deductibles and cost sharing for certain low-income Medicare beneficiaries.

States are permitted to offer a wide range of additional services. Some of the most commonly covered services are dental services, prescription drugs, and care in intermediate care facilities for the mentally retarded.

States that have chosen to cover the medically needy may offer more restricted benefits to the medically needy than to the categorically needy. However, States must cover at least the following benefits for the medically needy:

- prenatal and delivery services;
- ambulatory services for individuals under age 18 and individuals entitled to institutional services; and
- home health services for individuals entitled to care in nursing facilities.

States may limit the scope of covered benefits. For example, they may place limits on the number of days of hospital care or the number of physician visits covered. In general, covered benefits must be similar in amount, duration and scope for similar groups of beneficiaries throughout the State.

Cost Sharing

States are permitted to impose "nominal" fees, premiums, copayments or other charges on certain Medicaid services and recipients. Charges may not be imposed on:

- services provided to individuals under age 18;
- services related to pregnancy;
- family planning services;
- emergency services;
- health maintenance organization services to certain enrollees; and
- hospice services.

Medicaid providers may not deny services to an individual because of inability to pay cost-sharing charges.

Reasons for Change

The current Medicaid statute is full of restrictions that deny States the opportunity to experiment in program design and the flexibility to develop programs best suited to their individual needs. Although adopted in the name of ensuring equal treatment of Medicaid beneficiaries, these restrictions, including "statewideness," "comparability," and "amount, duration and scope" provisions, have proved to be unduly confining. Instead of broadening services, these requirements have been applied by the courts and by Federal bureaucrats to inhibit State program improvements.

The first of these restrictions, Medicaid's "statewideness" requirement, prevents States from covering divergent services in different areas of the State, thereby limiting experimentation within programs and preventing States from adapting their programs to geographic variations among their populations. Experimentation at the county or local level permits States to initiate innovative programs on a small scale, just as the division of our nation into States permits States to serve as laboratories for national programs. Small-scale experimentation permits program evaluation and adjustment before programs become too large to easily assess and improve.

In addition, the "statewideness" requirement limits the States' ability to offer specialized services to their Medicaid populations if States or localities decide that resources should be devoted to providing a service only in geographic areas where it is most needed. For example, a Federal district court recently enjoined the manner in which California used Medicaid funds in connection with methadone maintenance treatment because the service was covered only in those counties that chose to allocate funds from their financially limited local drug abuse programs for methadone maintenance treatment.

A second burdensome restriction is the "comparability" requirement, which prevents differentiation in the services provided to recipients within specific eligibility categories, and some aspects of differentiation in the services provided between eligibility categories. Under this restriction, States are largely restrained from tailoring benefits to the general characteristics and needs of distinct broad categories of Medicaid beneficiaries, such as the aged, the disabled and children. Even minor differentiation has been prevented by this requirement, and HCFA has disapproved a number of State plan amendments that would have improved program administration. In 1992, for example, HCFA disapproved an Arkansas proposal to cover two more drug prescriptions per month for beneficiaries at risk of institutionalization than it would cover for beneficiaries not at risk, simply because the beneficiaries were in the same eligibility category.

The third restriction impeding State flexibility is the "amount, duration, and scope" requirement, which prevents differentiation between diagnosis, type of illness, or condition in providing services and which mandates a minimum level of availability for services provided. This restriction prevents States from making any judg-

ments with respect to the value of providing services in light of the condition of beneficiaries.

The cost of "equal treatment" restrictions are no longer affordable. Although waivers have been granted permitting State avoidance of these requirements in some instances, the waiver process has become too cumbersome and time-consuming to accommodate the needs of reform throughout the 50 States. In light of the realities of current cost constraints, these restrictions on State experimentation and flexibility of administration can no longer be permitted to prevent the States from developing and implementing critical reforms necessary to rationalize State Medicaid programs.

One of the major themes articulated throughout the health care reform debate is the concept that everyone, regardless of income and "status" should bear some personal responsibility for their own lives and the cost of their care. Yet today's Medicaid program violates that fundamental principle of reform.

Title XIX significantly restricts the use of co-payments—even for Medicaid beneficiaries at the higher end of the income scale. The prohibition against permitting co-payments for services provided through a managed care organization is an example of a good idea gone awry. As States have increasingly moved to managed care for their Medicaid beneficiaries, HCFA has been unwilling to waive the prohibition against requiring modest co-payments for some services provided through managed care organizations so that, for example, States cannot even assess a nominal $1–10 charge for the non-emergency use of emergency rooms. Nor can a health plan charge a 50-cent co-payment on prescription drugs as a way of encouraging prudent purchasing on the part of a Medicaid enrollee.

Whether a Medicaid beneficiary is enrolled in managed care or continues to receive care through the old fee-for-service system, the inability of States to require nominal and reasonable co-payments is a major barrier to both the concept of personal responsibility and the incentive for beneficiaries to make the most rational and cost-effective choices of health care purchases possible.

Proposed Change

States will be given maximum flexibility to determine covered benefits and benefit levels. Funds not required to be spent under the minimum spending obligations could be spent for additional medical assistance, medically-related services, or program administration. States will be required to cover childhood immunizations under a schedule set by the State department of health. In addition, Federal Medicaid funds must be used to cover pre-pregnancy family planning services and supplies, as selected by the State. The Committee intends that every State will make available to Medicaid eligible individuals all medically accepted family planning methods and supplies, provided that abortion shall not be considered a method of family planning.

Since its inception the Federal Medicaid Program has covered the services provided by a Christian Science Sanatorium (nursing facility), a Christian Science Visiting Nurse Organization, and a Christian Science Nurse in a home setting. Nothing in this legislation is intended to preclude the States from including these services in their Medicaid plans.

States will be prohibited from: (a) instituting preexisting conditions exclusions for eligible Medicaid beneficiaries, and (b) imposing treatment limits or financial requirements on mental health services which are not imposed on services for other illnesses or diseases.

Federal Medicaid funds cannot be used to purchase services with the purpose of causing deaths, suicide, euthanasia or mercy killing. Providers will not be required to inform patients of the availability of such services. In addition, Federal Medicaid funds could not be used to pay for abortions except in cases of rape, incest or to save the life of the mother.

States will be permitted to impose premiums, copayments, coinsurance, or deductibles pursuant to a public schedule. Cost-sharing could be designed to encourage primary and preventive care and discourage unnecessary or less economical care and inappropriate use of emergency services. Amounts could vary for different population groups and could be scaled to reflect economic factors, employment status, family size, availability of other health insurance, or participation in employment training, drug abuse or alcohol treatment, counseling, or other programs promoting personal responsibility. States will be prohibited from charging premiums for families with a child or a pregnant woman with income below poverty. If States imposed any cost sharing requirements on services, such cost sharing charges for primary care and prevention services for pregnant women and children could not exceed "nominal" amounts.

Childhood immunizations

Present Law

The Vaccines for Children (VFC) program is an entitlement program enacted by Congress in the 1993 Budget Act. The Federal Government now purchases all the vaccines for children who are:

1. Eligible for Medicaid;
2. Without any health insurance;
3. Without health insurance that covers immunizations; or,
4. American Indian or Alaska Natives.

States can use their own funds to purchase additional vaccines at the same price the Federal Government pays to provide free vaccines to all children in the State, even those who have insurance coverage for vaccines.

The Federal agency responsible for negotiating prices with the vaccine manufacturers and consolidating orders from States is the Centers for Disease Control and Prevention (CDC). Prior to the VFC program, the CDC purchased childhood vaccines only for publicly-funded health clinics. The CDC negotiated prices substantially below market prices with vaccine manufacturers. Under VFC, manufacturers are required to sell their vaccines to the Federal Government at prices no greater than their May, 1993 Federal contract prices, plus inflation.

States are required to pay for the cost of delivering vaccines to physicians and other health care providers. Any health care provider authorized under State law can apply to be a program-registered provider. Registered providers are entitled to receive the

vaccines from the State free of charge. Registered providers cannot charge patients for the cost of vaccines. The provider can charge the patient a limited fee for administering the vaccination, but can't deny service to any child eligible to receive a free vaccine whose parent can't afford to pay the administration fee.

Reason for Change

The VFC program is really a Government vaccine purchase program based on the premise that cost was the most significant barrier to childhood immunization. However, numerous Congressional witnesses and a June, 1995 General Accounting Office (GAO) report have contradicted this basic premise. GAO stated that there is insufficient evidence to conclude that the cost of vaccine has been a barrier to timely immunization. GAO found that 95 percent of the nation's children are vaccinated by school age, and that immunization rates for preschool children even before VFC were at or near the 90 percent national goals for 1996. GAO found that more important barriers to full immunization resulted from missed opportunities at health clinics and private providers' offices, lack of parental and provider understanding and less than optimal hours.

Since 1965, Medicaid eligible children have been entitled to free immunizations. In addition, any child can be vaccinated for free in a public health clinic under the Federal Immunization Grant program known as the "317 Program" (Section 317 of the Public Health Service Act). The Centers for Disease Control and Prevention (CDC) allocations over the last four years for vaccines have exceeded $700 million. States may purchase additional funds at a discounted price for use in the public system. In addition, 12 States (even before VFC) have combined State and local resources with 317 funds to offer free vaccines to all providers for all patients in their practices.

Since 1992, CDC has given State Immunization Action Plan grants to finance infrastructure improvements (expanded clinic hours and staff, education and outreach for parents and providers, registries and tracking systems and links between immunization services and other programs). These grants amounted to about $400 million over the last four years.

Proposed Change

Repeals the VFC program. Clarifies that Federal Medicaid funds may be used to purchase vaccines through contracts under Section 317 of the Public Health Service Act.

The Committee is aware that the Secretary is authorized to contract with vaccine manufacturers for the purchase of childhood vaccines under Section 317 of the Public Health Service Act. In repealing the VFC program, the Committee intends that all contracting authority under Section 1928 of the Social Security Act is terminated. Contracts currently in effect were negotiated under the authority granted to the Secretary under Section 1928 of the Social Security Act and Section 317 of the Public Health Service Act and will continue to their conclusion pursuant to authority under Section 317. With respect to subsequent contracts under Section 317, all procedures and requirements for purchase and delivery of vac-

cine will revert to those in place prior to enactment of Section 1928.

The Committee understands that CDC has made representations to the States that Federal reimbursement is available for distribution of vaccines pursuant to Section 1928(d). To avoid wastage of vaccine, any products already purchased and delivered to the States, and for which the State has a distribution contract in effect on the date of enactment, shall be eligible for reimbursement for such distribution.

It is the intent of the Committee that the CDC shall, to the extent practicable and appropriate, enter into a contract with each manufacturer of the vaccine that meets the terms and conditions of the CDC for an award of such contract (including terms and conditions regarding safety and quality). With respect to multiple contracts entered into pursuant this provision, the CDC may have in effect different prices under each of such contracts.

Effective Date

Date of enactment.

Federally qualified health centers

Present Law

Federally qualified health centers (FQHCs) and rural health clinics (RHCs) are mandatory services under Medicaid law. States must pay FQHCs and RHCs cost-base reimbursement.

Reasons for Change

States need greater flexibility to determine payment rates to providers. The Committee also recognizes that over 1,000 community health centers and 2,500 rural health clinics play a unique role in the health care delivery system. In inner-city areas, community and migrant health centers are often the only providers of care to Medicaid patients and the uninsured. In rural areas, community and migrant health centers and rural health clinics are often the only providers for the residents of the area, whether they are on Medicaid or Medicare, have private insurance, or are uninsured.

The current Medicaid system recognizes the unique role of these centers and provides them with cost-based reimbursement in order to assure that the payments are sufficient to meet the health care needs of the Medicaid patients they serve. Unlike providers with large numbers of privately insured patients, these centers do not have reserves or available capital, and do not have the ability to cost-shift losses from insufficient payments under public programs.

The Committee recognizes that these centers are committed to serve all in their communities, and adopted this provision to address its concern that without a sufficient flow of funds to meet the needs of their Medicaid patients, the Community and Migrant Health Centers (CMHCs) and rural health clinics will be forced to reduce substantially their patient loads and many will close their doors. The provision will assure access to cost-effective preventive and primary health care in communities that need it most. Several recent studies have shown that Medicaid patients who regularly

use health centers have lower total annual health care costs than Medicaid patients who use other primary care providers. These studies showed that health center patient visits were 22 percent to 33 percent less expensive overall, and had between 27 percent to 44 percent lower inpatient costs and days.

Proposed Change

Establishes a one percent set-aside for grants to States for primary and preventive health care services provided in rural health clinics and federally qualified health centers. The Secretary of Health and Human Services will determine the methodology for determining the payment to these centers, and will make the payments directly to the centers. Payment by the Secretary will be in addition to any other revenues the centers receive from Medicare, either directly from States or from managed care plans. However, the Secretary is expected to take into account the amount of funds available from all other payment sources, including grant funds from State and Federal programs, when determining the amount of payment to be made to individual health centers.

Effective Date

Date of enactment.

INDIAN HEALTH PROGRAMS

Present Law

Native Americans may qualify for Medicaid in the same way as any other population. When services are furnished by a general contract provider, Federal funding is available at the State's matching rate. in the case of services provided to Medicaid beneficiaries by Indian Health Service (IHS) facilities, Federal matching funds are available at 100 percent, rather than at the State's matching rate.

Reason for Change

This provision is intended to assure that State plans properly address the payment for health care provided to low-income Native American people in those States where Indian Health Service-funded programs are operated. Health services for eligible Native Americans may be delivered directly by the IHS or by tribes, tribal organizations or urban Indian organizations through agreements with IHS authorized by Federal law. States are to consult with appropriate tribal and Indian organizations regarding the manner in which medical assistance shall be provided to eligible low-income Native Americans. Because the health service delivery system for Native Americans is unique and is governed by Federal law, the Committee wants to assure that the medical assistance needs of this system are properly considered by the States when designing their new plans.

Proposed Change

The Committee proposal recognizes the Federal Government's responsibility for health care for Native Americans by providing that the Federal medical assistance percentage of 100 percent continue to be used to reimburse for services provided to Native Americans through Indian Health Service (IHS) programs. IHS programs may be operated by IHS directly or by tribes, tribal organizations or urban Indian organizations under the authority of two Federal laws—the Indian Self-Determination Act and the Indian Health Care Improvement Act. This provision recognizes these facets of the Indian health care delivery system.

Effective Date

Date of enactment.

REIMBURSEMENT

Present Law

Each State sets its own payment rates and methodologies for reimbursing providers under Medicaid. However, payment for some items and services is limited to amounts that would be paid for similar items and services under Medicare. For some items including laboratory services, durable medical equipment, and eyeglasses, States are permitted to use competitive bidding or other means to establish a sole source contract for the item.

Specific Federal payment rules apply to certain services. The rules that have received the most attention are the "Boren Amendment," and cost-based reimbursement for community health centers and rural health clinics.

"Boren amendment"

The so-called "Boren Amendment" requires States to pay hospitals and nursing facilities rates that are "reasonable and adequate" to cover the costs that must be incurred by "efficiently and economically" operated facilities. At least 50 cases brought by hospital or nursing home groups in 24 States have been decided by the courts.

Cost-based reimbursement

States are required to pay rural health clinics (RHCs) and federally-qualified health centers (FQHCs) 100 percent of costs that are reasonable and related to the cost of furnishing services.

Reasons for Change

Current Medicaid payment standards were intended to serve as cost stabilizing mechanisms to counter the inflationary pressures of "cost-based" reimbursement. But this purpose has been subverted by the courts. The payment provisions have instead been made into traps for unwary States, while spawning expensive and burdensome litigation with Medicaid providers and exposing the States to broad judicial interference with their efforts at Medicaid cost containment.

The most problematic payment provision has been the "Boren Amendment," which covers payments to institutional providers such as hospitals and nursing homes. The "Boren Amendment" is widely recognized as a failure and a cause of program distortion.

The ambiguity of the "Boren Amendment" has proven unworkable, however, and has repeatedly been used by State and Federal courts to micro-manage the development of State reimbursement systems. Frequently, court involvement has centered on the method a State uses to establish rates, often without any judicial inquiry whatsoever into the overall adequacy of a State's rates. After costly and time-consuming litigation, courts have invalidated institutional payment provisions in many States, simply because the States did not demonstrate to the court's satisfaction that they had followed these procedural requirements, and without ever considering the bottom line of provider reimbursement. This focus on the States' "decision-making" processes has forced States to justify their rate setting methods in increasingly complex litigation against judicially developed procedural requirements of which they have had little or no advanced warning.

The development of judicially created procedural hurdles stemming from unclear statutory provisions has led to costly and unpredictable litigation for the States. The net effect of such litigation has been that State efforts to modernize reimbursement and incorporate efficiency incentives have been delayed for years. The payment standard provisions which have caused so much trouble under the current system have no place in a new medical assistance program.

Proposed Change

Provider payment rates will be set by the States. The "Boren Amendment" and cost-based reimbursement requirements for federally qualified health centers and rural health clinics will be repealed. If a State contracted with HMOs or similar entities on a risk basis for a package of services, the State will have to describe the State's actuarial methods for projecting expenditures and utilization for enrollees and setting capitation payment rates. The State will also have to provide for public notice and an opportunity to comment on this information.

Effective Date

Date of enactment.

PROVIDER STANDARDS

Present Law

States must have standards and procedures for determining the eligibility of providers of services to participate in the Medicaid program. Federal law specifies standards and certification procedures for institutional providers (including hospitals, nursing homes, and intermediate care facilities for the mentally retarded), health maintenance organizations, and certain other providers such as rural health clinics. Medicaid hospice, physician, and some other providers are defined in Medicare law. Laboratories participating

in Medicaid must meet Medicare requirements for laboratories. For most other non-institutional providers, State licensure laws govern qualifications for program providers. States generally follow their own procedures for certifying practitioners and other noninstitutional providers (e.g., pharmacies).

Reasons for Change

A view often expressed is that States cannot be trusted to manage the quality of their own health care programs and that only Federal regulation will assure quality care for low income beneficiaries. Yet the Federal Government's approach to quality over the 30 years of Medicaid's existence has been a focus on compliance review rather than quality review.

The existing Medicaid quality assurance system, although extensive and staff intensive, tends to focus not on quality of care for beneficiaries but on control of the utilization of resources and compliance with Federal program requirements. While Federal utilization controls are understandable when the Federal financial obligation is open-ended, they are less relevant under a capped program. Compliance reviews with highly prescriptive Federal requirements is inconsistent with any meaningful State flexibility.

The responsibility to address the quality assurance issue should be on the States, who can make available the best resources for determining the quality of care that is being delivered, whether in managed care organizations, fee-for-service programs or institutional settings. States should bear the obligation to develop quality assurance programs but be given the freedom to select those provisions that make the most sense in light of their particular programs and priorities. Standards could be based on model standards developed by the Federal Government or accrediting organizations, or Medicare program standards, or private industry standards, or on any combination of these sources. The State's plan will describe the essence of the State's quality assurance program, and serve as a public commitment to a quality service delivery system.

There are significant developments in the field of measuring and assuring quality in the actual delivery of health care services. These developments are helping to lay the foundation for more useful quality assurance efforts to assist beneficiaries in selecting providers, provide State agencies information to gauge performance of their contractors and assist health plans in improving their services. This approach, rather than federally-imposed process requirements, carry the greatest potential for assuring true quality in the delivery of services to low income families and individuals.

Proposed Change

States will establish and maintain provider standards. States will be required to develop their own quality assurance standards. At their option, States could use Medicare standards, standards developed by private accreditation organizations, or State licensing standards, or any combination of the above. The Committee intends that States not discriminate against any class of provider with which a State may contract to provide quality, cost-effective services to beneficiaries. The State must report and provide public

access to information concerning licensing revocations and other sanctions taken against providers and practitioners by State licensing authorities, peer review organizations or accreditation entities. If a State contracted with HMOs or similar entities on a risk basis for a package of services, the State will have to describe the required qualifications for participating organizations and a process for dissemination to prospective contractors of information on historic cost and utilization data.

Each State will be required to establish and maintain standards for maintaining quality of care in nursing homes. The standards must be promulgated through the State's legislative, regulatory or other rule making process. The standards cannot take effect unless the State has provided public notice and an opportunity for comment. The standards must be specified in the State plan. The State plan must include standards for the following:

1. Treatment of resident medical records;
2. Policies, procedures and bylaws for operation;
3. Quality assurance systems;
4. Resident assessment procedures, including care planning and outcome evaluation;
5. Safety and adequacy of the physical plant;
6. Qualifications for staff of facilities;
7. Utilization review; and
8. The protection and enforcement of residents' rights.

States will be required to establish and operate a program for the certification and decertification of nursing homes. The State's program must ensure public access to the results of surveys and evaluations of nursing homes. States must also have procedures for sanctioning nursing homes with deficiencies, and procedures for terminating the participation of nursing homes that jeopardize the health and safety of its residents.

Effective Date

Date of enactment.

DELIVERY SYSTEMS

Present Law

Most Medicaid beneficiaries receive services through the traditional fee-for-service system. Today, approximately 25 percent of all Medicaid beneficiaries are enrolled in some type of managed care plan. Medicaid beneficiaries may voluntarily enroll in a managed care plans. States may not require Medicaid beneficiaries to enroll in a managed care plan unless the State has obtained a waiver of the statutory "freedom-of-choice" requirement. With waivers, States may require eligibles to enroll in managed care programs, or select cost-effective providers from whom they must obtain all but emergency care. Among States using waiver options, few have provided for managed care arrangements for the elderly and disabled.

In some situations, States purchase private health insurance on behalf of Medicaid eligibles. Each State must implement guidelines to identify cases in which enrollment of a Medicaid eligible in a group health plan would be cost effective, then require that the eli-

gible individual enroll in the group health plan. In such cases, the State must pay the plan premiums, and all deductibles, coinsurance, and other cost-sharing obligations for items and services otherwise covered under the State's Medicaid program.

Reasons for Change

When it was enacted in 1965, the Medicaid program was conceived as a traditional indemnity-type insurance program for the prevailing fee-for-service, health care delivery system. Managed care was in its infancy and negligible percentages of the population participated in health maintenance organizations (HMOs). Over the last twenty years and, in particular, the last decade, the numbers of privately insured individuals participating in managed care organizations have grown rapidly as increasing numbers of employers have moved to find more efficient and effective coverage for their employees. In 1976 there were 6 million people receiving care in HMOs; by 1995 that number has risen to 56 million. Yet Medicaid remains a dinosaur—a behemoth out of place in today's health care delivery world.

Because Medicaid was designed to be a fee-for-service program, the barriers to the effective use of managed care permeate the statute. Some of the most difficult barriers include:

- *Freedom of Choice:* Federal law prescribes that all Medicaid beneficiaries be free to choose to receive their care from any doctor, clinic, or hospital that accepts Medicaid reimbursement. Beneficiaries are free to "doctor-shop," and to self-refer to expensive specialty care without regard to the cost effectiveness of any providers. Additionally, a State may not require that their Medicaid beneficiaries remain in an HMO for longer than 6 months, and then only if the HMO is federally qualified. Under these restrictions, managed care organizations are reluctant to enroll Medicaid beneficiaries because of the administrative costs of these changes and the inability to develop long-term plans of care for beneficiaries.
- *Limitations on Managed Care Organizations:* Federal law prescribes that when a State seeks to purchase managed care services for Medicaid beneficiaries, it can only purchase from federally or State qualified HMOs which draw at least 25 percent of their membership from privately insured beneficiaries (the "75/25" rule).
- *Limits on Co-Payments for Services:* Federal law and HCFA interpretations preclude a State or an HMO from assessing any co-payment, regardless of how nominal, for any service provided through an HMO to an enrolled Medicaid beneficiary.
- *Limitations on Service Coverage:* Federal law and HCFA interpretation preclude a State from buying a comprehensive package of services from a managed care entity and requiring that Medicaid beneficiaries be limited to receiving certain kinds of services from the managed care organization's network.
- *Limitations on Who Can Participate in Managed Care:* Federal law and HCFA interpretation preclude a State from enrolling those Medicaid beneficiaries who are also receiving Medicare into managed care organizations.

- *Limitations on Guaranteed Eligibility:* Federal law precludes States from certifying Medicaid beneficiaries as eligible for services for a specified period of time; instead, the law requires that States redetermine a beneficiary's eligibility every month, or at least once a quarter. This "on again, off again" approach to eligibility means that many managed care organizations won't enroll Medicaid beneficiaries because they are unable to plan and coordinate care for individuals who come on and off the rolls.
- *Limitations on Amount, Duration, Scope, and Comparability:* Because the current Federal law requires that every categorically eligible Medicaid recipient be entitled to exactly the same amount, duration, and scope of benefits and that all benefits to all eligibles be comparable, the law precludes States from permitting HMOs to compete based on the offer of an extra service or benefit to Medicaid enrollees in their plans.
- *Impermanence of Waiver Projects:* "Freedom of choice" waivers are limited to a two year period, with additional application and approval required beyond the initial period. States currently have no option to convert freedom of choice waivers to State plan amendments.
- *Waiver Requirements for Primary Care Case Management (PCCM) Programs:* Non-capitated PCCM programs can only be operated through freedom of choice waivers, not through State plan amendments.

Some of these provisions can be waived by the Federal Government through Section 1915(b) or Section 1115 of the Social Security Act. However, both waiver processes have become so complex, time consuming, and user-unfriendly, that waivers are clearly not the appropriate approach to allowing States to utilize a cost-effective service delivery model that is routinely used by employers, including State governments. Managed care techniques have already saved States money in a variety of ways—by decreasing the use of expensive emergency department services, by emphasizing preventive care and early intervention to prevent illness and, providing a degree of predictability to a notoriously volatile program.

States must be empowered to utilize the force of the market place to buy the same kind of high-quality, cost-effective care enjoyed by so many privately insured citizens for their Medicaid beneficiaries. Tinkering around the edges of a fee-for-service Medicaid structure will not afford them that opportunity.

Proposed Change

States will no longer be required to seek waivers to enroll Medicaid beneficiaries in managed care. If fee-for-service systems are used, States must determine and specify in their State plans provider qualifications, methods for determining provider payment rates, cost-sharing requirements and utilization controls. If managed care systems are used, States must determine and specify in their State plans the actuarial methods for calculating capitation payments, qualifications of health plans, and the bid process used by the State. The State must provide notice with opportunity for public comment on the capitation rates and actuarial methods.

Effective Date

Date of enactment.

WAIVERS

Present Law

States may apply to the Secretary of Health and Human Services for waivers of certain Medicaid requirements. Two basic types of waivers are program waivers and demonstration waivers. Demonstration waivers are authorized under section 1115 of the Social Security Act to allow States to experiment with program improvements. Program waivers are authorized under section 1915 of the Act to permit States to operate certain types of special programs.

1. Program waivers

a. Freedom of choice waivers

Under this provision, certain requirements may be waived to allow a State to require recipients to obtain services from certain providers with which the State has contracted or negotiated discounts. The provision also allows States to require enrollment in managed care systems. Many States have used the provision to mandate the use of primary care case management systems.

b. Home and community-based waivers

States may define the geographic areas and populations they wish to serve (e.g., mentally retarded persons), and waive certain financial eligibility standards and other requirements to offer home and community-based care to persons in nursing homes or at risk of institutionalization. States must demonstrate that average expenditures for a person receiving waiver services would not exceed expenditures for that person in the absence of the waiver.

2. Demonstration ("1115") waivers

Under section 1115 of the Social Security Act, the Secretary is permitted to waive compliance with any provision of Medicaid law for any experimental, pilot, or demonstration project which "is likely to assist in promoting the objectives" of the program. Recently, some States have received demonstration waiver approval for restructuring of their Medicaid programs. Generally, these States have extended eligibility to low-income uninsured persons not otherwise eligible for Medicaid, and have directed all participants to managed care programs. To date, the Secretary has approved 1,115 waiver applications from 12 States and applications from another 13 States are currently under review.

Reasons for Change

The authority to waive various provisions of Title XIX in order to facilitate State research and demonstration projects was little used until 1993, in part because it was such a cumbersome, unfriendly, and lengthy process. In early 1993, in response to requests for genuine flexibility in Medicaid from the nation's Governors, the 1115 waiver process was made more accessible to States. HCFA

committed to a 120-day review and approval process and agreed to only require States to answer one set of questions instead of the typical three or four. However, the promised flexibility never materialized. Today it takes well over a year for HCFA to process a waiver application, even where the State proposal is not radically different from those that have been previously been considered. It took 582 days to approve Oregon's waiver application. Florida's application took 218 days. Ohio's took 321 days. Massachusetts' took 374 days. Minnesota's and Delaware's took 274 and 292 days respectively. The following States are still waiting for an answer—New Hampshire, more than 475 days; Illinois, more than 380 days; Georgia, more than 300 days; Oklahoma, more than 270 days. Increasingly, Federal bureaucrats have forced States to adjust their program design to avoid even further delays in processing. And approval of the project does not mean that implementation can begin. The terms and conditions built in add another several months of submissions and review before the actual project can begin. The terms and conditions of waiver projects have also become increasingly numerous, restrictive, and burdensome.

Finally, the demonstration waiver authority has not been used by the Secretary to deal with some of the core areas of the fundamentally fee-for-service Medicaid program that must be reformed before States can exercise the full extent of their purchasing power. In numerous demonstration projects that have been approved in the last two years, the Secretary has declined to:

- Relieve States from any aspect of the Boren Amendment, covering provider reimbursement rates and procedures.
- Permit any reduction or limitation in coverage for any categorically eligible Medicaid beneficiary. This has made it extremely difficult to privatize the Medicaid program because Medicaid coverage is so much greater than that provided to most privately insured people.
- Permit the use of cost-sharing for Medical eligibles enrolled in managed care, even when everyone else in the plan is responsible for some nominal co-payments.
- Permit States to enroll those Medicaid beneficiaries who are also receiving Medicare into managed care. This means that the sickest and most expensive beneficiaries must continue to be served in the fee-for-service Medicaid program.

The Section 1115 waiver process is not the answer to the need for true program innovation and reform. States need to be freed from the stifling oversight of the Federal Government that is unavoidable under the present program.

Home and community-based care

During the late 1960s and the 1970s the number of individuals residing in institutions—psychiatric facilities, nursing homes, and intermediate care facilities for the mentally retarded—grew dramatically since States were to receive Medicaid reimbursement for long term care services only by institutionalizing people. Ultimately, however, States began to feel the impact of the high costs of providing care in these institutional settings. In early 1982, in response to the cost pressures of a cap in the rate of growth in the Federal share of the Medicaid program, Congress provided the De-

partment of Health and Human Services limited authority to grant waivers that would enable States to provide care for disabled and elderly individuals in home and community-based settings and still receive Medicaid reimbursement. However, the waiver authority under Section 1915(c) of the Social Security Act came with strings that continued to support the institutional bias of the program.

The rationale for these restrictions is that to provide Medicaid reimbursement for home and community-based services without the current ties to institutional status will create a "woodwork" effect that individuals being cared for by family and friends will seek services from providers who will bill Medicaid. But times have changed and so has the technology of providing cost efficient and effective services to people in their homes and communities that will prevent expensive entitlements that have been extended to institutional providers. Only statutory modifications will enable States to move beyond these statutory and bureaucratic barriers. States will be able to design and implement cost-effective health care programs only when they are freed from the strictures of the current Title XIX. Waivers are not the answer.

Proposed Change

The need for program waivers will be eliminated. States with Section 1115 waivers implemented as of September 1, 1995 will be allowed to continue such waivers under the terms and conditions of the waiver agreement, at the option of the State. In addition, States will be permitted to try innovative programs where funds from several programs could be combined with other program funds (e.g., AFDC, Food Stamps, Title V, Title XX) to use a more comprehensive strategy to providing coordinated services to low-income individuals and families.

Effective Date

Date of enactment.

DRUG REBATE PROGRAM

Present Law

Under the drug rebate program enacted in the Omnibus Budget Reconciliation Act of 1990, in order for Federal Medicaid payment to be available for prescription drugs, a manufacturer must have entered into a rebate agreement with the Secretary of Health and Human Services. The law requires that a manufacturer provide each State with a quarterly rebate amount for the products of the manufacturer that the State has purchased on behalf of eligible Medicaid recipients. Amounts of such rebates are based on the average manufacturer price for a drug and the lowest price available from the manufacturer to any wholesaler, retailer, nonprofit entity, or governmental entity within the U.S. Drugs dispensed under Medicaid managed care arrangements or by certain hospitals are not subject to rebate requirements. States are permitted to obtain additional rebates above the Federal minimum rebates. Finally, States must operate drug utilization review (DUR) programs under Federal guidelines.

Reasons for Change

The Medicaid drug rebate program was first enacted in 1990 in order to constrain the costs of pharmaceuticals by guaranteeing State Medicaid programs access to the "best price" or a certain minimum discount for pharmaceuticals. At that time, Medicaid was primarily a fee-for-service program. Because of the growing move toward the use of managed care within the Medicaid program, the drug rebate program has become less important as a price control mechanism, since States have the ability to negotiate the prices that will be paid for drugs through managed care contracts. This, in large part, obviates the need for the rebate structure. There is concern that rebates may be anti-competitive and constrain the ability of hospitals, HMOs, and other private sector purchasers of prescription drugs to negotiate discounts from pharmaceutical manufacturers. In addition, overly-high rebates can act as a disincentive to provider participation in Medicaid. For this reason, the bill precludes State supplemental rebates.

Proposed Change

Retains the Medicaid drug rebate program as an option for States. However, States may not require manufacturers to pay rebates in excess of the amounts payable under current law. Clarifies the inclusion of drugs dispensed by nursing facilities in the Medicaid drug rebate program. States will be permitted to operate a drug use review program under standards established by the State. Establishes a task force to report on the future of the Medicaid drug rebate program.

Effective Date

Date of enactment.

DISPROPORTIONATE SHARE HOSPITALS (DSH)

Present Law

States are required to make supplemental payments to hospitals ("disproportionate share hospitals," or "DSH" hospitals) that serve a disproportionate number of Medicaid and low-income patients. Federal law includes minimum criteria for DSH hospitals. States must designate as DSH hospitals all hospitals that meet the minimum criteria. However, States have flexibility to designate any other hospitals they choose as DSH hospitals. Some States have designated all hospitals in the State as DSH hospitals.

DSH hospitals must receive a "DSH payment," usually a lump sum payment over and above any other payments received for providing hospital services to Medicaid patients. States are free to set the amount of the DSH payment. Up until 1993, there was no limit on the amount of the DSH payment States could make.

Under DSH programs, coupled with provider donation and tax programs and intergovernmental transfers, some States made large DSH payments and received Federal matching funds without major increases in State spending for Medicaid. Although legislation enacted in 1991 and 1993 curtailed these State practices, FY 1994

State and Federal DSH payments combined were $16.9 billion or 12.3 percent of total Medicaid spending for services. The Federal share of FY 1994 DSH payments was $9.7 billion.

Reasons for Change

Beginning in 1990, DSH payments rose sharply. The Federal share of DSH payments grew from less than $1 billion in 1990 (2 percent of total Federal Medicaid spending) to more than $10 billion in 1992 (15 percent of total Federal Medicaid spending). The rapid growth in payments to DSH hospitals was a major factor in overall Medicaid spending growth between 1990 and 1992. By some estimates, payments to DSH hospitals accounted for 20 percent of Medicaid spending growth between 1990 and 1991, and more than 50 percent of Medicaid spending growth between 1991 and 1992.

Congress passed laws in 1991 and 1993 that have limited the Federal share of DSH payments nationally to 12 percent of Federal Medicaid spending each year. The Committee believes the focus of the DSH program should be returned to the original intent of providing assistance to the nation's "safety-net" hospitals—those that provide services to a high proportion of low-income patients.

Proposed Change

The Committee provision requires States to describe in the State Medicaid plan the methodology to be used to make payments to the highest volume providers of care to the poor. To qualify as a DSH hospital, the hospital's "low-income utilization rate" will have to exceed the lesser of: (1) one standard deviation above the mean low-income utilization rate for all hospitals participating in Medicaid in the State; or (2) one and one-quarter standard deviations above the mean low-income utilization rate for all hospitals participating in Medicaid in the U.S.

A hospital's "low-income utilization rate" will be determined by calculating the ratio of patient days attributable to Medicaid and uninsured patients to total patient days. "Patient days" will include each day a beneficiary is an inpatient in the hospital or makes one or more outpatient visits to the hospital in a day. States will be required to specify the methods by which hospitals will be able to identify Medicaid managed care enrollees for the purposes of qualifying and billing for Medicaid DSH payments.

An appeals process will be set up by the Secretary for hospitals that do not meet the minimum criteria for qualifying as a DSH hospital but can show that they are "essential safety net providers" or provide special services not available by any other provider in the area.

Effective Date

Date of enactment.

FEDERAL FUNDING

Present Law

Medicaid services and administrative costs are jointly financed by the Federal Government and the States. The Federal Govern-

ment has an open-ended commitment to match each State's expenditures for covered items and services furnished to eligible Medicaid recipients. The amount of Federal funds a State receives depends on the amount of State expenditures and the State's FMAP. Each State is responsible for the difference between its Medicaid total expenditures and the Federal share.

Based on quarterly statements of Medicaid expenditures, each State is entitled to Federal reimbursement for their Medicaid expenditures. The Federal reimbursement is determined by the State's "Federal medical assistance percentage" (FMAP), a statutory formula designed to give a higher matching rate to States with lower per capita incomes relative to the national average. Matching rates for services can range from 50 percent to 83 percent and are determined annually. The Federal share of administrative costs is generally 50 percent, although higher rates are authorized for specific items.

Reasons for Change

Medicaid is the third largest social spending program in the Federal budget and has become one of the fastest-growing components of both Federal and State budgets. At present, Medicaid is the first or second largest piece of every State's budget, totaling to about 20 percent of States' budgets, on average. Federal Medicaid spending has grown from less than $3 billion in 1970, to $15 billion in 1980, to $41 billion in 1990. According to the Congressional Budget Office, Federal spending on Medicaid will total almost $100 billion dollars in FY 1996. By 2002, Federal spending will total almost $180 billion—an 80 percent increase in just seven years. This means that Medicaid is expected to grow more than 10 percent per year into the foreseeable future. Clearly, this growth is not sustainable.

Currently, wide disparities in Federal Medicaid funding also exist across States, resulting in unequal access to health care for the poor. If the Federal Government were to lock in States' current spending on Medicaid, this will have the effect of freezing in place historical spending patterns across States. The Committee believes that moving to a needs-based formula will reduce the disparities between States over time by eliminating incentives to maintain extraordinarily high spending in high effort States.

Proposed Change

Federal Medicaid funding will continue to grow over the next seven years (1996–2002), but at a slower rate than under current law. Federal funding will be limited to the following growth rates:

FY 1996.....7.250 percent
FY 1997.....6.750 percent
FY 1998+.....4.424 percent

States could match Federal funds up to a maximum amount ("cap"). Each State's cap will be equal to the base year amount multiplied by a growth factor. A State's base year amount will be equal to the greater of the amount of Federal funds received in FY 1994 or FY 1995, minus the amount of Federal payments to dis-

proportionate share hospitals that exceed nine percent of total program spending in the base year.

Every State's base year amount will increase by 7.250 percent for FY 1996. For FY 1997 and later years, each State's cap will be determined by comparing the State's current Medicaid spending per person in poverty to a "needs-based amount." States with current Medicaid spending per person in poverty below the State's "needs-based amount" will be allowed higher growth rates.

The State's "needs-based amount" will be equal to the product of four factors: residents in poverty in the State, a case mix index, an input cost index, and national average spending per resident in poverty. Residents in poverty will be the average number of individuals in the State below the Federal poverty threshold in the most recent period of 3 calendar years for which data were available. The case mix index will equal the ratio between the State's expected per recipient spending and national average per recipient spending, given the State's relative proportions of aged, disabled, and other recipients. The input cost index will be the sum of 0.15 and the product of 0.85 and a hospital wage index. This index will equal the ratio between annual average wages for hospital employees in the State and the national average based on the area wage indices computed under Medicare's prospective payment system for inpatient hospital services. National average spending per resident in poverty will be computed for using the most recent data available.

Each State's cap will increase by at least two percent, but no greater than 25 percent above the growth rates for total Federal Medicaid funding. Thus, the maximum allowable growth rate for FY 1997 will be 8.44 percent (125 percent of 6.75 percent). The maximum allowable growth rate for FY 1998 and later years will be 5.53 percent (125 percent of 4.424 percent). In addition, there would be a "small State minimum" established. Under this rule, States receiving less than 0.21 percent of the total Federal funds would be allowed to grow at the maximum growth rate until the State exceeded the small State threshold. States could carry forward a "credit" for unspent Federal funds from previous years. States will be required to match these funds. The Secretary will publish States' cap amounts for each fiscal year by April 1 of the preceding fiscal year. The Committee proposal also raised the minimum Federal Medical Assistance Percentage (FMAP) to 60 percent.

The bill contains a special rule governing the allocations to the States of New Hampshire and Louisiana. Both of these States had been making payments to disproportionate share hospitals that were quite large in relation to their overall Medicaid expenditures. Both States were heavily impacted by the limits on disproportionate share payments adopted by P.L. 103–66 (OBRA 1993). Each State has proposed to the Committee that its allocation under the new title be limited, and its opportunity to "carry over" unused allocation amounts be suspended, until the State has increased its State contribution to the appropriate level.

The Committee has acceded to each State's request, on the condition that each State make specific progress in raising its State contribution toward the level required by law. Under the special rule, the allocation for New Hampshire will be set at $360 million per

year and the allocation for Louisiana will be set at $2.622 billion per year. The allocations for these States will remain frozen at those levels until they have increased their State contributions to the required level. The required State contributions will be keyed to the amount of State contribution in FY 1994, after eliminating excess disproportionate share payments which had previously been used to fund the State contributions. For New Hampshire, the base contribution is $203 million; for Louisiana, the base contribution is $355 million.

Operationally, the special rule will work as follows:

1. Each year, the Secretary will determine how much the State would have had to spend to earn the allocation from the Federal Government for that year if the special rule were not in place. This amount could vary from year to year as a result of changes in the FMAP.

2. From the amount determined above for each year, the Secretary will subtract the State's base contribution amount. This will yield the gap in State spending applicable to that year.

3. The State will then be required to spend an amount equal to the State's base contribution *plus* an additional percentage of the amount required to close the gap (i.e., 20 percent in FY 1996, 40 percent in FY 1997, 60 percent in FY 1998, 80 percent in FY 1999, and 100 percent in FY 2000).

If the State falls short of the required State contribution in any of these years, there would be a pro rata reduction in the State's allocation for that year.

Based on current law and current law FMAP rates, these provisions would require the States to spend approximately the following amounts in State funds for the specified years:

Year	New Hampshire	Louisiana
1996	$234,400,000	$489,000,000
1997	265,800,000	623,000,000
1998	297,200,000	757,000,000
1999	328,600,000	891,000,000
2000	360,000,000	1,025,000,000

Once the State reaches the required level of State contribution, it would then be permitted to participate in increases in its Federal allocation to the same extent as other States and under the general application of the growth rate formula.

Effective Date

Date of enactment.

ACCOUNTABILITY

Present Law

Each State's Medicaid program must be operated in accordance with a State plan for medical assistance which describes the State's basic policies for eligibility, covered benefits, payments to providers and administration. Current Federal law does not require public

review or opportunity for public comment in the development of State plans.

State plans must comply with all the requirements of Federal law. The State plan must be amended periodically to reflect changes in Federal law or regulations or changes in State law or policy. State plans must be approved by HCFA before they become effective.

States must engage in a variety of activities to ensure that the program is properly administered and assure the appropriate expenditure of Federal funds. For example, States must monitor their own administrative performance, collect information on program utilization and expenditures and complete reports required by the Secretary of Health and Human Services, and must have systems for reviewing the adequacy and appropriateness of services provided to beneficiaries.

Federal funds are available for expenditures made in accordance with the approved State plan. A State may exclude a provider on its own or in response to action by the Secretary; if the Secretary excludes a provider from Medicare, the State must exclude the provider from Medicaid. Payment for medically-related services that do not meet the definition of medical assistance is generally not permitted.

Each State is required to submit to the Secretary reports containing whatever information the Secretary requires and in any format the Secretary requires. States also are required to comply with provisions the Secretary finds necessary to assure the correctness and verification of reports. Reports specifically required by statute include quarterly budget estimates that are submitted to the Secretary prior to the beginning of each quarter, quarterly statements of expenditures that are submitted to the Secretary after the end of each quarter, and other reports on utilization and expenditures.

States must also have systems and procedures in place to detect, investigate and sanction fraud against or abuse of the Medicaid program by providers or beneficiaries. States are required to have Medicaid fraud control units (MFCUs) which investigate State law fraud violations and also review and prosecute cases involving neglect or abuse of recipients in nursing homes and other facilities.

Medicaid is the payer of last resort. It is secondary to Medicare, private insurance, or any other third party that may be liable for medical payments on a recipient's behalf. Each State is required to have systems for identifying third-party liability, pursuing third-party claims, and collecting medical support payments from absent parents.

The Secretary oversees the performance of the States by conducting audits of States' performance and program expenditures. The Secretary is permitted to assess penalties and disallowances when States are not in compliance with their State plans and applicable Federal laws and regulations.

Reasons for Change

In countless ways, the Federal bureaucracy has applied the Medicaid law in intrusive, highly technical and nonsensical ways, which has interfered with the proper flow of Federal funds to the

States and has added materially to the burden of program administration.

On numerous instances, HCFA has attempted to disallow State claims for Federal match money because of alleged technical flaws in plan documents. Although the HHS Departmental Appeals Board and the Federal courts have in many instances overturned these disallowance determinations, particularly where the substance of the State operation was in compliance with the general purpose of the law and the emphasis of "form over substance," the appeal process is not always successful and adds unnecessary costs and burdens to program administration.

HCFA has also disapproved amendments to reimbursement rates set forth in State plans on numerous occasions because the State failed to meet rigid regulatory public notice requirements, even where all affected interests were fully on notice of the changes.

The constant interruption of Federal funding caused by these regulatory actions, and the burden put on the States that have to respond to and oppose them, is not necessary to protect the Federal fiscal integrity. Such "oversight" does not lead to improved services for recipients—nor is it meant to. Rather, this type of Federal intervention merely serves to perpetuate a Federal bureaucracy that is too large, too focused on finding fault, however technical and insubstantial, and too far removed from the significant problems of program administration.

It is time to do away with this kind of regulatory oversight, and instead empower States to run their programs with only those Federal provisions that are truly necessary to assure that program funds are used for purposes intended by the broad aims of the program.

Proposed Change

States will be required to establish a written plan describing all the specific details of its programs and make the plan available to the general public. States must also submit a copy of the plans to the Secretary of HHS. States must identify objectives and goals for providing health care services, and the manner in which the plan is designed to meet the objectives and goals.

Goals and objectives related to rates of childhood immunizations, reductions in infant mortality and morbidity, and children with special health care needs will be required. Studies show that the high risk obstetrical and neonatal services provided at Level III regional specialty hospitals have contributed to the decline in U.S. infant mortality over the last 25 years. The Committee encourages States to put in place protections so that pregnant women and babies receive the basic, specialty and sub-specialty care they need in the facility appropriate to their level of risk, including Level III regional specialty care, in keeping with *The Guidelines for Perinatal Care,* American Academy of Pediatrics/American College of Obstetricians and Gynecologists.

States' plans must describe in detail the following information:

1. How the State intends to spend its program funds;
2. State agency roles and responsibilities;
3. The population groups the State plans to cover;
4. Eligibility requirements;

5. State spending allocations across eligibility groups;

6. The amount, duration and scope (including any cost sharing requirements) of covered services the State plans to provide for the populations it chooses to cover;

7. The projected percentage of the State's total Medicaid spending on benefits provided to each population group, and administration;

8. Standards for measuring and monitoring the quality of services provided, and payment to providers; and

9. Fiscal controls, including systems in place to detect and prevent fraud and abuse and establishing liability of other third party payers.

States will be required to go through a public process when developing the State's plans, and will be required to make the plans available to the public. States will also be required to send a copy of the most recent State plans to the Secretary. Each State with a plan will be required to establish and maintain an advisory committee for consultation in the development, revision, and monitoring the performance of the plan. Such consultation will include the development of strategic objectives and performance goals, the annual report, and the research design for evaluating the State's plan operations.

A State will be permitted to submit an amendment to its plan at any time. However, any amendment that will eliminate or restrict eligibility or benefits under the plan must be transmitted to the Secretary. The Secretary will be permitted to negotiate a satisfactory resolution to any dispute concerning the approval of a plan or the compliance of a plan.

Federal funds could only be used for the purpose of providing health care services to low-income persons. States could claim Federal matching funds for a specified list of services. Payments may be made for services to illegal aliens only in the case of emergency services. Spending for medically-related services could not exceed 5 percent of total spending under the State plan. States will be prohibited from shifting the burden of State matching requirements onto local units of government without their expressed consent. In addition, States will also be prohibited from supplanting present State health funding (e.g., public health activities) with Medicaid funding. Finally, the Committee proposal clarifies that States may only use provider donations and taxes to match Federal funds if such donations and taxes will qualify for Federal matching funds under current law.

As under current law, Federal matching will not be available for services that will have been paid for by a private insurer but for a provision of the insurance contract making the insurer secondary to Medicaid. Medicaid will remain the secondary payor of health care services to *all* federally operated or financed health care programs. In addition, States will be required to have systems in place to determine and collect from liable third-party payers. As a condition of eligibility for medical assistance under a State's plan, an individual will be required to assign to the State any rights to medical support and payment for medical care from any third party of the individual or any other person who is eligible and on whose be-

half the individual has the legal authority to execute an assignment of such rights.

It is the intent of the Committee that, in performing Medicaid third party liability ("TPL") recovery, State Medicaid agencies use all appropriate and available measures to identify cases in which Medicaid recipients have primary coverage by another health insurer. The Committee is concerned that States are unable to identify effectively liable third parties because other health insurers frequently do not share with the State information as to the identity of individuals covered by their plans. As a result, Medicaid is paying for services for which premiums have been paid to other insurers, and costs are being inappropriately borne by the States and the Federal Government. The Committee strongly encourages States to implement policies which will provide for enrollee information data exchanges between the State Medicaid agency and private health insurance plans, self-insured employer plans, and other potentially liable third parties.

The Committee also intends that nothing should prohibit a State from requiring a veteran to contribute part of a veterans pension, including the Aid and Attendance, and the Unusual Medical Expense components, to a State Veterans Home to help defray the cost of the veteran's care. Some veterans who reside in State Veterans Homes receive veterans pensions. Veterans pensions can consist of an Aid and Attendance component, an Unusual Medical Expense portion, and a pension component. Until recently, some States required veterans who reside in the State's Veterans Home who receive a VA pension to contribute the entire pension, after a disregard to meet a personal needs allowance, to the cost of their care in the Home. The Medicaid program then paid for the cost of care not covered by the pension and any other countable income, such as Social Security. This policy was prohibited by the Health Care Financing Administration as a consequence of a settlement agreement, resulting from a case brought in the Ninth Circuit. *Perley/King* v. *Palmer* v. *Shalala*. The settlement agreement stipulated that neither the Aid and Attendance nor the Unusual Medical Expense portions of the Veterans Administration pension may be collected by a State Home.

States will be required to annually audit the financial expenditures and controls used by the State agency receiving the Federal funds using the standards of the Single Audit Act. The Secretary may require States to perform a verification audit or may conduct one himself. The Secretary will audit the use of Federal funds to make sure they are spent on covered services for low-income persons. The Secretary will be permitted to assess appropriate penalties and take disallowances. Each State will be required to maintain fiscal controls, accounting procedures, and data processing safeguards that are reasonably necessary to assure the fiscal integrity of the State's activities. Each State's plan will be required to provide that the records of any provider could be audited to ensure that proper payments were made under the plan.

States will be required to submit an annual report to Congress and the Secretary of HHS. Reports will be required to include data on the following:

1. Achievement of performance goals including actions to be taken in case a goal was not met;
2. Program evaluations;
3. Fraud and abuse and quality control activities; and
4. Plan administration, including a description of the roles and responsibilities of State entities responsible for administering the program and organization charts for each, a description of any interstate compact entered into, and citations to State law and rules governing the State's activities under the program.

Independent evaluations of each State's program will be required at least every 3 years. States will be required to have fraud prevention programs and independent fraud control units. States will be required to have laws relating to medical child support.

Effective Date

Date of enactment.

WELFARE REFORM

I. PURPOSE AND SCOPE

This measure contains the provisions under the Finance Committee's jurisdiction that were included in H.R. 4, the Family Self-Sufficiency Act of 1995, which passed the Senate on September 19, 1995, by a vote of 87 to 12.

The Committee bill fundamentally reshapes the Nation's welfare programs. The most important change is to devolve to the States (and United States territories) primary responsibility for the Aid to Families with Dependent Children (AFDC) program and related programs under the Social Security Act. The Committee bill replaces the present AFDC entitlement to cash welfare, and the myriad of complicated Federal rules and regulations for the AFDC program, with block grants under which the States (and United States territories) are given great latitude to design a program to assist needy families with minor children become self-sufficient and productive members of the work force. States determine who will be eligible to receive assistance and the types of assistance to be provided. The Committee bill does contain a maintenance of effort requirement. States will be required to continue spending 80 percent of what they were spending on AFDC in FY 1994 or face a reduction in their Family Assistance Grant.

The Committee bill transforms welfare into a temporary program that places strong emphasis on employment skills and work activities. Able-bodied adults who have received benefits for two years (earlier at State option) must participate in a work activity. The JOBS program is repealed. A new work program is established under Title IV–A of the Social Security Act which provides States with more flexibility while strengthening the work requirements. Work participation rates are increased to 50 percent in FY 2000 for the overall caseload and 90 percent in FY 1999 for two parent families. Recipients will be required to work for at least 20 hours a week (increasing to 35 hours a week in FY 2002). Welfare is made temporary by limiting the receipt of benefits to five years except in the case of hardship. However, a State may continue to provide benefits for up to 20 percent of its caseload beyond the five year period for hardship cases.

The Committee bill also makes much needed reforms to the Supplemental Security Income (SSI) welfare program, which is funded solely by Federal dollars and has experienced rapid growth of certain populations in recent years. The Committee bill changes SSI eligibility for drug addiction and alcoholism impairments, for noncitizens who enter the United States on the basis that they not become a public charge and who have not worked in the United

States for specified time periods, for certain children with disabilities, and the age at which an individual qualifies as elderly.

The Committee bill provides an uniform rule for "deeming" a sponsor's income and resources to noncitizens for all means-tested programs authorized under the Social Security Act. For noncitizens currently residing in the U.S., the sponsor's income and resources are deemed to the noncitizen for the greater of five years after lawfully entering the United States or the time specified in the sponsor's affidavit of support. For noncitizens that enter the United States after the bill is enacted, there is a five year ban on receiving benefits for any Federal means-tested program.

The Committee bill strengthens the child support enforcement program by requiring States to improve paternity establishment programs, establish uniform tracking systems and a directory of new hires, and adopt uniform laws to expedite interstate child support collections. States will be required to collect an amount equal to $25 application fee plus 10 percent of any collections for non-AFDC families that use child support services.

Other provisions include limiting the growth of Title IV–E Foster Care administration costs will be limited to 10 percent a year. Beginning in FY 1997, the Social Services Block Grant will be reduced by 20 percent.

II. EXPLANATION OF PROVISIONS

SUBTITLE C—BLOCK GRANTS FOR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES

Present Law

The Aid to Families with Dependent Children ("AFDC") program was enacted in 1935 to provide Federal matching funds to allow States to make cash payments on behalf of needy dependent children. AFDC programs are currently operated in all 50 States, the District of Columbia, and three territories (Guam, Puerto Rico, and United States Virgin Islands).

The original AFDC legislation imposed very few requirements on States. Amendments to the program over the years have drastically increased requirements on States. Although States can set "standards of need" and benefit levels for the program, there is an extensive set of federal eligibility rules, especially with respect to how a family's income and resources are determined.

States must submit, for approval by the Secretary of HHS, a State plan that describes the cash benefits and services offered by the State and explains how the State intends to comply with 43 requirements of present law.

States must also have in effect an approved child support program, a work program, foster care and adoption assistance programs, and an eligibility and verification program.

The Family Support Act of 1988 established the Job Opportunities and Basic Skill Training Program (JOBS), to help needy families with children obtain the education, training and employment needed to avoid long-term welfare dependence. The JOBS program is currently operated in all 50 States, the District of Columbia, and

three territories (Guam, Puerto Rico and the United States Virgin Islands). In addition, Indian tribes and Alaska Native organizations can operate a JOBS program and receive funds directly from the Federal Government.

States must make available a range of services and activities under the JOBS program. States are required to offer:

(1) Educational activities (as appropriate), including high school or equivalent education (combined with training as needed), basic and remedial education to achieve a basic literacy level, and education for individuals with limited English proficiency;

(2) Job skills training;

(3) Job readiness activities to help prepare participants for work; and

(4) Job development and job placement.

States are also required to offer at least 2 of the following:

(1) Group and individual job search;

(2) On-the-job training;

(3) Work supplementation programs; and

(4) Community work experience (CWEP) programs or other approved work experience programs.

States may offer postsecondary education in appropriate cases and such other education, training, and employment activities.

A work assignment under the JOBS program must not result in the:

(1) Displacement of any currently employed worker or position;

(2) Impairment of contracts for services or collectively bargained agreements;

(3) Filling of a position when an employee has been laid off from an equivalent position or when an employer has reduced its workforce to create a vacancy for a subsidized worker; and

(4) Filling of any established position vacancy.

To the extent resources are available, a State must require nonexempt AFDC recipients to participate in the JOBS program. States must guarantee child care for AFDC recipients who need care for children under age 6 in order to engage in JOBS activities.

Recipients exempt from participation in the JOBS program are those who are:

(1) A parent or other relative caring for a child under age 3 (younger at State option);

(2) A parent or other relative caring for a child under age 6 if the State does not guarantee child care;

(3) Employed 30 hours or more a week;

(4) Under age 16 attending school full-time;

(5) Pregnant women past their first trimester;

(6) Living in areas where the program is not available;

(7) Ill, incapacitated, or of advanced age; and

(8) Needed in the home because of the illness or incapacity of another household member.

The Congressional Budget Office estimates that 60 percent of the AFDC caseload is currently exempt from participating in the JOBS program.

Beginning in FY 1990, States were required to have at least seven percent of their nonexempt AFDC caseload in a work activity for at least 20 hours a week. The participation rate increased to 20 percent in FY 1995. This participation requirement expires at the end of FY 1995.

In addition, a State must meet specified participation rates for two-parent families. At least one parent in a two-parent family must participate at least 16 hours weekly in a work experience program, a work supplementation program, on-the-job training or a State-designed work program (or educational activities for a parent under age 25 without a high school diploma). The participation rate for two-parent families is 50 percent for FY 1995; 60 percent for FY 1996; and 75 percent for FY 1997 and 1998. This participation requirement expires at the end of FY 1998.

Five States allow noncustodial parents to participate in the JOBS program.

Reasons for Change

Consolidating the AFDC program and related programs into a block grant provides States with much needed flexibility in the use of Federal funds to help needy families with minor children. Streamlining Federal requirements will allow States to devote more time to serving needy families and to develop programs that address the special circumstances of localities. States are guaranteed Federal funding for 5 years so they can make long-term plans without fear of reduced funding. The primary condition placed on State Family Assistance funds is an increased commitment to move able-bodied recipients from welfare to work. Removing the individual entitlement to cash benefits sends a clear message to welfare recipients that welfare assistance is temporary and is not intended to continue on year after year leading to welfare dependency.

The Committee believes that the most effective way to escape welfare and become self-sufficient is through employment. Able-bodied adults should not be allowed to stay on welfare year after year without working. Under current law, less than 10 percent of welfare recipients participate in some type of job readiness or work activity under the JOBS program because of exemptions and weak participation standards. The Committee bill addresses this problem by replacing the JOBS program with a work program that strengthens participation requirements while providing States more flexibility in offering employment activities to welfare recipients.

Summary of Principal Provisions

BLOCK GRANTS TO STATES

(Sec. 7201)

a. AFDC programs consolidated into State Family Assistance block grant program.

The AFDC program along with related programs are consolidated into a new grant to States called the "State Family Assistance Grant" to increase the flexibility of States in operating an assistance program for needy families with minor children. The State

Family Assistance Grant replaces the following AFDC programs under the Social Security Act:

(1) AFDC cash benefits.
(2) AFDC administration.
(3) AFDC work-related child care.
(4) Transitional child care.
(5) At-risk families child care.
(6) Emergency assistance.
(7) Funding for the JOBS program.

b. No individual entitlement.

The Committee bill ends the individual entitlement to assistance under the AFDC programs under Title IV–A.

c. Purposes.

The purposes of the new grant program are to provide Federal funds for temporary assistance to needy families with minor children so that such children can be maintained in their homes or the homes of relatives, to promote self-sufficiency of parents of needy children by placing greater emphasis on job preparation and employment, and to prevent and reduce the incidence of out-of-wedlock pregnancies, generally understood to be one of the root causes of welfare dependency.

d. State plan requirements.

Under the State Family Assistance Grant, States must submit to the Secretary of Health and Human Services (HHS), and update annually, a plan outlining how the State intends to do the following:

(1) Offer a program to serve needy families with minor children throughout the State (assistance may vary from locality to locality within a State);

(2) Provide assistance to needy families with minor children for up to five years (longer for hardship cases) and provide job preparation and work experience to adults in the family so that they become self-sufficient;

(3) Require at least one parent in a needy family receiving benefits to engage in work activities as soon as the State deems them to be work ready or after two years (whether or not consecutive), whichever is earlier;

(4) Not later than two years after the enactment of this act, require recipients who have received assistance for three months to engage in community service, unless the State opts out;

(5) Meet participation rates for the work program;

(6) If different from other recipients, provide benefits paid to needy families moving into the State and to noncitizens;

(7) Safeguard and restrict the use and disclosure of information about needy families receiving benefits;

(8) Reduce the incidence of out-of-wedlock pregnancies with special emphasis on teenage pregnancy; and

(9) Meet State goals and benchmarks over a 3-year period.

States must certify annually that it will operate a child support enforcement program under Title IV–D; a child protection program

under Title IV–B; adoption assistance and foster care programs under Title IV–E; and an income and eligibility verification system under section 1137. States must certify which State agency or agencies are responsible for the administration and supervision of the program. In this regard, a State may contract with public and private organizations to provide services to welfare recipients. States must certify that any reports required under Title IV–A will be filed with the Secretary of HHS and must provide an estimate of State funding for the program.

e. Payments to States and Indian tribes.

The total amount of the State Family Assistance grant is $16,803,769,000 for each of the fiscal years 1996 through 2000. Each eligible State is entitled to receive a State Family Assistance Grant equal to the actual federal AFDC and related program expenditures paid to the State for fiscal year 1994 (reduced by certain amounts paid to the State for Indian tribes and Alaska native organizations). Payments to States are made quarterly. States are allowed to carry forward unused grant funds to future years. $1 billion of the grant is set aside to be used by States for providing child care. A State may also transfer up to 30 percent of its Family Assistance Grant into its Child Care and Development Block Grant.

States may use State Family Assistance funds in any manner reasonably calculated to accomplish the purposes of Title IV–A, including assistance to families who left welfare for employment (for a transition period) and families at risk of going on welfare. The Committee intends that the types of expenditures which were authorized by Title IV–A before the effective date of the Committee bill will continue to be an authorized use of funds, except that not more than 15 percent of a State's grant can be used for administrative purposes. For example, authorized expenditures under present Title IV–A include cash benefits; work program services for recipients and noncustodial parents; work supplementation payments; child care services for recipients; families who left welfare for employment (for a transition period) and families at risk of going on welfare; transportation and other work-related expenses for recipients and families who left welfare for employment; pregnancy prevention education, medical and counseling services; emergency assistance to avoid destitution of a child or to provide temporary shelter; reasonable administration costs, including quality control systems; and welfare fraud detection.

f. Maintenance of effort requirement.

In order for a State to receive its full block grant amount in Fiscal Years 1997, 1998, 1999 and 2000, a State must spend at least 80 percent of what the State spent on AFDC benefits in Fiscal Year 1994 on the following programs: cash assistance; child care assistance; education, job training, and work; administrative costs; and any other use of funds allowable under Title I. A State can not count State spending supplanted from other State and local programs, State expenditures from funds made available by the Federal Government, State expenditures for the Medicaid program, or any other State expenditures for the purpose of obtaining Federal

matching funds other than under Title I of this act for purposes of meeting this requirement.

g. Child care grant.

An additional amount of $3 billion over five years will be made available to States to provide child care. To be eligible, a State must maintain its FY 1994 spending on Title IV–A child care. State allocations will be based on the At-Risk Child Care program allocation formula and State funds will be matched at the Medicaid match rate.

h. Contingency fund.

A $1 billion contingency fund is established to assist States in meeting the goals of this act. In order to be eligible for contingency funds, a State must:

(1) Have an average rate of total unemployment of at least 6.5 percent for the most recent three month period;

(2) Have an average rate of total unemployment of at least 110 percent of the average rate of unemployment for one of the corresponding three month periods in the preceding two years; and

(3) Maintain their level of FY 1994 State funding for AFDC and JOBS.

States expenditures exceeding FY 1994 State expenditures on AFDC and JOBS will be matched at the Medicaid match rate.

i. Supplemental grant.

Beginning in FY 1997, a supplemental grant is available to States which:

(1) Experience higher than national average population growth and had benefit levels below the national average in the previous fiscal year; or

(2) Has a benefit level that is below 35 percent of the national average benefit level in FY 1996; or

(3) Had a population growth rate that exceeded 10 percent from April 1, 1990 to July 1, 1994.

j. Federal loan fund.

The Federal Government is authorized to establish a revolving loan fund of $1.7 billion to be administered by the Secretary of the Treasury for supplemental funding needs for State programs funded under the State Family Assistance Grant. Loan funds may be used to provide assistance under this program and welfare anti-fraud activities. States may borrow from the revolving fund if the State has not been found to misuse funds under the State Family Assistance Grant. A State's outstanding loan balance may not exceed 10 percent of the State Family Assistance Grant at any time. States must repay their loans, with interest, within three years. In the event of default, the State's grant for the quarter after the default is reduced by the amount of the loan in default.

k. Work performance bonus.

By the end of FY 1996, the Secretary of HHS must develop a formula for allocating performance bonus payments to States that are

successful at moving recipients from welfare to work. States will be eligible to receive this performance bonus in FY 1998 and FY 1999. By June 30, 1999, the Secretary of HHS must develop a formula for allocating funds for two additional performance bonus funds that will be available to States in FY 2000.

l. Work program.

The JOBS program established under the Family Support Act of 1988 is repealed and replaced with a more flexible yet tougher work program. States must operate a work program to be eligible to receive funds under the new State Family Assistance Grant. Federal funding for the work program is included in the State's share of the grant. Indian tribes and Alaska Native organizations currently operating a JOBS program may continue to receive Federal funding (at FY 1994 levels) directly for that purpose.

The work program gives States more flexibility in offering work activities. Work is defined as:

(1) Unsubsidized job;
(2) Subsidized job;
(3) On-the-job training;
(4) Community service;
(5) Job search (for the first 4 weeks of receiving benefits); and
(6) Vocational training (for up to 25% of adult recipients not to exceed 12 months per individual).

An individual may be counted as participating in a work activity if the individual provides child care services to other individuals participating in the program for purposes of meeting the work requirements.

Not later than two years after the enactment of this act, States have the option of requiring recipients who have received assistance for three months to engage in community service.

All States can require noncustodial parents to participate in work under this program.

States must meet new minimum participation requirements based on the entire caseload:

FY 1996	25%
FY 1997	30%
FY 1998	35%
FY 1999	40%
FY 2000	50%

Participation rates are measured by averaging monthly participation rates for a year. The monthly participation rate is equal to the number of recipient families in which at least one parent is engaged in work activities for at least the required hours per week (20 hours in FY 1996 increasing to 35 hours in FY 2002) in a month divided by the total number of recipient families that include an adult who received benefits for the month. States can count for up to 3 months individuals being sanctioned for not complying with the work requirement and up to 6 months for individuals that have left welfare for work. States can reduce their annual participation requirement rate by the amount they have reduced their caseload from their FY 1995 level. Reductions due to changes in Federal law eligibility requirements do not count.

States have the option of exempting families that include a child under age 1 from the participation rates. If child care is not available or provided, a single custodial recipient with a child under age 6 can not be sanctioned for not working.

Beginning in FY 1996, participation for two-parent families means that at least one parent in a two-parent family must participate in work activities for at least 35 hours per week. In addition, the participation rate for two-parent families will be increased to 90 percent for FY 1999 and thereafter.

States not meeting the required participation rates in a fiscal year will have their grant reduced by up to five percent.

The Secretary of HHS is to conduct research on the cost/benefit of the work program and to evaluate promising State approaches to employing welfare recipients. The Secretary of HHS must also rank the States in order of their success in moving recipients into long-term private sector jobs, and review the three most and three least successful programs. The Department of Health and Human Services will develop these rankings based on data collected under the bill.

m. Requirements and limitations.

The State Family Assistance Grant is to be used to serve needy families with minor children. A minor child is an individual under 18 years old or, if a full-time student, under 19 years old and who resides with the individual's custodial parent or other caretaker relative.

States are required to enter into a personal responsibility contract with each family receiving assistance. This is a binding contract that must specify what the State and the recipient must do to get the family off welfare.

States are to determine standards of need, eligibility criteria, and types and levels of assistance under the State's program funded under the State Family Assistance Grant, subject to work requirements and limitations on assistance under Title IV–A. States must at least reduce pro rata and may deny assistance to families that refuse to comply work requirements. States may apply any or all the rules of another State to families who move from the other State for up to 12 months. States are given the explicit ability to deny benefits to unwed teen parents and to children born to families receiving assistance.

A family cannot receive assistance under a State's program funded under the State Family Assistance Grant for more than 60 months (whether or not consecutive) after September 30, 1995, unless the State exempts the family by reason of hardship (child only households are exempt from this time limit). States determine what constitutes a hardship for this purpose and are limited to granting hardship for a maximum of 20 percent of the average monthly caseload for the fiscal year. For purposes of an individual who was previously a minor child in a needy family, the 60 month period begins when that individual becomes the head of a household of a needy family with a minor child.

An individual who is convicted in a Federal or State court of having made a fraudulent statement or representation with respect to the place of such individual's residence in order to receive assist-

ance or benefits simultaneously from 2 or more States under programs in Titles IV, XVI or XIX, or the Food Stamp Act of 1977 is not eligible to receive assistance under a State program funded under the State Family Assistance Grant for 10 years beginning with the date of conviction. An individual who is a fugitive felon or who is violating probation or parole is not eligible to receive assistance under a State program funded under the State Family Assistance Grant.

n. Promoting responsible parenting.

The Committee bill includes a list of findings which show the increase in out-of-wedlock births and its impact on society. Unwed teen parents are required to live at home or in an adult supervised setting and attend school in order to receive benefits under this program. Additional funds are provided for States to establish second chance homes for unwed teen parents. States are given the explicit ability to deny benefits to unwed teen parents and to children born to families receiving assistance.

Beginning in FY 1998, States are eligible to receive a bonus for reducing their out-of-wedlock birth rate. If a State reduces its out-of-wedlock birth rate by at least one percent from their FY 1995 level, the State will have its Family Assistance Grant increased by $25 times the number of children living in families below the poverty line. If a State reduces its out-of-wedlock birth rate by at least two percent from their FY 1995 level, the State will have its Family Assistance Grant increased by $50 times the number of children living in families below the poverty line. States will not be eligible for bonus funds if their induced pregnancy termination rate exceeds their FY 1995 rate.

o. Penalties against States.

The Secretary of HHS is authorized to collect the following penalties from States for noncompliance with State Family Assistance Grant requirements:

(1) Any amount found by audit to be in violation of this program, plus 5 percent of such amount as a penalty (if misuse of funds was intentional), will be withheld from the next quarterly payment;

(2) 5 percent of the amount otherwise payable for a fiscal year will be withheld if the State fails to submit an annual report regarding the use of funds within six months after the end of the fiscal year unless Secretary of HHS determines the State has reasonable cause for such failure (the penalty is rescinded if the report is submitted within 12 months).

(3) Up to 5 percent of the amount otherwise payable for the next fiscal year will be withheld if the Secretary of HHS determines that the State has failed to meet the work participation rates for a fiscal year. In subsequent years in which the State fails to meet the work participation rates, the penalty shall be increased by 5 percent.

(4) Up to 5 percent of the amount otherwise payable for the next fiscal year will be withheld if the Secretary of HHS determines that a State is not participating in the Income and Eligibility Verification System designed to reduce welfare fraud.

(5) Up to 5 percent of the amount otherwise payable for the next fiscal year will be withheld if the Secretary determines that the State failed to enforce the penalties requested by the child support agency.

(6) Any amount borrowed from the revolving loan fund which is not repaid within three years, plus interest, will be withheld from the next quarterly payment.

States can enter into a corrective action plan with the Secretary of HHS prior to the deduction of any penalties from their State Family Assistance Grants. The Secretary of HHS may not reduce any quarterly payment to the States by more than 25 percent. Any remaining penalty (above 25 percent) will be withheld from the State's payments during succeeding payment periods. States are required to use State funds to replace reductions in the State Family Assistance Grants that are the result of above penalties. The Secretary may not impose a penalty on a State if the Secretary determines the State has reasonable cause. States have the ability to appeal any penalties levied against the State.

p. Audits.

Each State shall conduct annual audits approved by the Secretary of the Treasury and the chief executive office of the State. The entity conducting the audit must be independent of any agency administering activities under Title IV–A of the Social Security Act. Not later than 30 days after the completion of the annual audit, a State must provide a copy of the audit to the State legislature, the Secretary of the Treasury, and the Secretary of HHS.

q. Data collection and reporting.

The Secretary of HHS, in consultation with State and local government officials and other interested persons, shall develop a quality assurance system of data collection and reporting. Each State receiving a State Family Assistance Grant is required, not later than the 15th day of the first month of each calendar quarter, to submit to the Secretary of HHS disaggregated and aggregated monthly data on families receiving assistance, families applying for assistance, and families that became ineligible for assistance. States are to include the percentage of State funds used for cash assistance, the work program, child care, transitional services, administrative costs and overhead; child support received by the States for needy families receiving assistance; and the number noncustodial parents participating in the work program

Not later than 6 months after the date of enactment, the Secretary of HHS is required to submit to the Congress a report on the status of State automated data processing systems to assist in managing the States' programs funded under the State Family Assistance Grant, tracking program participants, and checking for individuals participating in more than 1 State program.

Not later than 6 months after the end of FY 1997, and each fiscal year thereafter, the Secretary of HHS shall submit a report to Congress describing whether the States are making progress at moving recipients from welfare to work and decreasing out-of-wedlock pregnancies.

r. Research, evaluations, and national studies.

The Secretary of HHS shall conduct research on the effects, costs, and benefits of operating State programs funded under the State Family Assistance Grant. The Secretary of HHS may assist States in developing innovative approaches to helping welfare recipients attain self-sufficiency through employment and shall evaluate the effectiveness of such approaches.

The Secretary of HHS is required annually to rank the States in order of their success in moving individuals receiving assistance into long-term private sector jobs. In addition, the Secretary is to undertake an annual review of the 3 States most recently ranked highest and the 3 States most recently ranked lowest.

The Secretary of HHS is required to conduct a study of outcomes measures for evaluating the success of a State in moving individuals receiving assistance off of welfare through employment and report to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives not later than September 30, 1998.

The Secretary of HHS shall annually rank States on their reduction of out-of-wedlock births and review the 5 States most recently ranked highest and the 5 States most recently ranked the lowest.

s. Study by the Census Bureau.

The Bureau of the Census is directed to expand the Survey of Income and Program Participation as necessary to obtain information to enable interested persons to evaluate the impact of State programs funded under the State Family Assistance Grant.

t. Waivers.

States that have a waiver under section 1115 or otherwise relating to AFDC programs under Title IV–A in effect on October 1, 1995, may continue to operate a program under the terms of the waiver notwithstanding any other provision of the Committee bill. The State is not, however, entitled to any Federal payments under the waiver.

A State may terminate a waiver, if it so chooses, and must submit a report to the Secretary of HHS on the result or effect of such waiver. A State is relieved of any accrued cost neutrality liabilities under the waiver if the State terminates the waiver by the later of January 1, 1996, or 90 days following the adjournment of the first regular session of the State legislature that begins after the date of enactment of the Committee bill.

u. State demonstration programs.

The Committee bill is not intended to limit in anyway the ability of a State to conduct demonstration projects in 1 or more political subdivisions directed at identifying innovative or effective programs.

Certain counties with populations greater than 500,000 will be able to participate in a demonstration program where the county can opt to receive its portion of the State Family Assistance Grant directly. In order to be eligible, a county must currently be administering an AFDC program that represents less than 25 percent of

the State's total welfare caseload and be located in a State with more than one County with a population greater than 500,000.

v. Direct funding and administration for Indian tribes.

Indian tribes and Alaska native organizations with a plan approved by the Secretary of HHS are eligible to receive direct funding. Funding to the Indian tribes shall be taken from the State Family Assistance Grant in the State where the tribe resides and is equal to the expenditures attributable to such Indian families.

w. Assistant Secretary for Family Support.

The Assistant Secretary for Family Support within the Department of Health and Human Services will administer the programs under Title IV–A and IV–D.

x. Limitation on Federal authority.

The Secretary of HHS and the Secretary of the Treasury may not regulate the conduct of States under this program or enforce any provision, except to the extent expressly provided under Title IV–A of the Social Security Act.

y. Appeal of adverse decision.

States shall continue to have the right to appeal any decision to the Departmental Appeals Board established in the Department of HHS.

z. Eligibility for child care assistance.

The State agency administering the program(s) under Title IV–A shall determine eligibility for all child care assistance provided under this part.

aa. Collection of overpayments from Federal tax refunds.

The Secretary of Treasury shall withhold any overpayments made under Title IV–A from an individuals income tax refund.

SERVICES PROVIDED BY CHARITABLE, RELIGIOUS, OR PRIVATE ORGANIZATIONS

(Sec. 7202)

States are allowed to contract with private and religious organizations to provide services to State Family Assistance Grantrecipients.

LIMITATIONS OF USE OF FUNDS FOR CERTAIN PURPOSES

(Sec. 7203)

No funds provided directly to institutions or organizations to provide services and administer programs shall be expended for sectarian worship or instruction. This shall not apply to assistance provided in the form of certificates, vouchers, or other forms of disbursement if the recipient chooses where the assistance shall be redeemed.

CENSUS DATA ON GRANDPARENTS AS PRIMARY CAREGIVERS FOR THEIR GRANDCHILDREN

(Sec. 7204)

The Bureau of the Census will collect data concerning the growing trend of grandparents who are the primary caregivers for their grandchildren.

STUDY OF EFFECT OF WELFARE REFORM ON GRANDPARENTS AS PRIMARY CAREGIVERS

(Sec. 7205)

The Secretary of HHS shall conduct a study evaluating the impact of amendments made by this Act on grandparents who have assumed the responsibility of providing care to their grandchildren. The study shall identify barriers to participation in public programs including inconsistent policies, standards, and definitions used by programs and agencies in the administration of Medicaid, assistance under a State program funded under part A of title IV of the Social Security Act, child support enforcement, and foster care programs on grandparents who have assumed the primary care role for their grandchildren. Not later than December 31, 1997, the Secretary shall submit such report.

DEVELOPMENT OF A PROTOTYPE OF COUNTERFEIT-RESISTANT SOCIAL SECURITY CARD REQUIRED

(Sec. 7206)

The Commissioner of Social Security shall develop a prototype of a counterfeit-resistant social security card. The Commissioner of Social Security also shall conduct a study and issue a report to Congress examining different methods of improving the social security card application process.

DISCLOSURE OF RECEIPT OF FEDERAL FUNDS

(Sec. 7207)

Whenever an organization that accepts Federal funds under this Act makes any communication that in any way promotes public support of opposition to any policy of a Federal, State, or local government, such communication shall include a statement that the organization accepts taxpayer dollars.

MODIFICATIONS TO THE JOB OPPORTUNITIES FOR CERTAIN LOW-INCOME INDIVIDUALS (JOLI) PROGRAM

(Sec. 7208)

Authorizes $25 million a year to continue the JOLI program.

DEMONSTRATION PROJECTS FOR SCHOOL UTILIZATION

(Sec. 7209)

The Secretary of Education shall make grants to 5 States for demonstration projects relating to the use of existing public school facilities for children.

CORRECTIVE COMPLIANCE PLAN

(Sec. 7210)

Before assessing a penalty against a State under this Act, the Federal Government shall notify the State and provide them with the opportunity to enter into a corrective action plan. The State shall submit a corrective action plan within 60 days. The Federal Government shall have 60 days to either except or reject the State's plan.

PARENTAL RESPONSIBILITY CONTRACTS

(Sec. 7211)

Each State receiving a State Family Assistance Grant shall assess the needs and skills of each parent applying for assistance and develop a binding parental responsibility contract for each recipient.

EXPENDITURE OF FEDERAL FUNDS IN ACCORDANCE WITH LAWS AND PROCEDURES APPLICABLE TO EXPENDITURE OF STATE FUNDS

(Sec. 7212)

Any funds received by a State under this act shall be expended in accordance with the laws and procedures applicable of the State's own revenues, including appropriation by the State legislature.

CONFORMING AMENDMENTS TO THE SOCIAL SECURITY ACT

(Sec. 7213)

The Committee bill contains a series of technical amendments to conform the provisions of the Committee bill to other provisions of the Social Security Act.

CONFORMING AMENDMENTS TO THE FOOD STAMP ACT OF 1977 AND RELATED PROVISIONS

(Sec. 7214)

The Committee bill contain a series of technical amendments to conform the provisions of the Committee bill to the Food Stamp Act of 1977 and related provisions.

CONFORMING AMENDMENTS TO OTHER LAWS

(Sec. 7215)

The Committee bill contains a series of technical amendments to conform the provisions of the Committee bill to other laws.

SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL FOR TECHNICAL AND CONFORMING AMENDMENTS

(Sec. 7216)

Not later than 90 days after the date of enactment of the Committee bill, the Secretary of HHS, in consultation with the heads of appropriate other Federal agencies, must submit to the appro-

priate committees of the Congress a legislative proposal providing for such technical conforming amendments to the law as are required to fully implement the provisions of the Committee bill.

EFFECTIVE DATE; TRANSITION RULE

(Sec. 7217)

States may elect to continue its present law AFDC programs until June 30, 1996, but the State Family Assistance grant for fiscal year 1996 will be reduced by the amount of Federal payments made before July 1, 1996.

Effective Date

Generally effective upon date of enactment.

SUBTITLE D—SUPPLEMENTAL SECURITY INCOME

General Description

The Supplemental Security Income (SSI) program was established by the 1972 amendments to the Social Security Act to provide cash assistance to needy aged (age 65 and over), blind, and disabled individuals. Disabled individuals are those unable to engage in any substantial gainful activity by reason of a medically determined physical or mental impairment expected to result in death or last at least 12 months. The SSI program is entirely funded by the Federal Government. Certain States are required to provide supplemental benefits or face reductions in Federal payments.

Chapter 1—Eligibility Restrictions

DENIAL OF SSI BENEFITS BY REASON OF DISABILITY TO DRUG ADDICTS AND ALCOHOLICS

(Sec. 7251)

Present Law

Individuals whose drug addiction or alcoholism is a contributing factor material to their disability are eligible to receive SSI cash benefits for up to three years if they meet SSI income and resource requirements. These recipients must have a representative payee, must participate in an approved treatment program when available and appropriate, and must allow their participation in a treatment program to be monitored. Medicaid benefits continue beyond the 3-year limit, as long as the individual remains disabled, unless the individual was expelled from SSI for failure to participate in a treatment program.

Reasons for Change

The number of SSI recipients whose alcoholism or drug addition is a contributing factor material to their disability has grown from roughly 20,000 to over 100,000 since 1990. The Committee believes this trend is inappropriately diverting scarce Federal resources from severely disabled individuals and is providing a perverse in-

centive contrary to the long-term interests of alcoholics and addicts by providing them with cash payments so long as they do not work.

Summary of Principal Provisions

An individual will no longer be considered disabled for the SSI program if alcoholism or drug addiction is a contributing factor material to the individual's disability. Individuals who have an addiction in addition to a qualifying disability must have their SSI checks sent to a representative payee and must be referred to treatment. In FY 1997 and FY 1998, an additional $50 million will be made available to States for substance abuse treatment.

Effective Date

Generally effective upon date of enactment. Individuals receiving SSI cash benefits on the date of enactment, and who cannot qualify for SSI benefits on the basis of another disabling condition, will no longer be eligible for SSI benefits effective January 1, 1997. The Social Security Administration must notify such individuals of the change in law within 90 days of date of enactment.

DENIAL OF SSI BENEFITS FOR 10 YEARS TO INDIVIDUALS FOUND TO HAVE FRAUDULENTLY MISREPRESENTED RESIDENCE IN ORDER TO OBTAIN BENEFITS SIMULTANEOUSLY IN TWO OR MORE STATES

(Sec. 7252)

An individual who is convicted in a Federal or State court of having made a fraudulent statement or representation with respect to the place of such individual's residence in order to receive assistance or benefits simultaneously from two or more States under programs under titles IV, XVI or XIX, or the Food Stamp Act of 1977 is not eligible to receive SSI benefits for 10 years beginning with the date of conviction.

DENIAL OF SSI BENEFITS FOR FUGITIVE FELONS AND PROBATION AND PAROLE VIOLATORS

(Sec. 7253)

An individual who is a fugitive felon or who is violating probation or parole is not eligible to receive SSI benefits.

EFFECTIVE DATES; APPLICATION TO CURRENT RECIPIENTS

(Sec. 7254)

The eligibility changes to the SSI program are generally effective for months beginning on or after the date of enactment of the Committee bill.

Individuals receiving SSI cash benefits on the date of enactment who will no longer qualify for SSI because of alcoholism or drug addiction or because of noncitizen status will continue to receive SSI cash benefits until January 1, 1997 (if the individual otherwise continues to be eligible). The Social Security Administration must notify such individuals of the change in law within 90 days after the date of enactment. An individual provided a notification who wishes to reapply for SSI benefits on another basis must reapply to the

Commissioner of Social Security within 4 months after the date of enactment and the Commissioner must make a determination of such individual's eligibility within 1 year after the date of enactment.

CHAPTER 2—BENEFITS FOR DISABLED CHILDREN

Present Law

There is no definition of childhood disability in statute. Instead, a needy individual under age 18 is determined eligible for SSI "if he suffers from any medically determinable physical or mental impairment of comparable severity" with that of an adult considered work disabled and otherwise eligible for SSI benefits.

Under current disability evaluation procedures, the Social Security Administration first decides if the impairment(s) of an individual under age 18 "meets or equals" an impairment in the "Listing of Impairments"—over 100 specific physical or mental conditions described in regulations. If an individual does not have a listed impairment, the Social Security Administration next determines if the individual's impairment "equals" the Listing. If indicated, the Social Security Administration must also consider whether the combined effects of all impairments are of sufficient severity to be disabling, or whether an individual's overall functional limitations resulting from his or her impairment(s) are of sufficient severity to be disabling.

If the Social Security Administration finds that the impairments of an individual under age 18 cannot meet or equal the "Listing of Impairments," it applies another set of disability evaluation rules, known as an "individualized functional assessment" (IFA).

Current law provides for continuing disability reviews of current recipients to ensure that such individuals remain disabled. Under the Social Security Independence and Program Improvements Act of 1994 (P.L. 103–296), beginning on October 1, 1995, the Commissioner of Social Security is required to conduct at least 100,000 continuing disability reviews each year of disabled SSI recipients. The provision expires on October 1, 1998.

Reasons for Change

The Committee provisions were developed as the minimum changes believed necessary to restore Congressional and public confidence in this program and preserve the program for families with children with severe disabilities. The Committee is aware of allegations of fraud and abuse in the program, however, the Committee provisions are not responses to these allegations per se but to concerns about eligibility policies and the appropriateness of program growth. The Committee notes that the General Accounting Office (GAO), in its most recent report on this matter issued in July 1995, States that studies to date have not been able to conclusively prove or disprove such allegations. Nonetheless, the Committee remains concerned about these allegations and believes its provisions may also help reduce opportunities for fraud and abuse. The Committee strongly encourages the Social Security Administration to pursue

vigorously remedial actions to detect and curb any fraud and abuse in the children's SSI program.

The Committee has reviewed carefully the growth in the children's SSI program. Over the past five years the rolls have grown from 300,000 to 900,000 children, and costs from $1.5 billion to $4.5 billion. Although a significant amount of this growth followed from Congressional instructions to the Social Security Administration, e.g., to conduct outreach programs to locate children eligible for the program and to improve the Listing for mental impairments, other growth resulted from regulations issued in 1991 by the Social Security Administration establishing the IFA which liberalized program eligibility criteria beyond Congressional intent. Substantial further growth in this program is projected.

The lack of a childhood disability definition is a fundamental defect in the current statute, and has led to substantial confusion over program eligibility. The Social Security Administration has been required to translate what are essentially two definitions of adult work disability in statute into a childhood disability definition.

The Committee has established a statutory definition of childhood disability. By this definition, the Committee intends that only needy children with severe disabilities be eligible for children's SSI. The term "pervasive" included in the definition of childhood disability in the Committee welfare reform bill reported in May has been deleted as that term implied some degree of impairment in almost all areas of a child's functioning or body systems. That was not the intent of the earlier proposed change to the statute. Nonetheless, the Committee intends that the children's SSI program serve children with only the most severe disabilities. At present, the Committee believes that the Listing and the other disability determination regulations as modified by the Committee bill properly reflect the severity of disability contemplated by the statutory definition. In those areas of the Listing that involve domains of functioning, the Committee expects no less than two marked impairments as the standard for qualification. The Committee suggests the Social Security Administration revisit the Listing, as appropriate, to ensure that it meets this standard. The Committee is also aware that the Social Security Administration uses the term "severe" to often mean "other than minor" in an initial screening procedure for disability determination and in other places. The Committee, however, uses the term "severe" in its common sense meaning.

However, the Committee does not intend to suggest by its definition of childhood disability that every child need be especially evaluated for functional limitations, or that this definition creates a supposition for any such examination. The Committee notes that under the current procedure for writing individual listings, level of functioning is an explicit consideration in deciding which impairments, with what medical or other findings, are of sufficient severity to be included in the Listing. Nonetheless, the Committee does not intend to limit the use of functional assessments and functional information, if reflecting sufficient severity and are otherwise appropriate.

The Committee bill includes a technical change to the Listing for mental disorders. The Committee has eliminated references to

maladaptive behavior in the domain of personal/behavioral function. Under the Listing for childhood metal disorders, maladaptive behavior may be counted twice in determining disability; one in the domain of personal/behavioral function, and again in the domain of social function. Under the Committee bill, such behavior may continue to be scored, but only once, and within the domain of social function. This change has been endorsed by various expert groups.

The Committee bill repeals the regulations establishing the IFA, and IFAs are no longer grounds for disability determinations. In the Committee's view, the IFA is a misnomer. Although the term conjures up images of a special kind of evaluation of a child's ability to function, such as a unique medical examination or clinical assessment by a psychologist, or perhaps special consideration of the disabling effects of multiple impairments, in fact the IFA is a set of regulations that permit individuals with modest conditions or impairments to be eligible for this program. The Committee is also aware that there is considerable confusion about the use of functional information in making disability determinations. The Committee notes that findings from functional assessments are substantially considered in the current Listing, and will continue to be. For example, a substantially improved Listing for childhood mental disorders was promulgated by the Social Security Administration in 1990, which emphasized functional assessment criteria and added new listings for certain specific conditions, such as Attention Deficit Hyperactivity Disorder (ADHD). As a disability determination methodology, the Committee also notes that the General Accounting Office in a March 1995 report sharply criticized the IFA, citing a number of fundamental flaws.

The Committee urges those who seek changes in eligibility standards or other program features to resolve such matters directly with Congress. As a general matter, it is impossible for Congress to properly oversee any program, especially an entitlement program, when rules are rewritten by a court and unilaterally implemented by an agency. The Committee is also deeply concerned about the false hopes such behavior creates for individuals who then expect to benefit from a program.

This circumstance certainly applies to children's SSI. As noted above, in 1991 the Social Security Administration substantially liberalized program eligibility regulations. This action was prompted by its reading of the Supreme Court decision in *Sullivan* v. *Zebley*. The *Zebley* decision was based on limited legislative history and obscure statutory language regarding children's SSI program, which the Committee is now correcting. But the Committee notes that several relevant bills were before the Congress at the time of the *Zebley* decision, but that the Congress had not yet determined to act on any of those measures. In the future, the Committee invites the Social Security Administration to consult with it on any substantive matter to avoid such misunderstandings.

The Committee believes that the children's SSI program requires further examination. The Committee bill requires both a study of the disability determination process and a National Commission on the Future of Disability. The National Commission also has the larger purpose of examining dramatic projected growth in SSI, generally, and SSDI and the concerns of individuals with disabilities

about barriers to independence and employment created by these programs.

For example, there has been some debate over the purpose of the children's SSI program. According to history of the original SSI legislation, the House Ways and Means Committee included children with disabilities in the SSI program to assist families receiving Aid to Families with Dependent Children (AFDC) with extra expenses the Committee assumed would be such families would have if they had a child with a disability (see H. Rept. 92–231 at 147–148). The Senate Finance Committee did not agree, however, believing the needs of children with disabilities were generally only greater for health care, and that most children would qualify for Medicaid (see S. Rept. 92–1230 at 385). The Senate receded in conference.

The Committee believes this is an important issue that needs to be revisited. It is easy to imagine extra expenses for a child with a disability, and helping families with such expenses will likely remain an appropriate rationale for this program. However, the best data available indicate that for many children receiving SSI their families do not incur extra disability-related expenses on their behalf, and that SSI is often used for general household expenses. Moreover, there is a small percentage of children who incur huge disability-related expenses barely touched by the SSI payment. These data raise fundamental questions of fairness and equity.

The Committee also believes there are many unmet needs for children with disabilities, and is aware of the controversy over whether some children would be better served by services, such as mental health treatment or purchase of items of assistive technology, rather than by cash payments. In the 23 years since the SSI program was created, substantial new Federal programs have been authorized to assist children with disabilities, including Federal funding for special education and expansion of Medicaid. The impact of these programs on cash needs of children with disabilities merits careful evaluation as well.

The Committee is determined to treat fairly those current recipients affected by the rules changes, and has included explicit protection for appeal and due process procedures and a partial grandfathering (until January 1, 1997), with a hold harmless provision for any overpayments. The Committee expects the Social Security Administration to be mindful of its experience with the hazards of large scale continuing disability reviews, and to conduct these reviews in an orderly fashion.

Summary of Principal Provisions

DEFINITION AND ELIGIBILITY RULES

(Sec. 7261)

This provision repeals the "comparable severity" test in statute for determining disability of individuals under age 18, and adds a definition of childhood disability to the statute:

> An individual under the age of 18 shall be considered disabled for the purposes of this Title if that individual has a medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which

can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.

Under the Listing that relates to mental disorders, the Social Security Administration is directed to eliminate references to maladaptive behavior in the domain of personal/behavior functioning.

For children whose eligibility for SSI may be affected by provisions of this bill, the Commissioner shall conduct a continuing disability review within 1 year after enactment. However, no individual shall be removed until such review is completed, and an individual's right to appeal and other due process procedures are preserved. Notwithstanding such review, no individual shall be removed from the rolls until January 1, 1997. A recipient shall be held harmless for any payments made until removed from the rolls.

ELIGIBILITY REDETERMINATIONS AND CONTINUING DISABILITY REVIEWS

(Sec. 7262)

The Commissioner is required to conduct a continuing disability review every three years for every individual under age 18 except for those individuals whose condition is not expected to improve. The Commissioner is required to redetermine eligibility for SSI for an individual whose low birth weight is a contributing factor to that individuals's disability determination no later than 12 months of receiving benefits. The Commissioner is required to redetermine eligibility for SSI for an individual who has reached 18 years of age.

ADDITIONAL ACCOUNTABILITY REQUIREMENTS

(Sec. 7263)

The Commissioner is required to advise representative payees on the appropriate expenditure of benefits, require representative payees to document expenditures, and to conduct reviews of a sample of representative payee records to identify instances of improper expenditures. This Commissioner is also authorized to pay any lump-sum payment into a dedicated savings account, to be used for certain defined purposes to benefit the child recipient.

Chapter 3—Studies Regarding Supplemental Security Income Program

ANNUAL REPORT ON THE SUPPLEMENTAL SECURITY INCOME PROGRAM

(Sec. 7271)

The Commissioner shall prepare and deliver annually a comprehensive report on the Supplemental Security Income program to the President and Congress.

IMPROVEMENTS TO DISABILITY EVALUATION

(Sec. 7272)

The Commissioner shall issue a request for comments in the Federal Register regarding improvements in the disability determination process for individuals under age 18.

STUDY OF DISABILITY DETERMINATION PROCESS

(Sec. 7273)

The Commissioner is directed to contract with the National Academy of Sciences, or other independent entity, for a study of the disability determination procedure, of both individuals under age 18 and adults.

STUDY BY GENERAL ACCOUNTING OFFICE

(Sec. 7274)

Not later than January 1, 1998, the Comptroller General of the United States shall study and report on the impact of the provisions contained in this subtitle on the Supplemental Security Income (SSI) program.

Chapter 4—National Commission on the Future of Disability

NATIONAL COMMISSION ON THE FUTURE OF DISABILITY

(Secs. 7281–7287)

A National Commission on the Future of Disability is established to examine growth in the SSDI and SSI and reported barriers to employment and independence created by these programs; and to make appropriate recommendations to the President and Congress.

Chapter 5—State Supplementation Programs

REPEAL OF MAINTENANCE OF EFFORT REQUIREMENTS APPLICABLE TO OPTIONAL STATE PROGRAMS FOR SUPPLEMENTATION OF SSI BENEFITS

(Sec. 7291)

Maintenance of effort requirement is repealed, effective September 30, 1995.

Chapter 6—Retirement Age Eligibility

ELIGIBILITY FOR SUPPLEMENTAL SECURITY INCOME BENEFITS BASED ON SOCIAL SECURITY RETIREMENT AGE

(Sec. 7295)

The age at which an individual can collect SSI cash benefits based on being elderly will be directly related to the age a retiree can collect full benefits from the Social Security program. Under current law, the retirement age for full benefits will increase from age 65 in the year 2002 to age 67 in the year 2027.

Effective Date

Generally effective upon date of enactment.

SUBTITLE E—CHILD SUPPORT

Present Law

The Child Support Enforcement (CSE) program was enacted in 1975 to address the problem of nonsupport of children. The 1975 legislation added a new part D to the title IV of the Social Security Act. This legislation authorized Federal matching funds to be used for locating absent parents, establishing paternity, establishing support obligation owed by the noncustodial parent, and obtaining child and spousal support. The basic responsibility for administering the program is left to the States, but the Federal Government plays a major role in funding, monitoring and evaluating State programs, providing technical assistance, and in certain instances, in giving direct assistance to the State in locating absents parents and obtaining support payments from them.

The current CSE program requires States to offer child support enforcement services for both welfare and nonwelfare families. For welfare families, services are automatic. Once an individual applies for AFDC or Medicaid the individual is required to cooperate with the State in establishing paternity and locating the father unless she is found to have good cause for refusing to cooperate. If an individual does not have a good cause for noncooperation, the family's AFDC benefit is reduced.

Applicants or recipients of AFDC must assign their rights to child or spousal support to the State. If the State collects child support from the noncustodial parent, the State and Federal Government get to keep the amount of money needed to offset the costs the State and Federal Government incurred because the family was on welfare. If any money is leftover, it is paid to the family. In an attempt to get individuals to cooperate, the first $50 of any amount collected goes to the family.

States that do not comply with their State child support plan face a reduction of their AFDC matching funds by 1 to 5 percent, depending on the severity of noncompliance. Penalties are suspended if the State submits an a corrective action plan that is approved by the Secretary.

States are required to charge an application fee for non-AFDC families that use child support services but States can only charge up to $25 per application. Most States only charge a nominal amount far below $25. In 1994, child support agencies collected less than 3 percent of total program costs in the form of fees.

Reasons for Change

The current child support system can be strengthened and improved to increase paternity establishment and collections of child support. An important part of child support enforcement is the ability to track a nonpaying, noncustodial parent. Because individuals can frequently change jobs to avoid paying support, a new system will be established to require employers to send to State registries information on all new hires within a specified time period.

These new hire registries will match information with outstanding support orders so support orders can be enforced more quickly.

Because most of the problems in the current system stem from interstate cases, the current Federal Parent Locator Service is expanded to include information from the State registries so that support orders can be more easily matched with workers. In addition, all States are required to adopt the Uniform Interstate Family Support Act (UIFSA) so that all States have uniform laws and procedures governing child support.

The Committee believes that non-AFDC families who utilize the child support enforcement system should pay a reasonable fee for the services they receive. Currently, States and the Federal Government provide child support enforcement services for non-AFDC families for only a nominal fee. The Federal Government pays for the majority of the costs associated with providing child support enforcement services to non-AFDC families. Therefore, working class taxpayers are paying most of the cost to provide child support enforcement services to non-AFDC families who may have even more financial resources than the taxpayer.

In June 13, 1995, the GAO testified before the subcommittee on human resources, Committee on Ways and Means, that providing child support enforcement services to non-AFDC families is costly. Since 1984, Federal and State government non-AFDC costs have risen over 600 percent to over $1.1 billion in fiscal year 1994. States have only charged minimal application and optional service fees thus doing little to help recover the Federal Government's 66 percent share of program costs.

Between 1984 and 1994, non-AFDC costs have risen 600 percent while recoveries of these costs only increased from 2 percent to 3 percent (from $3 million to $33 million). In 1994, the national average cost per non-AFDC case was about $136, while the average fee collected was $4. In contrast, private child support collection agencies charge between 25 and 33 percent of the support collected.

Summary of Principal Provisions

The Committee bill strengthens child support enforcement by increasing paternity acknowledgment, establishing more support orders, and increasing child support collections through additional enforcement techniques. In addition, a new system will be established that will better track the noncustodial parent.

Chapter 1—Eligibility for Services; Distribution of Payments

STATE OBLIGATION TO PROVIDE CHILD SUPPORT ENFORCEMENT SERVICES

(Sec. 7301)

States must provide child support services to recipients of programs under the Temporary Family Assistance grant, Medicaid, and Title IV–E. In addition, child support services must be provided to individuals who apply for services.

DISTRIBUTION OF CHILD SUPPORT COLLECTIONS
(Sec. 7302)

The $50 pass-through to families is ended. Instead, States are given the option of passing the entire child support payment through to families. If a State elects this option, the State must still pay the Federal share of the collection to the Federal Government. For arrearages that accrued before the custodial parent went on welfare, the State has the option of passing it through to the custodial parent or keeping the State's share. If the State keeps the State's share, the State must then pay the Federal share to the Federal Government. All arrearages that accrued after the family left welfare must be paid to the custodial parent. Only after all arrearages owed to the custodial parent have been repaid, any arrearages owed to the State and Federal Government are repaid.

RIGHTS TO NOTIFICATION AND HEARINGS
(Sec. 7303)

All individuals involved in the process of establishing or modifying child support orders must be notified and have access to a fair hearing or other formal complaint procedure.

PRIVACY SAFEGUARDS
(Sec. 7304)

States must implement safeguards against unauthorized use or disclosure of information relating to proceedings to establish paternity or to enforce child support. These safeguards must include prohibitions on release of information where there is a protective order or where the State has reason to believe a party is at risk of physical or emotional harm from the other party. This provision is effective October 1, 1997.

Chapter 2—Locate and Case Tracking

STATE CASE REGISTRY
(Sec. 7311)

States are required to collect information using automatic data processing systems. These systems must include:

(1) Each case in which an order has been entered or modified on or after October 1, 1998, and must use standard data elements such as name, Social Security number, and other uniform identification numbers;

(2) Payment records for cases being enforced by the State agency, including amount of current and past due support owed, amounts collected and distributed, birth date of the child to whom the obligation is owed, and the amount of any lien imposed by the State;

(3) Updates on case records in the State registry being enforced by the State on the basis of information received from judicial and administration actions, from proceedings, from orders relating to paternity and support, from data matches, and from other sources; and

(4) Extracts for purposes of sharing and matching with Federal and State data bases and locator services, including the Federal Parent Locator Service, and with the child support enforcement programs in other States.

COLLECTION AND DISBURSEMENT OF SUPPORT PAYMENTS

(Sec. 7312)

State child support agencies are required, beginning October 1, 1998, to operate a centralized, automated unit for collection and disbursement of child support under orders enforced by the child support agency. The purpose of the Disbursement Unit is to collect and disburse support payments, to generate orders and notices of withholding to employers, to keep an accurate identification of payments, to promptly distribute money to custodial parents or other States, and to furnish parents with a record of the current status of support payments. The Disbursement Unit must distribute all amounts payable within 2 business days after receiving the money and identifying information from the employer. The State Disbursement Unit may be established by linking local disbursement units through an automated information network.

STATE DIRECTORY OF NEW HIRES

(Sec. 7313)

States are required to establish, by October 1, 1997, a State Directory of New Hires to which employers and labor organizations in the State must furnish a W–4 form for each newly hired employee. Employers must submit the W–4 form within 30 days after the date of hire. The employer or labor organization may submit the report magnetically, electronically, or by first class mail. Government agencies are considered employers for purposes of New Hire reporting.

At State option, a State may sanction an employer failing to make a timely report up to $25 for each unreported employee and up to $500 for employees for whom they do not transmit a W–4 form if, under the laws of the State, there is shown to be a conspiracy between the employer and the employee to prevent the proper information from being filed.

By October 1, 1997, each State Directory of New Hires must conduct automated matches of the Social Security numbers of reported employees against the Social Security numbers of records in the State Case Registry being enforced by the State agency and must report the information on matches to the State child support agency. Then, within 2 business days, the State must issue a withholding order directing the employer to withhold wages in accordance with the child support order.

In addition, within 2 working days of receiving the W–4 information from employers, the State Directory of New Hires must furnish the information to the National Directory of New Hires for matching with the records of other State case registries. The State Directory of New Hires must also report quarterly to the National Directory of New Hires information on wages and unemployment

compensation (this information is taken directly from a report that States are currently required to submit to the Secretary of Labor).

The State child support agency must use the new hire information for purposes of establishing paternity as well as establishing, modifying, and enforcing child support obligations.

New hire information must also be disclosed to the Temporary Family Assistance, Medicaid, Unemployment Compensation, Food Stamp, and territorial cash assistance programs for income eligibility verification; to the Social Security Administration for use in determining the accuracy of Supplemental Security Income payments under Title XVI and in connection with benefits under Title II of the Social Security Act; to the Secretary of the Treasury for administration of the Earned Income Tax Credit program and for verification of claims concerning employment on tax returns; to State agencies administering unemployment and workers' compensation programs to assist determinations of the allowability of claims; and to researchers (but without individual identifiers) conducting studies that serve the purposes of the child support enforcement program.

AMENDMENTS CONCERNING INCOME WITHHOLDING

(Sec. 7314)

Since January 1, 1994, States have been required to use immediate wage withholding for all new support orders, regardless of whether a parent has applied for child support enforcement services. There are two times when this rule does not apply: (1) one of the parents demonstrates and the court or administrative agency finds that there is good cause not to do so; or (2) written agreement is reached between both parents which provides for an alternative arrangement.

States must have laws providing that all child support orders issued or modified before October 1, 1996, which are not otherwise subject to income withholding, will become subject to income withholding immediately if arrearage occurs.

LOCATOR INFORMATION FROM INTERSTATE NETWORKS

(Sec. 7315)

All State and the Federal child support enforcement agencies must have access to the motor vehicle and law enforcement locator systems in all States.

EXPANSION OF THE FEDERAL PARENT LOCATOR SERVICE

(Sec. 7316)

FPLS is already a central component of the Federal child support effort, and is especially useful in interstate cases. The FPLS would be expanded to include new sources of timely information that is to be used for the purposes of establishing parentage and establishing, modifying, or enforcing child support obligations and locating the custodial parent so that visitation orders can be enforced. Within the FPLS an automated registry known as the Federal Case Registry of Child Support Orders would be established. The Federal Case Registry contains abstracts of child support orders and

other information specified by the Secretary (such as names, Social Security numbers or other uniform identification numbers, State case identification numbers, wages or other income, and rights to health care coverage) to identify individuals who owe or are owed support, and the State which has jurisdiction over the case.

In addition to the Federal Case Registry, the provision establishes within the FPLS a National Directory of New Hires containing information supplied by State Directories of New Hires. When fully implemented, the Federal Directory of New Hires will contain identifying information on virtually every person who is hired in the United States. In addition, the Federal Case Registry will contain quarterly data supplied by the State Directory of New Hires on wages and unemployment compensation paid. Provisions are included in the bill to ensure accuracy and to safeguard information in the FPLS from inappropriate disclosure or use.

The Secretary is required to match data in the National Directory of New Hires against the child support order abstracts in the Federal Case Registry of Child Support Orders and to report information obtained from matches to the State child support agency responsible for the case within 2 days. The information is to be used for purposes of locating individuals to establish paternity, and to establish, modify, or enforce child support.

Collection and Use of Social Security Numbers for Use in Child Support Enforcement

(Sec. 7317)

States must have laws requiring that Social Security numbers be placed on applications and in the files for professional licenses, commercial drivers licenses, occupational licenses, marriage licenses, divorce decrees, death certificates, child support orders, and paternity determination or acknowledgment orders. If a State allows the use of a number other than the Social Security number; the State shall so advise any applicants.

Chapter 3—Streamlining and Uniformity of Procedures

Adoption of Uniform State Laws

(Sec. 7321)

By January 1, 1997, all States must have UIFSA and the procedures required for its implementation in effect.

Improvements to Full Faith and Credit for Child Support Orders

(Sec. 7322)

The provision changes and expands the recently enacted Federal law governing full faith and credit for child support orders by adding several provisions. One provision clarifies the definition of a child's home State; another makes several revisions to ensure that full faith and credit laws can be applied consistently with UIFSA; another clarifies the rules which child support order States must honor when there is more than one order.

ADMINISTRATIVE ENFORCEMENT IN INTERSTATE CASES
(Sec. 7323)

States are required to have laws that facilitate the enforcement of child support orders across State lines. States are required to have laws that permit them to send and receive, without registering the underlying order unless the enforcement action is contested by the obligor on the grounds of mistake of fact or invalid order. The transmission of the order itself serves as certification to the responding State of the arrears amount and of the fact that the initiating State met all procedural due process requirements. No court action is required or permitted by the responding State. In addition, each responding State must match the case against its data bases, take appropriate action if a match occurs, and send the collections, if any, to the initiating State. States must keep records of the number of requests they receive, the number of cases that result in a collection, and the amount collected. States must respond to interstate requests within 5 days.

USE OF FORMS IN INTERSTATE ENFORCEMENT
(Sec. 7324)

The Secretary must issue standardized forms that all States must use for income withholding, for imposing liens in interstate cases, and for issuing administrative subpoenas in interstate cases. The forms must be issued by June 30, 1996 and States must begin using the forms by October 1, 1996.

STATE LAWS PROVIDING EXPEDITED PROCEDURES
(Sec. 7325)

States must adopt procedures to expedite both the establishment of paternity and the establishment, enforcement, and modification of support:

(1) Ordering genetic testing;

(2) Entering a default order;

(3) Issuing subpoenas to obtain information necessary to establish, modify, or enforce an order;

(4) Obtaining access to records from State and local government agencies, law enforcement records, and corrections records;

(5) Directing parties to pay support to the appropriate government entity;

(6) Ordering income withholding;

(7) Securing assets to satisfy arrearages by intercepting or seizing periodic or lump sum payment from States or local agencies; these payments include unemployment compensation, workers' compensation, judgements, settlements, lottery winnings, assets held by financial institutions, and public and private retirement funds; and

(8) Increasing automatically the monthly support due to include amounts to offset arrears.

Chapter 4—Paternity Establishment

STATE LAWS CONCERNING PATERNITY ESTABLISHMENT (Sec. 7331)

States must strengthen their paternity establishment laws by requiring that paternity may be established until the child reaches age 21 and by requiring the child and all other parties to undergo genetic testing upon the request of a party, where the request is supported by a sworn statement establishing a reasonable possibility of parentage or nonparentage. When the tests are ordered by the State agency, States must pay for the costs, subject to recoupment at State option from the father if paternity is established.

States must have procedures that: create a simple civil process for establishing paternity under which benefits, rights and responsibilities of acknowledgement are explained to unwed parents; establish a paternity acknowledgement program through hospitals and birth record agencies (and other agencies as designated by the Secretary) and that require the agencies to use a uniform affidavit developed by the Secretary that is entitled to full faith and credit in any other State; create a signed acknowledgement of paternity that is considered a legal finding of paternity, unless rescinded within 60 days, and thereafter may be challenged in court only on the basis of fraud, duress, or material mistake of fact; allow minors who sign a voluntary acknowledgement to rescind it until age 18 or the date of the first proceeding to establish a support order, visitation, or custody rights; and provide that no judicial or administrative proceedings are required or permitted to ratify an acknowledgement which is not challenged by the parents.

States must also have procedures for admitting into evidence accredited genetic tests, unless any objection is made within a specified number of days, and if no objection is made, clarifying that test results are admissible without the need for foundation or other testimony; creating a rebuttable or, at State option, conclusive presumption of paternity upon genetic testing results indicating a threshold probability that the alleged father is the father of the child; requiring a default order to be entered in a paternity case upon a showing of service of process on the defendant and any additional showing required by the State law; providing that parties in a contested paternity action are not entitled to a jury trial; requiring issuance of an order for temporary support, upon motion of a party, pending an administrative or judicial determination of parentage, where paternity is indicated by genetic testing or other clear and convincing evidence; providing that bills for pregnancy, childbirth, and genetic testing are admissible without foundation testimony; ensuring that putative fathers have a reasonable opportunity to initiate paternity action; and providing for voluntary acknowledgments and adjudications of paternity to be filed with the State registry of birth records for data matches with the central registry established by the State.

The Secretary is required to develop an affidavit to be used for voluntary acknowledgement of paternity which includes the Social Security Number of each parent.

OUTREACH FOR VOLUNTARY PATERNITY ESTABLISHMENT

(Sec. 7332)

States will publicize the availability and encourage the use of procedures for voluntary establishment of paternity and child support by means the State deems appropriate.

COOPERATION BY APPLICANTS FOR AND RECIPIENTS OF TEMPORARY FAMILY ASSISTANCE

(Sec. 7333)

Individuals who apply for or receive public assistance under the Temporary Family Assistance Program must cooperate with child support enforcement efforts by providing specific identifying information about the other parent, unless the applicant or recipient is found to have good cause for refusing to cooperate. "Good cause" is defined by States. States may also require the applicant and child to submit to genetic testing. Responsibility for determining failure to cooperate is shifted from the agency that administers the Temporary Family Assistance Program to the agency that administers the child support program.

Chapter 5—Program Administration and Funding

PERFORMANCE-BASED INCENTIVES AND PENALTIES

(Sec. 7341)

The Committee bill maintains the Federal matching payment for child support activities at 66 percent.

Not later than 60 days after enactment, the Secretary shall establish a committee that includes State child support directors to develop a formula to distribute incentive payments to States. The formula shall include:

(1) Percentage of cases where paternity was established;
(2) Percentage of cases with a support order;
(3) Percentage of cases where a child support order is paid;
(4) Cost effectiveness of the program; and
(5) Amount of child support collected compared to the amount of outstanding child support owed.

Beginning in 1999, a new incentive system will be put in place. This system will reward good State performance by increasing the State's basic matching rate of 66 percent by adding up to 12 percentage points for outstanding performance in establishing paternity and by adding up to an additional 12 percentage points for overall performance. The Secretary will design the specific features of the system and, in doing so, will maintain overall Federal reimbursement of State programs through the combined matching rate and incentives at the level projected for the current combined matching and incentive payments to States.

The minimum paternity establishment ratio is either 90 percent or: (a) if the State paternity establishment ratio is between 50 percent and 90 percent for the fiscal year, the paternity establishment ratio of the State for the immediately preceding fiscal year plus 6 percentage points; or (b) if the State ratio is less than 50 percent

for a fiscal year, the paternity establishment ratio for the immediately preceding fiscal year plus 10 percentage points.

States are required to recycle incentive payments back into the child support program.

FEDERAL AND STATE REVIEWS AND AUDITS

(Sec. 7342)

The Committee provision shifts the focus of child support audits from process to performance outcomes. This goal is accomplished by adding a new State plan provision that requires States to annually review and report to the Secretary, using data from their automatic data processing system, both information adequate to determine the State's compliance with Federal requirements for expedited procedures and timely case processing as well as the information necessary to calculate their levels of accomplishment and rates of improvement on the new performance indicators established by the Committee bill (percentage of cases in which an order was established, percentage of cases in which support is being paid, ratio of child support collected to child support due, and cost-effectiveness of the program). The Secretary is required to determine the amount (if any) of incentives or penalties; the Secretary must also review State reports on compliance with Federal requirements and provide States with recommendations for corrective action. Audits must be conducted at least once every 3 years, or more often in the case of States that fail to meet Federal requirements. The purpose of the audits is to assess the completeness, reliability, accuracy, and security of data reported for use in calculating the performance indicators and to assess the adequacy of financial management of the State program.

These provisions take effect beginning with the calendar quarter that begins 12 months after enactment.

REQUIRED REPORTING PROCEDURES

(Sec. 7343)

The Secretary is required to establish procedures and uniform definitions for State collection and reporting of required information necessary to measure State compliance with expedited processes and timely case processing as well as the data necessary to perform the incentive calculations.

AUTOMATED DATA PROCESSING REQUIREMENTS

(Sec. 7344)

States are required to have a single Statewide automated data processing and information retrieval system which has the capacity to perform the following functions: to account for Federal, State, and local funds; to maintain data for Federal reporting; to calculate the State's performance for purposes of the incentive and penalty provisions; and to safeguard the integrity, accuracy, and completeness of, and access to, data in the automated systems (including policies restricting access to data).

The statutory provisions for State implementation of Federal automatic data processing requirements are revised to provide

that, first, all requirements enacted in or before the Family Support Act of 1988 are to be met by October 1, 1997, and second, that the requirements enacted in the Family Self-Sufficiency Act of 1995 are met by October 1, 1999. The October 1, 1999 deadline will be extended by one day for each day by which the Secretary fails to meet the deadline for regulations.

TECHNICAL ASSISTANCE

(Sec. 7345)

The Secretary can use 1 percent of the Federal share of child support collections on behalf of families in the Temporary Family Assistance program from the preceding year to provide technical assistance to the States. Technical assistance can include training of State and Federal staff, research and demonstration programs, and special projects of regional or national significance.

The Secretary must use 2 percent of the Federal share of collections on behalf of Temporary Family Assistance recipients for operation of the Federal Parent Locator Service to the extent that costs of the Parent Locator Service are not recovered by user fees.

REPORTS AND DATA COLLECTION BY THE SECRETARY

(Sec. 7346)

The Committee provision amends current data collection and reporting requirements to conform the requirements to changes made by this bill and to eliminate unnecessary and duplicative information. More specifically, States are required to report the following data each fiscal year: the total amount of child support payments collected, the cost to the State and Federal Governments of furnishing child support services, the number of cases involving families that became ineligible for aid under part A with respect to whom a child support payment was received, the total amount of current support collected and distributed, the total amount of past due support collected and distributed, and the total amount of support due and unpaid for all fiscal years.

Chapter 6—Establishment and Modification of Support Orders

NATIONAL CHILD SUPPORT GUIDELINES COMMISSION

(Sec. 7351)

A national child support guidelines commission is established to consider the adequacy of State child support guidelines, feasibility of adopting uniform terms in all child support orders, how to define income and under what circumstances income should be imputed, and the tax treatment of child support payments. In addition, they would recommend procedures to automatically adjust child support orders periodically and to help noncustodial parents address grievances regarding visitation and custody orders.

Simplified Process for Review and Adjustment of Child Support Orders

(Sec. 7352)

As under present law, States must review and, if appropriate, adjust child support orders enforced by the State child support agency every three years. However, States are given two simplified means by which they can use automated means to accomplish the review. First, States may adjust the order by applying the State guidelines and updating the reward amount. Second, States may apply a cost of living increase to the order. In either case, both parties must be given an opportunity to contest the adjustment.

States must also review and, upon a showing of a change in circumstances, adjust orders pursuant to the child support guidelines upon request of a party. States are required to give parties one notice of their right to request review and adjustment, which may be included in the order establishing the support amount.

Furnishing Consumer Reports for Certain Purposes Relating to Child Support

(Sec. 7353)

Authorized individuals seeking to establish or modify a child support order will be given access to the consumer report agency to determine the appropriate levels of payment.

Nonliability for Depository Institutions Providing Financial Records to State Child Support Enforcement Agencies in Child Support Cases

(Sec. 7354)

A depository institution shall not be liable under any Federal or State law to any person for disclosing any financial record of an individual to a State child support enforcement agency attempting to establish, modify, or enforce a child support obligation. An individual can only be sued for disclosing information if they knowingly, or by reason of negligence, disclosed a financial record of an individual for purposes other than those listed above.

Chapter 7—Enforcement of Support Orders

Internal Revenue Service Collection of Arrearages

(Sec. 7361)

No additional fee may be assessed for adjustments to an amount previously certified with respect to the same obligor.

Authority to Collect Support From Federal employees

(Sec. 7362)

The rules governing wage withholding for Federal employees are clarified and simplified by:

(1) Establishing that Federal employees are subject to wage withholding and other legal processes to collect child support;

(2) Establishing rules that Federal agencies must follow in responding to wage withholding or other legal processes to collect support;

(3) Deleting existing laws governing designation of agents to receive and respond to process and replace with streamlined provisions that require Federal agencies to designate agents and publish their name, title, address, and telephone number in the Federal registry annually;

(4) Requiring agents, upon receipt of process, to send written notice to the individual involved as soon as possible;

(5) Amending existing law governing allocation of monies owed by an individual to give priority to child support; and

(6) Broadening the definition of income to include funds such as insurance benefits, retirement and pension pay, survivor's benefits, compensation for death and black lung disease, veteran's benefits and workers' compensation.

ENFORCEMENT OF CHILD SUPPORT OBLIGATIONS OF MEMBERS OF THE ARMED FORCES

(Sec. 7363)

The Secretary of Defense must establish a central personnel locator service that contains residential or, in specified instances, duty addresses of every member of the Armed Forces (including retirees, the National Guard, and the Reserves). The locator service must be updated within 30 days of the individual member establishing a new address. Information from the locator service must be made available to the Federal Parent Locator Service. The Secretary of Defense must issue regulations to facilitate granting of leave for members of the Armed Forces to attend hearings to establish paternity or to establish child support orders.

The Secretary of each branch of the Armed Forces (including retirees, the Coast Guard, the National Guard, and the Reserves) is required to make child support payments directly to any State to which a custodial parent has assigned support rights as a condition of receiving public assistance. The Secretary of Defense must also ensure that payments to satisfy current support or child support arrears are made from disposable retirement pay. The Secretary of Defense must begin payroll deduction within 30 days or the first pay period after 30 days of receiving a wage withholding order.

VOIDING OF FRAUDULENT TRANSFERS

(Sec. 7364)

States must have in effect the Uniform Fraudulent Conveyance Act of 1981, the Uniform Fraudulent Transfer Act of 1984, or an equivalent law providing for voiding transfers of income or property in order to avoid payment of child support.

WORK REQUIREMENT FOR PERSONS OWING CHILD SUPPORT

(Sec. 7365)

States must have laws that direct courts to order individuals owing past-due support with respect to a child receiving assistance

under the Temporary Family Assistance program either to pay support due or participate in work activities.

DEFINITION OF SUPPORT ORDER

(Sec. 7366)

A support order is defined as an order issued by a court or an administrative process that requires support of a child or of a child and the parent with whom the child lives.

REPORTING ARREARAGES TO CREDIT BUREAUS

(Sec. 7367)

States must establish procedures where the State must report periodically to consumer reporting agencies the name of any parent who is delinquent in the payment of support, and the amount of overdue support owed by such parent. The parent who is delinquent in payment of support must be afforded all due process required under State law, including notice and reasonable opportunity to contest the accuracy of such information.

LIENS

(Sec. 7368)

States must establish procedures under which liens are imposed against real and personal property for amounts of overdue support owed by an absent parent who resides or owns property. States must accord full faith and credit to liens established in another State, without registration of the underlying order.

STATE LAW AUTHORIZING SUSPENSION OF LICENSES

(Sec. 7369)

Each State must have in effect laws under which the State has (an uses in appropriate cases) authority to withhold, suspend or restrict the use of driver's licenses, professional and occupational licenses, and recreational licenses of individuals owing overdue support or failing, after receiving appropriate notice, to comply with subpoenas or warrants relating to paternity or child support proceedings.

DENIAL OF PASSPORTS FOR NONPAYMENT OF CHILD SUPPORT

(Sec. 7370)

If an individual owes arrearages of child support in an amount exceeding $5,000, the Secretary shall transmit a certification to the Secretary of State to deny, revoke, or limit a passport.

INTERNATIONAL CHILD SUPPORT ENFORCEMENT

(Sec. 7371)

The Secretary of State is authorized to negotiate reciprocal agreements with foreign nations regarding the enforcement of child support obligations.

DENIAL OF MEANS-TESTED FEDERAL BENEFITS TO NONCUSTODIAL PARENTS WHO ARE DELINQUENT IN PAYING CHILD SUPPORT

(Sec. 7372)

A noncustodial parent who is more than two months delinquent in paying child support will not be eligible to receive any means-tested Federal benefits.

CHILD SUPPORT ENFORCEMENT FOR INDIAN TRIBES

(Sec. 7373)

States with Indian tribes within their borders must make reasonable efforts to enter into cooperative agreements with the tribes regarding the distribution and collection of child support. The Secretary of HHS may, in appropriate cases, make direct payments to Indian tribes who have approved child support enforcement programs.

FINANCIAL INSTITUTION DATA MATCHES

(Sec. 7374)

The Secretary shall establish procedures under which the State will enter into agreements with financial institutions to develop and operate a data matching system in which financial institutions will be required to provide information to the State on a quarterly basis on clients who are absent parents.

CHILD SUPPORT ENFORCEMENT FEES FOR NON-ASSISTANCE FAMILIES

(Sec. 7375)

States will be required to collect an amount equal to a $25 application fee and 6.6 percent of collections for non-AFDC families that use child support enforcement services. States will have flexibility in designing their own methods of collecting these fees including: paying the fees out of State funds; applying a fee to a particular service provided, such as paternity establishment; using a sliding-fee scale based on income; charging interest on child support arrearages; any other innovative method that the States see fit to utilize.

With regard to the collection fee, States: may not require a custodial parent with an income below 185 percent of poverty to pay the collection fee; may only charge up to 2 percent of collections for a custodial parent with an income between 185 and 300 percent of poverty; may only charge a custodial parent with an income above 300 percent of poverty an amount equal to what the State charged the noncustodial parent (States are still allowed to collect an application fee from any income level).

Also included is a sense of the Senate that says while States have the overall choice as to how to collect child support enforcement costs, States should first try to collect the costs incurred from any noncustodial parent who denies paternity and is later determined to be the father and any noncustodial parent who does not voluntarily comply with judicial or administrative enforcement orders.

Enforcement of Orders Against Parental Grandparents in Cases of Minor Parents

(Sec. 7376)

States must have in effect procedures under which a child support order may be enforced against the paternal grandparents of a minor parent in the mother of the child is receiving assistance under the Family Assistance Grant.

Sense of the Senate Regarding the Inability of the Noncustodial Parent to Pay Child Support

(Sec. 7377)

Sense of the Senate expressing that States should continue their efforts to enforce child support payments regardless of the employment status or location of the noncustodial parent and encouraging States to pursue pilot programs in which the parents of teen noncustodial parents are made to pay child support or take part in a work program.

Chapter 8—Medical Support

Technical Correction to ERISA Definition of Medical Child Support Order

(Sec. 7378)

This provision expands the definition of medical child support order in ERISA to clarify that any judgement, decree, or order that is issued by a court of competent jurisdiction or by an administrative adjudication has the force and effect of law.

Enforcement of Orders for Health Care Coverage

(Sec. 7379)

Establishes procedures so that when a noncustodial parent provides health care coverage for a child, and the parent changes employment, the State agency shall transfer coverage to the new employer, unless the noncustodial parent contests the notice.

Chapter 9—Enhancing Responsibility and Opportunity for Nonresidential Parents

Grants to States for Access and Visitation Programs

(Sec. 7381)

The Committee bill authorizes grants to States for access and visitation programs including mediation, counseling, education, development of parenting plans, and visitation enforcement. Visitation enforcement can include monitoring, supervision, neutral drop-off and pick-up, and development of guidelines for visitation and alternative custody agreements.

The Administration for Children and Families at HHS will administer the program. States are required to monitor and evaluate their programs and are given the authority to subcontract the program to courts, local public agencies, or private nonprofit agencies.

Programs operating under the grant will not have to be Statewide. Funding is authorized as capped spending under section IV–D of the Social Security Act. Projects are required to supplement rather than supplant State funds.

The amount of the grant to a State is equal to 90 percent of the State expenditures during the year for access and visitation programs or the allotment for the State for the fiscal year. The allotment to the State bears the same ratio to the amount appropriated for the fiscal year as the number of children living in the State with one biological parent divided by the national number of children living with one biological parent. The Administration for Children and Families will adjust allotments to ensure that no State is allotted less than $50,000 for fiscal years 1996 or 1997 or less than $100,000 for any year after 1997.

Chapter 10—Effect of Enactment

Effective Dates

(Sec. 7391)

Except as noted in the text of the bill for specific provisions, the general effective date for provisions in the bill is October 1, 1996. However, given that many of the changes required by this bill must be approved by State Legislatures, the bill contains a grace period tied to the meeting schedule of State Legislatures. More specifically, in any given State, the bill becomes effective either on October 1, 1996 or on the first day of the first calendar quarter after the close of the first regular session of the State Legislature that begins after the date of enactment of this bill. In the case of States that require a constitutional amendment to comply with the requirements of the bill, the grace period is extended either 1 year after the effective date of the necessary State constitutional amendment or 5 years after the date of enactment of this bill.

SUBTITLE F—NONCITIZENS

Present Law

Noncitizens wishing to immigrant to the United States must obtain a visa to enter the country legally. A noncitizen can obtain a visa through the INS (if they are already in the United States) or through the United States consulate in their country (if they are not yet in the United States).

In order to obtain admission to the United States, the noncitizen must prove to the consulate of the INS that they will be able to support themselves when they arrive in the United States. United States immigration law specifically States that any noncitizen who is likely at any time to use welfare after they arrive in the United States should be denied from entering the country. To verify that the noncitizen will not go on welfare after the noncitizen arrives in the United States, the noncitizen must show proof that:

(1) The noncitizen is independently wealthy;
(2) The noncitizen has job in the United States;
(3) A friend of relative will support the noncitizen; or
(4) A combination of all of the above.

If the noncitizen is relying on the financial support of a friend or relative, the friend or relative must sign an affidavit promising to financially support the noncitizen. The affidavit of support is an administrative form used by both the State Department and the INS. The affidavit must be signed and validated before the noncitizen can obtain a visa to legally enter the United States.

Under current law, noncitizens (except illegal noncitizens) are eligible for all means-tested programs. However, noncitizens who had to obtain an affidavit of support to enter the United States must have their sponsor's income "deemed" available to them for a period of time:

(1) 3 years for AFDC;
(2) 3 years for food stamps; and
(3) 5 years for SSI (this reverts to 3 years on September 30, 1996).

The deeming rule does not apply to noncitizens who enter the United States without a sponsor, such as refugees or asylees.

Reasons for Change

Except for asylees and refugees, noncitizens granted entry into the United States stipulate that they will be self-sufficient while living in the United States and will not become a public charge. Notwithstanding this stipulation, the number of noncitizens receiving welfare benefits have grown dramatically in the last decade. The Committee believes that noncitizens should live up to the condition of self-sufficiency under which they gained entry into the United States.

Summary of Principal Provisions

STATE OPTION TO PROHIBIT ASSISTANCE FOR CERTAIN ALIENS

(Sec. 7401)

States may prohibit the use of any Federal funds received for the provision of assistance under any means-tested program for any individual who is a noncitizen of the United States, except: asylees, refugees, and noncitizens whose deportation has been withheld for not more than five years after they enter the United States; and noncitiznes who served in the United States armed forces and their spouses and children.

DEEMED INCOME REQUIREMENT FOR FEDERAL AND FEDERALLY FUNDED PROGRAMS

(Sec. 7402)

A deeming period of 5 years or the length of time specified in a noncitizen's affidavit of support, whichever is longer, will be established for all Federally-funded means-tested programs. State or local governments may apply this provision to State and local means-tested programs. This provision will apply to all noncitizens, except: asylees, refugees, and noncitizens whose deportation has been withheld for not more than five years after they enter the United States; and noncitiznes who served in the United States armed forces and their spouses and children.

REQUIREMENTS FOR SPONSOR'S AFFIDAVIT OF SUPPORT
(Sec. 7403)

The document that individuals sign agreeing to sponsor noncitizens and making their income available to the noncitizen for purposes of determining eligibility for Federally-funded means-tested programs is made legally binding until the noncitizens has worked 40 quarters. The sponsor will be reqiured to reimburse Federal, State, and local governments for any benefits received by a noncitizen they have sponsored.

LIMITED ELIGIBILITY OF NONCITIZENS FOR SSI BENEFITS
(Sec. 7404)

Noncitizens will no longer be eligible to qualify for SSI cash benefits unless they have worked in the United States for a sufficient period to qualify for Social Security disability income (20 quarters of work) or old age benefits (40 quarters of work). Noncitizens who entered the United States as an asylee or refugee, or whose deportation has been withheld will be eligible for SSI benefits for not more than five years after entering the United States (if they otherwise meet the SSI program requirements). Noncitizens who served in the United States armed forces and their spouses and children will also be eligible (if they otherwise meet the SSI program requirements).

Noncitizens receiving SSI cash benefits on date of enactment, and who no longer will be eligible for SSI cash benefits, will continue receiving SSI cash benefits until January 1, 1997. The Social Security Administration must notify such individuals of the change in law within 90 days of the date of enactment.

TREATMENT OF NONCITIZENS
(Sec. 7405)

Any noncitizen that enters the United States on or after the bill's enactment date shall not be eligible to receive benefits under any Federally-funded means-tested program for five years, after which the terms established under their affidavit support will apply. Noncitizens who have worked in the United States for a sufficient period to qualify for Social Security disability income (20 quarters of work) or old age benefits (40 quarters of work); asylees, refugees, and noncitizens whose deportation has been withheld for not more than five years after entering the United States; and noncitizens who served in the United States armed forces and their spouses and children will be exempt from this provision. In addition, noncitizen children who are need of foster care or adoption assistance who meet the eligibility requirements under current law will be exempt from this provision.

INFORMATION REPORTING
(Sec. 7406)

At least four times a year, a State must submit a report to the Immigration and Naturalization Service (INS) containing the name

and address of any individual the State knows is unlawfully in the United States.

PROHIBITION ON PAYMENT OF FEDERAL BENEFITS TO CERTAIN PERSONS

(Sec. 7407)

Illegal aliens will be ineligible for any Federal benefits with the exception of:

(1) Emergency medical services;
(2) Short-term emergency disaster relief;
(3) School lunch;
(4) Benefits under the Child Nutrition Act of 1966; and
(5) Public health assistance for immunizations and the control of communicable diseases.

Effective Date

Upon date of enactment.

SUBTITLE G—ADDITIONAL PROVISIONS RELATING TO WELFARE REFORM

Chapter 1—Reductions in Federal Government Positions

REDUCTIONS

(Sec. 7411)

By December 31, 1995, the Secretary of Agriculture, Education, Labor, Housing and Urban Development, and Health and Human Services must submit a report to all relevant Congressional committees regarding the number full-time equivalent positions required by each agency to carry out the covered activities of the agency after the enactment of this legislation. The Secretary of each agency must take any actions that may be necessary, including reduction in force actions, to reduce the number of positions at the agency in accordance with their report.

No later than July 1, 1996 the General Accounting Office (GAO) must submit a report to the relevant Congressional committees regarding the determinations made by each Secretary and whether further reductions may be necessary.

REDUCTIONS IN FEDERAL BUREAUCRACY

(Sec. 7412)

The Secretary of Health and Human Services shall reduce by 75 percent the number of the full-time equivalent and full-time equivalent management positions related to any program that has been block granted under this act.

REDUCING PERSONNEL IN WASHINGTON, DC, AREA

(Sec. 7413)

The Secretary of Health and Human Services is encouraged to reduce personnel at agency headquarters before reducing field personnel.

Chapter 2—Block Grant for Social Services

Present Law

The Social Services Block Grant (Title XX) provides funds to States in order to provide a wide variety of social services, including:

(1) Child care;
(2) Family planning;
(3) Protective services for children and adults;
(4) Services for children and adults on foster care; and
(5) Employment services.

States have wide discretion over how they use Social Services Block Grant funds. States set their own eligibility requirements and are allowed to transfer up to 10 percent of their allotment to certain Federal health block grants, and for low-income home energy assistance (LIHEAP).

States can also use their block grant funds for staff training in the field of social services. This includes training at workshops, conferences, seminars, and educational institutions.

Funding for the Social Services Block Grant is capped at $2.8 billion a year. Funds are allocated among States according to the State's share of its total population. No State matching funds are required to receive Social Services Block Grant money.

Reasons for Change

Many of the functions funded under the Social Services Block Grant are addressed by other existing programs. The General Accounting Office (GAO) found evidence that States were transferring the costs of certain services from the Social Services Block Grant to other Federal programs. For example, child day care expenses and foster care services were transferred to the AFDC and foster care program for children who were AFDC eligible. These types of transfers free up Title XX funds to provide other social services to recipients who are not low-income and AFDC eligible.

During previous reductions to the Social Services Block Grant, States have managed to keep funding the same kinds of services by modifying eligibility criteria and targeting services to those most in need.

The Committee believes that non-AFDC families who utilize the child support enforcement system should pay a reasonable fee for the services they receive. Currently, States and the Federal Government provide child support enforcement services for non-AFDC families for only a nominal fee. The Federal Government pays for the majority of the costs associated with providing child support enforcement services to non-AFDC families. Therefore, working class taxpayers are paying most of the cost to provide child support enforcement services to non-AFDC families who may have even more financial resources than the taxpayer.

Summary of Principal Provisions

REDUCTION IN BLOCK GRANT FOR SOCIAL SERVICES

(Sec. 7421)

Beginning in FY 1997, the Social Services Block Grant will be reduced by 20 percent.

ESTABLISHING NATIONAL GOALS TO PREVENT TEENAGE PREGNANCIES

(Sec. 7422)

Not later than January 1, 1997, the Secretary of Health and Human Services shall establish and implement a strategy for preventing an additional 2 percent of out-of-wedlock births and assuring that 25 percent of the communities in the United States have teenage pregnancy prevention programs in place. Not later than June 30, 1998, and annually thereafter, the Secretary must report on the progress of meeting the above goals.

Effective Date

Upon date of enactment.

Chapter 3—Foster Care Maintenance Payments Program

Present Law

Title IV–E of the Social Security Act is intended to help States with foster care and adoption assistance programs for children that are AFDC eligible. Title IV–E helps finance the monthly maintenance payments, administration, child placement services, and training relative to foster care and adoption assistance.

Reasons for Change

The Committee believes that Title IV–E administrative costs are rising at a rate that is higher than what is necessary. The Title IV–E Foster Care program has a broad definition of administrative costs. States have become more aware of this broad definition and, consequently, more sophisticated in maximizing Federal funding under the Title IV–E Foster Care program.

The AFDC foster care caseload is expected to grow from 245,000 in 1994 to 298,000 in 1999 (a 22 percent increase). At the same time, the cost for AFDC foster care administrative and training cost increased from $1.2 billion to $2.1 billion (an 83 percent increase).

In the 1995 Red Book issued by the Department of Health and Human Services, the Inspector General's office recommended limiting future increases in administrative costs to no more that 10 percent a year. They state the reason for such action is because current "open-ended" legislation has allowed administrative costs to increase from $400 million in FY 1988 to an estimated $1.2 billion in FY 1994—approximately a 200 percent increase.

Summary of Principal Provision

LIMITATION ON GROWTH OF ADMINISTRATIVE EXPENSES FOR FOSTER CARE MAINTENANCE PAYMENTS PROGRAM

(Sec. 7431)

The growth of States' costs for administering the Title IV–E Foster Care program will be limited to 10 percent a year.

Effective Date

Upon date of enactment.

Chapter 4—Miscellaneous Provisions

EXEMPTION OF BATTERED INDIVIDUALS FROM CERTAIN REQUIREMENTS

(Sec. 7441)

States will have the authority to exempt individuals who have been battered or subject to extreme cruelty from the requirements of the welfare provisions contained in this Act.

SENSE OF THE SENATE ON LEGISLATIVE ACCOUNTABILITY FOR UNFUNDED MANDATES IN WELFARE REFORM LEGISLATION

(Sec. 7442)

Prior to the Senate acting on the conference to H.R. 4 or any other legislation containing welfare reform provisions, the Congressional Budget Office (CBO) shall prepare a 7 year analysis of the conference report detailing the costs to the States of implementing this legislation.

SENSE OF THE SENATE REGARDING ENFORCEMENT OF STATUTORY RAPE LAWS

(Sec. 7443)

Sense of the Senate that States and local jurisdictions should aggressively enforce statutory rape laws.

SANCTIONING FOR TESTING POSITIVE FOR CONTROLLED SUBSTANCES

(Sec. 7444)

States shall not be prohibited by the Federal Government from sanctioning welfare recipients who test positive for use of controlled substances.

ABSTINENCE EDUCATION

(Sec. 7445)

The Child and Maternal Health Block Grant authorization has been increased by $75 million a year to provide States with funds for abstinence education.

FRAUD UNDER MEANS-TESTED WELFARE AND PUBLIC ASSISTANCE PROGRAMS

(Sec. 7446)

An individual can not receive an increase in their benefit under any federally funded means-tested program if the increase is a result of loss of income due to being sanctioned under any Federal, State, or local means-tested program.

SUBTITLE H—REFORM OF THE EARNED INCOME TAX CREDIT

(Secs. 7460–7466 of the bill and sections 32, 6213(g)(2), 6696 and 6701 of the Code)

Present Law

In general

Under present law, certain eligible low-income workers are entitled to claim the earned income tax credit (EITC). The EITC is a "refundable" tax credit, meaning that the EITC first offsets any income taxes owed by an individual and then the remaining EITC is paid by check from the Federal Government. The amount of the EITC depends upon whether the individual has one, more than one, or no qualifying children and is determined by multiplying the applicable credit rate by the individual's earned income up to a maximum earned income amount. The maximum credit is the product of the credit rate and the maximum earned income amount.

The EITC is phased out at certain income levels. The maximum credit is reduced by a phaseout rate multiplied by the amount of earned income (or AGI, if greater) in excess of the beginning phaseout income amount. For individuals with earned income (or AGI, if greater) in excess of the ending phaseout income amount, no credit is allowed. The maximum earned income amount and the beginning phaseout income amount are indexed for inflation. The ending phaseout amount will also increase if there is inflation.

As enacted in Public Law 104–7 (H.R. 831), for taxable years beginning after December 31, 1995, an individual is not eligible for the EITC if the individual's total amount of "disqualified income" for the taxable year exceeds $2,350. Disqualified income is the sum of:

(1) interest (taxable and tax-exempt),
(2) dividends, and
(3) net rent and royalty income (if greater than zero).

The parameters for the EITC depend upon the number of qualifying children the individual claims. For 1995 the parameters are as follows:

	Two or more qualifying children	One qualifying child	No qualifying children
Credit Rate	36.00%	34.00%	7.65%
Maximum earned income amount for calculating credit	$8,640	$6,160	$4,100
Maximum Credit	$3,110	$2,094	$314
Phaseout begins	$11,290	$11,290	$5,130
Phaseout ends	$26,673	$24,396	$9,230
Phaseout rate	20.22%	15.98%	7.65%

Note: The maximum credit equals the credit rate times the maximum earned income amount (for example, 36 percent of $8,640 is $3,110).

For 1996, the parameters are as follows (dollar amounts are projections expressed in 1996 dollars):

	Two or more qualifying children	One qualifying child	No qualifying children
Credit Rate	40.00%	34.00%	7.65%
Maximum earned income amount for calculating credit	$8,910	$6,340	$4,230
Maximum Credit	$3,564	$2,156	$324
Phaseout begins	$11,630	$11,630	$5,290
Phaseout ends	$28,553	$25,119	$9,520
Phaseout rate	21.06%	15.98%	7.65%

For years after 1996, the credit rates and phaseout rates will be the same as in the preceding table.

Eligibility

In order to claim the EITC, an individual must either have a qualifying child or meet other requirements. A qualifying child must meet a relationship test, an age test, an identification test, and a residence test.

In order to claim the EITC without a qualifying child, an individual must not be a dependent and must be over age 24 and under age 65. In addition, the individual's principal place of abode must be located in the United States for more than one-half of the taxable year. For purposes of this test, a member of the Armed Forces stationed outside the United States on extended active duty is considered to be maintaining a principal place of abode in the United States.

To satisfy the identification test, individuals must include on their return the name and age of each qualifying child. For returns filed with respect to tax year 1995, individuals must provide a taxpayer identification number (TIN) for all qualifying children who were born on or before October 31, 1995. For returns filed with respect to tax year 1996, individuals must provide TINs for all qualifying children born on or before November 30, 1996. For returns filed with respect to tax year 1997 and all subsequent years, individuals must provide TINs for all qualifying children, regardless of

their age. An individual's TIN is generally that individual's Social Security number. Some individuals are exempt from Social Security taxes because of their religious beliefs. These individuals do not have a Social Security number; instead, the Internal Revenue Service administratively assigns them a taxpayer identification number.

Math errors

The IRS may assess additional tax due as a result of a math error without sending an individual a notice of deficiency and giving the individual an opportunity to petition the Tax Court. Where the IRS uses this assessment procedure for a math error, the individual must be given an explanation of the asserted error and a period of 60 days to request that the IRS abate its assessment. The IRS may not proceed to collect the amount of the assessment until the individual has agreed to it or has allowed the 60-day period for objecting to expire. If the individual files a request for abatement of the assessment specified in the notice, the IRS must abate the assessment. Any reassessment of the abated amount is subject to the ordinary deficiency procedures. The request for abatement of the assessment is the only procedure an individual may use prior to paying the assessed amount in order to contest an assessment arising out of a math error. Once the assessment is satisfied, however, the individual may file a claim for refund if he/she believes the assessment was made in error.

Return preparer penalties

An income tax return preparer is subject to a penalty of $250 if any part of an understatement of tax on a return or refund claim is due to the return preparer's taking a position for which there was not a realistic possibility of the position being sustained. The return preparer must have known (or reasonably should have known) of the unrealistic position and not disclosed that position. In addition, an income tax return preparer is subject to a penalty of $1,000 if any part of an understatement of tax on a return or refund claim is due to the return preparer's willful attempt in any manner to understate tax or negligent or intentional disregard of rules and regulations. An income tax return preparer is also subject to a penalty of $50 for each failure to (1) furnish a copy of a return or refund claim to the individual; (2) sign the return or refund claim; (3) furnish his or her identifying number; (4) furnish certain copies or lists of returns or refund claims; or (5) file certain information returns regarding his or her employees. In addition, tax preparers who endorse or negotiate checks made to individuals pay a penalty of $500 for each check endorsed or cashed.

Reasons for Change

The EITC is a unique means-tested entitlement program in that it is administered through the tax code. The Committee is concerned that this feature has led to the EITC being not well-targeted to the neediest individuals. Unlike other means-tested entitlement programs which look to a wide-range of factors to determine eligibility, individuals have been able to use certain provisions in the tax code to lower their AGI and claim the EITC even though they are not the intended beneficiaries of the program. The

Committee also believes recent findings of fraud and abuse in the EITC program indicate that reform of this rapidly expanding program is needed.

One way to improve the targeting of the credit to the neediest individuals is by expanding the definition of income used in phasing out the EITC. The Committee believes that the definition of AGI used currently in phasing out the EITC is too narrow and disregards other components of an individual's income level. Broadening the definition of AGI used in phasing out the EITC will prevent persons with substantial income from sources other than earnings from claiming the EITC. Tax-exempt interest, untaxed Social Security benefits, and untaxed distributions from pensions, annuities and individual retirement arrangements increase individuals' ability-to-pay and reduce the need for a tax credit. Similarly, denying losses reported on Schedules C, D, E, and F for purposes of determining an individual's eligibility for the EITC will also help determine whether participation in this entitlement program is appropriate.

The Committee believes that individuals with substantial assets could use proceeds from the sale of those assets rather than the EITC to support consumption in times of low income. Transfer programs such as AFDC, food stamps, and Medicaid have asset tests for determining eligibility. Such programs also have caseworkers available to make determinations about the assets owned by a potential claimant. In the case of the EITC, the Internal Revenue Service does not have caseworkers to assess the balance sheets of millions of individuals, and it does not currently have information on most individuals' assets. Therefore, in order to apply a proxy for an asset-based test, the recently enacted disqualified income test concentrates on the returns generated by those assets. Interest, dividend, and net rental and royalty income represent flows of income from assets that represent wealth of an individual. The Committee believes that net capital gains and other passive income represent other flows of income from assets that could be liquidated to support current consumption.

The method for phasing out the credit will be changed. Under present law, in 1996, individuals with two or more qualifying children would be able to claim the EITC even if they have AGI as high as $28,553. Individuals with one qualifying child would be able to claim the EITC even if they have AGI as high as $25,119. The Committee believes that individuals with this level of income should not benefit from an entitlement program distributed through a tax credit. Redesigning the phaseout will retarget the EITC entitlement program to low-income working families.

From its inception in 1975 to 1993, the EITC was only available to individuals with qualifying children. A provision in the Omnibus Budget Reconciliation Act of 1993 extended the EITC to certain individuals without qualifying children for taxable years beginning after December 31, 1993. The Committee believes that the EITC should be targeted to individuals with qualifying children, as was the case for the first 19 years of the program.

The Committee believes that individuals who are unauthorized to work in the United States should not be able to claim the EITC. To enforce the requirement that EITC claimants and their qualify-

ing children have proper Social Security numbers and to insure that EITC claimants have paid self-employment taxes on any self-employment income used to qualify for the EITC, the Committee believes the Internal Revenue Service should be able to use the streamlined procedures it currently uses for math and clerical errors.

Finally, the Committee believes that strong measures should be taken to deter income tax return preparers from filing fraudulent claims for the EITC and other tax matters. To this end, penalties for illegitimate claims are doubled.

Explanation of Provision

Modify definition of adjusted gross income used for phasing out the credit

The adjusted gross income ("AGI") amounts over which the EITC is phased out would be modified by:

A. Including the following items:
   (1) tax-exempt interest;
   (2) Social Security benefits not subject to income tax;
   (3) nontaxable distributions from pensions, annuities, and individual retirement arrangements; and
   (4) child support received, excluding the first $6,000 received per year. This amount is not indexed for inflation.

B. Excluding the following items:
   (1) net capital losses;
   (2) net losses from sole proprietorships (other than in farming);
   (3) net losses from sole proprietorships in farming;
   (4) net losses from other trades or businesses; and
   (5) net losses from nonbusiness rents and royalties.

Change in definition of disqualified income

For purposes of the disqualified income test (the "wealth test") added by Public Law 104–7 (H.R. 831), for taxable years beginning after December 31, 1995, the following items would be added to the definition of disqualified income: net capital gain income (if greater than zero) and net passive income (if greater than zero).

Phasing out the EITC over fixed dollar ranges

The method of phasing out the EITC would be changed. Rather than specifying a phaseout rate, the EITC would be phased out over fixed dollar income ranges. The maximum amount of EITC that an individual may claim would be reduced by a certain percentage for each $100 (or portion thereof) by which the individual's earned income (or modified AGI, if greater) exceeds the applicable phaseout income amount. For individuals with one qualifying child, the applicable percentage would be 0.86 percent, meaning that the EITC would be phased out over an income range of $11,600. For individuals with more than one qualifying child, the applicable percentage would be 0.66 percent, meaning that the EITC would be phased out over an income range of $15,100. These phaseout ranges are not indexed for inflation. Both the maximum earned income amount used for calculating the EITC and the income

amounts at which the EITC phaseout begins would continue to be indexed for inflation.

Maintain credit rate for individuals with two or more qualifying children at 1995 levels

The increase in the credit rate for individuals with two or more qualifying children that was to take effect in 1996 is repealed. The credit rate for individuals with two or more children would continue at 36 percent for 1996 and following years.

Repeal the EITC for individuals without qualifying children

In order to claim the EITC, an individual must have a qualifying child.

Earned income tax credit denied to individuals not authorized to be employed in the United States

Only individuals who are eligible to work in the United States would be eligible for the EITC. Individuals claiming the EITC would be required to provide a valid Social Security number for themselves (and, if married, their spouse's taxpayer identification number) and qualifying children. Social Security numbers would have to be valid for employment purposes in the United States. Individuals residing in the United States illegally would not be eligible for the EITC.

Use math error procedures for certain omissions

If an individual fails to provide a correct taxpayer identification number, such omission would be treated as a math error. This treatment would allow the Internal Revenue Service to use simpler procedures to resolve questions about the validity of a Social Security number. These procedures would also be allowed in instances of individuals who claim the EITC and fail to pay self-employment taxes.

Double civil penalties applicable to income tax return preparers and improve compliance

In the case of civil penalties applicable to income tax return preparers, the penalties would be doubled. In addition, the Secretary of the Treasury is encouraged to use the maximum review process that is administratively feasible to ensure that originators of electronic returns involving the EITC comply with the law.

With these changes, the parameters of the EITC for 1996 are as follows:

	Two or more qualifying children	One qualifying child	No qualifying children
Credit Rate	36.00%	34.00%	0.00%
Maximum earned income amount for calculating credit	$8,910	$6,340	$0
Maximum credit	$3,208	$2,156	$0
Phaseout begins	$11,630	$11,630	$0
Phaseout ends	$26,731	$23,231	$0
Percent credit reduced per $100 above beginning phaseout amount	0.66%	0.86%	0.00%

Effective Date

The provision is effective for taxable years beginning after December 31, 1995.

SUBTITLE I—INCREASE IN PUBLIC DEBT LIMIT

(Sec. 7471)

Current Law

The statutory limit on the public debt currently is $4.9 trillion. It was set at this level permanently in P.L. 103–66, enacted into law on August 10, 1993. The current debt limit will expire sometime in October or November 1995.

Reasons for Change

When the permanent debt limit is reached in October or November 1995, the Treasury will no longer be able to meet the Federal Government's financial obligations and to manage the debt effectively.

The Committee believes it is imperative to increase the debt limit on a permanent basis to facilitate the smooth functioning of the Federal Government and to prevent any disruption of financial markets.

Explanation of Provision

The bill increases the statutory limit on the public debt to $5.5 trillion. The new debt limit has no expiration date.

Effective Date

The provision is effective on the date of enactment.

SUBTITLE J—CORRECTION OF COST-OF-LIVING ADJUSTMENTS

(Sec. 7481)

Current Law

Some of the largest Federal entitlements programs with automatic cost-of-living adjustments (COLAs) linked to the Consumer Price Index are under Finance Committee jurisdiction. These programs are:

1. Social Security and Railroad Retirement;
2. Supplemental Security Income; and
3. Earned Income Tax Credit.

Automatic adjustments tied to the CPI also affect revenues. Income tax brackets, standard deductions and personal exemptions are under the jurisdiction of the Finance Committee.

Explanation of Provision

The accuracy of the CPI as a measure of changes in the cost of living has a great impact on the Federal budget because automatic cost-of-living increases for Federal retirement programs are based on the CPI. In addition, Federal income taxes are automatically adjusted using the CPI. For these reasons, the budget resolution for FY 96 called for the establishment of a non-partisan commission on the CPI. This commission presented an interim report in September 1995 and will reach its final conclusions in June 1996.

The bill includes a sense of the Senate that all cost-of-living adjustments required by Federal law should be corrected as soon as possible to accurately reflect future changes in the cost of living.

Congressional Budget Office Estimates of Committee Recommendations

TITLE VII--COMMITTEE ON FINANCE
SUBTITLE A--MEDICARE

By fiscal year, in billions of dollars

		1995	1996	1997	1998	1999	2000	2001	2002	7-year savings Total
CHANGES IN DIRECT SPENDING										
Chapter 1--Medicare Choice Plans										
Sec. 7001-7003	Establishment of Medicare Choice plans		-0.4	-1.8	-4.2	-6.2	-8.8	-12.3	-16.7	-50.4
	Total, Chapter 1		-0.4	-1.8	-4.2	-6.2	-8.8	-12.3	-16.7	-50.4
Chapter 2--Provisions Relating to Medicare Part A										
SubChapter A--General Provisions Relating to Part A										
Sec. 7011	PPS hospital payment update		-0.2	-1.3	-3.0	-4.8	-6.8	-8.9	-11.2	-36.1
Sec. 7012	PPS-exempt hospital payments		-0.2	-0.3	-0.5	-0.9	-1.1	-1.5	-1.6	-6.1
Sec. 7013	PPS capital payments		-1.3	-1.5	-1.6	-1.7	-1.8	-1.9	-1.9	-11.7
Sec. 7014	Disproportionate share hospital payments		-0.1	-0.3	-0.5	-0.7	-0.9	-0.9	-1.0	-4.5
Sec. 7015	Reduce indirect medical education payments		-0.4	-0.9	-1.5	-1.7	-1.7	-1.8	-1.9	-9.9
Sec. 7016	Graduate medical education and disproportionate share adjustment for Medicare Choice		0.0	0.5	1.5	1.8	2.0	2.3	2.6	10.7
Sec. 7017	Payments for hospice services		-0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.6
SubChapter B--Payments to Skilled Nursing Facilities										
Sec. 7031-7038	Prospective payment for SNFs		-0.2	-0.6	-1.0	-1.4	-1.9	-2.3	-2.9	-10.4
	Total, Chapter 2		-2.4	-4.6	-6.8	-9.4	-12.3	-15.1	-17.9	-68.6

TITLE VII--COMMITTEE ON FINANCE
SUBTITLE A--MEDICARE

By fiscal year, in billions of dollars

		1995	1996	1997	1998	1999	2000	2001	2002	7-year savings Total
Chapter 3--Provisions Relating to Medicare Part B										
SubChapter A--Payment Reforms										
Sec. 7041	Payments for physicians' services		-0.4	-1.3	-2.3	-3.2	-4.1	-5.1	-6.2	-22.6
Sec. 7042	Elimination of formula driven overpayments for certain outpatient hospital services		-0.9	-1.2	-1.5	-2.0	-2.5	-3.3	-4.5	-15.9
Sec. 7043	Payment for clinical laboratory diagnostic services		-0.1	-0.4	-0.7	-0.9	-1.1	-1.3	-1.6	-6.0
Sec. 7044-7045	Durable medical equipment and updates for orthotics and prosthetics		-0.3	-0.6	-0.7	-0.9	-1.0	-1.3	-1.5	-6.2
Sec. 7046	Payments for capital-related costs of outpatient hospital services		-0.0	-0.0	-0.1	-0.2	-0.2	-0.2	-0.3	-1.0
Sec. 7047	Payments for non-capital costs of outpatient hospital services		0.0	0.0	0.0	-0.3	-0.3	-0.4	-0.4	-1.4
Sec. 7048	Updates for ambulatory surgical centers		-0.0	-0.1	-0.1	-0.2	-0.2	-0.3	-0.4	-1.3
Sec. 7049	Payments for ambulance services		-0.0	-0.0	-0.1	-0.1	-0.1	-0.2	-0.3	-0.8
Sec. 7051	Raise Part B deductible to $150 in 1996 and $10 per year through 2002 /a		-0.7	-1.1	-1.3	-1.5	-1.7	-2.0	-2.2	-10.5
	Part B interactions, including FEHB		-0.0	-0.1	-0.1	-0.2	-0.2	-0.3	-0.2	-1.2
SubChapter B--Part B Premium										
Sec. 7052	Setting the Part B premium		-3.0	-3.9	-3.6	-4.6	-7.1	-9.4	-12.5	-44.2
Sec. 7053	Part B premium for high-income beneficiaries		0.0	-0.6	-1.3	-2.0	-2.5	-3.0	-3.5	-12.8
	Total, Chapter 3		-5.5	-9.2	-11.7	-15.9	-21.3	-26.7	-33.5	-123.9

TITLE VII--COMMITTEE ON FINANCE
SUBTITLE A--MEDICARE

By fiscal year, in billions of dollars

		1995	1996	1997	1998	1999	2000	2001	2002	7-year savings Total
Chapter 4--Provisions Relating to Medicare Parts A and B										
SubChapter A--General Provisions Relating to Part A and B										
Sec. 7055	Medicare second payer provisions		0.0	0.0	0.0	-1.3	-1.5	-1.7	-1.9	-6.5
SubChapter B--Payments for Home Health Services										
Sec. 7061-7063	Payment for home health services		0.0	-1.4	-2.3	-2.8	-3.3	-3.7	-4.3	-17.8
	Total, Chapter 4		**0.0**	**-1.4**	**-2.3**	**-4.1**	**-4.8**	**-5.5**	**-6.2**	**-24.3**
Chapter 5--Rural Areas										
Sec. 7071	Medicare-dependent small rural hospitals		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Sec. 7072	Medicare rural hospital flexibility		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Sec. 7073	Rural emergency access care hospitals		0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Sec. 7074	Payments to physicians in shortage areas		0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.4
Sec. 7075	Direct fee schedule payments to physician assistants and nurse practitioners		0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.3
	Total, Chapter 5		**0.1**	**0.2**	**0.2**	**0.2**	**0.2**	**0.2**	**0.2**	**1.4**
Chapter 6--Health Care Fraud and Abuse Prevention										
SubChapter A--Fraud and Abuse Control Program										
Sec. 7101-7102	Establishment of fraud and abuse control acount		-0.0	-0.2	-0.4	-0.5	-0.6	-0.7	-0.8	-3.2
Sec. 7111-7114	Expansion of exclusion authority		-0.0	-0.0	-0.0	-0.1	-0.1	-0.1	-0.1	-0.3
Sec. 7115, 7131	Social Security Act civil monetary penalties		-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.5
Sec. 7103, 7141-715	Other		-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.0	-0.1
	Total, Chapter 6		**-0.1**	**-0.3**	**-0.5**	**-0.6**	**-0.8**	**-0.9**	**-1.0**	**-4.2**

TITLE VII--COMMITTEE ON FINANCE
SUBTITLE A--MEDICARE

By fiscal year, in billions of dollars

		1995	1996	1997	1998	1999	2000	2001	2002	7-year savings Total
Total Change in Direct Spending			-8.4	-17.1	-25.3	-36.1	-47.8	-60.3	-75.2	-270.1
CHANGES IN REVENUES										
Chapter 1, Subchapter B										
Sec. 7006-7007	Medicare Choice Accounts		Negligible revenue impact							
Chapter 2, Subchapter A										
Sec. 7018	Extension of Medicare coverage and application of HI tax to all state and local employees		1.1	1.6	1.5	1.5	1.4	1.4	1.3	9.9
Total Change in Revenues			1.1	1.6	1.5	1.5	1.4	1.4	1.3	9.9
Total Effect on Deficit			-9.5	-18.7	-26.8	-37.5	-49.2	-61.7	-76.5	-279.9

TITLE VII--COMMITTEE ON FINANCE
SUBTITLE A--MEDICARE

By fiscal year, in billions of dollars

	1995	1996	1997	1998	1999	2000	2001	2002	7-year savings Total
COMPARISON OF SPENDING UNDER PROPOSAL WITH CURRENT LAW SPENDING									
Gross Mandatory Outlays for Medicare Benefits									
Current Law, BR baseline	177.8	198.6	219.1	240.1	263.0	287.7	314.8	344.8	
Proposed Law	177.8	193.3	206.5	219.7	233.5	249.6	266.9	285.6	
Difference	0.0	-5.4	-12.6	-20.4	-29.5	-38.1	-47.9	-59.2	-213.1
Less: Flat Part B Premiums									
Current Law, BR baseline	-20.1	-20.3	-22.0	-24.5	-26.1	-27.3	-28.7	-30.1	
Proposed Law	-20.1	-23.3	-25.9	-28.1	-30.7	-34.5	-38.1	-42.6	
Difference	0.0	-3.0	-3.9	-3.6	-4.6	-7.1	-9.4	-12.5	-44.2
Less: Income-Related Part B Premiums									
Current Law	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	
Proposed Law	0.0	0.0	-0.6	-1.3	-2.0	-2.5	-3.0	-3.5	
Difference	0.0	0.0	-0.6	-1.3	-2.0	-2.5	-3.0	-3.5	-12.8
Net Mandatory Outlays (excluding administration)									
Current Law	157.7	178.3	197.1	215.6	237.0	260.4	286.1	314.7	
Proposed Law	157.7	169.9	180.0	190.3	200.9	212.6	225.9	239.6	
Change in Net Medicare Outlays	0.0	-8.4	-17.1	-25.3	-36.1	-47.8	-60.3	-75.2	-270.1

TITLE VII--COMMITTEE ON FINANCE
SUBTITLE A--MEDICARE

By fiscal year, in billions of dollars

	1995	1996	1997	1998	1999	2000	2001	2002	7-year savings Total

FOOTNOTES:

/a includes Part A savings

NOTES:

1. These estimates assume an enactment date of November 15, 1995. The estimates would change if the proposal was enacted at a later date.
2. These estimates are based on draft legislative language as of 10/5/95.
3. The estimates do not take into account the "BELT" budget control mechanism.
4. The effects of medical savings acount provision are embodied in the Medicare Choice line. Possible interactions between FEHBP and the MSA provision are not reflected in this estimate.
5. To the extent that health care providers are able to offset lower reimbursements by shifting costs to other payers, federal revenues could fall.
6. These estimates do not incorporate changes in discretionary spending for administration.

Senate Committee on Finance
Subtitle B--Medicaid
Preliminary CBO Staff Estimate

10-Oct-95
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in billions of dollars	1995	1996	1997	1998	1999	2000	2001	2002	7-Year Total
CBO Baseline	89.2	99.3	110.0	122.1	134.8	148.1	162.6	177.8	
Proposed Law Medicaid outlays		94.2	101.0	105.6	110.3	115.3	120.4	125.9	
Proposed Changes		-5.1	-9.0	-16.4	-24.5	-32.9	-42.2	-51.9	-182.0

Notes:

Assumes enactment date of November 15, 1995

Excludes reductions in pool amounts reflecting savings in Medicaid achieved in other subtitles.

COMPARISON OF PROPOSED DIRECT SPENDING CHANGES TO CURRENT LAW
SUBTITLES C - J OF FINANCE RECONCILIATION RECOMMENDATIONS
Preliminary CBO staff estimates

(by fiscal year, in millions of dollars)

	1995	1996	1997	1998	1999	2000	2001	2002
PROJECTED SPENDING UNDER CURRENT LAW								
Family Support Payments a/	18,223	18,544	19,048	19,534	20,132	20,793	21,477	22,184
Food Stamp Program b/	26,245	27,110	28,620	30,164	31,706	33,406	35,035	36,603
Supplemental Security Income	24,322	24,497	29,894	32,967	36,058	42,612	39,287	46,511
Medicaid	89,216	99,292	110,021	122,060	134,827	148,110	162,590	177,786
Foster Care	3,540	4,146	4,508	4,930	5,356	5,809	6,290	6,798
Grants for Drug Treatment	0	0	0	0	0	0	0	0
Earned Income Tax Credit (outlay portion)	17,260	20,392	22,904	23,880	24,938	25,982	26,794	27,546
Social Services Block Grant	2,920	3,190	3,100	2,945	2,840	2,805	2,800	2,800
Total	181,726	197,171	218,095	236,480	255,857	279,517	294,273	320,228
PROPOSED CHANGES								
Family Support Payments a/	0	-395	-642	-972	-1,528	-1,984	-3,525	-4,398
Food Stamp Program b/	0	227	636	754	858	999	1,168	1,384
Supplemental Security Income	0	-298	-3,487	-4,492	-4,699	-5,253	-4,678	-5,384
Medicaid	0	-86	-531	-743	-824	-925	-1,054	-1,255
Foster Care	0	-70	-180	-200	-210	-225	-235	-235
Grants for Drug Treatment	0	0	23	40	27	10	0	0
Earned Income Tax Credit (outlay portion)	0	-214	-4,307	-4,727	-5,165	-5,655	-6,095	-6,428
Social Services Block Grant	0	0	-504	-560	-560	-560	-560	-560
Total	0	-836	-8,992	-10,901	-12,100	-13,593	-14,979	-16,876

PROJECTED SPENDING UNDER FINANCE RECONCILIATION RECOMMENDATIONS

Family Support Payments a/	18,223	18,149	18,406	18,562	18,604	18,809	17,952	17,786
Food Stamp Program b/	26,245	27,337	29,256	30,918	32,564	34,405	36,203	37,987
Supplemental Security Income	24,322	24,199	26,407	28,475	31,359	37,359	34,609	41,127
Medicaid	89,216	99,206	109,490	121,317	134,003	147,185	161,536	176,531
Foster Care	3,540	4,076	4,328	4,730	5,146	5,584	6,055	6,563
Grants for Drug Treatment	0	0	23	40	27	10	0	0
Earned Income Tax Credit (outlay portion)	17,260	20,178	18,597	19,153	19,773	20,327	20,699	21,118
Social Services Block Grant	2,920	3,190	2,596	2,385	2,280	2,245	2,240	2,240
Total	181,726	196,335	209,103	225,580	243,756	265,924	279,294	303,352
CHANGES TO REVENUES	0	58	1,168	1,397	1,617	1,843	2,109	2,470
NET DEFICIT EFFECT	0	-894	-10,160	-12,298	-13,717	-15,436	-17,088	-19,346

Notes:

Assumes Effective Date of November 15, 1995. Estimates will change with later effective date.

Details may not add to totals because of rounding.

a/ Under current law, Family Support Payments includes spending on Aid to Families with Dependent Children (AFDC), AFDC-related child care, administrative costs for child support enforcement, net federal savings from child support collections, and the Job Opportunities and Basic Skills Training program (JOBS). Under proposed law, Family Support Payments would include spending on the Temporary Assistance for Needy Families Block Grant, administrative costs for child support enforcement, and net federal savings from child support collections.

b/ Food Stamps includes Nutrition Assistance for Puerto Rico.

SUMMARY TABLE
FEDERAL BUDGET EFFECTS OF SUBTITLES C- J OF THE FINANCE RECONCILIATION BILL
Preliminary CBO staff estimates

(by fiscal year, in millions of dollars)

10/10/95
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	1996	1997	1998	1999	2000	2001	2002	7 year Total
SUBTITLE C: BLOCK GRANTS FOR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES								
Family Support Payments								
Budget Authority	2,657	-565	-880	-1,321	-1,738	-2,721	-3,216	-7,784
Outlays	176	43	-280	-736	-1,073	-2,412	-3,181	-7,463
Food Stamp Program								
Budget Authority	50	130	230	350	510	710	890	2,870
Outlays	50	130	230	350	510	710	890	2,870
Foster Care Program								
Budget Authority	0	0	0	10	25	35	45	115
Outlays	0	0	0	10	25	35	45	115
Old Age, Survivors, and Disability Insurance Program								
Budget Authority	*	0	0	0	0	0	0	0
Outlays	*	0	0	0	0	0	0	0
Direct Spending Total, All Accounts								
Budget Authority	2,707	-435	-650	-961	-1,203	-1,976	-2,281	-4,799
Outlays	226	173	-50	-376	-538	-1,667	-2,246	-4,478

SUBTITLE D: SUPPLEMENTAL SECURITY INCOME								
Supplemental Security Income								
Budget Authority	-294	-1,384	-1,752	-1,991	-2,339	-2,197	-2,591	-12,548
Outlays	-180	-1,312	-1,772	-1,964	-2,318	-2,176	-2,571	-12,293
Medicaid								
Budget Authority	-8	-80	-89	-108	-117	-125	-136	-663
Outlays	-8	-80	-89	-108	-117	-125	-136	-663
Food Stamps								
Budget Authority	25	162	210	230	260	285	310	1,482
Outlays	25	162	210	230	260	285	310	1,482
Grants for Treatment								
Budget Authority	0	50	50	0	0	0	0	100
Outlays	0	23	40	27	10	0	0	100
Direct Spending Total, All Accounts								
Budget Authority	-277	-1,252	-1,581	-1,869	-2,196	-2,037	-2,417	-11,629
Outlays	-163	-1,207	-1,611	-1,815	-2,165	-2,016	-2,397	-11,374

(continued)

Assumes Effective Date of November 15, 1995. Estimates will change with later effective date.

SUMMARY TABLE (continued)
FEDERAL BUDGET EFFECTS OF SUBTITLES C- J OF THE FINANCE RECONCILIATION BILL
Preliminary CBO staff estimates

(by fiscal year, in millions of dollars) 10/10/95

	1996	1997	1998	1999	2000	2001	2002	7 year Total
SUBTITLE E: CHILD SUPPORT								
Family Support Payments								
Budget Authority	-571	-685	-692	-792	-911	-1,113	-1,217	-5,982
Outlays	-571	-685	-692	-792	-911	-1,113	-1,217	-5,982
Food Stamp Program								
Budget Authority	144	166	169	173	174	168	179	1,174
Outlays	144	166	169	173	174	168	179	1,174
Medicaid								
Budget Authority	-5	-14	-41	-83	-120	-156	-186	-604
Outlays	-5	-14	-41	-83	-120	-156	-186	-604
Supplemental Security Income								
Budget Authority	-5	-10	-20	-35	-45	-40	-45	-200
Outlays	-5	-10	-20	-35	-45	-40	-45	-200
Direct Spending Total, All Accounts								
Budget Authority	-437	-543	-585	-736	-902	-1,141	-1,269	-5,612
Outlays	-437	-543	-585	-736	-902	-1,141	-1,269	-5,612

SUBTITLE F: NONCITZENS								
Supplemental Security Income								
Budget Authority	-113	-2,175	-2,710	-2710	-2,900	-2,472	-2,778	-15,858
Outlays	-113	-2,175	-2,710	-2710	-2,900	-2,472	-2,778	-15,858
Medicaid								
Budget Authority	-73	-438	-614	-634	-689	-774	-934	-4,156
Outlays	-73	-438	-614	-634	-689	-774	-934	-4,156
Food Stamps								
Budget Authority	3	173	135	95	45	-5	-5	441
Outlays	3	173	135	95	45	-5	-5	441
Direct Spending Total, All Accounts								
Budget Authority	-183	-2,440	-3,189	-3,249	-3,544	-3,251	-3,717	-19,573
Outlays	-183	-2,440	-3,189	-3,249	-3,544	-3,251	-3,717	-19,573
SUBTITLE G: MISCELLANEOUS								
Social Services Block Grant								
Budget Authority	0	-560	-560	-560	-560	-560	-560	-3,360
Outlays	0	-504	-560	-560	-560	-560	-560	-3,304
Foster Care								
Budget Authority	-90	-190	-200	-230	-250	-270	-280	-1,510
Outlays	-70	-180	-200	-220	-250	-270	-280	-1,470

(continued)

Assumes Effective Date of November 15, 1995. Estimates will change with later effective date.

SUMMARY TABLE (continued)
FEDERAL BUDGET EFFECTS OF SUBTITLES C- J OF THE FINANCE RECONCILIATION BILL
Preliminary CBO staff estimates

(by fiscal year, in millions of dollars) 10/10/95

	1996	1997	1998	1999	2000	2001	2002	7 year Total
SUBTITLE G: MISCELLANEOUS (cont)								
Supplemental Security Income								
Budget Authority	*	10	10	10	10	10	10	60
Outlays	*	10	10	10	10	10	10	60
Food Stamps								
Budget Authority	5	5	10	10	10	10	10	60
Outlays	5	5	10	10	10	10	10	60
Medicaid								
Budget Authority	*	1	1	1	1	1	1	6
Outlays	*	1	1	1	1	1	1	6
Direct Spending Total, All Accounts								
Budget Authority	-85	-734	-739	-769	-789	-809	-819	-4,744
Outlays	-65	-668	-739	-759	-789	-809	-819	-4,648
SUBTITLE H: EARNED INCOME TAX CREDIT								
Direct Spending Total, All Accounts								
Budget Authority	-214	-4,307	-4,727	-5,165	-5,655	-6,095	-6,428	-32,592
Outlays	-214	-4,307	-4,727	-5,165	-5,655	-6,095	-6,428	-32,592
Revenues	58	1,168	1,397	1,617	1,843	2,109	2,460	10,652

SUBTITLE I: DEBT LIMIT								
Direct Spending Total, All Accounts								
Budget Authority	0	0	0	0	0	0	0	0
Outlays	0	0	0	0	0	0	0	0
SUBTITLE J: CORRECTION OF COST OF LIVING ADJUSTMENTS								
Direct Spending Total, All Accounts								
Budget Authority	0	0	0	0	0	0	0	0
Outlays	0	0	0	0	0	0	0	0
TOTALS: SUBTITLES C - J								
Direct Spending								
Budget Authority	1,511	-9,711	-11,471	-12,749	-14,289	-15,309	-16,931	-78,949
Outlays	-836	-8,992	-10,901	-12,100	-13,593	-14,979	-16,876	-78,277
Revenues	58	1,168	1,397	1,617	1,843	2,109	2,460	10,652

Notes:
Assumes Effective Date of November 15, 1995. Estimates will change with later effective date.
Components may not sum to totals because of rounding
* Indicates figures below $500,000.

Statutory Language of Provisions Approved by the Committee on September 29, 1995

TITLE VII—COMMITTEE ON FINANCE

SEC. 7000. REFERENCES; TABLE OF CONTENTS.

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

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

(c) TABLE OF CONTENTS OF SUBTITLES A THROUGH J.—The table of contents of subtitles A through J of this title is as follows:

Subtitle A—Medicare

CHAPTER 1—MEDICARE CHOICE PLANS

Subchapter A—Establishment of Medicare Choice Plans

SEC. 7001. MEDICARE CHOICE PLANS.

(a) Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new part:

"PART D—MEDICARE CHOICE PLANS

"Subpart 1—Definitions

"SEC. 1895A. DEFINITIONS.

"(a) MEDICARE CHOICE PLAN.—In this part—

"(1) IN GENERAL.—The term 'medicare choice plan' means an eligible health plan with respect to which there is a contract in effect under this part to provide health benefits coverage to medicare choice eligible individuals.

"(2) MEDICARE CHOICE PLAN SPONSOR.—The terms 'medicare choice plan sponsor' and 'plan sponsor' mean a public or private entity which establishes or maintains a medicare choice plan.

"(b) TERMS RELATING TO HEALTH PLANS.—In this part:

"(1) ELIGIBLE HEALTH PLAN.—

"(A) IN GENERAL.—The term 'eligible health plan' means a policy, contract, or plan which is capable of providing health benefits coverage of items and services pro-

vided under the traditional medicare program to medicare choice eligible individuals.

"(B) TYPES OF INSURANCE.—The term 'eligible health plan' shall include any of the following types of plans of health insurance:

"(i) INDEMNITY OR FEE-FOR-SERVICE PLANS.—Private indemnity plans that reimburse hospitals, physicians, and other providers on the basis of a privately determined fee schedule.

"(ii) COORDINATED CARE PLANS.—Private managed or coordinated care plans which provide health care services through an integrated network of providers, including—

"(I) qualified health maintenance organizations as defined in section 1310(d) of the Public Health Service Act; and

"(II) preferred provider organization plans, point of service plans, provider-sponsored network plans, or other coordinated care plans.

"(iii) HIGH DEDUCTIBLE PLAN IN CONNECTION WITH MEDICARE MEDICAL SAVINGS ACCOUNT.—A high deductible health plan that—

"(I) requires an individual to pay a minimum annual per person deductible for insured medical expenses equal to at least $3,000;

"(II) has an annual limit on the aggregate deductible, coinsurance, and copayments an individual is required to pay for insured medical expenses which does not exceed $6,000; and

"(III) is operated in connection with a medicare choice account described in section 137(b) of the Internal Revenue Code of 1986.

"(iv) OTHER HEALTH CARE PLANS.—Any other private plan for the delivery of health care items and services that is not described in clause (i), (ii), or (iii).

"(2) UNION OR ASSOCIATION PLAN.—

"(A) IN GENERAL.—The term 'union or association plan' means an eligible health plan with a union sponsor, a Taft-Hartley sponsor, or a qualified association sponsor that—

"(i) is organized for purposes other than to market a health plan;

"(ii) may not condition its membership on health status, health claims experience, receipt of health care, medical history, or lack of evidence of insurability of a potential member;

"(iii) may not exclude a member or spouse of a member from health plan coverage based on factors described in clause (ii);

"(iv) is a permanent entity which receives a substantial majority of its financial support from active members; and

"(v) may not be owned or controlled by an insurance company.

"(B) UNION SPONSOR.—The term 'union sponsor' means an employee organization that establishes or maintains an eligible health plan other than pursuant to a collective bargaining agreement.

"(C) TAFT-HARTLEY SPONSOR.—The term 'Taft-Hartley sponsor' means, with respect to a group health plan established or maintained by 2 or more employees or jointly by 1 or more employees and 1 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.

"(D) QUALIFIED ASSOCIATION SPONSOR.—The term 'qualified association sponsor' 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) which establishes or maintains an eligible health plan.

"(E) TERMS.—In this paragraph, the terms 'employee', '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.

"(c) OTHER DEFINITIONS.—In this part:

"(1) AREAS.—

"(A) MEDICARE PAYMENT AREA.—

"(i) IN GENERAL.—Except as provided in clause (ii), the term 'medicare payment area' means—

"(I) a metropolitan statistical area (whether or not such area is in a single State) or in the case of a consolidated metropolitan statistical area, each primary metropolitan statistical area within the consolidated area; or

"(II) one area within each State composed of all areas that do not fall within a metropolitan statistical area.

"(ii) GEOGRAPHIC ADJUSTMENT.—Upon request of a State, the Secretary may make a geographic adjustment to a medicare payment area otherwise determined under clause (i).

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

"(B) MEDICARE SERVICE AREA.—

"(i) IN GENERAL.—Except as provided in clause (ii), the term 'medicare service area' means a medicare payment area.

"(ii) GEOGRAPHIC ADJUSTMENT.—The Secretary may designate a medicare service area other than a medicare payment area for a medicare choice plan if the Secretary determines that such designation would not result in the enrollment of enrollees in the plan in such area which are substantially nonrepresentative,

as determined in accordance with regulations of the Secretary, of the population in the medicare payment area.

"(2) MEDICARE CHOICE ELIGIBLE INDIVIDUAL.—

"(A) IN GENERAL.—The term 'medicare choice eligible individual' means an individual who is entitled to benefits under part A and enrolled under part B.

"(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—Such term shall not include an individual medically determined to have end-stage renal disease, except that an individual who develops end-stage renal disease while enrolled in a medicare choice plan may continue to be enrolled in that plan. Not later than December 31, 1999, the Secretary shall submit to the Congress recommendations on expanding the definition of 'medicare choice eligible individual' to include individuals with end-stage renal disease and the enrollment of such individuals in medicare choice plans.

"(3) TRADITIONAL MEDICARE PROGRAM.—The term 'traditional medicare program' means the program of benefits available to individuals entitled to benefits under part A and enrolled under part B of this title, other than enrollment in a medicare choice plan under this part.

"Subpart 2—Entitlement of Medicare Choice Eligible Individuals to Health Care Choices

"SEC. 1895B. ENTITLEMENT TO MEDICARE CHOICES.

"Each medicare choice eligible individual is entitled to choose to receive health care items and services covered under parts A and B—

"(1) through the traditional medicare program; or

"(2) by receiving payments toward the individual's enrollment in a medicare choice plan under this part.

"SEC. 1895C. ENROLLMENT PROCEDURES.

"(a) IN GENERAL.—Except as provided in section 1895G(a)(2), each medicare choice eligible individual shall be entitled to enroll in any medicare choice plan with a medicare service area including the geographic area in which the individual resides during—

"(1) the annual open enrollment period described in section 1895G(b)(1); or

"(2) any other enrollment period described in section 1895G(b)(2) applicable to the individual.

"(b) METHOD OF ENROLLMENT AND DISENROLLMENT.—

"(1) NOTICE PROVIDED TO THE SECRETARY.—Each medicare choice eligible individual desiring to enroll or terminate enrollment in a medicare choice plan shall provide the Secretary with notice of such enrollment or disenrollment during any enrollment period applicable to the individual. The Secretary shall, to the extent feasible, provide for the receipt of such notice by telephone, through the mail, and in person at local social security offices.

"(2) INFORMATION FORWARDED TO THE PLAN.—The Secretary shall promptly provide each medicare choice plan with

notice of an individual's enrollment or disenrollment with the plan.

"(c) NOTICES TO INDIVIDUALS TO ASSIST IN ENROLLMENT.—

"(1) OPEN SEASON NOTIFICATION.—

"(A) MAILING OF NOTICE.—By September 30 of each year beginning after 1995, the Secretary shall mail a notice of eligibility to each medicare choice eligible individual and each individual entitled to benefits under part A prior to the end of the annual open enrollment period described in section 1895G(b)(1).

"(B) NOTICE DESCRIBED.—The notice described in subparagraph (A) shall include an informational brochure that includes the information described in this section, and any other information that the Secretary determines will assist the individual's enrollment decision.

"(2) NOTIFICATION TO NEWLY MEDICARE CHOICE ELIGIBLE INDIVIDUALS.—With respect to an individual who becomes eligible to enroll in a medicare choice plan during the period described in section 1895G(b)(2)(A) and to whom paragraph (1) does not apply, the Secretary shall, not later than 2 months before the date on which the individual becomes eligible, mail to the individual the notice of eligibility described in paragraph (1).

"(d) SECRETARY'S MATERIALS; CONTENTS.—The notice and informational materials mailed by the Secretary under subsection (c) shall be written and formatted in the most easily understandable manner possible, and shall include, at a minimum, the following:

"(1) GENERAL INFORMATION.—General information with respect to coverage under this part during the next calendar year, including—

"(A) the part B premium rates that will be charged for part B coverage,

"(B) the deductible, copayment, and coinsurance amounts for coverage under the traditional medicare program,

"(C) a description of the coverage under the traditional medicare program and any changes in coverage under the program from the prior year,

"(D) a description of the individual's medicare payment area, and the standardized medicare payment amount available with respect to such individual,

"(E) information and instructions on how to enroll in a medicare choice plan,

"(F) the right of each medicare choice plan sponsor by law to terminate or refuse to renew its contract and the effect the termination or nonrenewal of its contract may have on individuals enrolled with the medicare choice plan under this part, and

"(G) to the extent available, quality indicators for the traditional medicare program and each medicare choice plan, including—

"(i) disenrollment rates for medicare enrollees for the previous 2 years (excluding disenrollment due to

death or moving outside the plan's medicare service area);, and

"(ii) information on medicare enrollee satisfaction and health outcomes.

"(2) PLAN-SPECIFIC INFORMATION.—Information for the next calendar year for each medicare choice plan in the individual's medicare payment area, including—

"(A) the plan's medicare service area,

"(B) the enrollee's rights to benefits under the plan, including—

"(i) covered items and services,

"(ii) deductible, coinsurance, and copayment amounts, and

"(iii) the enrollee's liability for payment amounts billed in excess of the plan's fee schedule,

"(C) the extent to which enrollees may select the providers of their choice (from within or outside the plan's network of providers if applicable) and the restrictions (if any) on the plan's payment for services furnished to the enrollees by other than the plan's participating providers,

"(D) out-of-area coverage provided by the plan,

"(E) coverage of emergency services and urgently needed care,

"(F) appeal rights of enrollees, including the right to address grievances to the Secretary or the applicable external review entity,

"(G) whether the plan is out-of-compliance with any requirements of this part (as determined by the Secretary),

"(H) the plan's premium price submitted under section 1895N(a)(1) and an indication of the difference between such premium price and the standardized medicare payment amount, and

"(I) optional supplemental coverage available from the plan, including—

"(i) the supplemental items and services covered, and

"(ii) the premium price for the optional supplemental benefits.

"(e) ASSISTANCE.—

"(1) AGREEMENTS WITH COMMISSIONER OF SOCIAL SECURITY.—In order to promote the efficient administration of this section and this part, 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 under this section.

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

"(3) PLANS.—Each medicare choice plan sponsor shall provide such information as the Secretary requests with respect to a medicare choice plan in order to carry out activities under subsection (d).

"SEC. 1895D. EFFECT OF ENROLLMENT.

"(a) PREMIUM DIFFERENTIALS.—If a medicare choice eligible individual enrolls in a medicare choice plan, the individual—

"(1) shall receive a rebate in the amount determined under section 1895N(b) if the plan's premium is less than the standardized medicare payment amount; and

"(2) shall be required to pay the plan's premium in excess of the standardized medicare payment amount.

"(b) PERIOD OF ENROLLMENT.—

"(1) ANNUAL ENROLLMENT PERIOD.—An individual enrolling in a medicare choice plan during the annual open enrollment period under section 1895G(b)(1) shall be enrolled in the plan for the calendar year following the open enrollment period.

"(2) SPECIAL ENROLLMENT PERIODS.—An individual enrolling in a plan under section 1895G(b)(2) shall be enrolled in the plan for the portion of the calender year on and after the date on which the enrollment becomes effective (as specified by the Secretary).

"(3) TERMINATIONS.—

"(A) IN GENERAL.—Except as otherwise provided in this subsection, an individual may not terminate enrollment in a medicare choice plan before the next annual open enrollment period applicable to the individual.

"(B) QUALIFYING EVENTS.—Notwithstanding subparagraph (A), an individual may terminate enrollment in a medicare choice plan if—

"(i) the individual moves to a new medicare service area, or

"(ii) the individual has experienced a qualifying event (as determined by the Secretary).

"(C) FOR CAUSE.—Notwithstanding subparagraph (A), an individual may terminate enrollment in a medicare choice plan if the plan fails to meet quality or capacity standards or for other cause as determined by the Secretary.

"(D) TERMINATION AFTER INITIAL ENROLLMENT.—An individual may terminate enrollment in a medicare choice plan within 90 days of the individual's initial enrollment in such medicare choice plan and enroll in another medicare choice plan or the traditional medicare program.

"(4) SEAMLESS ENROLLMENT.—If a medicare choice eligible individual is enrolled in a medicare choice plan under this part and such individual fails to provide the Secretary with notice of the individual's enrollment or disenrollment under section 1895C(b)(1) during any open enrollment period applicable to the individual, the individual shall be deemed to have reenrolled in the plan.

"(5) SPECIAL RULES FOR HIGH DEDUCTIBLE PLANS.—In the case of a high deductible plan described in section 1895A(b)(1)(B)(iii) operated in connection with a medicare choice account, an individual may not terminate enrollment in the plan (other than under paragraph (3) (B), (C), or (D)) with-

out at least 12 months notice given during the annual open enrollment period under section 1895G(b)(1).

"(6) SPECIAL RULES FOR UNION, TAFT-HARTLEY, OR ASSOCIATION PLANS.—The Secretary shall establish special enrollment rules for the enrollment of individuals in medicare choice plans that are union or association-sponsored health plans described in section 1895A(b)(2).

"(c) SOLE PAYMENTS.—Subject to subsections (d)(2) and (e) of section 1895H, payments under a contract to a medicare choice plan under section 1895O and for rebates under section 1895N(b) shall be instead of the amounts which (in the absence of the contract) would be otherwise payable under the traditional medicare program for items or services furnished to individuals enrolled with the plan under this section.

"Subpart 3—Medicare Choice Plan Requirements

"SEC. 1895G. AVAILABILITY AND ENROLLMENT.

"(a) GENERAL AVAILABILITY.—

"(1) IN GENERAL.—Except as provided in paragraph (2), each medicare choice plan sponsor shall provide that each medicare choice eligible individual shall be eligible to enroll under this part in a medicare choice plan of the sponsor during an enrollment period applicable to such individual if the plan's medicare service area includes the geographic area in which the individual resides.

"(2) EXCEPTIONS.—

"(A) ACCEPTANCE TO LIMITS OF CAPACITY.—Each medicare choice plan sponsor shall provide that, at any time during which enrollments are accepted, the plan sponsor will accept medicare choice eligible individuals in the order in which they apply for enrollment up to the limits of the medicare choice plan's capacity (as determined by the Secretary) and without restrictions, except as may be authorized in regulations. The preceding sentence shall not apply if it would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the medicare population in the medicare service area of the plan.

"(B) UNION, TAFT-HARTLEY, OR ASSOCIATION HEALTH PLAN.—A medicare choice plan sponsor of a union or association plan described in section 1895A(b)(2) shall limit its enrollment to members of the sponsoring group who are entitled to all rights and privileges of any other members of the group and spouses of such members. An association plan which is sponsored by a religious fraternal benefit society may limit membership to individuals who share the same religious convictions as the society.

"(b) ENROLLMENT PERIODS.—

"(1) ANNUAL OPEN ENROLLMENT PERIOD.—Each medicare choice plan sponsor shall offer an annual open enrollment period in November of each year for the enrollment and termination of enrollment of medicare choice eligible individuals for the next year.

"(2) ADDITIONAL PERIODS.—Each medicare choice plan sponsor shall accept the enrollment of an individual in the medicare choice plan—

"(A) during the initial medicare enrollment period specified by section 1837 that applies to the individual (effective as specified by section 1838), and

"(B) during the period specified by the Secretary following any termination of the enrollment of the individual in a medicare choice plan under subparagraph (B), (C), or (D) of section 1895D(b)(3).

"(c) PLAN PARTICIPATION IN ENROLLMENT PROCESS.—

"(1) IN GENERAL.—In addition to any informational materials distributed by the Secretary under section 1895C(c), a medicare choice plan sponsor may develop and distribute marketing materials and engage in marketing strategies in accordance with this subsection.

"(2) PLAN MARKETING AND ADVERTISING STANDARDS.—Any marketing material developed or distributed by a medicare choice plan sponsor and any marketing strategy developed by such plan sponsor—

"(A) shall accurately describe differences between health care coverage available under the plan and the health care coverage available under the traditional medicare program,

"(B) shall be pursued in a manner not intended to violate the nondiscrimination requirement of section 1895J(e)(1), and

"(C) shall not contain false or materially misleading information, and shall conform to any other fair marketing and advertising standards and requirements applicable to such plans under law.

"(3) PRIOR APPROVAL BY SECRETARY.—

"(A) IN GENERAL.—No marketing materials may be distributed by a medicare choice plan sponsor to (or for the use of) individuals eligible to enroll with the plan under this part unless—

"(i) at least 45 days before its distribution, the plan has submitted the material to the Secretary for review, and

"(ii) the Secretary has not disapproved the distribution of the material.

"(B) REVIEW.—The Secretary shall review all marketing materials submitted under guidelines established by the Secretary and shall disapprove such material if the Secretary determines, in the Secretary's discretion, that the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.

"(C) DEEMED APPROVAL.—If marketing material has been submitted under subparagraph (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 the materials under subparagraph (B) with respect to an area, the Secretary is

deemed not to have disapproved such distribution in all areas covered by the plan.

"SEC. 1895H. BENEFITS PROVIDED TO INDIVIDUALS.

"(a) BASIC BENEFITS.—Each medicare choice plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI—

"(1) those items and services covered under parts A and B of this title which are available to individuals residing in the medicare service area of the plan, and

"(2) additional health services as the Secretary may approve.

The Secretary shall approve any such additional health care services which the plan proposes to offer to such members, unless the Secretary determines that including such additional services will substantially discourage enrollment by medicare choice eligible individuals with the plan.

"(b) SUPPLEMENTAL BENEFITS.—Each medicare choice plan may offer optional supplemental benefits to each individual enrolled in the plan under this part for an additional premium amount. If the supplemental benefits are offered only to individuals enrolled in the sponsor's plan under this part, the additional premium amount shall be the same for all enrolled individuals in the medicare payment area. Such benefits may be marketed and sold by the medicare choice plan sponsor outside of the enrollment process described in section 1895D(b).

"(c) COST-SHARING.—

"(1) ENROLLEE COST-SHARING UNDER CHOICE PLAN MAY NOT EXCEED MEDICARE ENROLLEE COST.—Except as provided in paragraph (2), in no event may the average total amount of deductibles, coinsurance, and copayments charged an individual under a medicare choice plan with respect to basic benefits described in subsection (a)(1) for a year exceed the average total amount of deductibles, coinsurance, and copayments charged an individual under the traditional medicare program for a year.

"(2) HIGH DEDUCTIBLE PLANS.—Subparagraph (A) shall not apply to a high deductible plan described in section 1895A(b)(1)(B)(iii).

"(3) DETERMINATION ON OTHER BASIS.—If the Secretary determines that adequate data are not available to determine the average amount under paragraph (1), the Secretary may determine such amount with respect to all individuals in the medicare payment area, the State, or in the United States, eligible to enroll in such plan under this part or on the basis of other appropriate data.

"(d) NATIONAL COVERAGE DETERMINATION.—If there is a national coverage determination made in the period beginning on the date of an announcement under section 1895M(a) and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to the medicare choice plan of providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the de-

termination of the medicare payment amount included in the announcement made at the beginning of such period—

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

"(2) if such coverage determination provides for coverage of additional benefits or coverage under additional circumstances, section 1895I(b)(2) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period,

unless otherwise required by law.

"(e) OVERLAPPING PERIODS OF COVERAGE.—A contract under this part shall provide that 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) enrollment with a medicare choice plan under this part—

"(A) payment for such services until the date of the individual's discharge shall be made under this title as if the individual were not enrolled with the plan,

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

"(C) the plan sponsor shall nonetheless be paid the full amount otherwise payable to the plan under this part, or

"(2) termination of enrollment with a medicare choice plan under this part—

"(A) the plan sponsor 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), and

"(C) the plan sponsor shall not receive any payment with respect to the individual under this part during the period the individual is not enrolled.

"(f) ORGANIZATION AS SECONDARY PAYER.—Notwithstanding any other provision of law, a medicare choice plan sponsor may (in the case of the provision of services to an individual under this part under circumstances in which payment 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 the law, plan, or policy which is the primary payer under such circumstances—

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

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

"SEC. 1895L. LICENSING AND FINANCIAL REQUIREMENTS.

"(a) LICENSING REQUIREMENT.—

"(1) IN GENERAL.—A medicare choice plan sponsor shall be organized and licensed under applicable State law as a risk-

bearing entity eligible to offer health insurance or health benefits coverage in each State in which the medicare choice plan enrolls individuals under this part.

"(2) EXCEPTION FOR UNION, TAFT-HARTLEY, OR ASSOCIATION PLANS.—Paragraph (1) shall not apply to a union or association plan described in section 1895A(b)(2) if such plan is exempt from such requirements under the Employee Retirement Income Security Act of 1974.

"(3) COORDINATED CARE PLANS.—Paragraph (1) shall apply to a coordinated care plan except to the extent provided in section 1895R.

"(b) ASSUMPTION OF FULL FINANCIAL RISK.—A medicare choice plan sponsor shall assume full financial risk on a prospective basis for the provision of health care services for which benefits are required to be provided under section 1895H(a)(1), except that such plan sponsor may—

"(1) obtain insurance or make other arrangements for the cost of such health care services the aggregate value of which exceeds $5,000 in any year,

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

"(3) 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) 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.

"(c) PROTECTION AGAINST RISK OF INSOLVENCY.—

"(1) IN GENERAL.—A medicare choice plan sponsor shall make adequate provision against the risk of insolvency (including provision to prevent enrollees from being held liable to any person or entity for the plan sponsor's debts in the event of the plan sponsor's insolvency)—

"(A) as determined by the Secretary, or

"(B) as determined by a State which the Secretary determines requires solvency standards at least as stringent as the standards under subparagraph (A).

"(2) FACTORS TO CONSIDER.—In establishing standards under paragraph (1) for coordinated care plans described in section 1895A(b)(1)(B)(ii), the Secretary shall consult with interested parties and shall take into account—

"(A) a coordinated care plan sponsor's delivery system assets and its ability to provide services directly to enrollees through affiliated providers, and

"(B) alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters

of credit, guarantees, organizational insurance coverage, and partnerships with other licensed entities.

The Secretary is not required to include alternative means described in subparagraph (B) in the standards but may consider such alternatives where consistent with the standards.

"(d) PAYMENTS TO THE PLAN.—

"(1) PREPAID PAYMENT.—A medicare choice plan sponsor shall be compensated (except for deductibles, coinsurance, and copayments) for the provision of health care services to individuals enrolled under this part by a payment by the Secretary (and if applicable, the individual) 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.

"(2) SOLE PAYMENTS.—Subject to subsections (d)(2) and (e) of section 1895H, if an individual is enrolled under this part with a medicare choice plan, only the plan sponsor shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.

"SEC. 1895J. HEALTH PLAN STANDARDS.

"(a) IN GENERAL.—Each medicare choice plan sponsor shall meet the requirements of this section.

"(b) QUALITY ASSURANCE AND ACCREDITATION.—

"(1) INTERNAL REVIEW.—

"(A) IN GENERAL.—Each medicare choice plan sponsor must establish an ongoing quality assurance program (in accordance with regulations established by the Secretary) for health care services it provides to such individuals.

"(B) ELEMENTS OF PROGRAM.—The quality assurance program established under subparagraph (A) shall—

"(i) stress health outcomes,

"(ii) provide for the establishment of written protocols for utilization review, based on current standards of medical practice,

"(iii) provide review by physicians and other health care professionals of the process followed in the provision of such health care services,

"(iv) monitor and evaluate high-volume and high-risk services and the care of acute and chronic conditions,

"(v) evaluate the continuity and coordination of care that enrollees receive,

"(vi) have mechanisms to detect both underutilization and overutilization of services,

"(vii) after identifying areas for improvement, establish or alter practice parameters,

"(viii) take action to improve quality and assess the effectiveness of such action through systematic followup,

"(ix) make available information on quality and outcomes measures to facilitate beneficiary comparison and choice of health coverage options (in such form

and on such quality and outcomes measures as the Secretary determines to be appropriate), and

"(x) provide that the program is evaluated on an ongoing basis as to its effectiveness.

"(2) EXTERNAL REVIEW.—

"(A) IN GENERAL.—Each medicare choice plan sponsor shall, for each medicare choice plan it operates, have an agreement with an independent quality review and improvement organization approved by the Secretary.

"(B) FUNCTIONS OF ORGANIZATION.—Each independent quality review and improvement organization with an agreement under subparagraph (A) shall—

"(i) provide an alternative mechanism for addressing enrollee grievances,

"(ii) review plan performance based on accepted quality performance criteria,

"(iii) promote and make plans accountable for improved plan performance,

"(iv) integrate into ongoing external quality assurance activities a new set of quality indicators and standards developed specifically for the medicare population that would be used to determine whether a plan is providing quality care and appropriate continuity and coordination of care, and

"(v) report to the Secretary on those plans that have demonstrated unwillingness or inability to improve their performance.

"(3) ACCREDITATION.—Each medicare choice plan sponsor shall be required—

"(A) to meet accreditation standards established by the Secretary, or

"(B) to be accredited by an external independent accrediting organization, recognized by the Secretary as requiring standards at least as stringent as the standards established under subparagraph (A).

"(4) ENCOUNTER DATA.—The Secretary shall create incentives for medicare choice plan sponsors to report aggregate encounter data, including data on physician visits, nursing home days, home health days, hospital inpatient days, and rehabilitation services.

"(c) ACCESS.—Each medicare choice plan sponsor shall—

"(1) make the services described in section 1895H(a) (and such other health care services as such individuals have contracted for)—

"(A) available and accessible to each such individual, within the medicare service area of the plan, with reasonable promptness, and in a manner which assures continuity, and

"(B) when medically necessary, available and accessible 24 hours a day and 7 days a week,

"(2) provide for reimbursement with respect to such services which are provided to such an individual other than through the plan's providers, if—

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

"(B) it was not reasonable given the circumstances to obtain the services through the plan's providers,

"(3) provide access to appropriate providers, including credentialed specialists, for all medically necessary treatment and services, and

"(4) except as provided by the Secretary on a case-by-case basis, in the case of a coordinated care plan described in section 1895A(b)(1)(B)(ii), provide primary care services within 30 minutes or 30 miles from an enrollee's place of residence if the enrollee resides in a rural area.

"(d) CAPACITY.—Each medicare choice plan sponsor shall provide the Secretary with a demonstration of the plan's capacity to adequately service the plan's expected enrollment of individuals under this part.

"(e) CONSUMER PROTECTIONS.—

"(1) NONDISCRIMINATION.—Each medicare choice plan sponsor shall provide assurances to the Secretary that it will not deny enrollment to, expel, or refuse to reenroll any such individual because of the individual's health status or requirements for health care services, and that it will notify each such individual of such fact at the time of the individual's enrollment. A medicare choice plan sponsor may not cancel or refuse to renew a beneficiary except in the case of fraud or nonpayment of premium amounts due the plan.

"(2) GRIEVANCE PROCEDURES.—

"(A) IN GENERAL.—Each medicare choice plan sponsor shall provide meaningful procedures for hearing and resolving grievances between the plan (including any entity or individual through which the plan provides health care services) and members enrolled with the plan under this part.

"(B) HEARING REQUIREMENT.—A member enrolled with a medicare choice plan under this part who is dissatisfied by reason of his failure to receive any health service to which he believes he is entitled and at no greater charge than he believes he 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 plan sponsor a party. If the amount in controversy is $1,000 or more, the individual or plan sponsor 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 plan sponsor 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.

"(C) EXPEDITED REVIEW.—The Secretary shall provide an expedited review procedure under subparagraph (B) where a failure to receive any health care service or payment for such service would result in significant harm.

"(3) SUPPLEMENTAL COVERAGE IF PLAN TERMINATES THE CONTRACT.—Each medicare choice plan sponsor that provides items and services pursuant to a contract under this part shall provide assurances to the Secretary that in the event the contract is terminated, the sponsor shall provide or arrange for supplemental coverage of benefits under this title related to a preexisting condition with respect to any exclusion period, to all individuals enrolled with the entity who receive benefits under this title, for the lesser of 6 months or the duration of such period.

"(f) PROMPT PAYMENT.—

"(1) IN GENERAL.—Each medicare choice plan sponsor shall provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for services and supplies furnished to individuals pursuant to such contract, if the services or supplies are not furnished under a contract between the plan and the provider or supplier.

"(2) DIRECT PAYMENT.—In the case of a medicare choice plan sponsor which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with paragraph (1), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for such covered services furnished to individuals enrolled under this part under the contract. If the Secretary provides for such direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the plan sponsor under this part to reflect the amount of the Secretary's payments (and costs incurred by the Secretary in making such payments).

"(g) ADVANCE DIRECTIVES.—A contract under this part shall provide that a medicare choice plan sponsor shall meet the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).

"Subpart 4—Determination of Medicare Payment Amounts and Rebates

"SEC. 1895M. MEDICARE PAYMENT AMOUNTS.

"(a) IN GENERAL.—Not later than July 31 of each calendar year (beginning with 1996), the Secretary shall determine, and announce in a manner intended to provide notice to interested parties, a standardized medicare payment amount determined in accordance with this section for the following calendar year for each medicare payment area.

"(b) CALCULATION OF STANDARDIZED MEDICARE PAYMENT AMOUNTS.—For purposes of this part—

"(1) 1997.—

"(A) IN GENERAL.—The standardized medicare payment amount for calendar year 1997 for a medicare payment area shall be equal to the sum of—

"(i) 50 percent of the modified per capita rate for calendar year 1996, and

"(ii) 50 percent of the adjusted average national per capita rate for calendar year 1996,

increased by the percentage increase in the gross domestic product per capita for the 12-month period ending on June 30, 1996.

"(B) MODIFIED PER CAPITA RATE.—For purposes of subparagraph (A)(i), the modified per capita rate for calendar year 1996 for a medicare payment area shall be equal to the per capita rate which would have been determined (without regard to class) under section 1876(a)(1)(C) for 1995 if—

"(i) the applicable geographic area were the medicare payment area, and

"(ii) 50 percent of any payments attributable to sections 1886(d)(5)(B), 1886(h), and 1886(d)(5)(F) (relating to IME, GME, and DSH payments) were not taken into account,

increased by the percentage increase which the Secretary estimates will occur in medicare expenditures per capita for 1996 over medicare expenditures per capita for 1995.

"(C) ADJUSTED AVERAGE NATIONAL PER CAPITA RATE.—

"(i) IN GENERAL.—For purposes of subparagraph (A)(ii), the adjusted average national per capita rate for a medicare payment area for calendar year 1996 shall be equal to the sum, for all types of medicare services (as classified by the Secretary), of the product for each such type of—

"(I) the average national per capita rate for 1996,

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

"(III) an index that reflects for 1996 and that type of service the relative input price of such services in the medicare payment area as compared to the national average input price of such services.

In applying subclause (III), the Secretary shall apply those indices that are used in applying (or updating) medicare payment rates for specific areas and localities.

"(ii) AVERAGE NATIONAL PER CAPITA RATE.—For purposes of clause (i), the average national per capita rate for 1996 is the weighted average of the modified per capita rates determined under subparagraph (B) for all medicare payment areas for 1996.

"(2) SUCCEEDING YEARS.—

"(A) IN GENERAL.—The standardized medicare payment amount for any calendar year after 1997 in a medicare payment area shall be an amount equal to the standardized medicare payment amount determined for such area for the preceding year, increased by the percentage increase in the gross domestic product per capita for the

12-month period ending on June 30 of the preceding calendar year.

"(B) SPECIAL RULE FOR 1998.—In applying subparagraph (A) for 1998, the standardized medicare payment amount for the preceding calendar year shall be the amount which would have been determined if clause (ii) of paragraph (1)(B) had been applied by substituting '100 percent' for '50 percent'.

"(3) SPECIAL RULE FOR INDIVIDUALS WITH END-STAGE RENAL DISEASE.—In computing the standardized medicare payment amount for any medicare payment area, there shall not be taken into account any individuals with end-stage renal disease or any medicare expenditures for such individuals.

"(c) ADJUSTMENTS FOR PAYMENTS TO PLAN SPONSORS.—

"(1) IN GENERAL.—The rate of payment under section 1895O to a medicare choice plan sponsor with respect to any individual enrolled in a medicare choice plan of the sponsor shall be equal to the standardized medicare payment amount for the medicare payment area, adjusted for such risk factors as age, disability status, gender, institutional status, health status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence.

"(2) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish a separate rate of payment under section 1895O to a medicare choice plan sponsor with respect to any individual with end-stage renal disease enrolled in a medicare choice plan of the sponsor. Such rate of payment shall be actuarially equivalent to rates paid to other enrollees in the medicare payment area (or such other area as specified by the Secretary).

"(d) GEOGRAPHICAL ADJUSTMENTS.—

"(1) ANNUAL ADJUSTMENTS.—

"(A) IN GENERAL.—Unless Congress provides otherwise, beginning with calendar years after 1999, the Secretary shall, based on the analysis under paragraph (2) and to the extent the Secretary determines necessary, make annual differential adjustments to the standardized medicare payment amounts determined under subsection (b)(2) for calendar years 2000 and 2001 in a manner designed to achieve appropriate and equitable variation in standardized medicare payment amounts across medicare payment areas by calendar year 2002. Such variation shall be reasonably related to measurable geographic differences in medicare payment areas.

"(B) BUDGET NEUTRALITY.—The Secretary shall adjust the standardized medicare payment amounts under subsection (b) in a manner that ensures that total payments under this section for a year are not greater or less than total payments under this section would have been but for the application of subparagraph (A).

"(2) ANALYSIS.—The Secretary, in consultation with interested parties, shall conduct an analysis of the measurable input cost differences across medicare payment areas, including wage differentials, and other measurable variables identified by the Secretary. The Secretary shall also determine the degree to which medicare beneficiaries, including beneficiaries in rural and underserved areas, have access to more health plan choices by calendar year 2000 under this part, and the extent to which standardized medicare payment amounts have limited or enhanced such choices.

"(3) REPORT TO CONGRESS.—Not later then March 1, 1999, the Secretary shall submit a report to the appropriate committees of Congress that includes the results of the analysis described in paragraph (2) and the annual differential adjustments that the Secretary intends to implement under paragraph (1) for calendar years 2000 and 2001.

"(e) NOTICE IN CHANGES TO BENEFIT ASSUMPTIONS.—

"(1) IN GENERAL.—At least 45 days before making the announcement under subsection (a) for a year (beginning with the announcement for 1998), the Secretary shall provide for notice to medicare choice plans 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 plans an opportunity to comment on such proposed changes.

"(2) EXPLANATION.—In each announcement made under subsection (a) for a year (beginning with the announcement for 1998), 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 medicare choice plans can compute medicare payment rates under subsection (d) for classes of individuals located in each medicare payment area which is in whole or in part within the medicare service area of such a plan.

"(f) DEMONSTRATION PROJECT ON MARKET-BASED REIMBURSEMENT AND COMPETITIVE PRICING.—The Secretary shall establish 1 or more demonstration projects to determine the standardized medicare payment amounts described in subsection (b) through competitive bidding by medicare choice plans in a medicare payment area. Not later then December 31, 2001, the Secretary shall submit a report to the Congress on the success of such projects in determining standardized medicare payment amounts that are reflective of market price.

"SEC. 1895N. PREMIUMS AND REBATES.

"(a) SUBMISSION AND CHARGING OF PREMIUMS.—

"(1) IN GENERAL.—Each medicare choice plan sponsor shall file with the Secretary each year, in a form and manner and at a time specified by the Secretary, the amount of the monthly premium for coverage under each medicare choice plan it offers under this part in each medicare payment area in which the plan is being offered.

"(2) UNIFORM PREMIUM.—The premiums charged by a medicare choice plan sponsor under this part may not vary among individuals who reside in the same medicare payment area.

"(3) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each medicare choice plan sponsor shall permit the payment of monthly premiums on a monthly basis.

"(b) REBATES.—

"(1) IN GENERAL.—If the standardized medicare payment amount for the medicare payment area in which an individual resides exceeds the amount of the monthly premium for the plan in which the individual is enrolled (as submitted under subsection (a)(1)), the Secretary shall—

"(A) in the case of an individual—

"(i) who is enrolled in a high deductible health plan described in section 1895A(b)(1)(B)(iii), deposit 100 percent of such excess in the medicare choice account specified by the individual, or

"(ii) who is not so enrolled but who elects the application of this clause, deposit 100 percent of such excess in the medicare choice account specified by the individual; or

"(B)(i) pay to the medicare choice plan sponsor on behalf of such individual the monthly amount equal to 100 percent of such excess up to the amount of the premium amount of such individual for supplemental benefits described in section 1895H(b),

"(ii) pay to such individual an amount equal to 75 percent of the remainder of such excess, and

"(iii) deposit the remainder of such excess in the Federal Hospital Insurance Trust Fund.

"(2) TIME FOR PAYMENT.—

"(A) IN GENERAL.—A rebate under paragraph (1)(B)(ii) shall be paid as of the close of the calendar year to which the enrollment applied.

"(B) DEPOSITS IN MEDICARE CHOICE ACCOUNTS.—Deposits described in paragraph (1)(A) shall be made on a monthly basis.

"(C) OTHER PAYMENTS AND DEPOSITS.—Payments and deposits described in subparagraphs (B)(i) and (iii) shall be made on a monthly basis.

"(3) SOURCE OF REBATES.—Deposits and payments described in paragraph (1) shall be made in the same manner as payments are made under section 1895O(b).

"SEC. 1895O. PAYMENTS TO PLAN SPONSORS.

"(a) MONTHLY PAYMENTS.—

"(1) IN GENERAL.—For each individual enrolled with a plan under this part, the Secretary shall make monthly payments in advance to the medicare choice plan sponsor of the medicare choice plan with which the individual is enrolled in an amount equal to the medicare payment rate determined with respect to such individual under section 1895M(c).

"(2) RETROACTIVE ADJUSTMENTS.—The amount of payment under this paragraph may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled in the plan under this section and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

"(b) PAYMENTS FROM TRUST FUNDS.—The payment to a medicare choice plan sponsor under this section for a medicare-eligible individual shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under parts A and B are representative of the actuarial value of the total benefits under this part.

"Subpart 5—Contractual Authority; Temporary Certification; Regulations

"SEC. 1895P. GENERAL PERMISSION TO CONTRACT.

"The Secretary shall enter into a contract with any medicare choice plan sponsor in a medicare payment area if the requirements of this part are met with respect to the medicare choice plan and the plan sponsor.

"SEC. 1895Q. RENEWAL AND TERMINATION OF CONTRACT.

"(a) IN GENERAL.—Except as provided in subsection (b), each contract under this part 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.

"(b) TERMINATION FOR CAUSE.—

"(1) IN GENERAL.—In accordance with procedures established under paragraph (2), the Secretary may terminate any contact with a medicare choice plan sponsor at any time or may impose the intermediate sanctions described in paragraph (2) or (3) or subsection (f) (whichever is applicable) on the plan sponsor, if the Secretary finds that the plan sponsor—

"(A) has failed substantially to carry out the contract,

"(B) is carrying out the contract in a manner substantially inconsistent with the efficient and effective administration of this part, or

"(C) no longer substantially meets the applicable conditions of this part.

"(2) PROCEDURES.—The Secretary may terminate a contract with a medicare choice plan sponsor under this part or may impose the intermediate sanctions described in subsection (f)(3) on the plan in accordance with formal investigation and compliance procedures established by the Secretary under which—

"(A) the Secretary first provides the medicare choice plan sponsor with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1) and the medicare choice plan sponsor fails to develop or implement such a corrective action plan,

"(B) in deciding whether to impose sanctions, the Secretary considers aggravating factors such as whether a plan sponsor has a history of deficiencies or has not taken action to correct deficiencies the Secretary has brought to the plan sponsor's attention,

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

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

"(c) TERMS OF CONTRACT.—Each contract under this part—

"(1) 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 plan sponsor when there is reasonable evidence of some need for such inspection,

"(B) shall have the right to audit and inspect any books and records of the plan sponsor that pertain—

"(i) to the ability of the plan sponsor to bear the risk of potential financial losses, and

"(ii) shall require the plan sponsor with a contract 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 under this part with the plan sponsor,

"(C)(i) except as provided by the Secretary, shall require the plan sponsor to comply with requirements similar to the requirements of subsections (a) and (c) of section 1318 of the Public Health Service Act (relating to disclosure of certain financial information) and section 1301(c)(8) of such Act (relating to liability arrangements to protect members),

"(ii) shall require the plan sponsor to provide and supply information (described in section 1866(b)(2)(C)(ii)) in the manner such information is required to be provided or supplied under that section, and

"(iii) shall require the plan sponsor to notify the Secretary of loans and other special financial arrangements which are made between the plan sponsor and subcontractors, affiliates, and related parties, and

"(D) shall contain such other terms and conditions not inconsistent with this part (including requiring the plan sponsor to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

"(d) 5-YEAR LOCKOUT.—The Secretary may not enter into a contract under this part with a medicare choice plan sponsor if a previous contract with that plan sponsor under this part was terminated at the request of the plan sponsor within the preceding 5-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

"(e) APPLICATION OF OTHER FEDERAL LAWS.—The authority vested in the Secretary by this part may be performed without re-

gard 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.

"(f) REMEDIES FOR FAILURE TO COMPLY.—

"(1) FAILURE OF PLAN SPONSOR TO COMPLY WITH CONTRACT.—If the Secretary determines that a medicare choice plan sponsor—

"(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, and the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual,

"(B) imposes cost sharing on individuals enrolled under this part in excess of the cost sharing 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 plan 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 section, or

"(ii) to an individual or to any other entity under this section,

"(F) fails to comply with the requirements of section 1895J(f), 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 subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under 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 section after the date the Secretary notifies the plan sponsor 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 plan sponsor under this section for individuals enrolled after the date the Secretary notifies the plan sponsor 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) INTERMEDIATE SANCTIONS.—In the case of a medicare choice plan sponsor for which the Secretary makes a determination under subsection (b)(1) the basis of which is not described in subparagraph (A) thereof, the Secretary may apply the following intermediate sanctions:

"(A) Civil money penalties of not more than $25,000 for each determination under subsection (b)(1) 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 plan'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 (b)(2) during which the deficiency that is the basis of a determination under subsection (b)(1) exists.

"(C) Suspension of enrollment of individuals under this section after the date the Secretary notifies the plan sponsor of a determination under subsection (b)(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.

"(4) PROCEEDINGS.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under paragraph (2)(A) or (3)(A) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

"SEC. 1895R. TEMPORARY CERTIFICATION PROCESS FOR COORDINATED CARE PLANS.

"(a) FEDERAL ACTION ON CERTIFICATION.—

"(1) IN GENERAL.—If—

"(A) a State fails to substantially complete action on a licensing application of a coordinated care plan sponsor within 90 days of receipt of the completed application, or

"(B) a State denies a licensing application and the Secretary determines that the State's licensing standards or review process create an unreasonable barrier to market entry,

the Secretary shall evaluate such application pursuant to the procedures established under subsection (b).

"(2) UNREASONABLE BARRIERS TO MARKET ENTRY.—A State's licensing standards and review process shall not be

treated as unreasonable barriers to market entry under paragraph (1) if—

"(A) they are applied consistently to all coordinated care medicare choice plan applications,

"(B) are not directly in conflict, or inconsistent with, the Federal standards.

"(b) FEDERAL CERTIFICATION PROCEDURES.—

"(1) IN GENERAL.—The Secretary shall establish a process for certification of a coordinated care plan and its sponsor as meeting the requirements of this part in cases described in subsection (a)(1).

"(2) REQUIREMENTS.—Such process shall—

"(A) set forth the standards for certification,

"(B) provide that final action will be taken on an application for certification within 120 business days of receipt of the completed application,

"(C) provide that State law and regulations shall apply to the extent they have not been found to be an unreasonable barrier to market entry under subsection (a)(1)(B), and

"(D) require any person receiving a certificate to provide the Secretary with all reasonable information in order to ensure compliance with the certification.

"(3) EFFECT OF CERTIFICATIONS.—

"(A) IN GENERAL.—A certificate under this section shall be issued for not more than 36 months and may not be renewed.

"(B) COORDINATION WITH STATE.—A person receiving a certificate under this section shall continue to seek State licensure under subsection (a) during the period the certificate is in effect.

"(C) SUNSET.—No certificate shall be issued under this section after December 31, 2000, and no certificate under this section shall remain in effect after December 31, 2001.

"(c) REPORT.—Not later than December 31, 1998, the Secretary shall report to Congress on the temporary Federal certification system under subsection (b), including an analysis of State efforts to adopt licensing standards and review processes that take into account the fact that coordinated care plan sponsors provide services directly to enrollees through affiliated providers.

"(d) COORDINATED CARE PLAN.—In this section, the term 'coordinated care plan' means a plan described in section 1895A(b)(1)(B)(ii).

"(e) TRANSITION RULE FOR CERTAIN RISK CONTRACTORS.—A medicare choice plan sponsor that is an eligible organization (as defined in section 1876(b)) and that—

"(1) has a risk-sharing contract in effect under section 1876 as of the date of the enactment of this part, or

"(2) has an application for such a contract filed before such date and the contract is entered into before July 1, 1996,

shall be treated as meeting the Federal standards in effect under this section for any contract year beginning before January 1, 2000.

"(f) PARTIAL CAPITATION DEMONSTRATION.—The Secretary shall conduct a demonstration on alternative partial risk-sharing ar-

rangements between the Secretary and health care providers. The Secretary shall report to Congress no later than December 31, 1998, on the administrative feasibility of such partial capitation methods and the information necessary to implement such arrangements.

"SEC. 1895S. REGULATIONS.

"(a) IN GENERAL.—The Secretary shall establish such regulations as may be necessary to carry out the purposes of this part, including regulations setting forth the requirements to meet all quality, access, and solvency standards specified in sections 1895I and 1895J.

"(b) USE OF INTERIM, FINAL REGULATIONS.—In order to carry out the provisions of this part in a timely manner, the Secretary may, within 120 days after the date of the enactment of this part, promulgate regulations described in subsection (a) that take effect on an interim basis, after notice and opportunity for public comment."

(b) COORDINATION WITH FEHBP.—Notwithstanding any provision of part D of title XVIII of the Social Security Act (as added by subsection (a)), individuals who are enrolled in a health benefit plan under chapter 89 of title 5, United States Code, shall not be eligible to enroll in high deductible medicare choice plans described in section 1895A(b)(1)(B)(iii) of such Act until such time as the Director of the Office of Management and Budget certifies to the Secretary of Health and Human Services that the Office of Personnel Management has adopted policies which will ensure that the enrollment of such individuals in such plans will not result in increased expenditures for the Federal Government for health benefit plans under such chapter.

(c) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this chapter.

(2) OTHER AMENDMENTS.—(A) Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended—

(i) in the matter preceding clause (i), by inserting "or medicare choice plan under part D" after "eligible organization", and

(ii) in clause (i), by inserting "or under a contract under part D, " after "1972,".

(B) Section 1882(g)(1) (42 U.S.C. 1395ww(g)(1)) is amended in the first sentence by inserting ", or under a medicare choice plan under part D" before the end period.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contracts effective on and after January 1, 1997.

SEC. 7002. TREATMENT OF 1876 ORGANIZATIONS.

(a) TERMINATION OF 1876 RISK-SHARING ORGANIZATIONS.—Section 1876 (42 U.S.C. 1395mm) is amended by adding at the end the following new subsection:

"(k)(1) Except as provided in paragraph (2), this section shall not apply to risk-sharing contracts effective for contract years beginning on or after January 1, 1997.

"(2) An individual who is enrolled in part B only and is enrolled in an eligible organization with a risk-sharing contract under this section on December 31, 1996, may continue enrollment in such organization. Not later then July 1, 1996, the Secretary shall issue regulations relating to such individuals and such organizations."

(b) HMO LIMITS LIFTED.—Section 1301(b) of the Public Health Service Act (42 U.S.C. 300e(b)) is amended by adding at the end the following new paragraph:

"(6)(A) Effective January 1, 1997, if a member certifies that a medicare choice account has been established for the benefit of such member, a health maintenance organization may reduce the basic health services payment otherwise determined under paragraph (1) by requiring the payment of a deductible by the member for basic health services.

"(B) For purposes of this paragraph, the term 'medicare choice account' has the meaning given such term by section 7705 of the Internal Revenue Code of 1986."

SEC. 7003. SPECIAL RULE FOR CALCULATION OF PAYMENT RATES FOR 1996.

(a) IN GENERAL.—Notwithstanding any other provision of law, the per capita rate under section 1876 of the Social Security Act for 1996 for any class for a geographic area shall be equal to the sum of—

(1) 75 percent of the updated per capita rate for such class for such area, and

(2) 25 percent of the weighted average of the updated per capita rates for such class for all geographic areas, adjusted in the same manner as under section 1895M(b)(1)(C)(i) of the Social Security Act (as added by section 7001 of this Act) to reflect differences in input prices in the geographic area as compared to the national average input prices.

In no event shall any average per capita rate in a geographic area determined under the preceding sentence be less than such rate determined under section 1876 of such Act for 1995.

(b) UPDATED PER CAPITA RATES.—For purposes of subsection (a), the updated per capita rate for any class is the per capita rate of payment for 1995 determined under section 1876(a)(1)(C) of the Social Security Act for a county (or equivalent area), increased by the percentage increase which the Secretary estimates will occur in medicare expenditures per capita for 1996 over medicare expenditures per capita for 1995.

(c) PUBLICATION.—The Secretary shall publish the rates determined under subsection (a) no later than 30 days after the date of the enactment of this Act.

Subchapter B—Tax Provisions Relating to Medicare Choice Plans

SEC. 7006. MEDICARE CHOICE ACCOUNTS.

(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. MEDICARE CHOICE ACCOUNTS.

"(a) EXCLUSION.—

"(1) IN GENERAL.—Gross income shall not include any payment to the medicare choice account of an individual by the Secretary of Health and Human Services under section 1895N(b)(1) of the Social Security Act.

"(2) NO CONSTRUCTIVE RECEIPT.—No amount shall be included in the gross income of an individual solely because the individual may choose between—

"(A) the payment described in paragraph (1) or a rebate under section 1895N(b) of the Social Security Act, or

"(B) the payment of the individual's premium for supplemental benefits described in section 1895H(b) of such Act or such a rebate.

"(b) DEFINITIONS.—For purposes of this section—

"(1) MEDICARE CHOICE ACCOUNT.—The term 'medicare choice account' means a trust created or organized in the United States exclusively for the purpose of paying qualified medical expenses, 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 1895N(b)(1) 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 beneficiary, amounts paid by such beneficiary—

"(i) for medical care (as defined in section 213(d)) for—

"(I) the account beneficiary, or

"(II) the spouse of the account beneficiary if the spouse is entitled to benefits under part A of title XVIII of the Social Security Act and enrolled under part B of such title,

but only to the extent such amounts are not compensated for by insurance or otherwise, or

"(ii) for qualified long-term care services for the account beneficiary or such spouse.

"(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—Subparagraph (A) shall not apply to any payment for insurance other than insurance providing coverage for qualified long-term care services.

"(C) QUALIFIED LONG-TERM CARE SERVICES.—The term 'qualified long-term care services' means necessary diagnostic, preventive, therapeutic, rehabilitative, and maintenance (including personal care) services which are required by an individual during any period during which such individual is a functionally impaired individual (as determined in the manner prescribed by the Secretary).

"(3) ACCOUNT BENEFICIARY.—

"(A) IN GENERAL.—The term 'account beneficiary' means the individual on whose behalf the medicare choice account is maintained.

"(B) JOINT ACCOUNTS.—If married individuals are both enrolled in a medicare choice plan, they may establish a joint account and each spouse shall be treated as an account beneficiary.

"(4) MEDICARE CHOICE PLAN.—The term 'medicare choice plan' has the meaning given such term by section 1895A(a) of the Social Security Act.

"(5) 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 medicare choice account is exempt from taxation under this subtitle unless such account has ceased to be a medicare choice account by reason of paragraph (2). Notwithstanding the preceding sentence, any such account 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 medicare choice accounts, 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) IN GENERAL.—Any amount paid or distributed out of a medicare choice account to an account beneficiary which is

used exclusively to pay qualified medical expenses shall not be includible in gross income. Any amount paid or distributed out of a medicare choice account to an account beneficiary which is not used exclusively to pay qualified medical expenses shall be included in the gross income of the account beneficiary.

"(2) PENALTY FOR DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—The tax imposed by this chapter on an account beneficiary for any taxable year in which there is a payment or distribution to the account beneficiary from a medicare choice account which is not used exclusively to pay the qualified medical expenses shall be increased by 10 percent of the amount of such payment or distribution.

"(B) EXCEPTIONS.—Subparagraph (A) shall not apply if the payment or distribution is made on or after the date the account beneficiary—

"(i) becomes disabled within the meaning of section 72(m)(7), or

"(ii) dies.

"(C) SPECIAL RULES.—For purposes of subparagraph (A)—

"(i) all medicare choice accounts of the account beneficiary shall be treated as 1 account,

"(ii) all payments and distributions not used exclusively to pay qualified medical expenses 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 medicare choice account to the Secretary of Health and Human Services of an erroneous contribution to such account 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 medicare choice account of an account beneficiary to another medicare choice account of such account beneficiary.

"(5) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of section 213, any payment or distribution out of a medicare choice account for qualified medical expenses shall not be treated as an expense paid for medical care.

"(e) TREATMENT OF ACCOUNT AFTER DEATH OF ACCOUNT BENEFICIARY.—

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

"(A) IN GENERAL.—In the case of an account beneficiary's interest in a medicare choice account which is payable to (or for the benefit of) such beneficiary's spouse upon the death of such beneficiary, such account shall be treated as a medicare choice account 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 account, other than payments attributable to periods before such date, and

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

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

"(A) such account shall cease to be a medicare choice account 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 beneficiary, in such person's gross income for the taxable year which includes such date, or

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

"(f) REPORTS.—

"(1) IN GENERAL.—The trustee of a medicare choice account shall make such reports regarding such account to the Secretary and to the account beneficiary with respect to—

"(A) the fair market value of the assets in such account 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 beneficiary—

"(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 MEDICARE CHOICE ACCOUNTS 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. MEDICARE CHOICE ACCOUNTS.

"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 medicare choice account (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:

"(5) SPECIAL RULE FOR MEDICARE CHOICE ACCOUNTS.—An individual for whose benefit a medicare choice account (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 medicare choice account 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 medicare choice account described in section 137(b), or

"(E) 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 MEDICARE CHOICE ACCOUNTS.—

(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), and

"(B) section 137(f) (relating to medicare choice accounts)."

(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) EXCEPTION FROM CAPITALIZATION OF POLICY ACQUISITION EXPENSES.—Subparagraph (B) of section 848(e)(1) of such Code (defining specified insurance contract) is amended by striking "and" at the end of clause (ii), by striking the period at the end of clause

(iii) and inserting ", and", and by adding at the end the following new clause:

"(iv) any contract which is a medicare choice account (as defined in section 137(b))."

(f) 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. Medicare choice accounts.
"Sec. 138. Cross references to other Acts."

(2) The table of sections for 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. Medicare choice accounts."

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

SEC. 7007. CERTAIN REBATES INCLUDED IN GROSS INCOME.

(a) IN GENERAL.—Section 61(a) of the Internal Revenue Code of 1986 (defining gross income) is amended by striking "and" at the end of paragraph (14), by striking the period at the end of paragraph (15) and inserting "; and", and by adding at the end the following new paragraph:

"(16) Payments under section 1895N(b)(1)(B)(ii) of the Social Security Act."

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

CHAPTER 2—PROVISIONS RELATING TO PART A

Subchapter A—General Provisions Relating to Part A

SEC. 7011. PPS HOSPITAL PAYMENT UPDATE.

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 new subclauses:

"(XI) for fiscal years 1996 through 2002 for hospitals in all areas, the greater of—

"(aa) the market basket percentage increase minus 2.5 percentage points, or

"(bb) 1.1 percent (1.3 percent for discharges during fiscal year 1996 and 1.2 percent for discharges during fiscal year 1997), and

"(XII) for fiscal year 2003 and each subsequent fiscal year for hospitals in all areas, the market basket percentage increase.".

SEC. 7012. PPS-EXEMPT HOSPITAL PAYMENTS.

(a) UPDATE.—

(1) IN GENERAL.—Section 1886(b)(3)(B)(ii) (42 U.S.C. 1395ww(b)(3)(B)(ii)) is amended—

(A) in subclause (V)—

(i) by striking "1997" and inserting "1995", and

(ii) by striking "and" at the end,

(B) by redesignating subclause (VI) as subclause (VII); and

(C) by inserting after subclause (V), the following subclause:

"(VI) for fiscal years 1996 through 2002—

"(aa) the market basket percentage increase minus the applicable reduction (as defined in clause (vi)(II)),

"(bb) in the case of a hospital for a fiscal year for which the hospital's update adjustment percentage (as defined in clause (vi)(I)) is at least 10 percent, the market basket percentage increase, or

"(cc) in the case of a hospital for which 150 percent of the hospital's allowable operating costs of inpatient hospital services recognized under this title for the most recent cost reporting period for which information is available is less than the hospital's target amount (as determined under subparagraph (A)) for such cost reporting period, 0 percent,

except that the applicable percentage increase determined under item (aa) or (bb) may not be less than 1.4 percent for fiscal year 1996, 1.3 percent for fiscal year 1997, and 1.1 percent for fiscal years 1998 through 2002, and".

(2) DEFINITIONS.—Section 1886(b)(3)(B) (42 U.S.C. 1395ww(b)(3)(B)) is amended by adding at the end the following new clause:

"(vi) For purposes of clause (ii)(VI)—

"(I) a hospital's 'update adjustment percentage' for a fiscal year is the percentage by which the hospital's allowable operating costs of inpatient hospital services recognized under this

title for the most recent cost reporting period for which information is available exceeds the hospital's target amount (as determined under subparagraph (A)) for such cost reporting period, and

"(II) the 'applicable reduction' with respect to a hospital for a fiscal year is 2.5 percentage points, reduced by 0.25 percentage point for each percentage point (if any) the hospital's update adjustment percentage for the fiscal year is less than 10 percentage points.".

(3) EFFECT OF PAYMENT REDUCTION ON EXCEPTIONS AND ADJUSTMENTS.—Section 1886(b)(4)(A)(ii) (42 U.S.C. 1395ww(b)(4)(A)(ii)) is amended by striking "paragraph (3)(B)(ii)(V)" and inserting "subclause (V) or (VI) of paragraph (3)(B)(ii)".

(b) TARGET AMOUNTS FOR NEW REHABILITATION HOSPITALS AND LONG-TERM CARE HOSPITALS.—Section 1886(b)(3)(A) (42 U.S.C. 1395ww(b)(3)(A)) is amended—

(1) by redesignating clauses (i) and (ii) as subclauses (I) and (II), respectively;

(2) by inserting "(i)" after "(3)(A)"; and

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

"(ii) Notwithstanding clause (i), in the case of a rehabilitation hospital (or unit thereof) which first receives payments under this section—

"(I) on or before October 1, 1995, the target amount determined under this subparagraph for such hospital or unit for a cost reporting period beginning during a fiscal year shall not be less than 50 percent of the national mean of the target amounts determined under this paragraph for all rehabilitation hospitals (and units thereof) for cost reporting periods beginning during such fiscal year (determined without regard to this clause); and

"(II) on or after October 1, 1995, such target amount may not be greater than 130 percent of the national mean of the target amounts for such hospitals (and units thereof) for cost reporting periods beginning during fiscal year 1991.

"(iii) Notwithstanding clause (i), in the case of a hospital which has an average inpatient length of stay of greater than 25 days—

"(I) which first receives payments under this section as a hospital that is not a subsection (d) hospital (as defined in section 1886(d)(1)(B)) or a subsection (d) Puerto Rico hospital (as defined in section 1886(d)(9)(A)) on or before October 1, 1995, the target amount determined under this subparagraph for such hospital for a cost reporting period beginning during a fiscal year shall not be less than 50 percent of the national mean of the target amounts determined under this paragraph for all such hospitals for cost reporting periods beginning during such fiscal year (determined without regard to this clause); and

"(II) which first receives payment under this section as a hospital described in subclause (I) on or after October 1, 1995, such target amount may not be greater than 130 percent of such national mean of the target amounts for such hospitals for cost reporting periods beginning during fiscal year 1991.

"(iv) The Secretary shall, if the Secretary determines it is appropriate, calculate and implement a separate ceiling under clause (iii)(II) based on case-mix and DRG category.".

(c) DEVELOPMENT NATIONAL PROSPECTIVE PAYMENT RATES FOR CURRENT NON-PPS HOSPITALS.—

(1) IN GENERAL.—The Secretary of Health and Human Services, in consultation with the Prospective Payment Assessment Commission, appropriate providers of services, health plans, and other experts, shall develop a proposal to replace the current system under which hospitals that are not subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act) receive payment for the operating and capital-related costs of inpatient hospital services under part A of the medicare program with a prospective payment system.

(2) DEVELOPMENT OF SYSTEM FOR REHABILITATION AND LONG TERM CARE HOSPITALS.—

(A) IN GENERAL.—Not later then June 1, 1996, the Secretary of Health and Human Services shall submit a report to the Congress providing recommendations on a prospective payment system for rehabilitation hospitals (and units thereof) and hospitals which have an average inpatient length of stay of greater than 25 days.

(B) MATTERS INCLUDED.—The report submitted under subparagraph (A) shall include—

(i) the available and preferred systems of classifying rehabilitation patients relative to duration and intensity of inpatient services;

(ii) the means of calculating medicare program payments to reflect such patient requirements;

(iii) other adjustments deemed appropriate such as geographic variations in wages and other costs and outliers;

(iv) a schedule upon which it is deemed feasible to introduce a prospective payment system for such providers and whether any such system should be applied to other types of providers of rehabilitation services; and

(v) any other matters the Secretary determines are relevant including recommendations for other types of hospitals that are not subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act).

(d) CAPITAL 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) 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.".

SEC. 7013. CAPITAL PAYMENTS FOR PPS HOSPITALS.

(a) IN GENERAL.—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 Balanced Budget Reconciliation 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 the date of the enactment of such Act).".

(b) BUDGET NEUTRALITY ADJUSTMENT.—

(1) IN GENERAL.—The second sentence of section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended—

(A) by striking "fiscal years 1992 through 1995" and inserting "fiscal years 1996 through 2002"; and

(B) by striking "10 percent" and inserting "15 percent".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply on and after October 1, 1995.

(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 subparagraph:

"(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 Balanced Budget Reconciliation 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 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 as lessee of land, buildings, or fixed equipment from a lessor that is unrelated to the hospital 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 subparagraph:

"(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 re-

gard 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 80 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 by September 1, 1995, and

"(II) by September 1, 1995, the hospital has expended on the project at least $750,000 or 10 percent of the estimated cost of the project.

"(iv) Offsetting amounts, as described in 42 CFR 412.348(g)(8)(ii), shall apply except that subparagraph (B) of such section shall be revised to require that the additional payment that would otherwise be payable for the cost reporting period shall be reduced by the amount (if any) by which the hospital's current year medicare capital payments (excluding, if applicable, 75 percent of the hospital's capital-related disproportionate share payments) exceeds its medicare capital costs for such year.".

(2) LIMIT TO ADDITIONAL PAYMENTS.—The amendment made by subsection (a) shall not result in aggregate additional payments under the special exception process described in section 1886(b)(1)(D) for fiscal years 1996 through 2000 in excess of an amount equal to the sum of $50,000,000 per year more than would have been paid in such fiscal years if such amendment had not been enacted.

(3) CONFORMING AMENDMENT.—Section 1886(g)(1)(B) (42 U.S.C. 1395ww(g)(1)(B)) is amended by striking "may provide" and inserting "shall provide (in accordance with subparagraph (D)".

SEC. 7014. DISPROPORTIONATE SHARE HOSPITAL PAYMENTS.

(a) IN GENERAL.—Section 1886(d)(5)(F)(ii) (42 U.S.C. 1395ww(d)(5)(F)(ii)) is amended—

(1) by striking "The" and inserting "Subject to clause (ix), the";

(2) by redesignating subclauses (I) and (II) as items (aa) and (bb), respectively;

(3) by inserting "(I)" after "(ii)";

(4) by inserting "the applicable percentage determined under subclause (II) of the amount" after "discharge shall be";

(5) by adding at the end the following new subclause:

"(II) For purposes of subclause (I), the applicable percentage for discharges occurring during a fiscal year is 95 percent in fiscal year 1996, 90 percent in fiscal year 1997, 85 percent in fiscal year 1998, 80 percent in fiscal year 1999, and 75 percent in fiscal years 2000, 2001, and 2002."; and

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

"(ix) With respect to discharges occurring on or after October 1, 1995, the Secretary shall adjust the additional payment amounts provided in accordance with this subparagraph for each discharge such that the total amount of such additional payment amounts for discharges occurring over the 7-year period beginning on October 1, 1995, does not exceed an average 5 percent of the sum of the total estimated payments under this subsection over such 7-year period (other than payments under subparagraph (B) or this subparagraph).".

(b) NO RESTANDARDIZATION OF PAYMENT AMOUNTS REQUIRED.—Section 1886(d)(2)(C)(iv) (42 U.S.C. 1395ww(d)(2)(C)(iv)) is amended by striking "1990" and inserting ", 1990, and the modifications made to such paragraph by section 7014(a) of the Balanced Budget Reconciliation Act of 1995.".

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to discharges occurring on or after October 1, 1995.

SEC. 7015. INDIRECT MEDICAL EDUCATION PAYMENTS.

(a) IN GENERAL.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended to read as follows:

"(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor is equal to c × (((1+r) to the nth power) − 1), where 'r' is the ratio of the hospital's full-time equivalent interns and residents to beds and 'n' equals .405. For discharges occurring on or after—

"(I) May 1, 1986, and before October 1, 1995, 'c' is equal to 1.89;

"(II) October 1, 1995, and before October 1, 1996, 'c' is equal to 1.65;

"(III) October 1, 1996, and before October 1, 1997, 'c' is equal to 1.38; and

"(IV) October 1, 1997, and before October 1, 2001, 'c' is equal to 1.11.".

(b) NO RESTANDARDIZATION OF PAYMENT AMOUNTS REQUIRED.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by striking "of 1985" and inserting "of 1985, but not taking into account the amendments made by section 7015(a) of the Balanced Budget Reconciliation Act of 1995".

SEC. 7016. GRADUATE MEDICAL EDUCATION AND DISPROPORTIONATE SHARE PAYMENT ADJUSTMENTS FOR MEDICARE CHOICE.

Section 1886 (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

"(j) GRADUATE MEDICAL EDUCATION AND DISPROPORTIONATE SHARE PAYMENT ADJUSTMENTS FOR MEDICARE CHOICE.—

"(1) IN GENERAL.—For discharges occurring on or after January 1, 1997, a subsection (d) hospital shall receive payment for each discharge of an individual enrolled under part D with a medicare choice plan in an amount equal to the applicable percentage of the amount that the hospital would have received for such discharge under subsections (d)(5)(B), (relating to indirect medical education), (d)(5)(F) (relating to disproportionate share), and (h) (relating to direct graduate medi-

cal education), if such individual was enrolled in the traditional medicare program (as defined in section 1895A(c)(3)).

"(2) APPLICABLE PERCENTAGE.—For purposes of paragraph (1), the applicable percentage is—

"(A) for calendar year 1997, 50 percent; and

"(B) for calendar years after 1997, 100 percent.".

SEC. 7017. PAYMENTS FOR HOSPICE SERVICES.

Section 1814(i)(1)(C)(ii) (42 U.S.C. 1395f(i)(1)(C)(ii)) is amended by striking subclauses (IV), (V), and (VI), and inserting the following subclauses:

"(IV) for each of fiscal years 1996 through 2002, the greater of—

"(aa) the market basket percentage increase for the fiscal year minus 2.5 percentage points, or

"(bb) 1.1 percent (1.3 percent in fiscal year 1996 and 1.2 percent in fiscal year 1997); and

"(V) for a subsequent fiscal year, the market basket percentage increase for the fiscal year.".

SEC. 7018. EXTENDING MEDICARE COVERAGE OF, AND APPLICATION OF HOSPITAL INSURANCE TAX TO, ALL STATE AND LOCAL GOVERNMENT EMPLOYEES.

(a) IN GENERAL.—

(1) APPLICATION OF HOSPITAL INSURANCE TAX.—Section 3121(u)(2) of the Internal Revenue Code of 1986 is amended by striking subparagraphs (C) and (D).

(2) COVERAGE UNDER MEDICARE.—Section 210(p) (42 U.S.C. 410(p)) is amended by striking paragraphs (3) and (4).

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to services performed after December 31, 1995.

(b) TRANSITION IN BENEFITS FOR STATE AND LOCAL GOVERNMENT EMPLOYEES AND FORMER EMPLOYEES.—

(1) IN GENERAL.—

(A) EMPLOYEES NEWLY SUBJECT TO TAX.—For purposes of sections 226, 226A, and 1811 of the Social Security Act, in the case of any individual who performs services during the calendar quarter beginning January 1, 1996, the wages for which are subject to the tax imposed by section 3101(b) of the Internal Revenue Code of 1986 only because of the amendments made by subsection (a), the individual's medicare qualified State or local government employment (as defined in subparagraph (B)) performed before January 1, 1996, shall be considered to be "employment" (as defined for purposes of title II of such Act), but only for purposes of providing the individual (or another person) with entitlement to hospital insurance benefits under part A of title XVIII of such Act for months beginning with January 1996.

(B) MEDICARE QUALIFIED STATE OR LOCAL GOVERNMENT EMPLOYMENT DEFINED.—In this paragraph, the term "medicare qualified State or local government employment" means medicare qualified government employment described in section 210(p)(1)(B) of the Social Security Act

(determined without regard to section 210(p)(3) of such Act, as in effect before its repeal under subsection (a)(2)).

(2) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Federal Hospital Insurance Trust Fund from time to time such sums as the Secretary of Health and Human Services deems necessary for any fiscal year on account of—

(A) payments made or to be made during such fiscal year from such Trust Fund with respect to individuals who are entitled to benefits under title XVIII of the Social Security Act solely by reason of paragraph (1),

(B) the additional administrative expenses resulting or expected to result therefrom, and

(C) any loss in interest to such Trust Fund resulting from the payment of those amounts, in order to place such Trust Fund in the same position at the end of such fiscal year as it would have been in if this subsection had not been enacted.

(3) INFORMATION TO INDIVIDUALS WHO ARE PROSPECTIVE MEDICARE BENEFICIARIES BASED ON STATE AND LOCAL GOVERNMENT EMPLOYMENT.—

Section 226(g) (42 U.S.C. 426(g)) is amended—

(A) by redesignating paragraphs (1) through (3) as subparagraphs (A) through (C), respectively,

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

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

"(2) The Secretary, in consultation with State and local governments, shall provide procedures designed to assure that individuals who perform medicare qualified government employment by virtue of service described in section 210(a)(7) are fully informed with respect to (A) their eligibility or potential eligibility for hospital insurance benefits (based on such employment) under part A of title XVIII, (B) the requirements for, and conditions of, such eligibility, and (C) the necessity of timely application as a condition of becoming entitled under subsection (b)(2)(C), giving particular attention to individuals who apply for an annuity or retirement benefit and whose eligibility for such annuity or retirement benefit is based on a disability."

(c) TECHNICAL AMENDMENTS.—

(1) Subparagraph (A) of section 3121(u)(2) of the Internal Revenue Code of 1986 is amended by striking "subparagraphs (B) and (C)," and inserting "subparagraph (B),".

(2) Subparagraph (B) of section 210(p)(1) (42 U.S.C. 410(p)(1)) is amended by striking "paragraphs (2) and (3)." and inserting "paragraph (2)."

(3) Section 218 (42 U.S.C. 418) is amended by striking subsection (n).

(4) The amendments made by this subsection shall apply after December 31, 1995.

Subchapter B—Payments to Skilled Nursing Facilities

SEC. 7031. 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. 7032. 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 respiratory 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 input price changes in routine service costs 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 for 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 deter-

mines (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 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 nursing 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; 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).

"(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.—Subject to paragraph (3), 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 greater of—

"(A) the SNF market basket percentage increase for such subsequent fiscal year minus 2.5 percentage points; or

"(B) 1.1 percent (1.2 percent for fiscal year 1997).

"(3) REBASING OF AMOUNTS.—

"(A) IN GENERAL.—The Secretary shall provide for an adjustment 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 (beginning with fiscal years after fiscal year 1997) to a resident of a skilled nursing facility who requires intensive nursing or therapy services, the per stay limit 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, 1997, the Secretary, after consultation with the Prospective Payment Assessment Commission and skilled nursing facility experts, shall develop and publish 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) EXCEPTIONS AND ADJUSTMENTS TO LIMITS.—

"(1) IN GENERAL.—The Secretary may make exceptions and adjustments to the cost reporting period 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).

"(h) SPECIAL TREATMENT FOR MEDICARE LOW VOLUME SKILLED NURSING FACILITIES.—The Secretary shall determine an appropriate manner in which to apply this section, taking into account the purposes of this section, to non-routine costs of 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).".

(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. 7033. 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 adding 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 TO LOW MEDICARE VOLUME SKILLED NURSING FACILITIES.—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 additional payments made under this title as a result of adjustments under this subsection for cost reporting periods beginning during fiscal year 1994 increased (in a compounded manner) by the SNF market basket percentage increase (as defined in section 1888A(e)(3)) for each fiscal year; 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. 7034. REDUCTIONS IN PAYMENT FOR CAPITAL-RELATED COSTS.

Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

"(T) 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. 7035. 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 furnished to an individual who (at the time the item or service is furnished) is a resident of a skilled nursing facility, payment shall be made to the facility (without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise), except that this subparagraph shall not preclude a physician from providing evaluation and management services to patients under the physician's care.".

(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)) 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 section 7034, is amended by adding at the end the following new subparagraph:

"(U) In the case of an item or service furnished by a skilled nursing facility (or by others under arrangement with them made by a skilled nursing facility or under any other contracting or consulting arrangement or otherwise) for which payment 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. 7036. 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 subchapter 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. 7037. REPORT BY PROSPECTIVE PAYMENT ASSESSMENT COMMISSION.

Not later than October 1, 1997, the Prospective Payment Assessment 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 7032) 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. 7038. EFFECTIVE DATE.

Except as otherwise provided in this subchapter, the amendments made by this subchapter shall apply to services furnished during cost reporting periods (or portions of cost reporting periods) beginning on or after October 1, 1996.

CHAPTER 3—PROVISIONS RELATING TO PART B

SEC. 7041. PAYMENTS FOR PHYSICIANS' SERVICES.

(a) ESTABLISHING UPDATE TO CONVERSION FACTOR TO MATCH SPENDING UNDER SUSTAINABLE GROWTH RATE.—

(1) Section 1848(d)(2) (42 U.S.C. 1395ww(d)(2)) is amended to read as follows:

"(2) RECOMMENDATION OF UPDATE.—

"(A) IN GENERAL.—Not later than April 15 of each year (beginning with 1996), the Secretary shall transmit to the Congress a report that includes a recommendation on the appropriate update in the conversion factor for all physicians' services (as defined in subsection (f)(3)(A)) in the following year. In making the recommendation, the Secretary shall consider—

"(i) the percentage change in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for that year;

"(ii) such factors as enter into the calculation of the update adjustment factor as described in paragraph (3)(B); and

"(iii) access to services.

"(B) ADDITIONAL CONSIDERATIONS.—In making recommendations under subparagraph (A), the Secretary may also consider—

"(i) unexpected changes by physicians in response to the implementation of the fee schedule;

"(ii) unexpected changes in outlay projections;

"(iii) changes in the quality or appropriateness of care;

"(iv) any other relevant factors not measured in the resource-based payment methodology; and

"(v) changes in volume or intensity of services.

"(C) COMMISSION REVIEW.—The Physician Payment Review Commission shall review the report submitted under subparagraph (A) in a year and shall submit to the Congress, by not later than May 15 of the year, a report including its recommendations respecting the update in the conversion factor for the following year.".

(2) UPDATE.—Section 1848(d)(3) (42 U.S.C. 1395w-4(d)(3)) is amended to read as follows:

"(3) UPDATE.—

"(A) IN GENERAL.—Unless Congress otherwise provides, 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 30, 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, increased 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.—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), minus 1 and multiplied by 100; or

"(ii) less than 93 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), minus 1 and multiplied by 100.".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to physicians' services furnished on or after January 1, 1997.

(b) 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) PROCESS FOR ESTABLISHING SUSTAINABLE GROWTH RATE OF INCREASE.—

"(A) SECRETARY'S RECOMMENDATION.—By not later than April 15 of each year (beginning with 1996), the Secretary shall transmit to the Congress a recommendation on the sustainable growth rate for the fiscal year beginning in such year. In making the recommendation, the Secretary shall confer with organizations representing physicians and shall consider—

"(i) inflation,

"(ii) changes in numbers of enrollees (other than private plan enrollees) under this part,

"(iii) changes in the age composition of enrollees (other than private plan enrollees) under this part,

"(iv) changes in technology,

"(v) evidence of inappropriate utilization of services,

"(vi) evidence of lack of access to necessary physicians' services, and

"(vii) such other factors as the Secretary considers appropriate.

"(B) COMMISSION REVIEW.—The Physician Payment Review Commission shall review the recommendation transmitted during a year under subparagraph (A) and shall make its recommendation to Congress, by not later than May 15 of the year, respecting the sustainable growth rate for the fiscal year beginning in that year.

"(C) PUBLICATION OF SUSTAINABLE GROWTH RATE.—The Secretary shall cause to have the sustainable growth rate published in the Federal Register, in the last 15 days of October of each calendar year (beginning with 1997), for the fiscal year beginning in that year. The Secretary shall cause to have published in the Federal Register, by not later than January 1, 1997, the paragraph (2) for fiscal year 1997.

"(2) 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 (including the Balanced Budget Reconciliation Act of 1995), 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),

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, 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.

"(3) DEFINITIONS.—In this subsection:

"(A) SERVICES INCLUDED IN PHYSICIANS' SERVICES.—The term 'physicians' services' includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a private plan enrollee.

"(B) PRIVATE PLAN ENROLLEE.—The term 'private plan enrollee' means, with respect to a fiscal year, an individual enrolled under this part who has elected to receive benefits under this title for the fiscal year through a medicare choice plan offered under part D or through enrollment with an eligible organization with a risk-sharing contract under section 1876.".

(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) is amended—

(A) by striking "(or factors)" each place it appears in subsection (d)(1)(A) and (d)(1)(C)(ii);

(B) in subsection (d)(1)(A), by striking "or updates";

(C) in subsection (d)(1)(C)(ii), by striking "(or updates)"; and

(D) in subsection (i)(1)(C), by striking "conversion factors" and inserting "the conversion factor.

SEC. 7042. 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. 7043. PAYMENTS FOR CLINICAL LABORATORY DIAGNOSTIC SERVICES.

(a) FREEZE IN UPDATE.—Section 1833(h)(2)(A)(ii)(IV) (42 U.S.C. 1395*l*(h)(2)(A)(ii)(IV)) is amended by striking "and 1995" and inserting "through 2002".

(b) REDUCTION OF NATIONAL CAPS.—Section 1833(h)(4)(B) (42 U.S.C. 1395*l*(h)(4)(B)) is amended—

(1) by striking "and" at the end of clause (vi);

(2) in clause (vii)—

(A) by inserting "and before January 1, 1997," after "December 31, 1995,"; and

(B) by striking the period 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.".

(c) STUDY AND REPORT TO CONGRESS.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study of—

(A) the fee schedule determined under section 1833(h)(1) of the Social Security Act (42 U.S.C. (42 U.S.C. 1395*l*(h)(1)) relating to clinical laboratory services; and

(B) options for rebasing or otherwise revising the amounts payable for such services under such fee schedule, taking into account the amounts paid for such services by other large volume purchasers.

(2) REPORT.—Not later then 1 year after the date of the enactment of the Balanced Budget Reconciliation Act of 1995, the Secretary shall submit to Congress a report on the study conducted under paragraph (1).

SEC. 7044. DURABLE MEDICAL EQUIPMENT.

(a) FREEZE IN UPDATES.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended—

(1) in subparagraph (A), by striking "and" at the end;

(2) by redesignating subparagraph (B) as subparagraph (C); and

(3) by inserting after subparagraph (A), the following subparagraph:

"(B) for 1996 through 2002, the percentage increase is 0 percent; and".

(b) OXYGEN EQUIPMENT.—

(1) IN GENERAL.—Section 1834(a)(5)(A) (42 U.S.C. 1395m(a)(5)(A)) is amended to read as follows:

"(A) IN GENERAL.—Subject to subparagraphs (B), (C), and (E), payment for—

"(i) oxygen shall be made on a monthly basis in the monthly payment amount recognized under paragraph (9) for oxygen; and

"(ii) oxygen equipment (other than portable oxygen equipment) shall be made on a monthly basis in an amount equal to 60 percent of the monthly payment amount recognized under paragraph (9) for oxygen equipment.".

(2) PORTABLE OXYGEN EQUIPMENT.—Section 1834(a)(5)(B) (42 U.S.C. 1395m(a)(5)(B)) is amended by inserting "60 percent of" after "increased by".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to items and services furnished on or after January 1, 1996.

(c) UPGRADED DURABLE MEDICAL EQUIPMENT.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended by inserting after paragraph (15) the following new paragraph:

"(16) CERTAIN UPGRADED ITEMS.—

"(A) INDIVIDUAL'S RIGHT TO CHOOSE UPGRADED ITEM.—Notwithstanding any other provision of law, effective on the date on which the Secretary issues regulations under subparagraph (C), an individual may purchase or rent from a supplier an item of upgraded durable medical equipment for which payment would be made under this subsection if the item were a standard item.

"(B) PAYMENTS TO SUPPLIER.—In the case of the purchase or rental of an upgraded item under subparagraph (A)—

"(i) the supplier shall receive payment under this subsection with respect to such item as if such item were a standard item; and

"(ii) the individual purchasing or renting the item shall pay the supplier an amount equal to the difference between the supplier's charge and the amount under clause (i).

In no event may the supplier's charge for an upgraded item exceed the applicable fee schedule amount (if any) for such item.

"(C) CONSUMER PROTECTION SAFEGUARDS.—The Secretary shall issue regulations providing for consumer protection standards with respect to the furnishing of upgraded equipment under subparagraph (A). Such regulations shall provide for—

"(i) determination of fair market prices with respect to an upgraded item;

"(ii) full disclosure of the availability and price of standard items and proof of receipt of such disclosure information by the beneficiary before the furnishing of the upgraded item;

"(iii) conditions of participation for suppliers in the simplified billing arrangement;

"(iv) sanctions of suppliers who are determined to engage in coercive or abusive practices, including exclusion; and

"(v) such other safeguards as the Secretary determines are necessary.".

SEC. 7045. UPDATES FOR ORTHOTICS AND PROSTHETICS.

(a) IN GENERAL.—Section 1834(h)(4)(A)(iii) (42 U.S.C. 1395m(h)(4)(A)(iii)) is amended by striking "1994 and 1995" and inserting "1994 through 2002".

(b) EXTENSION OF FREEZE ON 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 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 1995 (as such charges were determined in accordance with section 13541 of OBRA—1993).

SEC. 7046. PAYMENTS FOR CAPITAL-RELATED COSTS OF OUTPATIENT HOSPITAL SERVICES.

Section 1861(v)(1)(S)(ii)(I) (42 U.S.C. 1395x(v)(1)(S)(ii)(I)) is amended by striking ", and by 10 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1992 through 1998" and inserting "by 10 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1992 through 1995, and by 15 percent for payments at-

tributable to portions of cost reporting periods occurring during fiscal years 1996 through 2002.".

SEC. 7047. PAYMENTS FOR NON-CAPITAL COSTS OF OUTPATIENT HOSPITAL SERVICES.

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. 7048. UPDATES FOR AMBULATORY SURGICAL SERVICES.

Section 1833(i)(2)(C) (42 U.S.C. 1395*l*(i)(2)(C)) is amended—

(1) by striking "1996" and inserting "2003"; and

(2) by inserting before the first sentence the following new sentence: "Notwithstanding the second sentence of subparagraph (A) or the second sentence of subparagraph (B), the Secretary shall not update amounts established under such subparagraphs for fiscal years 1996 through 2002."

SEC. 7049. PAYMENTS FOR AMBULANCE SERVICES.

Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)), as amended by sections 7034 and 7035(b), is amended by adding at the end the following new subparagraph:

"(V) In determining the reasonable cost or charge of ambulance services for fiscal years 1996 through 2002, the Secretary shall not recognize anycosts in excess of costs recognized as reasonable for fiscal year 1995.".

SEC. 7050. PHYSICIAN SUPERVISION OF NURSE ANESTHETISTS.

(a) PROMULGATION OF REVISED REGULATIONS.—The Secretary of Health and Human Services shall revise any regulations describing the conditions under which payment may be made for anesthesia services under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to provide that payment may be made under the medicare program for anesthesia services furnished in a hospital or an ambulatory surgical center by a certified registered nurse anesthetist who, under the law of the State in which the service is furnished, is permitted to administer anesthesia services without supervision by the physician performing the operation or the anesthesiologist.

(b) EFFECTIVE DATE.—The revisions to the regulations referred to in subsection (a) shall apply with respect to anesthesia services furnished on or after January 1, 1996.

SEC. 7051. PART B DEDUCTIBLE.

Section 1833(b) (42 U.S.C. 1395*l*(b)) is amended in the first sentence by striking "and $100 for 1991 and subsequent years" and inserting ", $100 for calendar years 1991 through 1995, $150 for calendar year 1996, and for calendar years after 1996, an amount equal to the deductible amount determined under this subsection in the prior calendar year, increased by $10.00".

SEC. 7052. PART B PREMIUM.

Section 1839(e)(1) (42 U.S.C. 1395r(e)(1)) is amended—

(1) in subparagraph (A), by striking "after after December 1995 and prior to January 1999" and inserting "after December 2002"; and

(2) in subparagraph (B)—

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

(B) in clause (v), by striking the period and inserting a comma, and

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

"(vi) 1996 shall be $53.00,

"(vii) 1997 shall be $57.00,

"(viii) 1998 shall be $61.00,

"(ix) 1999 shall be $66.00,

"(x) 2000 shall be $74.00,

"(xi) 2001 shall be $80.00, and

"(xii) 2002 shall be $89.00.".

SEC. 7053. INCREASE IN MEDICARE PART B PREMIUM FOR HIGH-INCOME INDIVIDUALS.

(a) IN GENERAL.—Part B of title XVIII is amended by inserting after section 1839 the following new section:

"INCREASE IN PREMIUM FOR HIGH-INCOME INDIVIDUALS

"SEC. 1839A. (a) INCREASE IN PREMIUM.—

"(1) IN GENERAL.—If this section applies to an individual for any calendar year, the monthly premium otherwise applicable under section 1839 for each month during the calendar year shall be increased by an amount equal to the supplemental Medicare part B premium.

"(2) INDIVIDUALS TO WHOM SECTION APPLIES.—This section shall apply to any individual for a calendar year if—

"(A) the individual is covered under this part for any month during the calendar year, and

"(B) the modified adjusted gross income of the taxpayer for the taxable year beginning in the calendar year exceeds the threshold amount.

"(b) PREMIUMS TO BE DEDUCTED BASED ON ESTIMATED AMOUNTS.—

"(1) IN GENERAL.—Each individual shall—

"(A) during the medicare open enrollment period under section 1895G(b)(1), or

"(B) during any other medicare enrollment period applicable to the individual under section 1895G(b)(2),

include with the medicare enrollment an estimate of the taxpayer's modified adjusted gross income for the following calendar year.

"(2) INDIVIDUALS NOT FILING ENROLLMENT FORM.—If an individual does not file a medicare enrollment form for any enrollment period applicable to the individual and the individual's coverage under this part continues without modification by reason of the failure to file, the individual's modified adjusted gross income shall be determined on the basis of the most recent information available to the Secretary from prior enrollment forms, the Secretary of the Treasury under section 6103(l)(15), or otherwise.

"(3) INDIVIDUALS FILING INCORRECT ENROLLMENT FORMS.—If, on the basis of information obtained from the Secretary of the Treasury under section 6103(l)(15), the Secretary determines that the information included with a medicare enrollment form under paragraph (1) is incorrect, the individual's modified adjusted gross income shall be determined on the

basis of the information obtained from the Secretary of the Treasury.

"(4) TRANSFER OF INFORMATION.—The Secretary shall notify the applicable agency under section 1840 of—

"(A) the estimates received under paragraph (1) or the determinations under paragraph (2) or (3), and

"(B) the amount of the premiums to be deducted under section 1840.

The premiums under subparagraph (B) shall be effective with respect to months beginning with the later of the month for which the enrollment is effective or the month following the month in which the notice is received. Such premium shall remain in effect until another premium takes effect under this subsection or there is an increase in the premium determined without regard to this section.

"(c) SUPPLEMENTAL MEDICARE PART B PREMIUM.—For purposes of subsection (a)—

"(1) IN GENERAL.—The supplemental Medicare part B premium for any month is an amount equal to the excess of—

"(A) 200 percent of the monthly actuarial rate for enrollees age 65 and over determined under subsection 1839(a)(1) for such month, over

"(B) the total monthly premium under section 1839 (determined without regard to subsections (b) and (f) of section 1839).

"(2) PHASEIN OF SUPPLEMENTAL PREMIUM.—

"(A) IN GENERAL.—If the modified adjusted gross income of the taxpayer for any taxable year exceeds the threshold amount by less than $50,000, the supplemental Medicare part B premium under this section for months in the calendar year in which the taxable year begins shall be an amount which bears the same ratio to the amount of the premium (without regard to this paragraph) as such excess bears to $50,000. The preceding sentence shall not apply to any individual whose threshold amount is zero.

"(B) PHASEIN RANGE FOR JOINT RETURNS.—In the case of a joint return under section 6013 of the Internal Revenue Code of 1986, subparagraph (A) shall be applied by substituting '$75,000' for '$50,000' each place it appears.

"(d) VERIFICATION AND ADJUSTMENTS OF SUPPLEMENTAL PREMIUMS.—

"(1) VERIFICATION.—Each individual to whom this section applies shall, on the basis of information shown on the return of tax imposed by chapter 1 of the Internal Revenue Code of 1986 for any taxable year, determine the difference (if any) between—

"(A) the aggregate supplemental Medicare part B premiums imposed by this section for months during the calendar year in which the taxable year begins, and

"(B) the aggregate amount of premiums deducted and paid under section 1840 for such months with respect to the individual.

Such determination shall be included on a form prescribed by the Secretary and the form shall be submitted to the Secretary

at such time and in such manner as the Secretary shall prescribe.

"(2) DEFICIENCY ADJUSTMENTS.—

"(A) IN GENERAL.—If the amount under paragraph (1)(A) exceeds the amount under paragraph (1)(B), the individual shall include with the form required to be filed under paragraph (1) a separate check made payable to the Secretary in an amount equal to such excess plus interest determined under subparagraph (B).

"(B) INTEREST ON UNDERPAYMENTS.—For purposes of subparagraph (A)—

"(i) IN GENERAL.—The amount of interest taken into account shall be the sum of the amounts determined under clause (ii) for each of the months in the taxable year.

"(ii) MONTHLY INTEREST.—Interest shall be computed for any month in an amount determined by applying the underpayment rate established under section 6621 of the Internal Revenue Code of 1986 to any portion of the underpayment for the period beginning on the first day of the following month and ending on the date the portion is paid. For purposes of this clause, payments shall be applied to months in order, beginning with the earliest.

"(iii) SAFE-HARBOR EXCEPTION.—No interest shall be imposed for any month if the individual's estimate of modified adjusted gross income under subsection (b) on which the supplemental Medicare part B premium for the month was based was not less than the individual's modified adjusted gross income determined on the basis of information shown on the return of tax imposed by chapter 1 of such Code for the taxable year ending with or within the calendar year preceding the calendar year in which the estimate was made.

"(3) OVERPAYMENT ADJUSTMENTS.—If the amount under paragraph (1)(B) exceeds the amount under paragraph (1)(A), the Secretary shall, at the Secretary's discretion—

"(A) credit such excess against any supplemental premium required under this section, or

"(B) make a payment to the individual in the amount of such excess.

"(4) ADJUSTMENTS BY SECRETARY.—If the Secretary determines, on the basis of information received from the Secretary of the Treasury under section 6103(l)(15), that there was an underpayment or overpayment of the aggregate supplemental Medicare part B premiums for months during any taxable year (after any other adjustment under this subsection), the Secretary shall—

"(A) notify the individual of such underpayment or overpayment,

"(B) in the case of an underpayment, give such individual an opportunity for a hearing with respect to such underpayment and a reasonable time for payment of such

underpayment and interest determined under paragraph (2)(B), and

"(C)(i) collect the amount of any underpayment and interest not paid under subparagraph (B) in such manner as the Secretary may prescribe, and

"(ii) take the actions described in paragraph (3) with respect to any overpayment.

"(5) TRANSFERS TO TRUST FUND.—Amounts equal to amounts paid under paragraphs (2)(A), (4)(B), and (4)(C)(i) shall be deposited into the Federal Supplementary Medical Insurance Trust Fund.

"(e) OTHER DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

"(1) THRESHOLD AMOUNT.—The term 'threshold amount' means—

"(A) except as otherwise provided in this paragraph, $50,000,

"(B) $75,000 in the case of a joint return, and

"(C) 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 for such year, and

"(ii) does not live apart from his spouse at all times during the taxable year.

"(2) MODIFIED ADJUSTED GROSS INCOME.—The term 'modified adjusted gross income' means adjusted gross income determined under section 62 of the Internal Revenue Code of 1986—

"(A) determined without regard to sections 135, 911, 931, and 933 of such Code, and

"(B) increased by the amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

"(3) JOINT RETURNS.—In the case of a joint return under section 6013 of such Code, this section shall be applied by taking into account the combined modified adjusted gross income of the spouses.

"(4) MARRIED INDIVIDUAL.—The determination of whether an individual is married shall be made in accordance with section 7703 of such Code.

"(5) AGREEMENTS.—In order to promote the efficient administration of this section, the Secretary may enter into agreements with the Commissioner of the Social Security Administration or the head of any other appropriate Federal agency under which such agency performs administrative responsibilities under this section."

(b) DISCLOSURE OF INFORMATION.—Section 6103(l) of the Internal Revenue Code of 1986 is amended by adding at the end the following new paragraph:

"(15) DISCLOSURE OF TAXPAYER RETURN INFORMATION TO SOCIAL SECURITY ADMINISTRATION FOR PURPOSES OF COLLECTING SUPPLEMENTAL PART B PREMIUMS.—

"(A) IN GENERAL.—The Secretary shall, upon written request from the Secretary of Health and Human Services, disclose to the Secretary with respect to any medicare beneficiary (as defined in paragraph (12)(E)(i)) identified in

the request whether or not (and the amount by which) the individual's modified adjusted gross income for any taxable year specified in the request exceeded the threshold amount.

"(B) RESTRICTION ON USE.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Department of Health and Human Services (or of any other Federal agency if an agreement under section 1839A(e)(5) of the Social Security Act is in effect) only for the purposes of, and to the extent necessary in, establishing an individual's correct supplemental Medicare part B premium under section 1839A of the such Act.

"(C) DEFINITIONS.—For purposes of this paragraph, any term used which is also used in section 1839A of the Social Security Act shall have the meaning given such term by such section."

(c) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1839(a) (42 U.S.C. 1395r(a)(2)) is amended by inserting "or section 1839A" after "subsections (b) and (e)".

(2) Paragraph (3) of section 1839(a) (42 U.S.C. 1395r(a)(3)) is amended by inserting "or section 1839A" after "subsection (e)".

(3) Section 1839(b) (42 U.S.C. 1395r(b)) is amended by inserting "(and as increased under section 1839A)" after "subsection (a) or (e)".

(4) Section 1839(f) (42 U.S.C. 1395r(f)) is amended by adding at the end the following new sentence: "This subsection shall not apply to the portion of the premium attributable to the supplemental premium under section 1839A."

(5) Section 1840(c) (42 U.S.C. 1395r(c)) is amended by inserting "or an individual determines that the estimate of modified adjusted gross income used in determining the supplemental premium under section 1839A is too low and results in a portion of the premium not being deducted," before "he may".

(d) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply to months after December 1996.

(2) INFORMATION FOR PRIOR YEARS.—The Secretary of Health and Human Services may request information under section 6013(l)(15) of the Social Security Act (as added by subsection (b)) for taxable years beginning after December 31, 1993.

CHAPTER 4—PROVISIONS RELATING TO PARTS A AND B

Subchapter A—General Provisions Relating to Parts A and B

SEC. 7055. SECONDARY PAYOR PROVISIONS.

(a) PERMANENT EXTENSION OF APPLICATION TO DISABLED BENEFICIARIES.—Section 1862(b)(1)(B)(iii) (42 U.S.C. 1395y(b)(1)(B)(iii)) is amended by striking ", and before October 1, 1998".

(b) INDIVIDUALS WITH END STAGE RENAL DISEASE.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the last sentence by striking "October 1, 1998" and inserting "the date of the enactment of the Balanced Budget Reconciliation Act of 1995"; and

(2) by adding at the end the following new sentence: "Effective for items and services furnished on or after the date of the enactment of the Balanced Budget Reconciliation Act of 1995, (with respect to periods beginning on or after the date that is 18 months prior to such date), clauses (i) and (ii) shall be applied by substituting '30-month' for '12-month' each place it appears.".

(c) EXTENSION OF TRANSFER OF DATA.—

(1) ELIMINATION OF SUNSET.—Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) ELIMINATION OF TERMINATION.—Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

(d) NO RETROACTIVE APPLICATION OF ESRD SECONDARY PAYER INTERPRETATION.—Notwithstanding any other provision of law, the April 1995 interpretation of section 1862(b)(1)(C) of the Social Security Act (42 U.S.C. 1395y(b)(1)(C)) issued by the Health Care Financing Administration shall not apply retroactively to a group health plan that paid benefits primary to title XVIII of such Act (42 U.S.C. 1395 et seq.) (but would have paid benefits secondary to such title in the absence of such section) on or after August 10, 1993, and before April 24, 1995, on behalf of an individual who, during such period—

(1) was entitled to benefits under such title under subsection (a) or (b) of section 226 of such Act (42 U.S.C. 426); and

(2) subsequently became entitled or eligible for benefits under such title under section 226A of such Act (42 U.S.C. 426–1).

SEC. 7056. TREATMENT OF ASSISTED SUICIDE.

(a) PROHIBITION OF PAYMENT.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) by striking "or" at the end of paragraph (14);

(2) by striking the period at the end of paragraph (15) and inserting "; or"; and

(3) by inserting after paragraph (15) and before the flush language at the end the following new paragraph:

"(16) where such expenses are for items and 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 caus-

ing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of an individual.".

(b) NO REQUIREMENT THAT HEALTH CARE PROVIDERS INFORM PATIENTS CONCERNING ASSISTING SUICIDE.—Section 1866(f)(1)(A)(i) (42 U.S.C. 1395cc(f)(1)(A)(i)) is amended by striking "paragraph (3))" and inserting "paragraph (3)), except that no health care provider or employee of a health care provider be required under this section to inform or counsel a patient regarding assisted suicide, euthanasia, mercy killing, or other service which purposefully causes the death of a person".

SEC. 7057. ADMINISTRATIVE PROVISIONS.

(a) INDIAN HEALTH SERVICE FACILITIES.—Nothing in this Act shall be construed to change the status under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) of—

(1) a Federally qualified health center (as defined in section 1861(aa)(4) of such Act) which is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act; or

(2) hospitals or skilled nursing facilities of the Indian Health Service, whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), that are eligible for payments under title XVIII of the Social Security Act, in accordance with section 1880 of such Act (42 U.S.C. 1395qq).

(b) CONFORMING AMENDMENT TO CERTIFICATION OF CHRISTIAN SCIENCE PROVIDERS.—

(1) HOSPITALS.—Section 1861(e) (42 U.S.C. 1395x(e)) is amended in the sixth sentence by striking "the First Church of Christ, Scientist, Boston, Massachusetts," and inserting "the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.,".

(2) SKILLED NURSING FACILITIES.—Section 1861(y)(1) (42 U.S.C. 1395x(y)(1)) is amended by striking "the First Church of Christ, Scientist, Boston, Massachusetts," and inserting "the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.,".

(3) GENERAL PROVISIONS.—

(A) UNIFORM REPORTING SYSTEMS.—Section 1122(h) (42 U.S.C. 1320a–1(h)) is amended by striking "the First Church of Christ, Scientist, Boston, Massachusetts" and inserting "the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.".

(B) PEER REVIEW.—Section 1162 (42 U.S.C. 1320c–11) is amended by striking "the First Church of Christ, Scientist, Boston, Massachusetts" and inserting "the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.".

(4) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on January 1, 1997.

Subchapter B—Payments for Home Health Services

SEC. 7061. PAYMENT FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Part C of title XVIII (42 U.S.C. 1395x et seq.) is amended by adding at the end the following new section:

"PAYMENT FOR HOME HEALTH SERVICES

"SEC. 1893. (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, under any other contracting or consulting arrangement, 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 (which shall be the same area used to determine the area wage index applicable to hospitals under section 1886(d)(3)(E)) 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.

"(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; 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 greater of—

"(i) the home health market basket percentage increase for such subsequent fiscal year minus 2.5 percentage points; or

"(ii) 1.1 percent (1.2 percent in fiscal year 1997).

"(3) REBASING OF RATES.—The Secretary shall adjust the national per visit payment rates under this subsection for cost reporting periods beginning on or after October 1, 1999, and every 2 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 such 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 (which shall be the same area used to determine the area wage index applicable to hospitals under section 1886(d)(3)(E)) 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—

"(I) each of fiscal years 1997 through 2000 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; and

"(II) each subsequent fiscal year, is the factor determined by the Secretary to necessary remove the effects of case-mix increases due to reporting improvements instead of real changes in patients' resource usage.

"(iii) REBASING OF PER EPISODE LIMITS.—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 AREA.—In the case of an area which the Secretary determines has insufficient number of home health agencies to establish an appropriate per episode limit, the Secretary may establish an area other than the area used to determine the area wage under section 1886(d)(3)(E)) for purposes of establishing an appropriate per episode limit.

"(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 Home Health Agency Prospective Payment Demonstration Project conducted by the Health Care Financing Administration. The Secretary may develop an alternate methodology for determining case-mix categories.

"(D) EPISODE.—For purposes of this paragraph, the term 'episode' means, with respect to a cost reporting period, 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).

"(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) PAYMENTS IN EXCESS OF LIMITS.—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, in such manner as the Secretary considers appropriate, reduce the payments under this section to the home health agency in the following fiscal year by 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 prior year without regard to clause (ii).

"(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.—

"(1) IN GENERAL.—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 payments 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).

"(2) USING OF ORGANIZATIONS TO CONDUCT REVIEWS.—The Secretary may use public of private organizations to conduct medical reviews in accordance with this subsection.

"(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.—

"(A) IN GENERAL.—The Secretary shall develop and implement a system designed to adjust payments to a home health agency for a fiscal year to eliminate any increase in growth of the percentage distribution of low-cost episodes for which home health services are furnished by the agency over such percentage distribution determined for the agency under subparagraph (B).

"(B) DISTRIBUTION.—The Secretary shall profile each home health agency to determine the distribution of all episodes by length of stay for each agency during the agency's first 12-month cost reporting period beginning during fiscal year 1994. The Secretary shall calculate the 25th percentile distribution for each agency for low-cost episodes.

"(C) LOW-COST EPISODE.—For purposes of this paragraph, 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 PROSPECTIVE PAYMENT ASSESSMENT COMMISSION.—During the first 3 years in which payments are made under this section, the Prospective Payment Assessment 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) On 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.".

(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 7032(b), is amended in the matter preceding paragraph (1) by striking "1888 and 1888A" and inserting "1888, 1888A, and 1893".

(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 1893(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 1893;

"(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), as amended by section 7035(a)(1), (42 U.S.C. 1395u(b)(6)) 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 1893(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 when any other contracting or consulting arrangement, or otherwise).".

(ii) 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)(F);".

(C) EXCLUSIONS FROM COVERAGE.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 7035(a)(2)(C), is amended—

(i) by striking "or" at the end of paragraph (15);

(ii) by striking the period at the end of paragraph (16) and inserting "or"; and

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

"(17) 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) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (c) shall apply to cost reporting periods beginning on or after October 1, 1996.

SEC. 7062. 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. 7063. 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 the 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.".

CHAPTER 5—RURAL AREAS

SEC. 7071. MEDICARE-DEPENDENT, SMALL, RURAL HOSPITAL PAYMENT EXTENSION.

(a) SPECIAL TREATMENT EXTENDED.—

(1) PAYMENT METHODOLOGY.—Section 1886(d)(5)(G)(i) (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(A) in clause (i), by striking "October 1, 1994," and inserting "October 1, 1994, or beginning on or after September 1, 1995, and before October 1, 2000,"; and

(B) in clause (ii)(II), by striking "October 1, 1994" and inserting "October 1, 1994, or beginning on or after September 1, 1995, and before October 1, 2000,".

(2) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(A) in the matter preceding clause (i), by striking "September 30, 1994," and inserting "September 30, 1994, and for cost reporting periods beginning on or after September 1, 1995, and before October 1, 2000,";

(B) in clause (ii), by striking "and" at the end;

(C) in clause (iii), by striking the period at the end and inserting ", and"; and

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

"(iv) with respect to discharges occurring during September 1995 through fiscal year 1999, the target amount for the preceding year increased by the applicable percentage increase under subparagraph (B)(iv).".

(3) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of OBRA–93 (42 U.S.C. 1395ww note) is amended by striking "or fiscal year 1994" and inserting ", fiscal year 1994, fiscal year 1995, fiscal year 1996, fiscal year 1997, fiscal year 1998, or fiscal year 1999".

(4) TECHNICAL CORRECTION.—Section 1886(d)(5)(G)(i) (42 U.S.C. 1395ww(d)(5)(G)(i)), as in effect before the amendment made by paragraph (1), is amended by striking all that follows the first period.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to discharges occurring on or after September 1, 1995.

SEC. 7072. MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.

(a) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.—Section 1820 (42 U.S.C. 1395i–4) is amended to read as follows:

"MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM

"SEC. 1820. (a) PURPOSE.—The purpose of this section is to—

"(1) ensure access to health care services for rural communities by allowing hospitals to be designated as critical access hospitals if such hospitals limit the scope of available inpatient acute care services;

"(2) provide more appropriate and flexible staffing and licensure standards;

"(3) enhance the financial security of critical access hospitals by requiring that medicare reimburse such facilities on a reasonable cost basis; and

"(4) promote linkages between critical access hospitals designated by the State under this section and broader programs supporting the development of and transition to integrated provider networks.

"(b) ESTABLISHMENT.—Any State that submits an application in accordance with subsection (c) may establish a medicare rural hospital flexibility program described in subsection (d).

"(c) APPLICATION.—A State may establish a medicare rural hospital flexibility program described in subsection (d) if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing—

"(1) assurances that the State—

"(A) has developed, or is in the process of developing, a State rural health care plan that—

"(i) provides for the creation of one or more rural health networks (as defined in subsection (e)) in the State,

"(ii) promotes regionalization of rural health services in the State, and

"(iii) improves access to hospital and other health services for rural residents of the State;

"(B) has developed the rural health care plan described in subparagraph (A) in consultation with the hospital association of the State, rural hospitals located in the State, and the State Office of Rural Health (or, in the case of a State in the process of developing such plan, that assures the Secretary that the State will consult with its State hospital association, rural hospitals located in the State, and the State Office of Rural Health in developing such plan);

"(2) assurances that the State has designated (consistent with the rural health care plan described in paragraph (1)(A)), or is in the process of so designating, rural nonprofit or public hospitals or facilities located in the State as critical access hospitals; and

"(3) such other information and assurances as the Secretary may require.

"(d) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM DESCRIBED.—

"(1) IN GENERAL.—A State that has submitted an application in accordance with subsection (c), may establish a medicare rural hospital flexibility program that provides that—

"(A) the State shall develop at least one rural health network (as defined in subsection (e)) in the State; and

"(B) at least one facility in the State shall be designated as a critical access hospital in accordance with paragraph (2).

"(2) STATE DESIGNATION OF FACILITIES.—

"(A) IN GENERAL.—A State may designate one or more facilities as a critical access hospital in accordance with subparagraph (B).

"(B) CRITERIA FOR DESIGNATION AS CRITICAL ACCESS HOSPITAL.—A State may designate a facility as a critical access hospital if the facility—

"(i) is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1886(d)(2)(D)) that—

"(I) is located more than a 35-mile drive from a hospital, or another facility described in this subsection, or

"(II) is certified by the State as being a necessary provider of health care services to residents in the area;

"(ii) makes available 24-hour emergency care services that a State determines are necessary for ensuring access to emergency care services in each area served by a critical access hospital;

"(iii) provides not more than 6 acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period not to exceed 72 hours (unless a longer period is required because transfer to a hospital is precluded because of inclement weather or other emergency conditions), except that a peer review organization or equivalent entity may, on request, waive the 72-hour restriction on a case-by-case basis;

"(iv) meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

"(I) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open and fully staffed, except insofar as the facility is required to make available emergency care services as determined under clause (ii) and must have nursing services available on a 24-hour basis, but need not otherwise staff the facility except when an inpatient is present,

"(II) the facility may provide any services otherwise required to be provided by a full-time, on-site dietitian, pharmacist, laboratory technician, medical technologist, and radiological technologist on a part-time, off-site basis under arrangements as defined in section 1861(w)(1), and

"(III) the inpatient care described in clause (iii) may be provided by a physician's assistant, nurse practitioner, or clinical nurse specialist subject to the oversight of a physician who need not be present in the facility; and

"(v) meets the requirements of subparagraph (I) of paragraph (2) of section 1861(aa).

"(e) RURAL HEALTH NETWORK DEFINED.—

"(1) IN GENERAL.—For purposes of this section, the term 'rural health network' means, with respect to a State, an organization consisting of—

"(A) at least 1 facility that the State has designated or plans to designate as a critical access hospital, and

"(B) at least 1 hospital that furnishes acute care services.

"(2) AGREEMENTS.—

"(A) IN GENERAL.—Each critical access hospital that is a member of a rural health network shall have an agreement with respect to each item described in subparagraph (B) with at least 1 hospital that is a member of the network.

"(B) ITEMS DESCRIBED.—The items described in this subparagraph are the following:

"(i) Patient referral and transfer.

"(ii) The development and use of communications systems including (where feasible)—

"(I) telemetry systems, and

"(II) systems for electronic sharing of patient data.

"(iii) The provision of emergency and non-emergency transportation among the facility and the hospital.

"(C) CREDENTIALING AND QUALITY ASSURANCE.—Each critical access hospital that is a member of a rural health network shall have an agreement with respect to credentialing and quality assurance with at least 1—

"(i) hospital that is a member of the network;

"(ii) peer review organization or equivalent entity; or

"(iii) other appropriate and qualified entity identified in the State rural health care plan.

"(f) CERTIFICATION BY THE SECRETARY.—The Secretary shall certify a facility as a critical access hospital if the facility—

"(1) is located in a State that has established a medicare rural hospital flexibility program in accordance with subsection (d);

"(2) is designated as a critical access hospital by the State in which it is located; and

"(3) meets such other criteria as the Secretary may require.

"(g) PERMITTING MAINTENANCE OF SWING BEDS.—Nothing in this section shall be construed to prohibit a State from designating or the Secretary from certifying a facility as a critical access hospital solely because, at the time the facility applies to the State for designation as a critical access hospital, there is in effect an agreement between the facility and the Secretary under section 1883 under which the facility's inpatient hospital facilities are used for the furnishing of extended care services, except that the number of beds used for the furnishing of such services may not exceed 12 beds (minus the number of inpatient beds used for providing inpatient care in the facility pursuant to subsection (d)(2)(B)(iii)). For purposes of the previous sentence, the number of beds of the facility used for the furnishing of extended care services shall not include any beds of a unit of the facility that is licensed as a distinct-part skilled nursing facility at the time the facility applies to the State for designation as a critical access hospital.

"(h) GRANTS.—

"(1) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM.—The Secretary may award grants to States that have submitted applications in accordance with subsection (c) for—

"(A) engaging in activities relating to planning and implementing a rural health care plan;

"(B) engaging in activities relating to planning and implementing rural health networks; and

"(C) designating facilities as critical access hospitals.

"(2) RURAL EMERGENCY MEDICAL SERVICES.—

"(A) IN GENERAL.—The Secretary may award grants to States that have submitted applications in accordance with subparagraph (B) for the establishment or expansion of a program for the provision of rural emergency medical services.

"(B) APPLICATION.—An application is in accordance with this subparagraph if the State submits to the Secretary at such time and in such form as the Secretary may require an application containing the assurances described in subparagraphs (A)(ii), (A)(iii), and (B) of subsection (c)(1) and paragraph (3) of such subsection.

"(i) TREATMENT OF RURAL PRIMARY CARE HOSPITALS.—A rural primary care hospital designated by the Secretary under this section prior to the date of the enactment of the Balanced Budget Reconciliation Act of 1995 shall receive payment under this title in the same manner and amount as critical access hospital certified by the Secretary under subsection (f) receives payment for such services.

"(j) WAIVER OF CONFLICTING PART A PROVISIONS.—The Secretary is authorized to waive such provisions of this part and part C as are necessary to conduct the program established under this section.

"(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for making grants to all States under subsection (h), $25,000,000 in each of the fiscal years 1996 through 2000.".

(b) REPORT ON ALTERNATIVE TO 72-HOUR RULE.—Not later than January 1, 1996, the Administrator of the Health Care Financing Administration shall submit to the Congress a report on the feasibility of, and administrative requirements necessary to establish an alternative for certain medical diagnoses (as determined by the Administrator) to the 72-hour limitation for inpatient care in critical access hospitals required by section 1820(d)(2)(B)(iii).

(c) CONTINUATION OF MAF'S.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall extend the Montana Medical Assistance Facility Demonstration Project until December 31, 2002. The demonstration project shall provide that new medical assistance facilities may be designated and that all medical assistance facilities shall receive reasonable cost reimbursement under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) for services provided to medicare beneficiaries.

(d) PART A AMENDMENTS RELATING TO RURAL PRIMARY CARE HOSPITALS AND CRITICAL ACCESS HOSPITALS.—

(1) DEFINITIONS.—Section 1861(mm) (42 U.S.C. 1395x(mm)) is amended to read as follows:

"CRITICAL ACCESS HOSPITAL; CRITICAL ACCESS HOSPITAL SERVICES

"(mm)(1) The term 'critical access hospital' means a facility certified by the Secretary as a critical access hospital under section 1820(f).

"(2) The term 'inpatient critical access hospital services' means items and services, furnished to an inpatient of a critical access hospital by such facility, that would be inpatient hospital services if furnished to an inpatient of a hospital by a hospital.".

(2) COVERAGE AND PAYMENT.—(A) Section 1812(a)(1) (42 U.S.C. 1395d(a)(1)) is amended by striking "or inpatient rural primary care hospital services" and inserting "or inpatient critical access hospital services".

(B) Sections 1813(a) and section 1813(b)(3)(A) (42 U.S.C. 1395e(a), 1395e(b)(3)(A)) are each amended by striking "inpatient rural primary care hospital services" each place it appears, and inserting "inpatient critical access hospital services".

(C) Section 1813(b)(3)(B) (42 U.S.C. 1395e(b)(3)(B)) is amended by striking "inpatient rural primary care hospital services" and inserting "inpatient critical access hospital services".

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

(i) in subsection (a)(8) by striking "rural primary care hospital" each place it appears and inserting "critical access hospital"; and

(ii) in subsection (b), by striking "other than a rural primary care hospital providing inpatient rural primary care hospital services," and inserting "other than a critical access hospital providing inpatient critical access hospital services,"; and

(iii) by amending subsection (*l*) to read as follows:

"(*l*) PAYMENT FOR INPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—The amount of payment under this part for inpatient critical access hospital services is the reasonable costs of the critical access hospital in providing such services.".

(3) TREATMENT OF CRITICAL ACCESS HOSPITALS AS PROVIDERS OF SERVICES.—(A) Section 1861(u) (42 U.S.C. 1395x(u)) is amended by striking "rural primary care hospital" and inserting "critical access hospital".

(B) The first sentence of section 1864(a) (42 U.S.C. 1395aa(a)) is amended by striking "a rural primary care hospital" and inserting "a critical access hospital".

(4) CONFORMING AMENDMENTS.—(A) Section 1128A(b)(1) (42 U.S.C. 1320a–7a(b)(1)) is amended by striking "rural primary care hospital" each place it appears and inserting "critical access hospital".

(B) Section 1128B(c) (42 U.S.C. 1320a–7b(c)) is amended by striking "rural primary care hospital" and inserting "critical access hospital".

(C) Section 1134 (42 U.S.C. 1320b–4) is amended by striking "rural primary care hospitals" each place it appears and inserting "critical access hospitals".

(D) Section 1138(a)(1) (42 U.S.C. 1320b–8(a)(1)) is amended—

(i) in the matter preceding subparagraph (A), by striking "rural primary care hospital" and inserting "critical access hospital"; and

(ii) in the matter preceding clause (i) of subparagraph (A), by striking "rural primary care hospital" and inserting "critical access hospital".

(E) Section 1816(c)(2)(C) (42 U.S.C. 1395h(c)(2)(C)) is amended by striking "rural primary care hospital" and inserting "critical access hospital".

(F) Section 1833 (42 U.S.C. 1395*l*) is amended—

(i) in subsection (h)(5)(A)(iii), by striking "rural primary care hospital" and inserting "critical access hospital";

(ii) in subsection (i)(1)(A), by striking "rural primary care hospital" and inserting "critical access hospital";

(iii) in subsection (i)(3)(A), by striking "rural primary care hospital services" and inserting "critical access hospital services";

(iv) in subsection (*l*)(5)(A), by striking "rural primary care hospital" each place it appears and inserting "critical access hospital"; and

(v) in subsection (*l*)(5)(B), by striking "rural primary care hospital" each place it appears and inserting "critical access hospital".

(G) Section 1835(c) (42 U.S.C. 1395n(c)) is amended by striking "rural primary care hospital" each place it appears and inserting "critical access hospital".

(H) Section 1842(b)(6)(A)(ii) (42 U.S.C. 1395u(b)(6)(A)(ii)) is amended by striking "rural primary care hospital" and inserting "critical access hospital".

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

(i) in subsection (a)—

(I) in paragraph (1), by striking "inpatient rural primary care hospital services" and inserting "inpatient critical access hospital services"; and

(II) in paragraph (2), by striking "rural primary care hospital" and inserting "critical access hospital";

(ii) in the last sentence of subsection (e), by striking "rural primary care hospital" and inserting "critical access hospital";

(iii) in subsection (v)(1)(S)(ii)(III), by striking "rural primary care hospital" and inserting "critical access hospital";

(iv) in subsection (w)(1), by striking "rural primary care hospital" and inserting "critical access hospital"; and

(v) in subsection (w)(2), by striking "rural primary care hospital" each place it appears and inserting "critical access hospital".

(J) Section 1862(a)(14) (42 U.S.C. 1395y(a)(14)) is amended by striking "rural primary care hospital" each place it appears and inserting "critical access hospital".

(K) Section 1866(a)(1) (42 U.S.C 1395cc(a)(1)) is amended—

(i) in subparagraph (F)(ii), by striking "rural primary care hospitals" and inserting "critical access hospitals";

(ii) in subparagraph (H), in the matter preceding clause (i), by striking "rural primary care hospitals" and "rural primary care hospital services" and inserting "critical access hospitals" and "critical access hospital services", respectively;

(iii) in subparagraph (I), in the matter preceding clause (i), by striking "rural primary care hospital" and inserting "critical access hospital"; and

(iv) in subparagraph (N)—

(I) in the matter preceding clause (i), by striking "rural primary care hospitals" and inserting "critical access hospitals", and

(II) in clause (i), by striking "rural primary care hospital" and inserting "critical access hospital".

(L) Section 1866(a)(3) (42 U.S.C 1395cc(a)(3)) is amended—

(i) by striking "rural primary care hospital" each place it appears in subparagraphs (A) and (B) and inserting "critical access hospital"; and

(ii) in subparagraph (C)(ii)(II), by striking "rural primary care hospitals" each place it appears and inserting "critical access hospitals".

(M) Section 1867(e)(5) (42 U.S.C. 1395dd(e)(5)) is amended by striking "rural primary care hospital" and inserting "critical access hospital".

(e) PAYMENT CONTINUED TO DESIGNATED EACHS.—Section 1886(d)(5)(D) (42 U.S.C. 1395ww(d)(5)(D)) is amended—

(1) in clause (iii)(III), by inserting "as in effect on September 30, 1995" before the period at the end; and

(2) in clause (v)—

(A) by inserting "as in effect on September 30, 1995" after "1820(i)(1)"; and

(B) by striking "1820(g)" and inserting "1820(e)".

(f) PART B AMENDMENTS RELATING TO CRITICAL ACCESS HOSPITALS.—

(1) COVERAGE.—(A) Section 1861(mm) (42 U.S.C. 1395x(mm)) as amended by subsection (d)(1), is amended by adding at the end the following new paragraph:

"(3) The term 'outpatient critical access hospital services' means medical and other health services furnished by a critical access hospital on an outpatient basis.".

(B) Section 1832(a)(2)(H) (42 U.S.C. 1395k(a)(2)(H)) is amended by striking "rural primary care hospital services" and inserting "critical access hospital services".

(2) PAYMENT.—(A) Section 1833(a) (42 U.S.C. 1395*l*(a)) is amended in paragraph (6), by striking "outpatient rural primary care hospital services" and inserting "outpatient critical access hospital services".

(B) Section 1834(g) (42 U.S.C. 1395m(g)) is amended to read as follows—

"(g) PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—The amount of payment under this part for outpatient

critical access hospital services is the reasonable costs of the critical access hospital in providing such services.".

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 1995.

SEC. 7073. 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 determined 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 subpara-

graph 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) COVERAGE AND PAYMENT FOR SERVICES.—

(1) COVERAGE.—Section 1832(a)(2) (42 U.S.C. 1395k(a)(2)) is amended—

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

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

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

"(K) rural emergency access care hospital services (as defined in section 1861(oo)(2)).".

(2) PAYMENT BASED ON PAYMENT FOR OUTPATIENT CRITICAL ACCESS HOSPITAL SERVICES.—

(A) IN GENERAL.—Section 1833(a)(6) (42 U.S.C. 1395l(a)(6)), as amended by section 7072(f)(2), is amended by striking "services," and inserting "services and rural emergency access care hospital services,".

(B) PAYMENT METHODOLOGY DESCRIBED.—Section 1834(g) (42 U.S.C. 1395m(g)), as amended by section 7072(f)(2)(B), is amended—

(i) in the heading, by striking "SERVICES" and inserting "SERVICES AND RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES"; and

(ii) 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.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to fiscal years beginning on or after October 1, 1995.

SEC. 7074. ADDITIONAL PAYMENTS FOR PHYSICIANS' SERVICES FURNISHED IN SHORTAGE AREAS.

(a) INCREASE IN AMOUNT OF ADDITIONAL PAYMENT.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended by striking "10 percent" and inserting "20 percent".

(b) RESTRICTION TO PRIMARY CARE SERVICES.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended by inserting after "physicians' services" the following: "consisting of primary care services (as defined in section 1842(i)(4))".

(c) EXTENSION OF PAYMENT FOR FORMER SHORTAGE AREAS.—

(1) IN GENERAL.—Section 1833(m) (42 U.S.C. 1395l(m)) is amended by striking "area," and inserting "area (or, in the case of an area for which the designation as a health professional shortage area under such section is withdrawn, in the case of physicians' services furnished to such an individual during the 3-year period beginning on the effective date of the withdrawal of such designation),".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to physicians' services furnished in an area for which the designation as a health professional shortage area under section 332(a)(1)(A) of the Public Health Service Act is withdrawn on or after January 1, 1996.

(d) REQUIRING CARRIERS TO REPORT ON SERVICES PROVIDED.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

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

(2) by inserting after subparagraph (I) the following new subparagraph:

"(J) will provide information to the Secretary (on such periodic basis as the Secretary may require) on the types of providers to whom the carrier makes additional payments for certain physicians' services pursuant to section 1833(m), together with a description of the services furnished by such providers; and".

(e) STUDY.—

(1) IN GENERAL.—The Physician Payment Review Commission shall conduct a study analyzing the effectiveness of the provision of additional payments under part B of the medicare program for physicians' services provided in health professional shortage areas in recruiting physicians to provide services in such areas.

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), and shall include in the report such recommendations as the Secretary considers appropriate.

(f) EFFECTIVE DATE.—The amendments made by subsections (a), (b), and (d) shall apply to physicians' services furnished on or after October 1, 1995.

SEC. 7075. PAYMENTS TO PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS FOR SERVICES FURNISHED IN OUTPATIENT OR HOME SETTINGS.

(a) COVERAGE IN OUTPATIENT OR HOME SETTINGS FOR PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS.—Section 1861(s)(2)(K) (42 U.S.C. 1395x(s)(2)(K)) is amended—

(1) in clause (i)—

(A) by striking "or" at the end of subclause (II); and

(B) by inserting "or (IV) in an outpatient or home setting as defined by the Secretary" following "shortage area,"; and

(2) in clause (ii)—

(A) by striking "in a skilled" and inserting "in (I) a skilled"; and

(B) by inserting ", or (II) in an outpatient or home setting (as defined by the Secretary)," after "(as defined in section 1919(a))".

(b) PAYMENTS TO PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS IN OUTPATIENT OR HOME SETTINGS.—

(1) IN GENERAL.—Section 1833(r)(1) (42 U.S.C. 1395*l*(r)(1)) is amended—

(A) by inserting "services described in section 1861(s)(2)(K)(ii)(II) (relating to nurse practitioner services furnished in outpatient or home settings), and services described in section 1861(s)(2)(K)(i)(IV) (relating to physician assistant services furnished in an outpatient or home setting" after "rural area),"; and

(B) by striking "or clinical nurse specialist" and inserting "clinical nurse specialist, or physician assistant".

(2) CONFORMING AMENDMENT.—Section 1842(b)(6)(C) (42 U.S.C. 1395u(b)(6)(C)) is amended by striking "clauses (i), (ii), or (iv)" and inserting "subclauses (I), (II), or (III) of clause (i), clause (ii)(I), or clause (iv)".

(c) PAYMENT UNDER THE FEE SCHEDULE TO PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS IN OUTPATIENT OR HOME SETTINGS.—

(1) PHYSICIAN ASSISTANTS.—Section 1842(b)(12) (42 U.S.C. 1395u(b)(12)) is amended by adding at the end the following new subparagraph:

"(C) With respect to services described in clauses (i)(IV), (ii)(II), and (iv) of section 1861(s)(2)(K) (relating to physician assistants and nurse practitioners furnishing services in outpatient or home settings)—

"(i) payment under this part may only be made on an assignment-related basis; and

"(ii) the amounts paid under this part shall be equal to 80 percent of (I) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848 for the same service provided by a physician who is not a specialist; or (II) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery.".

(2) CONFORMING AMENDMENT.—Section 1842(b)(12)(A) (42 U.S.C. 1395u(b)(12)(A)) is amended in the matter preceding clause (i) by striking "(i), (ii)," and inserting "subclauses (I), (II), or (III) of clause (i), or subclause (I) of clause (ii)".

(3) TECHNICAL AMENDMENT.—Section 1842(b)(12)(A) (42 U.S.C. 1395u(b)(12)(A)) is amended in the matter preceding clause (i) by striking "a physician assistants" and inserting "physician assistants".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 1995.

SEC. 7076. DEMONSTRATION PROJECTS TO PROMOTE TELEMEDICINE.

(a) DEFINITIONS.—For purposes of this section:

(1) RURAL HEALTH CARE PROVIDER.—The term "rural health care provider" means any public or private health care provider located in a rural area.

(2) NONHEALTH CARE ENTITY.—The term "nonhealth care entity" means any entity that is not involved in the provision of health care, including a business, educational institution, library, and prison.

(b) ESTABLISHMENT.—The Secretary, acting through the Office of Rural Health, shall award grants to eligible entities to establish demonstration projects under which an eligible entity establishes a rural-based consortium that enables members of the consortium to utilize the telecommunications network—

(1) to strengthen the delivery of health care services in the rural area through the use of telemedicine;

(2) to provide for consultations involving transmissions of detailed data about the patient that serves as a reasonable substitute for face-to-face interaction between the patient and consultant; and

(3) to make outside resources or business interaction more available to the rural area.

(c) ELIGIBLE ENTITY.—To be eligible to receive a grant under this section an applicant entity shall propose a consortium that includes as members at least—

(1) one rural health care provider; and

(2) one nonhealth care entity located in the same rural area as the rural health care provider described in paragraph (1).

The Secretary may waive the membership requirement under paragraph (2) if the members described in paragraph (1) are unable to locate a nonhealth care entity located in the same rural area to participate in the demonstration project.

(d) APPLICATION.—To be eligible to receive a grant under this section, an eligible entity described in subsection (c) shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including a description of the use to which the eligible entity would apply any amounts received under such grant, the source and amount of non-Federal funds the entity would pledge for the project, and a showing of the long-term sustainability of the project.

(e) GRANTS.—Grants under this section shall be distributed in accordance with the following requirements:

(1) GRANT LIMIT.—The Secretary may not make a grant to an eligible entity under this section in excess of $500,000 for each fiscal year in which an eligible entity conducts a project under this section.

(2) MATCHING FUNDS.—

(A) IN GENERAL.—The Secretary may not make a grant to an eligible entity under this section unless the eligible entity agrees to provide non-Federal funds in an

amount equal to not less than 20 percent of the total amount to be expended by the eligible entity in any fiscal year for the purpose of conducting the project under this section.

(B) ADJUSTMENTS.—The Secretary shall make necessary adjustments to the amount that an eligible entity may receive in a subsequent fiscal year if the eligible entity does not meet the requirements of subparagraph (A) in the preceding fiscal year.

(f) USE OF GRANT AMOUNTS.—

(1) IN GENERAL.—Amounts received under a grant awarded under this section shall be utilized for the development and operation of telemedicine systems that serve rural areas. All such grant funds must be used to further the provision of health services to rural areas.

(2) RULES OF USE.—

(A) PERMISSIBLE USAGES.—Grant funds awarded under this section—

(i) shall primarily be used to support the costs of establishing and operating a telemedicine system that provides specialty consultations to rural communities;

(ii) may be used to demonstrate the application of telemedicine for preceptorship of medical students, residents, and other health professions students in rural training sites;

(iii) may be used for transmission costs, salaries, maintenance of equipment, and compensation of specialists and referring practitioners;

(iv) may be used to pay the fees of consultants, but only to the extent that the total of such fees does not exceed 5 percent of the amount of the grant;

(v) may be used to demonstrate the use of telemedicine to facilitate collaboration between nonphysician primary care practitioners (including physician assistants, nurse practitioners, certified nurse-midwives, and clinical nurse specialists) and physicians; and

(vi) may be used to test reimbursement methodologies under the medicare program under title XVIII of the Social Security Act for practitioners participating in telemedicine activities.

(B) PROHIBITED USE OF FUNDS.—Grant funds shall not be used by members of a rural-based consortium for any of the following:

(i) Expenditures to purchase or lease equipment.

(ii) In the case of a member of a consortium that is an isolated rural facility, purchase of high-cost telecommunications technologies for the furnishing of telemedicine services that—

(I) incur high cost per minute of usage charges; or

(II) require consultants to be available at the same time as the patient and the referring physician.

(iii) Purchase or installation of transmission equipment or establishment or operation of a telecommunications common carrier network.

(iv) Expenditures for indirect costs (as determined by the Secretary) to the extent the expenditures would exceed more than 20 percent of the total grant funds.

(v) Construction (except for minor renovations related to the installation of equipment), or the acquisition or building of real property.

(g) MAINTENANCE OF EFFORT.—Any funds available for the activities covered by a demonstration project conducted under this section shall supplement, and shall not supplant, funds that are expended for similar purposes under any State, regional, or local program.

(h) EVALUATIONS.—Each eligible entity that conducts a demonstration project under this section shall submit to the Secretary such information and interim evaluations as the Secretary may require.

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $10,000,000 for each of the fiscal years 1996 through 1998.

SEC. 7077. PROPAC RECOMMENDATIONS ON URBAN MEDICARE DEPENDENT HOSPITALS.

Section 1886(e)(3)(A) (42 U.S.C. 1395ww(e)(3)(A)) is amended by adding at the end the following new sentence: "The Commission shall, beginning in 1996, report its recommendations to Congress on an appropriate update to be used for urban hospitals with a high proportion of medicare patient days and on actions to ensure that medicare beneficiaries served by such hospitals retain the same access and quality of care as medicare beneficiaries nationwide.".

CHAPTER 6—HEALTH CARE FRAUD AND ABUSE PREVENTION

SEC. 7100. SHORT TITLE.

This chapter may be cited as the "Health Care Fraud and Abuse Prevention Act of 1995".

Subchapter A—Fraud and Abuse Control Program

SEC. 7101. FRAUD AND ABUSE CONTROL PROGRAM.

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

"FRAUD AND ABUSE CONTROL PROGRAM

"SEC. 1128C. (a) ESTABLISHMENT OF PROGRAM.—

"(1) IN GENERAL.—Not later than January 1, 1996, the Secretary, acting through the Office of the Inspector General of the Department of Health and Human Services, and the Attorney General shall establish a program—

"(A) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to the delivery of and payment for health care in the United States,

"(B) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States,

"(C) to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B and other statutes applicable to health care fraud and abuse, and

"(D) to provide for the modification and establishment of safe harbors and to issue interpretative rulings and special fraud alerts pursuant to section 1128D.

"(2) COORDINATION WITH HEALTH PLANS.—In carrying out the program established under paragraph (1), the Secretary and the Attorney General shall consult with, and arrange for the sharing of data with representatives of health plans.

"(3) GUIDELINES.—

"(A) IN GENERAL.—The Secretary and the Attorney General shall issue guidelines to carry out the program under paragraph (1). The provisions of sections 553, 556, and 557 of title 5, United States Code, shall not apply in the issuance of such guidelines.

"(B) INFORMATION GUIDELINES.—

"(i) IN GENERAL.—Such guidelines shall include guidelines relating to the furnishing of information by health plans, providers, and others to enable the Secretary and the Attorney General to carry out the program (including coordination with health plans under paragraph (2)).

"(ii) CONFIDENTIALITY.—Such guidelines shall include procedures to assure that such information is provided and utilized in a manner that appropriately protects the confidentiality of the information and the

privacy of individuals receiving health care services and items.

"(iii) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) (relating to limitation on liability) shall apply to a person providing information to the Secretary or the Attorney General in conjunction with their performance of duties under this section.

"(4) ENSURING ACCESS TO DOCUMENTATION.—The Inspector General of the Department of Health and Human Services is authorized to exercise such authority described in paragraphs (3) through (9) of section 6 of the Inspector General Act of 1978 (5 U.S.C. App.) as necessary with respect to the activities under the fraud and abuse control program established under this subsection.

"(5) AUTHORITY OF INSPECTOR GENERAL.—Nothing in this Act shall be construed to diminish the authority of any Inspector General, including such authority as provided in the Inspector General Act of 1978 (5 U.S.C. App.).

"(b) ADDITIONAL USE OF FUNDS BY INSPECTOR GENERAL.—

"(1) REIMBURSEMENTS FOR INVESTIGATIONS.—The Inspector General of the Department of Health and Human Services is authorized to receive and retain for current use reimbursement for the costs of conducting investigations and audits and for monitoring compliance plans when such costs are ordered by a court, voluntarily agreed to by the payer, or otherwise.

"(2) CREDITING.—Funds received by the Inspector General under paragraph (1) as reimbursement for costs of conducting investigations shall be deposited to the credit of the appropriation from which initially paid, or to appropriations for similar purposes currently available at the time of deposit, and shall remain available for obligation for 1 year from the date of the deposit of such funds.

"(c) HEALTH PLAN DEFINED.—For purposes of this section, the term 'health plan' means a plan or program that provides health benefits, whether directly, through insurance, or otherwise, and includes—

"(1) a policy of health insurance;

"(2) a contract of a service benefit organization; and

"(3) a membership agreement with a health maintenance organization or other prepaid health plan.".

(b) ESTABLISHMENT OF HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

"(k) HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—

"(1) ESTABLISHMENT.—There is hereby established in the Trust Fund an expenditure account to be known as the 'Health Care Fraud and Abuse Control Account' (in this subsection referred to as the 'Account').

"(2) APPROPRIATED AMOUNTS TO TRUST FUND.—

"(A) IN GENERAL.—There are hereby appropriated to the Trust Fund—

"(i) such gifts and bequests as may be made as provided in subparagraph (B);

"(ii) such amounts as may be deposited in the Trust Fund as provided in sections 7141(b) and 7142(c) of the Balanced Budget Reconciliation Act of 1995, and title XI; and

"(iii) such amounts as are transferred to the Trust Fund under subparagraph (C).

"(B) AUTHORIZATION TO ACCEPT GIFTS.—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 Account or any activity financed through the Account.

"(C) TRANSFER OF AMOUNTS.—The Managing Trustee shall transfer to the Trust Fund, under rules similar to the rules in section 9601 of the Internal Revenue Code of 1986, an amount equal to the sum of the following:

"(i) Criminal fines recovered in cases involving a Federal health care offense (as defined in section 982(a)(6)(B) of title 18, United States Code).

"(ii) Civil monetary penalties and assessments imposed in health care cases, including amounts recovered under titles XI, XVIII, and XXI, and chapter 38 of title 31, United States Code (except as otherwise provided by law).

"(iii) Amounts resulting from the forfeiture of property by reason of a Federal health care offense.

"(iv) Penalties and damages obtained and otherwise creditable to miscellaneous receipts of the general fund of the Treasury obtained under sections 3729 through 3733 of title 31, United States Code (known as the False Claims Act), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator, for restitution or otherwise authorized by law).

"(3) APPROPRIATED AMOUNTS TO ACCOUNT.—

"(A) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund such sums as the Secretary and the Attorney General certify are necessary to carry out the purposes described in subparagraph (B), to be available without further appropriation, in an amount—

"(i) with respect to activities of the Office of the Inspector General of the Department of Health and Human Services and the Federal Bureau of Investigations in carrying out such purposes, not less than—

"(I) for fiscal year 1996, $110,000,000,

"(II) for fiscal year 1997, $140,000,000,

"(III) for fiscal year 1998, $160,000,000,

"(IV) for fiscal year 1999, $185,000,000,

"(V) for fiscal year 2000, $215,000,000,

"(VI) for fiscal year 2001, $240,000,000, and

"(VII) for fiscal year 2002, $270,000,000; and

"(ii) with respect to all activities (including the activities described in clause (i)) in carrying out such purposes, not more than—

"(I) for fiscal year 1996, $200,000,000, and

"(II) for each of the fiscal years 1997 through 2002, the limit for the preceding fiscal year, increased by 15 percent; and

"(iii) for each fiscal year after fiscal year 2002, within the limits for fiscal year 2002 as determined under clauses (i) and (ii).

"(B) USE OF FUNDS.—The purposes described in this subparagraph are as follows:

"(i) GENERAL USE.—To cover the costs (including equipment, salaries and benefits, and travel and training) of the administration and operation of the health care fraud and abuse control program established under section 1128C(a), including the costs of—

"(I) prosecuting health care matters (through criminal, civil, and administrative proceedings);

"(II) investigations;

"(III) financial and performance audits of health care programs and operations;

"(IV) inspections and other evaluations; and

"(V) provider and consumer education regarding compliance with the provisions of title XI.

"(ii) USE BY STATE MEDICAID FRAUD CONTROL UNITS FOR INVESTIGATION REIMBURSEMENTS.—To reimburse the various State medicaid fraud control units upon request to the Secretary for the costs of the activities authorized under section 2134(b).

"(4) ANNUAL REPORT.—The Secretary and the Attorney General shall submit jointly an annual report to Congress on the amount of revenue which is generated and disbursed, and the justification for such disbursements, by the Account in each fiscal year.".

SEC. 7102. APPLICATION OF CERTAIN HEALTH ANTI-FRAUD AND ABUSE SANCTIONS TO FRAUD AND ABUSE AGAINST FEDERAL HEALTH PROGRAMS.

(a) CRIMES.—

(1) SOCIAL SECURITY ACT.—Section 1128B (42 U.S.C. 1320a–7b) is amended as follows:

(A) In the heading, by striking "MEDICARE OR STATE HEALTH CARE PROGRAMS" and inserting "FEDERAL HEALTH CARE PROGRAMS".

(B) In subsection (a)(1), by striking "a program under title XVIII or a State health care program (as defined in section 1128(h))" and inserting "a Federal health care program".

(C) In subsection (a)(5), by striking "a program under title XVIII or a State health care program" and inserting "a Federal health care program".

(D) In the second sentence of subsection (a)—

(i) by striking "a State plan approved under title XIX" and inserting "a Federal health care program", and

(ii) by striking "the State may at its option (notwithstanding any other provision of that title or of such plan)" and inserting "the administrator of such program may at its option (notwithstanding any other provision of such program)".

(E) In subsection (b), by striking "title XVIII or a State health care program" each place it appears and inserting "a Federal health care program".

(F) In subsection (c), by inserting "(as defined in section 1128(h))" after "a State health care program".

(G) By adding at the end the following new subsection:

"(f) For purposes of this section, the term 'Federal health care program' means—

"(1) 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

"(2) any State health care program, as defined in section 1128(h).".

(2) IDENTIFICATION OF COMMUNITY SERVICE OPPORTUNITIES.—Section 1128B (42 U.S.C. 1320a–7b) is further amended by adding at the end the following new subsection:

"(g) The Secretary may—

"(1) in consultation with State and local health care officials, identify opportunities for the satisfaction of community service obligations that a court may impose upon the conviction of an offense under this section, and

"(2) make information concerning such opportunities available to Federal and State law enforcement officers and State and local health care officials.".

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1996.

SEC. 7103. HEALTH CARE FRAUD AND ABUSE GUIDANCE.

Title XI (42 U.S.C. 1301 et seq.), as amended by section 7101, is amended by inserting after section 1128C the following new section:

"HEALTH CARE FRAUD AND ABUSE GUIDANCE

"SEC. 1128D. (a) SOLICITATION AND PUBLICATION OF MODIFICATIONS TO EXISTING SAFE HARBORS AND NEW SAFE HARBORS.—

"(1) IN GENERAL.—

"(A) SOLICITATION OF PROPOSALS FOR SAFE HARBORS.—Not later than January 1, 1996, and not less than annually thereafter, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for—

"(i) modifications to existing safe harbors issued pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987 (42 U.S.C. 1320a–7b note);

"(ii) additional safe harbors specifying payment practices that shall not be treated as a criminal offense under section 1128B(b) and shall not serve as the basis for an exclusion under section 1128(b)(7);

"(iii) interpretive rulings to be issued pursuant to subsection (b); and

"(iv) special fraud alerts to be issued pursuant to subsection (c).

"(B) PUBLICATION OF PROPOSED MODIFICATIONS AND PROPOSED ADDITIONAL SAFE HARBORS.—After considering the proposals described in clauses (i) and (ii) of subparagraph (A), the Secretary, 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.

"(C) REPORT.—The Inspector General of the Department of Health and Human Services (in this section referred to as 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 (5 U.S.C. App.), describe the proposals received under clauses (i) and (ii) of subparagraph (A) and explain which proposals were included in the publication described in subparagraph (B), which proposals were not included in that publication, and the reasons for the rejection of the proposals that were not included.

"(2) CRITERIA FOR MODIFYING AND ESTABLISHING SAFE HARBORS.—In modifying and establishing safe harbors under paragraph (1)(B), the Secretary may consider the extent to which providing a safe harbor for the specified payment practice may result in any of the following:

"(A) An increase or decrease in access to health care services.

"(B) An increase or decrease in the quality of health care services.

"(C) An increase or decrease in patient freedom of choice among health care providers.

"(D) An increase or decrease in competition among health care providers.

"(E) An increase or decrease in the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

"(F) An increase or decrease in the cost to Federal health care programs (as defined in section 1128B(f)).

"(G) An increase or decrease in the potential overutilization of health care services.

"(H) The existence or nonexistence of any potential financial benefit to a health care professional or provider which may vary based on their decisions of—

"(i) whether to order a health care item or service; or

"(ii) whether to arrange for a referral of health care items or services to a particular practitioner or provider.

"(I) Any other factors the Secretary deems appropriate in the interest of preventing fraud and abuse in Federal health care programs (as so defined).

"(b) INTERPRETIVE RULINGS.—

"(1) IN GENERAL.—

"(A) REQUEST FOR INTERPRETIVE RULING.—Any person may present, at any time, a request to the Inspector General for a statement of the Inspector General's current interpretation of the meaning of a specific aspect of the application of sections 1128A and 1128B (in this section referred to as an 'interpretive ruling').

"(B) ISSUANCE AND EFFECT OF INTERPRETIVE RULING.—

"(i) IN GENERAL.—If appropriate, the Inspector General shall in consultation with the Attorney General, issue an interpretive ruling not later than 90 days after receiving a request described in subparagraph (A). Interpretive rulings shall not have the force of law and shall be treated as an interpretive rule within the meaning of section 553(b) of title 5, United States Code. All interpretive rulings issued pursuant to this clause shall be published in the Federal Register or otherwise made available for public inspection.

"(ii) REASONS FOR DENIAL.—If the Inspector General does not issue an interpretive ruling in response to a request described in subparagraph (A), the Inspector General shall notify the requesting party of such decision not later than 60 days after receiving such a request and shall identify the reasons for such decision.

"(2) CRITERIA FOR INTERPRETIVE RULINGS.—

"(A) IN GENERAL.—In determining whether to issue an interpretive ruling under paragraph (1)(B), the Inspector General may consider—

"(i) whether and to what extent the request identifies an ambiguity within the language of the statute, the existing safe harbors, or previous interpretive rulings; and

"(ii) whether the subject of the requested interpretive ruling can be adequately addressed by interpretation of the language of the statute, the existing safe harbor rules, or previous interpretive rulings, or whether the request would require a substantive ruling (as defined in section 552 of title 5, United States Code) not authorized under this subsection.

"(B) NO RULINGS ON FACTUAL ISSUES.—The Inspector General shall not give an interpretive ruling on any factual issue, including the intent of the parties or the fair market value of particular leased space or equipment.

"(c) SPECIAL FRAUD ALERTS.—

"(1) IN GENERAL.—

"(A) REQUEST FOR SPECIAL FRAUD ALERTS.—Any person may present, at any time, a request to the Inspector General for a notice which informs the public of practices which the Inspector General considers to be suspect or of particular concern under section 1128B(b) (in this subsection referred to as a 'special fraud alert').

"(B) ISSUANCE AND PUBLICATION OF SPECIAL FRAUD ALERTS.—Upon receipt of a request described in subparagraph (A), the Inspector General shall investigate the subject matter of the request to determine whether a special fraud alert should be issued. If appropriate, the Inspector 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.

"(2) CRITERIA FOR SPECIAL FRAUD ALERTS.—In determining whether to issue a special fraud alert upon a request described in paragraph (1), the Inspector General may consider—

"(A) 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 subsection (a)(2); and

"(B) the volume and frequency of the conduct that would be identified in the special fraud alert.".

Subchapter B—Revisions to Current Sanctions for Fraud and Abuse

SEC. 7111. MANDATORY EXCLUSION FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) INDIVIDUAL CONVICTED OF FELONY RELATING TO HEALTH CARE FRAUD.—

(1) IN GENERAL.—Section 1128(a) (42 U.S.C. 1320a–7(a)) is amended by adding at the end the following new paragraph:

"(3) FELONY CONVICTION RELATING TO HEALTH CARE FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Health Care Fraud and Abuse Prevention Act of 1995, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.".

(2) CONFORMING AMENDMENT.—Paragraph (1) of section 1128(b) (42 U.S.C. 1320a–7(b)) is amended to read as follows:

"(1) CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Health Care Fraud and Abuse Prevention Act of 1995, under Federal or State law—

"(A) of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct—

"(i) in connection with the delivery of a health care item or service, or

"(ii) with respect to any act or omission in a health care program (other than those specifically described in subsection (a)(1)) operated by or financed in whole or in part by any Federal, State, or local government agency; or

"(B) of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any Federal, State, or local government agency.".

(b) INDIVIDUAL CONVICTED OF FELONY RELATING TO CONTROLLED SUBSTANCE.—

(1) IN GENERAL.—Section 1128(a) (42 U.S.C. 1320a–7(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

"(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted after the date of the enactment of the Health Care Fraud and Abuse Prevention Act of 1995, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.".

(2) CONFORMING AMENDMENT.—Section 1128(b)(3) (42 U.S.C. 1320a–7(b)(3)) is amended—

(A) in the heading, by striking "CONVICTION" and inserting "MISDEMEANOR CONVICTION"; and

(B) by striking "criminal offense" and inserting "criminal offense consisting of a misdemeanor".

SEC. 7112. ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

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 published 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.".

SEC. 7113. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH OWNERSHIP OR CONTROL INTEREST IN SANCTIONED ENTITIES.

Section 1128(b) (42 U.S.C. 1320a–7(b)) is amended by adding at the end the following new paragraph:

"(15) INDIVIDUALS CONTROLLING A SANCTIONED ENTITY.—Any individual who has a direct or indirect ownership or control interest of 5 percent or more, or an ownership or control interest (as defined in section 1124(a)(3)) in, or who is an officer or managing employee (as defined in section 1126(b)) of, an entity—

"(A) that has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection; or

"(B) that has been excluded from participation under a program under title XVIII or under a State health care program.".

SEC. 7114. SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.

(a) MINIMUM PERIOD OF EXCLUSION FOR PRACTITIONERS AND PERSONS FAILING TO MEET STATUTORY OBLIGATIONS.—

(1) IN GENERAL.—The second sentence of section 1156(b)(1) (42 U.S.C. 1320c–5(b)(1)) is amended by striking "may prescribe)" and inserting "may prescribe, except that such period may not be less than 1 year)".

(2) CONFORMING AMENDMENT.—Section 1156(b)(2) (42 U.S.C. 1320c–5(b)(2)) is amended by striking "shall remain" and inserting "shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain".

(b) REPEAL OF "UNWILLING OR UNABLE" CONDITION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1) (42 U.S.C. 1320c–5(b)(1)) is amended—

(1) in the second sentence, by striking "and determines" and all that follows through "such obligations,"; and

(2) by striking the third sentence.

SEC. 7115. 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 "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 paragraph (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 substantially inconsistent with the efficient and effective administration of this section; or

"(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).".

(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 determination 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.

"(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 first provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1) and the organization fails to develop or implement such a plan;

"(B) in deciding whether to impose sanctions, the Secretary considers aggravating factors such as whether an organization has a history of deficiencies or has not taken action to correct deficiencies the Secretary has brought to the organization's attention;

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

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

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

(b) AGREEMENTS WITH PEER REVIEW ORGANIZATIONS.—Section 1876(i)(7)(A) (42 U.S.C. 1395mm(i)(7)(A)) is amended by striking "an agreement" and inserting "a written agreement".

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

SEC. 7116. CLARIFICATION OF AND ADDITIONS TO EXCEPTIONS TO ANTI-KICKBACK PENALTIES.

(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 amounts paid to a provider in connection with an item or service furnished to an individual, any discount or reduction in price given by the provider for such an item or service, or any other remuneration if the item or service is provided through a medicare choice plan.".

(b) VOLUME AND COMBINATION DISCOUNTS.—

(1) STUDY.—The Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall conduct a study evaluating the benefits of volume and combination discounts to the medicare program under title XVIII of the Social Security Act.

(2) CONTENTS OF STUDY.—

(A) IN GENERAL.—The Secretary, in consultation with health care providers and manufacturers, shall specifically examine the issues associated with the discounting or other reductions in price (including reductions in price applied to combinations of items or services or both, and reductions made available as part of capitation, risk sharing, decrease management or similar programs) obtained by a provider of services or other entity under title XVIII of the Social Security Act or a State health care program (as defined in section 1128(h) of such Act).

(B) SPECIFIC EVALUATION AND IDENTIFICATION.—The Secretary shall evaluate the provision of discounts on the medicare program under title XVIII of the Social Security Act and specifically identify mechanisms to assure that the medicare program benefits from such discounts.

(3) REPORT.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall report the findings of the study to the Committees on Finance and the Judiciary of the Senate and the Committees on Ways and Means, Commerce, and the Judiciary of the House of Representatives.

(4) REGULATIONS.—The Secretary shall develop regulations regarding the acceptability of such discounts based on the findings of the study described in this subsection. Such regulations shall not become effective unless such regulations are budget neutral.

SEC. 7117. EFFECTIVE DATE.

The amendments made by this subchapter shall take effect January 1, 1996.

Subchapter C—Administrative and Miscellaneous Provisions

SEC. 7121. ESTABLISHMENT OF THE HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM.

(a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.), as amended by sections 7101 and 7103, is amended by inserting after section 1128D the following new section:

"HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM

"SEC. 1128E. (a) GENERAL PURPOSE.—Not later than January 1, 1996, the Secretary shall establish a national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (c).

"(b) REPORTING OF INFORMATION.—

"(1) IN GENERAL.—Each government agency and health plan shall report any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner.

"(2) INFORMATION TO BE REPORTED.—The information to be reported under paragraph (1) includes:

"(A) The name and TIN (as defined in section 7701(a)(41) of the Internal Revenue Code of 1986) of any health care provider, supplier, or practitioner who is the subject of a final adverse action.

"(B) The name (if known) of any health care entity with which a health care provider, supplier, or practitioner is affiliated or associated.

"(C) The nature of the final adverse action and whether such action is on appeal.

"(D) A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information as the Secretary determines by regulation is required for appropriate interpretation of information reported under this section.

"(3) CONFIDENTIALITY.—In determining what information is required, the Secretary shall include procedures to assure that the privacy of individuals receiving health care services is appropriately protected.

"(4) TIMING AND FORM OF REPORTING.—The information required to be reported under this subsection shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes. Such information shall first be required to be reported on a date specified by the Secretary.

"(5) TO WHOM REPORTED.—The information required to be reported under this subsection shall be reported to the Secretary.

"(c) DISCLOSURE AND CORRECTION OF INFORMATION.—

"(1) DISCLOSURE.—With respect to the information about final adverse actions (not including settlements in which no findings of liability have been made) reported to the Secretary under this section respecting a health care provider, supplier, or practitioner, the Secretary shall, by regulation, provide for—

"(A) disclosure of the information, upon request, to the health care provider, supplier, or licensed practitioner, and

"(B) procedures in the case of disputed accuracy of the information.

"(2) CORRECTIONS.—Each Government agency and health plan shall report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, in such form and manner that the Secretary prescribes by regulation.

"(d) ACCESS TO REPORTED INFORMATION.—

"(1) AVAILABILITY.—The information in this database shall be available to Federal and State government agencies and health plans pursuant to procedures that the Secretary shall provide by regulation.

"(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information in this database (other than with respect to requests by Federal agencies). The amount of such a fee shall be sufficient to recover the full costs of operating the database. Such fees shall be available to the Secretary or, in the Secretary's discretion to the agency designated under this section to cover such costs.

"(e) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity, including the agency designated by the Secretary in subsection (b)(5) shall be held liable in any civil action with respect to any report made as required by this section, without knowledge of the falsity of the information contained in the report.

"(f) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

"(1) FINAL ADVERSE ACTION.—

"(A) IN GENERAL.—The term 'final adverse action' includes:

"(i) Civil judgments against a health care provider, supplier, or practitioner in Federal or State court related to the delivery of a health care item or service.

"(ii) Federal or State criminal convictions related to the delivery of a health care item or service.

"(iii) Actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including—

"(I) formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure or probation,

"(II) any other loss of license or the right to apply for, or renew, a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, non-renewability, or otherwise, or

"(III) any other negative action or finding by such Federal or State agency that is publicly available information.

"(iv) Exclusion from participation in Federal or State health care programs.

"(v) Any other adjudicated actions or decisions that the Secretary shall establish by regulation.

"(B) EXCEPTION.—The term does not include any action with respect to a malpractice claim.

"(2) PRACTITIONER.—The terms 'licensed health care practitioner', 'licensed practitioner', and 'practitioner' mean, with respect to a State, an individual who is licensed or otherwise authorized by the State to provide health care services (or any individual who, without authority holds himself or herself out to be so licensed or authorized).

"(3) HEALTH CARE PROVIDER.—The term 'health care provider' means a provider of services as defined in section 1861(u), and any entity, including a health maintenance organization, group medical practice, or any other individual or entity listed by the Secretary in regulation, that provides health care services.

"(4) SUPPLIER.—The term 'supplier' means a supplier of health care items and services described in subsections (a) and (b) of section 1819 and section 1861.

"(5) GOVERNMENT AGENCY.—The term 'Government agency' shall include:

"(A) The Department of Justice.

"(B) The Department of Health and Human Services.

"(C) Any other Federal agency that either administers or provides payment for the delivery of health care services, including, but not limited to the Department of Defense and the Veterans' Administration.

"(D) State law enforcement agencies.

"(E) State medicaid fraud control units.

"(F) Federal or State agencies responsible for the licensing and certification of health care providers and licensed health care practitioners.

"(6) HEALTH PLAN.—The term 'health plan' has the meaning given such term by section 1128C(c).

"(7) DETERMINATION OF CONVICTION.—For purposes of paragraph (1), the existence of a conviction shall be determined under paragraph (4) of section 1128(j).".

(b) IMPROVED PREVENTION IN ISSUANCE OF MEDICARE PROVIDER NUMBERS.—Section 1842(r) (42 U.S.C. 1395u(r)) is amended by adding at the end the following new sentence: "Under such system, the Secretary may impose appropriate fees on such physicians to cover the costs of investigation and recertification activities with respect to the issuance of the identifiers.".

Subchapter D—Civil Monetary Penalties

SEC. 7131. SOCIAL SECURITY ACT CIVIL MONETARY PENALTIES.

(a) GENERAL CIVIL MONETARY PENALTIES.—Section 1128A (42 U.S.C. 1320a–7a) is amended as follows:

(1) In the third sentence of subsection (a), by striking "programs under title XVIII" and inserting "Federal health care programs (as defined in section 1128B(f)(1))".

(2) In subsection (f)—

(A) by redesignating paragraph (3) as paragraph (4); and

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

"(3) With respect to amounts recovered arising out of a claim under a Federal health care program (as defined in section 1128B(f)), the portion of such amounts as is determined to have been paid by the program shall be repaid to the program, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amendments made by the Health Care Fraud and Abuse Prevention Act of 1995 (as estimated by the Secretary) shall be deposited into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C).".

(3) In subsection (i)—

(A) in paragraph (2), by striking "title V, XVIII, XIX, or XX of this Act" and inserting "a Federal health care program (as defined in section 1128B(f))",

(B) in paragraph (4), by striking "a health insurance or medical services program under title XVIII or XIX of this Act" and inserting "a Federal health care program (as so defined)", and

(C) in paragraph (5), by striking "title V, XVIII, XIX, or XX" and inserting "a Federal health care program (as so defined)".

(4) By adding at the end the following new subsection:

"(m)(1) For purposes of this section, with respect to a Federal health care program not contained in this Act, references to the Secretary in this section shall be deemed to be references to the Secretary or Administrator of the department or agency with jurisdiction over such program and references to the Inspector General of the Department of Health and Human Services in this section shall be deemed to be references to the Inspector General of the applicable department or agency.

"(2)(A) The Secretary and Administrator of the departments and agencies referred to in paragraph (1) may include in any action pursuant to this section, claims within the jurisdiction of other Federal departments or agencies as long as the following conditions are satisfied:

"(i) The case involves primarily claims submitted to the Federal health care programs of the department or agency initiating the action.

"(ii) The Secretary or Administrator of the department or agency initiating the action gives notice and an opportunity to participate in the investigation to the Inspector General of the department or agency with primary jurisdiction over the Federal health care programs to which the claims were submitted.

"(B) If the conditions specified in subparagraph (A) are fulfilled, the Inspector General of the department or agency initiating the action is authorized to exercise all powers granted under the Inspector General Act of 1978 with respect to the claims submitted to the other departments or agencies to the same manner and extent as provided in that Act with respect to claims submitted to such departments or agencies.".

(b) EXCLUDED INDIVIDUAL RETAINING OWNERSHIP OR CONTROL INTEREST IN PARTICIPATING ENTITY.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(1) by striking "or" at the end of paragraph (1)(D);

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

(3) by striking the semicolon at the end of paragraph (3) and inserting "; or"; and

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

"(4) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under title XVIII or a State health care program in accordance with this subsection or under section 1128 and who, at the time of a violation of this subsection, retains a direct or indirect ownership or control interest of 5 percent or more, or an ownership or control interest (as defined in section 1124(a)(3)) in, or who is an officer or managing employee (as defined in section 1126(b)) of, an entity that is participating in a program under title XVIII or a State health care program;".

(c) MODIFICATIONS OF AMOUNTS OF PENALTIES AND ASSESSMENTS.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by subsection (b), is amended in the matter following paragraph (4)—

(1) by striking "$2,000" and inserting "$10,000";

(2) by inserting "; in cases under paragraph (4), $10,000 for each day the prohibited relationship occurs" after "false or misleading information was given"; and

(3) by striking "twice the amount" and inserting "3 times the amount".

(d) CLAIM FOR ITEM OR SERVICE BASED ON INCORRECT CODING OR MEDICALLY UNNECESSARY SERVICES.—Section 1128A(a)(1) (42 U.S.C. 1320a–7a(a)(1)) is amended—

(1) in subparagraph (A) by striking "claimed," and inserting "claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or has reason to know will result in a greater payment to the person than the code the person knows or has reason to know is applicable to the item or service actually provided,";

(2) in subparagraph (C), by striking "or" at the end;

(3) in subparagraph (D), by striking "; or" and inserting ", or"; and

(4) by inserting after subparagraph (D) the following new subparagraph:

"(E) is for a medical or other item or service that a person knows or has reason to know is not medically necessary; or".

(e) PERMITTING SECRETARY TO IMPOSE CIVIL MONETARY PENALTY.—Section 1128A(b) (42 U.S.C. 1320a–7a(a)) is amended by adding the following new paragraph:

"(3) Any person (including any organization, agency, or other entity, but excluding a beneficiary as defined in subsection (i)(5)) who the Secretary determines has violated section 1128B(b) of this title shall be subject to a civil monetary penalty of not more than $10,000 for each such violation. In addition, such person shall be subject to an assessment of not more than twice the total amount of the remuneration offered, paid, solicited, or received in violation of section 1128B(b). The

total amount of remuneration subject to an assessment shall be calculated without regard to whether some portion thereof also may have been intended to serve a purpose other than one proscribed by section 1128B(b).".

(f) SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.—Section 1156(b)(3) (42 U.S.C. 1320c–5(b)(3)) is amended by striking "the actual or estimated cost" and inserting "up to $10,000 for each instance".

(g) PROCEDURAL PROVISIONS.—Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)), as amended by section 7115(a)(2), is 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 (B)(i) or (C)(i) in the same manner as such provisions apply to a civil money penalty or proceeding under section 1128A(a).".

(h) PROHIBITION AGAINST OFFERING INDUCEMENTS TO INDIVIDUALS ENROLLED UNDER PROGRAMS OR PLANS.—

(1) OFFER OF REMUNERATION.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

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

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

(C) by striking the semicolon at the end of paragraph (3) and inserting "; or"; and

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

"(4) offers to or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program;".

(2) REMUNERATION DEFINED.—Section 1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by adding the following new paragraph:

"(6) The term 'remuneration' includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. The term 'remuneration' does not include—

"(A) the waiver of coinsurance and deductible amounts by a person, if—

"(i) the waiver is not offered as part of any advertisement or solicitation;

"(ii) the person does not routinely waive coinsurance or deductible amounts; and

"(iii) the person—

"(I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need;

"(II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or

"(III) provides for any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary;

"(B) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been disclosed in writing to all beneficiaries, third party payers, and providers, to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary not later than 180 days after the date of the enactment of the Health Care Fraud and Abuse Prevention Act of 1995; or

"(C) incentives given to individuals to promote the delivery of preventive care as determined by the Secretary in regulations so promulgated.".

(i) EFFECTIVE DATE.—The amendments made by this section shall take effect January 1, 1996.

Subchapter E—Amendments to Criminal Law

SEC. 7141. HEALTH CARE FRAUD.

(a) IN GENERAL.—

(1) FINES AND IMPRISONMENT FOR HEALTH CARE FRAUD VIOLATIONS.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following new section:

"§ 1347. Health care fraud

"(a) Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice—

"(1) to defraud any health plan or other person, in connection with the delivery of or payment for health care benefits, items, or services; 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 plan, or person in connection with the delivery of or payment for health care benefits, items, or services;

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(g)(3) of this title), such person may be imprisoned for any term of years.

"(b) For purposes of this section, the term 'health plan' has the same meaning given such term in section 1128C(c) of the Social Security Act.".

(2) 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.".

(b) CRIMINAL FINES DEPOSITED IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—The Secretary of the Treasury shall deposit into the Federal Hospital Insurance Trust Fund pursuant to sec-

tion 1817(k)(2)(C) of the Social Security Act, as added by section 7101(b), an amount equal to the criminal fines imposed under section 1347 of title 18, United States Code (relating to health care fraud).

SEC. 7142. FORFEITURES FOR FEDERAL HEALTH CARE OFFENSES.

(a) IN GENERAL.—Section 982(a) of title 18, United States Code, is amended by adding after paragraph (5) the following new paragraph:

"(6)(A) The court, in imposing sentence on a person convicted of a Federal health care offense, shall order the person to forfeit property, real or personal, that constitutes or is derived, directly or indirectly, from gross proceeds traceable to the commission of the offense.

"(B) For purposes of this paragraph, the term 'Federal health care offense' means a violation of, or a criminal conspiracy to violate—

"(i) section 1347 of this title;

"(ii) section 1128B of the Social Security Act; and

"(iii) sections 287, 371, 664, 666, 669, 1001, 1027, 1341, 1343, 1920, or 1954 of this title if the violation or conspiracy relates to health care fraud.".

(b) CONFORMING AMENDMENT.—Section 982(b)(1)(A) of title 18, United States Code, is amended by inserting "or (a)(6)" after "(a)(1)".

(c) PROPERTY FORFEITED DEPOSITED IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—

(1) IN GENERAL.—After the payment of the costs of asset forfeiture has been made, and notwithstanding any other provision of law, the Secretary of the Treasury shall deposit into the Federal Hospital Insurance Trust Fund pursuant to section 1817(k)(2)(C) of the Social Security Act, as added by section 7101(b), an amount equal to the net amount realized from the forfeiture of property by reason of a Federal health care offense pursuant to section 982(a)(6) of title 18, United States Code.

(2) COSTS OF ASSET FORFEITURE.—For purposes of paragraph (1), the term "payment of the costs of asset forfeiture" means—

(A) the payment, at the discretion of the Attorney General, of any expenses necessary to seize, detain, inventory, safeguard, maintain, advertise, sell, or dispose of property under seizure, detention, or forfeited, or of any other necessary expenses incident to the seizure, detention, forfeiture, or disposal of such property, including payment for—

(i) contract services,

(ii) the employment of outside contractors to operate and manage properties or provide other specialized services necessary to dispose of such properties in an effort to maximize the return from such properties; and

(iii) reimbursement of any Federal, State, or local agency for any expenditures made to perform the functions described in this subparagraph;

(B) at the discretion of the Attorney General, the payment of awards for information or assistance leading to a civil or criminal forfeiture involving any Federal agency participating in the Health Care Fraud and Abuse Control Account;

(C) the compromise and payment of valid liens and mortgages against property that has been forfeited, subject to the discretion of the Attorney General to determine the validity of any such lien or mortgage and the amount of payment to be made, and the employment of attorneys and other personnel skilled in State real estate law as necessary;

(D) payment authorized in connection with remission or mitigation procedures relating to property forfeited; and

(E) the payment of State and local property taxes on forfeited real property that accrued between the date of the violation giving rise to the forfeiture and the date of the forfeiture order.

SEC. 7143. INJUNCTIVE RELIEF RELATING TO FEDERAL HEALTH CARE OFFENSES.

(a) IN GENERAL.—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 new subparagraph:

"(C) committing or about to commit a Federal health care offense (as defined in section 982(a)(6)(B) of this title);".

(b) FREEZING OF ASSETS.—Section 1345(a)(2) of title 18, United States Code, is amended by inserting "or a Federal health care offense (as defined in section 982(a)(6)(B))" after "title)".

SEC. 7144. 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 new subsection:

"(c) A person who is privy to grand jury information concerning a Federal health care offense (as defined in section 982(a)(6)(B))—

"(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 investigation or civil proceeding relating to health care fraud.".

SEC. 7145. FALSE STATEMENTS.

(a) IN GENERAL.—Chapter 47 of title 18, United States Code, is amended by adding at the end the following new section:

"§ 1033. False statements relating to health care matters

"(a) Whoever, in any matter involving a health plan, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme,

or device a material fact, or makes any false, fictitious, or fraudulent statements 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) For purposes of this section, the term 'health plan' has the same meaning given such term in section 1128C(c) of the Social Security Act.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 47 of title 18, United States Code, in amended by adding at the end the following:

"1033. False statements relating to health care matters.".

SEC. 7146. OBSTRUCTION OF CRIMINAL INVESTIGATIONS OF FEDERAL HEALTH CARE OFFENSES.

(a) IN GENERAL.—Chapter 73 of title 18, United States Code, is amended by adding at the end the following new section:

"§ 1518. Obstruction of criminal investigations of Federal 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 Federal 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 'Federal health care offense' has the same meaning given such term in section 982(a)(6)(B) 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:

"1518. Obstruction of Criminal Investigations of Federal Health Care Offenses.".

SEC. 7147. THEFT OR EMBEZZLEMENT.

(a) IN GENERAL.—Chapter 31 of title 18, United States Code, is amended by adding at the end the following new section:

"§ 669. Theft or embezzlement in connection with health care

"(a) Whoever willfully embezzles, steals, or otherwise 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 plan, shall be fined under this title or imprisoned not more than 10 years, or both.

"(b) As used in this section the term 'health plan' has the same meaning given such term in section 1128C(c) of the Social Security Act.".

(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. 7148. LAUNDERING OF MONETARY INSTRUMENTS.

Section 1956(c)(7) of title 18, United States Code, is amended by adding at the end the following new subparagraph:

"(F) Any act or activity constituting an offense involving a Federal health care offense as that term is defined in section 982(a)(6)(B) of this title.".

SEC. 7149. AUTHORIZED INVESTIGATIVE DEMAND PROCEDURES.

(a) IN GENERAL.—Chapter 233 of title 18, United States Code, is amended by adding after section 3485 the following new section:

"§ 3486. Authorized investigative demand procedures

"(a)(1)(A) In any investigation relating to functions set forth in paragraph (2), the Attorney General or designee may issue in writing and cause to be served a subpoena compelling 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.

"(B) A custodian of records may be required to give testimony concerning the production and authentication of such records.

"(C) 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; except that such production shall not be required more than 500 miles distant from the place where the subpoena is served.

"(D) Witnesses summoned under this section shall be paid the same fees and mileage that are paid witnesses in the courts of the United States.

"(E) A subpoena 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 subpoena are authorized for any investigation with respect to any act or activity constituting or involving health care fraud, including a scheme or artifice—

"(A) to defraud any health plan or other person, in connection with the delivery of or payment for health care benefits, items, or services; or

"(B) 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 or, any health plan, or person in connection with the delivery of or payment for health care benefits, items, or services.

"(b)(1) A subpoena issued under this section may be served by any person designated in the subpoena to serve it.

"(2) Service upon a natural person may be made by personal delivery of the subpoena to such person.

"(3) Service may be made upon a domestic or foreign 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.

"(4) 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)(1) 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 such person carries on business or may be found, to compel compliance with the subpoena.

"(2) 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 required under subsection (a)(1)(B).

"(3) Any failure to obey the order of the court may be punished by the court as a contempt thereof.

"(4) All process in any such case may be served in any judicial district in which such person may be found.

"(d) Notwithstanding any Federal, State, or local law, any person, including officers, agents, and employees, receiving a subpoena under this section, who complies in good faith with the subpoena 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.

"(e)(1) Health information about an individual that is disclosed under this section may not be used in, or disclosed to any person for use in, any administrative, civil, or criminal action or investigation directed against the individual who is the subject of the information unless the action or investigation arises out of and is directly related to receipt of health care or payment for health care or action involving a fraudulent claim related to health; or if authorized by an appropriate order of a court of competent jurisdiction, granted after application showing good cause therefore.

"(2) In assessing good cause, the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services.

"(3) Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

"(f) As used in this section the term 'health plan' has the same meaning given such term in section 1128C(c) of the Social Security Act.".

(b) CLERICAL AMENDMENT.—The table of sections for chapter 223 of title 18, United States Code, is amended by inserting after the item relating to section 3405 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 Department of Justice subpoena (issued under section 3486)," after "subpoena".

Subchapter F—State Health Care Fraud Control Units

SEC. 7151. STATE HEALTH CARE FRAUD CONTROL UNITS.

(a) EXTENSION OF CONCURRENT AUTHORITY TO INVESTIGATE AND PROSECUTE FRAUD IN OTHER FEDERAL PROGRAMS.—Paragraph (3) of section 2134(b), as added by section 7191(a) of this Act, is amended—

(1) by inserting "(A)" after "in connection with"; and

(2) by striking "plan." and inserting "plan; and (B) upon the approval of the relevant Federal agency, any aspect of the provision of health care services and activities of providers of such services under any Federal health care program (as defined in section 1128B(f)(1)).".

(b) EXTENSION OF AUTHORITY TO INVESTIGATE AND PROSECUTE PATIENT ABUSE IN NON-MEDICAID BOARD AND CARE FACILITIES.—Paragraph (4) of section 2134(b), as added by section 7191(a) of this Act, is amended to read as follows:

"(4)(A) The entity has—

"(i) procedures for reviewing complaints of abuse or neglect of patients in health care facilities which receive payments under the medicaid plan under this title;

"(ii) at the option of the entity, procedures for reviewing complaints of abuse or neglect of patients residing in board and care facilities; and

"(iii) where appropriate, procedures for acting upon such complaints under the criminal laws of the State or for referring such complaints to other State agencies for action.

"(B) For purposes of this paragraph, the term 'board and care facility' means a residential setting which receives payment from or on behalf of two or more unrelated adults who reside in such facility, and for whom one or both of the following is provided:

"(i) Nursing care services provided by, or under the supervision of, a registered nurse, licensed practical nurse, or licensed nursing assistant.

"(ii) Personal care services that assist residents with the activities of daily living, including personal hygiene, dressing, bathing, eating, toileting, ambulation, transfer, positioning, self-medication, body care, travel to medical services, essential shopping, meal preparation, laundry, and housework.".

CHAPTER 7—OTHER PROVISIONS FOR TRUST FUND SOLVENCY

Subchapter A—General Provisions

SEC. 7171. CONFORMING AGE FOR ELIGIBILITY UNDER MEDICARE TO RETIREMENT AGE FOR SOCIAL SECURITY BENEFITS.

(a) ENTITLEMENT TO HOSPITAL INSURANCE BENEFITS.—Section 226 (42 U.S.C. 426) is amended by striking "age 65" each place such term appears and inserting "retirement age".

(b) HOSPITAL INSURANCE BENEFITS FOR THE AGED.—Section 1811 (42 U.S.C. 1395c) is amended by striking "age 65" each place such term appears and inserting "retirement age (as such term is defined in section 216(*l*)(1))".

(c) HOSPITAL INSURANCE BENEFITS FOR UNINSURED ELDERLY INDIVIDUALS NOT OTHERWISE ELIGIBLE.—Section 1818 (42 U.S.C. 1395i–2) is amended—

(1) in subsection (a)(1), by striking "age of 65" and inserting "retirement age (as such term is defined in section 216(*l*)(1))";

(2) in subsection (d)(1), by striking "age 65" and inserting "retirement age (as such term is defined in section 216(*l*)(1))"; and

(3) in subsection (d)(3), by striking "65" and inserting "retirement age (as such term is defined in section 216(*l*)(1))".

(d) HOSPITAL INSURANCE BENEFITS FOR DISABLED INDIVIDUALS WHO HAVE EXHAUSTED OTHER ENTITLEMENT.—Section 1818A(a)(1) (42 U.S.C. 1395i–2a(a)(1)) is amended by striking "the age of 65" and inserting "retirement age (as such term is defined in section 216(*l*)(1))".

(e) ELIGIBILITY FOR PART B BENEFITS.—

(1) IN GENERAL.—Section 1836 (42 U.S.C. 1395o) is amended by striking "age 65" each place such term appears and inserting "retirement age (as such term is defined in section 216(*l*)(1))".

(2) ENROLLMENT PERIODS.—Section 1837 (42 U.S.C. 1395p) is amended by striking "age 65" and "the age of 65" each place such terms appear and inserting "retirement age (as such term is defined in section 216(*l*)(1))".

(3) COVERAGE PERIOD.—Section 1838(c) (42 U.S.C. 1395q(c)) is amended by striking "the age of 65" and inserting "retirement age (as such term is defined in section 216(*l*)(1))".

(4) AMOUNTS OF PREMIUMS.—Section 1839 (42 U.S.C. 1395r) is amended by striking "age 65" and "the age of 65" each place such terms appear and inserting "retirement age (as such term is defined in section 216(*l*)(1))".

(f) APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS AND CONTINGENCY RESERVE.—Section 1844(a)(1) (42 U.S.C. 1395w) is amended by striking "age 65" each place such term appears and inserting "retirement age".

(g) MEDICARE SECONDARY PAYER.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended by striking "age 65" each place such term appears and inserting "retirement age (as such term is defined in section 216(*l*)(1))".

(h) MEDICARE SUPPLEMENTAL POLICIES.—Section 1882(s)(2)(A) (42 U.S.C. 1395ss(s)(2)(A)) is amended by striking "65 years of age" and inserting "retirement age (as such term is defined in section 216(*l*)(1))".

SEC. 7172. NONDISCHARGEABILITY OF CERTAIN MEDICARE DEBTS.

Section 523(a) of title 11, United States Code, is amended—

(1) by striking "; or" at the end of paragraph (12);

(2) by inserting "or" at the end of paragraph (15)(B);

(3) by striking the period at the end of paragraph (16) and inserting "or"; and

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

"(17) for an overpayment to a provider or supplier made from the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Trust Fund.".

SEC. 7173. TRANSFERS OF CERTAIN PART B SAVINGS TO HOSPITAL INSURANCE TRUST FUND.

Section 1841 (42 U.S.C. 1395t) is amended by adding at the end the following new subsection:

"(j) There are hereby appropriated for each fiscal year to the Federal Hospital Insurance Trust Fund amounts equal to the estimated savings to the general fund of the Treasury for such year resulting from the amendments made by sections 7051 (relating to the part B deductible), 7052 (relating to the part B premium), and 7053 (relating to the part B premium for high-income individuals) of the Balanced Budget Reconciliation Act of 1995. The Secretary of the Treasury shall from time to time transfer from the general fund of the Treasury to the Federal Hospital Insurance Trust Fund amounts equal to such estimated savings in the form of public-debt obligations issued exclusively to the Federal Hospital Insurance Trust Fund.".

Subchapter B—Budget Expenditure Limiting Tool

SEC. 7175. BUDGET EXPENDITURE LIMITING TOOL.

(a) IN GENERAL.—Title XVIII is amended by adding at the end the following new section:

"BUDGET EXPENDITURE LIMITING TOOL

"SEC. 1893. (a) IMPLEMENTATION OF MEDICARE BUDGET COMPLIANCE ORDERS.—

"(1) IN GENERAL.—If a medicare budget compliance order is issued with respect to a fiscal year, then, notwithstanding any other provision of this title, the Secretary shall make the adjustments to applicable payment rates specified in the order.

"(2) EFFECT OF ADJUSTMENTS.—

"(A) ITEMS ADJUSTED.—Any adjustment under paragraph (1) shall apply solely for purposes of determining—

"(i) the applicable payment rates actually paid during the fiscal year, and

"(ii) the amount of any premium or coinsurance an individual is required to pay under this title.

"(B) ADJUSTMENTS NOT TO OTHERWISE APPLY.—Any adjustment under paragraph (1) shall not apply for any other

purpose not described in subparagraph (A), including for purposes of determining—

"(i) in the case of a scheduled rate increase described in subsection (c)(3), the rate in effect for a fiscal year in determining the amount of the increase for any subsequent fiscal year, and

"(ii) the rate to which an adjustment under this section applies for a subsequent fiscal year.

"(b) MEDICARE BUDGET COMPLIANCE ORDERS.—In this section—

"(1) DOWNWARD ADJUSTMENTS IN RATES.—A medicare budget compliance order is an order issued by the President under subsection (e)(5) or (e)(6)(B) which sets forth (in the manner described in subsection (c)) the adjustments in applicable payment rates for fee-for-service expenditures as are necessary—

"(A) in the case of an order under subsection (e)(5), to eliminate the medicare outlay deficit estimated for the fiscal year in the OMB final report under subsection (e)(4), and

"(B) in the case of an order under subsection (e)(6)(B), to eliminate any increase in such deficit in the OMB updated report under subsection (e)(6)(A).

"(2) UPWARD ADJUSTMENT IN RATES.—A medicare budget compliance order is an order issued by the President under subsection (e)(6)(C) which sets forth (in the manner described in subsection (c)) increases in the applicable payment rates for fee-for-service expenditures for the portion of the fiscal year specified in the order as are necessary to correct any reduction of the medicare outlay deficit estimated for the fiscal year in the OMB updated report under subsection (e)(6)(A).

"(3) APPLICABLE PAYMENT RATES.—The term 'applicable payment rate' means the rate (determined without regard to this section) at which payment is made under parts A and B for fee-for-service expenditures for items and services covered under parts A and B.

"(c) METHODS FOR MAKING ADJUSTMENTS.—

"(1) RATE REDUCTIONS.—Except as provided in paragraph (3), a medicare budget compliance order described in subsection (b)(1) shall provide the following adjustments in the following order:

"(A) First, a uniform percentage reduction in each of the scheduled rate increases specified in paragraph (4) as is necessary to reduce medicare outlays by the amount of the medicare outlay deficit for the fiscal year.

"(B) Second, if the medicare outlay deficit exceeds the reduction in outlays resulting from an elimination of the scheduled rate increases, a uniform percentage reduction in each of the applicable payment rates as is necessary to reduce medicare outlays by the amount of that excess.

"(2) RATE INCREASES.—Except as provided in paragraph (3), a medicare budget compliance order described in subsection (b)(2) shall provide—

"(A) a uniform percentage increase in each of the applicable payment rates described in paragraph (1)(B) as is necessary to increase medicare outlays for such payments by the lesser of the estimated reduction in the medicare outlay deficit or the amount of reductions under paragraph (1)(B), and

"(B) a uniform percentage increase in rates for which scheduled increases were reduced under paragraph (1)(B) to the extent of the lesser of the remainder of the reduction in the medicare outlay deficit or the amount of the reduction in such scheduled increases.

"(3) GEOGRAPHICAL ADJUSTMENTS.—

"(A) ADJUSTMENTS TO PERCENTAGES.—

"(i) IN GENERAL.—Unless Congress provides otherwise, beginning with fiscal years on or after October 1, 1999, the Secretary may, based on the analysis under subparagraph (B) and to the extent the Secretary determines necessary, adjust the percentage changes to the applicable payment rates required by this section in a manner designed to reflect an appropriate and equitable variation in rates of growth in per capita spending across medicare payment areas. Such variation shall be reasonably related to measurable geographic differences in medicare payment areas and the degree to which such patterns of rates of growth in per capita spending contribute to a medicare outlay deficit.

"(ii) BUDGET NEUTRALITY.—If the Secretary takes action under clause (i), the Secretary shall adjust the applicable payment rates in a manner that ensures that total outlays for a fiscal year are not greater or less than total outlays under this section would have been but for the application of clause (i).

"(B) ANALYSIS.—The Secretary, in consultation with interested parties, shall conduct an analysis of the measurable differences in rates of growth of spending across medicare payment areas using measurable variables as identified by the Secretary.

"(C) NOTICE.—If the Secretary decides to take action under subparagraph (A), the Secretary shall provide notice to Congress 1 year before the effective date of the action as to the variables the Secretary will use to determine variations in rates of growth in per capita spending and a preliminary assessment regarding how these variations may impact a medicare budget compliance order.

"(4) SCHEDULED RATE INCREASES.—For purposes of paragraph (1), a scheduled rate increase is any increase in an applicable payment which is made pursuant to an automatic adjustment required by part A or part B.

"(5) SPECIAL RULES FOR TIMING OF REDUCTIONS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), any reduction in applicable payment rates pursuant to a medicare budget compliance order shall be applied to payments for services furnished during the fiscal

year. For purposes of the preceding sentence, in the case of inpatient services furnished for an individual, the services shall be considered to be furnished on the date of the individual's discharge from the inpatient facility.

"(B) PAYMENT ON THE BASIS OF COST REPORTING PERIODS.—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 medicare budget compliance order shall provide for the payment adjustment under such subsection for a fiscal year through the appropriate percentage 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.

"(6) TIMING OF UPDATED ADJUSTMENTS.—Any increase or decrease in applicable payment rates pursuant to a medicare budget compliance order under subsection (e)(6) shall be made in the same manner as provided under paragraph (5), but shall only apply for the portion of the fiscal year occurring on and after March 1.

"(7) NO INCREASE IN BENEFICIARY CHARGES IN ASSIGNMENT-RELATED CASES.—If a reduction in payment amounts is made under subsection (a) for services for which payment under part B of title XVIII of the Social Security Act is made on the basis of an assignment described in section 1842(b)(3)(B)(ii), in accordance with section 1842(b)(6)(B), or under the procedure described in section 1870(f)(1), of such Act, the person furnishing the services shall be considered to have accepted payment of the reasonable charge for the services, less any reduction in payment amount made pursuant to a sequestration order, as payment in full.

"(d) MEDICARE OUTLAY DEFICITS AND RELATED TERMS.—In this section:

"(1) MEDICARE OUTLAY DEFICIT.—

"(A) IN GENERAL.—The term 'medicare outlay deficit' means the excess (if any) of—

"(i) the outlays with respect to items and services for which payment is made under part A or B, over

"(ii) the baseline medicare outlays.

"(B) SPECIFIC FISCAL YEAR.—The medicare outlay deficit for any fiscal year is the sum of—

"(i) the amount determined under subparagraph (A) for the fiscal year (without regard to this section), plus

"(ii) the amount determined under subparagraph (A) for the preceding fiscal year (determined after application of this section).

"(C) AMOUNTS BASED ON ESTIMATES.—The medicare outlay deficit for any fiscal year shall be determined on the

basis of the OMB final and updated reports under subsection (e).

"(2) MEDICARE BASELINE OUTLAYS.—The medicare baseline outlays shall be determined in accordance with the following table:

"In the case of fiscal year:	The baseline is (in billions):
1996	$193.3
1997	$206.5
1998	$219.7
1999	$233.5
2000	$249.6
2001	$266.9
2002	$285.6

"(3) OUTLAYS.—The term 'outlays' has the meaning given such term by section 3 of the Congressional Budget and Impoundment Control Act of 1974.

"(4) OMB.—The term 'OMB' means the Director of the Office of Management and Budget.

"(5) CBO.—The term 'CBO' means the Director of the Congressional Budget Office.

"(e) REPORTS AND ORDERS.—

"(1) TIMETABLE.—The timetable for the calendar year in which a fiscal year begins is as follows:

"Date:	Action to be completed:
August 15	Initial CBO/OMB snapshot
October 10	CBO final report
October 15	OMB final report/order
November 15	GAO compliance report
March 1 of next year	OMB/CBO updated report/order
April 1 of next year	GAO compliance report.

"(2) SUBMISSION AND AVAILABILITY.—Each report required by this section shall be submitted to the Committee on Ways and Means of the House of Representatives, the Committee on Finance of the Senate, and the President, and in the case of OMB and CBO, to each other. On the following day, a notice of the report shall be printed in the Federal Register.

"(3) SNAPSHOT.—CBO and OMB shall each prepare an estimate of the medicare outlay deficit for the fiscal year beginning October 1.

"(4) FINAL REPORTS.—

"(A) IN GENERAL.—The final reports of CBO and OMB shall each include—

"(i) an estimate of the medicare outlay deficit (if any) for the fiscal year beginning October 1, and

"(ii) the percentage reductions described in subsection (c)(1) necessary to offset the deficit.

"(B) DIFFERENCES.—Each OMB report shall explain any differences between the CBO and OMB estimates of the medicare outlay deficit and any required percentage reduction.

"(5) PRESIDENTIAL ORDER.—On the date specified in paragraph (1), if in its final report OMB estimates a medicare outlay deficit for the fiscal year beginning October 1, the President shall issue an order fully implementing without change

all percentage reductions required by the OMB calculations set forth in the report. The order shall be effective on issuance.

"(6) OMB AND CBO UPDATED REPORTS; ORDER.—

"(A) REPORTS.—The updated reports of OMB and CBO shall include—

"(i) an estimate of the differences between its current estimate of the medicare outlay deficit for the fiscal year and the estimate included in its final report,

"(ii) if a medicare budget compliance order is in effect for the fiscal year and if the estimate finds the deficit to be greater than that included in the OMB or CBO final report, the percentage decreases specified in subsection (c)(1) or (c)(3) necessary to offset the increase over the remainder of the fiscal year, and

"(iii) if the estimate finds the deficit to be less than that included in the final report, the percentage increases described in subsection (c)(2) or (c)(3) necessary to offset the reduction.

"(B) ORDER IMPLEMENTING DECREASES.—The President shall issue an order fully implementing without change the percentage decreases described in the OMB updated report under subparagraph (A)(ii).

"(C) ORDER IMPLEMENTING INCREASES.—The President shall issue an order fully implementing without change the percentage increases described in the OMB updated report under subparagraph (A)(iii).

"(7) REPORTS BASED ON CBO.—Any report required by this subsection shall be based on the economic and technical assumptions used by the CBO in its initial snapshot under paragraph (3).

"(8) GAO COMPLIANCE REPORTS.—On the dates specified in paragraph (1), the Comptroller General shall submit to the Congress and the President a report on—

"(A) the extent to which each order issued by the President under this section complies with all of the requirements contained in this section, either certifying that the order fully and accurately complies with such requirements or indicating the respects in which it does not; and

"(B) the extent to which each report issued by OMB or CBO under this section complies with all of the requirements contained in this section, either certifying that the report fully and accurately complies with such requirements or indicating the respects in which it does not.

"(f) MODIFICATION OF PRESIDENTIAL ORDER.—

"(1) IN GENERAL.—At any time after the OMB final report or updated report is issued under subsection (e), but before the close of the 20th calendar day of the session of Congress beginning after the issuance of either such report, the Majority Leader of either House of Congress may introduce a joint resolution, which contains provisions directing the President to modify the Presidential order issued under subsection (e)(5) or (e)(6)(B) in connection with either such report or to provide an alternative to reduce the medicare outlay deficit for the fiscal year for which such order was issued. After the introduction of

the first such joint resolution in either House of Congress with respect to any final report or updated report, then no other joint resolution issued with respect to such order shall be subject to the procedures set forth in this subsection.

"(2) PROCEDURES.—Except as provided in paragraph (3), the procedures under section 258A of the Balanced Budget and Emergency Deficit Control Act of 1985 shall apply to a joint resolution under paragraph (1).

"(3) DECREASE IN AMOUNT OF MEDICARE OUTLAY DEFICIT REDUCTION REQUIRES THREE-FIFTHS VOTE.—It shall not be in order in either the House of Representatives or the Senate to consider any provision which would have the effect of—

"(A) decreasing the medicare baseline outlay for any fiscal year, or

"(B) decreasing medicare outlay reductions for any fiscal year below the amount of the medicare outlay deficit specified in the OMB final or updated report,

unless at least three-fifths of the Members of that House agree to the consideration of the joint resolution, amendment, or conference report.

"(4) RULEMAKING AUTHORITY.—The provisions of paragraphs (2) and (3) are enacted by the Congress—

"(A) as an exercise of the rulemaking power of the House of Representatives and the Senate, respectively, and as such they are deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of joint resolutions described in paragraph (1), and they supersede other rules only to the extent they are inconsistent therewith, and

"(B) with full recognition of the constitutional right of either House to change the rules relating to the procedure of that House at any time, in the same manner, and to the same extent as in the case of any other rule of that House."

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to fiscal years 1996 through 2002.

Subtitle B—Transformation of the Medicaid Program

SEC. 7190. SHORT TITLE.

This subtitle may be cited as the "Medicaid Transformation Act of 1995".

SEC. 7191. TRANSFORMATION OF MEDICAID PROGRAM.

(a) IN GENERAL.—The Social Security Act is amended by adding at the end the following new title:

"TITLE XXI—MEDICAID PROGRAM FOR LOW-INCOME INDIVIDUALS AND FAMILIES

"TABLE OF CONTENTS OF TITLE

"SEC. 2100. PURPOSE; STATE MEDICAID PLANS.

"(a) PURPOSE.—The purpose of this title is to provide funds to States to enable them to provide medical assistance to low-income individuals and families in a more effective, efficient, and responsive manner.

"(b) STATE PLAN REQUIRED.—A State is not eligible for payment under section 2122 of this title unless the State has submitted to the Secretary under part E a plan (in this title referred to as a 'medicaid plan') that—

"(1) sets forth how the State intends to use the funds provided under this title to provide medical assistance to needy individuals and families consistent with the provisions of this title; and

"(2) is approved under such part.

"(c) CONTINUED APPROVAL.—An approved medicaid plan shall continue in effect unless and until—

"(1) the State amends the plan under section 2152;

"(2) the State terminates participation under this title; or

"(3) the Secretary finds substantial noncompliance of the plan with the requirements of this title under section 2153.

"(d) STATE ENTITLEMENT.—This title constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to provide for the payment to States of amounts provided under part C.

"PART A—OBJECTIVES, GOALS, AND PERFORMANCE UNDER STATE PLANS

"SEC. 2101. DESCRIPTION OF STRATEGIC OBJECTIVES AND PERFORMANCE GOALS.

"(a) DESCRIPTION.—A medicaid plan shall include a description of the strategic objectives and performance goals the State has established for providing health care services to low-income populations under this title, including a general description of the manner in which the plan is designed to meet these objectives and goals.

"(b) CERTAIN OBJECTIVES AND GOALS REQUIRED.—A medicaid plan shall include strategic objectives and performance goals relating to—

"(1) rates of childhood immunizations;

"(2) reductions in infant mortality and morbidity; and

"(3) standards of care and access to services for children with special health care needs as defined by the State.

"(c) CONSIDERATIONS.—In specifying these objectives and goals the State may consider factors such as the following:

"(1) The State's priorities with respect to providing assistance to low-income populations.

"(2) The State's priorities with respect to the general public health and the health status of individuals eligible for assistance under the medicaid plan.

"(3) The State's financial resources, the particular economic conditions in the State, and relative adequacy of the health care infrastructure in different regions of the State.

"(d) PERFORMANCE MEASURES.—To the extent practicable—

"(1) one or more performance goals shall be established by the State for each strategic objective identified in the medicaid plan; and

"(2) the medicaid plan shall describe, how program performance will be—

"(A) measured through objective, independently verifiable means, and

"(B) compared against performance goals, in order to determine the State's performance under this title.

"(e) PERIOD COVERED.—

"(1) STRATEGIC OBJECTIVES.—The strategic objectives shall cover a period of not less than 5 years and shall be updated and revised at least every 3 years.

"(2) PERFORMANCE GOALS.—The performance goals shall be established for dates that are not more than 3 years apart.

"SEC. 2102. ANNUAL REPORTS.

"(a) IN GENERAL.—In the case of a State with a medicaid plan that is in effect for part or all of a fiscal year, no later than March 31 following such fiscal year (or March 31, 1998, in the case of fiscal year 1996) the State shall prepare and submit to the Secretary and the Congress a report on program activities and performance under this title for such fiscal year.

"(b) CONTENTS.—Each annual report under this section for a fiscal year shall include the following:

"(1) EXPENDITURE AND BENEFICIARY SUMMARY.—

"(A) INITIAL SUMMARY.—For the report for fiscal year 1997 (and, if applicable, fiscal year 1996), a summary of all expenditures under the medicaid plan during the fiscal year (and during any portions of fiscal year 1996 during which the medicaid plan was in effect under this title) as follows:

"(i) Aggregate medical assistance expenditures, disaggregated to the extent required to determine compliance with the set-aside requirements of subsections (a) through (c) of section 2112 and to compute the case mix index under section 2121(d)(3).

"(ii) For each general category of eligible individuals specified in subsection (c)(1), aggregate medical assistance expenditures and the total and average number of eligible individuals under the medicaid plan.

"(iii) By each general category of eligible individuals, total expenditures for each of the categories of health care items and services specified in subsection (c)(2) which are covered under the medicaid plan and provided on a fee-for-service basis.

"(iv) By each general category of eligible individuals, total expenditures for payments to capitated health care organizations (as defined in section 2114(c)(1)).

"(v) Total administrative expenditures.

"(B) SUBSEQUENT SUMMARIES.—For reports for each succeeding fiscal year, a summary of—

"(i) all expenditures under the medicaid plan consistent with the reporting format specified by the Medicaid Task Force under section 2106(d)(1); and

"(ii) the total and average number of eligible individuals under the medicaid plan for each general category of eligible individuals.

"(2) UTILIZATION SUMMARY.—

"(A) INITIAL SUMMARY.—For the report for fiscal year 1997 (and, if applicable, fiscal year 1996), summary statistics on the utilization of health care services under the medicaid plan during the year (and during any portions of fiscal year 1996 during which the medicaid plan was in effect under this title) as follows:

"(i) For each general category of eligible individuals and for each of the categories of health care items and services which are covered under the medicaid plan and provided on a fee-for-service basis, the number and percentage of persons who received such a type of service or item during the period covered by the report.

"(ii) Summary of health care utilization data reported to the State by capitated health care organizations.

"(B) SUBSEQUENT SUMMARIES.—For reports for each succeeding fiscal year, summary statistics on the utilization of health care services under the medicaid plan consistent with the reporting format specified by the Medicaid Task Force under section 2106(d)(1).

"(3) ACHIEVEMENT OF PERFORMANCE GOALS.—With respect to each performance goal established under section 2101 and applicable to the year involved—

"(A) a brief description of the goal;

"(B) a description of the methods to be used to measure the attainment of such goal;

"(C) data on the actual performance with respect to the goal;

"(D) a review of the extent to which the goal was achieved, based on such data; and

"(E) if a performance goal has not been met—

"(i) why the goal was not met, and

"(ii) actions to be taken in response to such performance, including adjustments in performance goals or program activities for subsequent years.

"(4) PROGRAM EVALUATIONS.—A summary of the findings of evaluations under section 2103 completed during the fiscal year covered by the report.

"(5) FRAUD AND ABUSE AND QUALITY CONTROL ACTIVITIES.—A general description of the State's activities under part D to detect and deter fraud and abuse and to assure quality of services provided under the program.

"(6) PLAN ADMINISTRATION.—

"(A) A description of the administrative roles and responsibilities of entities in the State responsible for administration of this title.

"(B) Organizational charts for each entity in the State primarily responsible for activities under this title.

"(C) An estimate of the percentage of expenditures to be used for plan administration.

"(D) A brief description of each interstate compact (if any) the State has entered into with other States with respect to activities under this title.

"(E) General citations to the State statutes and administrative rules governing the State's activities under this title.

"(7) INPATIENT HOSPITAL PAYMENTS.—With respect to inpatient hospital services provided under the medicaid plan on a fee-for-service basis, a description of the average amount paid per discharge in the fiscal year compared either to the average charge for such services or to the State's estimate of the average amount paid per discharge by commercial health insurers in the State.

"(c) SPECIAL RULES.—For purposes of this section:

"(1) IDENTIFICATION OF GENERAL CATEGORIES OF INDIVIDUALS.—Each of the following is a general category of eligible individuals:

"(A) Pregnant women.

"(B) Children.

"(C) Blind or disabled adults under retirement age.

"(D) Persons who have attained retirement age.

"(E) Other adults.

"(2) TREATMENT OF HEALTH CARE ITEMS AND SERVICES.—The health care items and services described in each subparagraph of section 2171(a)(1) shall be considered a separate category of health care items and services.

"SEC. 2103. PERIODIC, INDEPENDENT EVALUATIONS.

"(a) IN GENERAL.—During fiscal year 1998 and every third fiscal year thereafter, each State shall provide for an evaluation of the operation of its medicaid plan approved under this title.

"(b) INDEPENDENT.—Each such evaluation with respect to an activity under the medicaid plan shall be conducted by an entity that is neither responsible under State law for the submission of the State plan (or part thereof) nor responsible for administering (or supervising the administration of) the activity. If consistent with the previous sentence, such an entity may be a college or university, a State agency, a legislative branch agency in a State, or an independent contractor.

"(c) RESEARCH DESIGN.—Each such evaluation shall be conducted in accordance with a research design that is based on generally accepted models of survey design and sampling and statistical analysis.

"SEC. 2104. DESCRIPTION OF PROCESS FOR MEDICAID PLAN DEVELOPMENT.

"Each medicaid plan shall include a description of the process under which the plan shall be developed and implemented in the State (consistent with section 2105).

"SEC. 2105. CONSULTATION IN MEDICAID PLAN DEVELOPMENT.

"(a) PUBLIC PROCESS.—

"(1) IN GENERAL.—Before submitting a medicaid plan or a plan amendment described in paragraph (3) to the Secretary under part E, a State shall provide—

"(A) public notice respecting the submittal of the proposed plan or amendment, including a general description of the plan or amendment;

"(B) a means for the public to inspect or obtain a copy (at reasonable charge) of the proposed plan or amendment; and

"(C) an opportunity for submittal and consideration of public comments on the proposed plan or amendment.

The previous sentence shall not apply to a revision of a medicaid plan (or revision of an amendment to a plan) made by a State under section 2153(c)(1) or to a plan amendment withdrawal described in section 2153(c)(4).

"(2) CONTENTS OF NOTICE.—A notice under paragraph (1)(A) for a proposed plan or amendment shall include a description of—

"(A) the general purpose of the proposed plan or amendment, including applicable effective dates;

"(B) where the public may inspect the proposed plan or amendment;

"(C) how the public may obtain a copy of the proposed plan or amendment and the applicable charge (if any) for the copy; and

"(D) how the public may submit comments on the proposed plan or amendment, including any deadlines applicable to consideration of such comments.

"(3) AMENDMENTS DESCRIBED.—An amendment to a medicaid plan described in this paragraph is an amendment which makes a material and substantial change in eligibility under the medicaid plan or the benefits provided under the plan.

"(4) PUBLICATION.—Notices under this subsection may be published (as selected by the State) in one or more daily newspapers of general circulation in the State or in any publication used by the State to publish State statutes or rules.

"(5) COMPARABLE PROCESS.—A separate notice, or notices, shall not be required under this subsection for a State if notice of the medicaid plan or an amendment to the plan will be provided under a process specified in State law that is substantially equivalent to the notice process specified in this subsection.

"(b) ADVISORY COMMITTEE.—

"(1) IN GENERAL.—Each State with a medicaid plan shall establish and maintain an advisory committee.

"(2) CONSULTATION.—The State shall periodically consult with the advisory committee in the development, revision, and monitoring the performance of the medicaid plan, including—

"(A) the development of strategic objectives and performance goals under section 2101;

"(B) the annual report under section 2102; and

"(C) the research design under section 2103(c).

"(3) GEOGRAPHIC DIVERSITY.—The composition of the advisory committee shall be chosen in a manner that assures some representation on the advisory committee of the different general geographic regions of the State. Nothing in the previous sentence shall be construed as requiring proportional representation of geographic areas in a State.

"(4) CONSTRUCTION.—Nothing in this title shall be construed as preventing a State from establishing more than 1 advisory committee, including specialized advisory committees that focus on specific population groups, provider groups, or geographic areas.

"SEC. 2106. MEDICAID TASK FORCE.

"(a) IN GENERAL.—The Secretary shall provide for the establishment of a Medicaid Task Force (in this section referred to as the 'Task Force').

"(b) COMPOSITION.—The Task Force shall consist of 6 members appointed by the chair of the National Governors Association and 6 members appointed by the vice chair of the National Governors Association.

"(c) ADVISORY GROUP FOR TASK FORCE.—The Secretary shall provide for the establishment of an advisory group to assist the Task Force in carrying out its duties under this section, consisting of 1 representative appointed by each of the following associations:

"(1) National Committee for Quality Assurance.

"(2) Joint Commission for the Accreditation of Healthcare Organizations.

"(3) Group Health Association of America.

"(4) American Managed Care and Review Association.

"(5) Association of State and Territorial Health Officers.

"(6) American Medical Association.

"(7) American Hospital Association.

"(8) American College of Gerontology.

"(9) American Health Care Association.

"(10) National Healthcare Anti-Fraud Association.

"(11) National Association of Health Data Organizations.

"(12) American Academy of Actuaries.

"(13) National Association of State Medicaid Directors.

"(14) An association identified by the Secretary as representing the interests of disabled individuals.

"(15) An association identified by the Secretary as representing the interests of children.

"(16) An association identified by the Secretary as representing the interests of the elderly.

"(17) An association identified by the Secretary as representing the interests of mentally ill individuals.

Any reference in this subsection to a particular group shall be deemed a reference to any successor to such group.

"(d) DUTIES.—

"(1) FORMAT FOR EXPENDITURE AND UTILIZATION SUMMARIES.—The Task Force shall specify, by not later than December 31, 1996, the format of expenditure summaries and utilization summaries required under section 2102. Such format may provide for the reporting of different information from that required under section 2102(b), but shall include the reporting of at least the information described in section 2102(b)(1)(A)(i).

"(2) MODELS AND SUGGESTIONS.—The Task Force shall study and report to Congress and the States, by not later than April 1, 1997, recommendations on the following:

"(A) Recommended models for strategic objectives and performance goals for consideration by States in the development of such objectives and goals under section 2102, including alternative models for each of the objectives and goals described in section 2101(b).

"(B) For each suggested model for a strategic objective or performance goal suggested methodologies for States to consider in measuring and verifying the objective or goal.

"(C) An assessment of the potential usefulness to States of quality assurance safeguards, utilization data sets, and accreditation programs that are used or under development in the private sector.

"(D) Recommended designs and evaluation methodologies for consideration by States in providing for independent evaluations under section 2103.

"(3) CONSTRUCTION.—Nothing in this subsection shall be construed as requiring a State to adopt any of the strategic objectives or performance goals suggested under paragraph (2).

"(e) ADMINISTRATIVE ASSISTANCE.—Administrative support for the Task Force shall be provided by the Agency for Health Care Policy and Research (or, in the absence of such Agency, the Secretary).

"PART B—ELIGIBILITY, BENEFITS, AND SET-ASIDES

"SEC. 2111. ELIGIBILITY AND BENEFITS.

"(a) IN GENERAL.—Each medicaid plan shall—

"(1) be designed to serve all political subdivisions in the State;

"(2) provide for making medical assistance available (subject to the State flexibility described in section 2115) to any pregnant woman or child under the age of 13 whose family income does not exceed 100 percent of the poverty line applicable to a family of the size involved;

"(3) provide for making medical assistance available (subject to the State flexibility described in section 2115) to any individual with a disability (as defined by the State); and

"(4) describe how the State will provide medical assistance to any other population group.

"(b) DESCRIPTION OF GENERAL ELEMENTS.—Each medicaid plan shall include a description (consistent with this title) of the following:

"(1) ELEMENTS RELATING TO ELIGIBILITY.—The general eligibility standards of the plan, including—

"(A) any limitations as to the duration of eligibility;

"(B) any eligibility standards relating to age, income and resources (including any standards relating to spenddowns), residency, disability status, immigration status, or employment status of individuals;

"(C) methods of establishing and continuing eligibility and enrollment, including the methodology for computing family income;

"(D) the eligibility standards in the plan that protect the income and resources of a married individual who is living in the community and whose spouse is residing in an institution in order to prevent the impoverishment of the community spouse; and

"(E) any other standards relating to eligibility for medical assistance under the plan.

"(2) SCOPE OF ASSISTANCE.—The amount, duration, and scope of health care services and items covered under the plan, including differences among different eligible population groups.

"(3) DELIVERY METHOD.—The State's approach to delivery of medical assistance, including a general description of—

"(A) the use (or intended use) of vouchers, fee-for-service, or managed care arrangements (such as capitated health care plans, case management, and case coordination); and

"(B) utilization control systems.

"(4) FEE-FOR-SERVICE BENEFITS.—To the extent that medical assistance is furnished on a fee-for-service basis—

"(A) how the State determines the qualifications of health care providers eligible to provide such assistance; and

"(B) how the State determines rates of reimbursement for providing such assistance.

"(5) COST-SHARING.—Beneficiary cost-sharing (if any), including variations in such cost-sharing by population group or type of service and financial responsibilities of parents of recipients under 19 years of age and the spouses of recipients.

"(6) UTILIZATION INCENTIVES.—Incentives or requirements (if any) to encourage the appropriate utilization of services.

"(7) SUPPORT FOR CERTAIN HOSPITALS.—

"(A) IN GENERAL.—With respect to hospitals described in subparagraph (B) located in the State, as reported to the State by the Secretary, the medicaid plan shall include a description of the extent to which provisions have been made for expenditures for items and services furnished by such hospitals and covered under the plan.

"(B) HOSPITALS DESCRIBED.—

"(i) IN GENERAL.—Except as provided in clause (iii), a hospital described in this subparagraph is a hospital determined to be eligible for purposes of this title in accordance with the criteria described in clause (ii) and such procedures as the Secretary may require,

including such reporting requirements as the Secretary determines necessary to ensure continuing eligibility.

"(ii) CRITERIA FOR ELIGIBILITY.—A hospital meets the criteria described in this clause if the hospital is a short-term acute care general hospital or a children's hospital and the hospital's low-income utilization rate exceeds the lesser of—

"(I) 1 standard deviation above the mean low-income utilization rate for hospitals receiving payments under a medicaid plan in the State in which such hospital is located; or

"(II) 1¼ standard deviation above the mean low-income utilization rate for hospitals receiving such payments in all States.

"(iii) SPECIAL ELIGIBILITY.—A hospital not described in clause (i) may be eligible for purposes of this title, if upon application to the Secretary, such hospital is determined by the Secretary to be a hospital which provides essential access to vulnerable populations, offers special services to such populations, or meets other criteria consistent with this title as determined by the Secretary.

"(iv) LOW-INCOME UTILIZATION RATE.—For purposes of clause (i), the term 'low-income utilization rate' means, for a hospital, a fraction (expressed as a percentage), the numerator of which is the hospital's number of patient days attributable to patients who (for such days) were eligible for medical assistance under a medicaid plan or were uninsured in a period, and the denominator of which is the total number of the hospital's patient days in that period.

"(v) PATIENT DAYS.—For purposes of clause (iv), the term 'patient day' includes each day in which—

"(I) an individual, including a newborn, is an inpatient in the hospital, whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere; or

"(II) an individual makes one or more outpatient visits to the hospital.

"(c) IMMUNIZATIONS FOR CHILDREN.—The medicaid plan shall provide medical assistance for immunizations for children eligible for any medical assistance under the medicaid plan, in accordance with a schedule for immunizations established by the Health Department of the State in consultation with the individuals and entities in the State responsible for the administration of the plan.

"(d) FAMILY PLANNING SERVICES.—The medicaid plan shall provide prepregnancy planning services and supplies as specified by the State.

"(e) PREEXISTING CONDITION EXCLUSIONS.—Notwithstanding any other provision of this title—

"(1) a medicaid plan may not deny or exclude coverage of any item or service for an eligible individual for benefits under

the medicaid plan for such item or service on the basis of a preexisting condition; and

"(2) if a State contracts or makes other arrangements (through the eligible individual or through another entity) with a capitated health care organization, insurer, or other entity, for the provision of items or services to eligible individuals under the medicaid plan and the State permits such organization, insurer, or other entity to exclude coverage of a covered item or service on the basis of a preexisting condition, the State shall provide, through its medicaid plan, for such coverage (through direct payment or otherwise) for any such covered item or service denied or excluded on the basis of a preexisting condition.

"(f) MENTAL HEALTH SERVICES.—A medicaid plan shall not impose treatment limits or financial requirements on mental illness services which are not imposed on services for other illnesses or diseases. The plan may require pre-admission screening, prior authorization of services, or other mechanisms limiting coverage of mental illness services to services that are medically necessary.

"SEC. 2112. SET-ASIDES OF FUNDS FOR POPULATION GROUPS.

"(a) FOR TARGETED LOW-INCOME FAMILIES.—

"(1) IN GENERAL.—Subject to subsection (e), a medicaid plan shall provide that the amount of funds expended under the plan for medical assistance for targeted low-income families (as defined in paragraph (3)) for a fiscal year shall be not less than the minimum low-income-family amount specified in paragraph (2).

"(2) MINIMUM LOW-INCOME-FAMILY AMOUNT.—The minimum low-income-family amount specified in this paragraph for a State is equal to 85 percent of the expenditures under title XIX for medical assistance in the State during Federal fiscal year 1995 which were attributable to expenditures for medical assistance for mandated benefits (as defined in subsection (h)) furnished to individuals—

"(A) who (at the time of furnishing the assistance) were under 65 years of age;

"(B) whose coverage (at such time) under a State plan under title XIX was required under Federal law; and

"(C) whose eligibility for such coverage (at such time) was not on a basis directly related to disability status, including being blind.

"(3) TARGETED LOW-INCOME FAMILY DEFINED.—For purposes of this subsection, the term 'targeted low-income family' means a family (which may be an individual)—

"(A) which includes a child or a pregnant woman; and

"(B) the income of which does not exceed 185 percent of the poverty line applicable to a family of the size involved.

"(b) FOR LOW-INCOME ELDERLY.—

"(1) IN GENERAL.—Subject to subsection (e), a medicaid plan shall provide that the amount of funds expended under the plan for medical assistance for eligible low-income individuals who have attained retirement age for a fiscal year shall

be not less than the minimum low-income-elderly amount specified in paragraph (2).

"(2) MINIMUM LOW-INCOME-ELDERLY AMOUNT.—The minimum low-income-elderly amount specified in this subparagraph for a State is equal to 85 percent of the expenditures under title XIX for medical assistance in the State during Federal fiscal year 1995 which were attributable to expenditures for medical assistance for mandated benefits furnished to individuals—

"(A) whose eligibility for such assistance was based on their being 65 years of age or older; and

"(B)(i) whose coverage (at such time) under a State plan under title XIX was required under Federal law, or (ii) who (at such time) were residents of a nursing facility.

"(c) FOR LOW-INCOME DISABLED PERSONS.—

"(1) IN GENERAL.—Subject to subsection (e), a medicaid plan shall provide that the amount of funds expended under the plan for medical assistance for eligible low-income individuals who have not attained retirement age and are eligible for such assistance on the basis of a disability, including being blind, for a fiscal year is not less than the minimum low-income-disabled amount specified in paragraph (2).

"(2) MINIMUM LOW-INCOME-DISABLED AMOUNT.—The minimum low-income-disabled amount specified in this paragraph for a State is equal to 85 percent of the expenditures under title XIX for medical assistance in the State during Federal fiscal year 1995 which were attributable to expenditures for medical assistance for mandated benefits furnished to individuals—

"(A) whose coverage (at such time) under a State plan under title XIX was required under Federal law; and

"(B) whose coverage (at such time) was on a basis directly related to disability status, including being blind, and not to age status.

"(d) USE OF RESIDUAL FUNDS.—

"(1) IN GENERAL.—Subject to limitations on payment under section 2123, any funds not required to be expended under the set-asides under the previous subsections may only be expended under the medicaid plan for any of the following:

"(A) ADDITIONAL MEDICAL ASSISTANCE.—Medical assistance for eligible low-income individuals (as defined in section 2171(b)), in addition to any medical assistance made available under a previous subsection.

"(B) MEDICALLY-RELATED SERVICES.—Payment for medically-related services (as defined in paragraph (2)).

"(C) ADMINISTRATION.—Payment for the administration of the medicaid plan.

"(2) MEDICALLY-RELATED SERVICES DEFINED.—For purposes of this title, the term 'medically-related services' means services reasonably related to, or in direct support of, the State's attainment of one or more of the strategic objectives and performance goals established under section 2101, but does not include items and services included on the list under section 2171(a)(1) (relating to the definition of medical assistance).

"(e) COMPUTATIONS.—

"(1) MINIMUM AMOUNTS.—States shall calculate the minimum amounts under subsections (a)(2), (b)(2), and (c)(2) in a reasonable manner consistent with reports submitted to the Secretary for the fiscal years involved.

"(2) EXCLUSION OF PAYMENTS FOR CERTAIN ALIENS.—For purposes of this section, medical assistance attributable to the exception provided under section 1903(v)(2) shall not be considered to be expenditures for medical assistance.

"(f) BENEFITS INCLUDED FOR PURPOSES OF COMPUTING SET ASIDES.—For purposes of this section, the term 'mandated benefits'—

"(1) means medical assistance for items and services described in section 1905(a) to the extent such assistance with respect to such items and services was required to be provided under title XIX; and

"(2) does not include expenditures attributable to disproportionate share payment adjustments described in section 1923.

"SEC. 2113. PREMIUMS AND COST-SHARING.

"(a) IN GENERAL.—Subject to subsection (b), if any charges are imposed under the medicaid plan for cost-sharing (as defined in subsection (d)), such cost-sharing shall be pursuant to a public cost-sharing schedule.

"(b) LIMITATION ON PREMIUM AND CERTAIN COST-SHARING FOR LOW-INCOME FAMILIES INCLUDING CHILDREN OR PREGNANT WOMEN.—

"(1) IN GENERAL.—In the case of a family described in paragraph (2)—

"(A) the plan shall not impose any premium; and

"(B) the plan shall not (except as provided in subsection (c)(1)) impose any cost-sharing with respect to primary and preventive care services (as defined by the State) covered under the medicaid plan for children or pregnant women unless such cost-sharing is nominal in nature.

"(2) FAMILY DESCRIBED.—A family described in this paragraph is a family (which may be an individual) which—

"(A) includes a child or a pregnant woman;

"(B) is made eligible for medical assistance under the medicaid plan; and

"(C) the income of which does not exceed 100 percent of the poverty line applicable to a family of the size involved.

"(c) CERTAIN COST-SHARING PERMITTED.—Nothing in this section shall be construed as preventing a medicaid plan (consistent with subsection (b))—

"(1) from imposing cost-sharing to discourage the inappropriate use of emergency medical services delivered through a hospital emergency room, a medical transportation provider, or otherwise;

"(2) from imposing premiums and cost-sharing differentially in order to encourage the use of primary and preventive care and discourage unnecessary or less economical care;

"(3) from scaling cost-sharing in a manner that reflects economic factors, employment status, and family size;

"(4) from scaling cost-sharing based on the availability to the individual or family of other health insurance coverage; or

"(5) from scaling cost-sharing based on participation in employment training program, drug or alcohol abuse treatment, counseling programs, or other programs promoting personal responsibility.

"(d) COST-SHARING DEFINED.—For purposes of this section, the term 'cost-sharing' includes copayments, deductibles, coinsurance, and other charges for the provision of health care services.

"SEC. 2114. DESCRIPTION OF PROCESS FOR DEVELOPING CAPITATION PAYMENT RATES.

"(a) IN GENERAL.—If a State contracts (or intends to contract) with a capitated health care organization (as defined in subsection (c)(1)) under which the State makes a capitation payment (as defined in subsection (c)(2)) to the organization for providing or arranging for the provision of medical assistance under the medicaid plan for a group of services, including at least inpatient hospital services and physicians' services, the plan shall include a description of the following:

"(1) USE OF ACTUARIAL SCIENCE.—The extent and manner in which the State uses actuarial science—

"(A) to analyze and project health care expenditures and utilization for individuals enrolled (or to be enrolled) in such an organization under the medicaid plan; and

"(B) to develop capitation payment rates, including a brief description of the general methodologies used by actuaries.

"(2) QUALIFICATIONS OF ORGANIZATIONS.—The general qualifications, including any accreditation, State licensure or certification, or provider network standards, required by the State for participation of capitated health care organizations under the medicaid plan.

"(3) DISSEMINATION PROCESS.—The process used by the State under subsection (b) and otherwise to disseminate, before entering into contracts with capitated health care organizations, actuarial information to such organizations on the historical fee-for-service costs (or, if not available, other recent financial data associated with providing covered services) and utilization associated with individuals described in paragraph (1)(A).

"(4) IDENTIFICATION OF ENROLLEES IN CAPITATED HEALTH CARE ORGANIZATIONS.—The method used by the State by which hospitals may identify enrollees in capitated health care organizations for the purposes of qualifying and billing for disproportionate share payments under the medicaid plan approved under this title as described in section 2111(b)(7).

"(b) PUBLIC NOTICE AND COMMENT.—Under the medicaid plan the State shall provide a process for providing, before the beginning of each contract year—

"(1) public notice of—

"(A) the amounts of the capitation payments (if any) made under the plan for the contract year preceding the public notice, and

"(B)(i) the information described under subsection (a)(1) with respect to capitation payments for the contract year involved or (ii) the amounts of the capitation payments the State expects to make for the contract year involved,

unless such information is designated as proprietary and not subject to public disclosure under State law; and

"(2) an opportunity for receiving public comment on the amounts and information for which notice is provided under paragraph (1).

"(c) DEFINITIONS.—For purposes of this title:

"(1) CAPITATED HEALTH CARE ORGANIZATION.—The term 'capitated health care organization' means a health maintenance organization or any other entity (including a health insuring organization, managed care organization, prepaid health plan, integrated service network, or similar entity) which under State law is permitted to accept capitation payments for providing (or arranging for the provision of) a group of items and services including at least inpatient hospital services and physicians' services.

"(2) CAPITATION PAYMENT.—The term 'capitation payment' means, with respect to payment, payment on a prepaid capitation basis or any other risk basis to an entity for the entity's provision (or arranging for the provision) of a group of items and services, including at least inpatient hospital services and physicians' services.

"SEC. 2115. CONSTRUCTION.

"(a) STATE FLEXIBILITY IN BENEFITS, PROVIDER PAYMENTS, GEOGRAPHICAL COVERAGE AREA, AND SELECTION OF PROVIDERS.—Nothing in this title (other than subsections (c) and (d) of section 2111) shall be construed as requiring a State—

"(1) to provide medical assistance for any particular items or services;

"(2) to provide for any payments with respect to any specific health care providers or any level of payments for any services;

"(3) to provide for the same medical assistance in all geographical areas or political subdivisions of the State;

"(4) to provide that the medical assistance made available to any individual eligible for medical assistance must not be less in amount, duration, or scope than the medical assistance made available to any other such individual; or

"(5) to provide that any individual eligible for medical assistance with respect to an item or service may choose to obtain such assistance from any institution, agency, or person qualified to provide the item or service.

"(b) STATE FLEXIBILITY WITH RESPECT TO MANAGED CARE.—Nothing in this title shall be construed—

"(1) to limit a State's ability to contract with, on a capitated basis or otherwise, health care plans or individual

health care providers for the provision or arrangement of medical assistance;

"(2) to limit a State's ability to contract with health care plans or other entities for case management services or for coordination of medical assistance; or

"(3) to restrict a State from establishing capitation rates on the basis of competition among health care plans or negotiations between the State and one or more health care plans.

"SEC. 2116. CAUSES OF ACTION.

"(a) IN GENERAL.—No person, including an applicant, beneficiary, provider, or health plan, shall have a cause of action under this title against a State in relation to a State's compliance or failure to comply with the provisions of this title or with the provisions of a medicaid plan. Nothing in this title shall affect any cause of action under any other provision of Federal law in relation to a State's compliance (or failure to comply) with this title or with the provisions of a medicaid plan.

"(b) APPLICATION OF CERTAIN LAWS.—

"(1) IN GENERAL.—No person shall on the ground of sex or religion be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any program or activity funded in whole or in part with funds made available under this title.

"(2) FINDING OF NONCOMPLIANCE; REFERRAL.—

"(A) IN GENERAL.—Whenever the Secretary finds that a State, or an entity that has received a payment from an allotment to a State under this title, has failed to comply with paragraph (1), the Secretary shall notify the chief executive officer of the State and shall request such officer to secure compliance. If within a reasonable period of time, not to exceed 60 days, the chief executive officer fails or refuses to secure compliance, the Secretary may—

"(i) refer the matter to the Attorney General of the United States with a recommendation that an appropriate civil action be instituted; or

"(ii) take such other action as may be provided by law.

"(B) AUTHORITY OF ATTORNEY GENERAL; CIVIL ACTIONS.—When a matter is referred to the Attorney General pursuant to this paragraph, or whenever the Attorney General has reason to believe that the entity is engaged in a pattern or practice in violation of paragraph (1), the Attorney General may bring a civil action in any appropriate district court of the United States for such relief as may be appropriate, including injunctive relief.

"(c) NO EFFECT ON STATE LAW.—Nothing in subsection (a) or (b) may be construed as affecting any actions brought under State law.

"SEC. 2117. TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES.

"(a) SPECIAL TREATMENT FOR INSTITUTIONALIZED SPOUSES.—

"(1) SUPERSEDES OTHER PROVISIONS.—In determining the eligibility for medical assistance of an institutionalized spouse

(as defined in subsection (h)(1)), the provisions of this section supersede any other provision of this title which is inconsistent with them.

"(2) NO COMPARABLE TREATMENT REQUIRED.—Any different treatment provided under this section for institutionalized spouses shall not require such treatment for other individuals.

"(3) DOES NOT AFFECT CERTAIN DETERMINATIONS.—Except as this section specifically provides, this section does not apply to—

"(A) the determination of what constitutes income or resources; or

"(B) the methodology and standards for determining and evaluating income and resources.

"(b) RULES FOR TREATMENT OF INCOME.—

"(1) SEPARATE TREATMENT OF INCOME.—During any month in which an institutionalized spouse is in the institution, except as provided in paragraph (2), no income of the community spouse shall be deemed available to the institutionalized spouse.

"(2) ATTRIBUTION OF INCOME.—In determining the income of an institutionalized spouse or community spouse for purposes of the post-eligibility income determination described in subsection (d), except as otherwise provided in this section and regardless of any State laws relating to community property or the division of marital property, the following rules apply:

"(A) NON-TRUST PROPERTY.—Subject to subparagraphs (C) and (D), in the case of income not from a trust, unless the instrument providing the income otherwise specifically provides—

"(i) if payment of income is made solely in the name of the institutionalized spouse or the community spouse, the income shall be considered available only to that respective spouse;

"(ii) if payment of income is made in the names of the institutionalized spouse and the community spouse, ½ of the income shall be considered available to each of them; and

"(iii) if payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, ½ of the joint interest shall be considered available to each spouse).

"(B) TRUST PROPERTY.—In the case of a trust—

"(i) except as provided in clause (ii), income shall be attributed in accordance with the provisions of this title; and

"(ii) income shall be considered available to each spouse as provided in the trust, or, in the absence of a specific provision in the trust—

"(I) if payment of income is made solely to the institutionalized spouse or the community spouse,

the income shall be considered available only to that respective spouse,

"(II) if payment of income is made to both the institutionalized spouse and the community spouse, ½ of the income shall be considered available to each of them, and

"(III) if payment of income is made to the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest (or, if payment is made with respect to both spouses and no such interest is specified, ½ of the joint interest shall be considered available to each spouse).

"(C) PROPERTY WITH NO INSTRUMENT.—In the case of income not from a trust in which there is no instrument establishing ownership, subject to subparagraph (D), ½ of the income shall be considered to be available to the institutionalized spouse and ½ to the community spouse.

"(D) REBUTTING OWNERSHIP.—The rules of subparagraphs (A) and (C) are superseded to the extent that an institutionalized spouse can establish, by a preponderance of the evidence, that the ownership interests in income are other than as provided under such subparagraphs.

"(c) RULES FOR TREATMENT OF RESOURCES.—

"(1) COMPUTATION OF SPOUSAL SHARE AT TIME OF INSTITUTIONALIZATION.—

"(A) TOTAL JOINT RESOURCES.—There shall be computed (as of the beginning of the first continuous period of institutionalization (beginning on or after September 30, 1989) of the institutionalized spouse)—

"(i) the total value of the resources to the extent either the institutionalized spouse or the community spouse has an ownership interest; and

"(ii) a spousal share which is equal to ½ of such total value.

"(B) ASSESSMENT.—At the request of an institutionalized spouse or community spouse, at the beginning of the first continuous period of institutionalization (beginning on or after September 30, 1989) of the institutionalized spouse and upon the receipt of relevant documentation of resources, the State shall promptly assess and document the total value described in subparagraph (A)(i) and shall provide a copy of such assessment and documentation to each spouse and shall retain a copy of the assessment for use under this section. If the request is not part of an application for medical assistance under a medicaid plan approved under this title, the State may, at its option as a condition of providing the assessment, require payment of a fee not exceeding the reasonable expenses of providing and documenting the assessment. At the time of providing the copy of the assessment, the State shall include a notice indicating that the spouse will have a right to a fair hearing under subsection (e)(2).

"(2) ATTRIBUTION OF RESOURCES AT TIME OF INITIAL ELIGIBILITY DETERMINATION.—In determining the resources of an institutionalized spouse at the time of application for benefits under a medicaid plan approved under this title, regardless of any State laws relating to community property or the division of marital property—

"(A) except as provided in subparagraph (B), all the resources held by either the institutionalized spouse, community spouse, or both, shall be considered to be available to the institutionalized spouse; and

"(B) resources shall be considered to be available to an institutionalized spouse, but only to the extent that the amount of such resources exceeds the amount computed under subsection (f)(2)(A) (as of the time of application for benefits).

"(3) ASSIGNMENT OF SUPPORT RIGHTS.—The institutionalized spouse shall not be ineligible by reason of resources determined under paragraph (2) to be available for the cost of care where—

"(A) the institutionalized spouse has assigned to the State any rights to support from the community spouse;

"(B) the institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but the State has the right to bring a support proceeding against a community spouse without such assignment; or

"(C) the State determines that denial of eligibility would work an undue hardship.

"(4) SEPARATE TREATMENT OF RESOURCES AFTER ELIGIBILITY FOR BENEFITS ESTABLISHED.—During the continuous period in which an institutionalized spouse is in an institution and after the month in which an institutionalized spouse is determined to be eligible for benefits under a medicaid plan approved under this title, no resources of the community spouse shall be deemed available to the institutionalized spouse.

"(5) RESOURCES DEFINED.—For purposes of this section, the term 'resources' does not include—

"(A) resources excluded under subsection (a) or (d) of section 1613; and

"(B) resources that would be excluded under section 1613(a)(2)(A) but for the limitation on total value described in such section.

"(d) PROTECTING INCOME FOR COMMUNITY SPOUSE.—

"(1) ALLOWANCES TO BE OFFSET FROM INCOME OF INSTITUTIONALIZED SPOUSE.—After an institutionalized spouse is determined or redetermined to be eligible for medical assistance under a medicaid plan approved under this title, in determining the amount of the spouse's income that is to be applied monthly to payment for the costs of care in the institution, there shall be deducted from the spouse's monthly income the following amounts in the following order:

"(A) A personal needs allowance (described in paragraph (2)(A)), in an amount not less than the amount specified in paragraph (2)(B).

"(B) A community spouse monthly income allowance (as defined in subparagraph (3)), but only to the extent income of the institutionalized spouse is made available to, or for the benefit of, the community spouse.

"(C) A family allowance, for each family member, equal to at least ⅓ of the amount by which the amount described in paragraph (4)(A)(i) exceeds the amount of the monthly income of that family member.

"(D) Amounts for incurred expenses for medical or remedial care for the institutionalized spouse as provided under paragraph (6).

For purposes of subparagraph (C), the term 'family member' only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse.

"(2) PERSONAL NEEDS ALLOWANCE.—

"(A) IN GENERAL.—For purposes of this section, the term 'personal needs allowance' means an allowance—

"(i) which is reasonable in amount for clothing and other personal needs of the individual (or couple) while in an institution; and

"(ii) which is not less (and may be greater) than the minimum monthly personal needs allowance described in subparagraph (B).

"(B) MINIMUM MONTHLY PERSONAL NEEDS ALLOWANCE.—The minimum monthly personal needs allowance described in this subparagraph is $30 for an institutionalized individual and $60 for an institutionalized couple (if both are aged, blind, or disabled, and their incomes are considered available to each other in determining eligibility).

"(3) COMMUNITY SPOUSE MONTHLY INCOME ALLOWANCE DEFINED.—

"(A) IN GENERAL.—For purposes of this section (except as provided in subparagraph (B)), the community spouse monthly income allowance for a community spouse is an amount by which—

"(i) except as provided in subsection (e), the minimum monthly maintenance needs allowance (established under and in accordance with paragraph (4)) for the spouse; exceeds

"(ii) the amount of monthly income otherwise available to the community spouse (determined without regard to such an allowance).

"(B) COURT ORDERED SUPPORT.—If a court has entered an order against an institutionalized spouse for monthly income for the support of the community spouse, the community spouse monthly income allowance for the spouse shall be not less than the amount of the monthly income so ordered.

"(4) ESTABLISHMENT OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—

"(A) IN GENERAL.—Each State shall establish a minimum monthly maintenance needs allowance for each com-

munity spouse which, subject to subparagraph (C), is equal to or exceeds—

"(i) the applicable percent (described in subparagraph (B)) of 1/12 of the poverty line applicable to a family unit of 2 members); plus

"(ii) an excess shelter allowance (as defined in paragraph (5)).

A revision of the poverty line referred to in clause (i) shall apply to medical assistance furnished during and after the second calendar quarter that begins after the date of publication of the revision.

"(B) APPLICABLE PERCENT.—For purposes of subparagraph (A)(i), the applicable percent described in this paragraph, effective as of July 1, 1992, is 150 percent.

"(C) CAP ON MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—The minimum monthly maintenance needs allowance established under subparagraph (A) may not exceed $1,500 (subject to adjustment under subsections (e) and (g)).

"(5) EXCESS SHELTER ALLOWANCE DEFINED.—For purposes of paragraph (4)(A)(ii), the term 'excess shelter allowance' means, for a community spouse, the amount by which the sum of—

"(A) the spouse's expenses for rent or mortgage payment (including principal and interest), taxes and insurance and, in the case of a condominium or cooperative, required maintenance charge, for the community spouse's principal residence; and

"(B) the standard utility allowance (used by the State under section 5(e) of the Food Stamp Act of 1977) or, if the State does not use such an allowance, the spouse's actual utility expenses,

exceeds 30 percent of the amount described in paragraph (4)(A)(i), except that, in the case of a condominium or cooperative, for which a maintenance charge is included under subparagraph (A), any allowance under subparagraph (B) shall be reduced to the extent the maintenance charge includes utility expenses.

"(6) INCURRED EXPENSES.—For purposes of this section, with respect to the post-eligibility treatment of income of individuals who are institutionalized or who would otherwise require institutionalization but for the provision of home or community-based services, there shall be disregarded reparation payments made by the Federal Republic of Germany and, there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including—

"(A) medicare and other health insurance premiums, deductibles, or coinsurance; and

"(B) necessary medical or remedial care recognized under State law but not covered under the medicaid plan approved under this title, subject to reasonable limits the State may establish on the amount of these expenses.

"(e) NOTICE AND FAIR HEARING.—

"(1) NOTICE.—Upon—

"(A) a determination of eligibility for medical assistance under a medicaid plan approved under this title of an institutionalized spouse; or

"(B) a request by either the institutionalized spouse, or the community spouse, or a representative acting on behalf of either spouse;

each State shall notify both spouses (in the case described in subparagraph (A)) or the spouse making the request (in the case described in subparagraph (B)) of the amount of the community spouse monthly income allowance (described in subsection (d)(1)(B)), of the amount of any family allowances (described in subsection (d)(1)(C)), of the method for computing the amount of the community spouse resources allowance permitted under subsection (f), and of the spouse's right to a fair hearing under this subsection respecting ownership or availability of income or resources, and the determination of the community spouse monthly income or resource allowance.

"(2) FAIR HEARING.—

"(A) IN GENERAL.—If either the institutionalized spouse or the community spouse is dissatisfied with a determination of—

"(i) the community spouse monthly income allowance;

"(ii) the amount of monthly income otherwise available to the community spouse (as applied under subsection (d)(2)(B));

"(iii) the computation of the spousal share of resources under subsection (c)(1);

"(iv) the attribution of resources under subsection (c)(2); or

"(v) the determination of the community spouse resource allowance (as determined under subsection (f)(2));

such spouse is entitled to a fair hearing with respect to such determination if an application for benefits under a medicaid plan approved under this title has been made on behalf of the institutionalized spouse. Any such hearing respecting the determination of the community spouse resource allowance shall be held within 30 days of the date of the request for the hearing.

"(B) REVISION OF MINIMUM MONTHLY MAINTENANCE NEEDS ALLOWANCE.—If either such spouse establishes that the community spouse needs income, above the level otherwise provided by the minimum monthly maintenance needs allowance, due to exceptional circumstances resulting in significant financial duress, there shall be substituted, for the minimum monthly maintenance needs allowance in subsection (d)(2)(A), an amount adequate to provide such additional income as is necessary.

"(C) REVISION OF COMMUNITY SPOUSE RESOURCE ALLOWANCE.—If either such spouse establishes that the community spouse resource allowance (in relation to the amount of income generated by such an allowance) is inad-

equate to raise the community spouse's income to the minimum monthly maintenance needs allowance, there shall be substituted, for the community spouse resource allowance under subsection (f)(2), an amount adequate to provide such a minimum monthly maintenance needs allowance.

"(f) PERMITTING TRANSFER OF RESOURCES TO COMMUNITY SPOUSE.—

"(1) IN GENERAL.—An institutionalized spouse may transfer an amount equal to the community spouse resource allowance (as determined under paragraph (2)), but only to the extent the resources of the institutionalized spouse are transferred to, or for the sole benefit of, the community spouse. The transfer under the preceding sentence shall be made as soon as practicable after the date of the initial determination of eligibility, taking into account such time as may be necessary to obtain a court order under paragraph (3).

"(2) COMMUNITY SPOUSE RESOURCE ALLOWANCE DETERMINED.—For purposes of paragraph (1), the community spouse resource allowance for a community spouse is an amount (if any) by which—

"(A) the greatest of—

"(i) $12,000 (subject to adjustment under subsection (g)), or, if greater (but not to exceed the amount specified in clause (ii)(II)) an amount specified under the State plan,

"(ii) the lesser of (I) the spousal share computed under subsection (c)(1), or (II) $60,000 (subject to adjustment under subsection (g)),

"(iii) the amount established under subsection (e)(2); or

"(iv) the amount transferred under a court order under paragraph (3);

exceeds

"(B) the amount of the resources otherwise available to the community spouse (determined without regard to such an allowance).

"(g) INDEXING DOLLAR AMOUNTS.—For services furnished during a calendar year after 1989, the dollar amounts specified in subsections (d)(3)(C), (f)(2)(A)(i), and (f)(2)(A)(ii)(II) shall be increased by the same percentage as the percentage increase in the consumer price index for all urban consumers (all items; U.S. city average) between September 1988 and the September before the calendar year involved.

"(h) DEFINITIONS.—For purposes of this section:

"(1) INSTITUTIONALIZED SPOUSE.—The term 'institutionalized spouse' means an individual who is in a medical institution or nursing facility and is married to a spouse who is not in a medical institution or nursing facility. The term does not include any such individual who is not likely to meet the requirements of the preceding sentence for at least 30 consecutive days.

"(2) COMMUNITY SPOUSE.—The term 'community spouse' means the spouse of an institutionalized spouse.

"PART C—PAYMENTS TO STATES

"SEC. 2121. ALLOTMENT OF FUNDS AMONG STATES.

"(a) ALLOTMENTS.—

"(1) COMPUTATION.—The Secretary shall provide for the computation of State obligation and outlay allotments in accordance with this section for each fiscal year beginning with fiscal year 1996.

"(2) LIMITATION ON OBLIGATIONS.—

"(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall not enter into obligations with any State under this title for a fiscal year in excess of the obligation allotment for that State for the fiscal year under paragraph (4). The sum of such obligation allotments for all States in any fiscal year (excluding amounts carried over under subparagraph (B) and excluding changes in allotments effected under paragraph (4)(D)) shall not exceed the aggregate limit on new obligation authority specified in paragraph (3) for that fiscal year.

"(B) ADJUSTMENTS.—

"(i) CARRYOVER OF ALLOTMENT PERMITTED.—If the amount of obligations entered into under this part with a State for quarters in a fiscal year is less than the amount of the obligation allotment under this section to the State for the fiscal year, the amount of the difference shall be added to the amount of the State obligation allotment otherwise provided under this section for the succeeding fiscal year.

"(ii) REDUCTION FOR POST-ENACTMENT NEW OBLIGATIONS UNDER TITLE XIX IN FISCAL YEAR 1996.—The amount of the obligation allotment otherwise provided under this section for fiscal year 1996 for a State shall be reduced by the amount of the obligations entered into with respect to the State under section 1903(a) after the date of the enactment of this title.

"(3) AGGREGATE LIMIT ON NEW OBLIGATION AUTHORITY.—

"(A) IN GENERAL.—For purposes of this subsection, subject to subparagraph (C), the aggregate limit on new obligation authority, for a fiscal year, is the pool amount under subsection (b) for the fiscal year, divided by the payout adjustment factor (described in subparagraph (B)) for the fiscal year.

"(B) PAYOUT ADJUSTMENT FACTOR.—For purposes of this subsection, the payout adjustment factor—

"(i) for fiscal year 1996 is .950;

"(ii) for fiscal year 1997 is .986; and

"(iii) for a subsequent fiscal year is .998.

"(C) TRANSITIONAL ADJUSTMENT FOR PRE-ENACTMENT-OBLIGATION OUTLAYS.—In order to account for pre-enactment-obligation outlays described in paragraph (4)(C)(iv), in determining the aggregate limit on new obligation authority under subparagraph (A) for fiscal year 1996, the pool amount for such fiscal year is equal to—

"(i) the pool amount for such year; reduced by

"(ii) $24.624 billion.

"(4) OBLIGATION ALLOTMENTS.—

"(A) GENERAL RULE FOR 50 STATES AND THE DISTRICT OF COLUMBIA.—Except as provided in this paragraph, the obligation allotment for any of the 50 States or the District of Columbia for a fiscal year (beginning with fiscal year 1997) is an amount that bears the same ratio to the outlay allotment under subsection (c)(2) for such State or District (not taking into account any adjustment due to an election under paragraph (4)) for the fiscal year as the ratio of—

"(i) the aggregate limit on new obligation authority (less the total of the obligation allotments under subparagraph (B)) for the fiscal year; to

"(ii) the pool amount (less the sum of the outlay allotments for the territories) for such fiscal year.

"(B) TERRITORIES.—The obligation allotment for each of the Commonwealths and territories for a fiscal year is the outlay allotment for such Commonwealth or territory (as determined under subsection (c)(5)) for the fiscal year divided by the payout adjustment factor for the fiscal year (as defined in paragraph (3)(B)).

"(C) TRANSITIONAL RULE FOR FISCAL YEAR 1996.—

"(i) IN GENERAL.—The obligation amount for fiscal year 1996 for any State, including the District of Columbia, a Commonwealth, or territory, is determined according to the formula: A=(B-C)/D, where—

"(I) 'A' is the obligation amount for such State;

"(II) 'B' is the outlay allotment of such State for fiscal year 1996 (as determined under subsection (c));

"(III) 'C' is the amount of the pre-enactment-obligation outlays (as established for such State under clause (ii)); and

"(IV) 'D' is the payout adjustment factor for such fiscal year (as defined in paragraph (3)(B)).

"(ii) PRE-ENACTMENT-OBLIGATION OUTLAY AMOUNTS.—Within 30 days after the date of the enactment of this title, the Secretary shall estimate (based on the best data available) and publish in the Federal Register the amount of the pre-enactment-obligation outlays (as defined in clause (iv)) for each State, including the District of Columbia, Commonwealths, and territories. The total of such amounts shall equal the dollar amount specified in paragraph (3)(C)(ii).

"(iii) AGREEMENT.—The submission of a medicaid plan by a State under this title is deemed to constitute the State's acceptance of the obligation allotment limitations under this subsection, including the formula for computing the amount of such obligation allotment.

"(iv) PRE-ENACTMENT-OBLIGATION OUTLAYS DEFINED.—For purposes of this subsection, the term 'pre-enactment-obligation outlays' means, for a State, the

outlays of the Federal Government that result from obligations that have been incurred under title XIX with respect to the State before the date of the enactment of this title, but for which payments to States have not been made as of such date of enactment.

"(D) ADJUSTMENT TO REFLECT ADOPTION OF ALTERNATIVE GROWTH FORMULA.—Any State that has elected an alternative growth formula under subsection (c)(4) which increases or decreases the dollar amount of an outlay allotment for a fiscal year is deemed to have increased or decreased, respectively, its obligation amount for such fiscal year by the amount of such increase or decrease.

"(b) POOL OF AVAILABLE FUNDS.—

"(1) IN GENERAL.—For purposes of this section and subject to section 2124, the pool amount under this subsection for—

"(A) fiscal year 1996 is $94.104 billion;

"(B) fiscal year 1997 is $100.451 billion;

"(C) fiscal year 1998 is $104.880 billion;

"(D) fiscal year 1999 is $109.501 billion;

"(E) fiscal year 2000 is $114.338 billion;

"(F) fiscal year 2001 is $119.393 billion;

"(G) fiscal year 2002 is $124.673 billion; and

"(H) each subsequent fiscal year is the pool amount under this paragraph for the previous fiscal year increased by the lesser of 4 percent or the annual percentage increase in the gross domestic product for the 12-month period ending in June before the beginning of that subsequent fiscal year.

"(2) NATIONAL MEDICAID GROWTH PERCENTAGE.—For purposes of this section for a fiscal year (beginning with fiscal year 1997), the national medicaid growth percentage is the percentage by which—

"(A) the pool amount under paragraph (1) for the fiscal year; exceeds

"(B) such pool amount for the previous fiscal year.

"(c) STATE OUTLAY ALLOTMENTS.—

"(1) FISCAL YEAR 1996.—

"(A) IN GENERAL.—Except as provided in paragraph (6), for each of the 50 States and the District of Columbia, the amount of the State outlay allotment under this subsection for fiscal year 1996 is, subject to paragraph (4), equal to—

"(i) the greater of—

"(I) the total amount of Federal expenditures (minus the excess DSH amount) made to such State or District under title XIX for the 4 quarters in fiscal year 1995, or

"(II) the total amount of Federal expenditures made to such State or District under title XIX for the 4 quarters in fiscal year 1994; increased by

"(ii) 7.25 percent; and multiplied by

"(iii) the scalar factor described in subparagraph (E).

"(B) COMPUTATION OF EXPENDITURES.—The amount of Federal expenditures described in subparagraph (A)(i) shall be computed, using data reported for the appropriate fiscal year on line 11 of the HCFA Form 64.

"(C) LIMITATION ON ADJUSTMENT.—The amount computed under subparagraph (B) shall not be subject to adjustment (based on any subsequent disallowances or otherwise).

"(D) EXCESS DSH AMOUNT.—For purposes of subparagraph (A)(i)(I), the term 'excess DSH amount' means, for each of the 50 States and the District of Columbia, the excess of—

"(i) the total amount of Federal expenditures made with respect to such State or District under section 1923 for calendar quarters in fiscal year 1995; over

"(ii) 9 percent of the total amount of Federal expenditures made to such State or District under title XIX for such calendar quarters.

"(E) SCALAR FACTOR.—The scalar factor under this subparagraph for fiscal year 1996 is such proportion so that, when it is applied under subparagraph (A)(iii) for the fiscal year, the total of the outlay allotments under this paragraph for all the 50 States and the District of Columbia for the fiscal year (not taking into account any increase or decrease in an outlay allotment for a fiscal year attributable to the election of an alternative growth formula under paragraph (4)) is equal to the amount by which (i) the pool amount for the fiscal year (as determined under subsection (b)), exceeds (ii) the sum of the outlay allotments provided under paragraph (5) for the Commonwealths and territories for the fiscal year.

"(2) COMPUTATION OF STATE OUTLAY ALLOTMENTS.—

"(A) IN GENERAL.—Subject to the succeeding provisions of this subsection, the amount of the State outlay allotment under this subsection for each of the 50 States and the District of Columbia for a fiscal year (beginning with fiscal year 1997) is equal to the product of—

"(i) the needs-based amount determined under subparagraph (B) for such State or District for the fiscal year; and

"(ii) the scalar factor described in subparagraph (C) for the fiscal year.

"(B) NEEDS-BASED AMOUNT.—The needs-based amount under this subparagraph for a State or the District of Columbia for a fiscal year is equal to the product of—

"(i) the State's or District's aggregate expenditure need for the fiscal year (as determined under subsection (d)); and

"(ii) the State's or District's Federal medical assistance percentage (as determined under section 2122(c) (without regard to paragraph (3)(A)(i) thereof)) for the previous fiscal year (or, in the case of fiscal

year 1997, the Federal medical assistance percentage determined under section 1905(b) for fiscal year 1996).

"(C) SCALAR FACTOR.—The scalar factor under this subparagraph for a fiscal year is such proportion so that, when it is applied under subparagraph (A)(ii) for the fiscal year (taking into account the floors and ceilings under paragraph (3)), the total of the outlay allotments under this subsection for all the 50 States and the District of Columbia for the fiscal year (not taking into account any increase or decrease in an outlay allotment for a fiscal year attributable to the election of an alternative growth formula under paragraph (4)) is equal to the amount by which (i) the pool amount for the fiscal year (as determined under subsection (b)), exceeds (ii) the sum of the outlay allotments provided under paragraph (5) for the Commonwealths and territories for the fiscal year.

"(3) FLOORS AND CEILINGS.—

"(A) FLOOR.—In no case shall the amount of the State outlay allotment under paragraph (2) for a fiscal year be less than the greater of—

"(i) 102 percent of the amount of the State outlay allotment under this subsection for the previous fiscal year; or

"(ii) .21 percent of the pool amount for such fiscal year.

"(B) CEILING.—In no case shall the amount of the State outlay allotment under paragraph (2) for a fiscal year be greater than the product of—

"(i) the State outlay allotment under this subsection for the State or the District of Columbia for the preceding fiscal year; and

"(ii) 125 percent of the national medicaid growth percentage (as determined under subsection (b)(2)) for the fiscal year involved; or

"(4) ELECTION OF ALTERNATIVE GROWTH FORMULA.—

"(A) ELECTION.—In order to reduce variations in increases or decreases in outlay allotments over time, any of the 50 States or the District of Columbia may elect (by notice provided to the Secretary by not later than April 1, 1996) to adopt an alternative growth rate formula under this paragraph for the determination of such State's or District's outlay allotment in fiscal year 1996 and for the increase or decrease in the amount of such allotment in subsequent fiscal years.

"(B) FORMULA.—The alternative growth formula under this paragraph may be any formula under which—

"(i) a portion of the State outlay allotment for fiscal year 1996 under paragraph (1) is deferred and applied to increase the amount of its outlay allotment for one or more subsequent fiscal years, so long as the total amount of such increases for all such subsequent fiscal years does not exceed the amount of the outlay allotment deferred from fiscal year 1996; or

"(ii) a portion of the State outlay allotment for one or more of the 3 fiscal years immediately following fiscal year 1996 under paragraph (2) is applied to increase the amount of its outlay allotment for fiscal year 1996, so long as the total amount of such increase does not exceed 25 percent of the amount of the outlay allotment for fiscal year 1996 otherwise determined under paragraph (1).

"(5) COMMONWEALTHS AND TERRITORIES.—The outlay allotment for each of the Commonwealths and territories for a fiscal year is the maximum amount that could have been certified under section 1108(c) with respect to the Commonwealth or territory for the fiscal year with respect to title XIX, if the national medicaid growth percentage (as determined under subsection (b)(2)) for the fiscal year had been substituted (beginning with fiscal year 1997) for the percentage increase referred to in section 1108(c)(1)(B).

"(6) SPECIAL RULE.—

"(A) IN GENERAL.—Notwithstanding the preceding paragraphs of this subsection, the State outlay allotment for—

"(i) New Hampshire for each of the fiscal years 1996 through 2000, is $360,000,000; and

"(ii) Louisiana for each of the fiscal years 1996 through 2000, is $2.622 billion.

"(B) EXCEPTION.—A State described in subparagraph (A) may apply to the Secretary for use of the State outlay allotment otherwise determined under this subsection for any fiscal year, if such State notifies the Secretary not later than March 1 preceding such fiscal year that such State will be able to expend sufficient State funds in such fiscal year to qualify for such allotment.

"(d) AGGREGATE EXPENDITURE NEED DETERMINED.—

"(1) IN GENERAL.—For purposes of subsection (c), the aggregate expenditure need for a State or the District of Columbia for a fiscal year is equal to the product of the following 4 factors:

"(A) RESIDENTS IN POVERTY.—The average annual number of residents in poverty of such State or District with respect to the fiscal year (as determined under paragraph (2)).

"(B) CASE MIX INDEX.—The average of the case mix indexes for such State or District (as determined under paragraph (3)) for the 3 most recent fiscal years for which data are available.

"(C) INPUT COST INDEX.—The average of the input cost indexes for such State or District (as determined under paragraph (4)) for the 3 most recent fiscal years for which data are available.

"(D) NATIONAL AVERAGE SPENDING PER RESIDENT IN POVERTY.—The national average spending per resident in poverty (as determined under paragraph (5)).

"(2) RESIDENTS IN POVERTY.—For purposes of this section:

"(A) IN GENERAL.—The term 'average annual number of residents in poverty' means, with respect to a State or the District of Columbia and a fiscal year, the average annual number of residents in poverty (as defined in subparagraph (B)) in such State or District (based on data made generally available by the Bureau of the Census from the Current Population Survey) for the most recent 3-calendar-year period (ending before the fiscal year) for which such data are available.

"(B) RESIDENT IN POVERTY DEFINED.—The term 'resident in poverty' means an individual described in section 1614(a)(1)(B)(i) whose family income does not exceed 100 percent of the poverty line for the year involved applicable to a family of the size involved threshold.

"(3) CASE MIX INDEX.—

"(A) IN GENERAL.—For purposes of this subsection, the case mix index for a State or the District of Columbia for a fiscal year is equal to—

"(i) the sum of—

"(I) the per recipient expenditures with respect to elderly individuals in such State or District for the fiscal year (determined under subparagraph (B)),

"(II) the per recipient expenditures with respect to the blind and disabled individuals in such State or District for the fiscal year (determined under subparagraph (C)), and

"(III) the per recipient expenditures with respect to other individuals in such State or District (determined under subparagraph (D));

divided by—

"(ii) the national average spending per recipient determined under subparagraph (E) for the fiscal year involved.

"(B) PER RECIPIENT EXPENDITURES FOR THE ELDERLY.—For purposes of subparagraph (A)(I)(i), the per recipient expenditures with respect to elderly individuals in a State or the District of Columbia for a fiscal year is equal to the product of—

"(i) the national average per recipient expenditures under this title in the 50 States and the District of Columbia for the most recent fiscal year for which data are available for individuals who have attained retirement age; and

"(ii) the proportion, of all individuals who received medical assistance under this title in such State or District in the most recent fiscal year referred to in clause (i), that were individuals described in such clause.

"(C) PER RECIPIENT EXPENDITURES FOR THE BLIND AND DISABLED.—For purposes of subparagraph (A)(i)(II), the per recipient expenditures with respect to blind and disabled individuals in a State or the District of Columbia for a fiscal year is equal to the product of—

"(i) the national average per recipient expenditures under this title in the 50 States and the District of Columbia for the most recent fiscal year for which data are available for individuals who are eligible for medical assistance because such individuals are blind or disabled and under retirement age; and

"(ii) the proportion, of all individuals who received medical assistance under this title in such State or District in the most recent fiscal year referred to in clause (i), that were individuals described in such clause.

"(D) PER RECIPIENT EXPENDITURES FOR OTHER INDIVIDUALS.—For purposes of subparagraph (A)(i)(III), the per recipient expenditures with respect to other individuals in a State or the District of Columbia for a fiscal year is equal to the product of—

"(i) the national average per recipient expenditures under this title in the 50 States and the District of Columbia for the most recent fiscal year for which data are available for individuals who are not described in subparagraph (B)(i) or (C)(i); and

"(ii) the proportion, of all individuals who received medical assistance under this title in such State or District in the most recent fiscal year referred to in clause (i), that were individuals described in such clause.

"(E) NATIONAL AVERAGE SPENDING PER RECIPIENT.—For purposes of this paragraph, the national average expenditures per recipient for a fiscal year is equal to the sum of—

"(i) the product of (I) the national average described in subparagraph (B)(i), and (II) the proportion, of all individuals who received medical assistance under this title in any of the 50 States or the District of Columbia in the fiscal year referred to in such subparagraph, who are described in such subparagraph;

"(ii) the product of (I) the national average described in subparagraph (C)(i), and (II) the proportion, of all individuals who received medical assistance under this title in any of the 50 States or the District of Columbia in the fiscal year referred to in such subparagraph, who are described in such subparagraph; and

"(iii) the product of (I) the national average described in subparagraph (D)(i), and (II) the proportion, of all individuals who received medical assistance under this title in any of the 50 States or the District of Columbia in the fiscal year referred to in such subparagraph, who are described in such subparagraph.

"(F) DETERMINATION OF NATIONAL AVERAGES AND PROPORTIONS.—

"(i) IN GENERAL.—The national averages per recipient and the proportions referred to in clauses (i) and (ii), respectively, of subparagraphs (B), (C), and (D)

and subparagraph (E) shall be determined by the Secretary using the most recent data available.

"(ii) USE OF MEDICAID DATA.—If for a fiscal year there is inadequate data to compute such averages and proportions based on expenditures and numbers of individuals receiving medical assistance under this title, the Secretary may compute such averages based on expenditures and numbers of such individuals under title XIX for the most recent fiscal year for which data are available and, for this purpose—

"(I) any reference in subparagraph (B)(i) to 'individuals who have attained retirement age' is deemed a reference to 'individuals whose eligibility for medical assistance is based on having attained retirement age';

"(II) the reference in subparagraph (C)(i) to 'and under retirement age' shall be considered to be deleted; and

"(III) individuals whose basis for eligibility for medical assistance was reported as unknown shall not be counted as individuals under subparagraph (D)(i).

"(iii) EXPENDITURE DEFINED.—For purposes of this paragraph, the term 'expenditure' means expenditures for medical assistance under the medicaid plan, other than medical assistance attributable to disproportionate share payment adjustments described in section 2111(b)(7) (or section 1923, in the case of fiscal year 1995).

"(4) INPUT COST INDEX.—

"(A) IN GENERAL.—For purposes of this section, the input cost index for a State or the District of Columbia for a fiscal year is the sum of—

"(i) 0.15; and

"(ii) 0.85 multiplied by the ratio of (I) the annual average wages for hospital employees in such State or District for the fiscal year (as determined under subparagraph (B)), to (II) the annual average wages for hospital employees in the 50 States and the District of Columbia for such year (as determined under such subparagraph).

"(B) DETERMINATION OF ANNUAL AVERAGE WAGES OF HOSPITAL EMPLOYEES.—The Secretary shall provide for the determination of annual average wages for hospital employees in a State or the District of Columbia and, collectively, in the 50 States and the District of Columbia for a fiscal year based on the area wage data applicable to hospitals under 1886(d)(2)(E) (or, if such data no longer exists, comparable data of hospital wages) for the fiscal year involved.

"(5) NATIONAL AVERAGE SPENDING PER RESIDENT IN POVERTY.—For purposes of this subsection, the national average spending per resident in poverty—

"(A) for fiscal year 1997 is equal to—

"(i) the sum (for each of the 50 States and the District of Columbia) of the total of the Federal and State expenditures under title XIX for medical assistance for calendar quarters in fiscal year 1995 (other than such expenditures under section 1923), increased by the percentage specified in subsection (c)(1)(A)(ii), divided by

"(ii) the average of the sum of the number of residents in poverty (as defined in paragraph (2)(A)) for all of the 50 States and the District of Columbia for the 3 most recent fiscal years for which data are available, and increased by

"(iii) the national medicaid growth percentage (as defined in subsection (b)(2)) for fiscal year 1997;

"(B) for a succeeding fiscal year is equal to the national average spending per resident in poverty under this paragraph for the preceding fiscal year increased by the national medicaid growth percentage (as so defined) for the fiscal year involved.

"(e) PUBLICATION OF OBLIGATION AND OUTLAY ALLOTMENTS.—

"(1) NOTICE OF PRELIMINARY ALLOTMENTS.—Not later than April 1 before the beginning of each fiscal year (beginning with fiscal year 1997), the Secretary shall initially compute and publish in the Federal Register notice of the proposed obligation and outlay allotments for each State and the District of Columbia under this section (not taking into account subsection (a)(2)(B)) for the fiscal year. The Secretary shall include in the notice a description of the methodology and data used in deriving such allotments for the year.

"(2) REVIEW BY GAO.—The Comptroller General shall submit to Congress by not later than May 15 of each such fiscal year, a report analyzing such allotments and the extent to which such allotments comply with the precise requirements of this section.

"(3) NOTICE OF FINAL ALLOTMENTS.—Not later than July 1 before the beginning of each such fiscal year, the Secretary, taking into consideration the analysis contained in the report of the Comptroller General under paragraph (2), shall compute and publish in the Federal Register notice of the final allotments under this section (both taking into account and not taking into account subsection (a)(2)(B)) for the fiscal year. The Secretary shall include in the notice a description of any changes in such allotments from the initial allotments published under paragraph (1) for the fiscal year and the reasons for such changes. Once published under this paragraph, the Secretary is not authorized to change such allotments.

"(4) GAO REPORT ON FINAL ALLOTMENTS.—The Comptroller General shall submit to Congress by not later than August 1 of each such fiscal year, a report analyzing the final allotments under paragraph (3) and the extent to which such allotments comply with the precise requirements of this section.

"SEC. 2122. PAYMENTS TO STATES.

"(a) AMOUNT OF PAYMENT.—From the allotment of a State under section 2121 for a fiscal year, subject to the succeeding provi-

sions of this title, the Secretary shall pay to each State which has a medicaid plan approved under part E, for each quarter in the fiscal year—

"(1) an amount equal to the Federal medical assistance percentage (as defined in subsection (c)) of the total amount expended during such quarter as medical assistance under the plan; plus

"(2) an amount equal to the Federal medical assistance percentage of the total amount expended during such quarter for medically-related services (as defined in section 2112(d)(2)); plus

"(3) an amount equal to—

"(A) 90 percent of the amounts expended during such quarter for the design, development, and installation of information systems and for providing incentives to promote the enforcement of medical support orders, plus

"(B) 75 percent of the amounts expended during such quarter for medical personnel, administrative support of medical personnel, operation and maintenance of information systems, modification of information systems, quality assurance activities, utilization review, medical and peer review, anti-fraud activities, independent evaluations, coordination of benefits, and meeting reporting requirements under this title, plus

"(C) 50 percent of so much of the remainder of the amounts expended during such quarter as are expended by the State in the administration of the State plan.

"(b) PAYMENT PROCESS.—

"(1) QUARTERLY ESTIMATES.—Prior to the beginning of each quarter, the Secretary shall estimate the amount to which a State will be entitled under subsection (a) for such quarter, such estimates to be based on (A) a report filed by the State containing its estimate of the total sum to be expended in such quarter in accordance with the provisions of such subsections, and stating the amount appropriated or made available by the State and its political subdivisions for such expenditures in such quarter, and if such amount is less than the State's proportionate share of the total sum of such estimated expenditures, the source or sources from which the difference is expected to be derived, and (B) such other investigation as the Secretary may find necessary.

"(2) PAYMENT.—

"(A) IN GENERAL.—The Secretary shall then pay to the State, in such installments as the Secretary may determine and in accordance with section 6503(a) of title 31, United States Code, the amount so estimated, reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section (or section 1903) to such State for any prior quarter and with respect to which adjustment has not already been made under this subsection (or under section 1903(d)).

"(B) TREATMENT AS OVERPAYMENTS.—Expenditures for which payments were made to the State under subsection

(a) shall be treated as an overpayment to the extent that the State or local agency administering such plan has been reimbursed for such expenditures by a third party pursuant to the provisions of its plan in compliance with section 2135.

"(C) RECOVERY OF OVERPAYMENTS.—For purposes of this subsection, when an overpayment is discovered, which was made by a State to a person or other entity, the State shall have a period of 60 days in which to recover or attempt to recover such overpayment before adjustment is made in the Federal payment to such State on account of such overpayment. Except as otherwise provided in subparagraph (D), the adjustment in the Federal payment shall be made at the end of the 60 days, whether or not recovery was made.

"(D) NO ADJUSTMENT FOR UNCOLLECTABLES.—In any case where the State is unable to recover a debt which represents an overpayment (or any portion thereof) made to a person or other entity on account of such debt having been discharged in bankruptcy or otherwise being uncollectable, no adjustment shall be made in the Federal payment to such State on account of such overpayment (or portion thereof).

"(3) FEDERAL SHARE OF RECOVERIES.—The pro rata share to which the United States is equitably entitled, as determined by the Secretary, of the net amount recovered during any quarter by the State or any political subdivision thereof with respect to medical assistance furnished under the State plan shall be considered an overpayment to be adjusted under this subsection.

"(4) TIMING OF OBLIGATION OF FUNDS.—Upon the making of any estimate by the Secretary under this subsection, any appropriations available for payments under this section shall be deemed obligated.

"(5) DISALLOWANCES.—In any case in which the Secretary estimates that there has been an overpayment under this section to a State on the basis of a claim by such State that has been disallowed by the Secretary under section 1116(d), and such State disputes such disallowance, the amount of the Federal payment in controversy shall, at the option of the State, be retained by such State or recovered by the Secretary pending a final determination with respect to such payment amount. If such final determination is to the effect that any amount was properly disallowed, and the State chose to retain payment of the amount in controversy, the Secretary shall offset, from any subsequent payments made to such State under this title, an amount equal to the proper amount of the disallowance plus interest on such amount disallowed for the period beginning on the date such amount was disallowed and ending on the date of such final determination at a rate (determined by the Secretary) based on the average of the bond equivalent of the weekly 90-day treasury bill auction rates during such period.

"(c) FEDERAL MEDICAL ASSISTANCE PERCENTAGE DEFINED.—

"(1) IN GENERAL.—For purposes of this section, except as provided in subsection (f), the Federal medical assistance percentage, with respect to each of the 50 States or the District of Columbia, is 100 percent less the State percentage.

"(2) STATE PERCENTAGE.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the State percentage is that percentage which bears the same ratio to 45 percent as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii.

"(B) EXCEPTION.—For purposes of this title only, for Alaska, the State percentage is that percentage which bears the same ratio to 45 percent as the square of the adjusted per capita income of such State bears to the square of the per capita income of the continental United States. For purposes of the preceding sentence, the adjusted per capita income for Alaska shall be determined by dividing the State's most recent 3-year average per capita by the input cost index for such State (as determined in section 2121(d)(4)).

"(3) LIMITATION ON RANGE.—In no case shall the Federal medical assistance percentage be—

"(A) less than—

"(i) 60 percent, or

"(ii) 50 percent, in the case of any other provision of law other than this title; or

"(B) more than 83 percent.

"(4) PROMULGATION.—The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1101(a)(8)(B).

"(d) PROVIDER-RELATED DONATIONS AND HEALTH CARE RELATED TAXES.—

"(1) GENERAL LIMITATIONS.—

"(A) REDUCTION IN MEDICAL ASSISTANCE EXPENDITURES.—Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State (as defined in paragraph (5)(D)) under this section for quarters in any fiscal year, the total amount expended during such fiscal year as medical assistance under the medicaid plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during the fiscal year—

"(i) from provider-related donations (as defined in paragraph (2)(A)), other than—

"(I) bona fide provider-related donations (as defined in paragraph (2)(B)), and

"(II) donations described in paragraph (2)(C);

"(ii) from health care related taxes (as defined in paragraph (3)(A)), other than broad-based health care related taxes (as defined in paragraph (3)(B)); or

"(iii) from a broad-based health care related tax, if there is in effect a hold harmless provision (described in paragraph (4)) with respect to the tax.

"(B) REDUCTION IN ADMINISTRATIVE EXPENDITURES.—Notwithstanding the previous provisions of this section, for purposes of determining the amount to be paid to a State under this section for all quarters in a Federal fiscal year (beginning with fiscal year 1996), the total amount expended during the fiscal year for administrative expenditures under the medicaid plan (as determined without regard to this subsection) shall be reduced by the sum of any revenues received by the State (or by a unit of local government in the State) during such quarters from donations described in paragraph (2)(C), to the extent the amount of such donations exceeds 10 percent of the amounts expended under the medicaid plan approved under this title during the fiscal year for purposes described in subsection (a)(3).

"(2) PROVIDER-RELATED DONATIONS.—

"(A) IN GENERAL.—For purposes of this subsection, the term 'provider-related donation' means any donation or other voluntary payment (whether in cash or in kind) made (directly or indirectly) to a State or unit of local government by—

"(i) a health care provider (as defined in paragraph (5)(B));

"(ii) an entity related to a health care provider (as defined in paragraph (5)(C)); or

"(iii) an entity providing goods or services under the State plan for which payment is made to the State under subsection (a)(3).

"(B) BONA FIDE PROVIDER-RELATED DONATIONS.—For purposes of paragraph (1)(A)(i)(I), the term 'bona fide provider-related donation' means a provider-related donation that has no direct or indirect relationship (as determined by the Secretary) to payments made under this title to that provider, to providers furnishing the same class of items and services as that provider, or to any related entity, as established by the State to the satisfaction of the Secretary. The Secretary may by regulation specify types of provider-related donations described in the previous sentence that will be considered to be bona fide provider-related donations.

"(C) DONATIONS DESCRIBED.—For purposes of paragraph (1)(A)(i)(II), donations described in this subparagraph are funds expended by a hospital, clinic, or similar entity for the direct cost (including costs of training and of preparing and distributing outreach materials) of State or local agency personnel who are stationed at the hospital, clinic, or entity to determine the eligibility of individuals for medical assistance under a medicaid plan approved under this title and to provide outreach services to eligible or potentially eligible individuals.

"(3) HEALTH CARE RELATED TAXES.—

"(A) IN GENERAL.—For purposes of this subsection, the term 'health care related tax' means a tax (as defined in paragraph (5)(F)) that—

"(i) is related to health care items or services, or to the provision of, the authority to provide, or payment for, such items or services; or

"(ii) is not limited to such items or services but provides for treatment of individuals or entities that are providing or paying for such items or services that is different from the treatment provided to other individuals or entities.

In applying clause (i), a tax is considered to relate to health care items or services if at least 85 percent of the burden of such tax falls on health care providers.

"(B) BROAD-BASED HEALTH CARE RELATED TAX.—For purposes of this subsection, the term 'broad-based health care related tax' means a health care related tax which is imposed with respect to a class of health care items or services (as described in paragraph (5)(A)) or with respect to providers of such items or services and which, except as provided in subparagraphs (D) and (E)—

"(i) is imposed at least with respect to all items or services in the class furnished by all non-Federal, nonpublic providers in the State (or, in the case of a tax imposed by a unit of local government, the area over which the unit has jurisdiction) or is imposed with respect to all non-Federal, nonpublic providers in the class; and

"(ii) is imposed uniformly (in accordance with subparagraph (C)).

"(C) UNIFORM IMPOSITION OF TAX.—

"(i) IN GENERAL.—Subject to clause (ii), for purposes of subparagraph (B)(ii), a tax is considered to be imposed uniformly if—

"(I) in the case of a tax consisting of a licensing fee or similar tax on a class of health care items or services (or providers of such items or services), the amount of the tax imposed is the same for every provider providing items or services within the class;

"(II) in the case of a tax consisting of a licensing fee or similar tax imposed on a class of health care items or services (or providers of such services) on the basis of the number of beds (licensed or otherwise) of the provider, or the number of patient days or other unit of service, the amount of the tax is the same for each bed, or each unit of service, of each provider of such items or services in the class;

"(III) in the case of a tax based on revenues or receipts with respect to a class of items or services (or providers of items or services) the tax is imposed at a uniform rate for all items and services (or providers of such items of services) in the

class on all the gross revenues or receipts, or net operating revenues, relating to the provision of all such items or services (or all such providers) in the State (or, in the case of a tax imposed by a unit of local government within the State, in the area over which the unit has jurisdiction); or

"(IV) in the case of any other tax, the State establishes to the satisfaction of the Secretary that the tax is imposed uniformly.

"(ii) DETERMINATION OF NONUNIFORMITY.—Subject to subparagraphs (D) and (E), a tax imposed with respect to a class of health care items and services is not considered to be imposed uniformly if the tax provides for any credits, exclusions, or deductions which have as their purpose or effect the return to providers of all or a portion of the tax paid in a manner that is inconsistent with subclauses (I) and (II) of subparagraph (E)(ii) or provides for a hold harmless provision described in paragraph (4).

"(D) EXCEPTIONS TO NONUNIFORMITY DETERMINATIONS.—A tax imposed with respect to a class of health care items and services is considered to be imposed uniformly—

"(i) notwithstanding that the tax is not imposed with respect to items or services (or the providers thereof) for which payment is made under a medicaid plan approved under this title or title XVIII; or

"(ii) in the case of a tax described in subparagraph (C)(i)(III), notwithstanding that the tax provides for exclusion (in whole or in part) of revenues or receipts from a medicaid plan approved under this title or title XVIII.

"(E) WAIVER APPLICATION FOR TREATMENTS AS BROAD-BASED TAX.—

"(i) IN GENERAL.—A State may submit an application to the Secretary requesting that the Secretary treat a tax as a broad-based health care related tax, notwithstanding that the tax does not apply to all health care items or services in class (or all providers of such items and services), provides for a credit, deduction, or exclusion, is not applied uniformly, or otherwise does not meet the requirements of subparagraph (B) or (C). Permissible waivers may include exemptions for rural or sole-community providers.

"(ii) WAIVER APPROVAL REQUIREMENTS.—The Secretary shall approve such an application if the State establishes to the satisfaction of the Secretary that—

"(I) the net impact of the tax and associated expenditures under the medicaid plan approved under this title as proposed by the State is generally redistributive in nature; and

"(II) the amount of the tax is not directly correlated to payments under such plan for items or services with respect to which the tax is imposed.

"(iii) DETERMINATION OF REDISTRIBUTIVE NATURE.—In determining whether a tax for which a waiver is sought is generally redistributive in nature, the Secretary shall, if requested by the State—

"(I) compare the tax to a tax that meets any of the uniformity requirements of subparagraphs (C) or (D); and

"(II) consider in the aggregate all classes (or providers) of health care items or services that are subject to the same tax.

"(iv) TERM OF WAIVER.—A tax for which the Secretary has approved an application for waiver shall not be subject to the requirements of a further waiver application solely because a change in the rate of tax.

"(F) TREATMENT OF MANAGED CARE PREMIUMS.—No tax on the payment or receipt of premiums or similar periodic payments to health maintenance organizations or health care insurers shall be treated as a health care related tax unless and until the Secretary, after consultation with the States pursuant to section 5(c) of the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, adopts a final regulation specifically subjecting such taxes, or any of such taxes, to the provisions of this subsection.

"(4) HOLD HARMLESS DETERMINATION.—For purposes of paragraph (1)(A)(iii), there is in effect a hold harmless provision with respect to a broad-based health care related tax imposed with respect to a class of items or services if the Secretary determines that any of the following applies:

"(A) The State or other unit of government imposing the tax provides (directly or indirectly) for a payment (other than under a medicaid plan approved under this title) to taxpayers and the amount of such payment is positively correlated either to the amount of such tax or to the difference between the amount of the tax and the amount of payment under the medicaid plan.

"(B) All or any portion of the payment made under this title to the taxpayer varies based only upon the amount of the total tax paid.

"(C) The State or other unit of government imposing the tax provides (directly or indirectly) for any payment, offset, or waiver that guarantees to hold taxpayers harmless for any portion of the costs of the tax.

Notwithstanding the provisions of this paragraph, no hold harmless shall be found to be in effect with respect to a tax enacted or extended prior to October 1, 1995, because of the existence in the State of a program of financial aid or of tax credits for recipients of health care items or services from providers that are subject to an otherwise valid health care related tax.

"(5) DEFINITIONS AND SPECIAL RULES.—For purposes of this subsection:

"(A) CLASSES OF HEALTH CARE ITEMS AND SERVICES.—Each of the following shall be considered a separate class of health care items and services:

"(i) Inpatient hospital services.

"(ii) Outpatient hospital services.

"(iii) Nursing facility services (other than services of intermediate care facilities for the mentally retarded).

"(iv) Services of intermediate care facilities for the mentally retarded.

"(v) Physicians' services.

"(vi) Home health care services.

"(vii) Outpatient prescription drugs.

"(viii) Services of health maintenance organizations (and other organizations with contracts under section 2114) not otherwise subject to a tax described in this subsection.

"(ix) Such other classification of health care items and services consistent with this subparagraph as the Secretary may establish by regulation.

"(B) HEALTH CARE PROVIDER.—The term 'health care provider' means an individual or person that receives payments for the provision of health care items or services.

"(C) RELATED ENTITIES.—An entity is considered to be 'related' to a health care provider if the entity—

"(i) is an organization, association, corporation or partnership formed by or on behalf of health care providers;

"(ii) is a person with an ownership or control interest (as defined in section 1124(a)(3)) in the provider;

"(iii) is the employee, spouse, parent, child, or sibling of the provider (or of a person described in clause (ii)); or

"(iv) has a similar, close relationship (as defined in regulations) to the provider.

"(D) STATE.—The term 'State' means only the 50 States and the District of Columbia.

"(E) STATE FISCAL YEAR.—The 'State fiscal year' means, with respect to a specified year, a State fiscal year ending in that specified year.

"(F) TAX.—The term 'tax' includes any licensing fee, assessment, or other mandatory payment, but does not include any fee or charge associated with a State regulatory, authorizing, financial assistance, or other program in which health care providers are eligible to participate, or payment of a criminal or civil fine or penalty (other than a fine or penalty imposed in lieu of or instead of a fee, assessment, or other mandatory payment).

"(G) UNIT OF LOCAL GOVERNMENT.—The term 'unit of local government' means, with respect to a State, a city, county, special purpose district, or other governmental unit in the State.

"(6) CERTAIN IMPOSITION OF HEALTH CARE RELATED TAXES PROHIBITED.—No payment may be made to a State under this section with respect to State expenditures attributable to health care related taxes or broad-based health care related

taxes imposed on hospitals described in section 501(c)(3) of the Internal Revenue Code of 1986 which do not accept reimbursement under a medicaid plan.

"(e) TREATMENT OF STATE EXPENDITURES.—

"(1) IN GENERAL.—No payment may be made to a State under this section unless such State provides not less than 40 percent of the non-Federal share of the expenditures under the medicaid plan.

"(2) TREATMENT OF CERTAIN EXPENDITURES.—In determining State expenditures under this section:

"(A) TRANSFERS FROM OTHER STATE AND LOCAL PROGRAMS.—Such expenditures shall not include funding supplanted by transfers from other State and local programs.

"(B) EXCLUSION OF FEDERAL AMOUNTS.—Such expenditures shall not include amounts made available by the Federal Government and any State funds which are used to match Federal funds or are expended as a condition of receiving Federal funds under Federal programs other than under this title.

"(f) SPECIAL RULES.—For purposes of this title:

"(1) COMMONWEALTHS AND TERRITORIES.—In the case of Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa, the Federal medical assistance percentages are 50 percent.

"(2) INDIAN HEALTH PROGRAMS.—The Federal medical assistance percentages shall be 100 percent with respect to the amounts expended as medical assistance for services which are provided by—

"(A) the Indian Health Service;

"(B) an Indian health program operated by an Indian tribe or tribal organization pursuant to a contract, grant, cooperative agreement, or compact with the Indian Health Service under authority of the Indian Self-Determination Act (25 U.S.C. 450 et seq.); or

"(C) an urban Indian health program operated by an urban Indian organization pursuant to a grant or contract with the Indian Health Service under authority of title V of the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

"(3) NO STATE MATCHING REQUIRED FOR CERTAIN EXPENDITURES.—In applying subsection (a)(1) with respect to medical assistance provided to unlawful aliens pursuant to the exception specified in section 2123(f)(2), payment shall be made for the amount of such assistance without regard to any need for a State match.

"(4) SPECIAL RULE.—

"(A) IN GENERAL.—Notwithstanding subsection (a), in order to receive the full State outlay allotment described in section 2121(c)(6), a State shall expend State funds in a fiscal year under a medicaid plan approved under this title in an amount not less than the adjusted base year State expenditures, plus an applicable percentage of the difference between such expenditures and the amount necessary to qualify for the full State outlay allotment so de-

scribed in such fiscal year as determined under this section without regard to this paragraph.

"(B) REDUCTION IN ALLOTMENT IF EXPENDITURE LIMIT NOT MET.—In the event a State fails to expend State funds in an amount required by subparagraph (A) for a fiscal year, the outlay allotment described in section 2121(c)(6) for such year shall be reduced by an amount which bears the same ratio to such outlay allotment as the State funds expended in such fiscal year bears to the amount required by subparagraph (A).

"(C) ADJUSTED BASE YEAR STATE EXPENDITURES.—For purposes of this paragraph, the term 'adjusted base year State expenditures' means—

"(i) for New Hampshire, $203,000,000; and

"(ii) for Louisiana, $355,000,000.

"(D) APPLICABLE PERCENTAGE.—For purposes of this paragraph, the applicable percentage for any fiscal year is specified in the following table:

"Fiscal year:	Applicable Percentage:
1996	20
1997	40
1998	60
1999	80
2000	100.

"(g) AUTHORITY TO USE PORTION OF PAYMENT FOR OTHER PURPOSES.—

"(1) IN GENERAL.—A State may use not more than 30 percent of the amount of the grant made to the State under this section for a fiscal year to carry out a State program pursuant to a waiver granted under section 1115 which may include waivers of any or all of the following provisions of law:

"(A) Part A of title IV.

"(B) Title V.

"(C) Title XVI.

"(D) Title XVIII.

"(E) Title XX.

"(F) The Food Stamp Act of 1977.

"(2) SUFFICIENT FUNDING DETERMINATION.—Prior to using any amounts received from a payment under this title for a fiscal year to carry out a State program pursuant to any or all of the provisions of law described in paragraph (1), the appropriate State agency shall make a determination that sufficient amounts will remain available for such fiscal year to carry out the medicaid plan approved under this title.

"(3) APPLICABLE RULES.—Any amount paid to the State under this title that is used to carry out a State program pursuant to a provision of law specified in paragraph (1) shall not be subject to the requirements of this title, but shall be subject to the requirements that apply to Federal funds provided directly under the provision of law to carry out the program.

"(4) EXPEDITED WAIVER PROCESS.—Notwithstanding any other provision of law, the Secretary shall approve or disapprove a waiver described in paragraph (1) and submitted

under section 1115 not later than 90 days after the date the completed application is received. Any application for such a waiver which is not approved or disapproved within such 90-day period shall be deemed approved.

"(5) SECRETARIAL ENCOURAGEMENT OF WAIVERS.—The Secretary shall encourage States to operate a waiver described in paragraph (1) and to evaluate, using random sampling and other characteristics of accepted scientific evaluations, the result or effect of such waiver.

"SEC. 2123. LIMITATION ON USE OF FUNDS; DISALLOWANCE.

"(a) IN GENERAL.—Funds provided to a State under this title shall only be used to carry out the purposes of this title.

"(b) DISALLOWANCES FOR EXCLUDED PROVIDERS.—

"(1) IN GENERAL.—No payment shall be made to a State under this part for expenditures for items and services furnished—

"(A) by a provider who was excluded from participation under title V, XVIII, or XX or under this title pursuant to section 1128, 1128A, 1156, or 1842(j)(2); or

"(B) under the medical direction or on the prescription of a physician who was so excluded, if the provider of the services knew or had reason to know of the exclusion.

"(2) EXCEPTION FOR EMERGENCY SERVICES.—Paragraph (1) shall not apply to emergency items or services, not including hospital emergency room services.

"(c) LIMITATION.—No Federal financial assistance is available for expenditures under the medicaid plan for medically-related services for a quarter to the extent such expenditures exceed 5 percent of the total expenditures under the plan for the quarter.

"(d) TREATMENT OF THIRD PARTY LIABILITY.—No payment shall be made to a State under this part for expenditures for medical assistance provided for an individual under its medicaid plan to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), a service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the individual is eligible for or is provided medical assistance under the plan.

"(e) MEDICAID AS SECONDARY PAYER.—Except as otherwise provided by law, no payment shall be made to a State under this part for expenditures for medical assistance provided for an individual under its medicaid plan to the extent that payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under any other federally operated or financed health care program as identified by the Secretary. For purposes of this subsection, rules similar to the rules for overpayments under section 2122(b) shall apply.

"(f) LIMITATION ON PAYMENTS TO EMERGENCY SERVICES FOR NONLAWFUL ALIENS.—

"(1) IN GENERAL.—Notwithstanding the preceding provisions of this section, except as provided in paragraph (2), no payment shall be made to a State under this part for medical

assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

"(2) EXCEPTION FOR EMERGENCY SERVICES.—Payment may be made under this section for care and services that are furnished to an alien described in paragraph (1) only if—

"(A) such care and services are necessary for the treatment of an emergency medical condition of the alien;

"(B) such alien otherwise meets the eligibility requirements for medical assistance under the medicaid plan (other than a requirement of the receipt of aid or assistance under title IV, supplemental security income benefits under title XVI, or a State supplementary payment); and

"(C) such care and services are not related to an organ transplant procedure.

"(3) EMERGENCY MEDICAL CONDITION DEFINED.—For purposes of this subsection, the term 'emergency medical condition' means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

"(A) placing the patient's health in serious jeopardy;

"(B) serious impairment to bodily functions; or

"(C) serious dysfunction of any bodily organ or part.

"(g) LIMITATION ON PAYMENT FOR ABORTIONS.—

"(1) IN GENERAL.—No payment shall be made to a State under this part for any amount expended under the medicaid plan to pay for any abortion or to assist in the purchase, in whole or in part, of health benefit coverage that includes coverage of abortion.

"(2) EXCEPTION.—Paragraph (1) shall not apply to an abortion—

"(A) if the pregnancy is the result of an act of rape or incest; or

"(B) in the case where a woman suffers from a physical disorder, illness, or injury that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

"(h) TREATMENT OF ASSISTED SUICIDE.—

"(1) PROHIBITION OF PAYMENT.—No payment shall be made to a State under this part for amounts expended under the medicaid plan to pay for, or to assist in the purchase, in whole or in part, of health benefit coverage that includes payment for any drug, biological product, or service which was furnished for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.

"(2) NO REQUIREMENT THAT HEALTH CARE PROVIDERS INFORM PATIENTS CONCERNING ASSISTED SUICIDE.—No State may require under its medicaid plan that a health care provider or employee of a health care provider be required to inform or counsel a patient regarding assisted suicide, euthanasia, mercy killing, or other services which purposefully causes the death of a person.

"(i) UNAUTHORIZED USE OF FUNDS.—No payment shall be made to a State under this part with respect to State expenditures—

"(1) to purchase or improve land or construct or remodel buildings;

"(2) to pay basic room and board costs, except when provided as part of a temporary, respite care service in a facility approved by the State which is not a private residence;

"(3) to provide educational services which the State makes generally available to its residents without cost and without regard to income; or

"(4) to provide vocational rehabilitation or other employment training and related services which are available to eligible individuals through other Federal, State or local programs and funding sources.

"SEC. 2124. GRANT PROGRAM FOR COMMUNITY HEALTH CENTERS AND RURAL HEALTH CLINICS.

"(a) IN GENERAL.—From the pool amount determined under section 2121(b)(1) for a fiscal year, the Secretary shall set aside an amount equal to 1 percent of such amount.

"(b) USE OF FUNDS.—Fifty percent of the amount set aside by the Secretary under subsection (a) shall only be used for grants for primary and preventive health care services provided at rural health clinics (as defined in section 1861(aa)(2)) and 50 percent of such amount shall only be used for grants for such services provided at Federally-qualified health centers (as defined in section 1861(aa)(4)).

"(c) GRANT AMOUNTS.—The Secretary shall provide the methodology for determining the amount of each grant made under subsection (b).

"PART D—PROGRAM INTEGRITY AND QUALITY

"SEC. 2131. USE OF AUDITS TO ACHIEVE FISCAL INTEGRITY.

"(a) FINANCIAL AUDITS OF PROGRAM.—

"(1) IN GENERAL.—Each medicaid plan shall provide for an annual audit of the State's expenditures from amounts received under this title, in compliance with chapter 75 of title 31, United States Code.

"(2) VERIFICATION AUDITS.—If, after consultation with the State and the Comptroller General and after a fair hearing, the Secretary determines that a State's audit under paragraph (1) was performed in substantial violation of chapter 75 of title 31, United States Code, the Secretary may—

"(A) require that the State provide for a verification audit in compliance with such chapter; or

"(B) conduct such a verification audit.

"(3) AVAILABILITY OF AUDIT REPORTS.—Within 30 days after completion of each audit or verification audit under this subsection, the State shall—

"(A) provide the Secretary with a copy of the audit report, including the State's response to any recommendations of the auditor; and

"(B) make the audit report available for public inspection in the same manner as proposed medicaid plan amendments are made available under section 2105.

"(b) FISCAL CONTROLS.—

"(1) IN GENERAL.—With respect to the accounting and expenditure of funds under this title, each State shall adopt and maintain such fiscal controls, accounting procedures, and data processing safeguards as the State deems reasonably necessary to assure the fiscal integrity of the State's activities under this title.

"(2) CONSISTENCY WITH GENERALLY ACCEPTED ACCOUNTING PRINCIPLES.—Such controls and procedures shall be generally consistent with generally accepted accounting principles as recognized by the Governmental Accounting Standards Board or the Comptroller General.

"(c) AUDITS OF PROVIDERS.—Each medicaid plan shall provide that the records of any entity providing items or services for which payment may be made under the plan may be audited as necessary to ensure that proper payments are made under the plan.

"SEC. 2132. FRAUD PREVENTION PROGRAM.

"(a) ESTABLISHMENT.—Each medicaid plan shall provide for the establishment and maintenance of an effective program for the detection and prevention of fraud and abuse by beneficiaries, providers, and others in connection with the operation of the program.

"(b) PROGRAM REQUIREMENTS.—The program established pursuant to subsection (a) shall include at least the following requirements:

"(1) DISCLOSURE OF INFORMATION.—Any disclosing entity (as defined in section 1124(a)) receiving payments under the medicaid plan shall comply with the requirements of section 1124.

"(2) SUPPLY OF INFORMATION.—An entity (other than an individual practitioner or a group of practitioners) that furnishes, or arranges for the furnishing of, an item or service under the medicaid plan shall supply upon request specifically addressed to the entity by the Secretary or the State agency the information described in section 1128(b)(9).

"(3) EXCLUSION.—

"(A) IN GENERAL.—The medicaid plan shall exclude any specified individual or entity from participation in the plan for the period specified by the Secretary when required by the Secretary to do so pursuant to section 1128 or section 1128A, and provide that no payment may be made under the plan with respect to any item or service furnished by such individual or entity during such period.

"(B) AUTHORITY.—In addition to any other authority, a State may exclude any individual or entity for purposes of participating under the medicaid plan for any reason for which the Secretary could exclude the individual or entity from participation in a program under title XVIII or under section 1128, 1128A, or 1866(b)(2).

"(4) NOTICE.—The medicaid plan shall provide that whenever a provider of services or any other person is terminated, suspended, or otherwise sanctioned or prohibited from partici-

pating under the plan, the State agency responsible for administering the plan shall promptly notify the Secretary and, in the case of a physician, the State medical licensing board of such action.

"(5) ACCESS TO INFORMATION.—The medicaid plan shall provide that the State will provide information and access to certain information respecting sanctions taken against health care practitioners and providers by State licensing authorities in accordance with section 2133.

"SEC. 2133. INFORMATION CONCERNING SANCTIONS TAKEN BY STATE LICENSING AUTHORITIES AGAINST HEALTH CARE PRACTITIONERS AND PROVIDERS.

"(a) INFORMATION REPORTING REQUIREMENT.—The requirement referred to in section 2132(b)(5) is that the State must provide for the following:

"(1) INFORMATION REPORTING SYSTEM.—The State must have in effect a system of reporting the following information with respect to formal proceedings (as defined by the Secretary in regulations) concluded against a health care practitioner or entity by any authority of the State (or of a political subdivision thereof) responsible for the licensing of health care practitioners (or any peer review organization or private accreditation entity reviewing the services provided by health care practitioners) or entities:

"(A) Any adverse action taken by such licensing authority as a result of the proceeding, including any revocation or suspension of a license (and the length of any such suspension), reprimand, censure, or probation.

"(B) Any dismissal or closure of the proceedings by reason of the practitioner or entity surrendering the license or leaving the State or jurisdiction.

"(C) Any other loss of the license of the practitioner or entity, whether by operation of law, voluntary surrender, or otherwise.

"(D) Any negative action or finding by such authority, organization, or entity regarding the practitioner or entity.

"(2) ACCESS TO DOCUMENTS.—The State must provide the Secretary (or an entity designated by the Secretary) with access to such documents of the authority described in paragraph (1) as may be necessary for the Secretary to determine the facts and circumstances concerning the actions and determinations described in such paragraph for the purpose of carrying out this Act.

"(b) FORM OF INFORMATION.—The information described in subsection (a)(1) shall be provided to the Secretary (or to an appropriate private or public agency, under suitable arrangements made by the Secretary with respect to receipt, storage, protection of confidentiality, and dissemination of information) in such a form and manner as the Secretary determines to be appropriate in order to provide for activities of the Secretary under this Act and in order to provide, directly or through suitable arrangements made by the Secretary, information—

"(1) to agencies administering Federal health care programs, including private entities administering such programs under contract;

"(2) to licensing authorities described in subsection (a)(1);

"(3) to State agencies administering or supervising the administration of State health care programs (as defined in section 1128(h));

"(4) to utilization and quality control peer review organizations described in part B of title XI and to appropriate entities with contracts under section 1154(a)(4)(C) with respect to eligible organizations reviewed under the contracts;

"(5) to State medicaid fraud control units (as defined in section 2134(b));

"(6) to hospitals and other health care entities (as defined in section 431 of the Health Care Quality Improvement Act of 1986), with respect to physicians or other licensed health care practitioners that have entered (or may be entering) into an employment or affiliation relationship with, or have applied for clinical privileges or appointments to the medical staff of, such hospitals or other health care entities (and such information shall be deemed to be disclosed pursuant to section 427 of, and be subject to the provisions of, that Act);

"(7) to the Attorney General and such other law enforcement officials as the Secretary deems appropriate; and

"(8) upon request, to the Comptroller General,

in order for such authorities to determine the fitness of individuals to provide health care services, to protect the health and safety of individuals receiving health care through such programs, and to protect the fiscal integrity of such programs.

"(c) CONFIDENTIALITY OF INFORMATION PROVIDED.—The Secretary shall provide for suitable safeguards for the confidentiality of the information furnished under subsection (a). Nothing in this subsection shall prevent the disclosure of such information by a party which is otherwise authorized, under applicable State law, to make such disclosure.

"(d) APPROPRIATE COORDINATION.—The Secretary shall provide for the maximum appropriate coordination in the implementation of subsection (a) of this section and section 422 of the Health Care Quality Improvement Act of 1986 and section 1128E.

"SEC. 2134. STATE MEDICAID FRAUD CONTROL UNITS.

"(a) IN GENERAL.—Each medicaid plan shall provide for a State medicaid fraud control unit that effectively carries out the functions and requirements described in such subsection, unless the State demonstrates to the satisfaction of the Secretary that the effective operation of such a unit in the State would not be cost-effective because minimal fraud exists in connection with the provision of covered services to eligible individuals under the plan, and that beneficiaries under the plan will be protected from abuse and neglect in connection with the provision of medical assistance under the plan without the existence of such a unit

"(b) UNITS DESCRIBED.—For purposes of this section, the term 'State medicaid fraud control unit' means a single identifiable entity of the State government which meets the following requirements:

"(1) ORGANIZATION.—The entity—

"(A) is a unit of the office of the State Attorney General or of another department of State government which possesses statewide authority to prosecute individuals for criminal violations;

"(B) is in a State the constitution of which does not provide for the criminal prosecution of individuals by a statewide authority and has formal procedures that—

"(i) assure its referral of suspected criminal violations relating to the program under this title to the appropriate authority or authorities in the State for prosecution, and

"(ii) assure its assistance of, and coordination with, such authority or authorities in such prosecutions; or

"(C) has a formal working relationship with the office of the State Attorney General and has formal procedures (including procedures for its referral of suspected criminal violations to such office) which provide effective coordination of activities between the entity and such office with respect to the detection, investigation, and prosecution of suspected criminal violations relating to the program under this title.

"(2) INDEPENDENCE.—The entity is separate and distinct from any State agency that has principal responsibilities for administering or supervising the administration of the medicaid plan.

"(3) FUNCTION.—The entity's function is conducting a statewide program for the investigation and prosecution of violations of all applicable State laws regarding any and all aspects of fraud in connection with any aspect of the provision of medical assistance and the activities of providers of such assistance under the medicaid plan.

"(4) REVIEW OF COMPLAINTS.—The entity has procedures for reviewing complaints of the abuse and neglect of patients of health care facilities which receive payments under the medicaid plan approved under this title, and, where appropriate, for acting upon such complaints under the criminal laws of the State or for referring them to other State agencies for action.

"(5) OVERPAYMENTS.—

"(A) IN GENERAL.—The entity provides for the collection, or referral for collection to a single State agency, of overpayments that are made under the medicaid plan to health care providers and that are discovered by the entity in carrying out its activities.

"(B) TREATMENT OF CERTAIN OVERPAYMENTS.—If an overpayment is the direct result of the failure of the provider (or the provider's billing agent) to adhere to a change in the State's billing instructions, the entity may recover the overpayment only if the entity demonstrates that the provider (or the provider's billing agent) received reasonable written or electronic notice of the change in the billing instructions before the submission of the claims on which the overpayment is based.

"(6) PERSONNEL.—The entity employs such auditors, attorneys, investigators, and other necessary personnel and is organized in such a manner as is necessary to promote the effective and efficient conduct of the entity's activities.

"SEC. 2135. RECOVERIES FROM THIRD PARTIES AND OTHERS.

"(a) THIRD PARTY LIABILITY.—Each medicaid plan shall provide for reasonable steps—

"(1) to ascertain the legal liability of third parties to pay for care and services available under the plan, including the collection of sufficient information to enable States to pursue claims against third parties; and

"(2) to seek reimbursement for medical assistance provided to the extent legal liability is established if the amount expected to be recovered exceeds the costs of the recovery.

"(b) BENEFICIARY PROTECTION.—

"(1) IN GENERAL.—Each medicaid plan shall provide that in the case of a person furnishing services under the plan for which a third party may be liable for payment—

"(A) the person may not seek to collect from the individual (or financially responsible relative) payment of an amount for the service more than could be collected under the plan in the absence of such third party liability; and

"(B) may not refuse to furnish services to such an individual because of a third party's potential liability for payment for the service.

"(2) PENALTY.—A medicaid plan may provide for a reduction of any payment amount otherwise due with respect to a person who furnishes services under the plan in an amount equal to up to 3 times the amount of any payment sought to be collected by that person in violation of paragraph (1)(A).

"(c) GENERAL LIABILITY.—The State shall prohibit any health insurer, including a group health plan as defined in section 607 of the Employee Retirement Income Security Act of 1974, a service benefit plan, or a health maintenance organization, in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance under a medicaid plan for any State.

"(d) ACQUISITION OF RIGHTS OF BENEFICIARIES.—To the extent that payment has been made under a medicaid plan in any case where a third party has a legal liability to make payment for such assistance, the State shall have in effect laws under which, to the extent that payment has been made under the plan for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services.

"(e) ASSIGNMENT OF MEDICAL SUPPORT RIGHTS.—The medicaid plan shall provide for mandatory assignment of rights of payment for medical support and other medical care owed to recipients in accordance with section 2136.

"(f) REQUIRED LAWS RELATING TO MEDICAL CHILD SUPPORT.—

"(1) IN GENERAL.— Each State with a medicaid plan shall have in effect the following laws:

"(A) A law that prohibits an insurer from denying enrollment of a child under the health coverage of the child's parent on the ground that—

"(i) the child was born out of wedlock;

"(ii) the child is not claimed as a dependent on the parent's Federal income tax return; or

"(iii) the child does not reside with the parent or in the insurer's service area.

"(B) In any case in which a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage through an insurer, a law that requires such insurer—

"(i) to permit such parent to enroll under such family coverage any such child who is otherwise eligible for such coverage (without regard to any enrollment season restrictions);

"(ii) if such a parent is enrolled but fails to make application to obtain coverage of such child, to enroll such child under such family coverage upon application by the child's other parent or by the State agency administering the program under this title or part D of title IV; and

"(iii) not to disenroll, or eliminate coverage of, such a child unless the insurer is provided satisfactory written evidence that—

"(I) such court or administrative order is no longer in effect, or

"(II) the child is or will be enrolled in comparable health coverage through another insurer which will take effect not later than the effective date of such disenrollment.

"(C) In any case in which a parent is required by a court or administrative order to provide health coverage for a child and the parent is eligible for family health coverage through an employer doing business in the State, a law that requires such employer—

"(i) to permit such parent to enroll under such family coverage any such child who is otherwise eligible for such coverage (without regard to any enrollment season restrictions);

"(ii) if such a parent is enrolled but fails to make application to obtain coverage of such child, to enroll such child under such family coverage upon application by the child's other parent or by the State agency administering the program under this title or part D of title IV; and

"(iii) not to disenroll, or eliminate coverage of, any such child unless—

"(I) the employer is provided satisfactory written evidence that such court or administrative order is no longer in effect, or the child is or will be enrolled in comparable health coverage which

will take effect not later than the effective date of such disenrollment, or

"(II) the employer has eliminated family health coverage for all of its employees; and

"(iv) to withhold from such employee's compensation the employee's share (if any) of premiums for health coverage (except that the amount so withheld may not exceed the maximum amount permitted to be withheld under section 303(b) of the Consumer Credit Protection Act), and to pay such share of premiums to the insurer, except that the Secretary may provide by regulation for appropriate circumstances under which an employer may withhold less than such employee's share of such premiums.

"(D) A law that prohibits an insurer from imposing requirements on a State agency, which has been assigned the rights of an individual eligible for medical assistance under a medicaid plan approved under this title and covered for health benefits from the insurer, that are different from requirements applicable to an agent or assignee of any other individual so covered.

"(E) A law that requires an insurer, in any case in which a child has health coverage through the insurer of a noncustodial parent—

"(i) to provide such information to the custodial parent as may be necessary for the child to obtain benefits through such coverage;

"(ii) to permit the custodial parent (or provider, with the custodial parent's approval) to submit claims for covered services without the approval of the noncustodial parent; and

"(iii) to make payment on claims submitted in accordance with clause (ii) directly to such custodial parent, the provider, or the State agency.

"(F) A law that permits the State agency under the medicaid plan approved under this title to garnish the wages, salary, or other employment income of, and requires withholding amounts from State tax refunds to, any person who—

"(i) is required by court or administrative order to provide coverage of the costs of health services to a child who is eligible for medical assistance under a medicaid plan approved under this title;

"(ii) has received payment from a third party for the costs of such services to such child; but

"(iii) has not used such payments to reimburse, as appropriate, either the other parent or guardian of such child or the provider of such services,

to the extent necessary to reimburse the State agency for expenditures for such costs under its plan under this title, but any claims for current or past-due child support shall take priority over any such claims for the costs of such services.

"(2) DEFINITION.—For purposes of this subsection, the term 'insurer' includes a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974, a health maintenance organization, and an entity offering a service benefit plan.

"(g) ESTATE RECOVERIES AND LIENS PERMITTED.—

"(1) IN GENERAL.—Except as provided in paragraph (2), a State may take such actions as it considers appropriate to adjust or recover from the individual or the individual's estate any amounts paid as medical assistance to or on behalf of the individual under the medicaid plan, including through the imposition of liens against the property or estate of the individual.

"(2) NO LIEN ON HOMES OR FAMILY FARMS.—For purposes of paragraph (1), a State may not impose a lien on the principal residence (within the meaning of section 1034 of the Internal Revenue Code of 1986) of moderate value or the family farm owned by the individual as a condition of the spouse of the individual receiving nursing facility or other long term care benefits under its medicaid plan.

"SEC. 2136. ASSIGNMENT OF RIGHTS OF PAYMENT.

"(a) IN GENERAL.—For the purpose of assisting in the collection of medical support payments and other payments for medical care owed to recipients of medical assistance under the medicaid plan, each medicaid plan shall—

"(1) provide that, as a condition of eligibility for medical assistance under the plan to an individual who has the legal capacity to execute an assignment for himself, the individual is required—

"(A) to assign the State any rights, of the individual or of any other person who is eligible for medical assistance under the plan and on whose behalf the individual has the legal authority to execute an assignment of such rights, to support (specified as support for the purpose of medical care by a court or administrative order) and to payment for medical care from any third party,

"(B) to cooperate with the State (i) in establishing the paternity of such person (referred to in subparagraph (A)) if the person is a child born out of wedlock, and (ii) in obtaining support and payments (described in subparagraph (A)) for himself and for such person, unless (in either case) the individual is pregnant woman or the individual is found to have good cause for refusing to cooperate as determined by the State, and

"(C) to cooperate with the State in identifying, and providing information to assist the State in pursuing, any third party who may be liable to pay for care and services available under the plan, unless such individual has good cause for refusing to cooperate as determined by the State; and

"(2) provide for entering into cooperative arrangements, including financial arrangements, with any appropriate agency of any State (including, with respect to the enforcement and collection of rights of payment for medical care by or through a

parent, with a State's agency established or designated under section 454(3)) and with appropriate courts and law enforcement officials, to assist the agency or agencies administering the plan with respect to—

"(A) the enforcement and collection of rights to support or payment assigned under this section, and

"(B) any other matters of common concern.

"(b) USE OF AMOUNTS COLLECTED.—Such part of any amount collected by the State under an assignment made under the provisions of this section shall be retained by the State as is necessary to reimburse it for medical assistance payments made on behalf of an individual with respect to whom such assignment was executed (with appropriate reimbursement of the Federal Government to the extent of its participation in the financing of such medical assistance), and the remainder of such amount collected shall be paid to such individual.

"SEC. 2137. QUALITY ASSURANCE STANDARDS FOR NURSING FACILITIES.

"(a) STANDARDS FOR AND CERTIFICATION OF CERTAIN FACILITIES.—

"(1) STANDARDS FOR FACILITIES.—

"(A) IN GENERAL.—Each medicaid plan shall provide for the establishment and maintenance of procedures described in subparagraph (B) and standards consistent with the contents described in subparagraph (C) for nursing facilities which furnish services under the plan.

"(B) PROCEDURES DESCRIBED.—The procedures described in this subparagraph are—

"(i) procedures for the investigation of—

"(I) complaints by residents of nursing facilities, and

"(II) the abuse, neglect, and misappropriation of property of such residents; and

"(ii) procedures governing the discharge and transfer of residents sufficient to protect the health and safety of such residents, including the opportunity for a fair hearing and appeal of such discharges and transfers.

"(C) 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, as defined by the State.

"(vii) Utilization review.

"(viii) The protection and enforcement of resident rights described in subparagraph (D).

"(D) 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, including the confidentiality of medical records.

"(v) To voice grievances without discrimination or reprisal.

"(vi) To examine the results of State certification program inspections.

"(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 representative 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, and from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed—

"(I) to ensure the physical safety of the resident or other residents; and

"(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used, except in emergency circumstances specified by the Secretary until such an order could reasonably be obtained.

"(xii) To reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered.

"(xiii) To be provided with 30 days prior written notice of a pending transfer or discharge.

"(xiv) To request an assessment under section 2117(c)(1)(B).

"(E) PROCESS FOR ESTABLISHMENT.—The procedures and standards established by the State for facilities under this paragraph shall be promulgated either through the State's legislative, regulatory, or other process, and may only take effect after the State has provided the public with notice and an opportunity for comment.

"(2) CERTIFICATION PROGRAM.—

"(A) IN GENERAL.—Each medicaid plan shall provide for the establishment and operation of a program consistent with the requirements of subparagraph (B) for the certification of nursing facilities which follow the procedures and meet the standards established under paragraph (1) and the decertification of facilities which fail to follow such procedures or to meet such standards.

"(B) REQUIREMENTS FOR PROGRAM.—In addition to any other requirements the State may impose, in establishing and operating the certification program under subparagraph (A), the State shall ensure the following:

"(i) The State shall ensure public access (as defined by the State) to the certification program's evaluations of participating facilities, including compliance records and enforcement actions and other reports by the State regarding the ownership, compliance histories, and services provided by certified facilities.

"(ii) Not less often than every 4 years, the State shall audit its expenditures under the program, through an entity designated by the State which is not affiliated with the program, as designated by the State.

"(b) INTERMEDIATE SANCTION AUTHORITY.—

"(1) AUTHORITY.—In addition to any other authority under State law, where a State determines that a nursing facility which is certified for participation under the medicaid plan no longer substantially meets the requirements for such a facility under this title and further determines that the facility's deficiencies—

"(A) immediately jeopardize the health and safety of its residents, the State shall at least provide for the termination of the facility's certification for participation under the plan; or

"(B) do not immediately jeopardize the health and safety of its residents, the State 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 the plan with respect to any individual admitted to such facility after a date specified by the State.

"(2) NOTICE AND OPPORTUNITY FOR HEARING.—The State shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer substantially meets the requirements for such a facility under the plan, to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

"(3) EFFECTIVENESS.—The State'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 State, and its effectiveness shall terminate at the earlier of—

"(A) when the State 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.

If a facility to which subparagraph (B) applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the State shall terminate such facility's certification for participation under the medicaid plan effective with the first day of the first month following the month specified in such clause.

"(4) NOTICE TO OMBUDSMAN.—The State shall provide notice of any findings of noncompliance by a facility and notice of any adverse action taken against the facility to the State long-term care ombudsman.

"SEC. 2138. OTHER PROVISIONS PROMOTING PROGRAM INTEGRITY.

"(a) PUBLIC ACCESS TO SURVEY RESULTS.—Each medicaid plan shall provide that upon completion of a survey of any health care facility or organization by a State agency to carry out the plan, the agency shall make public in readily available form and place the pertinent findings of the survey relating to the compliance of the facility or organization with requirements of law.

"(b) RECORD KEEPING.—Each medicaid plan shall provide for agreements with persons or institutions providing services under the plan under which the person or institution agrees—

"(1) to keep such records, including ledgers, books, and original evidence of costs, as are necessary to fully disclose the extent of the services provided to individuals receiving assistance under the plan; and

"(2) to furnish the State agency with such information regarding any payments claimed by such person or institution for providing services under the plan, as the State agency may from time to time request.

"PART E—ESTABLISHMENT AND AMENDMENT OF MEDICAID PLANS

"SEC. 2151. SUBMITTAL AND APPROVAL OF MEDICAID PLANS.

"(a) SUBMITTAL.—As a condition of receiving funding under part C, each State shall submit to the Secretary a medicaid plan that meets the applicable requirements of this title.

"(b) APPROVAL.—Except as the Secretary may provide under section 2153, a medicaid plan submitted under subsection (a)—

"(1) shall be approved for purposes of this title; and

"(2) shall be effective beginning with a calendar quarter that is specified in the plan, but in no case earlier than the first calendar quarter that begins at least 60 days after the date the plan is submitted.

"SEC. 2152. SUBMITTAL AND APPROVAL OF PLAN AMENDMENTS.

"(a) SUBMITTAL OF AMENDMENTS.—A State may amend, in whole or in part, its medicaid plan at any time through transmittal of a plan amendment under this section.

"(b) APPROVAL.—Except as the Secretary may provide under section 2153, an amendment to a medicaid plan submitted under subsection (a)—

"(1) shall be approved for purposes of this title; and

"(2) shall be effective as provided in subsection (c).

"(c) EFFECTIVE DATES FOR AMENDMENTS.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, an amendment to medicaid plan shall take effect on one or more effective dates specified in the amendment.

"(2) AMENDMENTS RELATING TO ELIGIBILITY OR BENEFITS.—Except as provided in paragraph (4):

"(A) NOTICE REQUIREMENT.—Any plan amendment that eliminates or restricts eligibility or benefits under the plan may not take effect unless the State certifies that it has provided prior or contemporaneous public notice of the change, in a form and manner provided under applicable State law.

"(B) TIMELY TRANSMITTAL.—Any plan amendment that eliminates or restricts eligibility or benefits under the plan shall not be effective for longer than a 60 day period unless the amendment has been transmitted to the Secretary before the end of such period.

"(3) OTHER AMENDMENTS.—Subject to paragraph (4), any plan amendment that is not described in paragraph (2) becomes effective in a State fiscal year may not remain in effect after the end of such fiscal year (or, if later, the end of the 90-day period on which it becomes effective) unless the amendment has been transmitted to the Secretary.

"(4) EXCEPTION.—The requirements of paragraphs (2) and (3) shall not apply to a plan amendment that is submitted on a timely basis pursuant to a court order or an order of the Secretary.

"SEC. 2153. SANCTIONS FOR SUBSTANTIAL NONCOMPLIANCE.

"(a) PROMPT REVIEW OF PLAN SUBMITTALS.—The Secretary shall promptly review medicaid plans and plan amendments submitted under this part to determine if they substantially comply with the requirements of this title.

"(b) DETERMINATIONS OF SUBSTANTIAL NONCOMPLIANCE.—

"(1) AT TIME OF PLAN OR AMENDMENT SUBMITTAL.—

"(A) IN GENERAL.—If the Secretary, during the 30-day period beginning on the date of submittal of a medicaid plan or plan amendment—

"(i) determines that the plan or amendment substantially violates (within the meaning of subsection (c)) a requirement of this title; and

"(ii) provides written notice of such determination to the State,

the Secretary shall issue an order specifying that the plan or amendment, insofar as it is in substantial violation of such a requirement, shall not be effective, except as provided in subsection (c), beginning at the end of a period of not less than 30 days (or 120 days in the case of the initial submission of the medicaid plan) specified in the order beginning on the date of the notice of the determination.

"(B) EXTENSION OF TIME PERIODS.—The time periods specified in subparagraph (A) may be extended by written agreement of the Secretary and the State involved.

"(2) VIOLATIONS IN ADMINISTRATION OF PLAN.—

"(A) IN GENERAL.—If the Secretary determines, after reasonable notice and opportunity for a hearing for the State, that in the administration of a medicaid plan there is a substantial violation of a requirement of this title, the Secretary shall provide the State with written notice of the determination and with an order to remedy such violation. Such an order shall become effective prospectively, as specified in the order, after the date of receipt of such written notice. Such an order may include the withholding of funds, consistent with subsection (f), for parts of the medicaid plan affected by such violation, until the Secretary is satisfied that the violation has been corrected.

"(B) EFFECTIVENESS.—If the Secretary issues an order under paragraph (1), the order shall become effective, except as provided in subsection (c), beginning at the end of a period (of not less than 30 days) specified in the order beginning on the date of the notice of the determination to the State.

"(C) TIMELINESS OF DETERMINATIONS RELATING TO REPORT-BASED COMPLIANCE.—The Secretary shall make determinations under this paragraph respecting violations relating to information contained in an annual report under section 2102, an independent evaluation under section 2103, or an audit report under section 2131 not later than 30 days after the date of transmittal of the report or evaluation to the Secretary.

"(3) CONSULTATION WITH STATE.—Before making a determination adverse to a State under this section, the Secretary shall (within any time periods provided under this section)—

"(A) reasonably consult with the State involved;

"(B) offer the State a reasonable opportunity to clarify the submission and submit further information to substantiate compliance with the requirements of this title; and

"(C) reasonably consider any such clarifications and information submitted.

"(4) JUSTIFICATION OF ANY INCONSISTENCIES IN DETERMINATIONS.—If the Secretary makes a determination under this section that is, in whole or in part, inconsistent with any previous determination issued by the Secretary under this title, the Secretary shall include in the determination a detailed explanation and justification for any such difference.

"(5) SUBSTANTIAL VIOLATION DEFINED.—For purposes of this title, a medicaid plan (or amendment to such a plan) or the administration of the medicaid plan is considered to 'substantially violate' a requirement of this title if a provision of the plan or amendment (or an omission from the plan or amendment) or the administration of the plan—

"(A) is material and substantial in nature and effect; and

"(B) is inconsistent with an express requirement of this title.

A failure to meet a strategic objective or performance goal (as described in section 2101) shall not be considered to substantially violate a requirement of this title.

"(c) STATE RESPONSE TO ORDERS.—

"(1) STATE RESPONSE BY REVISING PLAN.—

"(A) IN GENERAL.—Insofar as an order under subsection (b)(1) relates to a substantial violation by a medicaid plan or plan amendment, a State may respond (before the date the order becomes effective) to such an order by submitting a written revision of the plan or plan amendment to substantially comply with the requirements of this part.

"(B) REVIEW OF REVISION.—In the case of submission of such a revision, the Secretary shall promptly review the submission and shall withhold any action on the order during the period of such review.

"(C) SECRETARIAL RESPONSE.—The revision shall be considered to have corrected the deficiency (and the order rescinded insofar as it relates to such deficiency) unless the Secretary determines and notifies the State in writing, within 15 days after the date the Secretary receives the revision, that the plan or amendment, as proposed to be revised, still substantially violates a requirement of this title. In such case the State may respond by seeking reconsideration or a hearing under paragraph (2).

"(D) REVISION RETROACTIVE.—If the revision provides for substantial compliance, the revision may be treated, at the option of the State, as being effective either as of the effective date of the provision to which it relates or such later date as the State and Secretary may agree.

"(2) STATE RESPONSE BY SEEKING RECONSIDERATION OR AN ADMINISTRATIVE HEARING.—A State may respond to an order under subsection (b) by filing a request with the Secretary for—

"(A) a reconsideration of the determination, pursuant to subsection (d)(1); or

"(B) a review of the determination through an administrative hearing, pursuant to subsection (d)(2).

In such case, the order shall not take effect before the completion of the reconsideration or hearing.

"(3) STATE RESPONSE BY CORRECTIVE ACTION PLAN.—

"(A) IN GENERAL.—In the case of an order described in subsection (b)(2) that relates to a substantial violation in the administration of the medicaid plan, a State may respond to such an order by submitting a corrective action plan with the Secretary to correct deficiencies in the administration of the plan which are the subject of the order.

"(B) REVIEW OF CORRECTIVE ACTION PLAN.—In such case, the Secretary shall withhold any action on the order for a period (not to exceed 30 days) during which the Secretary reviews the corrective action plan.

"(C) SECRETARIAL RESPONSE.—The corrective action plan shall be considered to have corrected the deficiency (and the order rescinded insofar as it relates to such defi-

ciency) unless the Secretary determines and notifies the State in writing, within 15 days after the date the Secretary receives the corrective action plan, that the State's administration of the medicaid plan, as proposed to be corrected in the plan, will still substantially violate a requirement of this title. In such case the State may respond by seeking reconsideration or a hearing under paragraph (2).

"(4) STATE RESPONSE BY WITHDRAWAL OF PLAN AMENDMENT; FAILURE TO RESPOND.—Insofar as an order relates to a substantial violation in a plan amendment submitted, a State may respond to such an order by withdrawing the plan amendment and the medicaid plan shall be treated as though the amendment had not been made.

"(d) ADMINISTRATIVE REVIEW AND HEARING.—

"(1) RECONSIDERATION.—Within 30 days after the date of receipt of a request under subsection (b)(2)(A), the Secretary shall notify the State of the time and place at which a hearing will be held for the purpose of reconsidering the Secretary's determination. The hearing shall be held not less than 20 days nor more than 60 days after the date notice of the hearing is furnished to the State, unless the Secretary and the State agree in writing to holding the hearing at another time. The Secretary shall affirm, modify, or reverse the original determination within 60 days of the conclusion of the hearing.

"(2) ADMINISTRATIVE HEARING.—Within 30 days after the date of receipt of a request under subsection (b)(2)(B), an administrative law judge shall schedule a hearing for the purpose of reviewing the Secretary's determination. The hearing shall be held not less than 20 days nor more than 60 days after the date notice of the hearing is furnished to the State, unless the Secretary and the State agree in writing to holding the hearing at another time. The administrative law judge shall affirm, modify, or reverse the determination within 60 days of the conclusion of the hearing.

"(e) JUDICIAL REVIEW.—

"(1) IN GENERAL.—A State which is dissatisfied with a final determination made by the Secretary under subsection (d)(1) or a final determination of an administrative law judge under subsection (d)(2) may, within 60 days after it has been notified of such determination, file with the United States court of appeals for the circuit in which the State is located a petition for review of such determination. A copy of the petition shall be forthwith transmitted by the clerk of the court to the Secretary and, in the case of a determination under subsection (d)(2), to the administrative law judge involved. The Secretary (or judge involved) thereupon shall file in the court the record of the proceedings on which the final determination was based, as provided in section 2112 of title 28, United States Code.

"(2) STANDARD FOR REVIEW.—The findings of fact by the Secretary or administrative law judge, if supported by substantial evidence, shall be conclusive, but the court, for good cause shown, may remand the case to the Secretary or judge to take further evidence, and the Secretary or judge may thereupon make new or modified findings of fact and may modify a pre-

vious determination, and shall certify to the court the transcript and record of the further proceedings. Such new or modified findings of fact shall likewise be conclusive if supported by substantial evidence.

"(3) JURISDICTION OF APPELLATE COURT.—The court shall have jurisdiction to affirm the action of the Secretary or judge or to set it aside, in whole or in part. The judgment of the court shall be subject to review by the Supreme Court of the United States upon certiorari or certification as provided in section 1254 of title 28, United States Code.

"(f) WITHHOLDING OF FUNDS.—

"(1) IN GENERAL.—Any order under this section relating to the withholding of funds shall be effective not earlier than the effective date of the order and shall only relate to the portions of a medicaid plan or administration thereof which substantially violate a requirement of this title. In the case of a failure to meet a set-aside requirement under section 2112, any withholding shall only apply to the extent of such failure.

"(2) SUSPENSION OF WITHHOLDING.—The Secretary may suspend withholding of funds under paragraph (1) during the period reconsideration or administrative and judicial review is pending under subsection (d) or (e).

"(3) RESTORATION OF FUNDS.—Any funds withheld under this subsection under an order shall be immediately restored to a State—

"(A) to the extent and at the time the order is—

"(i) modified or withdrawn by the Secretary upon reconsideration,

"(ii) modified or reversed by an administrative law judge, or

"(iii) set aside (in whole or in part) by an appellate court; or

"(B) when the Secretary determines that the deficiency which was the basis for the order is corrected;

"(C) when the Secretary determines that violation which was the basis for the order is resolved or the amendment which was the basis for the order is withdrawn; or

"(D) at any time upon the initiative of the Secretary.

"SEC. 2154. SECRETARIAL AUTHORITY.

"(a) NEGOTIATED AGREEMENT AND DISPUTE RESOLUTION.—

"(1) NEGOTIATIONS.—Nothing in this part shall be construed as preventing the Secretary and a State from at any time negotiating a satisfactory resolution to any dispute concerning the approval of a medicaid plan (or amendments to a medicaid plan) or the compliance of a medicaid plan (including its administration) with requirements of this title.

"(2) COOPERATION.—The Secretary shall act in a cooperative manner with the States in carrying out this title. In the event of a dispute between a State and the Secretary, the Secretary shall, whenever practicable, engage in informal dispute resolution activities in lieu of formal enforcement or sanctions under section 2153.

"(b) LIMITATIONS ON DELEGATION OF DECISION-MAKING AUTHORITY.—The Secretary may not delegate (other than to the Ad-

ministrator of the Health Care Financing Administration) the authority to make determinations or reconsiderations respecting the approval of medicaid plans (or amendments to such plans) or the compliance of a medicaid plan (including its administration) with requirements of this title. Such Administrator may not further delegate such authority to any individual, including any regional official of such Administration.

"(c) REQUIRING FORMAL RULEMAKING FOR CHANGES IN SECRETARIAL ADMINISTRATION.—The Secretary shall carry out the administration of the program under this title only through a prospective formal rulemaking process, including issuing notices of proposed rule making, publishing proposed rules or modifications to rules in the Federal Register, and soliciting public comment.

"PART F—GENERAL PROVISIONS

"SEC. 2171. DEFINITIONS.

"(a) MEDICAL ASSISTANCE.—

"(1) IN GENERAL.—For purposes of this title, except as provided in paragraphs (2) and (3), the term 'medical assistance' means payment of part or all the cost of any of the following for eligible low-income individuals (as defined in subsection (b)) as specified under the medicaid plan:

"(A) Inpatient hospital services.

"(B) Outpatient hospital services.

"(C) Physician services.

"(D) Surgical services.

"(E) Clinic services and other ambulatory health care services.

"(F) Nursing facility services.

"(G) Intermediate care facility services for the mentally retarded.

"(H) Prescription drugs and biologicals.

"(I) Over-the-counter medications.

"(J) Laboratory and radiological services.

"(K) Family planning services and supplies.

"(L) Acute inpatient mental health services, including services furnished in a State-operated mental hospital and including residential or other 24-hour therapeutically planned structured services in the case of a child.

"(M) Outpatient and intensive community-based mental health services, including psychiatrist rehabilitation, day treatment, intensive in-home services for children, and partial hospitalization.

"(N) Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices).

"(O) Disposable medical supplies.

"(P) Home and community-based services and related supportive services (such as home health nursing services, home health aide services, personal care, assistance with activities of daily living, chore services, day care services, respite care services, training for family members, and minor modifications to the home).

"(Q) Community supported living arrangements.

"(R) Nursing care services (such as nurse practitioner services, nurse midwife services, advanced practice nurse services, private duty nursing care, pediatric nurse services, and respiratory care services) in a home, school, or other setting.

"(S) Dental services.

"(T) Inpatient substance abuse treatment services and residential substance abuse treatment services.

"(U) Outpatient substance abuse treatment services.

"(V) Case management services.

"(W) Care coordination services.

"(X) Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.

"(Y) Hospice care.

"(Z) Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services (whether in a facility, home, school, or other setting) if recognized by State law and if the service is—

"(i) prescribed by or furnished by a physician or other licensed or registered practitioner within the scope of practice as defined by State law,

"(ii) performed under the general supervision or at the direction of a physician, or

"(iii) furnished by a health care facility that is operated by a State or local government or is licensed under State law and operating within the scope of the license.

"(AA) Premiums for private health care insurance coverage, including private long-term care insurance coverage.

"(BB) Medical transportation.

"(CC) Medicare cost-sharing (as defined in subsection (c)).

"(DD) Enabling services (such as transportation, translation, and outreach services) designed to increase the accessibility of primary and preventive health care services for eligible low-income individuals.

"(EE) Any other health care services or items specified by the Secretary.

"(2) EXCLUSION OF CERTAIN PAYMENTS.—Such term does not include the payment with respect to care or services for—

"(A) any individual who is an inmate of a public institution (except as a patient in a State psychiatric hospital); and

"(B) any individual who is not an eligible low-income individual.

"(3) CLARIFICATION OF VACCINE PURCHASES.—Such term includes, for any fiscal year, payment for the purchase of vaccines through contracts negotiated with the Centers for Disease Control and Prevention under section 317 of the Public Health Service Act, but only if—

"(A) the State has expended all grant funds available for such purchase under such section 317 for all fiscal years preceding such fiscal year; and

"(B) the total number of doses of each vaccine purchased during such year does not exceed—

"(i) the number of doses of each vaccine sufficient to immunize, according to the immunization schedule specified by the State, the annual birth cohort of children in targeted low-income families (as defined in section 2112(a)(3)), less

"(ii) 75 percent of the number of doses of each vaccine purchased by the State during the preceding fiscal year with funds available under such section 317.

"(b) ELIGIBLE LOW-INCOME INDIVIDUAL.—For purposes of this title, the term 'eligible low-income individual' means an individual who has been determined eligible by the State for medical assistance under the medicaid plan and whose family income (as determined under the plan) does not exceed a percentage (specified in the medicaid plan and not to exceed 250 percent) of the poverty line applicable to a family of the size involved. In determining the amount of income under the previous sentence, a State may exclude costs incurred for medical care or other types of remedial care recognized by the State.

"(c) MEDICARE COST-SHARING.—For purposes of this title, the term 'medicare cost-sharing' means any of the following:

"(1)(A) Premiums under section 1839.

"(B) Premiums under section 1818 or 1818A.

"(2) Coinsurance under title XVIII, including coinsurance described in section 1813.

"(3) Deductibles established under title XVIII, including those described in section 1813 and section 1833(b).

"(4) The difference between the amount that is paid under section 1833(a) and the amount that would be paid under such section if any reference to '80 percent' therein were deemed a reference to '100 percent'.

"(5) Premiums for enrollment of an individual with an eligible organization under section 1876 or with a Medicare Choice organization under part D of title XVIII.

"(d) ADDITIONAL DEFINITIONS.—For purposes of this title:

"(1) CHILD.—The term 'child' means an individual under 19 years of age.

"(2) POVERTY LINE DEFINED.—The term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section).

"(3) PREGNANT WOMAN.—The term 'pregnant woman' includes a woman during the 60-day period beginning on the last day of the pregnancy.

"(4) RETIREMENT AGE.—The term 'retirement age' has the meaning given such term by section 216(*l*)(1).

"SEC. 2172. TREATMENT OF TERRITORIES.

"Notwithstanding any other requirement of this title, the Secretary may waive or modify any requirement of this title with re-

spect to the medical assistance program for a State other than the 50 States and the District of Columbia, other than a waiver of—

"(1) the Federal medical assistance percentage;

"(2) the limitation on total payments in a fiscal year to the amount of the allotment under section 2121(c); or

"(3) the requirement that payment may be made for medical assistance only with respect to amounts expended by the State for care and services described in paragraph (1) of section 2171(a) and medically-related services (as defined in section 2112(d)(2)).

"SEC. 2173. DESCRIPTION OF TREATMENT OF INDIAN HEALTH PROGRAMS.

"In the case of a State in which one or more Indian health programs described in section 2122(f)(2) are operated, the medicaid plan shall include a description of—

"(1) what provision (if any) has been made for payment for items and services furnished by such programs; and

"(2) the manner in which medical assistance for low-income eligible individuals who are Indians will be provided, as determined by the State in consultation with the appropriate Indian tribes and tribal organizations.

"SEC. 2174. APPLICATION OF CERTAIN GENERAL PROVISIONS.

"The following sections in part A of title XI shall apply to States under this title in the same manner as they applied to a State under title XIX:

"(1) Section 1101(a)(1) (relating to definition of State).

"(2) Section 1116 (relating to administrative and judicial review), but only insofar as consistent with the provisions of part C.

"(3) Section 1124 (relating to disclosure of ownership and related information).

"(4) Section 1126 (relating to disclosure of information about certain convicted individuals).

"(5) Section 1132 (relating to periods within which claims must be filed).".

(b) ANTI-FRAUD PROVISIONS.—

(1) IN GENERAL.—Section 1128(h)(1) (42 U.S.C. 1320a–7(h)(1)) is amended by inserting "or a medicaid plan under title XXI" after "title XIX".

(2) PENALTIES FOR THE FRAUDULENT CONVERSION OF ASSETS IN ORDER TO OBTAIN MEDICAID BENEFITS.—Section 1128B(b) (42 U.S.C. 1320a–7b(b)) is amended by striking "or" at the end of paragraph (4), by inserting "or" at the end of paragraph (5), and by inserting after paragraph (5) the following new paragraph:

"(6) knowingly and willfully converts assets, by transfer (including any transfer in trust), aiding in such a transfer, or otherwise, in order for an individual to become eligible for benefits under a State health care program,".

(3) CONTINUED ROLE OF INSPECTOR GENERAL.—The Inspector General in the Department of Health and Human Services shall have the same responsibilities and duties in relation to fraud and abuse and related matters under the medicaid pro-

gram under title XXI of the Social Security Act as such Inspector General has had in relation to the medicaid program under title XIX of such Act before the date of the enactment of this Act.

(c) CERTIFIED AMOUNT FOR PUERTO RICO.—Paragraph (1) of section 1108(c) (42 U.S.C. 1308(c)) is amended by striking "$116,500,000 for fiscal year 1994" and inserting "$200,000,000 for fiscal year 1996".

(d) TERMINATION OF PROGRAM FOR DISTRIBUTION OF PEDIATRIC VACCINES

(1) IN GENERAL.—Subject to paragraph (2), section 1928 (42 U.S.C. 1396s) is repealed, effective on the date of the enactment of this Act.

(2) TRANSITION.—

(A) NO EFFECT ON CERTAIN DISTRIBUTIONS.—Such repeal shall not affect the distribution of vaccines purchased and delivered to the States before the date of the enactment of this Act.

(B) NO PURCHASES AFTER ENACTMENT.—No vaccine may be purchased after the date of the enactment of this Act by the Federal Government or any State under section 1928(d) of the Social Security Act.

(e) TERMINATION OF CURRENT PROGRAM; LIMITATION ON MEDICAID PAYMENTS IN FISCAL YEAR 1996.—

(1) IN GENERAL.—Title XIX is amended—

(A) by redesignating section 1931 as section 1932; and

(B) by inserting after section 1930 the following new section:

"TERMINATION OF PROGRAM; LIMITATION ON NEW OBLIGATION AUTHORITY

"SEC. 1931. (a) ELIMINATION OF INDIVIDUAL ENTITLEMENT.—Effective on the date of the enactment of this section—

"(1) except as provided in subsection (b), the Federal Government has no obligation to provide payment with respect to items and services provided under this title; and

"(2) this title shall not be construed as providing for an entitlement, under Federal law in relation to the Federal Government, in an individual or person (including any provider) at the time of provision or receipt of services.

"(b) LIMITATION ON OBLIGATION AUTHORITY.—Notwithstanding any other provision of this title—

"(1) AFTER ENACTMENT, BEFORE NEW MEDICAID.—Subject to paragraph (2), the Secretary is authorized to enter into obligations with any State under this title for expenses incurred after the date of the enactment of this section and during fiscal year 1996, but not in excess of the obligation allotment for that State for fiscal year 1996 under section 2121(a)(4)(C).

"(2) NONE AFTER NEW MEDICAID.—The Secretary is not authorized to enter into any obligation with any State under this title for expenses incurred on or after the earlier of—

"(A) October 1, 1996; or

"(B) the first day of the first quarter on which the State plan under title XXI is first effective.

"(3) AGREEMENT.—A State's submission of claims for payment under section 1903 after the date of the enactment of this section with respect to which the limitation described in paragraph (1) applies is deemed to constitute the State's acceptance of the obligation limitation under such paragraph, including the formula for computing the amount of such obligation limitation.

"(c) REQUIREMENT FOR TIMELY SUBMITTAL OF CLAIMS.—No payment shall be made to a State under this title with respect to an obligation incurred before the date of the enactment of this section, unless the State has submitted to the Secretary, by not later than June 30, 1996, a claim for Federal financial participation for expenses paid by the State with respect to such obligations. Nothing in subsection (a) or (b) shall be construed as affecting the obligation of the Federal Government to pay claims described in the previous sentence.".

(2) REPEAL OF TITLE.—Title XIX is repealed effective October 1, 1996.

(f) MEDICAID TRANSITION.—

(1) TREATMENT OF CERTAIN CAUSES OF ACTION.—No cause of action under title XIX of the Social Security Act which seeks to require a State to establish or maintain minimum payment rates under such title or claim which seeks reimbursement for any period before the date of the enactment of this Act based on the alleged failure of the State to comply with title XIX and which has not become final as of such date shall be brought or continued.

(2) TREATMENT OF CERTAIN DISALLOWANCES.—Notwithstanding any provision of law, in the case where payment has been made under section 1903(a) of the Social Security Act to a State before October 1, 1995, and for which a disallowance has not been taken as of such date (or, if so taken, has not been completed (including judicial review) by such date), the Secretary of Health and Human Services shall discontinue the disallowance proceeding and, if such disallowance has been taken as of the date of the enactment of this Act, any payment reductions effected shall be rescinded and the payments returned to the State.

(3) EXTENSION OF MORATORIUM.—Section 6408(a)(3) of the Omnibus Budget Reconciliation Act of 1989, as amended by section 13642 of the Omnibus Budget Reconciliation Act of 1993, is amended by striking "December 31, 1995" and inserting "the first day of the first quarter on which the medicaid plan for the State of Michigan is first effective under title XXI of such Act".

(g) NO APPLICATION OF PRIOR MEDICAID JUDGMENTS TO NEW MEDICAID PROGRAM.—No judicial or administrative decision rendered regarding requirements imposed under title XIX of the Social Security Act with respect to a State shall have any application to the medicaid plan of the State title XXI of such Act. A State may, pursuant to the previous sentence, seek the abrogation or modification of any such decision after the date of termination of the State plan under title XIX of such Act.

(h) TECHNICAL AND CONFORMING AMENDMENTS.—

(1) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation, as appropriate, with the heads of other Federal agencies, shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of, and amendments made by, sections 7191 and 7192.

(2) TRANSITIONAL RULE.—Any reference in any provision of law to title XIX of the Social Security Act or any provision thereof shall be deemed to be a reference to such title or provision as in effect on the day before the date of the enactment of this Act.

SEC. 7192. MEDICAID DRUG REBATE PROGRAM.

(a) IN GENERAL.—Title XXI, as added by section 7191, is amended—

(1) in section 2123, by adding at the end the following new subsection:

"(j) LIMITATION ON PAYMENT FOR CERTAIN OUTPATIENT PRESCRIPTION DRUGS.—

"(1) IN GENERAL.—No payment shall be made to a State under this part for medical assistance for covered outpatient drugs (as defined in section 2175(j)(2)) of a manufacturer provided under the medicaid plan unless the manufacturer (as defined in section 2175(j)(5)) of the drug—

"(A) has entered into a medicaid rebate agreement with the Secretary under section 2175; and

"(B) is otherwise complying with the provisions of such section.

"(2) CONSTRUCTION.—Nothing in this subsection shall be construed as requiring a State to participate in the medicaid rebate agreement under section 2175.

"(3) USE OF SUPPLEMENTAL REBATES PROHIBITED.—No payment shall be made under this part to a State that requires manufacturer rebates for covered outpatient drugs (as so defined) in excess of the rebate amount payable under section 2175."; and

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

"SEC. 2175. MEDICAID DRUG REBATE AGREEMENTS.

"(a) REQUIREMENT FOR REBATE AGREEMENT.—

"(1) IN GENERAL.—Pursuant to section 2123(j), in order for payment to be made to a State under part C for medical assistance for covered outpatient drugs of a manufacturer, the manufacturer must have entered into and have in effect a rebate agreement described in subsection (b) with the Secretary, on behalf of States (except that, the Secretary may authorize a State to enter directly into agreements with a manufacturer), and must meet the requirements of paragraph (5) (with respect to drugs purchased by a covered entity on or after the first day of the first month that begins after the date of the enactment of title VI of the Veterans Health Care Act of 1992 and paragraph (6). Any such agreement entered into prior to May 1, 1991, shall be deemed to have been entered into on January

1, 1991, and the amount of the rebate to be paid by the manufacturer under such agreement shall be calculated as if the agreement had been entered into on January 1, 1991. If a manufacturer has not entered into such an agreement before May 1, 1991, such an agreement, subsequently entered into, shall not be effective until the first day of the calendar quarter that begins more than 60 days after the date the agreement is entered into.

"(2) EFFECTIVE DATE.—Paragraph (1) shall apply to drugs dispensed under this title on or after January 1, 1991, except that such paragraph shall not apply to drugs dispensed before May 1, 1991, if the Secretary determines that there were extenuating circumstances with respect to the first calendar quarter of 1991.

"(3) AUTHORIZING PAYMENT FOR DRUGS NOT COVERED UNDER REBATE AGREEMENTS.—Paragraph (1) shall not apply to the dispensing of a covered outpatient drug if—

"(A) the State has made a determination that the availability of such drug is essential to the health of beneficiaries under the medicaid plan;

"(B) the drug has been given a rating of 1–A or 1–P by the Food and Drug Administration; and

"(C)(i) the physician has obtained approval for the use of the drug in advance of dispensing such drug in accordance with a prior authorization program described in subsection (d)(5), or

"(ii) the Secretary has reviewed and approved the State's determination under subparagraph (A).

"(3) AUTHORIZING PAYMENT FOR DRUGS NOT COVERED UNDER REBATE AGREEMENTS.—Paragraph (1) shall not apply to the dispensing of a covered outpatient drug if (A)(i) the State has made a determination that the availability of the drug is essential to the health of beneficiaries under the medicaid plan for medical assistance; (ii) such drug has been given a rating of 1-A by the Food and Drug Administration; and (iii)(I) the physician has obtained approval for use of the drug in advance of its dispensing in accordance with a prior authorization program described in subsection (d), or (II) the Secretary has reviewed and approved the State's determination under subparagraph (A); or (B) the Secretary determines that in the first calendar quarter of 1991, there were extenuating circumstances.

"(4) EFFECT ON EXISTING AGREEMENTS.—

"(A) IN GENERAL.—In the case of a rebate agreement in effect between a State and a manufacturer on the date of the enactment of title IV of the Omnibus Budget Reconciliation Act of 1990, such agreement, for the initial agreement period specified therein, shall be considered to be a rebate agreement in effect under this section with respect to that State, if the State agrees to report to the Secretary any rebates paid pursuant to the agreement and such agreement provides for a minimum aggregate rebate of 10 percent of the sum of the amounts determined under subparagraph (B) for all of the manufacturer's drugs paid for by the State under the agreement. If, after the initial

agreement period, the State establishes to the satisfaction of the Secretary that an agreement in effect on the date of the enactment of title IV of the Omnibus Budget Reconciliation Act of 1990 provides for rebates that are at least as large as the rebates otherwise required under this section, and the State agrees to report any rebates under the agreement to the Secretary, the agreement shall be considered to be a rebate agreement in compliance with the section for the renewal periods of such agreement.

"(B) AMOUNT DETERMINED.—The amount determined under this subparagraph with respect to a manufacturer's drug paid for by a State under an agreement described in the first sentence of subparagraph (A) is an amount equal to the product of—

"(i) the average manufacturer's price for such drug; and

"(ii) the number of dosage units of such drug paid for by the State under such agreement.

"(5) LIMITATION ON PRICES OF DRUGS PURCHASED BY COVERED ENTITIES.—

"(A) AGREEMENT WITH SECRETARY.—A manufacturer meets the requirements of this paragraph if the manufacturer has entered into an agreement with the Secretary that meets the requirements of section 340B of the Public Health Service Act with respect to covered outpatient drugs purchased by a covered entity on or after the first day of the first month that begins after the date of the enactment of title VI of the Veterans Health Care Act of 1992.

"(B) COVERED ENTITY DEFINED.—In this subsection, the term 'covered entity' means an entity described in section 340B(a)(4) of the Public Health Service Act.

"(C) ESTABLISHMENT OF ALTERNATIVE MECHANISM TO ENSURE AGAINST DUPLICATE DISCOUNTS OR REBATES.—If the Secretary does not establish a mechanism under section 340B(a)(5)(A) of the Public Health Service Act within 12 months of the date of the enactment of such section, the following requirements shall apply:

"(i) Each covered entity shall inform the single State agency under this title when it is seeking reimbursement from the medicaid plan for medical assistance with respect to a unit of any covered outpatient drug which is subject to an agreement under section 340B(a) of such Act.

"(ii) Each such single State agency shall provide a means by which a covered entity shall indicate on any drug reimbursement claims form (or format, where electronic claims management is used) that a unit of the drug that is the subject of the form is subject to an agreement under section 340B of such Act, and not submit to any manufacturer a claim for a rebate payment under subsection (b) with respect to such a drug.

"(D) EFFECT OF SUBSEQUENT AMENDMENTS.—In determining whether an agreement under subparagraph (A)

meets the requirements of section 340B of the Public Health Service Act, the Secretary shall not take into account any amendments to such section that are enacted after the enactment of title VI of the Veterans Health Care Act of 1992.

"(E) DETERMINATION OF COMPLIANCE.—A manufacturer is deemed to meet the requirements of this paragraph if the manufacturer establishes to the satisfaction of the Secretary that the manufacturer would comply (and has offered to comply) with the provisions of section 340B of the Public Health Service Act (as in effect immediately after the enactment title VI of the Veterans Health Care Act of 1992, and would have entered into an agreement under such section (as such section was in effect at such time), but for a legislative change in such section after such enactment.

"(6) REQUIREMENTS RELATING TO MASTER AGREEMENTS FOR DRUGS PROCURED BY DEPARTMENT OF VETERANS AFFAIRS AND CERTAIN OTHER FEDERAL AGENCIES.—

"(A) IN GENERAL.—A manufacturer meets the requirements of this paragraph if the manufacturer complies with the provisions of section 8126 of title 38, United States Code, including the requirement of entering into a master agreement with the Secretary of Veterans Affairs under such section.

"(B) EFFECT OF SUBSEQUENT AMENDMENTS.—In determining whether a master agreement described in subparagraph (A) meets the requirements of section 8126 of title 38, United States Code, the Secretary shall not take into account any amendments to such section that are enacted after the enactment of title VI of the Veterans Health Care Act of 1992.

"(C) DETERMINATION OF COMPLIANCE.—A manufacturer is deemed to meet the requirements of this paragraph if the manufacturer establishes to the satisfaction of the Secretary that the manufacturer would comply (and has offered to comply) with the provisions of section 8126 of title 38, United States Code (as in effect immediately after the enactment of title VI of the Veterans Health Care Act of 1992) and would have entered into an agreement under such section (as such section was in effect at such time), but for a legislative change in such section after such enactment.

"(b) TERMS OF REBATE AGREEMENT.—

"(1) PERIODIC REBATES.—

"(A) IN GENERAL.—A rebate agreement under this subsection shall require the manufacturer to provide, to each medicaid plan approved under this title, a rebate for a rebate period in an amount specified in subsection (c) for covered outpatient drugs of the manufacturer dispensed after December 31, 1990, for which payment was made under the medicaid plan for such period. Such rebate shall be paid by the manufacturer not later than 30 days after

the date of receipt of the information described in paragraph (2) for the period involved.

"(B) OFFSET AGAINST MEDICAL ASSISTANCE.—Amounts received by a State under this section (or under an agreement authorized by the Secretary under subsection (a)(1) or an agreement described in subsection (a)(4)) in any quarter shall be considered to be a reduction in the amount expended under the medicaid plan in the quarter for medical assistance for purposes of this title.

"(2) STATE PROVISION OF INFORMATION.—

"(A) STATE RESPONSIBILITY.—Each State agency under this title shall report to each manufacturer not later than 60 days after the end of each rebate period and in a form consistent with a standard reporting format established by the Secretary, information on the total number of units of each dosage form and strength and package size of each covered outpatient drug dispensed after December 31, 1990, for which payment was made under the plan for the period, and shall promptly transmit a copy of such report to the Secretary.

"(B) AUDITS.—A manufacturer may audit the information provided (or required to be provided) under subparagraph (A). Adjustments to rebates shall be made to the extent that information indicates that utilization was greater or less than the amount previously specified.

"(3) MANUFACTURER PROVISION OF PRICE INFORMATION.—

"(A) IN GENERAL.—Each manufacturer with an agreement in effect under this section shall report to the Secretary—

"(i) not later than 30 days after the last day of each rebate period under the agreement (beginning on or after January 1, 1991), on the average manufacturer price (as defined in subsection (j)(1)) and, for single source drugs and innovator multiple source drugs, the manufacturer's best price (as defined in subsection (c)(1)(C)) for each covered outpatient drug for the rebate period under the agreement; and

"(ii) not later than 30 days after the date of entering into an agreement under this section on the average manufacturer price (as defined in subsection (j)(1)) as of October 1, 1990, for each of the manufacturer's covered outpatient drugs.

"(B) VERIFICATION SURVEYS OF AVERAGE MANUFACTURER PRICE.—The Secretary may survey wholesalers and manufacturers that directly distribute their covered outpatient drugs, when necessary, to verify manufacturer prices reported under subparagraph (A). The Secretary may impose a civil monetary penalty in an amount not to exceed $10,000 on a wholesaler, manufacturer, or direct seller, if the wholesaler, manufacturer, or direct seller of a covered outpatient drug refuses a request for information by the Secretary in connection with a survey under this subparagraph. The provisions of section 1128A (other than subsections (a) (with respect to amounts of penalties or ad-

ditional assessments) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(C) PENALTIES.—

"(i) FAILURE TO PROVIDE TIMELY INFORMATION.—In the case of a manufacturer with an agreement under this section that fails to provide information required under subparagraph (A) on a timely basis, the amount of the penalty shall be $10,000 for each day in which such information has not been provided and such amount shall be paid to the Treasury. If such information is not reported within 90 days of the deadline imposed, the agreement shall be suspended for services furnished after the end of such 90-day period and until the date such information is reported (but in no case shall such suspension be for a period of less than 30 days).

"(ii) FALSE INFORMATION.—Any manufacturer with an agreement under this section, or a wholesaler or direct seller, that knowingly provides false information under subparagraph (A) or (B) is subject to a civil money penalty in an amount not to exceed $100,000 for each item of false information. Any such civil money penalty shall be in addition to other penalties as may be prescribed by law. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this subparagraph in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

"(D) CONFIDENTIALITY OF INFORMATION.—Notwithstanding any other provision of law, information disclosed by manufacturers or wholesalers under this paragraph or under an agreement with the Secretary of Veterans Affairs described in subsection (a)(6)(A)(ii) is confidential and shall not be disclosed by the Secretary or the Secretary of Veterans Affairs or a State agency (or contractor therewith) in a form which discloses the identity of a specific manufacturer or wholesaler or the prices charged for drugs by such manufacturer or wholesaler, except—

"(i) as the Secretary determines to be necessary to carry out this section;

"(ii) to permit the Comptroller General to review the information provided; and

"(iii) to permit the Director of the Congressional Budget Office to review the information provided.

"(4) LENGTH OF AGREEMENT.—

"(A) IN GENERAL.—A rebate agreement shall be effective for an initial period of not less than 1 year and shall be automatically renewed for a period of not less than 1 year unless terminated under subparagraph (B).

"(B) TERMINATION.—

"(i) BY THE SECRETARY.—The Secretary may provide for termination of a rebate agreement for viola-

tion of the requirements of the agreement or other good cause shown. Such termination shall not be effective earlier than 60 days after the date of notice of such termination. The Secretary shall provide, upon request, a manufacturer with a hearing concerning such a termination, but such hearing shall not delay the effective date of the termination. Failure of a State to provide any advance notice of such a termination as required by regulation shall not affect the State's right to terminate coverage of the drugs affected by such termination as of the effective date of such termination.

"(ii) BY A MANUFACTURER.—A manufacturer may terminate a rebate agreement under this section for any reason. Any such termination shall not be effective until the calendar quarter beginning at least 60 days after the date the manufacturer provides notice to the Secretary.

"(iii) EFFECTIVENESS OF TERMINATION.—Any termination under this subparagraph shall not affect rebates due under the agreement before the effective date of its termination.

"(iv) NOTICE TO STATES.—In the case of a termination under this subparagraph, the Secretary shall provide notice of such termination to the States within not less than 30 days before the effective date of such termination.

"(v) APPLICATION TO TERMINATIONS OF OTHER AGREEMENTS.—The provisions of this subparagraph shall apply to the terminations of agreements described in section 340B(a)(1) of the Public Health Service Act and master agreements described in section 8126(a) of title 38, United States Code.

"(C) DELAY BEFORE REENTRY.—In the case of any rebate agreement with a manufacturer under this section which is terminated, another such agreement with the manufacturer (or a successor manufacturer) may not be entered into until a period of 1 calendar quarter has elapsed since the date of the termination, unless the Secretary finds good cause for an earlier reinstatement of such an agreement.

"(5) SETTLEMENT OF DISPUTES.—

"(A) SECRETARY.—The Secretary shall have the authority to resolve, settle, and compromise disputes regarding the amounts of rebates owed under this section.

"(B) STATE.—Each State, with respect to covered outpatient drugs paid for under the State's medicaid plan, shall have authority, independent of the Secretary' authority under subparagraph (A), to resolve, settle, and compromise disputes regarding the amounts of rebates owed under this section. Any such action shall be deemed to comply with the requirements of this title, and such covered outpatient drugs shall be eligible for payment under the medicaid plan approved under this title.

"(C) AMOUNT OF REBATE.—The Secretary shall limit the amount of the rebate payable in any case in which the Secretary determines that, because of unusual circumstances or questionable data, the provisions of subsection (c) result in a rebate amount that is inequitable or otherwise inconsistent with the purposes of this section.

"(c) DETERMINATION OF AMOUNT OF REBATE.—

"(1) BASIC REBATE FOR SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE DRUGS.—

"(A) IN GENERAL.—Except as provided in paragraph (2), the amount of the rebate specified in this subsection for a rebate period (as defined in subsection (j)(8)) with respect to each dosage form and strength of a single source drug or an innovator multiple source drug shall be equal to the product of—

"(i) the total number of units of each dosage form and strength paid for under the medicaid plan in the rebate period (as reported by the State); and

"(ii) subject to subparagraph (B)(ii), the greater of—

"(I) the difference between the average manufacturer price and the best price (as defined in subparagraph (C)) for the dosage form and strength of the drug, or

"(II) the minimum rebate percentage (specified in subparagraph (B)(i)) of such average manufacturer price,

of or the rebate period.

"(B) MINIMUM REBATE PERCENTAGE.—For purposes of subparagraph (A)(ii)(II), the minimum rebate percentage for rebate periods beginning after December 31, 1995, is 15.1 percent.

"(C) BEST PRICE DEFINED.—For purposes of this section:

"(i) IN GENERAL.—The term 'best price' means, with respect to a single source drug or innovator multiple source drug of a manufacturer, the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the United States, excluding—

"(I) any prices charged on or after October 1, 1992, to the Indian Health Service, the Department of Veterans Affairs, a State home receiving funds under section 1741 of title 38, United States Code, the Department of Defense, the Public Health Service, or a covered entity described in subsection (a)(5)(B);

"(II) any prices charged under the Federal Supply Schedule of the General Services Administration;

"(III) any prices used under a State pharmaceutical assistance program; and

"(IV) any depot prices and single award contract prices, as defined by the Secretary, of any agency of the Federal Government.

"(ii) SPECIAL RULES.—The term 'best price'—

"(I) shall be inclusive of cash discounts, free goods that are contingent on any purchase requirement, volume discounts, and rebates (other than rebates under this section);

"(II) shall be determined without regard to special packaging, labeling, or identifiers on the dosage form or product or package; and

"(III) shall not take into account prices that are merely nominal in amount.

"(2) ADDITIONAL REBATE FOR SINGLE SOURCE AND INNOVATOR MULTIPLE SOURCE DRUGS.—

"(A) IN GENERAL.—The amount of the rebate specified in this subsection for a rebate period, with respect to each dosage form and strength of a single source drug or an innovator multiple source drug, shall be increased by an amount equal to the product of—

"(i) the total number of units of such dosage form and strength dispensed after December 31, 1990, for which payment was made under the medicaid plan for the rebate period; and

"(ii) the amount (if any) by which—

"(I) the average manufacturer price for the dosage form and strength of the drug for the period, exceeds

"(II) the average manufacturer price for such dosage form and strength for the calendar quarter beginning July 1, 1990 (without regard to whether or not the drug has been sold or transferred to an entity, including a division or subsidiary of the manufacturer, after the first day of such quarter), increased by the percentage by which the consumer price index for all urban consumers (United States city average) for the month before the month in which the rebate period begins exceeds such index for September 1990.

"(B) TREATMENT OF SUBSEQUENTLY APPROVED DRUGS.—In the case of a covered outpatient drug approved by the Food and Drug Administration after October 1, 1990, clause (ii)(II) of subparagraph (A) shall be applied by substituting 'the first full calendar quarter after the day on which the drug was first marketed' for 'the calendar quarter beginning July 1, 1990' and 'the month prior to the first month of the first full calendar quarter after the day on which the drug was first marketed' for 'September 1990'.

"(3) REBATE FOR OTHER DRUGS.—

"(A) IN GENERAL.—The amount of the rebate paid to a State for a rebate period with respect to each dosage form and strength of covered outpatient drugs (other than single

source drugs and innovator multiple source drugs) shall be equal to the product of—

"(i) the applicable percentage (as described in subparagraph (B)) of the average manufacturer price for the dosage form and strength for the rebate period; and

"(ii) the total number of units of such dosage form and strength dispensed after December 31, 1990, for which payment was made under the medicaid plan for the rebate period.

"(B) APPLICABLE PERCENTAGE DEFINED.—For purposes of subparagraph (A)(i), the 'applicable percentage' is 11 percent.

"(4) REBATE LIMITED TO AMOUNT OF STATE PAYMENT IF DRUG PRIMARILY DISPENSED TO NURSING FACILITY PATIENTS.—

"(A) IN GENERAL.—Upon request of the manufacturer of a covered outpatient drug, the Secretary shall limit, in accordance with subparagraph (B), the amount of the rebate under this subsection with respect to a dosage form and strength of such drug if the majority of the estimated number of units of such dosage form and strength that are subject to rebates under this section were dispensed to inpatients of nursing facilities.

"(B) AMOUNT OF REBATE.—In the case of a covered outpatient drug subject to subparagraph (A), the amount of the rebate specified in this subsection for a rebate period, with respect to each dosage form and strength of such drug, shall not exceed the amount paid under the medicaid plan with respect to such dosage form and strength of the drug in the rebate period (without consideration of any dispensing fees paid).

"(5) SUPPLEMENTAL REBATES PROHIBITED.—No rebates shall be required to be paid by manufacturers with respect to covered outpatient drugs furnished to individuals in any State that provides for the collection of such rebates in excess of the rebate amount payable under this section.

"(d) LIMITATIONS ON COVERAGE OF DRUGS.—

"(1) PERMISSIBLE RESTRICTIONS.—

"(A) IN GENERAL.—A State may subject to prior authorization any covered outpatient drug. Any such prior authorization program shall comply with the requirements of paragraph (5).

"(B) ADDITIONAL RESTRICTIONS.—A State may exclude or otherwise restrict coverage of a covered outpatient drug if—

"(i) the drug is contained in the list referred to in paragraph (2);

"(ii) the drug is subject to such restrictions pursuant to an agreement between a manufacturer and a State authorized by the Secretary under subsection (a)(1) or in effect pursuant to subsection (a)(4); or

"(iii) the State has excluded coverage of the drug from its formulary established in accordance with paragraph (4).

"(2) LIST OF DRUGS SUBJECT TO RESTRICTION.—The following drugs or classes of drugs, or their medical uses, may be excluded from coverage or otherwise restricted:

"(A) Agents when used for anorexia, weight loss, or weight gain.

"(B) Agents when used to promote fertility.

"(C) Agents when used for cosmetic purposes or hair growth.

"(D) Agents when used for the symptomatic relief of cough and colds.

"(E) Agents when used to promote smoking cessation.

"(F) Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.

"(G) Nonprescription drugs.

"(H) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

"(I) Barbiturates.

"(J) Benzodiazepines.

"(3) ADDITIONS TO DRUG LISTINGS.—The Secretary shall, by regulation, periodically add to the list of drugs or classes of drugs described in paragraph (2), or their medical uses, which the Secretary has determined to be subject to clinical abuse or inappropriate use.

"(4) REQUIREMENTS FOR FORMULARIES.—A State may establish a formulary if the formulary meets the following requirements:

"(A) The formulary is developed by a committee consisting of physicians, pharmacists, and other appropriate individuals appointed by the Governor of the State (or, at the option of the State, the State's drug use review board established under subsection (f)(3)).

"(B) Except as provided in subparagraph (C), the formulary includes the covered outpatient drugs of any manufacturer which has entered into and complies with an agreement under subsection (a) (other than any drug excluded from coverage or otherwise restricted under paragraph (2)).

"(C) A covered outpatient drug may be excluded with respect to the treatment of a specific disease or condition for an identified population (if any) only if, based on the drug's labeling (or, in the case of a drug the prescribed use of which is not approved under the Federal Food, Drug, and Cosmetic Act but is a medically accepted indication, based on information from the appropriate compendia described in subsection (j)(6)), the excluded drug does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, or clinical outcome of such treatment for such population over other drugs included in the formulary and there is a written explanation (available to the public) of the basis for the exclusion.

"(D) The medicaid plan permits coverage of a drug excluded from the formulary (other than any drug excluded from coverage or otherwise restricted under paragraph (2)) pursuant to a prior authorization program that is consistent with paragraph (5).

"(E) The formulary meets such other requirements as the Secretary may impose in order to achieve program savings consistent with protecting the health of program beneficiaries.

A prior authorization program established by a State under paragraph (5) is not a formulary subject to the requirements of this paragraph.

"(5) REQUIREMENTS OF PRIOR AUTHORIZATION PROGRAMS.—A medicaid plan approved under this title may require, as a condition of coverage or payment for a covered outpatient drug for which Federal financial participation is available in accordance with this section, with respect to drugs dispensed on or after July 1, 1991, the approval of the drug before its dispensing for any medically accepted indication (as defined in subsection (j)(6)) only if the system providing for such approval—

"(A) provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization; and

"(B) except with respect to the drugs on the list referred to in paragraph (2), provides for the dispensing of at least 72-hour supply of a covered outpatient prescription drug in an emergency situation (as defined by the Secretary).

"(6) OTHER PERMISSIBLE RESTRICTIONS.—A State may impose limitations, with respect to all such drugs in a therapeutic class, on the minimum or maximum quantities per prescription or on the number of refills, if such limitations are necessary to discourage waste, and may address instances of fraud or abuse by individuals in any manner authorized under this Act.

"(e) ESTABLISHMENT OF UPPER PAYMENT LIMITS.—The Health Care Financing Administration shall establish a Federal upper reimbursement limit for each multiple source drug for which the FDA has rated three or more products therapeutically and pharmaceutically equivalent, regardless of whether all such additional formulations are rated as such and shall use only such formulations when determining any such upper limit.

"(f) DRUG USE REVIEW.—

"(1) IN GENERAL.—A State participating in the medicaid rebate agreement may provide for a drug use review program to educate physicians and pharmacists to identify and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists, and patients, or associated with specific drugs or groups of drugs, as well as potential and actual severe adverse reactions to drugs.

"(2) APPLICATION OF STATE STANDARDS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), a State with a drug use review program under

this subsection shall establish and operate the program under such standards as it may establish.

"(B) DATA ON DRUG USE.—The program shall assess data on drug use against predetermined standards, consistent with—

"(i) compendia which shall consist of—

"(I) American Hospital Formulary Service Drug Information,

"(II) United States Pharmacopeia-Drug Information,

"(III) the DRUGDEX Information System, and

"(IV) American Medical Association Drug Evaluations; and

"(ii) the peer-reviewed medical literature.

"(g) ELECTRONIC CLAIMS MANAGEMENT.—In accordance with chapter 35 of title 44, United States Code (relating to coordination of Federal information policy), the Secretary shall encourage each State to establish, as its principal means of processing claims for covered outpatient drugs under its medicaid plan, a point-of-sale electronic claims management system, for the purpose of performing on-line, real time eligibility verifications, claims data capture, adjudication of claims, and assisting pharmacists (and other authorized persons) in applying for and receiving payment.

"(h) ANNUAL REPORT.—

"(1) IN GENERAL.—Not later than May 1 of each year, the Secretary shall transmit to the Committee on Finance of the Senate and the Committee on Commerce of the House of Representatives a report on the operation of this section in the preceding fiscal year.

"(2) DETAILS.—Each report shall include information on—

"(A) ingredient costs paid under this title for single source drugs, multiple source drugs, and nonprescription covered outpatient drugs;

"(B) the total value of rebates received and number of manufacturers providing such rebates;

"(C) the effect of inflation on the value of rebates required under this section;

"(D) trends in prices paid under this title for covered outpatient drugs; and

"(E) Federal and State administrative costs associated with compliance with the provisions of this title.

"(i) EXEMPTION FOR CAPITATED HEALTH CARE ORGANIZATIONS, HOSPITALS, AND NURSING FACILITIES.—

"(1) IN GENERAL.—Except as provided in paragraph (2), the requirements of the medicaid rebate agreement under this section shall not apply with respect to covered outpatient drugs dispensed by or through—

"(A) a capitated health care organization (as defined in section 2114(c)(1)); or

"(B) a hospital or nursing facility that dispenses covered outpatient drugs using a drug formulary system and bills the State no more than the hospital's purchasing costs for covered outpatient drugs.

"(2) CONSTRUCTION IN DETERMINING BEST PRICE.—Nothing in paragraph (1) shall be construed as excluding amounts paid by the entities described in such paragraph for covered outpatient drugs from the determination of the best price (as defined in subsection (c)(1)(C)) for such drugs.

"(j) DEFINITIONS.—For purposes of this section:

"(1) AVERAGE MANUFACTURER PRICE.—The term 'average manufacturer price' means, with respect to a covered outpatient drug of a manufacturer for a rebate period, the average price paid to the manufacturer for the drug in the United States by wholesalers for drugs distributed to the retail pharmacy class of trade, after deducting customary prompt pay discounts.

"(2) COVERED OUTPATIENT DRUG.—Subject to the exceptions in paragraph (3), the term 'covered outpatient drug' means—

"(A) of those drugs which are treated as prescribed drugs for purposes of this title, a drug which may be dispensed only upon prescription (except as provided in subparagraph (D)); and—

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

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

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

"(B) a biological product, other than a vaccine which—

"(i) may only be dispensed upon prescription,

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

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

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

"(D) a drug which may be sold without a prescription (commonly referred to as an 'over-the-counter drug'), if the drug is prescribed by a physician (or other person authorized to prescribe under State law).

"(3) LIMITING DEFINITION.—The term 'covered outpatient drug' does not include any drug, biological product, or insulin provided as part of, or as incident to and in the same setting as, any of the following (and for which payment may be made under this title as part of payment for the following and not as direct reimbursement for the drug):

"(A) Inpatient hospital services.

"(B) Hospice services.

"(C) Dental services, except that drugs for which the medicaid plan authorizes direct reimbursement to the dispensing dentist are covered outpatient drugs.

"(D) Physicians' services.

"(E) Outpatient hospital services.

"(F) Nursing facility services and services provided by an intermediate care facility for the mentally retarded.

"(G) Other laboratory and x-ray services.

"(H) Renal dialysis services.

Such term also does not include any such drug or product for which a National Drug Code number is not required by the Food and Drug Administration or a drug or biological used for a medical indication which is not a medically accepted indication. Any drug, biological product, or insulin excluded from the definition of such term as a result of this paragraph shall be treated as a covered outpatient drug for purposes of determining the best price (as defined in subsection (c)(1)(C)) for such drug, biological product, or insulin.

"(4) OVER-THE-COUNTER DRUG.—The term 'over-the-counter drug' means a drug that may be sold without a prescription.

"(5) MANUFACTURER.—The term 'manufacturer' means, with respect to a covered outpatient drug, the entity holding legal title to or possession of the National Drug Code number for such drug.

"(6) MEDICALLY ACCEPTED INDICATION.—The term 'medically accepted indication' means any use for a covered outpatient drug which is approved under the Federal Food, Drug, and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the compendia described in subsection (f)(2)(B)(i).

"(7) MULTIPLE SOURCE DRUG; INNOVATOR MULTIPLE SOURCE DRUG; NONINNOVATOR MULTIPLE SOURCE DRUG; SINGLE SOURCE DRUG.—

"(A) DEFINED.—

"(i) MULTIPLE SOURCE DRUG.—The term 'multiple source drug' means, with respect to a rebate period, a covered outpatient drug (not including any drug de-

scribed in paragraph (2)(D)) for which there are 2 or more drug products which—

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

"(II) except as provided in subparagraph (B), are pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C) and as determined by the Food and Drug Administration; and

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

"(ii) INNOVATOR MULTIPLE SOURCE DRUG.—The term 'innovator multiple source drug' means a multiple source drug that was originally marketed under a new drug application or product licensing application approved by the Food and Drug Administration.

"(iii) NONINNOVATOR MULTIPLE SOURCE DRUG.—The term 'noninnovator multiple source drug' means a multiple source drug that is not an innovator multiple source drug.

"(iv) SINGLE SOURCE DRUG.—The term 'single source drug' means a covered outpatient drug (not including any drug described in paragraph (2)(D)) which is produced or distributed under a new drug application or product licensing application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application or product licensing application.

"(B) EXCEPTION.—Subparagraph (A)(i)(II) shall not apply if the Food and Drug Administration changes by regulation the requirement that, for purposes of the publication described in subparagraph (A)(i)(I), in order for drug products to be rated as therapeutically equivalent, they must be pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C).

"(C) SPECIAL RULES.—For purposes of this paragraph—

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

"(ii) drugs are bioequivalent if they do not present a known or potential bioequivalence problem, or, if they do present such a problem, they are shown to meet an appropriate standard of bioequivalence; and

"(iii) a drug product is considered to be sold or marketed in a State if it appears in a published national listing of average wholesale prices selected by the Secretary, if the listed product is generally avail-

able to the public through retail pharmacies in that State.

"(8) REBATE PERIOD.—The term 'rebate period' means, with respect to an agreement under subsection (a), a calendar quarter or other period specified by the Secretary with respect to the payment of rebates under such agreement.

"(9) STATE AGENCY.—The term 'State agency' means the agency designated under this title to administer or supervise the administration of the medicaid plan for medical assistance.".

(b) MEDICAID DRUG REBATE PROGRAM TASK FORCE.—

(1) IN GENERAL.—Not later than June 1, 1998, the Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall provide for the establishment of a Medicaid Drug Rebate Program Task Force (in this subsection referred to as the "Task Force").

(2) COMPOSITION.—The Task Force shall consist of volunteer representatives appointed by—

(A) the chair and vice chair of the National Governors Association (NGA);

(B) the National Association of State Medicaid Directors;

(C) associations representing the prescription and generic drug industries;

(D) an association representing pharmacies; and

(E) an association representing the interests of medicaid recipients.

(3) DUTIES.—The Task Force shall study whether the medicaid drug rebate program under section 2175 of the Social Security Act, as added by this section, should be retained or repealed. The study shall assess—

(A) the extent to which State medicaid programs rely on the drug rebate program to manage prescription drug expenditures;

(B) the impact of repealing the program on recipient access to prescription drugs and pharmacy services;

(C) the impact of retaining the program on the prescription and generic drug industries; and

(D) the likely actions States would take to manage prescription drug expenditures in the absence of drug rebate revenue.

(4) ADMINISTRATIVE ASSISTANCE.—Administrative support for the Task Force shall be provided by the Agency for Health Care Policy and Research (or, in the absence of such Agency, the Secretary).

(5) REPORT.—Not later than October 1, 1998, the Task Force shall report the results of the study to the Secretary. The report shall be transmitted to the Committee on Finance and Special Committee on Aging of the Senate and the Committee on Commerce of the House of Representatives.

(c) CLERICAL AMENDMENT.—The table of sections for title XXI, as added by section 7191(a), is amended by adding at the end the following new item:

"Sec. 2175. Medicaid drug rebate agreements.".

(d) SPECIAL EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by this section shall take effect as if included in the amendment made by section 7191.

(2) RETROACTIVE APPLICATION OF CERTAIN PROVISIONS.—Subsections (b)(5), (c)(4), and (c)(5) of section 2175 of the Social Security Act, as added by this section, shall take effect as if included in the enactment of the Omnibus Budget Reconciliation Act of 1990.

SEC. 7193. WAIVERS.

(a) CONTINUATION OF WAIVERS.—

(1) IN GENERAL.—Except as provided in paragraph (2), if any waiver granted to a State under section 1115 of the Social Security Act (42 U.S.C. 1315) or otherwise which relates to the provision of assistance under a State plan under title XIX of such Act has been implemented as of September 1, 1995, the waiver may continue, at the option of the State, subject to the terms and conditions of such waiver.

(2) FINANCING LIMITATION.—Notwithstanding any other provision of law, beginning with fiscal year 1996, a State operating under a waiver described in paragraph (1) shall receive the payment provided for in the waiver to the extent such payment does not exceed the payment under title XXI of the Social Security Act, as added by section 7191(a), such State would otherwise receive for the fiscal year.

(b) STATE OPTION TO TERMINATE WAIVER.—

(1) IN GENERAL.—A State may terminate a waiver described in subsection (a) before the expiration of the waiver.

(2) REPORT.—A State which terminates a waiver under paragraph (1) shall submit a report to the Secretary of Health and Human Services summarizing the waiver and any available information concerning the result or effect of such waiver.

(3) HOLD HARMLESS PROVISION.—

(A) IN GENERAL.—Notwithstanding any other provision of law, a State that, not later than the date described in subparagraph (B), submits a written request to terminate a waiver described in subsection (a) shall be held harmless for accrued cost neutrality liabilities incurred under the terms and conditions of such waiver.

(B) DATE DESCRIBED.—The date described in this subparagraph is the later of—

(i) January 1, 1996; or

(ii) 90 days following the adjournment of the first regular session of the State legislature that begins after the date of the enactment of this Act.

(c) CONTINUATION OF INDIVIDUAL WAIVERS.—A State may elect to continue one or more individual waivers described in subsection (a)(1).

SEC. 7194. CHILDREN WITH SPECIAL HEALTH CARE NEEDS.

(a) CLASSIFICATION SYSTEM TO IDENTIFY CHILDREN WITH SPECIAL HEALTH CARE NEEDS.—

(1) IN GENERAL.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall, through the Health Care Financing Administration, develop a national, quantifiable classification system to identify children with special health care needs.

(2) CHILDREN WITH SPECIAL HEALTH CARE NEEDS.—For purposes of this section, children with special health care needs are children—

(A) with conditions which are, or can be anticipated to be, of at least a year's duration, and

(B) who require services significantly greater than well children.

(3) REQUIREMENTS OF CLASSIFICATION SYSTEM.—The classification system developed in accordance with this section—

(A) shall be based on commonly recognized diagnostic codes;

(B) shall be compatible with State and health plan data systems;

(C) shall be capable of serving as a basis for identifying such children and their medical expenditures and monitoring the quality of care received; and

(D) shall incorporate the consideration of the severity status, prognosis, and desired outcome for each such child, including tertiary prevention, maintenance of function, or improvement of function.

(b) DEMONSTRATION PROJECTS TO USE CLASSIFICATION SYSTEM AND TO PROVIDE METHODS OF ASSURING QUALITY CARE FOR CHILDREN WITH SPECIAL HEALTH CARE NEEDS.—

(1) IN GENERAL.—Upon completion of the development of the classification system under subsection (a), the Secretary shall make grants to not more than 5 States to conduct 5-year demonstration projects in accordance with this subsection for the purpose of—

(A) testing the reliability and validity of such classification system;

(B) developing methods of assuring quality care for children with special health care needs; and

(C) providing for initial methods for identifying children with special health care needs based on diagnoses accounting for the majority of the chronic conditions affecting children in the State which are likely to require significant medical interventions whether in number of interventions or costs.

Each State grant may be used without fiscal year limitation.

(2) REQUIREMENTS OF PROJECT.—

(A) IN GENERAL.—A project conducted in accordance with this subsection shall provide that the State in developing methods described in paragraph (1)(B), shall develop—

(i) adequate capitation rates specific to children with special health care needs; and

(ii) quality indicators, including system performance standards, care guidelines for specific popu-

lations, outcomes measures, and patient and parent satisfaction.

(B) APPROPRIATE REPRESENTATIVES.—The design and implementation of such a project shall include representatives of providers of services to such children and appropriate State agencies and programs.

(3) APPLICATIONS.—Each State desiring to conduct a demonstration project under this subsection, including projects which are statewide, substate, or regional in cooperation with a contiguous State or States, shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require.

(4) REPORTS.—A State that conducts a demonstration project under this section shall prepare and submit to the Secretary annual and final reports in such form and containing such information as the Secretary may require.

(5) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $2,000,000 for each of fiscal years 1997, 1998, 1999, 2000, and 2001 for the purpose of conducting demonstration projects in accordance with this subsection.

SEC. 7195. CBO REPORTS.

(a) STUDY.—The Director of the Congressional Budget Office shall prepare an annual analysis of the effects of the amendments made by section 7191 on the health insurance status of children, individuals who have attained retirement age, and the disabled.

(b) REPORT.—The Director of the Congressional Budget Office shall submit a report of the results of the analysis required under subsection (a) by May 15 of each year to the Committee on Finance of the Senate and the Committee on Commerce of the House of Representatives.

Subtitle C—Block Grants for Temporary Assistance for Needy Families

SEC. 7200. SHORT TITLE.

This subtitle may be cited as the "Work Opportunity Act of 1995".

SEC. 7201. BLOCK GRANTS TO STATES.

(a) REPEALS.—

(1) IN GENERAL.—Parts A and F of title IV (42 U.S.C. 601 et seq. and 682 et seq.) are hereby repealed.

(2) RULES AND REGULATIONS.—The Secretary of Health and Human Services shall ensure that any rules and regulations relating to the provisions of law repealed in paragraph (1) shall cease to have effect on and after the date of the repeal of such provisions.

(b) BLOCK GRANTS TO STATES FOR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES WITH MINOR CHILDREN.—Title IV (42 U.S.C. 601 et seq.) is amended by inserting before part B the following:

"PART A—BLOCK GRANTS TO STATES FOR TEMPORARY ASSISTANCE FOR NEEDY FAMILIES WITH MINOR CHILDREN

"SEC. 400. NO INDIVIDUAL ENTITLEMENT.

"Notwithstanding any other provision of law, no individual is entitled to any assistance under this part.

"SEC. 401. PURPOSE.

"The purpose of this part is to increase the flexibility of States in operating a program designed to—

"(1) provide assistance to needy families with minor children;

"(2) provide job preparation and opportunities for such families; and

"(3) prevent and reduce the incidence of out-of-wedlock pregnancies, with a special emphasis on teenage pregnancies, and establish annual goals for preventing and reducing such pregnancies with respect to fiscal years 1996 through 2000.

"SEC. 402. ELIGIBLE STATES; STATE PLAN.

"(a) IN GENERAL.—As used in this part, the term 'eligible State' means, with respect to a fiscal year, a State that has submitted to the Secretary a plan that includes the following:

"(1) OUTLINE OF FAMILY ASSISTANCE PROGRAM.—A written document that outlines how the State intends to do the following:

"(A) Conduct a program designed to serve all political subdivisions in the State to—

"(i) provide assistance to needy families with not less than 1 minor child (or any expectant family); and

"(ii) provide a parent or caretaker in such families with work experience, assistance in finding employment, and other work preparation activities and sup-

port services that the State considers appropriate to enable such families to leave the program and become self-sufficient.

"(B) Require a parent or caretaker receiving assistance under the program to engage in work (as defined by the State) when the State determines the parent or caretaker is ready to engage in work, or after 24 months (whether or not consecutive) of receiving assistance under the program, whichever is earlier.

"(C) Satisfy the minimum participation rates specified in section 404.

"(D) Treat—

"(i) families with minor children moving into the State from another State; and

"(ii) noncitizens of the United States.

"(E) Safeguard and restrict the use and disclosure of information about individuals and families receiving assistance under the program.

"(F) Establish goals and take action to prevent and reduce the incidence of out-of-wedlock pregnancies, with special emphasis on teenage pregnancies.

"(G) COMMUNITY SERVICE.—Not later than 2 years after the date of the enactment of this Act, consistent with the exception provided in section 404(d), require participation by, and offer to, unless the State opts out of this provision by notifying the Secretary, a parent or caretaker receiving assistance under the program, after receiving such assistance for 3 months—

"(i) is not exempt from work requirements; and

"(ii) is not engaged in work as determined under section 404(c),

in community service employment, with minimum hours per week and tasks to be determined by the State.

"(2) FAMILY ASSISTANCE PROGRAM STRATEGIC PLAN.—

"(A) IN GENERAL.—A single comprehensive State Family Assistance Program Strategic Plan (hereafter referred to in this section as the 'State Plan') describing a 3-year strategic plan for the statewide program designed to meet the State goals and reach the State benchmarks for program activities of the family assistance program.

"(B) CONTENTS OF THE STATE PLAN.—The State plan shall include:

"(i) STATE GOALS.—A description of the goals of the 3-year plan, including outcome related goals of and benchmarks for program activities of the family assistance program.

"(ii) CURRENT YEAR PLAN.—A description of how the goals and benchmarks described in clause (i) will be achieved, or how progress toward the goals and benchmarks will be achieved, during the fiscal year in which the plan has been submitted.

"(iii) PERFORMANCE INDICATORS.—A description of performance indicators to be used in measuring or as-

sessing the relevant output service levels and outcomes of relevant program activities.

"(iv) EXTERNAL FACTORS.—Information on those key factors external to the program and beyond the control of the State that could significantly affect the attainment of the goals and benchmarks.

"(v) EVALUATION MECHANISMS.—Information on a mechanism for conducting program evaluation, to be used to compare actual results with the goals and benchmarks and designate the results on a scale ranging from highly successful to failing to reach the goals and benchmarks of the program.

"(vi) MINIMUM PARTICIPATION RATES.—Information on how the minimum participation rates specified in section 404 will be satisfied.

"(vii) ESTIMATE OF EXPENDITURES.—An estimate of the total amount of State or local expenditures under the program for the fiscal year in which the plan is submitted.

"(3) CERTIFICATION THAT THE STATE WILL OPERATE A CHILD SUPPORT ENFORCEMENT PROGRAM.—A certification by the chief executive officer of the State that, during the fiscal year, the State will operate a child support enforcement program under the State plan approved under part D.

"(4) CERTIFICATION THAT THE STATE WILL OPERATE A CHILD PROTECTION PROGRAM.—A certification by the chief executive officer of the State that, during the fiscal year, the State will operate a child protection program under the State plan approved under part B.

"(5) CERTIFICATION THAT THE STATE WILL OPERATE A FOSTER CARE AND ADOPTION ASSISTANCE PROGRAM.—A certification by the chief executive officer of the State that, during the fiscal year, the State will operate a foster care and adoption assistance program under the State plan approved under part E.

"(6) CERTIFICATION THAT THE STATE WILL PARTICIPATE IN THE INCOME AND ELIGIBILITY VERIFICATION SYSTEM.—A certification by the chief executive officer of the State that, during the fiscal year, the State will participate in the income and eligibility verification system required by section 1137.

"(7) CERTIFICATION OF THE ADMINISTRATION OF THE PROGRAM.—A certification by the chief executive officer of the State specifying which State agency or agencies are responsible for the administration and supervision of the State program for the fiscal year and ensuring that local governments and private sector organizations have been consulted regarding the plan and design of welfare services in the State so that services are provided in a manner appropriate to local populations.

"(8) CERTIFICATION THAT REQUIRED REPORTS WILL BE SUBMITTED.—A certification by the chief executive officer of the State that the State shall provide the Secretary with any reports required under this part.

"(b) CERTIFICATION THAT THE STATE WILL PROVIDE ACCESS TO INDIANS.—

"(1) IN GENERAL.—In recognition of the Federal Government's trust responsibility to, and government-to-government relationship with, Indian tribes, the Secretary shall ensure that Indians receive at least their equitable share of services under the State program, by requiring a certification by the chief executive officer of each State described in paragraph (2) that, during the fiscal year, the State shall provide Indians in each Indian tribe that does not have a tribal family assistance plan approved under section 414 for a fiscal year with equitable access to assistance under the State program funded under this part.

"(2) STATE DESCRIBED.—For purposes of paragraph (1), a State described in this paragraph is a State in which there is an Indian tribe that does not have a tribal family assistance plan approved under section 414 for a fiscal year.

"(c) DISTRIBUTION OF STATE PLAN.—

"(1) PUBLIC AVAILABILITY OF SUMMARY.—The State shall make available to the public a summary of the State plan submitted under this section.

"(2) COPY TO AUDITOR.—The State shall provide the approved entity conducting the audit under section 408 with a copy of the State plan submitted under this section.

"(d) DEFINITIONS.—For purposes of this part, the following definitions shall apply:

"(1) ADULT.—The term 'adult' means an individual who is not a minor child.

"(2) MINOR CHILD.—The term 'minor child' means an individual—

"(A) who—

"(i) has not attained 18 years of age; or

"(ii) has not attained 19 years of age and is a full-time student in a secondary school (or in the equivalent level of vocational or technical training); and

"(B) who resides with such individual's custodial parent or other caretaker relative.

"(3) FISCAL YEAR.—The term 'fiscal year' means any 12-month period ending on September 30 of a calendar year.

"(4) INDIAN, INDIAN TRIBE, AND TRIBAL ORGANIZATION.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the terms 'Indian', 'Indian tribe', and 'tribal organization' have the meaning given such terms by section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b).

"(B) IN ALASKA.—For purposes of making tribal family assistance grants under section 414 on behalf of Indians in Alaska, the term 'Indian tribe' shall mean only the following Alaska Native regional nonprofit corporations:

"(i) Arctic Slope Native Association.

"(ii) Kawerak, Inc.

"(iii) Maniilaq Association.

"(iv) Association of Village Council Presidents.

"(v) Tanana Chiefs Conference.

"(vi) Cook Inlet Tribal Council.

"(vii) Bristol Bay Native Association.

"(viii) Aleutian and Pribilof Island Association.
"(ix) Chugachmuit.
"(x) Tlingit Haida Central Council.
"(xi) Kodiak Area Native Association.
"(xii) Copper River Native Association.

"(5) STATE.—Except as otherwise specifically provided, the term 'State' includes the several States, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, Guam, and American Samoa.

"SEC. 403. PAYMENTS TO STATES AND INDIAN TRIBES.

"(a) GRANT AMOUNT.—

"(1) IN GENERAL.—Subject to the provisions of paragraphs (3) and (5), section 407 (relating to penalties), and section 414(g), for each of fiscal years 1996, 1997, 1998, 1999, and 2000, the Secretary shall pay—

"(A) each eligible State a grant in an amount equal to the State family assistance grant for the fiscal year, for each of fiscal years 1998 and 1999, the amount of the State's job placement performance bonus determined under subsection (f)(1) for the fiscal year, and for fiscal year 2000, the amount of the State's share of the performance bonus and high performance bonus determined under section 418 for such fiscal year; and

"(B) each Indian tribe with an approved tribal family assistance plan a tribal family assistance grant in accordance with section 414.

"(2) STATE FAMILY ASSISTANCE GRANT.—

"(A) IN GENERAL.—

"(i) BASIC AMOUNT.—For purposes of paragraph (1)(A), a State family assistance grant for any State for a fiscal year is an amount equal to the sum of—

"(I) the total amount of the Federal payments to the State under section 403 (other than Federal payments to the State described in subparagraphs (A), (B) and (C) of section 419(a)(2)) for fiscal year 1994 (as such section 403 was in effect during such fiscal year), plus

"(II) the total amount of the Federal payments to the State under subparagraphs (A), (B) and (C) of section 419(a)(2),

as such payments were reported by the State on February 14, 1995, and as adjusted under clause (ii).

"(ii) ADJUSTMENTS.—The payments described in clause (i) shall be—

"(I) reduced by the amount, if any, determined under subparagraph (B);

"(II) reduced by the amount determined under subsection (f)(2)(B);

"(III) reduced by the amount, if any, determined under subsection (i)(3)(C)(iii);

"(IV) for fiscal year 2000, reduced by the amount determined under section 418(a)(3); and

"(V) increased by the amount, if any, determined under subparagraph (D).

"(B) AMOUNT ATTRIBUTABLE TO CERTAIN INDIAN FAMILIES SERVED BY INDIAN TRIBES.—

"(i) IN GENERAL.—For purposes of subparagraph (A), the amount determined under this subparagraph is an amount equal to the Federal payments to the State under this section for fiscal year 1994 (as in effect during such fiscal year) attributable to expenditures by the State under parts A and F of this title (as so in effect) for Indian families described in clause (ii).

"(ii) INDIAN FAMILIES DESCRIBED.—For purposes of clause (i), Indian families described in this clause are Indian families who reside in a service area or areas of an Indian tribe receiving a tribal family assistance grant under section 414.

"(C) NOTIFICATION.—Not later than 3 months prior to the payment of each quarterly installment of a State grant under subsection (a)(1), the Secretary shall notify the State of the amount of the reduction determined under subparagraph (B) with respect to the State.

"(D) AMOUNT ATTRIBUTABLE TO STATE PLAN AMENDMENTS.—

"(i) IN GENERAL.—For purposes of subparagraph (A) and subject to the limitation in clause (ii), the amount determined under this subparagraph is an amount equal to the Federal payment under section 403(a)(5) to the State for emergency assistance in fiscal year 1995 under any State plan amendment made under section 402 during fiscal year 1994 (as such sections were in effect before the date of the enactment of the Work Opportunity Act of 1995).

"(ii) LIMITATION.—Amounts made available under clause (i) to all States shall not exceed $800,000,000 for the 5-fiscal year period beginning in fiscal year 1996. If amounts available under this subparagraph are less than the total amount of emergency assistance payments referred to in clause (i), the amount payable to a State shall be equal to an amount which bears the same relationship to the total amount available under this clause as the State emergency assistance payment bears to the total amount of such payments.

"(iii) BUDGET SCORING.—Notwithstanding section 257(b)(2) of the Balanced Budget and Emergency Deficit Control Act of 1985, the baseline shall assume that no grant shall be made under this subparagraph after fiscal year 2000.

"(3) SUPPLEMENTAL GRANT AMOUNT FOR POPULATION INCREASES IN CERTAIN STATES.—

"(A) IN GENERAL.—The amount of the grant payable under paragraph (1) to a qualifying State for each of fiscal years 1997, 1998, 1999, and 2000 shall be increased by an amount equal to 2.5 percent of the amount that the State received under this section in the preceding fiscal year.

"(B) INCREASE TO REMAIN IN EFFECT EVEN IF STATE FAILS TO QUALIFY IN LATER YEARS.—Subject to section 407, in no event shall the amount of a grant payable under paragraph (1) to a State for any fiscal year be less than the amount the State received under this section for the preceding fiscal year.

"(C) QUALIFYING STATE.—

"(i) IN GENERAL.—For purposes of this paragraph, the term 'qualifying State', with respect to any fiscal year, means a State that—

"(I) had an average level of State welfare spending per poor person in the preceding fiscal year that was less than the national average level of State welfare spending per poor person in the preceding fiscal year; and

"(II) had an estimated rate of State population growth as determined by the Bureau of the Census for the most recent fiscal year for which information is available that was greater than the average rate of population growth for all States as determined by the Bureau of the Census for such fiscal year.

"(ii) CERTAIN STATES DEEMED QUALIFYING STATES.—For purposes of this paragraph, a State shall be deemed to be a qualifying State for fiscal years 1997, 1998, 1999, and 2000 if—

"(I) the level of State welfare spending per poor person in fiscal year 1996 was less than 35 percent of the national average level of State welfare spending per poor person in fiscal year 1996; or

"(II) a State has extremely high population growth (which for purposes of this clause shall be defined as a greater than ten percent increase in population from April 1, 1990 to July 1, 1994, as determined by the Bureau of the Census).

"(iii) STATE MUST QUALIFY IN FISCAL YEAR 1997.—A State shall not be eligible to be a qualifying State under clause (i) for fiscal years after 1997 if the State was not a qualifying State under clause (i) in fiscal year 1997.

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

"(i) LEVEL OF STATE WELFARE SPENDING PER POOR PERSON.—The term 'level of State welfare spending per poor person' means, with respect to a State for any fiscal year—

"(I) the amount of the grant received by the State under this section (prior to the application of section 407); divided by

"(II) the number of the individuals in the State who had an income below the poverty line according to the 1990 decennial census.

"(ii) NATIONAL AVERAGE LEVEL OF STATE WELFARE SPENDING PER POOR PERSON.—The term 'national aver-

age level of State welfare spending per poor person' means an amount equal to—

"(I) the amount paid in grants under this section (prior to the application of section 407); divided by

"(II) the number of individuals in all States with an income below the poverty line according to the 1990 decennial census.

"(iii) POVERTY LINE.—The term 'poverty line' has the same meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)).

"(iv) STATE.—The term 'State' means each of the 50 States of the United States.

"(4) APPROPRIATION.—

"(A) STATES.—There are authorized to be appropriated and there are appropriated $16,803,769,000 for each fiscal year described in paragraph (1) for the purpose of paying—

"(i) grants to States under paragraph (1)(A); and

"(ii) tribal family assistance grants under paragraph (1)(B).

"(B) ADJUSTMENT FOR QUALIFYING STATES.—For the purpose of increasing the amount of the grant payable to a State under paragraph (1) in accordance with paragraph (3), there are authorized to be appropriated and there are appropriated—

"(i) for fiscal year 1997, $85,860,000;

"(ii) for fiscal year 1998, $173,276,000;

"(iii) for fiscal year 1999, $263,468,000; and

"(iv) for fiscal year 2000, $355,310,000.

"(5) WELFARE PARTNERSHIP.—

"(A) IN GENERAL.—The amount of the grant otherwise determined under paragraph (1) for fiscal year 1997, 1998, 1999, or 2000 shall be reduced by the amount by which State expenditures under the State program funded under this part for the preceding fiscal year is less than 80 percent of historic State expenditures.

"(B) HISTORIC STATE EXPENDITURES.—For purposes of this paragraph—

"(i) IN GENERAL.—The term 'historic State expenditures' means expenditures by a State under parts A and F of title IV for fiscal year 1994, as in effect during such fiscal year.

"(ii) HOLD HARMLESS.—In no event shall the historic State expenditures applicable to any fiscal year exceed the amount which bears the same ratio to the amount determined under clause (i) as—

"(I) the grant amount otherwise determined under paragraph (1) for the preceding fiscal year (without regard to section 407), bears to

"(II) the total amount of Federal payments to the State under section 403 for fiscal year 1994 (as in effect during such fiscal year).

"(C) DETERMINATION OF STATE EXPENDITURES FOR PRECEDING FISCAL YEAR.—

"(i) IN GENERAL.—For purposes of this paragraph, the expenditures of a State under the State program funded under this part for a preceding fiscal year shall be equal to the sum of the State's expenditures under the program in the preceding fiscal year for—

"(I) cash assistance;

"(II) child care assistance;

"(III) education, job training, and work;

"(IV) administrative costs; and

"(V) any other use of funds allowable under section 403(b)(1).

"(ii) TRANSFERS FROM OTHER STATE AND LOCAL PROGRAMS.—In determining State expenditures under clause (i), such expenditures shall not include funding supplanted by transfers from other State and local programs.

"(D) EXCLUSION OF FEDERAL AMOUNTS.—For purposes of this paragraph, State expenditures shall not include any expenditures from amounts made available by the Federal Government, State funds expended for the medicaid program under title XIX of this Act or any successor to such program, and any State funds which are used to match Federal funds or are expended as a condition of receiving Federal funds under Federal programs other than under this part.

"(b) USE OF GRANT.—

"(1) IN GENERAL.—Subject to this part, a State to which a grant is made under this section may use the grant—

"(A) in any manner that is reasonably calculated to accomplish the purpose of this part; or

"(B) in any manner that such State used amounts received under part A or F of this title, as such parts were in effect before October 1, 1995;

except that not more than 15 percent of the grant may be used for administrative purposes.

"(2) AUTHORITY TO TREAT INTERSTATE IMMIGRANTS UNDER RULES OF FORMER STATE.—A State to which a grant is made under this section may apply to a family some or all of the rules (including benefit amounts) of the program operated under this part of another State if the family has moved to the State from the other State and has resided in the State for less than 12 months.

"(3) AUTHORITY TO RESERVE CERTAIN AMOUNTS FOR ASSISTANCE.—A State may reserve amounts paid to the State under this part for any fiscal year for the purpose of providing, without fiscal year limitation, assistance under the State program operated under this part. In the case of amounts paid to the State that are set aside in accordance with section 419(a), the State may reserve such amounts for any fiscal year only for the purpose of providing without fiscal year limitation child care assistance under this part.

"(4) AUTHORITY TO OPERATE EMPLOYMENT PLACEMENT PROGRAM.—A State to which a grant is made under this section may use a portion of the grant to make payments (or provide job placement vouchers) to State-approved public and private job placement agencies that provide employment placement services to individuals who receive assistance under the State program funded under this part.

"(5) TRANSFERABILITY OF GRANT AMOUNTS.—A State may use up to 30 percent of amounts received from a grant under this part for a fiscal year to carry out State activities under the Child Care and Development Block Grant Act of 1990 (42 U.S.C. 9858 et seq.) (relating to child care block grants).

"(c) TIMING OF PAYMENTS.—The Secretary shall pay each grant payable to a State under this section in quarterly installments.

"(d) FEDERAL LOAN FUND FOR STATE WELFARE PROGRAMS.—

"(1) ESTABLISHMENT.—There is hereby established in the Treasury of the United States a revolving loan fund which shall be known as the 'Federal Loan Fund for State Welfare Programs' (hereafter for purposes of this section referred to as the 'fund').

"(2) DEPOSITS INTO FUND.—

"(A) APPROPRIATION.—Out of any money in the Treasury of the United States not otherwise appropriated, $1,700,000,000 are hereby appropriated for fiscal year 1996 for payment to the fund.

"(B) LOAN REPAYMENTS.—The Secretary shall deposit into the fund any principal or interest payment received with respect to a loan made under this subsection.

"(3) AVAILABILITY.—Amounts in the fund are authorized to remain available without fiscal year limitation for the purpose of making loans and receiving payments of principal and interest on such loans, in accordance with this subsection.

"(4) USE OF FUND.—

"(A) LOANS TO STATES.—The Secretary shall make loans from the fund to any loan-eligible State, as defined in subparagraph (D), for a period to maturity of not more than 3 years.

"(B) RATE OF INTEREST.—The Secretary shall charge and collect interest on any loan made under subparagraph (A) at a rate equal to the current average market yield on outstanding marketable obligations of the United States with remaining periods to maturity comparable to the period to maturity of the loan.

"(C) MAXIMUM LOAN.—The cumulative amount of any loans made to a State under subparagraph (A) during fiscal years 1996 through 2000 shall not exceed 10 percent of the State family assistance grant under subsection (a)(2) for a fiscal year.

"(D) LOAN-ELIGIBLE STATE.—For purposes of subparagraph (A), a loan-eligible State is a State which has not had a penalty described in section 407(a)(1) imposed against it at any time prior to the loan being made.

"(5) LIMITATION ON USE OF LOAN.—A State shall use a loan received under this subsection only for any purpose for which

grant amounts received by the State under subsection (a) may be used including—

"(A) welfare anti-fraud activities; and

"(B) the provision of assistance under the State program to Indian families that have moved from the service area of an Indian tribe with a tribal family assistance plan approved under section 414.

"(e) SPECIAL RULE FOR INDIAN TRIBES THAT RECEIVED JOBS FUNDS.—

"(1) IN GENERAL.—The Secretary shall pay to each eligible Indian tribe for each of fiscal years 1996, 1997, 1998, 1999, and 2000 a grant in an amount equal to the amount received by such Indian tribe in fiscal year 1994 under section 482(i) (as in effect during such fiscal year) for the purpose of operating a program to make work activities available to members of the Indian tribe.

"(2) ELIGIBLE INDIAN TRIBE.—For purposes of paragraph (1), the term 'eligible Indian tribe' means an Indian tribe or Alaska Native organization that conducted a job opportunities and basic skills training program in fiscal year 1995 under section 482(i) (as in effect during such fiscal year).

"(3) APPROPRIATION.—There are authorized to be appropriated and there are hereby appropriated $7,638,474 for each fiscal year described in paragraph (1) for the purpose of paying grants in accordance with such paragraph.

"(f) JOB PLACEMENT PERFORMANCE BONUS.—

"(1) IN GENERAL.—The job placement performance bonus determined with respect to a State and a fiscal year is an amount equal to the amount of the State's allocation of the job placement performance fund determined in accordance with the formula developed under paragraph (2).

"(2) ALLOCATION FORMULA; BONUS FUND.—

"(A) ALLOCATION FORMULA.—

"(i) IN GENERAL.—Not later than September 30, 1996, the Secretary of Health and Human Services shall develop and publish in the Federal Register a formula for allocating amounts in the job placement performance bonus fund to States based on the number of families that received assistance under a State program funded under this part in the preceding fiscal year that became ineligible for assistance under the State program as a result of unsubsidized employment during such year.

"(ii) FACTORS TO CONSIDER.—In developing the allocation formula under clause (i), the Secretary shall—

"(I) provide a greater financial bonus for individuals in families described in clause (i) who remain employed for greater periods of time or are at greater risk of long-term welfare dependency; and

"(II) take into account the unemployment conditions of each State or geographic area.

"(B) JOB PLACEMENT PERFORMANCE BONUS FUND.—

"(i) IN GENERAL.—The amount in the job placement performance bonus fund for a fiscal year shall be an amount equal to the applicable percentage of the amount appropriated under section 403(a)(2)(A)(i) for such fiscal year.

"(ii) APPLICABLE PERCENTAGE.—For purposes of clause (i)(I), the applicable percentage shall be determined in accordance with the following table:

"For fiscal year:	The applicable percentage is:
1998	3
1999	4.

"(g) SECRETARY.—For purposes of this section, the term 'Secretary' means the Secretary of the Treasury.

"(h) CONTINGENCY FUND.—

"(1) ESTABLISHMENT.—There is hereby established in the Treasury of the United States a fund which shall be known as the 'Contingency Fund for State Welfare Programs' (hereafter in this section referred to as the 'Fund').

"(2) DEPOSITS INTO FUND.—Out of any money in the Treasury of the United States not otherwise appropriated, there are hereby appropriated for fiscal years 1996, 1997, 1998, 1999, 2000, 2001, and 2002 such sums as are necessary for payment to the Fund in a total amount not to exceed $1,000,000,000.

"(3) COMPUTATION OF GRANT.—

"(A) IN GENERAL.—Subject to subparagraph (B), the Secretary of the Treasury shall pay to each eligible State in a fiscal year an amount equal to the Federal medical assistance percentage for such State for such fiscal year (as defined in section 2122(c)) of so much of the expenditures by the State in such year under the State program funded under this part as exceed the historic State expenditures for such State.

"(B) LIMITATION.—The total amount paid to a State under subparagraph (A) for any fiscal year shall not exceed an amount equal to 20 percent of the annual amount determined for such State under the State program funded under this part (without regard to this subsection) for such fiscal year.

"(C) METHOD OF COMPUTATION, PAYMENT, AND RECONCILIATION.—

"(i) METHOD OF COMPUTATION.—The method of computing and paying such amounts shall be as follows:

"(I) The Secretary of Health and Human Services shall estimate the amount to be paid to the State for each quarter under the provisions of subparagraph (A), such estimate to be based on a report filed by the State containing its estimate of the total sum to be expended in such quarter and such other information as the Secretary may find necessary.

"(II) The Secretary of Health and Human Services shall then certify to the Secretary of the

Treasury the amount so estimated by the Secretary of Health and Human Services.

"(ii) METHOD OF PAYMENT.—The Secretary of the Treasury shall thereupon, through the Fiscal Service of the Department of the Treasury and prior to audit or settlement by the General Accounting Office, pay to the State, at the time or times fixed by the Secretary of Health and Human Services, the amount so certified.

"(iii) METHOD OF RECONCILIATION.—If at the end of each fiscal year, the Secretary of Health and Human Services finds that a State which received amounts from the Fund in such fiscal year did not meet the maintenance of effort requirement under paragraph (5)(B) for such fiscal year, the Secretary shall reduce the State family assistance grant for such State for the succeeding fiscal year by such amounts.

"(4) USE OF GRANT.—

"(A) IN GENERAL.—An eligible State may use the grant—

"(i) in any manner that is reasonably calculated to accomplish the purpose of this part; or

"(ii) in any manner that such State used amounts received under part A or F of this title, as such parts were in effect before October 1, 1995.

"(B) REFUND OF UNUSED PORTION.—Any amount of a grant under this subsection not used during the fiscal year shall be returned to the Fund.

"(5) ELIGIBLE STATE.—

"(A) IN GENERAL.—For purposes of this subsection, a State is an eligible State with respect to a fiscal year, if—

"(i)(I) the average rate of total unemployment in such State (seasonally adjusted) for the period consisting of the most recent 3 months for which data for all States are published equals or exceeds 6.5 percent, and

"(II) the average rate of total unemployment in such State (seasonally adjusted) for the 3-month period equals or exceeds 110 percent of such average rate for either (or both) of the corresponding 3-month periods ending in the 2 preceding calendar years; and

"(ii) has met the maintenance of effort requirement under subparagraph (B) for the State program funded under this part for the fiscal year.

"(B) MAINTENANCE OF EFFORT.—The maintenance of effort requirement for any State under this subparagraph for any fiscal year is the expenditure of an amount at least equal to 100 percent of the level of historic State expenditures for such State (as determined under subsection (a)(5)).

"(6) ANNUAL REPORTS.—The Secretary of the Treasury shall annually report to the Congress on the status of the Fund.

"SEC. 404. MANDATORY WORK REQUIREMENTS.

"(a) PARTICIPATION RATE REQUIREMENTS.—A State to which a grant is made under section 403 for a fiscal year shall achieve the minimum participation rate specified in the following tables for the fiscal year with respect to—

"(1) all families receiving assistance under the State program funded under this part:

"If the fiscal year is:	The minimum participation rate for all families is:
1996	25
1997	30
1998	35
1999	40
2000 or thereafter	50;

and

"(2) with respect to 2-parent families receiving such assistance:

"If the fiscal year is:	The minimum participation rate is:
1996	60
1997 or 1998	75
1999 or thereafter	90.

"(b) CALCULATION OF PARTICIPATION RATES.—

"(1) FOR ALL FAMILIES.—

"(A) AVERAGE MONTHLY RATE.—For purposes of subsection (a)(1), the participation rate for all families of a State for a fiscal year is the average of the participation rates for all families of the State for each month in the fiscal year.

"(B) MONTHLY PARTICIPATION RATES.—The participation rate of a State for all families of the State for a month, expressed as a percentage, is—

"(i) the sum of—

"(I) the number of all families receiving assistance under the State program funded under this part that include an adult who is engaged in work for the month;

"(II) the number of all families receiving assistance under the State program funded under this part that are subject in such month to a penalty described in paragraph (1)(A) or (2)(A) of subsection (d) but have not been subject to such penalty for more than 3 months within the preceding 12-month period (whether or not consecutive); and

"(III) the number of all families that received assistance under the State program under this part during the previous 6-month period that have become ineligible to receive assistance during such period because of employment and which include an adult who is employed for the month; divided by

"(ii) the total number of all families receiving assistance under the State program funded under this part during the month that include an adult receiving assistance.

"(2) 2-PARENT FAMILIES.—

"(A) AVERAGE MONTHLY RATE.—For purposes of subsection (a)(2), the participation rate for 2-parent families of a State for a fiscal year is the average of the participation rates for 2-parent families of the State for each month in the fiscal year.

"(B) MONTHLY PARTICIPATION RATES.—The participation rate of a State for 2-parent families of the State for a month, expressed as a percentage, is—

"(i) the total number of 2-parent families described in paragraph (1)(B)(i); divided by

"(ii) the total number of 2-parent families receiving assistance under the State program funded under this part during the month that include an adult.

"(3) PRO RATA REDUCTION OF PARTICIPATION RATE DUE TO CASELOAD REDUCTIONS NOT REQUIRED BY FEDERAL LAW.—

"(A) IN GENERAL.—The Secretary shall prescribe regulations for reducing the minimum participation rate otherwise required by this section for a fiscal year by the number of percentage points equal to the number of percentage points (if any) by which—

"(i) the number of families receiving assistance during the fiscal year under the State program funded under this part is less than

"(ii) the number of families that received aid under the State plan approved under part A of this title (as in effect before October 1, 1995) during the fiscal year immediately preceding such effective date.

The minimum participation rate shall not be reduced to the extent that the Secretary determines that the reduction in the number of families receiving such assistance is required by Federal law.

"(B) ELIGIBILITY CHANGES NOT COUNTED.—The regulations described in subparagraph (A) shall not take into account families that are diverted from a State program funded under this part as a result of differences in eligibility criteria under a State program funded under this part and eligibility criteria under such State's plan under the aid to families with dependent children program, as such plan was in effect on the day before the date of the enactment of the Work Opportunity Act of 1995.

"(4) STATE OPTION TO INCLUDE INDIVIDUALS RECEIVING ASSISTANCE UNDER A TRIBAL FAMILY ASSISTANCE PLAN.—For purposes of paragraphs (1)(B) and (2)(B), a State may, at its option, include families receiving assistance under a tribal family assistance plan approved under section 414. For purposes of the previous sentence, an individual who receives assistance under a tribal family assistance plan approved under section 414 shall be treated as being engaged in work if the individual

is participating in work under standards that are comparable to State standards for being engaged in work.

"(5) STATE OPTION FOR PARTICIPATION REQUIREMENT EXEMPTIONS.—For any fiscal year, a State may, at its option, not require an individual who is the parent or caretaker relative of a minor child who is less than 12 months of age to engage in work and may exclude such an individual from the determination of the minimum participation rate specified for such fiscal year in subsection (a).

"(c) ENGAGED IN WORK.—

"(1) ALL FAMILIES.—For purposes of subsection (b)(1)(B)(i)(I), an adult is engaged in work for a month in a fiscal year if the adult is participating in work for at least the minimum average number of hours per week specified in the following table during the month, not fewer than 20 hours per week of which are attributable to a work activity:

"If the month is in fiscal year:	The minimum average number of hours per week is:
1996	20
1997	20
1998	20
1999	25
2000	30
2001	30
2002	35
2003 or thereafter	35.

"(2) 2-PARENT FAMILIES.—For purposes of subsection (b)(2)(A), an adult is engaged in work for a month in a fiscal year if the adult is participating in work for at least 35 hours per week during the month, not fewer than 30 hours per week of which are attributable to work activities described in paragraph (3).

"(3) DEFINITION OF WORK ACTIVITIES.—For purposes of this subsection, the term 'work activities' means—

"(A) unsubsidized employment;

"(B) subsidized employment;

"(C) on-the-job training;

"(D) community service programs;

"(E) job search (only for the first 4 weeks in which an individual is required to participate in work activities under this section); and

"(F) vocational educational training (not to exceed 12 months with respect to any individual).

"(4) LIMITATION ON VOCATIONAL EDUCATION ACTIVITIES COUNTED AS WORK.—For purposes of determining monthly participation rates under paragraphs (1)(B)(i)(I) and (2)(B)(i) of subsection (b), not more than 25 percent of adults in all families and in 2-parent families determined to be engaged in work in the State for a month may meet the work activity requirement through participation in vocational educational training.

"(d) PENALTIES AGAINST INDIVIDUALS.—

"(1) IN GENERAL.—Except as provided in paragraph (2), if an adult in a family receiving assistance under the State pro-

gram funded under this part refuses to engage in work required under subsection (c)(1) or (c)(2), a State to which a grant is made under section 403 shall—

"(A) reduce the amount of assistance otherwise payable to the family pro rata (or more, at the option of the State) with respect to any period during a month in which the adult so refuses; or

"(B) terminate such assistance,

subject to such good cause and other exceptions as the State may establish.

"(2) EXCEPTION.—Notwithstanding paragraph (1), a State may not reduce or terminate assistance under the State program based on a refusal of an adult to work if such adult is a single custodial parent caring for a child age 5 or under and has a demonstrated inability (as determined by the State) to obtain needed child care, for one or more of the following reasons:

"(A) Unavailability of appropriate child care within a reasonable distance of the individual's home or work site.

"(B) Unavailability or unsuitability of informal child care by a relative or under other arrangements.

"(C) Unavailability of appropriate and affordable formal child care arrangements.

"(e) NONDISPLACEMENT IN WORK ACTIVITIES.—

"(1) IN GENERAL.—Subject to paragraph (2), an adult in a family receiving assistance under this part may fill a vacant employment position in order to engage in a work activity described in subsection (c)(3).

"(2) NO FILLING OF CERTAIN VACANCIES.—No adult in a work activity described in subsection (c)(3) shall be employed or assigned—

"(A) when any other individual is on layoff from the same or any substantially equivalent job; or

"(B) when the employer has terminated the employment of any regular employee or otherwise caused an involuntary reduction of its workforce in order to fill the vacancy so created with an adult described in paragraph (1).

"(3) NO PREEMPTION.—Nothing in this subsection shall preempt or supersede any provision of State or local law that provides greater protection for employees from displacement.

"(f) SENSE OF THE CONGRESS.—It is the sense of the Congress that in complying with this section, each State that operates a program funded under this part is encouraged to assign the highest priority to requiring adults in 2-parent families and adults in single-parent families that include older preschool or school-age children to be engaged in work activities.

"(g) ENCOURAGEMENT TO PROVIDE CHILD CARE SERVICES.—An individual participating in a State community service program may be treated as being engaged in work under subsection (c) if such individual provides child care services to other individuals participating in the community service program in the manner, and for the period of time each week, determined appropriate by the State.

"SEC. 405. REQUIREMENTS AND LIMITATIONS.

"(a) STATE REQUIRED TO ENTER INTO A PERSONAL RESPONSIBILITY CONTRACT WITH EACH FAMILY RECEIVING ASSISTANCE.—

"(1) IN GENERAL.—Each State to which a grant is made under section 403 shall require each family receiving assistance under the State program funded under this part to enter into—

"(A) a personal responsibility contract (as developed by the State) with the State; or

"(B) a limited benefit plan.

"(2) PERSONAL RESPONSIBILITY CONTRACT.—For purposes of this subsection, the term 'personal responsibility contract' means a binding contract between the State and each family receiving assistance under the State program funded under this part that—

"(A) outlines the steps each family and the State will take to get the family off of welfare and to become self-sufficient;

"(B) specifies a negotiated time-limited period of eligibility for receipt of assistance that is consistent with unique family circumstances and is based on a reasonable plan to facilitate the transition of the family to self-sufficiency;

"(C) provides that the family will automatically enter into a limited benefit plan if the family is out of compliance with the personal responsibility contract; and

"(D) provides that the contract shall be invalid if the State agency fails to comply with the contract.

"(3) LIMITED BENEFIT PLAN.—For purposes of this subsection, the term 'limited benefit plan' means a plan which provides for a reduced level of assistance and later termination of assistance to a family that has entered into the plan in accordance with a schedule to be determined by the State.

"(4) ASSESSMENT.—The State agency shall provide, through a case manager, an initial and thorough assessment of the skills, prior work experience, and employability of each parent for use in developing and negotiating a personal responsibility contract.

"(5) DISPUTE RESOLUTION.—The State agency described in section 402(a)(7) shall establish a dispute resolution procedure for disputes related to participation in the personal responsibility contract that provides the opportunity for a hearing.

"(b) NO ASSISTANCE FOR MORE THAN 5 YEARS.—

"(1) IN GENERAL.—Except as provided under paragraphs (2) and (3), a State to which a grant is made under section 403 may not use any part of the grant to provide assistance to a family that includes an adult who has received assistance under the program operated under this part for the lesser of—

"(A) the period of time established at the option of the State; or

"(B) 60 months (whether or not consecutive) after September 30, 1995.

"(2) MINOR CHILD EXCEPTION.—If an individual received assistance under the State program operated under this part

as a minor child in a needy family, any period during which such individual's family received assistance shall not be counted for purposes of applying the limitation described in paragraph (1) to an application for assistance under such program by such individual as the head of a household of a needy family with minor children.

"(3) HARDSHIP EXCEPTION.—

"(A) IN GENERAL.—The State may exempt a family from the application of paragraph (1) by reason of hardship.

"(B) LIMITATION.—The number of families with respect to which an exemption made by a State under subparagraph (A) is in effect for a fiscal year shall not exceed 20 percent of the average monthly number of families to which the State is providing assistance under the program operated under this part.

"(c) DENIAL OF ASSISTANCE FOR 10 YEARS TO A PERSON FOUND TO HAVE FRAUDULENTLY MISREPRESENTED RESIDENCE IN ORDER TO OBTAIN ASSISTANCE IN 2 OR MORE STATES.—An individual shall not be considered an eligible individual for the purposes of this part during the 10-year period that begins on the date the individual is convicted in Federal or State court of having made a fraudulent statement or representation with respect to the place of residence of the individual in order to receive assistance simultaneously from 2 or more States under programs that are funded under this title, title XXI, or the Food Stamp Act of 1977, or benefits in 2 or more States under the supplemental security income program under title XVI.

"(d) DENIAL OF ASSISTANCE FOR FUGITIVE FELONS AND PROBATION AND PAROLE VIOLATORS.—

"(1) IN GENERAL.—An individual shall not be considered an eligible individual for the purposes of this part if such individual is—

"(A) fleeing to avoid prosecution, or custody or confinement after conviction, under the laws of the place from which the individual flees, for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which the individual flees, or which, in the case of the State of New Jersey, is a high misdemeanor under the laws of such State; or

"(B) violating a condition of probation or parole imposed under Federal or State law.

"(2) EXCHANGE OF INFORMATION WITH LAW ENFORCEMENT AGENCIES.—Notwithstanding any other provision of law, a State shall furnish any Federal, State, or local law enforcement officer, upon the request of the officer, with the current address, Social Security number, and photograph (if applicable) of any recipient of assistance under this part, if the officer furnishes the agency with the name of the recipient and notifies the agency that—

"(A) such recipient—

"(i) is described in subparagraph (A) or (B) of paragraph (1); or

"(ii) has information that is necessary for the officer to conduct the officer's official duties; and

"(B) the location or apprehension of the recipient is within such officer's official duties.

"(e) STATE OPTION TO REQUIRE ASSIGNMENT OF SUPPORT.—At the option of the State, a State to which a grant is made under section 403 may provide that an individual applying for or receiving assistance under the State program funded under this part shall be required to assign to the State any rights to support from any other person the individual may have in such individual's own behalf or in behalf of any other family member for whom the individual is applying for or receiving assistance.

"(f) DENIAL OF ASSISTANCE FOR ABSENT CHILD.—Each State to which a grant is made under section 403—

"(1) may not use any part of the grant to provide assistance to a family with respect to any minor child who has been, or is expected by the caretaker relative in the family to be, absent from the home for a period of 45 consecutive days or, at the option of the State, such period of not less than 30 and not more than 90 consecutive days as the State may provide for in the State plan;

"(2) at the option of the State, may establish such good cause exceptions to paragraph (1) as the State considers appropriate if such exceptions are provided for in the State plan; and

"(3) shall provide that a caretaker relative shall not be considered an eligible individual for purposes of this part if the caretaker relative fails to notify the State agency of an absence of a minor child from the home for the period specified in or provided for under paragraph (1), by the end of the 5-day period that begins on the date that it becomes clear to the caretaker relative that the minor child will be absent for the period so specified or provided for in paragraph (1).

"SEC. 406. PROMOTING RESPONSIBLE PARENTING.

"(a) FINDINGS.—The Congress makes the following findings:

"(1) Marriage is the foundation of a successful society.

"(2) Marriage is an essential institution of a successful society which promotes the interests of children.

"(3) Promotion of responsible fatherhood and motherhood is integral to successful child rearing and the wellbeing of children.

"(4) In 1992, only 54 percent of single-parent families with children had a child support order established and, of that 54 percent, only about one half received the full amount due. Of the cases enforced through the public child support enforcement system, only 18 percent of the caseload has a collection.

"(5) The number of individuals receiving aid to families with dependent children (hereafter in this subsection referred to as 'AFDC') has more than tripled since 1965. More than two-thirds of these recipients are children. Eighty-nine percent of children receiving AFDC benefits now live in homes in which no father is present.

"(A)(i) The average monthly number of children receiving AFDC benefits—

"(I) was 3,300,000 in 1965;

"(II) was 6,200,000 in 1970;
"(III) was 7,400,000 in 1980; and
"(IV) was 9,300,000 in 1992.

"(ii) While the number of children receiving AFDC benefits increased nearly threefold between 1965 and 1992, the total number of children in the United States aged 0 to 18 has declined by 5.5 percent.

"(B) The Department of Health and Human Services has estimated that 12,000,000 children will receive AFDC benefits within 10 years.

"(C) The increase in the number of children receiving public assistance is closely related to the increase in births to unmarried women. Between 1970 and 1991, the percentage of live births to unmarried women increased nearly threefold, from 10.7 percent to 29.5 percent.

"(6) The increase of out-of-wedlock pregnancies and births is well documented as follows:

"(A) It is estimated that the rate of nonmarital teen pregnancy rose 23 percent from 54 pregnancies per 1,000 unmarried teenagers in 1976 to 66.7 pregnancies in 1991. The overall rate of nonmarital pregnancy rose 14 percent from 90.8 pregnancies per 1,000 unmarried women in 1980 to 103 in both 1991 and 1992. In contrast, the overall pregnancy rate for married couples decreased 7.3 percent between 1980 and 1991, from 126.9 pregnancies per 1,000 married women in 1980 to 117.6 pregnancies in 1991.

"(B) The total of all out-of-wedlock births between 1970 and 1991 has risen from 10.7 percent to 29.5 percent and if the current trend continues, 50 percent of all births by the year 2015 will be out-of-wedlock.

"(7) The negative consequences of an out-of-wedlock birth on the mother, the child, the family, and society are well documented as follows:

"(A) Young women 17 and under who give birth outside of marriage are more likely to go on public assistance and to spend more years on welfare once enrolled. These combined effects of 'younger and longer' increase total AFDC costs per household by 25 percent to 30 percent for 17-year olds.

"(B) Children born out-of-wedlock have a substantially higher risk of being born at a very low or moderately low birth weight.

"(C) Children born out-of-wedlock are more likely to experience low verbal cognitive attainment, as well as more child abuse, and neglect.

"(D) Children born out-of-wedlock were more likely to have lower cognitive scores, lower educational aspirations, and a greater likelihood of becoming teenage parents themselves.

"(E) Being born out-of-wedlock significantly reduces the chances of the child growing up to have an intact marriage.

"(F) Children born out-of-wedlock are 3 more times likely to be on welfare when they grow up.

"(8) Currently 35 percent of children in single-parent homes were born out-of-wedlock, nearly the same percentage as that of children in single-parent homes whose parents are divorced (37 percent). While many parents find themselves, through divorce or tragic circumstances beyond their control, facing the difficult task of raising children alone, nevertheless, the negative consequences of raising children in single-parent homes are well documented as follows:

"(A) Only 9 percent of married-couple families with children under 18 years of age have income below the national poverty level. In contrast, 46 percent of female-headed households with children under 18 years of age are below the national poverty level.

"(B) Among single-parent families, nearly ½ of the mothers who never married received AFDC while only ⅙ of divorced mothers received AFDC.

"(C) Children born into families receiving welfare assistance are 3 times more likely to be on welfare when they reach adulthood than children not born into families receiving welfare.

"(D) Mothers under 20 years of age are at the greatest risk of bearing low birth-weight babies.

"(E) The younger the single parent mother, the less likely she is to finish high school.

"(F) Young women who have children before finishing high school are more likely to receive welfare assistance for a longer period of time.

"(G) Between 1985 and 1990, the public cost of births to teenage mothers under the aid to families with dependent children program, the food stamp program, and the medicaid program has been estimated at $120,000,000,000.

"(H) The absence of a father in the life of a child has a negative effect on school performance and peer adjustment.

"(I) Children of teenage single parents have lower cognitive scores, lower educational aspirations, and a greater likelihood of becoming teenage parents themselves.

"(J) Children of single-parent homes are 3 times more likely to fail and repeat a year in grade school than are children from intact two-parent families.

"(K) Children from single-parent homes are almost 4 times more likely to be expelled or suspended from school.

"(L) Neighborhoods with larger percentages of youth aged 12 through 20 and areas with higher percentages of single-parent households have higher rates of violent crime.

"(M) Of those youth held for criminal offenses within the State juvenile justice system, only 29.8 percent lived primarily in a home with both parents. In contrast to these incarcerated youth, 73.9 percent of the 62,800,000 children in the Nation's resident population were living with both parents.

"(9) Therefore, in light of this demonstration of the crisis in our Nation, it is the sense of the Congress that prevention

of out-of-wedlock pregnancy and reduction in out-of-wedlock birth are very important Government interests and the policy contained in provisions of this title is intended to address the crisis.

"(b) STATE OPTION TO DENY ASSISTANCE FOR OUT-OF-WEDLOCK BIRTHS TO MINORS.—At the option of the State, a State to which a grant is made under section 403 may provide that the grant shall not be used to provide assistance for a child born out-of-wedlock to an individual who has not attained 18 years of age, or for the individual, until the individual attains such age.

"(c) STATE OPTION TO DENY ASSISTANCE FOR CHILDREN BORN TO FAMILIES RECEIVING ASSISTANCE.—At the option of the State, a State to which a grant is made under section 403 may provide that the grant shall not be used to provide assistance for a minor child who is born to—

"(1) a recipient of assistance under the program funded under this part; or

"(2) an individual who received such benefits at any time during the 10-month period ending with the birth of the child.

"(d) REQUIREMENT THAT TEENAGE PARENTS LIVE IN ADULT-SUPERVISED SETTINGS.—

"(1) IN GENERAL.—

"(A) REQUIREMENT.—Except as provided in paragraph (2), if a State provides assistance under the State program funded under this part to an individual described in subparagraph (B), such individual may only receive assistance under the program if such individual and the child of the individual reside in a place of residence maintained by a parent, legal guardian, or other adult relative of such individual as such parent's, guardian's, or adult relative's own home.

"(B) INDIVIDUAL DESCRIBED.— For purposes of subparagraph (A), an individual described in this subparagraph is an individual who is—

"(i) under the age of 18; and

"(ii) not married and has a minor child in his or her care.

"(2) EXCEPTION.—

"(A) PROVISION OF, OR ASSISTANCE IN LOCATING, ADULT-SUPERVISED LIVING ARRANGEMENT.—In the case of an individual who is described in subparagraph (B), the State agency shall provide, or assist such individual in locating, a second chance home, maternity home, or other appropriate adult-supervised supportive living arrangement, taking into consideration the needs and concerns of the such individual, unless the State agency determines that the individual's current living arrangement is appropriate, and thereafter shall require that such parent and the child of such parent reside in such living arrangement as a condition of the continued receipt of assistance under the plan (or in an alternative appropriate arrangement, should circumstances change and the current arrangement cease to be appropriate).

"(B) INDIVIDUAL DESCRIBED.—For purposes of subparagraph (A), an individual is described in this subparagraph if the individual is described in paragraph (1)(B) and—

"(ii) such individual has no parent, legal guardian or other appropriate adult relative as described in (iii) of his or her own who is living or whose whereabouts are known;

"(iii) no living parent, legal guardian, or other appropriate adult relative who would otherwise meet applicable State criteria to act as such individual's legal guardian, of such individual allows the individual to live in the home of such parent, guardian, or relative;

"(iv) the State agency determines that—

"(I) the individual or the individual's custodial minor child is being or has been subjected to serious physical or emotional harm, sexual abuse, or exploitation in the residence of such individual's own parent or legal guardian; or

"(II) substantial evidence exists of an act or failure to act that presents an imminent or serious harm if such individual and such individual's minor child lived in the same residence with such individual's own parent or legal guardian; or

"(v) the State agency otherwise determines that it is in the best interest of the minor child to waive the requirement of paragraph (1) with respect to such individual or minor child.

"(C) SECOND-CHANCE HOME.—For purposes of this paragraph, the term 'second-chance home' means an entity that provides individuals described in subparagraph (B) with a supportive and supervised living arrangement in which such individuals are required to learn parenting skills, including child development, family budgeting, health and nutrition, and other skills to promote their long-term economic independence and the well-being of their children.

"(3) ASSISTANCE TO STATES IN PROVIDING OR LOCATING ADULT-SUPERVISED SUPPORTIVE LIVING ARRANGEMENTS FOR UNMARRIED TEENAGE PARENTS.—

"(A) IN GENERAL.—For each of fiscal years 1996 through 2002, each State that provides assistance under the State program to individuals described in paragraph (1)(B) shall be entitled to receive a grant in an amount determined under subparagraph (B) for the purpose of providing or locating adult-supervised supportive living arrangements for individuals described in paragraph (1)(B) in accordance with this subsection.

"(B) AMOUNT DETERMINED.—

"(i) IN GENERAL.—The amount determined under this subparagraph is an amount that bears the same ratio to the amount specified under clause (ii) as the amount of the State family assistance grant for the State for such fiscal year (described in section

403(a)(2)) bears to the amount appropriated for such fiscal year in accordance with section 403(a)(4)(A).

"(ii) AMOUNT SPECIFIED.—The amount specified in this subparagraph is—

"(I) for fiscal year 1996, $25,000,000;

"(II) for fiscal year 1997, $25,000,000; and

"(III) for each of fiscal years 1998, 1999, 2000, 2001, and 2002, $20,000,000.

"(C) ASSISTANCE TO STATES IN PROVIDING OR LOCATING ADULT-SUPERVISED SUPPORTIVE LIVING ARRANGEMENTS FOR UNMARRIED TEENAGE PARENTS.—There are authorized to be appropriated and there are appropriated for fiscal years 1996, 1997, 1998, 1999, 2000, 2001, and 2002 such sums specified in subparagraph (B)(ii) for the purpose of paying grants to States in accordance with the provisions of this paragraph.

"(e) REQUIREMENT THAT TEENAGE PARENTS ATTEND HIGH SCHOOL OR OTHER EQUIVALENT TRAINING PROGRAM.—If a State provides assistance under the State program funded under this part to an individual described in subsection (d)(1)(B) who has not successfully completed a high-school education (or its equivalent) and whose minor child is at least 12 weeks of age, the State shall not provide such individual with assistance under the program (or, at the option of the State, shall provide a reduced level of such assistance) if the individual does not participate in—

"(1) educational activities directed toward the attainment of a high school diploma or its equivalent; or

"(2) an alternative educational or training program that has been approved by the State.

"(f) GRANT INCREASED TO REWARD STATES THAT REDUCE OUT-OF-WEDLOCK BIRTHS.—

"(1) IN GENERAL.—The amount of the grant payable to a State under section 403(a)(1)(A) for fiscal years 1998, 1999, and 2000 shall be increased by—

"(A) an amount equal to the product of $25 multiplied by the number of children in the State in families with incomes below the poverty line, according to the most recently available census data, if—

"(i) the illegitimacy ratio of the State for the most recent fiscal year for which such information is available is at least 1 percentage point lower than the illegitimacy ratio of the State for fiscal year 1995 (or, if such information is not available, the first available year after 1995 for which such data is available); and

"(ii) the rate of induced pregnancy terminations for the same most recent fiscal year in the State is not higher than the rate of induced pregnancy terminations in the State for fiscal year 1995 (or, the same first available year); or

"(B) an amount equal to the product of $50 multiplied by the number of children in the State in families with incomes below the poverty line, according to the most recently available census data, if—

"(i) the illegitimacy ratio of the State for the most recent fiscal year for which information is available is at least 2 percentage points lower than the illegitimacy ratio of the State for fiscal year 1995 (or, if such information is not available, the first available year after 1995 for which such data is available); and

"(ii) the rate of induced pregnancy terminations in the State for the same most recent fiscal year is not higher than the rate of induced pregnancy terminations in the State for fiscal year 1995 (or, the same first available fiscal year).

"(2) DETERMINATION OF THE SECRETARY.—The Secretary shall not increase the grant amount under paragraph (1) if the Secretary determines that the relevant difference between the illegitimacy ratio of a State for an applicable fiscal year and the illegitimacy ratio of such State for fiscal year 1995 or, where appropriate, the first available year after 1995 for which such data is available, is the result of a change in State methods of reporting data used to calculate the illegitimacy ratio or if the Secretary determines that the relevant non-increase in the rate of induced pregnancy terminations for an applicable fiscal year as compared to fiscal year 1995 or, the appropriate fiscal year, is the result of a change in State methods of reporting data used to calculate the rate of induced pregnancy terminations.

"(3) ILLEGITIMACY RATIO.—For purposes of this subsection, the term 'illegitimacy ratio' means, with respect to a State and a fiscal year—

"(A) the number of out-of-wedlock births that occurred in the State during the most recent fiscal year for which such information is available; divided by

"(B) the number of births that occurred in the State during the most recent fiscal year for which such information is available.

"(4) POVERTY LINE.—For purposes of this subsection, the term 'poverty line' has the meaning given such term in section 403(a)(3)(D)(iii).

"(5) AVAILABILITY OF AMOUNTS.—There are authorized to be appropriated and there are appropriated such sums as may be necessary for fiscal years 1998, 1999, and 2000 for the purpose of increasing the amount of the grant payable to a State under section 403(a)(1) in accordance with this subsection.

"(g) STATE OPTION TO DENY ASSISTANCE IN CERTAIN SITUATIONS.—Nothing in this subsection shall be construed to restrict the authority of a State to exercise its option to limit assistance under this part to individuals if such limitation is not inconsistent with the provisions of this part.

"SEC. 407. STATE PENALTIES.

"(a) IN GENERAL.—Subject to the provisions of subsection (b), the Secretary shall deduct from the grant otherwise payable under section 403 the following penalties:

"(1) FOR USE OF GRANT IN VIOLATION OF THIS PART.—If an audit conducted under section 408 finds that an amount paid to a State under section 403 for a fiscal year has been used in

violation of this part, then the Secretary shall reduce the amount of the grant otherwise payable to the State under such section for the immediately succeeding fiscal year quarter by the amount so used. If the State does not prove to the satisfaction of the Secretary that such unlawful expenditure was not made by the State in intentional violation of the requirements of this part, then the Secretary shall impose an additional penalty of 5 percent of such grant (determined without regard to this section).

"(2) FOR FAILURE TO SUBMIT REQUIRED REPORT.—

"(A) IN GENERAL.—If the Secretary determines that a State has not, within 6 months after the end of a fiscal year, submitted the report required by section 409 for the fiscal year, the Secretary shall reduce by 5 percent the amount of the grant that would (in the absence of this section) be payable to the State under section 403 for the immediately succeeding fiscal year.

"(B) RESCISSION OF PENALTY.—The Secretary shall rescind a penalty imposed on a State under subparagraph (A) with respect to a report for a fiscal year if the State submits the report before the end of the immediately succeeding fiscal year.

"(3) FOR FAILURE TO SATISFY MINIMUM PARTICIPATION RATES.—

"(A) IN GENERAL.—If the Secretary determines that a State has failed to satisfy the minimum participation rates specified in section 404(a) for a fiscal year, the Secretary shall reduce the amount of the grant that would (in the absence of this section) be payable to the State under section 403 for the immediately succeeding fiscal year by—

"(i) in the first year in which the State fails to satisfy such rates, 5 percent; and

"(ii) in subsequent years in which the State fails to satisfy such rates, the percent reduction determined under this subparagraph (if any) in the preceding year, increased by 5 percent.

"(B) PENALTY BASED ON SEVERITY OF FAILURE.—The Secretary shall impose reductions under subparagraph (A) on the basis of the degree of noncompliance.

"(4) FOR FAILURE TO PARTICIPATE IN THE INCOME AND ELIGIBILITY VERIFICATION SYSTEM.—If the Secretary determines that a State program funded under this part is not participating during a fiscal year in the income and eligibility verification system required by section 1137, the Secretary shall reduce by not more than 5 percent the amount of the grant that would (in the absence of this section) be payable to the State under section 403 for the immediately succeeding fiscal year.

"(5) FOR FAILURE TO COMPLY WITH PATERNITY ESTABLISHMENT AND CHILD SUPPORT ENFORCEMENT REQUIREMENTS UNDER PART D.—Notwithstanding any other provision of this Act, if the Secretary determines that the State agency that administers a program funded under this part does not enforce the penalties requested by the agency administering part D against recipients of assistance under the State program who

fail to cooperate in establishing paternity in accordance with such part, the Secretary shall reduce by not more than 5 percent the amount of the grant that would (in the absence of this section) be payable to the State under section 403 for the immediately succeeding fiscal year.

"(6) FOR FAILURE TO TIMELY REPAY A FEDERAL LOAN FUND FOR STATE WELFARE PROGRAMS.—If the Secretary determines that a State has failed to repay any amount borrowed from the Federal Loan Fund for State Welfare Programs established under section 403(d) within the period of maturity applicable to such loan, plus any interest owed on such loan, then the Secretary shall reduce the amount of the grant otherwise payable to the State under section 403 for the immediately succeeding fiscal year quarter by the outstanding loan amount, plus the interest owed on such outstanding amount. The Secretary may not forgive any outstanding loan amount nor interest owed thereon.

"(b) REQUIREMENTS.—

"(1) LIMITATION ON AMOUNT OF PENALTY.—

"(A) IN GENERAL.—In imposing the penalties described in subsection (a), the Secretary shall not reduce any quarterly payment to a State by more than 25 percent.

"(B) CARRYFORWARD OF UNRECOVERED PENALTIES.—To the extent that subparagraph (A) prevents the Secretary from recovering during a fiscal year the full amount of all penalties imposed on a State under subsection (a) for a prior fiscal year, the Secretary shall apply any remaining amount of such penalties to the grant otherwise payable to the State under section 403 for the immediately succeeding fiscal year.

"(2) STATE FUNDS TO REPLACE REDUCTIONS IN GRANT.—A State which has a penalty imposed against it under subsection (a) shall expend additional State funds in an amount equal to the amount of the penalty for the purpose of providing assistance under the State program under this part.

"(3) REASONABLE CAUSE FOR NONCOMPLIANCE.—The Secretary may not impose a penalty on a State under subsection (a) if the Secretary determines that the State has reasonable cause for failing to comply with a requirement for which a penalty is imposed under such subsection.

"(c) CERTIFICATION OF AMOUNT OF PENALTIES.—If the Secretary is required to reduce the amount of any grant under this section, the Secretary shall certify the amount of such reduction to the Secretary of the Treasury and the Secretary of the Treasury shall reduce the amount paid to the State under section 403 by such amount.

"(d) EFFECTIVE DATES.—

"(1) IN GENERAL.—The penalties described in paragraphs (2) through (6) of subsection (a) shall apply—

"(A) with respect to periods beginning 6 months after the Secretary issues final rules with respect to such penalties; or

"(B) with respect to fiscal years beginning on or after October 1, 1996;

whichever is later.

"(2) MISUSE OF FUNDS.—The penalties described in subsection (a)(1) shall apply with respect to fiscal years beginning on or after October 1, 1995.

"SEC. 408. AUDITS.

"(a) IN GENERAL.—Each State shall, not less than annually, audit the State expenditures from amounts received under this part. Such audit shall—

"(1) determine the extent to which such expenditures were or were not expended in accordance with this part; and

"(2) be conducted by an approved entity (as defined in subsection (b)) in accordance with generally accepted auditing principles.

"(b) APPROVED ENTITY.—For purposes of subsection (a), the term 'approved entity' means an entity that—

"(1) is approved by the Secretary of the Treasury;

"(2) is approved by the chief executive officer of the State; and

"(3) is independent of any agency administering activities funded under this part.

"(c) AUDIT REPORT.—Not later than 30 days following the completion of an audit under this subsection, a State shall submit a copy of the audit to the State legislature, the Secretary of the Treasury, and the Secretary of Health and Human Services.

"(d) ADDITIONAL ACCOUNTING REQUIREMENTS.—The provisions of chapter 75 of title 31, United States Code, shall apply to the audit requirements of this section.

"SEC. 409. DATA COLLECTION AND REPORTING.

"(a) IN GENERAL.—The Secretary, in consultation with State and local government officials and other interested persons, shall develop a quality assurance system of data collection and reporting that promotes accountability and ensures the improvement and integrity of programs funded under this part.

"(b) STATE SUBMISSIONS.—

"(1) IN GENERAL.—Not later than the 15th day of the first month of each calendar quarter, each State to which a grant is made under section 410(h) shall submit to the Secretary the data described in paragraphs (2) and (3) with respect to families described in paragraph (4).

"(2) DISAGGREGATED DATA DESCRIBED.—The data described in this paragraph with respect to families described in paragraph (4) is a sample of monthly disaggregated case record data containing the following:

"(A) The age of the adults and children (including pregnant women) in each family.

"(B) The marital and familial status of each member of the family (including whether the family is a 2-parent family and whether a child is living with an adult relative other than a parent).

"(C) The gender, educational level, work experience, and race of the head of each family.

"(D) The health status of each member of the family (including whether any member of the family is seriously

ill, disabled, or incapacitated and is being cared for by another member of the family).

"(E) The type and amount of any benefit or assistance received by the family, including—

"(i) the amount of and reason for any reduction in assistance, and

"(ii) if assistance is terminated, whether termination is due to employment, sanction, or time limit.

"(F) Any benefit or assistance received by a member of the family with respect to housing, food stamps, job training, or the Head Start program.

"(G) The number of months since the family filed the most recent application for assistance under the program and if assistance was denied, the reason for the denial.

"(H) The number of times a family has applied for and received assistance under the State program and the number of months assistance has been received each time assistance has been provided to the family.

"(I) The employment status of the adults in the family (including the number of hours worked and the amount earned).

"(J) The date on which an adult in the family began to engage in work, the number of hours the adult engaged in work, the work activity in which the adult participated, and the amount of child care assistance provided to the adult (if any).

"(K) The number of individuals in each family receiving assistance and the number of individuals in each family not receiving assistance, and the relationship of each individual to the youngest child in the family.

"(L) The citizenship status of each member of the family.

"(M) The housing arrangement of each member of the family.

"(N) The amount of unearned income, child support, assets, and other financial factors considered in determining eligibility for assistance under the State program.

"(O) The location in the State of each family receiving assistance.

"(P) Any other data that the Secretary determines is necessary to ensure efficient and effective program administration.

"(3) AGGREGATED MONTHLY DATA.—The data described in this paragraph is the following aggregated monthly data with respect to the families described in paragraph (4):

"(A) The number of families.

"(B) The number of adults in each family.

"(C) The number of children in each family.

"(D) The number of families for which assistance has been terminated because of employment, sanctions, or time limits.

"(4) FAMILIES DESCRIBED.—The families described in this paragraph are—

"(A) families receiving assistance under a State program funded under this part for each month in the calendar quarter preceding the calendar quarter in which the data is submitted;

"(B) families applying for such assistance during such preceding calendar quarter; and

"(C) families that became ineligible to receive such assistance during such preceding calendar quarter.

"(5) APPROPRIATE SUBSETS OF DATA COLLECTED.—The Secretary shall determine appropriate subsets of the data described in paragraphs (2) and (3) that a State is required to submit under paragraph (1) with respect to families described in subparagraphs (B) and (C) of paragraph (4).

"(6) SAMPLING AND OTHER METHODS.—The Secretary shall provide the States with such case sampling plans and data collection procedures as the Secretary deems necessary to produce statistically valid estimates of each State's program performance. The Secretary is authorized to develop and implement procedures for verifying the quality of data submitted by the States.

"(c) REPORT ON USE OF FEDERAL FUNDS TO COVER ADMINISTRATIVE COSTS AND OVERHEAD.—The report required by subsection (a) for a fiscal year shall include a statement of—

"(1) the total amount and percentage of the Federal funds paid to the State under this part for the fiscal year that are used to cover administrative costs or overhead; and

"(2) the total amount of State funds that are used to cover such costs or overhead.

"(d) REPORT ON STATE EXPENDITURES ON PROGRAMS FOR NEEDY FAMILIES.—The report required by subsection (a) for a fiscal year shall include a statement of the total amount expended by the State during the fiscal year on the program under this part and the purposes for which such amount was spent.

"(e) REPORT ON NONCUSTODIAL PARENTS PARTICIPATING IN WORK ACTIVITIES.—The report required by subsection (a) for a fiscal year shall include the number of noncustodial parents in the State who participated in work activities during the fiscal year.

"(f) REPORT ON CHILD SUPPORT COLLECTED.—The report required by subsection (a) for a fiscal year shall include the total amount of child support collected by the State agency administering the State program under part D on behalf of a family receiving assistance under this part.

"(g) REPORT ON CHILD CARE.—The report required by subsection (a) for a fiscal year shall include the total amount expended by the State for child care under the program under this part, along with a description of the types of child care provided, including child care provided in the case of a family that—

"(1) has ceased to receive assistance under this part because of employment; or

"(2) is not receiving assistance under this part but would be at risk of becoming eligible for such assistance if child care was not provided.

"(h) REPORT ON TRANSITIONAL SERVICES.—The report required by subsection (a) for a fiscal year shall include the total amount ex-

pended by the State for providing transitional services to a family that has ceased to receive assistance under this part because of employment, along with a description of such services.

"(i) SECRETARY'S REPORT ON DATA PROCESSING.—

"(1) IN GENERAL.—Not later than 6 months after the date of the enactment of the Work Opportunity Act of 1995, the Secretary shall prepare and submit to the Congress a report on—

"(A) the status of the automated data processing systems operated by the States to assist management in the administration of State programs under this part (whether in effect before or after October 1, 1995); and

"(B) what would be required to establish a system capable of—

"(i) tracking participants in public programs over time; and

"(ii) checking case records of the States to determine whether individuals are participating in public programs in 2 or more States.

"(2) PREFERRED CONTENTS.—The report required by paragraph (1) should include—

"(A) a plan for building on the automated data processing systems of the States to establish a system with the capabilities described in paragraph (1)(B); and

"(B) an estimate of the amount of time required to establish such a system and of the cost of establishing such a system.

"(j) REPORT TO CONGRESS.—Not later than 6 months after the end of fiscal year 1997, and each fiscal year thereafter, the Secretary shall transmit to the Congress a report describing—

"(1) whether the States are meeting—

"(A) the participation rates described in section 404(a); and

"(B) the objectives of—

"(i) increasing employment and earnings of needy families, and child support collections; and

"(ii) decreasing out-of-wedlock pregnancies and child poverty;

"(3) the demographic and financial characteristics of families applying for assistance, families receiving assistance, and families that become ineligible to receive assistance;

"(4) the characteristics of each State program funded under this part; and

"(5) the trends in employment and earnings of needy families with minor children.

"SEC. 410. RESEARCH, EVALUATIONS, AND NATIONAL STUDIES.

"(a) RESEARCH.—The Secretary shall conduct research on the benefits, effects, and costs of operating different State programs funded under this part, including time limits relating to eligibility for assistance. The research shall include studies on the effects of different programs and the operation of such programs on welfare dependency, illegitimacy, teen pregnancy, employment rates, child well-being, and any other area the Secretary deems appropriate.

"(b) DEVELOPMENT AND EVALUATION OF INNOVATIVE APPROACHES TO REDUCING WELFARE DEPENDENCY AND INCREASING CHILD WELL-BEING.—

"(1) IN GENERAL.—The Secretary may assist States in developing, and shall evaluate, innovative approaches for reducing welfare dependency and increasing the well-being of minor children with respect to recipients of assistance under programs funded under this part. The Secretary may provide funds for training and technical assistance to carry out the approaches developed pursuant to this paragraph.

"(2) EVALUATIONS.—In performing the evaluations under paragraph (1), the Secretary shall, to the maximum extent feasible, use random assignment as an evaluation methodology.

"(c) DISSEMINATION OF INFORMATION.—The Secretary shall develop innovative methods of disseminating information on any research, evaluations, and studies conducted under this section, including the facilitation of the sharing of information and best practices among States and localities through the use of computers and other technologies.

"(d) ANNUAL RANKING OF STATES AND REVIEW OF MOST AND LEAST SUCCESSFUL WORK PROGRAMS.—

"(1) ANNUAL RANKING OF STATES.—The Secretary shall rank annually the States to which grants are paid under section 403 in the order of their success in placing recipients of assistance under the State program funded under this part into long-term private sector jobs, reducing the overall welfare caseload, and, when a practicable method for calculating this information becomes available, diverting individuals from formally applying to the State program and receiving assistance. In ranking States under this subsection, the Secretary shall take into account the average number of minor children in families in the State that have incomes below the poverty line and the amount of funding provided each State for such families.

"(2) ANNUAL REVIEW OF MOST AND LEAST SUCCESSFUL WORK PROGRAMS.—The Secretary shall review the programs of the 3 States most recently ranked highest under paragraph (1) and the 3 States most recently ranked lowest under paragraph (1) that provide parents with work experience, assistance in finding employment, and other work preparation activities and support services to enable the families of such parents to leave the program and become self-sufficient.

"(e) ANNUAL RANKING OF STATES AND REVIEW OF ISSUES RELATING TO OUT-OF-WEDLOCK BIRTHS.—

"(1) ANNUAL RANKING OF STATES.—

"(A) IN GENERAL.—The Secretary shall annually rank States to which grants are paid under section 403 based on the following ranking factors (developed with information reported by the State under section 406(f)):

"(i) ABSOLUTE OUT-OF-WEDLOCK RATIOS.—The ratio represented by—

"(I) the total number of out-of-wedlock births in families receiving assistance under the State program under this part in the State for the most

recent fiscal year for which information is available; over

"(II) the total number of births in families receiving assistance under the State program under this part in the State for such year.

"(ii) NET CHANGES IN THE OUT-OF-WEDLOCK RATIO.—The difference between the ratio described in subparagraph (A)(i) for the most recent fiscal year for which information is available and such State's ratio determined for the preceding year.

"(2) ANNUAL REVIEW.—The Secretary shall review the programs of the 5 States most recently ranked highest under paragraph (1) and the 5 States most recently ranked the lowest under paragraph (1).

"(f) STUDY ON ALTERNATIVE OUTCOMES MEASURES.—

"(1) STUDY.—The Secretary shall, in cooperation with the States, study and analyze outcomes measures for evaluating the success of a State in moving individuals out of the welfare system through employment as an alternative to the minimum participation rates described in section 404. The study shall include a determination as to whether such alternative outcomes measures should be applied on a national or a State-by-State basis and a preliminary assessment of the job placement performance bonus established under section 403(f).

"(2) REPORT.—Not later than September 30, 1998, the Secretary shall submit to the Committee on Finance of the Senate and the Committee on Ways and Means of the House of Representatives a report containing the findings of the study described in paragraph (1).

"(g) STATE-INITIATED STUDIES.—A State shall be eligible to receive funding to evaluate the State's family assistance program funded under this part if—

"(1) the State submits a proposal to the Secretary for such evaluation,

"(2) the Secretary determines that the design and approach of the evaluation is rigorous and is likely to yield information that is credible and will be useful to other States, and

"(3) unless otherwise waived by the Secretary, the State provides a non-Federal share of at least 10 percent of the cost of such study.

"(h) ADDITIONAL AMOUNT FOR STUDIES AND DEMONSTRATIONS.—

"(1) IN GENERAL.—There are authorized to be appropriated and there are appropriated for each fiscal year described in section 403(a)(1) an additional $20,000,000 for the purpose of paying—

"(A) the Federal share of any State-initiated study approved under subsection (g);

"(B) an amount determined by the Secretary to be necessary to operate and evaluate demonstration projects, relating to part A of title IV of this Act, that are in effect or approved under section 1115 as of October 1, 1995, and are continued after such date;

"(C) the cost of conducting the research described in subsection (a); and

"(D) the cost of developing and evaluating innovative approaches for reducing welfare dependency and increasing the well-being of minor children under subsection (b).

"(2) ALLOCATION.—Of the amount appropriated under paragraph (1) for a fiscal year—

"(A) 50 percent shall be allocated for the purposes described in subparagraphs (A) and (B) of paragraph (1), and

"(B) 50 percent shall be allocated for the purposes described in subparagraphs (C) and (D) of paragraph (1).

"SEC. 411. STUDY BY THE CENSUS BUREAU.

"(a) IN GENERAL.—The Bureau of the Census shall expand the Survey of Income and Program Participation as necessary to obtain such information as will enable interested persons to evaluate the impact of the amendments made by the Work Opportunity Act of 1995 on a random national sample of recipients of assistance under State programs funded under this part and (as appropriate) other low-income families, and in doing so, shall pay particular attention to the issues of out-of-wedlock births, welfare dependency, the beginning and end of welfare spells, and the causes of repeat welfare spells.

"(b) APPROPRIATION.—Out of any money in the Treasury of the United States not otherwise appropriated, the Secretary of the Treasury shall pay to the Bureau of the Census $10,000,000 for each of fiscal years 1996, 1997, 1998, 1999, and 2000 to carry out subsection (a).

"SEC. 412. WAIVERS.

"(a) CONTINUATION OF WAIVERS.—

"(1) IN GENERAL.—Except as provided in paragraph (2), if any waiver granted to a State under section 1115 or otherwise which relates to the provision of assistance under a State plan under this part is in effect or approved by the Secretary as of October 1, 1995, the amendments made by subtitle D of title I and subtitles C, D, E, F, and G of title VII of the Balanced Budget Reconciliation Act of 1995 shall not apply with respect to the State before the expiration (determined without regard to any extensions) of the waiver to the extent such amendments are inconsistent with the terms of the waiver.

"(2) FINANCING LIMITATION.—Notwithstanding any other provision of law, beginning with fiscal year 1996, a State operating under a waiver described in paragraph (1) shall receive the payment described for such State for such fiscal year under section 403, in lieu of any other payment provided for in the waiver.

"(b) STATE OPTION TO TERMINATE WAIVER.—

"(1) IN GENERAL.—A State may terminate a waiver described in subsection (a) before the expiration of the waiver.

"(2) REPORT.—A State which terminates a waiver under paragraph (1) shall submit a report to the Secretary summarizing the waiver and any available information concerning the result or effect of such waiver.

"(3) HOLD HARMLESS PROVISION.—

"(A) IN GENERAL.—Notwithstanding any other provision of law, a State that, not later than the date described in subparagraph (B), submits a written request to terminate a waiver described in subsection (a) shall be held harmless for accrued cost neutrality liabilities incurred under the terms and conditions of such waiver.

"(B) DATE DESCRIBED.—The date described in this subparagraph is the later of—

"(i) January 1, 1996; or

"(ii) 90 days following the adjournment of the first regular session of the State legislature that begins after the date of the enactment of the Work Opportunity Act of 1995.

"(c) SECRETARIAL ENCOURAGEMENT OF CURRENT WAIVERS.—The Secretary shall encourage any State operating a waiver described in subsection (a) to continue such waiver and to evaluate, using random sampling and other characteristics of accepted scientific evaluations, the result or effect of such waiver.

"(d) CONTINUATION OF INDIVIDUAL WAIVERS.—A State may elect to continue one or more individual waivers described in subsection (a)(1).

"SEC. 413. STATE AND COUNTY DEMONSTRATION PROGRAMS.

"(a) NO LIMITATION OF STATE DEMONSTRATION PROJECTS.—Nothing in this part shall be construed as limiting a State's ability to conduct demonstration projects for the purpose of identifying innovative or effective program designs in 1 or more political subdivisions of the State: *Provided,* That such State contains more than one county with a population of greater than 500,000.

"(b) COUNTY WELFARE DEMONSTRATION PROJECT.—

"(1) IN GENERAL.—The Secretary of Health and Human Services and the Secretary of Agriculture shall jointly enter into negotiations with all counties having a population greater than 500,000 desiring to conduct a demonstration project described in paragraph (2) for the purpose of establishing appropriate rules to govern the establishment and operation of such project.

"(2) DEMONSTRATION PROJECT DESCRIBED.—The demonstration project described in this paragraph shall provide that—

"(A) a county participating in the demonstration project shall have the authority and duty to administer the operation of the program described under this part as if the county were considered a State for the purpose of this part;

"(B) the State in which the county participating in the demonstration project is located shall pass through directly to the county the portion of the grant received by the State under section 403 which the State determines is attributable to the residents of such county; and

"(C) the duration of the project shall be for 5 years.

"(3) COMMENCEMENT OF PROJECT.—After the conclusion of the negotiations described in paragraph (2), the Secretary of Health and Human Services and the Secretary of Agriculture may authorize a county to conduct the demonstration project

described in paragraph (2) in accordance with the rules established during the negotiations.

"(4) REPORT.—Not later then 6 months after the termination of a demonstration project operated under this subsection, the Secretary of Health and Human Services and the Secretary of Agriculture shall submit to the Congress a report that includes—

"(A) a description of the demonstration project;

"(B) the rules negotiated with respect to the project; and

"(C) the innovations (if any) that the county was able to initiate under the project.

"(5) ELIGIBLE COUNTY.—A county may participate in a demonstration project under this subsection if the county is—

"(A) a county that is already administering the welfare program under this part;

"(B) represents less than 25 percent of the State's total welfare caseload.

"SEC. 414. DIRECT FUNDING AND ADMINISTRATION BY INDIAN TRIBES.

"(a) PURPOSE.—The purpose of this section is—

"(1) to strengthen and enhance the control and flexibility of local governments over local programs; and

"(2) in recognition of the principles contained in the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.)—

"(A) to provide direct Federal funding to Indian tribes for the tribal administration of the program funded under this part; or

"(B) to enable Indian tribes to enter into agreements, contracts, or compacts with intertribal consortia, States, or other entities for the administration of such program on behalf of the Indian tribe.

"(b) GRANT AMOUNTS FOR INDIAN TRIBES.—

"(1) IN GENERAL.—For each of fiscal years 1996, 1997, 1998, 1999, and 2000, the Secretary shall pay to each Indian tribe that has an approved tribal family assistance plan a tribal family assistance grant for the fiscal year in an amount equal to the amount determined under paragraph (2).

"(2) AMOUNT DETERMINED.—

"(A) IN GENERAL.—The amount determined under this paragraph is an amount equal to the total amount of the Federal payments to a State or States under section 403 for fiscal year 1994 (as in effect during such fiscal year) attributable to expenditures by the State or States under part A and part F of this title (as so in effect) in such year for Indian families residing in the service area or areas identified by the Indian tribe in subsection (c)(1)(C).

"(B) USE OF STATE SUBMITTED DATA.—

"(i) IN GENERAL.—The Secretary shall use State submitted data to make each determination under subparagraph (A).

"(ii) DISAGREEMENT WITH DETERMINATION.—If an Indian tribe or tribal organization disagrees with

State submitted data described under clause (i), the Indian tribe or tribal organization may submit to the Secretary such additional information as may be relevant to making the determination under subparagraph (A) and the Secretary may consider such information before making such determination.

"(c) 3-YEAR TRIBAL FAMILY ASSISTANCE PLAN.—

"(1) IN GENERAL.—Any Indian tribe that desires to receive a tribal family assistance grant shall submit to the Secretary a 3-year tribal family assistance plan that—

"(A) outlines the Indian tribe's approach to providing welfare-related services for the 3-year period, consistent with the purposes of this section;

"(B) specifies whether the welfare-related services provided under the plan will be provided by the Indian tribe or through agreements, contracts, or compacts with intertribal consortia, States, or other entities;

"(C) identifies the population and service area or areas to be served by such plan;

"(D) provides that a family receiving assistance under the plan may not receive duplicative assistance from other State or tribal programs funded under this part;

"(E) identifies the employment opportunities in or near the service area or areas of the Indian tribe and the manner in which the Indian tribe will cooperate and participate in enhancing such opportunities for recipients of assistance under the plan consistent with any applicable State standards; and

"(F) applies the fiscal accountability provisions of section 5(f)(1) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450c(f)(1)), relating to the submission of a single-agency audit report required by chapter 75 of title 31, United States Code.

"(2) APPROVAL.—The Secretary shall approve each tribal family assistance plan submitted in accordance with paragraph (1).

"(3) CONSORTIUM OF TRIBES.—Nothing in this section shall preclude the development and submission of a single plan by the participating Indian tribes of an intertribal consortium.

"(d) MINIMUM WORK PARTICIPATION REQUIREMENTS AND TIME LIMITS.—The Secretary, with the participation of Indian tribes, shall establish for each Indian tribe receiving a grant under this section minimum work participation requirements, appropriate time limits for receipt of welfare-related services under such grant, and penalties against individuals—

"(1) consistent with the purposes of this section;

"(2) consistent with the economic conditions and resources available to each tribe; and

"(3) similar to comparable provisions in section 404(d).

"(e) EMERGENCY ASSISTANCE.—Nothing in this section shall preclude an Indian tribe from seeking emergency assistance from any Federal loan program or emergency fund.

"(f) ACCOUNTABILITY.—Nothing in this section shall be construed to limit the ability of the Secretary to maintain program funding accountability consistent with—

"(1) generally accepted accounting principles; and

"(2) the requirements of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450 et seq.).

"(g) TRIBAL PENALTIES.—For the purpose of ensuring the proper use of tribal family assistance grants, the following provisions shall apply to an Indian tribe with an approved tribal assistance plan:

"(1) The provisions of subsections (a)(1), (a)(6), and (b) of section 407, in the same manner as such subsections apply to a State.

"(2) The provisions of section 407(a)(3), except that such subsection shall be applied by substituting 'the minimum requirements established under subsection (d) of section 414' for 'the minimum participation rates specified in section 404'.

"(h) DATA COLLECTION AND REPORTING.—For the purpose of ensuring uniformity in data collection, section 409 shall apply to an Indian tribe with an approved tribal family assistance plan.

"(i) SPECIAL RULE FOR INDIAN TRIBES IN ALASKA.—

"(1) IN GENERAL.—Notwithstanding any other provision of this section, and except as provided in paragraph (2), an Indian tribe in the State of Alaska that receives a tribal family assistance grant under this section shall use such grant to operate a program in accordance with the requirements applicable to the program of the State of Alaska funded under this part.

"(2) WAIVER.—An Indian tribe described in paragraph (1) may apply to the appropriate State authority to receive a waiver of the requirement of paragraph (1).

"SEC. 415. ASSISTANT SECRETARY FOR FAMILY SUPPORT.

"The programs under this part and part D of this title shall be administered by an Assistant Secretary for Family Support within the Department of Health and Human Services, who shall be appointed by the President, by and with the advice and consent of the Senate, and who shall be in addition to any other Assistant Secretary of Health and Human Services provided for by law.

"SEC. 416. LIMITATION ON FEDERAL AUTHORITY.

"The Secretary of Health and Human Services and the Secretary of the Treasury may not regulate the conduct of States under this part or enforce any provision of this part, except to the extent expressly provided in this part.

"SEC. 417. APPEAL OF ADVERSE DECISION.

"(a) IN GENERAL.—The Secretary shall notify the chief executive officer of a State of any adverse decision or action under this part, including any decision with respect to the State's plan or the imposition of a penalty under section 407.

"(b) ADMINISTRATIVE REVIEW OF ADVERSE DECISION.—

"(1) IN GENERAL.—Within 60 days after the date a State receives notice of an adverse decision under this section, the State may appeal the decision, in whole or in part, to the Departmental Appeals Board established in the Department of

Health and Human Services (hereafter referred to in this section as the 'Board') by filing an appeal with the Board.

"(2) PROCEDURAL RULES.—The Board shall consider a State's appeal on the basis of such documentation as the State may submit and as the Board may require to support the final decision of the Board. In deciding whether to uphold an adverse decision or any portion thereof, the Board shall conduct a thorough review of the issues and take into account all relevant evidence. The Board shall make a final determination with respect to an appeal filed under this paragraph not less than 60 days after the date the appeal is filed.

"(c) JUDICIAL REVIEW OF ADVERSE DECISION.—

"(1) IN GENERAL.—Within 90 days after the date of a final decision by the Board with respect to an adverse decision regarding a State under this section, the State may obtain judicial review of the final decision (and the findings incorporated into the final decision) by filing an action in—

"(A) the district court of the United States for the judicial district in which the principal or headquarters office of the State agency is located; or

"(B) the United States District Court for the District of Columbia.

"(2) PROCEDURAL RULES.—The district court in which an action is filed shall review the final decision of the Board on the record established in the administrative proceeding, in accordance with the standards of review prescribed by subparagraphs (A) through (E) of section 706(2) of title 5, United States Code. The review shall be on the basis of the documents and supporting data submitted to the Board.

"SEC. 418. PERFORMANCE BONUS AND HIGH PERFORMANCE BONUS.

"(a) IN GENERAL.—

"(1) PERFORMANCE BONUS.—In addition to the State family assistance grant, for fiscal year 2000, the Secretary shall pay to each qualified State an amount equal to the State's share of the performance bonus fund described in paragraph (3).

"(2) QUALIFIED STATE.—For purposes of this subsection, the term 'qualified State' means a State that during the measurement period—

"(A) exceeds the overall average performance achieved by all States with respect to a measurement category, or

"(B) improves the State's performance in a measurement category by at least 15 percent over the State's baseline period.

"(3) BONUS FUND.—The amount of the bonus fund for fiscal year 2000 shall be an amount equal to 5 percent of the amount appropriated under section 403(a)(2)(A)(i) for such fiscal year.

"(b) HIGH PERFORMANCE BONUS.—

"(1) IN GENERAL.—In addition to the amount provided under subsection (a), each of the 10 high performance States in each measurement category shall be entitled to receive a share of the high performance bonus fund described in paragraph (3).

"(2) HIGH PERFORMANCE STATES.—For purposes of this subsection, the term 'high performance States' means with respect

to each measurement category during the measurement period—

"(A) the 5 States that have the highest percentage of improvement with respect to the State's performance in the measurement category over the State's baseline period; and

"(B) the 5 States that have the highest overall average performance with respect to the measurement category.

"(3) HIGH PERFORMANCE BONUS FUND.—There are authorized to be appropriated and there are appropriated the amount of the high performance bonus fund for fiscal year 2000 equal to the amount of the reduction in State family assistance grants for all States for fiscal years 1996, 1997, 1998, and 1999 resulting from the application of section 407 (other than subsection (a)(6) thereof).

"(c) DEFINITIONS AND SPECIAL RULES.— For purposes of this section:

"(1) MEASUREMENT CATEGORY.—A measurement category means any of the following categories:

"(A) A reduction in the average length of time families in the State receive assistance during a fiscal year under the State program funded under this part.

"(B) An increase in the percentage of families receiving such assistance under this part that receive child support payments under part D.

"(C) An increase in the number of families that received assistance under a State program funded under this part in the preceding fiscal year that became ineligible for assistance under the State program as a result of unsubsidized employment during such year.

"(D) An increase in the amount earned by families that receive assistance under this part.

"(E) A reduction in the percentage of families that become eligible for assistance under this part within 18 months after becoming ineligible for such assistance.

"(2) MEASUREMENT PERIOD; BASELINE PERIOD.—

"(A) MEASUREMENT PERIOD.—The term 'measurement period' means the period beginning not later than 6 months after the date of the enactment of the Work Opportunity Act of 1995 and ending on September 30, 1999.

"(B) BASELINE PERIOD.—The term 'baseline period' means fiscal year 1994.

"(3) ALLOCATION FORMULA.—For purposes of determining a State's share of the performance bonus fund under subsection (a)(1), and the State's share of the high performance bonus fund under subsection (b)(1), the Secretary shall, not later than June 30, 1999, develop and publish in the Federal Register a formula for allocating amounts in the performance bonus fund to qualified States and a formula for allocating amounts in the high performance bonus fund to high performance States. Such formulas shall be based on each State's proportional share of the total amount appropriated under section 403(a)(2)(A) for fiscal year 2000.

"SEC. 419. AMOUNTS FOR CHILD CARE.

"(a) CHILD CARE ALLOCATION.—

"(1) IN GENERAL.—From the amount appropriated under section 403(a)(4)(A) for a fiscal year, the Secretary shall set aside an amount equal to the total amount of the Federal payments for fiscal year 1994 to States under section—

"(A) 402(g)(3)(A) of this Act (as such section was in effect before October 1, 1995) for amounts expended for child care pursuant to paragraph (1) of such section;

"(B) 403(l)(1)(A) of this Act (as so in effect) for amounts expended for child care pursuant to section 402(g)(1)(A) of this Act (as so in effect), in the case of a State with respect to which section 1108 of this Act applies; and

"(C) 403(n) of this Act (as so in effect) for child care services pursuant to section 402(i) of this Act (as so in effect).

"(2) DISTRIBUTION.—From amounts set aside for a fiscal year under paragraph (1), the Secretary shall pay to a State an amount equal to the total amounts of Federal payments for fiscal year 1994 to the State under section—

"(A) 402(g)(3)(A) of this Act (as such section was in effect before October 1, 1995) for amounts expended for child care pursuant to paragraph (1) of such section;

"(B) 403(l)(1)(A) of this Act (as so in effect) for amounts expended for child care pursuant to section 402(g)(1)(A) of this Act (as so in effect), in the case of a State with respect to which section 1108 of this Act applies; and

"(C) 403(n) of this Act (as so in effect) for child care services pursuant to section 402(i) of this Act (as so in effect).

"(3) USE OF FUNDS.—Amounts received by a State under paragraph (2) shall only be used to provide child care assistance under this part.

"(4) FEDERAL PAYMENTS.—For purposes of paragraphs (1) and (2), Federal payments for fiscal year 1994 means such payments as reported by the State on February 14, 1995.

"(b) ADDITIONAL APPROPRIATION.—

"(1) IN GENERAL.—There are authorized to be appropriated and there are appropriated, $3,000,000,000 to be distributed to the States during the 5-fiscal year period beginning in fiscal year 1996 for the provision of child care assistance.

"(2) DISTRIBUTION.—

"(A) IN GENERAL.—The Secretary shall use amounts made available under paragraph (1) to make grants to States. The total amount of grants awarded to a State under this paragraph shall be based on the formula used for determining the amount of Federal payments to the State for fiscal year 1994 under section 403(n) (as such section was in effect before October 1, 1995) for child care services pursuant to section 402(i) (as so in effect) as such amount relates to the total amount of such Federal payments to all States for such fiscal year.

"(B) FISCAL YEAR 2000.—With respect to the last quarter of fiscal year 2000, if the Secretary determines that any allotment to a State under this subsection will not be used by such State for carrying out the purpose for which the allotment is available, the Secretary shall make such allotment available for carrying out such purpose to 1 or more other States which apply for such funds to the extent the Secretary determines that such other States will be able to use such additional allotments for carrying out such purpose. Such available allotments shall be reallocated to a State pursuant to section 402(i) (as such section was in effect before October 1, 1995) by substituting 'the number of children residing in all States applying for such funds' for 'the number of children residing in the United States in the second preceding fiscal year'. Any amount made available to a State from an appropriation for a fiscal year in accordance with the preceding sentence shall, for purposes of this part, be regarded as part of such State's payment (as determined under this subsection) for such year.

"(3) AMOUNT OF FUNDS.—The Secretary shall pay to each eligible State in a fiscal year an amount equal to the Federal medical assistance percentage for such State for such fiscal year (as defined in section 2122(c)) of so much of the expenditures by the State for child care in such year as exceed the State set-aside for such State under subsection (a) for such year and the amount of State expenditures in fiscal year 1994 that equal the non-Federal share for the programs described in subparagraphs (A), (B) and (C) of subsection (a)(1).

"(4) BUDGET SCORING.—Notwithstanding section 257(b)(2) of the Balanced Budget and Emergency Deficit Control Act of 1985, the baseline shall assume that no grant shall be made under this subsection after fiscal year 2000.

"(c) ADMINISTRATIVE PROVISIONS.—

"(1) STATE OPTION.—For purposes of section 402(a)(1)(B), a State may, at its option, not require a single parent with a child under the age of 6 to participate in work for more than an average of 20 hours per week during a month and may count such parent as being engaged in work for a month for purposes of section 404(c)(1) if such parent participates in work for an average of 20 hours per week during such month.

"(2) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to provide an entitlement to child care services to any child.

"SEC. 420. ELIGIBILITY FOR CHILD CARE ASSISTANCE.

Notwithstanding section 658T of the Child Care and Development Block Grant Act of 1990, the State agency specified in section 402(a)(7) shall determine eligibility for child care assistance provided under this part in accordance with criteria determined by the State.

"SEC. 421. COLLECTION OF OVERPAYMENTS FROM FEDERAL TAX REFUNDS.

"(a) IN GENERAL.—Upon receiving notice from the Secretary of Health and Human Services that a State agency administering a plan approved under this part has notified the Secretary that a named individual has been overpaid under the State plan approved under this part, the Secretary of the Treasury shall determine whether any amounts as refunds of Federal taxes paid are payable to such individual, regardless of whether such individual filed a tax return as a married or unmarried individual. If the Secretary of the Treasury finds that any such amount is payable, the Secretary hall withhold from such refunds an amount equal to the overpayment sought to be collected by the State and pay such amount to the State agency.

"(b) REGULATIONS.—The Secretary of the Treasury shall issue regulations, after review by the Secretary of Health and Human Services, that provide—

"(1) that a State may only submit under subsection (a) requests for collection of overpayments with respect to individuals—

"(A) who are no longer receiving assistance under the State plan approved under this part,

"(B) with respect to whom the State has already taken appropriate action under State law against the income or resources of the individuals or families involved to collect the past-due legally enforceable debt; and

"(C) to whom the State agency has given notice of its intent to request withholding by the Secretary of the Treasury from the income tax refunds of such individuals;

"(2) that the Secretary of the Treasury will give a timely and appropriate notice to any other person filing a joint return with the individual whose refund is subject to withholding under subsection (a); and

"(3) the procedures that the State and the Secretary of the Treasury will follow in carrying out this section which, to the maximum extent feasible and consistent with the specific provisions of this section, will be the same as those issued pursuant to section 464(b) applicable to collection of past-due child support.".

(c) CONFORMING AMENDMENTS RELATING TO COLLECTION OF OVERPAYMENTS.—

(1) Section 6402 of the Internal Revenue Code of 1986 (relating to authority to make credits or refunds) is amended—

(A) in subsection (a), by striking "(c) and (d)" and inserting "(c), (d), and (e)";

(B) by redesignating subsections (e) through (i) as subsections (f) through (j), respectively; and

(C) by inserting after subsection (d) the following:

"(e) COLLECTION OF OVERPAYMENTS UNDER TITLE IV–A OF THE SOCIAL SECURITY ACT.—The amount of any overpayment to be refunded to the person making the overpayment shall be reduced (after reductions pursuant to subsections (c) and (d), but before a credit against future liability for an internal revenue tax) in accordance with section 421 of the Social Security Act (concerning re-

covery of overpayments to individuals under State plans approved under part A of title IV of such Act).".

(2) Paragraph (10) of section 6103(*l*) of such Code is amended—

(A) by striking "(c) or (d)" each place it appears and inserting "(c), (d), or (e)"; and

(B) by adding at the end of subparagraph (B) the following new sentence: "Any return information disclosed with respect to section 6402(e) shall only be disclosed to officers and employees of the State agency requesting such information.".

(3) The matter preceding subparagraph (A) of section 6103(p)(4) of such Code is amended—

(A) by striking "(5), (10)" and inserting "(5)"; and

(B) by striking "(9), or (12)" and inserting "(9), (10), or (12)".

(4) Section 552a(a)(8)(B)(iv)(III) of title 5, United States Code, is amended by striking "section 464 or 1137 of the Social Security Act" and inserting "section 421, 464, or 1137 of the Social Security Act.".

SEC. 7202. SERVICES PROVIDED BY CHARITABLE, RELIGIOUS, OR PRIVATE ORGANIZATIONS.

(a) IN GENERAL.—

(1) STATE OPTIONS.—Notwithstanding any other provision of law, a State may—

(A) administer and provide services under the programs described in subparagraphs (A) and (B)(i) of paragraph (2) through contracts with charitable, religious, or private organizations; and

(B) provide beneficiaries of assistance under the programs described in subparagraphs (A) and (B)(ii) of paragraph (2) with certificates, vouchers, or other forms of disbursement which are redeemable with such organizations.

(2) PROGRAMS DESCRIBED.—The programs described in this paragraph are the following programs:

(A) A State program funded under part A of title IV of the Social Security Act (as amended by section 7201).

(B) Any other program that is established or modified under title I or III of this Act or this subtitle or subtitle D of this title that—

(i) permits contracts with organizations; or

(ii) permits certificates, vouchers, or other forms of disbursement to be provided to beneficiaries, as a means of providing assistance.

(b) RELIGIOUS ORGANIZATIONS.—The purpose of this section is to allow religious organizations to contract, or to accept certificates, vouchers, or other forms of disbursement under any program described in subsection (a)(2), on the same basis as any other provider without impairing the religious character of such organizations, and without diminishing the religious freedom of beneficiaries of assistance funded under such program.

(c) NONDISCRIMINATION AGAINST RELIGIOUS ORGANIZATIONS.—Religious organizations are eligible, on the same basis as any other private organization, as contractors to provide assistance, or to ac-

cept certificates, vouchers, or other forms of disbursement, under any program described in subsection (a)(2) so long as the programs are implemented consistent with the Establishment Clause of the United States Constitution. Neither the Federal Government nor a State receiving funds under such programs shall discriminate against an organization which is or applies to be a contractor to provide assistance, or which accepts certificates, vouchers, or other forms of disbursement, on the basis that the organization has a religious character.

(d) RELIGIOUS CHARACTER AND FREEDOM.—

(1) RELIGIOUS ORGANIZATIONS.—Notwithstanding any other provision of law, any religious organization with a contract described in subsection (a)(1)(A), or which accepts certificates, vouchers, or other forms of disbursement under subsection (a)(1)(B), shall retain its independence from Federal, State, and local governments, including such organization's control over the definition, development, practice, and expression of its religious beliefs.

(2) ADDITIONAL SAFEGUARDS.—Neither the Federal Government nor a State shall require a religious organization to—

(A) alter its form of internal governance; or

(B) remove religious art, icons, scripture, or other symbols;

in order to be eligible to contract to provide assistance, or to accept certificates, vouchers, or other forms of disbursement, funded under a program described in subsection (a)(2).

(e) RIGHTS OF BENEFICIARIES OF ASSISTANCE.—

(1) IN GENERAL.—If an individual described in paragraph (2) has an objection to the religious character of the organization or institution from which the individual receives, or would receive, assistance funded under any program described in subsection (a)(2), the State in which the individual resides shall provide such individual (if otherwise eligible for such assistance) with assistance from an alternative provider the value of which is not less than the value of the assistance which the individual would have received from such organization.

(2) INDIVIDUAL DESCRIBED.—An individual described in this paragraph is an individual who receives, applies for, or requests to apply for, assistance under a program described in subsection (a)(2).

(f) NONDISCRIMINATION IN EMPLOYMENT.—

(1) IN GENERAL.—Except as provided in paragraph (2), nothing in this section shall be construed to modify or affect the provisions of any other Federal or State law or regulation that relates to discrimination in employment on the basis of religion.

(2) EXCEPTION.—A religious organization with a contract described in subsection (a)(1)(A), or which accepts certificates, vouchers, or other forms of disbursement under subsection (a)(1)(B), may require that an employee rendering service pursuant to such contract, or pursuant to the organization's acceptance of certificates, vouchers, or other forms of disbursement adhere to—

(A) the religious tenets and teachings of such organization; and

(B) any rules of the organization regarding the use of drugs or alcohol.

(g) NONDISCRIMINATION AGAINST BENEFICIARIES.—Except as otherwise provided in law, a religious organization shall not discriminate against an individual in regard to rendering assistance funded under any program described in subsection (a)(2) on the basis of religion, a religious belief, or refusal to actively participate in a religious practice.

(h) FISCAL ACCOUNTABILITY.—

(1) IN GENERAL.—Except as provided in paragraph (2), any religious organization contracting to provide assistance funded under any program described in subsection (a)(2) shall be subject to the same regulations as other contractors to account in accord with generally accepted auditing principles for the use of such funds provided under such programs.

(2) LIMITED AUDIT.—If such organization segregates Federal funds provided under such programs into separate accounts, then only the financial assistance provided with such funds shall be subject to audit.

(i) COMPLIANCE.—A religious organization which has its rights under this section violated may enforce its claim exclusively by asserting a civil action for such relief as may be appropriate, including injunctive relief or damages, in an appropriate State court against the entity or agency that allegedly commits such violation.

SEC. 7203. LIMITATIONS ON USE OF FUNDS FOR CERTAIN PURPOSES.

No funds provided directly to institutions or organizations to provide services and administer programs described in section 7202(a)(2) and programs established or modified under subtitle D of title I of this Act, this subtitle, or subtitle D, E, F, or G of this title shall be expended for sectarian worship or instruction. This section shall not apply to financial assistance provided to or on behalf of beneficiaries of assistance in the form of certificates, vouchers, or other forms of disbursement, if such beneficiary may choose where such assistance shall be redeemed.

SEC. 7204. CENSUS DATA ON GRANDPARENTS AS PRIMARY CAREGIVERS FOR THEIR GRANDCHILDREN.

(a) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Commerce (hereafter in this section referred to as the "Secretary"), in carrying out the provisions of section 141 of title 13, United States Code, shall expand the data collection efforts of the Bureau of the Census (hereafter in this section referred to as the "Bureau") to enable the Bureau to collect statistically significant data, in connection with its decennial census and its mid-decade census, concerning the growing trend of grandparents who are the primary caregivers for their grandchildren.

(b) EXPANDED CENSUS QUESTION.—In carrying out the provisions of subsection (a), the Secretary shall expand the Bureau's census question that details households which include both grandparents and their grandchildren. The expanded question shall be formulated to distinguish between the following households:

(1) A household in which a grandparent temporarily provides a home for a grandchild for a period of weeks or months during periods of parental distress.

(2) A household in which a grandparent provides a home for a grandchild and serves as the primary caregiver for the grandchild.

SEC. 7205. STUDY OF EFFECT OF WELFARE REFORM ON GRANDPARENTS AS PRIMARY CAREGIVERS.

(a) IN GENERAL.—The Secretary of Health and Human Services (hereafter in this section referred to as the "Secretary") shall conduct a study evaluating the impact of amendments made by subtitle D of title I of this Act, this subtitle, and subtitles D, E, F, and G of this title on grandparents who have assumed the responsibility of providing care to their grandchildren. In such study, the Secretary shall identify barriers to participation in public programs including inconsistent policies, standards, and definitions used by programs and agencies in the administration of medicaid, assistance under a State program funded under part A of title IV of the Social Security Act, child support enforcement, and foster care programs on grandparents who have assumed the care-giving role for children whose natural parents are unable to provide care.

(b) REPORT.—Not later than December 31, 1997, the Secretary shall submit a report setting forth the findings of the study described in subsection (a) to the Committee on Ways and Means and the Committee on Economic and Educational Opportunities of the House of Representatives and the Committee on Finance, the Committee on Labor and Human Resources, and the Special Committee on Aging of the Senate. The report shall include such recommendations for administrative or legislative changes as the Secretary considers appropriate.

SEC. 7206. DEVELOPMENT OF PROTOTYPE OF COUNTERFEIT-RESISTANT SOCIAL SECURITY CARD REQUIRED.

(a) DEVELOPMENT.—

(1) IN GENERAL.—The Commissioner of Social Security (hereafter in this section referred to as the "Commissioner") shall in accordance with the provisions of this section develop a prototype of a counterfeit-resistant social security card. Such prototype card shall—

(A) be made of a durable, tamper-resistant material such as plastic or polyester,

(B) employ technologies that provide security features, such as magnetic stripes, holograms, and integrated circuits, and

(C) be developed so as to provide individuals with reliable proof of citizenship or legal resident alien status.

(2) ASSISTANCE BY ATTORNEY GENERAL.—The Attorney General of the United States shall provide such information and assistance as the Commissioner deems necessary to achieve the purposes of this section.

(b) STUDY AND REPORT.—

(1) IN GENERAL.—The Commissioner shall conduct a study and issue a report to Congress which examines different methods of improving the social security card application process.

(2) ELEMENTS OF STUDY.—The study shall include an evaluation of the cost and work load implications of issuing a counterfeit-resistant social security card for all individuals over a 3, 5, and 10 year period. The study shall also evaluate the feasibility and cost implications of imposing a user fee for replacement cards and cards issued to individuals who apply for such a card prior to the scheduled 3, 5, and 10 yea. phase-in options.

(3) DISTRIBUTION OF REPORT.—Copies of the report described in this subsection along with a facsimile of the prototype card as described in subsection (a) shall be submitted to the Committees on Ways and Means and Judiciary of the House of Representatives and the Committees on Finance and Judiciary of the Senate within 1 year of the date of the enactment of this Act.

SEC. 7207. DISCLOSURE OF RECEIPT OF FEDERAL FUNDS.

(a) IN GENERAL.—Whenever an organization that accepts Federal funds under subtitle D of title I of this Act, this subtitle, or subtitle D, E, F, or G of this title or the amendments made by such title or subtitles makes any communication that in any way intends to promote public support or opposition to any policy of a Federal, State, or local government through any broadcasting station, newspaper, magazine, outdoor advertising facility, direct mailing, or any other type of general public advertising, such communication shall state the following: "This was prepared and paid for by an organization that accepts taxpayer dollars.".

(b) FAILURE TO COMPLY.—If an organization makes any communication described in subsection (a) and fails to provide the statement required by that subsection, such organization shall be ineligible to receive Federal funds under subtitle D of title I of this Act, this subtitle, or subtitle D, E, F, or G of this title or the amendments made by such title and subtitles.

(c) DEFINITION.—For purposes of this section, the term "organization" means an organization described in section 501(c) of the Internal Revenue Code of 1986.

(d) EFFECTIVE DATES.—This section shall take effect—

(1) with respect to printed communications 1 year after the date of enactment of this Act; and

(2) with respect to any other communication on the date of enactment of this Act.

SEC. 7208. MODIFICATIONS TO THE JOB OPPORTUNITIES FOR CERTAIN LOW-INCOME INDIVIDUALS PROGRAM.

Section 505 of the Family Support Act of 1988 (42 U.S.C. 1315 note) is amended—

(1) in the heading, by striking "demonstration";

(2) by striking "demonstration" each place it appears;

(3) in subsection (a), by striking "in each of fiscal years" and all that follows through "10" and inserting "shall enter into agreements with";

(4) in subsection (b)(3), by striking "aid to families with dependent children under part A of title IV of the Social Security Act" and inserting "assistance under the State program funded

under part A of title IV of the Social Security Act in the State in which the individual resides";

(5) in subsection (c)—

(A) in paragraph (1)(C), by striking "aid to families with dependent children under part A of title IV of the Social Security Act" and inserting "assistance under the State program funded under part A of title IV of the Social Security Act";

(B) in paragraph (2), by striking "aid to families with dependent children under title IV of such Act" and inserting "assistance under the State program funded under part A of title IV of the Social Security Act";

(6) in subsection (d), by striking "job opportunities and basic skills training program (as provided for under title IV of the Social Security Act" and inserting "the State program funded under part A of title IV of the Social Security Act"; and

(7) by striking subsections (e) through (g) and inserting the following:

"(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of conducting projects under this section, there is authorized to be appropriated an amount not to exceed $25,000,000 for any fiscal year.".

SEC. 7209. DEMONSTRATION PROJECTS FOR SCHOOL UTILIZATION.

(a) FINDINGS.—It is the goal of the United States that children grow to be self-sufficient citizens, that parents equip themselves to provide the best parental care and guidance to their children, and that welfare dependency, crime, and the deterioration of neighborhoods be eliminated. It will contribute to these goals to increase the level of parents' involvement in their children's school and other activities, to increase the amount of time parents spend with or in close proximity to their children, to increase the portion of the day and night when children are in a safe and healthy environment and not exposed to unfavorable influences, to increase the opportunities for children to participate in safe, healthy, and enjoyable extra-curricular and organized developmental and recreational activities, and to make more accessible the opportunities for parents, especially those dependent on public assistance, to increase and enhance their parenting and living skills. All of these contributions can be facilitated by establishing the neighborhood public school as a focal point for such activities and by extending the hours of the day in which its facilities are available for such activities.

(b) GRANTS.—The Secretary of Education (hereafter in this section referred to as the "Secretary") shall make demonstration grants as provided in subsection (c) to States to enable them to increase the number of hours during each day when existing public school facilities are available for use for the purposes set forth in subsection (d).

(c) SELECTION OF STATES.—The Secretary shall make grants to not more than 5 States for demonstration projects in accordance with this section. Each State shall select the number and location of schools based on the amount of funds it deems necessary for a school properly to achieve the goals of this program. The schools selected must have a significant percentage of students receiving benefits under part A of title IV of the Social Security Act. No more

than 2 percent of the grant to any State shall be used for administrative expenses of any kind by any entity (except that none of the activities set forth in paragraphs (1) and (2) of subsection (d) shall be considered an administrative activity the expenses for which are limited by this subsection).

(d) USE OF FUNDS.—The grants made under subsection (b), in order that school facilities can be more fully utilized, shall be used to provide funding for, among other things—

(1) extending the length of the school day, expanding the scope of student programs offered before and after pre-existing school hours, enabling volunteers and parents or professionals paid from other sources to teach, tutor, coach, organize, advise, or monitor students before and after pre-existing school hours, and providing security, supplies, utilities, and janitorial services before and after pre-existing school hours for these programs,

(2) making the school facilities available for community and neighborhood clubs, civic associations and organizations, Boy and Girl Scouts and similar organizations, adult education classes, organized sports, parental education classes, and other educational, recreational, and social activities.

None of the funds provided under this section can be used to supplant funds already provided to a school facility for services, equipment, personnel, or utilities nor can funds be used to pay costs associated with operating school facilities during hours those facilities are already available for student or community use.

(e) APPLICATIONS.—

(1) IN GENERAL.—The Governor of each State desiring to conduct a demonstration project under this section shall prepare and submit to the Secretary an application in such manner and containing such information as the Secretary may require. The Secretary shall actively encourage States to submit such applications.

(2) APPROVAL.—The Secretary shall consider all applications received from States desiring to conduct demonstration projects under this section and shall approve such applications in a number of States to be determined by the Secretary (not to exceed 5), taking into account the overall funding levels available under this section.

(f) DURATION.—A demonstration project under this section shall be conducted for not more than 4 years plus an additional time period of up to 12 months for final evaluation and reporting. The Secretary may terminate a project if the Secretary determines that the State conducting the project is not in substantial compliance with the terms of the application approved by the Secretary under this section.

(g) EVALUATION PLAN.—

(1) STANDARDS.—Not later than 3 months after the date of the enactment of this section, the Secretary shall develop standards for evaluating the effectiveness of each demonstration project in contributing toward meeting the objectives set forth in subsection (a), which shall include the requirement that an independent expert entity selected by the Secretary provide an evaluation of all demonstration projects, which eval-

uations shall be included in the appropriate State's annual and final reports to the Secretary under subsection (h)(1).

(2) SUBMISSION OF PLAN.—Each State conducting a demonstration project under this section shall submit an evaluation plan (meeting the standards developed by the Secretary under paragraph (1)) to the Secretary not later than 90 days after the State is notified of the Secretary's approval for such project. A State shall not receive any Federal funds for the operation of the demonstration project until the Secretary approves such evaluation plan.

(h) REPORTS.—

(1) STATE.—A State that conducts a demonstration project under this section shall prepare and submit to the Secretary annual and final reports in accordance with the State's evaluation plan under subsection (g)(2) for such demonstration project.

(2) SECRETARY.—The Secretary shall prepare and submit to the Congress annual reports concerning each demonstration project under this section.

(i) AUTHORIZATIONS.—

(1) GRANTS.—There are authorized to be appropriated for grants under subsection (b) for each of fiscal years 1996, 1997, 1998, 1999, and 2000, $10,000,000.

(2) ADMINISTRATION.—There are authorized to be appropriated $1,000,000 for each of fiscal years 1996, 1997, 1998, 1999, and 2000 for the administration of this section by the Secretary, including development of standards and evaluation of all demonstration projects by an independent expert entity under subsection (g)(1).

SEC. 7210. CORRECTIVE COMPLIANCE PLAN.

(a) IN GENERAL.—

(1) NOTIFICATION OF VIOLATION.—Notwithstanding any other provision of law, the Federal Government shall, prior to assessing a penalty against a State under any program established or modified under subtitle D of title I of this Act, this subtitle, or subtitle D, E, F, or G of this title, notify the State of the violation of law for which such penalty would be assessed and allow the State the opportunity to enter into a corrective compliance plan in accordance with this section which outlines how the State will correct any violations for which such penalty would be assessed and how the State will insure continuing compliance with the requirements of such program.

(2) 60-DAY PERIOD TO PROPOSE A CORRECTIVE COMPLIANCE PLAN.—Any State notified under paragraph (1) shall have 60 days in which to submit to the Federal Government a corrective compliance plan to correct any violations described in such paragraph.

(3) ACCEPTANCE OF PLAN.—The Federal Government shall have 60 days to accept or reject the State's corrective compliance plan and may consult with the State during this period to modify the plan. If the Federal Government does not accept or reject the corrective compliance plan during the period, the corrective compliance plan shall be deemed to be accepted.

(b) FAILURE TO CORRECT.—If a corrective compliance plan is accepted by the Federal Government, no penalty shall be imposed with respect to a violation described in subsection (a) if the State corrects the violation pursuant to the plan. If a State has not corrected the violation in a timely manner under the plan, some or all of the penalty shall be assessed.

SEC. 7211. PARENTAL RESPONSIBILITY CONTRACTS.

(a) ASSESSMENT.—Notwithstanding any other provision of, or amendment made by, this subtitle, each State to which a grant is made under section 403 of the Social Security Act shall provide that the State agency, through a case manager, shall make an initial assessment of the education level, parenting skills, and history of parenting activities and involvement of each parent who is applying for financial assistance under the State plan funded under part A of title IV of the Social Security Act.

(b) PARENTAL RESPONSIBILITY CONTRACTS.—On the basis of the assessment made under subsection (a) with respect to each parent applicant, the case manager, in consultation with the parent applicant (hereafter in this subsection referred to as the "client") and, if possible, the client's spouse if one is present, shall develop a parental responsibility contract for the client, which meets the following requirements:

(1) Sets forth the obligations of the client, including all of the following the case manager believes are within the ability and capacity of the client, are not incompatible with the employment or school activities of the client, and are not inconsistent with each other in the client's case or with the well being of the client's children:

(A) Attend school, if necessary, and maintain certain grades and attendance.

(B) Keep school-age children of the client in school.

(C) Immunize children of the client.

(D) Attend parenting and money management classes.

(E) Participate in parent and teacher associations and other activities intended to involve parents in their children's school activities and in the affairs of their children's school.

(F) Attend school activities with their children where attendance or participation by both children and parents is appropriate.

(G) Undergo appropriate substance abuse treatment counseling.

(H) Any other appropriate activity, at the option of the State.

(2) Provides that the client shall accept any bona fide offer of unsubsidized full-time employment, unless the client has good cause for not doing so.

(c) PENALTIES FOR NONCOMPLIANCE WITH PARENTAL RESPONSIBILITY CONTRACT.—

(1) IN GENERAL.—Except as provided in paragraph (2), the following penalties shall apply:

(A) PROGRESSIVE REDUCTIONS IN ASSISTANCE FOR 1ST AND 2ND ACTS OF NON-COMPLIANCE.—The State plan described in section 402 of the Social Security Act shall pro-

vide that the amount of assistance otherwise payable under part A of title IV of such Act to a family that includes a client who, with respect to a parental responsibility contract signed by the client, commits an act of noncompliance without good cause, shall be reduced by—

(i) 33 percent for the 1st such act of noncompliance; or

(ii) 66 percent for the 2nd such act of noncompliance.

(B) DENIAL OF ASSISTANCE FOR 3RD AND SUBSEQUENT ACTS OF NONCOMPLIANCE.—The State shall provide that in the case of the 3rd or subsequent such act of noncompliance, the family of which the client is a member shall not thereafter be eligible for assistance under this part.

(C) LENGTH OF PENALTIES.—The penalty for an act of noncompliance shall not exceed the greater of—

(i) in the case of—

(I) the 1st act of noncompliance, 1 month,

(II) the 2nd act of noncompliance, 3 months, or

(III) the 3rd or subsequent act of noncompliance, 6 months; or

(ii) the period ending with the cessation of such act of noncompliance.

(D) DENIAL OF ASSISTANCE TO ADULTS REFUSING TO ACCEPT A BONA FIDE OFFER OF EMPLOYMENT.—The State plan shall provide that if an unemployed individual who has attained 18 years of age refuses to accept a bona fide offer of employment without good cause, such act of noncompliance shall be considered a 3rd or subsequent act of noncompliance.

(2) STATE FLEXIBILITY.—The State plan may provide for different penalties than those specified in paragraph (1).

SEC. 7212. EXPENDITURE OF FEDERAL FUNDS IN ACCORDANCE WITH LAWS AND PROCEDURES APPLICABLE TO EXPENDITURE OF STATE FUNDS.

(a) IN GENERAL.—Notwithstanding any other provision of law, any funds received by a State under the provisions of law specified in subsection (b) shall be expended only in accordance with the laws and procedures applicable to expenditures of the State's own revenues, including appropriation by the State legislature, consistent with the terms and conditions required under such provisions of law.

(b) PROVISIONS OF LAW.—The provisions of law specified in this subsection are the following:

(1) Part A of title IV of the Social Security Act (relating to block grants for temporary assistance to needy families).

(2) The section of the Food Stamp Act of 1977 relating to the optional State food assistance block grants.

(3) The Child Care and Development Block Grant Act of 1990 (relating to block grants for child care).

SEC. 7213. CONFORMING AMENDMENTS TO THE SOCIAL SECURITY ACT.

(a) AMENDMENTS TO TITLE II.—

(1) Section 205(c)(2)(C)(vi) (42 U.S.C. 405(c)(2)(C)(vi)), as so redesignated by section 321(a)(9)(B) of the Social Security Independence and Program Improvements Act of 1994, is amended—

(A) by inserting "an agency administering a program funded under part A of title IV or" before "an agency operating"; and

(B) by striking "A or D of title IV of this Act" and inserting "D of such title".

(2) Section 228(d)(1) (42 U.S.C. 428(d)(1)) is amended by inserting "under a State program funded under" before "part A of title IV".

(b) AMENDMENT TO PART B OF TITLE IV.—Section 422(b)(2) (42 U.S.C. 622(b)(2)) is amended by striking "under the State plan approved" and inserting "under the State program funded.".

(c) AMENDMENTS TO PART D OF TITLE IV.—

(1) Section 451 (42 U.S.C. 651) is amended by striking "aid" and inserting "assistance under a State program funded".

(2) Section 452(a)(10)(C) (42 U.S.C. 652(a)(10)(C)) is amended—

(A) by striking "aid to families with dependent children" and inserting "assistance under a State program funded under part A";

(B) by striking "such aid" and inserting "such assistance"; and

(C) by striking "402(a)(26) or".

(3) Section 452(a)(10)(F) (42 U.S.C. 652(a)(10)(F)) is amended—

(A) by striking "aid under a State plan approved" and inserting "assistance under a State program funded"; and

(B) by striking "in accordance with the standards referred to in section 402(a)(26)(B)(ii)" and inserting "by the State".

(4) Section 452(b) (42 U.S.C. 652(b)) is amended in the first sentence by striking "aid under the State plan approved under part A" and inserting "assistance under a State program funded under part A".

(5) Section 452(d)(3)(B)(i) (42 U.S.C. 652(d)(3)(B)(i)) is amended by striking "1115(c)" and inserting "1115(b)".

(6) Section 452(g)(2)(A)(ii)(I) (42 U.S.C. 652(g)(2)(A)(ii)(I)) is amended by striking "aid is being paid under the State's plan approved under part A or E" and inserting "assistance is being provided under the State program funded under part A or aid is being paid under the State's plan approved under part E".

(7) Section 452(g)(2)(A) (42 U.S.C. 652(g)(2)(A)) is amended in the matter following clause (iii) by striking "aid was being paid under the State's plan approved under part A or E" and inserting "assistance was being provided under the State program funded under part A or aid was being paid under the State's plan approved under part E".

(8) Section 452(g)(2) (42 U.S.C. 652(g)(2)) is amended in the matter following subparagraph (B)—

(A) by striking "who is a dependent child" and inserting "with respect to whom assistance is being provided under the State program funded under part A";

(B) by inserting "by the State agency administering the State plan approved under this part" after "found"; and

(C) by striking "under section 402(a)(26)" and inserting "with the State in establishing paternity".

(9) Section 452(h) (42 U.S.C. 652(h)) is amended by striking "under section 402(a)(26)".

(10) Section 453(c)(3) (42 U.S.C. 653(c)(3)) is amended by striking "aid" and inserting "assistance under a State program funded".

(11) Section 454 (42 U.S.C. 654)) is amended—

(A) in paragraph (5)(A)—

(i) by striking "under section 402(a)(26)"; and

(ii) by striking "except that this paragraph shall not apply to such payments for any month following the first month in which the amount collected is sufficient to make such family ineligible for assistance under the State plan approved under part A;"; and

(B) in paragraph (6)(D), by striking "aid under a State plan approved" and inserting "assistance under a State program funded".

(12) Section 456 (42 U.S.C. 656) is amended—

(A) in subsection (a)(1), by striking "under section 402(a)(26)"; and

(B) by striking subsection (b) and inserting the following:

"(b) A debt which is a support obligation enforceable under this title is not released by a discharge in bankruptcy under title 11, United States Code.".

(13) Section 466(a)(3)(B) (42 U.S.C. 666(a)(3)(B)) is amended by striking "402(a)(26) or".

(14) Section 466(b)(2) (42 U.S.C. 666(b)(2)) is amended by striking "aid" and inserting "assistance under a State program funded".

(15) Section 469(a) (42 U.S.C. 669(a)) is amended—

(A) by striking "aid under plans approved" and inserting "assistance under State programs funded"; and

(B) by striking "such aid" and inserting "such assistance".

(d) AMENDMENTS TO PART E OF TITLE IV.—

(1) Section 470 (42 U.S.C. 670) is amended—

(A) by striking "would be" and inserting "would have been"; and

(B) by inserting "(as such plan was in effect on June 1, 1995)" after "part A".

(2) Section 471(17) (42 U.S.C. 671(17)) is amended by striking "plans approved under parts A and D" and inserting "program funded under part A and plan approved under part D".

(3) Section 472(a) (42 U.S.C. 672(a)) is amended—

(A) in the matter preceding paragraph (1)—

(i) by striking "would meet" and inserting "would have met";

(ii) by inserting "(as such sections were in effect on June 1, 1995)" after "407"; and

(iii) by inserting "(as so in effect)" after "406(a)"; and

(B) in paragraph (4)—

(i) in subparagraph (A)—

(I) by inserting "would have" after "(A)"; and

(II) by inserting "(as in effect on June 1, 1995)" after "section 402"; and

(ii) in subparagraph (B)(ii), by inserting "(as in effect on June 1, 1995)" after "406(a)".

(4) Section 472(h) (42 U.S.C. 672(h)) is amended to read as follows:

"(h)(1) For purposes of the medicaid program under title XIX of this Act or any successor to such program, any child with respect to whom foster care maintenance payments are made under this section shall be deemed to be a dependent child as defined in section 406 (as in effect as of June 1, 1995) and shall be deemed to be a recipient of aid to families with dependent children under part A of this title (as so in effect). For purposes of title XX, any child with respect to whom foster care maintenance payments are made under this section shall be deemed to be a minor child in a needy family under a State program funded under part A and shall be deemed to be a recipient of assistance under such part.

"(2) For purposes of paragraph (1), a child whose costs in a foster family home or child care institution are covered by the foster care maintenance payments being made with respect to the child's minor parent, as provided in section 475(4)(B), shall be considered a child with respect to whom foster care maintenance payments are made under this section.".

(5) Section 473(a)(2) (42 U.S.C. 673(a)(2)) is amended—

(A) in subparagraph (A)(i)—

(i) by inserting "(as such sections were in effect on June 1, 1995)" after "407";

(ii) by inserting "(as so in effect)" after "specified in section 406(a)"; and

(iii) by inserting "(as such section was in effect on June 1, 1995)" after "403";

(B) in subparagraph (B)(i)—

(i) by inserting "would have" after "(B)(i)"; and

(ii) by inserting "(as in effect on June 1, 1995)" after "section 402"; and

(C) in subparagraph (B)(ii)(II), by inserting "(as in effect on June 1, 1995)" after "406(a)".

(6) Section 473(b) (42 U.S.C. 673(b)) is amended to read as follows:

"(b)(1) For purposes of the medicaid program under title XIX of this Act or any successor to such program, any child who is described in paragraph (3) shall be deemed to be a dependent child as defined in section 406 (as in effect as of June 1, 1995) and shall be deemed to be a recipient of aid to families with dependent chil-

dren under part A of this title (as so in effect) in the State where such child resides.

"(2) For purposes of title XX, any child who is described in paragraph (3) shall be deemed to be a minor child in a needy family under a State program funded under part A and shall be deemed to be a recipient of assistance under such part.

"(3) A child described in this paragraph is any child—

"(A)(i) who is a child described in subsection (a)(2), and

"(ii) with respect to whom an adoption assistance agreement is in effect under this section (whether or nor adoption assistance payments are provided under the agreement or are being made under this section), including any such child who has been placed for adoption in accordance with applicable State and local law (whether or not an interlocutory or other judicial decree of adoption has been issued), or

"(B) with respect to whom foster care maintenance payments are being made under section 472.

"(4) For purposes of paragraphs (1) and (2), a child whose costs in a foster family home or child-care institution are covered by the foster care maintenance payments being made with respect to the child's minor parent, as provided in section 475(4)(B), shall be considered a child with respect to whom foster care maintenance payments are being made under section 472.".

(e) AMENDMENT TO TITLE X.—Section 1002(a)(7) (42 U.S.C. 1202(a)(7)) is amended by striking "aid to families with dependent children under the State plan approved under section 402 of this Act" and inserting "assistance under a State program funded under part A of title IV".

(f) AMENDMENTS TO TITLE XI.—

(1) Section 1109 (42 U.S.C. 1309) is amended by striking "or part A of title IV,".

(2) Section 1115 (42 U.S.C. 1315) is amended—

(A) in subsection (a)(2)—

(i) by inserting "(A)" after "(2)";

(ii) by striking "403,";

(iii) by striking the period at the end and inserting ", and"; and

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

"(B) costs of such project which would not otherwise be a permissible use of funds under part A of title IV and which are not included as part of the costs of projects under section 1110, shall to the extent and for the period prescribed by the Secretary, be regarded as a permissible use of funds under such part."; and

(B) in subsection (c)(3), by striking "under the program of aid to families with dependent children" and inserting "part A of such title".

(3) Section 1116 (42 U.S.C. 1316) is amended—

(A) in each of subsections (a)(1), (b), and (d), by striking "or part A of title IV,"; and

(B) in subsection (a)(3), by striking "404,".

(4) Section 1118 (42 U.S.C. 1318) is amended—

(A) by striking "403(a),";

(B) by striking "and part A of title IV,"; and

(C) by striking ", and shall, in the case of American Samoa, mean 75 per centum with respect to part A of title IV".

(5) Section 1119 (42 U.S.C. 1319) is amended—

(A) by striking "or part A of title IV"; and

(B) by striking "403(a),".

(6) Section 1133(a) (42 U.S.C. 1320b–3(a)) is amended by striking "or part A of title IV,".

(7) Section 1136 (42 U.S.C. 1320b–6) is repealed.

(8) Section 1137 (42 U.S.C. 1320b–7) is amended—

(A) in subsection (b), by striking paragraph (1) and inserting the following:

"(1) any State program funded under part A of title IV of this Act;"; and

(B) in subsection (d)(1)(B)—

(i) by striking "In this subsection—" and all that follows through "(ii) in" and inserting "In this subsection, in";

(ii) by redesignating subclauses (I), (II), and (III) as clauses (i), (ii), and (iii); and

(iii) by moving such redesignated material 2 ems to the left.

(9) Section 1108 (42 U.S.C. 1308) is amended—

(A) in subsection (a)—

(i) in the matter preceding paragraph (1)—

(I) by inserting "(or paid, in the case of part A of title IV)" after "certified"; and

(II) by striking "or, in the case of" and all that follows through "section 403(k)";

(ii) in paragraph (1)—

(I) in subparagraph (F), by striking "or";

(II) in subparagraph (G), by striking "the fiscal year 1989 and each fiscal year thereafter;" and inserting "each of the fiscal years 1989 through 1995, or"; and

(III) by inserting after subparagraph (G), the following new subparagraph:

"(H) $100,039,000 with respect to fiscal year 1996 and each fiscal year thereafter;";

(iii) in paragraph (2)—

(I) in subparagraph (F), by striking "or";

(II) in subparagraph (G), by striking "the fiscal year 1989 and each fiscal year thereafter;" and inserting "each of the fiscal years 1989 through 1995, or"; and

(III) by inserting after subparagraph (G), the following new subparagraph:

"(H) $3,489,000 with respect to fiscal year 1996 and each fiscal year thereafter;"; and

(iv) in paragraph (3)—

(I) in subparagraph (F), by striking "or";

(II) in subparagraph (G), by striking "the fiscal year 1989 and each fiscal year thereafter." and

inserting "each of the fiscal years 1989 through 1995, or"; and

(III) by inserting after subparagraph (G), the following new subparagraph:

"(H) $4,593,000 with respect to fiscal year 1996 and each fiscal year thereafter."; and

(B) in subsection (d), by striking "(exclusive of any amounts" and all that follows through "section 403(k) applies)".

(g) AMENDMENT TO TITLE XIV.—Section 1402(a)(7) (42 U.S.C. 1352(a)(7)) is amended by striking "aid to families with dependent children under the State plan approved under section 402 of this Act" and inserting "assistance under a State program funded under part A of title IV".

(h) AMENDMENT TO TITLE XVI AS IN EFFECT WITH RESPECT TO THE TERRITORIES.—Section 1602(a)(11), as in effect without regard to the amendment made by section 301 of the Social Security Amendments of 1972 (42 U.S.C. 1382 note), is amended by striking "aid under the State plan approved" and inserting "assistance under a State program funded".

(i) AMENDMENT TO TITLE XVI AS IN EFFECT WITH RESPECT TO THE STATES.—Section 1611(c)(5)(A) (42 U.S.C. 1382(c)(5)(A)) is amended to read as follows: "(A) a State program funded under part A of title IV,".

SEC. 7214. CONFORMING AMENDMENTS TO THE FOOD STAMP ACT OF 1977 AND RELATED PROVISIONS.

(a) Section 5 of the Food Stamp Act of 1977 (7 U.S.C. 2014) is amended—

(1) in the second sentence of subsection (a), by striking "plan approved" and all that follows through "title IV of the Social Security Act" and inserting "program funded under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.) that the Secretary determines complies with standards established by the Secretary that ensure that the standards under the State program are comparable to or more restrictive than those in effect on June 1, 1995";

(2) in subsection (d)(5)—

(A) by striking "assistance to families with dependent children" and inserting "assistance under a State program funded"; and

(B) by striking paragraph (13) and redesignating paragraphs (14), (15), and (16) as paragraphs (13), (14), and (15), respectively;

(3) in subsection (j), by striking "plan approved under part A of title IV of such Act (42 U.S.C. 601 et seq.)" and inserting "program funded under part A of title IV of the Act (42 U.S.C. 601 et seq.) that the Secretary determines complies with standards established by the Secretary that ensure that the standards under the State program are comparable to or more restrictive than those in effect on June 1, 1995".

(b) Section 6 of such Act (7 U.S.C. 2015) is amended—

(1) in subsection (c)(5), by striking "the State plan approved" and inserting "the State program funded";

(2) in subsection (e)—

(A) by striking "aid to families with dependent children" and inserting "benefits under a State program funded"; and

(B) by inserting before the semicolon the following: "that the Secretary determines complies with standards established by the Secretary that ensure that the standards under the State program are comparable to or more restrictive than those in effect on June 1, 1995"; and

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

"(i) Notwithstanding any other provision of this Act, a household may not receive benefits under this Act as a result of the household's eligibility under a State program funded under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.), unless the Secretary determines that any household with income above 130 percent of the poverty guidelines is not eligible for the program.".

(c) Section 16(g)(4) of such Act (7 U.S.C. 2025(g)(4)) is amended by striking "State plans under the Aid to Families with Dependent Children Program under" and inserting "State programs funded under part A of".

(d) Section 17 of such Act (7 U.S.C. 2026) is amended—

(1) in the first sentence of subsection (b)(1)(A), by striking "to aid to families with dependent children under part A of title IV of the Social Security Act" and inserting "or are receiving assistance under a State program funded under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.)"; and

(2) in subsection (b)(3), by adding at the end the following new subparagraph:

"(I) The Secretary may not grant a waiver under this paragraph on or after October 1, 1995. Any reference in this paragraph to a provision of title IV of the Social Security Act shall be deemed to be a reference to such provision as in effect on September 30, 1995.";

(e) Section 20 of such Act (7 U.S.C. 2029) is amended—

(1) in subsection (a)(2)(B) by striking "operating—" and all that follows through "(ii) any other" and inserting "operating any"; and

(2) in subsection (b)—

(A) in paragraph (1)—

(i) by striking "(b)(1) A household" and inserting "(b) A household"; and

(ii) in subparagraph (B), by striking "training program" and inserting "activity";

(B) by striking paragraph (2); and

(C) by redesignating subparagraphs (A) through (F) as paragraphs (1) through (6), respectively.

(f) Section 5(h)(1) of the Agriculture and Consumer Protection Act of 1973 (Public Law 93–186; 7 U.S.C. 612c note) is amended by striking "the program for aid to families with dependent children" and inserting "the State program funded".

(g) Section 9 of the National School Lunch Act (42 U.S.C. 1758) is amended—

(1) in subsection (b)—

(A) in paragraph (2)(C)(ii)(II)—

(i) by striking "program for aid to families with dependent children" and inserting "State program funded"; and

(ii) by inserting before the period at the end the following: "that the Secretary determines complies with standards established by the Secretary that ensure that the standards under the State program are comparable to or more restrictive than those in effect on June 1, 1995"; and

(B) in paragraph (6)—

(i) in subparagraph (A)(ii)—

(I) by striking "an AFDC assistance unit (under the aid to families with dependent children program authorized" and inserting "a family (under the State program funded"; and

(II) by striking ", in a State" and all that follows through "9902(2)))" and inserting "that the Secretary determines complies with standards established by the Secretary that ensure that the standards under the State program are comparable to or more restrictive than those in effect on June 1, 1995"; and

(ii) in subparagraph (B), by striking "aid to families with dependent children" and inserting "assistance under the State program funded under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.) that the Secretary determines complies with standards established by the Secretary that ensure that the standards under the State program are comparable to or more restrictive than those in effect on June 1, 1995"; and

(2) in subsection (d)(2)(C)—

(A) by striking "program for aid to families with dependent children" and inserting "State program funded"; and

(B) by inserting before the period at the end the following: "that the Secretary determines complies with standards established by the Secretary that ensure that the standards under the State program are comparable to or more restrictive than those in effect on June 1, 1995".

(h) Section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786) is amended—

(1) in subsection (d)(2)(A)(ii)(II)—

(A) by striking "program for aid to families with dependent children established" and inserting "State program funded"; and

(B) by inserting before the semicolon the following: "that the Secretary determines complies with standards established by the Secretary that ensure that the standards under the State program are comparable to or more restrictive than those in effect on June 1, 1995";

(2) in subsection (e)(4)(A), by striking "program for aid to families with dependent children" and inserting "State program funded"; and

(3) in subsection (f)(1)(C)(iii), by striking "aid to families with dependent children," and inserting "State program funded under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.) and with the".

SEC. 7215. CONFORMING AMENDMENTS TO OTHER LAWS.

(a) Subsection (b) of section 508 of the Unemployment Compensation Amendments of 1976 (Public Law 94–566; 90 Stat. 2689) is amended to read as follows:

"(b) PROVISION FOR REIMBURSEMENT OF EXPENSES.—For purposes of section 455 of the Social Security Act, expenses incurred to reimburse State employment offices for furnishing information requested of such offices—

"(1) pursuant to the third sentence of section 3(a) of the Act entitled 'An Act to provide for the establishment of a national employment system and for cooperation with the States in the promotion of such system, and for other purposes', approved June 6, 1933 (29 U.S.C. 49b(a)), or

"(2) by a State or local agency charged with the duty of carrying a State plan for child support approved under part D of title IV of the Social Security Act,

shall be considered to constitute expenses incurred in the administration of such State plan.".

(b) Section 9121 of the Omnibus Budget Reconciliation Act of 1987 (42 U.S.C. 602 note) is repealed.

(c) Section 9122 of the Omnibus Budget Reconciliation Act of 1987 (42 U.S.C. 602 note) is repealed.

(d) Section 221 of the Housing and Urban-Rural Recovery Act of 1983 (42 U.S.C. 602 note), relating to treatment under AFDC of certain rental payments for federally assisted housing, is repealed.

(e) Section 159 of the Tax Equity and Fiscal Responsibility Act of 1982 (42 U.S.C. 602 note) is repealed.

(f) Section 202(d) of the Social Security Amendments of 1967 (81 Stat. 882; 42 U.S.C. 602 note) is repealed.

(g) Section 903 of the Stewart B. McKinney Homeless Assistance Amendments Act of 1988 (42 U.S.C. 11381 note), relating to demonstration projects to reduce number of AFDC families in welfare hotels, is amended—

(1) in subsection (a), by striking "aid to families with dependent children under a State plan approved" and inserting "assistance under a State program funded"; and

(2) in subsection (c), by striking "aid to families with dependent children in the State under a State plan approved" and inserting "assistance in the State under a State program funded".

(h) The Higher Education Act of 1965 (20 U.S.C. 1001 et seq.) is amended—

(1) in section 404C(c)(3) (20 U.S.C. 1070a–23(c)(3)), by striking "(Aid to Families with Dependent Children)"; and

(2) in section 480(b)(2) (20 U.S.C. 1087vv(b)(2)), by striking "aid to families with dependent children under a State plan approved" and inserting "assistance under a State program funded".

(i) The Carl D. Perkins Vocational and Applied Technology Education Act (20 U.S.C. 2301 et seq.) is amended—

(1) in section 231(d)(3)(A)(ii) (20 U.S.C. 2341(d)(3)(A)(ii)), by striking "the program for aid to dependent children" and inserting "the State program funded";

(2) in section 232(b)(2)(B) (20 U.S.C. 2341a(b)(2)(B)), by striking "the program for aid to families with dependent children" and inserting "the State program funded"; and

(3) in section 521(14)(B)(iii) (20 U.S.C. 2471(14)(B)(iii)), by striking "the program for aid to families with dependent children" and inserting "the State program funded".

(j) The Elementary and Secondary Education Act of 1965 (20 U.S.C. 2701 et seq.) is amended—

(1) in section 1113(a)(5) (20 U.S.C. 6313(a)(5)), by striking "Aid to Families with Dependent Children Program" and inserting "State program funded under part A of title IV of the Social Security Act";

(2) in section 1124(c)(5) (20 U.S.C. 6333(c)(5)), by striking "the program of aid to families with dependent children under a State plan approved under" and inserting "a State program funded under part A of"; and

(3) in section 5203(b)(2) (20 U.S.C. 7233(b)(2))—

(A) in subparagraph (A)(xi), by striking "Aid to Families with Dependent Children benefits" and inserting "assistance under a State program funded under part A of title IV of the Social Security Act"; and

(B) in subparagraph (B)(viii), by striking "Aid to Families with Dependent Children" and inserting "assistance under the State program funded under part A of title IV of the Social Security Act".

(k) Chapter VII of title I of Public Law 99–88 (25 U.S.C. 13d–1) is amended to read as follows: "*Provided further,* That general assistance payments made by the Bureau of Indian Affairs shall be made—

"(1) after April 29, 1985, and before October 1, 1995, on the basis of Aid to Families with Dependent Children (AFDC) standards of need; and

"(2) on and after October 1, 1995, on the basis of standards of need established under the State program funded under part A of title IV of the Social Security Act,

except that where a State ratably reduces its AFDC or State program payments, the Bureau shall reduce general assistance payments in such State by the same percentage as the State has reduced the AFDC or State program payment.".

(l) The Internal Revenue Code of 1986 is amended—

(1) in section 51(d)(9), by striking all that follows "agency as" and inserting "being eligible for financial assistance under part A of title IV of the Social Security Act and as having continually received such financial assistance during the 90-day period which immediately precedes the date on which such individual is hired by the employer.";

(2) in section 3304(a)(16), by striking "eligibility for aid or services," and all that follows through "children approved" and inserting "eligibility for assistance, or the amount of such assistance, under a State program funded";

(3) in section 6103(l)(7)(D)(i), by striking "aid to families with dependent children provided under a State plan approved" and inserting "a State program funded";

(4) in section 6334(a)(11)(A), by striking "(relating to aid to families with dependent children)"; and

(5) in section 7523(b)(3)(C), by striking "aid to families with dependent children" and inserting "assistance under a State program funded under part A of title IV of the Social Security Act".

(m) Section 3(b) of the Wagner-Peyser Act (29 U.S.C. 49b(b)) is amended by striking "State plan approved under part A of title IV" and inserting "State program funded under part A of title IV".

(n) The Job Training Partnership Act (29 U.S.C. 1501 et seq.) is amended—

(1) in section 4(29)(A)(i) (29 U.S.C. 1503(29)(A)(i)), by striking "(42 U.S.C. 601 et seq.)";

(2) in section 106(b)(6)(C) (29 U.S.C. 1516(b)(6)(C)), by striking "State aid to families with dependent children records," and inserting "records collected under the State program funded under part A of title IV of the Social Security Act,";

(3) in section 121(b)(2) (29 U.S.C. 1531(b)(2))—

(A) by striking "the JOBS program" and inserting "the work activities required under title IV of the Social Security Act"; and

(B) by striking the second sentence;

(4) in section 123(c) (29 U.S.C. 1533(c))—

(A) in paragraph (1)(E), by repealing clause (vi); and

(B) in paragraph (2)(D), by repealing clause (v);

(5) in section 203(b)(3) (29 U.S.C. 1603(b)(3)), by striking ", including recipients under the JOBS program";

(6) in subparagraphs (A) and (B) of section 204(a)(1) (29 U.S.C. 1604(a)(1) (A) and (B)), by striking "(such as the JOBS program)" each place it appears;

(7) in section 205(a) (29 U.S.C. 1605(a)), by striking paragraph (4) and inserting the following:

"(4) the portions of title IV of the Social Security Act relating to work activities;";

(8) in section 253 (29 U.S.C. 1632)—

(A) in subsection (b)(2), by repealing subparagraph (C); and

(B) in paragraphs (1)(B) and (2)(B) of subsection (c), by striking "the JOBS program or" each place it appears;

(9) in section 264 (29 U.S.C. 1644)—

(A) in subparagraphs (A) and (B) of subsection (b)(1), by striking "(such as the JOBS program)" each place it appears; and

(B) in subparagraphs (A) and (B) of subsection (d)(3), by striking "and the JOBS program" each place it appears;

(10) in section 265(b) (29 U.S.C. 1645(b)), by striking paragraph (6) and inserting the following:

"(6) the portion of title IV of the Social Security Act relating to work activities;";

(11) in the second sentence of section 429(e) (29 U.S.C. 1699(e)), by striking "and shall be in an amount that does not exceed the maximum amount that may be provided by the State pursuant to section 402(g)(1)(C) of the Social Security Act (42 U.S.C. 602(g)(1)(C))";

(12) in section 454(c) (29 U.S.C. 1734(c)), by striking "JOBS and";

(13) in section 455(b) (29 U.S.C. 1735(b)), by striking "the JOBS program,";

(14) in section 501(1) (29 U.S.C. 1791(1)), by striking "aid to families with dependent children under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.)" and inserting "assistance under the State program funded under part A of title IV of the Social Security Act";

(15) in section 506(1)(A) (29 U.S.C. 1791e(1)(A)), by striking "aid to families with dependent children" and inserting "assistance under the State program funded";

(16) in section 508(a)(2)(A) (29 U.S.C. 1791g(a)(2)(A)), by striking "aid to families with dependent children" and inserting "assistance under the State program funded"; and

(17) in section 701(b)(2)(A) (29 U.S.C. 1792(b)(2)(A))—

(A) in clause (v), by striking the semicolon and inserting "; and"; and

(B) by striking clause (vi).

(o) Section 3803(c)(2)(C)(iv) of title 31, United States Code, is amended to read as follows:

"(iv) assistance under a State program funded under part A of title IV of the Social Security Act".

(p) Section 2605(b)(2)(A)(i) of the Low-Income Home Energy Assistance Act of 1981 (42 U.S.C. 8624(b)(2)(A)(i)) is amended to read as follows:

"(i) assistance under the State program funded under part A of title IV of the Social Security Act;".

(q) Section 303(f)(2) of the Family Support Act of 1988 (42 U.S.C. 602 note) is amended—

(1) by striking "(A)"; and

(2) by striking subparagraphs (B) and (C).

(r) The Balanced Budget and Emergency Deficit Control Act of 1985 (2 U.S.C. 900 et seq.)) is amended—

(1) in section 255(h) (2 U.S.C. 905(h), by striking "Aid to families with dependent children (75–0412–0–1–609);" and inserting "Block grants to States for temporary assistance for needy families;"; and

(2) in section 256 (2 U.S.C. 906)—

(A) by striking subsection (k); and

(B) by redesignating subsection (l) as subsection (k).

(s) The Immigration and Nationality Act (8 U.S.C. 1101 et seq.) is amended—

(1) in section 210(f) (8 U.S.C. 1160(f)), by striking "aid under a State plan approved under" each place it appears and inserting "assistance under a State program funded under";

(2) in section 245A(h) (8 U.S.C. 1255a(h))—

(A) in paragraph (1)(A)(i), by striking "program of aid to families with dependent children" and inserting "State program of assistance"; and

(B) in paragraph (2)(B), by striking "aid to families with dependent children" and inserting "assistance under a State program funded under part A of title IV of the Social Security Act"; and

(3) in section 412(e)(4) (8 U.S.C. 1522(e)(4)), by striking "State plan approved" and inserting "State program funded".

(t) Section 640(a)(4)(B)(i) of the Head Start Act (42 U.S.C. 9835(a)(4)(B)(i)) is amended by striking "program of aid to families with dependent children under a State plan approved" and inserting "State program of assistance funded".

(u) Section 9 of the Act of April 19, 1950 (64 Stat. 47, chapter 92; 25 U.S.C. 639) is repealed.

(v) Subparagraph (E) of section 213(d)(6) of the School-To-Work Opportunities Act of 1994 (20 U.S.C. 6143(d)(6)) is amended to read as follows:

"(E) part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.) relating to work activities;".

SEC. 7216. SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL FOR TECHNICAL AND CONFORMING AMENDMENTS.

Not later than 90 days after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation, as appropriate, with the heads of other Federal agencies, shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of subtitle D of title I of this Act, this subtitle, and subtitles D, E, F, and G of this title.

SEC. 7217. EFFECTIVE DATE; TRANSITION RULE.

(a) IN GENERAL.—Except as otherwise provided in this subtitle, this subtitle and the amendments made by this subtitle shall take effect on October 1, 1995.

(b) TRANSITION RULE.—

(1) STATE OPTION TO CONTINUE AFDC PROGRAM.—

(A) 9-MONTH EXTENSION.—A State may continue a State program under parts A and F of title IV of the Social Security Act, as in effect on September 30, 1995 (for purposes of this paragraph, the "State AFDC program") until June 30, 1996.

(B) REDUCTION OF FISCAL YEAR 1996 GRANT.—In the case of any State opting to continue the State AFDC program pursuant to subparagraph (A), the State family assistance grant paid to such State under section 403(a) of the Social Security Act (as added by section 7201 and as in effect on and after October 1, 1995) for fiscal year 1996 (after the termination of the State AFDC program) shall be reduced by an amount equal to the total Federal payment to such State under section 403 of the Social Security Act (as in effect on September 30, 1995) for such fiscal year.

(2) CLAIMS, ACTIONS, AND PROCEEDINGS.—The amendments made by this subtitle shall not apply with respect to—

(A) powers, duties, functions, rights, claims, penalties, or obligations applicable to aid, assistance, or services provided before the effective date of this subtitle under the provisions amended; and

(B) administrative actions and proceedings commenced before such date, or authorized before such date to be commenced, under such provisions.

(3) CLOSING OUT ACCOUNT FOR THOSE PROGRAMS TERMINATED OR SUBSTANTIALLY MODIFIED BY THIS SUBTITLE.—In closing out accounts, Federal and State officials may use scientifically acceptable statistical sampling techniques. Claims made under programs which are repealed or substantially amended in this subtitle and which involve State expenditures in cases where assistance or services were provided during a prior fiscal year, shall be treated as expenditures during fiscal year 1995 for purposes of reimbursement even if payment was made by a State on or after October 1, 1995. States shall complete the filing of all claims no later than September 30, 1997. Federal department heads shall—

(A) use the single audit procedure to review and resolve any claims in connection with the close out of programs, and

(B) reimburse States for any payments made for assistance or services provided during a prior fiscal year from funds for fiscal year 1995, rather than the funds authorized by this subtitle.

(c) SUNSET.—The amendment made by section 7201(b) shall be effective only during the 5-year period beginning on October 1, 1995.

Subtitle D—Supplemental Security Income

CHAPTER 1—ELIGIBILITY RESTRICTIONS

SEC. 7251. DENIAL OF SUPPLEMENTAL SECURITY INCOME BENEFITS BY REASON OF DISABILITY TO DRUG ADDICTS AND ALCOHOLICS.

(a) IN GENERAL.—Section 1614(a)(3) (42 U.S.C. 1382c(a)(3)) is amended by adding at the end the following:

"(I) Notwithstanding subparagraph (A), an individual shall not be considered to be disabled for purposes of this title if alcoholism or drug addiction would (but for this subparagraph) be a contributing factor material to the Commissioner's determination that the individual is disabled.".

(b) REPRESENTATIVE PAYEE REQUIREMENTS.—

(1) Section 1631(a)(2)(A)(ii)(II) (42 U.S.C. 1383(a)(2)(A)(ii)(II)) is amended to read as follows:

"(II) In the case of an individual eligible for benefits under this title by reason of disability, if such individual also has an alcoholism or drug addiction condition (as determined by the Commissioner of Social Security), the payment of such benefits to a representative payee shall be deemed to serve the interest of the individual. In any case in which such payment is so deemed under this subclause to serve the interest of an individual, the Commissioner shall include, in the individual's notification of such eligibility, a notice that such alcoholism or drug addiction condition accompanies the disability upon which such eligibility is based and that the Commissioner is therefore required to pay the individual's benefits to a representative payee.".

(2) Section 1631(a)(2)(B)(vii) (42 U.S.C. 1383(a)(2)(B)(vii)) is amended by striking "eligible for benefits" and all that follows through "is disabled" and inserting "described in subparagraph (A)(ii)(II)".

(3) Section 1631(a)(2)(B)(ix)(II) (42 U.S.C. 1383(a)(2)(B)(ix)(II)) is amended by striking all that follows "15 years, or" and inserting "described in subparagraph (A)(ii)(II)".

(4) Section 1631(a)(2)(D)(i)(II) (42 U.S.C. 1383(a)(2)(D)(i)(II)) is amended by striking "eligible for benefits" and all that follows through "is disabled" and inserting "described in subparagraph (A)(ii)(II)".

(c) TREATMENT SERVICES FOR INDIVIDUALS WITH A SUBSTANCE ABUSE CONDITION.—

(1) IN GENERAL.—Title XVI (42 U.S.C. 1381 et seq.) is amended by adding at the end the following new section:

"TREATMENT SERVICES FOR INDIVIDUALS WITH A SUBSTANCE ABUSE CONDITION

"SEC. 1636. (a) In the case of any individual eligible for benefits under this title by reason of disability who is identified as having a substance abuse condition, the Commissioner of Social Security shall make provision for referral of such individual to the appropriate State agency administering the State plan for substance abuse treatment services approved under subpart II of part B of

title XIX of the Public Health Service Act (42 U.S.C. 300x–21 et seq.).

"(b) No individual described in subsection (a) shall be an eligible individual or eligible spouse for purposes of this title if such individual refuses without good cause to accept the referred services described under subsection (a).

(2) CONFORMING AMENDMENT.—Section 1614(a)(4) (42 U.S.C. 1382c(a)(4)) is amended by inserting after the second sentence the following new sentence: "For purposes of the preceding sentence, any individual identified by the Commissioner as having a substance abuse condition shall seek and complete appropriate treatment as needed.".

(d) CONFORMING AMENDMENTS.—

(1) Section 1611(e) (42 U.S.C. 1382(e)) is amended by striking paragraph (3).

(2) Section 1634 (42 U.S.C. 1383c) is amended by striking subsection (e).

(3) Section 201(c)(1) of the Social Security Independence and Program Improvements Act of 1994 (42 U.S.C. 425 note) is amended—

(A) by striking "—" and all that follows through "(A)" the 1st place it appears;

(B) by striking "and" the 3rd place it appears;

(C) by striking subparagraph (B);

(D) by striking "either subparagraph (A) or subparagraph (B)" and inserting "the preceding sentence"; and

(E) by striking "subparagraph (A) or (B)" and inserting "the preceding sentence".

(e) SUPPLEMENTAL FUNDING FOR ALCOHOL AND SUBSTANCE ABUSE TREATMENT PROGRAMS.—

(1) IN GENERAL.—Out of any money in the Treasury not otherwise appropriated, there are hereby appropriated to supplement State and Tribal programs funded under section 1933 of the Public Health Service Act (42 U.S.C. 300x–33), $50,000,000 for each of the fiscal years 1997 and 1998.

(2) ADDITIONAL FUNDS.—Amounts appropriated under paragraph (1) shall be in addition to any funds otherwise appropriated for allotments under section 1933 of the Public Health Service Act (42 U.S.C. 300x–33) and shall be allocated pursuant to such section 1933.

(3) USE OF FUNDS.—A State or Tribal government receiving an allotment under this subsection shall consider as priorities, for purposes of expending funds allotted under this subsection, activities relating to the treatment of the abuse of alcohol and other drugs.

SEC. 7252. DENIAL OF SSI BENEFITS FOR 10 YEARS TO INDIVIDUALS FOUND TO HAVE FRAUDULENTLY MISREPRESENTED RESIDENCE IN ORDER TO OBTAIN BENEFITS SIMULTANEOUSLY IN 2 OR MORE STATES.

Section 1614(a) (42 U.S.C. 1382c(a)) is amended by adding at the end the following new paragraph:

"(5) An individual shall not be considered an eligible individual for purposes of this title during the 10-year period beginning on the date the individual is convicted in Federal or State court of having

made a fraudulent statement or representation with respect to the place of residence of the individual in order to receive assistance simultaneously from 2 or more States under programs that are funded under part A of title IV, title XXI, or the Food Stamp Act of 1977, or benefits in 2 or more States under the supplemental security income program under title XVI.".

SEC. 7253. DENIAL OF SSI BENEFITS FOR FUGITIVE FELONS AND PROBATION AND PAROLE VIOLATORS.

(a) IN GENERAL.—Section 1611(e) (42 U.S.C. 1382(e)), as amended by section 7251(c)(1), is amended by inserting after paragraph (2) the following new paragraph:

"(3) A person shall not be an eligible individual or eligible spouse for purposes of this title with respect to any month if during such month the person is—

"(A) fleeing to avoid prosecution, or custody or confinement after conviction, under the laws of the place from which the person flees, for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which the person flees, or which, in the case of the State of New Jersey, is a high misdemeanor under the laws of such State; or

"(B) violating a condition of probation or parole imposed under Federal or State law.".

(b) EXCHANGE OF INFORMATION WITH LAW ENFORCEMENT AGENCIES.—Section 1631(e) (42 U.S.C. 1383(e)) is amended by inserting after paragraph (3) the following new paragraph:

"(4) Notwithstanding any other provision of law, the Commissioner shall furnish any Federal, State, or local law enforcement officer, upon the request of the officer, with the current address, Social Security number, and photograph (if applicable) of any recipient of benefits under this title, if the officer furnishes the agency with the name of the recipient and notifies the agency that—

"(A) the recipient—

"(i) is fleeing to avoid prosecution, or custody or confinement after conviction, under the laws of the place from which the person flees, for a crime, or an attempt to commit a crime, which is a felony under the laws of the place from which the person flees, or which, in the case of the State of New Jersey, is a high misdemeanor under the laws of such State;

"(ii) is violating a condition of probation or parole imposed under Federal or State law; or

"(iii) has information that is necessary for the officer to conduct the officer's official duties; and

"(B) the location or apprehension of the recipient is within the officer's official duties.".

SEC. 7254. EFFECTIVE DATES; APPLICATION TO CURRENT RECIPIENTS.

(a) SECTION 7251.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by section 7251 shall apply to applicants for benefits for months beginning on or after the date of the enactment of this Act, without regard to whether regulations have been issued to implement such amendments.

(2) APPLICATION TO CURRENT RECIPIENTS.—

(A) APPLICATION AND NOTICE.—Notwithstanding any other provision of law, in the case of an individual who is receiving supplemental security income benefits under title XVI of the Social Security Act as of the date of the enactment of this Act and whose eligibility for such benefits would terminate by reason of the amendments made by section 7251, such amendments shall apply with respect to the benefits of such individual, including such individual's treatment (if any) provided pursuant to such title as in effect on the day before the date of such enactment, for months beginning on or after January 1, 1997, and the Commissioner of Social Security shall so notify the individual not later than 90 days after the date of the enactment of this Act.

(B) REAPPLICATION.—

(i) IN GENERAL.—Not later than 120 days after the date of the enactment of this Act, each individual notified pursuant to subparagraph (A) who desires to reapply for benefits under title XVI of the Social Security Act, as amended by this title, shall reapply to the Commissioner of Social Security.

(ii) DETERMINATION OF ELIGIBILITY.—Not later than 1 year after the date of the enactment of this Act, the Commissioner of Social Security shall determine the eligibility of each individual who reapplies for benefits under clause (i) pursuant to the procedures of such title.

(3) ADDITIONAL APPLICATION OF PAYEE REPRESENTATIVE REQUIREMENTS.—The amendments made by section 7251(b) shall also apply—

(A) in the case of any individual who is receiving supplemental security income benefits under title XVI of the Social Security Act as of the date of the enactment of this Act, on and after the date of such individual's first continuing disability review occurring after such date of enactment, and

(B) in the case of any individual who receives supplemental security income benefits under title XVI of the Social Security Act and has attained age 65, in such manner as determined appropriate by the Commissioner of Social Security.

(b) OTHER AMENDMENTS.—The amendments made by sections 7252 and 7253 shall take effect on the date of the enactment of this Act.

CHAPTER 2—BENEFITS FOR DISABLED CHILDREN

SEC. 7261. DEFINITION AND ELIGIBILITY RULES.

(a) DEFINITION OF CHILDHOOD DISABILITY.—Section 1614(a)(3) (42 U.S.C. 1382c(a)(3)), as amended by section 7251(a), is amended—

(1) in subparagraph (A), by striking "An individual" and inserting "Except as provided in subparagraph (C), an individual";

(2) in subparagraph (A), by striking "(or, in the case of an individual under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity)";

(3) by redesignating subparagraphs (C) through (I) as subparagraphs (D) through (J), respectively;

(4) by inserting after subparagraph (B) the following new subparagraph:

"(C) An individual under the age of 18 shall be considered disabled for the purposes of this title if that individual has a medically determinable physical or mental impairment, which results in marked and severe functional limitations, and which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months."; and

(5) in subparagraph (F), as redesignated by paragraph (3), by striking "(D)" and inserting "(E)".

(b) CHANGES TO CHILDHOOD SSI REGULATIONS.—

(1) MODIFICATION TO MEDICAL CRITERIA FOR EVALUATION OF MENTAL AND EMOTIONAL DISORDERS.—The Commissioner of Social Security shall modify sections 112.00C.2. and 112.02B.2.c.(2) of appendix 1 to subpart P of part 404 of title 20, Code of Federal Regulations, to eliminate references to maladaptive behavior in the domain of personal/behavorial function.

(2) DISCONTINUANCE OF INDIVIDUALIZED FUNCTIONAL ASSESSMENT.—The Commissioner of Social Security shall discontinue the individualized functional assessment for children set forth in sections 416.924d and 416.924e of title 20, Code of Federal Regulations.

(c) EFFECTIVE DATE; REGULATIONS; APPLICATION TO CURRENT RECIPIENTS.—

(1) IN GENERAL.—The amendments made by subsections (a) and (b) shall apply to applicants for benefits for months beginning on or after the date of the enactment of this Act, without regard to whether regulations have been issued to implement such amendments.

(2) REGULATIONS.—The Commissioner of Social Security shall issue such regulations as the Commissioner determines to be necessary to implement the amendments made by subsections (a) and (b) not later than 60 days after the date of the enactment of this Act.

(3) APPLICATION TO CURRENT RECIPIENTS.—

(A) ELIGIBILITY DETERMINATIONS.—Not later than 1 year after the date of the enactment of this Act, the Commissioner of Social Security shall redetermine the eligibility of any individual under age 18 who is receiving supplemental security income benefits based on a disability under title XVI of the Social Security Act as of the date of the enactment of this Act and whose eligibility for such benefits may terminate by reason of the amendments made by subsection (a) or (b). With respect to any redetermination under this subparagraph—

(i) section 1614(a)(4) of the Social Security Act (42 U.S.C. 1382c(a)(4)) shall not apply;

(ii) the Commissioner of Social Security shall apply the eligibility criteria for new applicants for benefits under title XVI of such Act;

(iii) the Commissioner shall give such redetermination priority over all continuing eligibility reviews and other reviews under such title; and

(iv) such redetermination shall be counted as a review or redetermination otherwise required to be made under section 208 of the Social Security Independence and Program Improvements Act of 1994 or any other provision of title XVI of the Social Security Act.

(B) GRANDFATHER PROVISION.—The amendments made by subsections (a) and (b), and the redetermination under subparagraph (A), shall only apply with respect to the benefits of an individual described in subparagraph (A) for months beginning on or after January 1, 1997.

(C) NOTICE.—Not later than 90 days after the date of the enactment of this Act, the Commissioner of Social Security shall notify an individual described in subparagraph (A) of the provisions of this paragraph.

SEC. 7262. ELIGIBILITY REDETERMINATIONS AND CONTINUING DISABILITY REVIEWS.

(a) CONTINUING DISABILITY REVIEWS RELATING TO CERTAIN CHILDREN.—Section 1614(a)(3)(H) (42 U.S.C. 1382c(a)(3)(H)), as redesignated by section 7261(a)(3), is amended—

(1) by inserting "(i)" after "(H)"; and

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

"(ii)(I) Not less frequently than once every 3 years, the Commissioner shall review in accordance with paragraph (4) the continued eligibility for benefits under this title of each individual who has not attained 18 years of age and is eligible for such benefits by reason of an impairment (or combination of impairments) which may improve (or, which is unlikely to improve, at the option of the Commissioner).

"(II) A parent or guardian of a recipient whose case is reviewed under this clause shall present, at the time of review, evidence demonstrating that the recipient is, and has been, receiving treatment, to the extent considered medically necessary and available, of the condition which was the basis for providing benefits under this title.".

(b) DISABILITY ELIGIBILITY REDETERMINATIONS REQUIRED FOR SSI RECIPIENTS WHO ATTAIN 18 YEARS OF AGE.—

(1) IN GENERAL.—Section 1614(a)(3)(H) (42 U.S.C. 1382c(a)(3)(H)), as amended by subsection (a), is amended by adding at the end the following new clause:

"(iii) If an individual is eligible for benefits under this title by reason of disability for the month preceding the month in which the individual attains the age of 18 years, the Commissioner shall redetermine such eligibility—

"(I) during the 1-year period beginning on the individual's 18th birthday; and

"(II) by applying the criteria used in determining the initial eligibility for applicants who have attained the age of 18 years.

With respect to a redetermination under this clause, paragraph (4) shall not apply and such redetermination shall be considered a substitute for a review or redetermination otherwise required under any other provision of this subparagraph during that 1-year period.".

(2) CONFORMING REPEAL.—Section 207 of the Social Security Independence and Program Improvements Act of 1994 (42 U.S.C. 1382 note; 108 Stat. 1516) is hereby repealed.

(c) CONTINUING DISABILITY REVIEW REQUIRED FOR LOW BIRTH WEIGHT BABIES.—Section 1614(a)(3)(H) (42 U.S.C. 1382c(a)(3)(H)), as amended by subsections (a) and (b), is amended by adding at the end the following new clause:

"(iv)(I) Not later than 12 months after the birth of an individual, the Commissioner shall review in accordance with paragraph (4) the continuing eligibility for benefits under this title by reason of disability of such individual whose low birth weight is a contributing factor material to the Commissioner's determination that the individual is disabled.

"(II) A review under subclause (I) shall be considered a substitute for a review otherwise required under any other provision of this subparagraph during that 12-month period.

"(III) A parent or guardian of a recipient whose case is reviewed under this clause shall present, at the time of review, evidence demonstrating that the recipient is, and has been, receiving treatment, to the extent considered medically necessary and available, of the condition which was the basis for providing benefits under this title.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to benefits for months beginning on or after the date of the enactment of this Act, without regard to whether regulations have been issued to implement such amendments.

SEC. 7263. ADDITIONAL ACCOUNTABILITY REQUIREMENTS.

(a) TIGHTENING OF REPRESENTATIVE PAYEE REQUIREMENTS.—

(1) CLARIFICATION OF ROLE.—Section 1631(a)(2)(B)(ii) (42 U.S.C. 1383(a)(2)(B)(ii)) is amended by striking "and" at the end of subclause (II), by striking the period at the end of subclause (IV) and inserting "; and", and by adding after subclause (IV) the following new subclause:

"(V) advise such person through the notice of award of benefits, and at such other times as the Commissioner of Social Security deems appropriate, of specific examples of appropriate expenditures of benefits under this title and the proper role of a representative payee.".

(2) DOCUMENTATION OF EXPENDITURES REQUIRED.—

(A) IN GENERAL.—Subparagraph (C)(i) of section 1631(a)(2) (42 U.S.C. 1383(a)(2)) is amended to read as follows:

"(C)(i) In any case where payment is made to a representative payee of an individual or spouse, the Commissioner of Social Security shall—

"(I) require such representative payee to document expenditures and keep contemporaneous records of transactions made using such payment; and

"(II) implement statistically valid procedures for reviewing a sample of such contemporaneous records in order to identify instances in which such representative payee is not properly using such payment.".

(B) CONFORMING AMENDMENT WITH RESPECT TO PARENT PAYEES.—Clause (ii) of section 1631(a)(2)(C) (42 U.S.C. 1383(a)(2)(C)) is amended by striking "Clause (i)" and inserting "Subclauses (II) and (III) of clause (i)".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to benefits paid after the date of the enactment of this Act.

(b) DEDICATED SAVINGS ACCOUNTS.—

(1) IN GENERAL.—Section 1631(a)(2)(B) (42 U.S.C. 1383(a)(2)(B)) is amended by adding at the end the following new clause:

"(xiv) Notwithstanding clause (x), the Commissioner of Social Security may, at the request of the representative payee, pay any lump sum payment for the benefit of a child into a dedicated savings account that could only be used to purchase for such child—

"(I) education and job skills training;

"(II) special equipment or housing modifications or both specifically related to, and required by the nature of, the child's disability; and

"(III) appropriate therapy and rehabilitation.".

(2) DISREGARD OF TRUST FUNDS.—Section 1613(a) (42 U.S.C. 1382b) is amended—

(A) by striking "and" at the end of paragraph (9),

(B) by striking the period at the end of paragraph (10) the first place it appears and inserting a semicolon,

(C) by redesignating paragraph (10) the second place it appears as paragraph (11) and striking the period at the end of such paragraph and inserting "; and", and

(D) by inserting after paragraph (11), as so redesignated, the following new paragraph:

"(12) all amounts deposited in, or interest credited to, a dedicated savings account described in section 1631(a)(2)(B)(xiv).".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to payments made after the date of the enactment of this Act.

CHAPTER 3—STUDIES REGARDING SUPPLEMENTAL SECURITY INCOME PROGRAM

SEC. 7271. ANNUAL REPORT ON THE SUPPLEMENTAL SECURITY INCOME PROGRAM.

Title XVI is amended by adding at the end the following new section:

"SEC. 1636. ANNUAL REPORT ON PROGRAM.

"(a) DESCRIPTION OF REPORT.—Not later than May 30 of each year, the Commissioner of Social Security shall prepare and deliver

a report annually to the President and the Congress regarding the program under this title, including—

"(1) a comprehensive description of the program;

"(2) historical and current data on allowances and denials, including number of applications and allowance rates at initial determinations, reconsiderations, administrative law judge hearings, council of appeals hearings, and Federal court appeal hearings;

"(3) historical and current data on characteristics of recipients and program costs, by recipient group (aged, blind, work disabled adults, and children);

"(4) projections of future number of recipients and program costs, through at least 25 years;

"(5) number of redeterminations and continuing disability reviews, and the outcomes of such redeterminations and reviews;

"(6) data on the utilization of work incentives;

"(7) detailed information on administrative and other program operation costs;

"(8) summaries of relevant research undertaken by the Social Security Administration, or by other researchers;

"(9) State supplementation program operations;

"(10) a historical summary of statutory changes to this title; and

"(11) such other information as the Commissioner deems useful.

"(b) VIEWS OF MEMBERS OF THE SOCIAL SECURITY ADVISORY COUNCIL.—Each member of the Social Security Advisory Council shall be permitted to provide an individual report, or a joint report if agreed, of views of the program under this title, to be included in the annual report under this section.".

SEC. 7272. IMPROVEMENTS TO DISABILITY EVALUATION.

(a) REQUEST FOR COMMENTS.—

(1) IN GENERAL.—Not later than 60 days after the date of the enactment of this Act, the Commissioner of Social Security shall issue a request for comments in the Federal Register regarding improvements to the disability evaluation and determination procedures for individuals under age 18 to ensure the comprehensive assessment of such individuals, including—

(A) additions to conditions which should be presumptively disabling at birth or ages 0 through 3 years;

(B) specific changes in individual listings in the Listing of Impairments set forth in appendix 1 of subpart P of part 404 of title 20, Code of Federal Regulations;

(C) improvements in regulations regarding determinations based on regulations providing for medical and functional equivalence to such Listing of Impairments, and consideration of multiple impairments; and

(D) any other changes to the disability determination procedures.

(2) REVIEW AND REGULATORY ACTION.—The Commissioner of Social Security shall promptly review such comments and issue any regulations implementing any necessary changes not

later than 18 months after the date of the enactment of this Act.

SEC. 7273. STUDY OF DISABILITY DETERMINATION PROCESS.

(a) IN GENERAL.—Not later than 90 days after the date of the enactment of this Act, and from funds otherwise appropriated, the Commissioner of Social Security shall make arrangements with the National Academy of Sciences, or other independent entity, to conduct a study of the disability determination process under titles II and XVI of the Social Security Act. This study shall be undertaken in consultation with professionals representing appropriate disciplines.

(b) STUDY COMPONENTS.—The study described in subsection (a) shall include—

(1) an initial phase examining the appropriateness of, and making recommendations regarding—

(A) the definitions of disability in effect on the date of the enactment of this Act and the advantages and disadvantages of alternative definitions; and

(B) the operation of the disability determination process, including the appropriate method of performing comprehensive assessments of individuals under age 18 with physical and mental impairments;

(2) a second phase, which may be concurrent with the initial phase, examining the validity, reliability, and consistency with current scientific knowledge of the standards and individual listings in the Listing of Impairments set forth in appendix 1 of subpart P of part 404 of title 20, Code of Federal Regulations, and of related evaluation procedures as promulgated by the Commissioner of Social Security; and

(3) such other issues as the applicable entity considers appropriate.

(c) REPORTS AND REGULATIONS.—

(1) REPORTS.—The Commissioner of Social Security shall request the applicable entity, to submit an interim report and a final report of the findings and recommendations resulting from the study described in this section to the President and the Congress not later than 18 months and 24 months, respectively, from the date of the contract for such study, and such additional reports as the Commissioner deems appropriate after consultation with the applicable entity.

(2) REGULATIONS.—The Commissioner of Social Security shall review both the interim and final reports, and shall issue regulations implementing any necessary changes following each report.

SEC. 7274. STUDY BY GENERAL ACCOUNTING OFFICE.

Not later than January 1, 1998, the Comptroller General of the United States shall study and report on the impact of the amendments made by, and the provisions of, this title on the supplemental security income program under title XVI of the Social Security Act.

CHAPTER 4—NATIONAL COMMISSION ON THE FUTURE OF DISABILITY

SEC. 7281. ESTABLISHMENT.

There is established a commission to be known as the National Commission on the Future of Disability (referred to in this subtitle as the "Commission"), the expenses of which shall be paid from funds otherwise appropriated for the Social Security Administration.

SEC. 7282. DUTIES OF THE COMMISSION.

(a) IN GENERAL.—The Commission shall develop and carry out a comprehensive study of all matters related to the nature, purpose, and adequacy of all Federal programs serving individuals with disabilities. In particular, the Commission shall study the disability insurance program under title II of the Social Security Act and the supplemental security income program under title XVI of such Act.

(b) MATTERS STUDIED.—The Commission shall prepare an inventory of Federal programs serving individuals with disabilities, and shall examine—

(1) trends and projections regarding the size and characteristics of the population of individuals with disabilities, and the implications of such analyses for program planning;

(2) the feasibility and design of performance standards for the Nation's disability programs;

(3) the adequacy of Federal efforts in rehabilitation research and training, and opportunities to improve the lives of individuals with disabilities through all manners of scientific and engineering research; and

(4) the adequacy of policy research available to the Federal Government, and what actions might be undertaken to improve the quality and scope of such research.

(c) RECOMMENDATIONS.—The Commission shall submit to the appropriate committees of the Congress and to the President recommendations and, as appropriate, proposals for legislation, regarding—

(1) which (if any) Federal disability programs should be eliminated or augmented;

(2) what new Federal disability programs (if any) should be established;

(3) the suitability of the organization and location of disability programs within the Federal Government;

(4) other actions the Federal Government should take to prevent disabilities and disadvantages associated with disabilities; and

(5) such other matters as the Commission considers appropriate.

SEC. 7283. MEMBERSHIP.

(a) NUMBER AND APPOINTMENT.—

(1) IN GENERAL.—The Commission shall be composed of 15 members, of whom—

(A) five shall be appointed by the President, of whom not more than 3 shall be of the same major political party;

(B) three shall be appointed by the Majority Leader of the Senate;

(C) two shall be appointed by the Minority Leader of the Senate;

(D) three shall be appointed by the Speaker of the House of Representatives; and

(E) two shall be appointed by the Minority Leader of the House of Representatives.

(2) REPRESENTATION.—The Commission members shall be chosen based on their education, training, or experience. In appointing individuals as members of the Commission, the President and the Majority and Minority Leaders of the Senate and the Speaker and Minority Leader of the House of Representatives shall seek to ensure that the membership of the Commission reflects the diversity of individuals with disabilities in the United States.

(b) COMPTROLLER GENERAL.—The Comptroller General shall serve on the Commission as an ex officio member of the Commission to advise and oversee the methodology and approach of the study of the Commission.

(c) PROHIBITION AGAINST OFFICER OR EMPLOYEE.—No officer or employee of any government shall be appointed under subsection (a).

(d) DEADLINE FOR APPOINTMENT; TERM OF APPOINTMENT.—Members of the Commission shall be appointed not later than 60 days after the date of the enactment of this Act. The members shall serve on the Commission for the life of the Commission.

(e) MEETINGS.—The Commission shall locate its headquarters in the District of Columbia, and shall meet at the call of the Chairperson, but not less than 4 times each year during the life of the Commission.

(f) QUORUM.—Ten members of the Commission shall constitute a quorum, but a lesser number may hold hearings.

(g) CHAIRPERSON AND VICE CHAIRPERSON.—Not later than 15 days after the members of the Commission are appointed, such members shall designate a Chairperson and Vice Chairperson from among the members of the Commission.

(h) CONTINUATION OF MEMBERSHIP.—If a member of the Commission becomes an officer or employee of any government after appointment to the Commission, the individual may continue as a member until a successor member is appointed.

(i) VACANCIES.—A vacancy on the Commission shall be filled in the manner in which the original appointment was made not later than 30 days after the Commission is given notice of the vacancy.

(j) COMPENSATION.—Members of the Commission shall receive no additional pay, allowances, or benefits by reason of their service on the Commission.

(k) TRAVEL EXPENSES.—Each member of the Commission shall receive travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.

SEC. 7284. STAFF AND SUPPORT SERVICES.

(a) DIRECTOR.—

(1) APPOINTMENT.—Upon consultation with the members of the Commission, the Chairperson shall appoint a Director of the Commission.

(2) COMPENSATION.—The Director shall be paid the rate of basic pay for level V of the Executive Schedule.

(b) STAFF.—With the approval of the Commission, the Director may appoint such personnel as the Director considers appropriate.

(c) APPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title relating to classification and General Schedule pay rates.

(d) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the Director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(e) STAFF OF FEDERAL AGENCIES.—Upon the request of the Commission, the head of any Federal agency may detail, on a reimbursable basis, any of the personnel of such agency to the Commission to assist in carrying out the duties of the Commission under this subtitle.

(f) OTHER RESOURCES.—The Commission shall have reasonable access to materials, resources, statistical data, and other information from the Library of Congress and agencies and elected representatives of the executive and legislative branches of the Federal Government. The Chairperson of the Commission shall make requests for such access in writing when necessary.

(g) PHYSICAL FACILITIES.—The Administrator of the General Services Administration shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals required for proper functioning of the Commission.

SEC. 7285. POWERS OF COMMISSION.

(a) HEARINGS.—The Commission may conduct public hearings or forums at the discretion of the Commission, at any time and place the Commission is able to secure facilities and witnesses, for the purpose of carrying out the duties of the Commission under this subtitle.

(b) DELEGATION OF AUTHORITY.—Any member or agent of the Commission may, if authorized by the Commission, take any action the Commission is authorized to take by this section.

(c) INFORMATION.—The Commission may secure directly from any Federal agency information necessary to enable the Commission to carry out its duties under this subtitle. Upon request of the Chairperson or Vice Chairperson of the Commission, the head of a Federal agency shall furnish the information to the Commission to the extent permitted by law.

(d) GIFTS, BEQUESTS, AND DEVISES.—The Commission may accept, use, and dispose of gifts, bequests, or devises of services or property, both real and personal, for the purpose of aiding or facilitating the work of the Commission. Gifts, bequests, or devises of money and proceeds from sales of other property received as gifts,

bequests, or devises shall be deposited in the Treasury and shall be available for disbursement upon order of the Commission.

(e) MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as other Federal agencies.

SEC. 7286. REPORTS.

(a) INTERIM REPORT.—Not later than 1 year prior to the date on which the Commission terminates pursuant to section 7287, the Commission shall submit an interim report to the President and to the Congress. The interim report shall contain a detailed statement of the findings and conclusions of the Commission, together with the Commission's recommendations for legislative and administrative action, based on the activities of the Commission.

(b) FINAL REPORT.—Not later than the date on which the Commission terminates, the Commission shall submit to the Congress and to the President a final report containing—

(1) a detailed statement of final findings, conclusions, and recommendations; and

(2) an assessment of the extent to which recommendations of the Commission included in the interim report under subsection (a) have been implemented.

(c) PRINTING AND PUBLIC DISTRIBUTION.—Upon receipt of each report of the Commission under this section, the President shall—

(1) order the report to be printed; and

(2) make the report available to the public upon request.

SEC. 7287. TERMINATION.

The Commission shall terminate on the date that is 2 years after the date on which the members of the Commission have met and designated a Chairperson and Vice Chairperson.

CHAPTER 5—STATE SUPPLEMENTATION PROGRAMS

SEC. 7291. REPEAL OF MAINTENANCE OF EFFORT REQUIREMENTS APPLICABLE TO OPTIONAL STATE PROGRAMS FOR SUPPLEMENTATION OF SSI BENEFITS.

(a) IN GENERAL.—Section 1618 (42 U.S.C. 1382g) is repealed.

(b) EFFECTIVE DATE.—The repeal made by subsection (a) shall apply with respect to calendar quarters beginning after September 30, 1995.

CHAPTER 6—RETIREMENT AGE ELIGIBILITY

SEC. 7295. ELIGIBILITY FOR SUPPLEMENTAL SECURITY INCOME BENEFITS BASED ON SOCIAL SECURITY RETIREMENT AGE.

(a) IN GENERAL.—Section 1614(a)(1)(A) (42 U.S.C. 1382C(a)(1)(A)) is amended by striking "is 65 years of age or older," and inserting "has attained retirement age.".

(b) RETIREMENT AGE DEFINED.—Section 1614 (42 U.S.C. 1382c) is amended by adding at the end the following new subsection:

"Retirement Age

"(g) For purposes of this title, the term "retirement age" has the meaning given such term by section 216(l)(1).".

(c) CONFORMING AMENDMENTS.—Sections 1601, 1612(b)(4), 1615(a)(1), and 1620(b)(2) (42 U.S.C. 1381, 1382a(b)(4), 1382d(a)(1), and 1382i(b)(2)) are amended by striking "age 65" each place it appears and inserting "retirement age".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to applicants for benefits for months beginning after September 30, 1995.

Subtitle E—Child Support

CHAPTER 1—ELIGIBILITY FOR SERVICES; DISTRIBUTION OF PAYMENTS

SEC. 7301. STATE OBLIGATION TO PROVIDE CHILD SUPPORT ENFORCEMENT SERVICES.

(a) STATE PLAN REQUIREMENTS.—Section 454 (42 U.S.C. 654) is amended—

(1) by striking paragraph (4) and inserting the following new paragraph:

"(4) provide that the State will—

"(A) provide services relating to the establishment of paternity or the establishment, modification, or enforcement of child support obligations, as appropriate, under the plan with respect to—

"(i) each child for whom (I) assistance is provided under the State program funded under part A of this title, (II) benefits or services are provided under the State program funded under part E of this title, or (III) medical assistance is provided under the State plan approved under title XXI, unless the State agency administering the plan determines (in accordance with paragraph (29)) that it is against the best interests of the child to do so; and

"(ii) any other child, if an individual applies for such services with respect to the child; and

"(B) enforce any support obligation established with respect to—

"(i) a child with respect to whom the State provides services under the plan; or

"(ii) the custodial parent of such a child."; and

(2) by striking paragraph (6) and inserting the following new subparagraph:

"(6) provide that—

"(A) services under the plan shall be made available to nonresidents on the same terms as to residents; and

"(B) application and collection fees are imposed and collected and costs in excess of such fees are collected in accordance with section 454C with respect to services under the plan for—

"(i) any individual not receiving assistance under any State program funded under part A; or

"(ii) any individual receiving such assistance but solely through a program funded under section 419);".

(b) CONTINUATION OF SERVICES FOR FAMILIES CEASING TO RECEIVE ASSISTANCE UNDER THE STATE PROGRAM FUNDED UNDER PART A.—Section 454 (42 U.S.C. 654) is amended—

(1) by striking "and" at the end of paragraph (23);

(2) by striking the period at the end of paragraph (24) and inserting "; and"; and

(3) by adding after paragraph (24) the following new paragraph:

"(25) provide that when a family with respect to which services are provided under the plan ceases to receive assistance under the State program funded under part A, the State shall provide appropriate notice to the family and continue to provide such services, subject to the same conditions and on the same basis as in the case of individuals to whom services are furnished under this section, except that an application or other request to continue services shall not be required of such a family and certain fees shall be imposed with respect to such family under section 454C(a)(1).".

(c) CONFORMING AMENDMENTS.—

(1) Section 452(b) (42 U.S.C. 652(b)) is amended by striking "454(6)" and inserting "454(4)".

(2) Section 452(g)(2)(A) (42 U.S.C. 652(g)(2)(A)) is amended by striking "454(6)" each place it appears and inserting "454(4)(A)(ii)".

(3) Section 466(a)(3)(B) (42 U.S.C. 666(a)(3)(B)) is amended by striking "in the case of overdue support which a State has agreed to collect under section 454(6)" and inserting "in any other case".

(4) Section 466(e) (42 U.S.C. 666(e)) is amended by striking "paragraph (4) or (6) of section 454" and inserting "section 454(4)".

SEC. 7302. DISTRIBUTION OF CHILD SUPPORT COLLECTIONS.

(a) IN GENERAL.—Section 457 (42 U.S.C. 657) is amended to read as follows:

"SEC. 457. DISTRIBUTION OF COLLECTED SUPPORT.

"(a) IN GENERAL.—An amount collected on behalf of a family as support by a State pursuant to a plan approved under this part shall be distributed as follows:

"(1) FAMILIES RECEIVING ASSISTANCE.—In the case of a family receiving assistance from the State, the State shall—

"(A) retain, or distribute to the family, the State share of the amount so collected; and

"(B) pay to the Federal Government the Federal share of the amount so collected.

"(2) FAMILIES THAT FORMERLY RECEIVED ASSISTANCE.—In the case of a family that formerly received assistance from the State:

"(A) CURRENT SUPPORT PAYMENTS.—The State shall, with regard to amounts collected which represent amounts owed for the current month, distribute the amounts so collected to the family.

"(B) PAYMENT OF ARREARAGES.—The State shall, with regard to amounts collected which exceed amounts owed for the current month, distribute the amounts so collected as follows:

"(i) DISTRIBUTION TO THE FAMILY TO SATISFY ARREARAGES THAT ACCRUED AFTER THE FAMILY RECEIVED ASSISTANCE.—The State shall distribute the amount so

collected to the family to the extent necessary to satisfy any support arrearages with respect to the family that accrued after the family stopped receiving assistance from the State.

"(ii) DISTRIBUTION TO THE FAMILY TO SATISFY ARREARAGES THAT ACCRUED BEFORE OR WHILE THE FAMILY RECEIVED ASSISTANCE TO THE EXTENT PAYMENTS EXCEED ASSISTANCE RECEIVED.—In the case of arrearages of support obligations with respect to the family that were assigned to the State making or receiving the collection, as a condition of receiving assistance from the State, and which accrued before or while the family received such assistance, the State may retain all or a part of the State share and if the State does so retain, shall retain and pay to the Federal Government the Federal share of amounts so collected, to the extent the amount so retained does not exceed the amount of assistance provided to the family by the State.

"(iii) DISTRIBUTION OF THE REMAINDER TO THE FAMILY.—To the extent that neither clause (i) nor clause (ii) applies to the amount so collected, the State shall distribute the amount to the family.

"(3) FAMILIES THAT NEVER RECEIVED ASSISTANCE.—In the case of any other family, the State shall distribute the amount so collected to the family.

"(4) FAMILIES UNDER CERTAIN AGREEMENTS.—In the case of a family receiving assistance from an Indian tribe, distribute the amount so collected pursuant to an agreement entered into pursuant to a State plan under section 454(32).

"(b) TRANSITION RULE.—Any rights to support obligations which were assigned to a State as a condition of receiving assistance from the State under part A before the effective date of the Balanced Budget Reconciliation Act of 1995 shall remain assigned after such date.

"(c) DEFINITIONS.—As used in subsection (a):

"(1) ASSISTANCE.—The term 'assistance from the State' means—

"(A) assistance under the State program funded under part A or under the State plan approved under part A of this title (as in effect before October 1, 1995); or

"(B) benefits under the State plan approved under part E of this title.

"(2) FEDERAL SHARE.—The term 'Federal share' means, with respect to an amount collected by the State to satisfy a support obligation owed to a family for a time period—

"(A) the greatest Federal medical assistance percentage in effect for the State for fiscal year 1995 or any succeeding fiscal year; or

"(B) if support is not owed to the family for any month for which the family received aid to families with dependent children under the State plan approved under part A of this title (as in effect before October 1, 1995), the Fed-

eral reimbursement percentage for the fiscal year in which the time period occurs.

"(3) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term 'Federal medical assistance percentage' means—

"(A) the Federal medical assistance percentage (as defined in section 2122(c)) in the case of any State for which subparagraph (B) does not apply; or

"(B) the Federal medical assistance percentage (as defined in section 1118), in the case of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

"(4) FEDERAL REIMBURSEMENT PERCENTAGE.—The term 'Federal reimbursement percentage' means, with respect to a fiscal year—

"(A) the total amount paid to the State under section 403 for the fiscal year; divided by

"(B) the total amount expended by the State to carry out the State program under part A during the fiscal year.

"(5) STATE SHARE.—The term 'State share' means 100 percent minus the Federal share.".

(b) CONFORMING AMENDMENT.—Section 464(a)(1) (42 U.S.C. 664(a)(1)) is amended by striking "section 457(b)(4) or (d)(3)" and inserting "section 457".

(c) CLERICAL AMENDMENTS.—Section 454 (42 U.S.C. 654) is amended—

(1) in paragraph (11)—

(A) by striking "(11)" and inserting "(11)(A)"; and

(B) by inserting after the semicolon "and"; and

(2) by redesignating paragraph (12) as subparagraph (B) of paragraph (11).

(d) EFFECTIVE DATE.—

(1) GENERAL RULE.—Except as provided in paragraphs (2) and (3), the amendment made by subsection (a) shall become effective on October 1, 1999.

(2) EARLIER EFFECTIVE DATE FOR RULES RELATING TO DISTRIBUTION OF SUPPORT COLLECTED FOR FAMILIES RECEIVING ASSISTANCE.—Section 457(a)(1) of the Social Security Act, as added by the amendment made by subsection (a), shall become effective on October 1, 1995.

(3) SPECIAL RULE.—A State may elect to have the amendment made by subsection (a) become effective on a date earlier than October 1, 1999, which date shall coincide with the operation of the single statewide automated data processing and information retrieval system required by section 454A of the Social Security Act (as added by section 7344(a)(2)) and the State disbursement unit required by section 454B of the Social Security Act (as added by section 7312(b)), and the existence of State requirements for assignment of support as a condition of eligibility for assistance under part A of the Social Security Act (as added by subtitle C).

(4) CLERICAL AMENDMENTS.—The amendments made by subsection (b) shall become effective on October 1, 1995.

SEC. 7303. RIGHTS TO NOTIFICATION AND HEARINGS.

(a) IN GENERAL.—Section 454 (42 U.S.C. 654), as amended by section 7302(b), is amended by inserting after paragraph (11) the following new paragraph:

"(12) establish procedures to provide that—

"(A) individuals who are applying for or receiving services under this part, or are parties to cases in which services are being provided under this part—

"(i) receive notice of all proceedings in which support obligations might be established or modified; and

"(ii) receive a copy of any order establishing or modifying a child support obligation, or (in the case of a petition for modification) a notice of determination that there should be no change in the amount of the child support award, within 14 days after issuance of such order or determination; and

"(B) individuals applying for or receiving services under this part have access to a fair hearing or other formal complaint procedure that meets standards established by the Secretary and ensures prompt consideration and resolution of complaints (but the resort to such procedure shall not stay the enforcement of any support order);".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall become effective on October 1, 1997.

SEC. 7304. PRIVACY SAFEGUARDS.

(a) STATE PLAN REQUIREMENT.—Section 454 (42 U.S.C. 654), as amended by section 7301(b), is amended—

(1) by striking "and" at the end of paragraph (24);

(2) by striking the period at the end of paragraph (25) and inserting "; and"; and

(3) by adding after paragraph (25) the following new paragraph:

"(26) will have in effect safeguards, applicable to all confidential information handled by the State agency, that are designed to protect the privacy rights of the parties, including—

"(A) safeguards against unauthorized use or disclosure of information relating to proceedings or actions to establish paternity, or to establish or enforce support;

"(B) prohibitions against the release of information on the whereabouts of 1 party to another party against whom a protective order with respect to the former party has been entered; and

"(C) prohibitions against the release of information on the whereabouts of 1 party to another party if the State has reason to believe that the release of the information may result in physical or emotional harm to the former party.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall become effective on October 1, 1997.

CHAPTER 2—LOCATE AND CASE TRACKING

SEC. 7311. STATE CASE REGISTRY.

Section 454A, as added by section 7344(a)(2), is amended by adding at the end the following new subsections:

"(e) STATE CASE REGISTRY.—

"(1) CONTENTS.—The automated system required by this section shall include a registry (which shall be known as the 'State case registry') that contains records with respect to—

"(A) each case in which services are being provided by the State agency under the State plan approved under this part; and

"(B) each support order established or modified in the State on or after October 1, 1998.

"(2) LINKING OF LOCAL REGISTRIES.—The State case registry may be established by linking local case registries of support orders through an automated information network, subject to this section.

"(3) USE OF STANDARDIZED DATA ELEMENTS.—Such records shall use standardized data elements for both parents (such as names, social security numbers and other uniform identification numbers, dates of birth, and case identification numbers), and contain such other information (such as on-case status) as the Secretary may require.

"(4) PAYMENT RECORDS.—Each case record in the State case registry with respect to which services are being provided under the State plan approved under this part and with respect to which a support order has been established shall include a record of—

"(A) the amount of monthly (or other periodic) support owed under the order, and other amounts (including arrearages, interest or late payment penalties, and fees) due or overdue under the order;

"(B) any amount described in subparagraph (A) that has been collected;

"(C) the distribution of such collected amounts;

"(D) the birth date of any child for whom the order requires the provision of support; and

"(E) the amount of any lien imposed with respect to the order pursuant to section 466(a)(4).

"(5) UPDATING AND MONITORING.—The State agency operating the automated system required by this section shall promptly establish and maintain, and regularly monitor, case records in the State case registry with respect to which services are being provided under the State plan approved under this part, on the basis of—

"(A) information on administrative actions and administrative and judicial proceedings and orders relating to paternity and support;

"(B) information obtained from comparison with Federal, State, or local sources of information;

"(C) information on support collections and distributions; and

"(D) any other relevant information.

"(f) INFORMATION COMPARISONS AND OTHER DISCLOSURES OF INFORMATION.—The State shall use the automated system required by this section to extract information from (at such times, and in such standardized format or formats, as may be required by the Secretary), to share and compare information with, and to receive information from, other data bases and information comparison services, in order to obtain (or provide) information necessary to enable the State agency (or the Secretary or other State or Federal agencies) to carry out this part, subject to section 6103 of the Internal Revenue Code of 1986. Such information comparison activities shall include the following:

"(1) FEDERAL CASE REGISTRY OF CHILD SUPPORT ORDERS.—Furnishing to the Federal Case Registry of Child Support Orders established under section 453(h) (and update as necessary, with information including notice of expiration of orders) the minimum amount of information on child support cases recorded in the State case registry that is necessary to operate the registry (as specified by the Secretary in regulations).

"(2) FEDERAL PARENT LOCATOR SERVICE.—Exchanging information with the Federal Parent Locator Service for the purposes specified in section 453.

"(3) TEMPORARY FAMILY ASSISTANCE AND MEDICAID AGENCIES.—Exchanging information with State agencies (of the State and of other States) administering programs funded under part A, programs operated under State plans under title XXI, and other programs designated by the Secretary, as necessary to perform State agency responsibilities under this part and under such programs.

"(4) INTRASTATE AND INTERSTATE INFORMATION COMPARISONS.—Exchanging information with other agencies of the State, agencies of other States, and interstate information networks, as necessary and appropriate to carry out (or assist other States to carry out) the purposes of this part.".

SEC. 7312. COLLECTION AND DISBURSEMENT OF SUPPORT PAYMENTS.

(a) STATE PLAN REQUIREMENT.—Section 454 (42 U.S.C. 654), as amended by sections 7301(b) and 7304(a), is amended—

(1) by striking "and" at the end of paragraph (25);

(2) by striking the period at the end of paragraph (26) and inserting "; and"; and

(3) by adding after paragraph (26) the following new paragraph:

"(27) provide that, on and after October 1, 1998, the State agency will—

"(A) operate a State disbursement unit in accordance with section 454B; and

"(B) have sufficient State staff (consisting of State employees), and (at State option) private or governmental contractors reporting directly to the State agency, to—

"(i) provide automated monitoring and enforcement of support collections through the unit (including carrying out the automated data processing responsibilities described in section 454A(g)); and

"(ii) take the actions described in section 466(c)(1) in appropriate cases.".

(b) ESTABLISHMENT OF STATE DISBURSEMENT UNIT.—Part D of title IV (42 U.S.C. 651–669), as amended by section 7344(a)(2), is amended by inserting after section 454A the following new section:

"SEC. 454B. COLLECTION AND DISBURSEMENT OF SUPPORT PAYMENTS.

"(a) STATE DISBURSEMENT UNIT.—

"(1) IN GENERAL.—In order for a State to meet the requirements of this section, the State agency must establish and operate a unit (which shall be known as the 'State disbursement unit') for the collection and disbursement of payments under support orders in all cases being enforced by the State pursuant to section 454(4).

"(2) OPERATION.—The State disbursement unit shall be operated—

"(A) directly by the State agency (or 2 or more State agencies under a regional cooperative agreement), or (to the extent appropriate) by a contractor responsible directly to the State agency; and

"(B) in coordination with the automated system established by the State pursuant to section 454A.

"(3) LINKING OF LOCAL DISBURSEMENT UNITS.—The State disbursement unit may be established by linking local disbursement units through an automated information network, subject to this section. The Secretary must agree that the system will not cost more nor take more time to establish or operate than a centralized system. In addition, employers shall be given 1 location to which income withholding is sent.

"(b) REQUIRED PROCEDURES.—The State disbursement unit shall use automated procedures, electronic processes, and computer-driven technology to the maximum extent feasible, efficient, and economical, for the collection and disbursement of support payments, including procedures—

"(1) for receipt of payments from parents, employers, and other States, and for disbursements to custodial parents and other obligees, the State agency, and the agencies of other States;

"(2) for accurate identification of payments;

"(3) to ensure prompt disbursement of the custodial parent's share of any payment; and

"(4) to furnish to any parent, upon request, timely information on the current status of support payments under an order requiring payments to be made by or to the parent.

"(c) TIMING OF DISBURSEMENTS.—

"(1) IN GENERAL.—Except as provided in paragraph (2), the State disbursement unit shall distribute all amounts payable under section 457(a) within 2 business days after receipt from the employer or other source of periodic income, if sufficient information identifying the payee is provided.

"(2) PERMISSIVE RETENTION OF ARREARAGES.—The State disbursement unit may delay the distribution of collections toward arrearages until the resolution of any timely appeal with respect to such arrearages.

"(d) BUSINESS DAY DEFINED.—As used in this section, the term 'business day' means a day on which State offices are open for regular business.".

(c) USE OF AUTOMATED SYSTEM.—Section 454A, as added by section 7344(a)(2) and as amended by section 7311, is amended by adding at the end the following new subsection:

"(g) COLLECTION AND DISTRIBUTION OF SUPPORT PAYMENTS.—

"(1) IN GENERAL.—The State shall use the automated system required by this section, to the maximum extent feasible, to assist and facilitate the collection and disbursement of support payments through the State disbursement unit operated under section 454B, through the performance of functions, including, at a minimum—

"(A) transmission of orders and notices to employers (and other debtors) for the withholding of wages and other income—

"(i) within 2 business days after receipt from a court, another State, an employer, the Federal Parent Locator Service, or another source recognized by the State of notice of, and the income source subject to, such withholding; and

"(ii) using uniform formats prescribed by the Secretary;

"(B) ongoing monitoring to promptly identify failures to make timely payment of support; and

"(C) automatic use of enforcement procedures (including procedures authorized pursuant to section 466(c)) where payments are not timely made.

"(2) BUSINESS DAY DEFINED.—As used in paragraph (1), the term 'business day' means a day on which State offices are open for regular business.".

(d) EFFECTIVE DATE.—The amendments made by this section shall become effective on October 1, 1998.

SEC. 7313. STATE DIRECTORY OF NEW HIRES.

(a) STATE PLAN REQUIREMENT.—Section 454 (42 U.S.C. 654), as amended by sections 7301(b), 7304(a) and 7312(a), is amended—

(1) by striking "and" at the end of paragraph (26);

(2) by striking the period at the end of paragraph (27) and inserting "; and"; and

(3) by adding after paragraph (27) the following new paragraph:

"(28) provide that, on and after October 1, 1997, the State will operate a State Directory of New Hires in accordance with section 453A.".

(b) STATE DIRECTORY OF NEW HIRES.—Part D of title IV (42 U.S.C. 651–669) is amended by inserting after section 453 the following new section:

"SEC. 453A. STATE DIRECTORY OF NEW HIRES.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—Not later than October 1, 1997, each State shall establish an automated directory (to be known as the 'State Directory of New Hires') which shall contain infor-

mation supplied in accordance with subsection (b) by employers on each newly hired employee.

"(2) DEFINITIONS.—As used in this section:

"(A) EMPLOYEE.—The term 'employee'—

"(i) means an individual who is an employee within the meaning of chapter 24 of the Internal Revenue Code of 1986; and

"(ii) does not include an employee of a Federal or State agency performing intelligence or counterintelligence functions, if the head of such agency has determined that reporting pursuant to paragraph (1) with respect to the employee could endanger the safety of the employee or compromise an ongoing investigation or intelligence mission.

"(B) EMPLOYER.—The term 'employer' includes—

"(i) any governmental entity, and

"(ii) any labor organization.

"(C) LABOR ORGANIZATION.—The term 'labor organization' shall have the meaning given such term in section 2(5) of the National Labor Relations Act, and includes any entity (also known as a 'hiring hall') which is used by the organization and an employer to carry out requirements described in section 8(f)(3) of such Act of an agreement between the organization and the employer.

"(b) EMPLOYER INFORMATION.—

"(1) REPORTING REQUIREMENT.—

"(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), each employer shall furnish to the Directory of New Hires of the State in which a newly hired employee works, a report that contains the name, address, and social security number of the employee, and the name of, and identifying number assigned under section 6109 of the Internal Revenue Code of 1986 to, the employer.

"(B) MULTISTATE EMPLOYERS.—An employer that has employees who are employed in 2 or more States and that transmits reports magnetically or electronically may comply with subparagraph (A) by designating 1 State in which such employer has employees to which it will transmit the report described in subparagraph (A), and transmitting such report to such State. Any employer that transmits reports pursuant to this subparagraph shall notify the Secretary in writing as to which State such employer designates for the purpose of sending reports.

"(C) FEDERAL GOVERNMENT EMPLOYERS.—Any department, agency, or instrumentality of the United States shall comply with subparagraph (A) by transmitting the report described in subparagraph (A) to the National Directory of New Hires established pursuant to section 453.

"(2) TIMING OF REPORT.—The report required by paragraph (1) with respect to an employee shall be made not later than the later of—

"(A) 30 days after the date the employer hires the employee; or

"(B) in the case of an employer that reports by magnetic or electronic means, the 1st business day of the week following the date on which the employee 1st receives wages or other compensation from the employer.

"(c) REPORTING FORMAT AND METHOD.—Each report required by subsection (b) shall be made on a W–4 form and may be transmitted by 1st class mail, magnetically, or electronically.

"(d) CIVIL MONEY PENALTIES ON NONCOMPLYING EMPLOYERS.—The State shall have the option to set a State civil money penalty which shall be less than—

"(1) $25; or

"(2) $500 if, under State law, the failure is the result of a conspiracy between the employer and the employee to not supply the required report or to supply a false or incomplete report.

"(e) ENTRY OF EMPLOYER INFORMATION.—Information shall be entered into the data base maintained by the State Directory of New Hires within 5 business days of receipt from an employer pursuant to subsection (b).

"(f) INFORMATION COMPARISONS.—

"(1) IN GENERAL.—Not later than October 1, 1998, an agency designated by the State shall, directly or by contract, conduct automated comparisons of the social security numbers reported by employers pursuant to subsection (b) and the social security numbers appearing in the records of the State case registry for cases being enforced under the State plan.

"(2) NOTICE OF MATCH.—When an information comparison conducted under paragraph (1) reveals a match with respect to the social security number of an individual required to provide support under a support order, the State Directory of New Hires shall provide the agency administering the State plan approved under this part of the appropriate State with the name, address, and social security number of the employee to whom the social security number is assigned, and the name of, and identifying number assigned under section 6109 of the Internal Revenue Code of 1986 to, the employer.

"(g) TRANSMISSION OF INFORMATION.—

"(1) TRANSMISSION OF WAGE WITHHOLDING NOTICES TO EMPLOYERS.—Within 2 business days after the date information regarding a newly hired employee is entered into the State Directory of New Hires, the State agency enforcing the employee's child support obligation shall transmit a notice to the employer of the employee directing the employer to withhold from the wages of the employee an amount equal to the monthly (or other periodic) child support obligation of the employee, unless the employee's wages are not subject to withholding pursuant to section 466(b)(3).

"(2) TRANSMISSIONS TO THE NATIONAL DIRECTORY OF NEW HIRES.—

"(A) NEW HIRE INFORMATION.—Within 2 business days after the date information regarding a newly hired employee is entered into the State Directory of New Hires,

the State Directory of New Hires shall furnish the information to the National Directory of New Hires.

"(B) WAGE AND UNEMPLOYMENT COMPENSATION INFORMATION.—The State Directory of New Hires shall, on a quarterly basis, furnish to the National Directory of New Hires extracts of the reports required under section 303(a)(6) to be made to the Secretary of Labor concerning the wages and unemployment compensation paid to individuals, by such dates, in such format, and containing such information as the Secretary of Health and Human Services shall specify in regulations.

"(3) BUSINESS DAY DEFINED.—As used in this subsection, the term 'business day' means a day on which State offices are open for regular business.

"(h) OTHER USES OF NEW HIRE INFORMATION.—

"(1) LOCATION OF CHILD SUPPORT OBLIGORS.—The agency administering the State plan approved under this part shall use information received pursuant to subsection (f)(2) to locate individuals for purposes of establishing paternity and establishing, modifying, and enforcing child support obligations.

"(2) VERIFICATION OF ELIGIBILITY FOR CERTAIN PROGRAMS.—A State agency responsible for administering a program specified in section 1137(b) shall have access to information reported by employers pursuant to subsection (b) of this section for purposes of verifying eligibility for the program.

"(3) ADMINISTRATION OF EMPLOYMENT SECURITY AND WORKERS' COMPENSATION.—State agencies operating employment security and workers' compensation programs shall have access to information reported by employers pursuant to subsection (b) for the purposes of administering such programs.".

(c) QUARTERLY WAGE REPORTING.—Section 1137(a)(3) (42 U.S.C. 1320b–7(a)(3)) is amended—

(1) by inserting "(including State and local governmental entities)" after "employers"; and

(2) by inserting ", and except that no report shall be filed with respect to an employee of a State agency performing intelligence or counterintelligence functions, if the head of such agency has determined that filing such a report could endanger the safety of the employee or compromise an ongoing investigation or intelligence mission" after "paragraph (2)".

SEC. 7314. AMENDMENTS CONCERNING INCOME WITHHOLDING.

(a) MANDATORY INCOME WITHHOLDING.—

(1) IN GENERAL.—Section 466(a)(1) (42 U.S.C. 666(a)(1)) is amended to read as follows:

"(1)(A) Procedures described in subsection (b) for the withholding from income of amounts payable as support in cases subject to enforcement under the State plan.

"(B) Procedures under which the wages of a person with a support obligation imposed by a support order issued (or modified) in the State before October 1, 1996, if not otherwise subject to withholding under subsection (b), shall become subject to withholding as provided in subsection (b) if arrearages occur, without the need for a judicial or administrative hearing.".

(2) CONFORMING AMENDMENTS.—

(A) Section 466(b) (42 U.S.C. 666(b)) is amended in the matter preceding paragraph (1), by striking "subsection (a)(1)" and inserting "subsection (a)(1)(A)".

(B) Section 466(b)(4) (42 U.S.C. 666(b)(4)) is amended to read as follows:

"(4)(A) Such withholding must be carried out in full compliance with all procedural due process requirements of the State, and the State must send notice to each absent parent to whom paragraph (1) applies—

"(i) that the withholding has commenced; and

"(ii) of the procedures to follow if the absent parent desires to contest such withholding on the grounds that the withholding or the amount withheld is improper due to a mistake of fact.

"(B) The notice under subparagraph (A) shall include the information provided to the employer under paragraph (6)(A).".

(C) Section 466(b)(5) (42 U.S.C. 666(b)(5)) is amended by striking all that follows "administered by" and inserting "the State through the State disbursement unit established pursuant to section 454B, in accordance with the requirements of section 454B.".

(D) Section 466(b)(6)(A) (42 U.S.C. 666(b)(6)(A)) is amended—

(i) in clause (i), by striking "to the appropriate agency" and all that follows and inserting "to the State disbursement unit within 2 business days after the date the amount would (but for this subsection) have been paid or credited to the employee, for distribution in accordance with this part.";

(ii) in clause (ii), by inserting "be in a standard format prescribed by the Secretary, and" after "shall"; and

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

"(iii) As used in this subparagraph, the term 'business day' means a day on which State offices are open for regular business.".

(E) Section 466(b)(6)(D) (42 U.S.C. 666(b)(6)(D)) is amended by striking "any employer" and all that follows and inserting "any employer who—

"(i) discharges from employment, refuses to employ, or takes disciplinary action against any absent parent subject to wage withholding required by this subsection because of the existence of such withholding and the obligations or additional obligations which it imposes upon the employer; or

"(ii) fails to withhold support from wages, or to pay such amounts to the State disbursement unit in accordance with this subsection.".

(F) Section 466(b) (42 U.S.C. 666(b)) is amended by adding at the end the following new paragraph:

"(11) Procedures under which the agency administering the State plan approved under this part may execute a with-

holding order through electronic means and without advance notice to the obligor.".

(b) CONFORMING AMENDMENT.—Section 466(c) (42 U.S.C. 666(c)) is repealed.

SEC. 7315. LOCATOR INFORMATION FROM INTERSTATE NETWORKS.

Section 466(a) (42 U.S.C. 666(a)) is amended by adding at the end the following new paragraph:

"(12) Procedures to ensure that all Federal and State agencies conducting activities under this part have access to any system used by the State to locate an individual for purposes relating to motor vehicles or law enforcement.".

SEC. 7316. EXPANSION OF THE FEDERAL PARENT LOCATOR SERVICE.

(a) EXPANDED AUTHORITY TO LOCATE INDIVIDUALS AND ASSETS.—Section 453 (42 U.S.C. 653) is amended—

(1) in subsection (a), by striking all that follows "subsection (c))" and inserting ", for the purpose of establishing parentage, establishing, setting the amount of, modifying, or enforcing child support obligations, or enforcing child visitation orders—

"(1) information on, or facilitating the discovery of, the location of any individual—

"(A) who is under an obligation to pay child support or provide child visitation rights;

"(B) against whom such an obligation is sought;

"(C) to whom such an obligation is owed,

including the individual's social security number (or numbers), most recent address, and the name, address, and employer identification number of the individual's employer;

"(2) information on the individual's wages (or other income) from, and benefits of, employment (including rights to or enrollment in group health care coverage); and

"(3) information on the type, status, location, and amount of any assets of, or debts owed by or to, any such individual."; and

(2) in subsection (b), in the matter preceding paragraph (1), by striking "social security" and all that follows through "absent parent" and inserting "information described in subsection (a)".

(b) AUTHORIZED PERSON FOR INFORMATION REGARDING VISITATION RIGHTS.—Section 453(c) (42 U.S.C. 653(c)) is amended—

(1) in paragraph (1), by striking "support" and inserting "support or to seek to enforce orders providing child visitation rights";

(2) in paragraph (2), by striking ", or any agent of such court; and" and inserting "or to issue an order against a resident parent for visitation rights, or any agent of such court;";

(3) by striking the period at the end of paragraph (3) and inserting "; and"; and

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

"(4) the absent parent, only with regard to a court order against a resident parent for child visitation rights.".

(c) REIMBURSEMENT FOR INFORMATION FROM FEDERAL AGENCIES.—Section 453(e)(2) (42 U.S.C. 653(e)(2)) is amended in the 4th

sentence by inserting "in an amount which the Secretary determines to be reasonable payment for the information exchange (which amount shall not include payment for the costs of obtaining, compiling, or maintaining the information)" before the period.

(d) REIMBURSEMENT FOR REPORTS BY STATE AGENCIES.—Section 453 (42 U.S.C. 653) is amended by adding at the end the following new subsection:

"(g) The Secretary may reimburse Federal and State agencies for the costs incurred by such entities in furnishing information requested by the Secretary under this section in an amount which the Secretary determines to be reasonable payment for the information exchange (which amount shall not include payment for the costs of obtaining, compiling, or maintaining the information).".

(e) TECHNICAL AMENDMENTS.—

(1) Sections 452(a)(9), 453(a), 453(b), 463(a), 463(e), and 463(f) (42 U.S.C. 652(a)(9), 653(a), 653(b), 663(a), 663(e), and 663(f)) are each amended by inserting "Federal" before "Parent" each place such term appears.

(2) Section 453 (42 U.S.C. 653) is amended in the heading by adding "FEDERAL" before "PARENT".

(f) NEW COMPONENTS.—Section 453 (42 U.S.C. 653), as amended by subsection (d) of this section, is amended by adding at the end the following new subsection:

"(h)(1) Not later than October 1, 1998, in order to assist States in administering programs under State plans approved under this part and programs funded under part A, and for the other purposes specified in this section, the Secretary shall establish and maintain in the Federal Parent Locator Service an automated registry (which shall be known as the 'Federal Case Registry of Child Support Orders'), which shall contain abstracts of support orders and other information described in paragraph (2) with respect to each case in each State case registry maintained pursuant to section 454A(e), as furnished (and regularly updated), pursuant to section 454A(f), by State agencies administering programs under this part.

"(2) The information referred to in paragraph (1) with respect to a case shall be such information as the Secretary may specify in regulations (including the names, social security numbers or other uniform identification numbers, and State case identification numbers) to identify the individuals who owe or are owed support (or with respect to or on behalf of whom support obligations are sought to be established), and the State or States which have the case.

"(i)(1) In order to assist States in administering programs under State plans approved under this part and programs funded under part A, and for the other purposes specified in this section, the Secretary shall, not later than October 1, 1996, establish and maintain in the Federal Parent Locator Service an automated directory to be known as the National Directory of New Hires, which shall contain the information supplied pursuant to section 453A(g)(2).

"(2) Information shall be entered into the data base maintained by the National Directory of New Hires within 2 business days of receipt pursuant to section 453A(g)(2).

"(3) The Secretary of the Treasury shall have access to the information in the National Directory of New Hires for purposes of administering section 32 of the Internal Revenue Code of 1986, or the advance payment of the earned income tax credit under section 3507 of such Code, and verifying a claim with respect to employment in a tax return.

"(4) The Secretary shall maintain within the National Directory of New Hires a list of multistate employers that report information regarding newly hired employees pursuant to section 453A(b)(1)(B), and the State which each such employer has designated to receive such information.

"(j)(1)(A) The Secretary shall transmit information on individuals and employers maintained under this section to the Social Security Administration to the extent necessary for verification in accordance with subparagraph (B).

"(B) The Social Security Administration shall verify the accuracy of, correct, or supply to the extent possible, and report to the Secretary, the following information supplied by the Secretary pursuant to subparagraph (A):

"(i) The name, social security number, and birth date of each such individual.

"(ii) The employer identification number of each such employer.

"(2) For the purpose of locating individuals in a paternity establishment case or a case involving the establishment, modification, or enforcement of a support order, the Secretary shall—

"(A) compare information in the National Directory of New Hires against information in the support case abstracts in the Federal Case Registry of Child Support Orders not less often than every 2 business days; and

"(B) within 2 such days after such a comparison reveals a match with respect to an individual, report the information to the State agency responsible for the case.

"(3) To the extent and with the frequency that the Secretary determines to be effective in assisting States to carry out their responsibilities under programs operated under this part and programs funded under part A, the Secretary shall—

"(A) compare the information in each component of the Federal Parent Locator Service maintained under this section against the information in each other such component (other than the comparison required by paragraph (2)), and report instances in which such a comparison reveals a match with respect to an individual to State agencies operating such programs; and

"(B) disclose information in such registries to such State agencies.

"(4) The National Directory of New Hires shall provide the Commissioner of Social Security with all information in the National Directory, which shall be used to determine the accuracy of payments under the supplemental security income program under title XVI and in connection with benefits under title II.

"(5) The Secretary may provide access to information reported by employers pursuant to section 453A(b) for research purposes

found by the Secretary to be likely to contribute to achieving the purposes of part A or this part, but without personal identifiers.

"(k)(1) The Secretary shall reimburse the Commissioner of Social Security, at a rate negotiated between the Secretary and the Commissioner, for the costs incurred by the Commissioner in performing the verification services described in subsection (j).

"(2) The Secretary shall reimburse costs incurred by State directories of new hires in furnishing information as required by subsection (j)(3), at rates which the Secretary determines to be reasonable (which rates shall not include payment for the costs of obtaining, compiling, or maintaining such information).

"(3) A State or Federal agency that receives information from the Secretary pursuant to this section shall reimburse the Secretary for costs incurred by the Secretary in furnishing the information, at rates which the Secretary determines to be reasonable (which rates shall include payment for the costs of obtaining, verifying, maintaining, and comparing the information).

"(l) Information in the Federal Parent Locator Service, and information resulting from comparisons using such information, shall not be used or disclosed except as expressly provided in this section, subject to section 6103 of the Internal Revenue Code of 1986.

"(m) The Secretary shall establish and implement safeguards with respect to the entities established under this section designed to—

"(1) ensure the accuracy and completeness of information in the Federal Parent Locator Service; and

"(2) restrict access to confidential information in the Federal Parent Locator Service to authorized persons, and restrict use of such information to authorized purposes.

"(n) Each department, agency, and instrumentality of the United States shall on a quarterly basis report to the Federal Parent Locator Service the name and social security number of each employee and the wages paid to the employee during the previous quarter, except that no report shall be filed with respect to an employee of a department, agency, or instrumentality performing intelligence or counterintelligence functions, if the head of such department, agency, or instrumentality has determined that filing such a report could endanger the safety of the employee or compromise an ongoing investigation or intelligence mission.".

(f) CONFORMING AMENDMENTS.—

(1) TO PART D OF TITLE IV OF THE SOCIAL SECURITY ACT.—Section 454(8)(B) (42 U.S.C. 654(8)(B)) is amended to read as follows:

"(B) the Federal Parent Locator Service established under section 453;".

(2) TO FEDERAL UNEMPLOYMENT TAX ACT.—Section 3304(a)(16) of the Internal Revenue Code of 1986 is amended—

(A) by striking "Secretary of Health, Education, and Welfare" each place such term appears and inserting "Secretary of Health and Human Services";

(B) in subparagraph (B), by striking "such information" and all that follows and inserting "information furnished under subparagraph (A) or (B) is used only for the purposes authorized under such subparagraph;";

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

(D) by redesignating subparagraph (B) as subparagraph (C); and

(E) by inserting after subparagraph (A) the following new subparagraph:

"(B) wage and unemployment compensation information contained in the records of such agency shall be furnished to the Secretary of Health and Human Services (in accordance with regulations promulgated by such Secretary) as necessary for the purposes of the National Directory of New Hires established under section 453(i) of the Social Security Act, and".

(3) TO STATE GRANT PROGRAM UNDER TITLE III OF THE SOCIAL SECURITY ACT.—Subsection (h) of section 303 (42 U.S.C. 503) is amended to read as follows:

"(h)(1) The State agency charged with the administration of the State law shall, on a reimbursable basis—

"(A) disclose quarterly, to the Secretary of Health and Human Services wage and claim information, as required pursuant to section 453(i)(1), contained in the records of such agency;

"(B) ensure that information provided pursuant to subparagraph (A) meets such standards relating to correctness and verification as the Secretary of Health and Human Services, with the concurrence of the Secretary of Labor, may find necessary; and

"(C) establish such safeguards as the Secretary of Labor determines are necessary to insure that information disclosed under subparagraph (A) is used only for purposes of section 453(i)(1) in carrying out the child support enforcement program under title IV.

"(2) Whenever the Secretary of Labor, after reasonable notice and opportunity for hearing to the State agency charged with the administration of the State law, finds that there is a failure to comply substantially with the requirements of paragraph (1), the Secretary of Labor shall notify such State agency that further payments will not be made to the State until the Secretary of Labor is satisfied that there is no longer any such failure. Until the Secretary of Labor is so satisfied, the Secretary shall make no future certification to the Secretary of the Treasury with respect to the State.

"(3) For purposes of this subsection—

"(A) the term 'wage information' means information regarding wages paid to an individual, the social security account number of such individual, and the name, address, State, and the Federal employer identification number of the employer paying such wages to such individual; and

"(B) the term 'claim information' means information regarding whether an individual is receiving, has received, or has made application for, unemployment compensation, the amount of any such compensation being received (or to be received by such individual), and the individual's current (or most recent) home address.".

SEC. 7317. COLLECTION AND USE OF SOCIAL SECURITY NUMBERS FOR USE IN CHILD SUPPORT ENFORCEMENT.

(a) STATE LAW REQUIREMENT.—Section 466(a) (42 U.S.C. 666(a)), as amended by section 7315, is amended by adding at the end the following new paragraph:

"(13) Procedures requiring that the social security number of—

"(A) any applicant for a professional license, commercial driver's license, occupational license, or marriage license be recorded on the application;

"(B) any individual who is subject to a divorce decree, support order, or paternity determination or acknowledgment be placed in the records relating to the matter; and

"(C) any individual who has died be placed in the records relating to the death and be recorded on the death certificate.

For purposes of subparagraph (A), if a State allows the use of a number other than the social security number, the State shall so advise any applicants.".

(b) CONFORMING AMENDMENTS.—Section 205(c)(2)(C) (42 U.S.C. 405(c)(2)(C)), as amended by section 321(a)(9) of the Social Security Independence and Program Improvements Act of 1994, is amended—

(1) in clause (i), by striking "may require" and inserting "shall require";

(2) in clause (ii), by inserting after the 1st sentence the following: "In the administration of any law involving the issuance of a marriage certificate or license, each State shall require each party named in the certificate or license to furnish to the State (or political subdivision thereof), or any State agency having administrative responsibility for the law involved, the social security number of the party.";

(3) in clause (ii), by inserting "or marriage certificate" after "Such numbers shall not be recorded on the birth certificate".

(4) in clause (vi), by striking "may" and inserting "shall"; and

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

"(x) An agency of a State (or a political subdivision thereof) charged with the administration of any law concerning the issuance or renewal of a license, certificate, permit, or other authorization to engage in a profession, an occupation, or a commercial activity shall require all applicants for issuance or renewal of the license, certificate, permit, or other authorization to provide the applicant's social security number to the agency for the purpose of administering such laws, and for the purpose of responding to requests for information from an agency operating pursuant to part D of title IV.

"(xi) All divorce decrees, support orders, and paternity determinations issued, and all paternity acknowledgments made, in each State shall include the social security number of each party to the decree, order, determination, or acknowledgement in the

records relating to the matter, for the purpose of responding to requests for information from an agency operating pursuant to part D of title IV.".

CHAPTER 3—STREAMLINING AND UNIFORMITY OF PROCEDURES

SEC. 7321. ADOPTION OF UNIFORM STATE LAWS.

Section 466 (42 U.S.C. 666) is amended by adding at the end the following new subsection:

"(f)(1) In order to satisfy section 454(20)(A) on or after January 1, 1997, each State must have in effect the Uniform Interstate Family Support Act, as approved by the National Conference of Commissioners on Uniform State Laws in August 1992 (with the modifications and additions specified in this subsection), and the procedures required to implement such Act.

"(2) The State law enacted pursuant to paragraph (1) may be applied to any case involving an order which is established or modified in a State and which is sought to be modified or enforced in another State.

"(3) The State law enacted pursuant to paragraph (1) of this subsection shall contain the following provision in lieu of section 611(a)(1) of the Uniform Interstate Family Support Act:

"'(1) the following requirements are met:

"'(i) the child, the individual obligee, and the obligor—

"'(I) do not reside in the issuing State; and

"'(II) either reside in this State or are subject to the jurisdiction of this State pursuant to section 201; and

"'(ii) in any case where another State is exercising or seeks to exercise jurisdiction to modify the order, the conditions of section 204 are met to the same extent as required for proceedings to establish orders; or'.

"(4) The State law enacted pursuant to paragraph (1) shall provide that, in any proceeding subject to the law, process may be served (and proved) upon persons in the State by any means acceptable in any State which is the initiating or responding State in the proceeding.".

SEC. 7322. IMPROVEMENTS TO FULL FAITH AND CREDIT FOR CHILD SUPPORT ORDERS.

Section 1738B of title 28, United States Code, is amended—

(1) in subsection (a)(2), by striking "subsection (e)" and inserting "subsections (e), (f), and (i)";

(2) in subsection (b), by inserting after the 2nd undesignated paragraph the following:

"'child's home State' means the State in which a child lived with a parent or a person acting as parent for at least 6 consecutive months immediately preceding the time of filing of a petition or comparable pleading for support and, if a child is less than 6 months old, the State in which the child lived from birth with any of them. A period of temporary absence of any of them is counted as part of the 6-month period.";

(3) in subsection (c), by inserting "by a court of a State" before "is made";

(4) in subsection (c)(1), by inserting "and subsections (e), (f), and (g)" after "located";

(5) in subsection (d)—

(A) by inserting "individual" before "contestant"; and

(B) by striking "subsection (e)" and inserting "subsections (e) and (f)";

(6) in subsection (e), by striking "make a modification of a child support order with respect to a child that is made" and inserting "modify a child support order issued";

(7) in subsection (e)(1), by inserting "pursuant to subsection (i)" before the semicolon;

(8) in subsection (e)(2)—

(A) by inserting "individual" before "contestant" each place such term appears; and

(B) by striking "to that court's making the modification and assuming" and inserting "with the State of continuing, exclusive jurisdiction for a court of another State to modify the order and assume";

(9) by redesignating subsections (f) and (g) as subsections (g) and (h), respectively;

(10) by inserting after subsection (e) the following new subsection:

"(f) RECOGNITION OF CHILD SUPPORT ORDERS.—If 1 or more child support orders have been issued in this or another State with regard to an obligor and a child, a court shall apply the following rules in determining which order to recognize for purposes of continuing, exclusive jurisdiction and enforcement:

"(1) If only 1 court has issued a child support order, the order of that court must be recognized.

"(2) If 2 or more courts have issued child support orders for the same obligor and child, and only 1 of the courts would have continuing, exclusive jurisdiction under this section, the order of that court must be recognized.

"(3) If 2 or more courts have issued child support orders for the same obligor and child, and more than 1 of the courts would have continuing, exclusive jurisdiction under this section, an order issued by a court in the current home State of the child must be recognized, but if an order has not been issued in the current home State of the child, the order most recently issued must be recognized.

"(4) If 2 or more courts have issued child support orders for the same obligor and child, and none of the courts would have continuing, exclusive jurisdiction under this section, a court may issue a child support order, which must be recognized.

"(5) The court that has issued an order recognized under this subsection is the court having continuing, exclusive jurisdiction.";

(11) in subsection (g) (as so redesignated)—

(A) by striking "PRIOR" and inserting "MODIFIED"; and

(B) by striking "subsection (e)" and inserting "subsections (e) and (f)";

(12) in subsection (h) (as so redesignated)—

(A) in paragraph (2), by inserting "including the duration of current payments and other obligations of support" before the comma; and

(B) in paragraph (3), by inserting "arrears under" after "enforce"; and

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

"(i) REGISTRATION FOR MODIFICATION.—If there is no individual contestant or child residing in the issuing State, the party or support enforcement agency seeking to modify, or to modify and enforce, a child support order issued in another State shall register that order in a State with jurisdiction over the nonmovant for the purpose of modification.".

SEC. 7323. ADMINISTRATIVE ENFORCEMENT IN INTERSTATE CASES.

Section 466(a) (42 U.S.C. 666(a)), as amended by sections 7315 and 7317(a), is amended by adding at the end the following new paragraph:

"(14) Procedures under which—

"(A)(i) the State shall respond within 5 business days to a request made by another State to enforce a support order; and

"(ii) the term 'business day' means a day on which State offices are open for regular business;

"(B) the State may, by electronic or other means, transmit to another State a request for assistance in a case involving the enforcement of a support order, which request—

"(i) shall include such information as will enable the State to which the request is transmitted to compare the information about the case to the information in the data bases of the State; and

"(ii) shall constitute a certification by the requesting State—

"(I) of the amount of support under the order the payment of which is in arrears; and

"(II) that the requesting State has complied with all procedural due process requirements applicable to the case;

"(C) if the State provides assistance to another State pursuant to this paragraph with respect to a case, neither State shall consider the case to be transferred to the caseload of such other State; and

"(D) the State shall maintain records of—

"(i) the number of such requests for assistance received by the State;

"(ii) the number of cases for which the State collected support in response to such a request; and

"(iii) the amount of such collected support.".

SEC. 7324. USE OF FORMS IN INTERSTATE ENFORCEMENT.

(a) PROMULGATION.—Section 452(a) (42 U.S.C. 652(a)) is amended—

(1) by striking "and" at the end of paragraph (9);

(2) by striking the period at the end of paragraph (10) and inserting "; and"; and

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

"(11) not later than 60 days after the date of the enactment of the Balance Budget Reconciliation Act of 1995, establish an advisory committee, which shall include State directors of programs under this part, and not later than June 30, 1996, after consultation with the advisory committee, promulgate forms to be used by States in interstate cases for—

"(A) collection of child support through income withholding;

"(B) imposition of liens; and

"(C) administrative subpoenas.".

(b) USE BY STATES.—Section 454(9) (42 U.S.C. 654(9)) is amended—

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

(2) by inserting "and" at the end of subparagraph (D); and

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

"(E) no later than October 1, 1996, in using the forms promulgated pursuant to section 452(a)(11) for income withholding, imposition of liens, and issuance of administrative subpoenas in interstate child support cases;".

SEC. 7325. STATE LAWS PROVIDING EXPEDITED PROCEDURES.

(a) STATE LAW REQUIREMENTS.—Section 466 (42 U.S.C. 666), as amended by section 7314, is amended—

(1) in subsection (a)(2), by striking the 1st sentence and inserting the following: "Expedited administrative and judicial procedures (including the procedures specified in subsection (c)) for establishing paternity and for establishing, modifying, and enforcing support obligations."; and

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

"(c) The procedures specified in this subsection are the following:

"(1) Procedures which give the State agency the authority to take the following actions relating to establishment or enforcement of support orders, without the necessity of obtaining an order from any other judicial or administrative tribunal, and to recognize and enforce the authority of State agencies of other States) to take the following actions:

"(A) To order genetic testing for the purpose of paternity establishment as provided in section 466(a)(5).

"(B) To subpoena any financial or other information needed to establish, modify, or enforce a support order, and to impose penalties for failure to respond to such a subpoena.

"(C) To require all entities in the State (including for-profit, nonprofit, and governmental employers) to provide promptly, in response to a request by the State agency of that or any other State administering a program under this part, information on the employment, compensation, and benefits of any individual employed by such entity as an employee or contractor, and to sanction failure to respond to any such request.

"(D) To obtain access, subject to safeguards on privacy and information security, to the following records (includ-

ing automated access, in the case of records maintained in automated data bases):

"(i) Records of other State and local government agencies, including—

"(I) vital statistics (including records of marriage, birth, and divorce);

"(II) State and local tax and revenue records (including information on residence address, employer, income and assets);

"(III) records concerning real and titled personal property;

"(IV) records of occupational and professional licenses, and records concerning the ownership and control of corporations, partnerships, and other business entities;

"(V) employment security records;

"(VI) records of agencies administering public assistance programs;

"(VII) records of the motor vehicle department; and

"(VIII) corrections records.

"(ii) Certain records held by private entities, including—

"(I) customer records of public utilities and cable television companies; and

"(II) information (including information on assets and liabilities) on individuals who owe or are owed support (or against or with respect to whom a support obligation is sought) held by financial institutions (subject to limitations on liability of such entities arising from affording such access), as provided pursuant to agreements described in subsection (a)(18).

"(E) In cases where support is subject to an assignment in order to comply with a requirement imposed pursuant to part A or section 2136, or to a requirement to pay through the State disbursement unit established pursuant to section 454B, upon providing notice to obligor and obligee, to direct the obligor or other payor to change the payee to the appropriate government entity.

"(F) To order income withholding in accordance with subsections (a)(1) and (b) of section 466.

"(G) In cases in which there is a support arrearage, to secure assets to satisfy the arrearage by—

"(i) intercepting or seizing periodic or lump-sum payments from—

"(I) a State or local agency, including unemployment compensation, workers' compensation, and other benefits; and

"(II) judgments, settlements, and lotteries;

"(ii) attaching and seizing assets of the obligor held in financial institutions;

"(iii) attaching public and private retirement funds; and

"(iv) imposing liens in accordance with subsection (a)(4) and, in appropriate cases, to force sale of property and distribution of proceeds.

"(H) For the purpose of securing overdue support, to increase the amount of monthly support payments to include amounts for arrearages, subject to such conditions or limitations as the State may provide.

Such procedures shall be subject to due process safeguards, including (as appropriate) requirements for notice, opportunity to contest the action, and opportunity for an appeal on the record to an independent administrative or judicial tribunal.

"(2) The expedited procedures required under subsection (a)(2) shall include the following rules and authority, applicable with respect to all proceedings to establish paternity or to establish, modify, or enforce support orders:

"(A) Procedures under which—

"(i) each party to any paternity or child support proceeding is required (subject to privacy safeguards) to file with the tribunal and the State case registry upon entry of an order, and to update as appropriate, information on location and identity of the party, including social security number, residential and mailing addresses, telephone number, driver's license number, and name, address, and name and telephone number of employer; and

"(ii) in any subsequent child support enforcement action between the parties, upon sufficient showing that diligent effort has been made to ascertain the location of such a party, the tribunal may deem State due process requirements for notice and service of process to be met with respect to the party, upon delivery of written notice to the most recent residential or employer address filed with the tribunal pursuant to clause (i).

"(B) Procedures under which—

"(i) the State agency and any administrative or judicial tribunal with authority to hear child support and paternity cases exerts statewide jurisdiction over the parties; and

"(ii) in a State in which orders are issued by courts or administrative tribunals, a case may be transferred between local jurisdictions in the State without need for any additional filing by the petitioner, or service of process upon the respondent, to retain jurisdiction over the parties.".

(b) AUTOMATION OF STATE AGENCY FUNCTIONS.—Section 454A, as added by section 7344(a)(2) and as amended by sections 7311 and 7312(c), is amended by adding at the end the following new subsection:

"(h) EXPEDITED ADMINISTRATIVE PROCEDURES.—The automated system required by this section shall be used, to the maximum extent feasible, to implement the expedited administrative procedures required by section 466(c).".

CHAPTER 4—PATERNITY ESTABLISHMENT

SEC. 7331. STATE LAWS CONCERNING PATERNITY ESTABLISHMENT.

(a) STATE LAWS REQUIRED.—Section 466(a)(5) (42 U.S.C. 666(a)(5)) is amended to read as follows:

"(5)(A)(i) Procedures which permit the establishment of the paternity of a child at any time before the child attains 21 years of age.

"(ii) As of August 16, 1984, clause (i) shall also apply to a child for whom paternity has not been established or for whom a paternity action was brought but dismissed because a statute of limitations of less than 21 years was then in effect in the State.

"(B)(i) Procedures under which the State is required, in a contested paternity case, unless otherwise barred by State law, to require the child and all other parties (other than individuals found under section 454(29) to have good cause for refusing to cooperate) to submit to genetic tests upon the request of any such party if the request is supported by a sworn statement by the party—

"(I) alleging paternity, and setting forth facts establishing a reasonable possibility of the requisite sexual contact between the parties; or

"(II) denying paternity, and setting forth facts establishing a reasonable possibility of the nonexistence of sexual contact between the parties.

"(ii) Procedures which require the State agency in any case in which the agency orders genetic testing—

"(I) to pay costs of such tests, subject to recoupment (where the State so elects) from the alleged father if paternity is established; and

"(II) to obtain additional testing in any case where an original test result is contested, upon request and advance payment by the contestant.

"(C)(i) Procedures for a simple civil process for voluntarily acknowledging paternity under which the State must provide that, before a mother and a putative father can sign an acknowledgment of paternity, the mother and the putative father must be given notice, orally and in writing, of the alternatives to, the legal consequences of, and the rights (including, if 1 parent is a minor, any rights afforded due to minority status) and responsibilities that arise from, signing the acknowledgment.

"(ii) Such procedures must include a hospital-based program for the voluntary acknowledgment of paternity focusing on the period immediately before or after the birth of a child, subject to such good cause and other exceptions as the State shall establish and taking into account the best interests of the child.

"(iii)(I) Such procedures must require the State agency responsible for maintaining birth records to offer voluntary paternity establishment services.

"(II)(aa) The Secretary shall prescribe regulations governing voluntary paternity establishment services offered by hospitals and birth record agencies.

"(bb) The Secretary shall prescribe regulations specifying the types of other entities that may offer voluntary paternity establishment services, and governing the provision of such services, which shall include a requirement that such an entity must use the same notice provisions used by, use the same materials used by, provide the personnel providing such services with the same training provided by, and evaluate the provision of such services in the same manner as the provision of such services is evaluated by, voluntary paternity establishment programs of hospitals and birth record agencies.

"(iv) Such procedures must require the State to develop and use an affidavit for the voluntary acknowledgment of paternity which includes the minimum requirements of the affidavit developed by the Secretary under section 452(a)(7) for the voluntary acknowledgment of paternity, and to give full faith and credit to such an affidavit signed in any other State according to its procedures.

"(D)(i) Procedures under which the name of the father shall be included on the record of birth of the child only—

"(I) if the father and mother have signed a voluntary acknowledgment of paternity; or

"(II) pursuant to an order issued in a judicial or administrative proceeding.

Nothing in this clause shall preclude a State agency from obtaining an admission of paternity from the father for submission in a judicial or administrative proceeding, or prohibit an order issued in a judicial or administrative proceeding which bases a legal finding of paternity on an admission of paternity by the father and any other additional showing required by State law.

"(ii) Procedures under which—

"(I) a voluntary acknowledgment of paternity is considered a legal finding of paternity, subject to the right of any signatory to rescind the acknowledgment within 60 days;

"(II) after the 60-day period referred to in subclause (I), a signed voluntary acknowledgment of paternity may be challenged in court only on the basis of fraud, duress, or material mistake of fact, with the burden of proof upon the challenger, and under which the legal responsibilities (including child support obligations) of any signatory arising from the acknowledgment may not be suspended during the challenge, except for good cause shown; and

"(III) judicial or administrative proceedings are not required or permitted to ratify an unchallenged acknowledgment of paternity.

"(E) Procedures under which judicial or administrative proceedings are not required or permitted to ratify an unchallenged acknowledgment of paternity.

"(F) Procedures—

"(i) requiring the admission into evidence, for purposes of establishing paternity, of the results of any genetic test that is—

"(I) of a type generally acknowledged as reliable by accreditation bodies designated by the Secretary; and

"(II) performed by a laboratory approved by such an accreditation body;

"(ii) requiring an objection to genetic testing results to be made in writing not later than a specified number of days before any hearing at which the results may be introduced into evidence (or, at State option, not later than a specified number of days after receipt of the results); and

"(iii) making the test results admissible as evidence of paternity without the need for foundation testimony or other proof of authenticity or accuracy, unless objection is made.

"(G) Procedures which create a rebuttable or, at the option of the State, conclusive presumption of paternity upon genetic testing results indicating a threshold probability that the alleged father is the father of the child.

"(H) Procedures requiring a default order to be entered in a paternity case upon a showing of service of process on the defendant and any additional showing required by State law.

"(I) Procedures providing that the parties to an action to establish paternity are not entitled to a trial by jury.

"(J) Procedures which require that a temporary order be issued, upon motion by a party, requiring the provision of child support pending an administrative or judicial determination of parentage, where there is clear and convincing evidence of paternity (on the basis of genetic tests or other evidence).

"(K) Procedures under which bills for pregnancy, childbirth, and genetic testing are admissible as evidence without requiring third-party foundation testimony, and shall constitute prima facie evidence of amounts incurred for such services or for testing on behalf of the child.

"(L) Procedures ensuring that the putative father has a reasonable opportunity to initiate a paternity action.

"(M) Procedures under which voluntary acknowledgments and adjudications of paternity by judicial or administrative processes are filed with the State registry of birth records for comparison with information in the State case registry.".

(b) NATIONAL PATERNITY ACKNOWLEDGMENT AFFIDAVIT.—Section 452(a)(7) (42 U.S.C. 652(a)(7)) is amended by inserting ", and develop an affidavit to be used for the voluntary acknowledgment of paternity which shall include the social security number of each parent" before the semicolon.

(c) TECHNICAL AMENDMENT.—Section 468 (42 U.S.C. 668) is amended by striking "a simple civil process for voluntarily acknowledging paternity and".

SEC. 7332. OUTREACH FOR VOLUNTARY PATERNITY ESTABLISHMENT.

Section 454(23) (42 U.S.C. 654(23)) is amended by inserting "and will publicize the availability and encourage the use of proce-

dures for voluntary establishment of paternity and child support by means the State deems appropriate" before the semicolon.

SEC. 7333. COOPERATION BY APPLICANTS FOR AND RECIPIENTS OF TEMPORARY FAMILY ASSISTANCE.

Section 454 (42 U.S.C. 654), as amended by sections 7301(b), 7304(a), 7312(a), and 7313(a), is amended—

(1) by striking "and" at the end of paragraph (27);

(2) by striking the period at the end of paragraph (28) and inserting "; and"; and

(3) by inserting after paragraph (28) the following new paragraph:

"(29) provide that the State agency responsible for administering the State plan—

"(A) shall make the determination (and redetermination at appropriate intervals) as to whether an individual who has applied for or is receiving assistance under the State program funded under part A or the State program under title XXI is cooperating in good faith with the State in establishing the paternity of, or in establishing, modifying, or enforcing a support order for, any child of the individual by providing the State agency with the name of, and such other information as the State agency may require with respect to, the noncustodial parent of the child, subject to such good cause and other exceptions as the State shall establish and taking into account the best interests of the child;

"(B) shall require the individual to supply additional necessary information and appear at interviews, hearings, and legal proceedings;

"(C) shall require the individual and the child to submit to genetic tests pursuant to judicial or administrative order; and

"(D) shall promptly notify the individual and the State agency administering the State program funded under part A and the State agency administering the State program under title XXI of each such determination, and if noncooperation is determined, the basis therefore.".

CHAPTER 5—PROGRAM ADMINISTRATION AND FUNDING

SEC. 7341. PERFORMANCE-BASED INCENTIVES AND PENALTIES.

(a) INCENTIVE PAYMENTS.—

(1) IN GENERAL.—Section 458 (42 U.S.C. 658) is amended—

(A) in subsection (a), by striking "aid to families" and all through the end period, and inserting "assistance under a program funded under part A, and regardless of the economic circumstances of their parents, the Secretary shall, from the support collected which would otherwise represent the reimbursement to the Federal government under section 457, pay to each State for each fiscal year, on a quarterly basis (as described in subsection (e)) beginning with the quarter commencing October 1, 1999, an in-

centive payment in an amount determined under subsections (b) and (c).";

(B) by striking subsections (b) and (c) and inserting the following:

"(b)(1) Not later than 60 days after the date of the enactment of the Balanced Budget Reconciliation Act of 1995, the Secretary shall establish a committee which shall include State directors of programs under this part and which shall develop for the Secretary's approval a formula for the distribution of incentive payments to the States.

"(2) The formula developed and approved under paragraph (1)—

"(A) shall result in a percentage of the collections described in subsection (a) being distributed to each State based on the State's comparative performance in the following areas and any other areas approved by the Secretary under this subsection:

"(i) The IV-D paternity establishment percentage, as defined in section 452(g)(2).

"(ii) The percentage of cases with a support order with respect to which services are being provided under the State plan approved under this part.

"(iii) The percentage of cases with a support order in which child support is paid with respect to which services are being so provided.

"(iv) In cases receiving services under the State plan approved under this part, the amount of child support collected compared to the amount of outstanding child support owed.

"(v) The cost-effectiveness of the State program;

"(B) shall take into consideration—

"(i) the impact that incentives can have on reducing the need to provide public assistance and on permanently removing families from public assistance;

"(ii) the need to balance accuracy and fairness with simplicity of understanding and data gathering;

"(iii) the need to reward performance which improves short- and long-term program outcomes, especially establishing paternity and support orders and encouraging the timely payment of support;

"(iv) the Statewide paternity establishment percentage;

"(v) baseline data on current performance and projected costs of performance increases to assure that top performing States can actually achieve the top incentive levels with a reasonable resource investment;

"(vi) performance outcomes which would warrant an increase in the total incentive payments made to the States; and

"(vii) the use or distribution of any portion of the total incentive payments in excess of the total of the payments which may be distributed under subsection (c);

"(C) shall be determined so as to distribute to the States total incentive payments equal to the total incentive payments

for all States in fiscal year 1994, plus a portion of any increase in the reimbursement to the Federal Government under section 457 from fiscal year 1999 or any other increase based on other performance outcomes approved by the Secretary under this subsection;

"(D) shall use a definition of the term 'State' which does not include any area within the jurisdiction of an Indian tribal government; and

"(E) shall use a definition of the term 'Statewide paternity establishment percentage' to mean with respect to a State and a fiscal year—

"(i) the total number of children in the State who were born out of wedlock, who have not attained 1 year of age and for whom paternity is established or acknowledged during the fiscal year; divided by

"(ii) the total number of children born out of wedlock in the State during the fiscal year.

"(c) The total amount of the incentives payment made by the Secretary to a State in a fiscal year shall not exceed 90 percent of the total amounts expended by such State during such year for the operation of the plan approved under section 454, less payments to the State pursuant to section 455 for such year.";

(2) in subsection (d), by striking ", and any amounts" through "shall be excluded".

(b) PAYMENTS TO POLITICAL SUBDIVISIONS.—Section 454(22) (42 U.S.C. 654(22)) is amended by inserting before the semicolon the following: ", but a political subdivision shall not be entitled to receive, and the State may retain, any amount in excess of the amount the political subdivision expends on the State program under this part, less the amount equal to the percentage of that expenditure paid by the Secretary under section 455".

(c) CALCULATION OF IV–D PATERNITY ESTABLISHMENT PERCENTAGE.—

(1) Section 452(g)(1) (42 U.S.C. 652(g)(1)) is amended—

(A) in the matter preceding subparagraph (A) by inserting "its overall performance in child support enforcement is satisfactory (as defined in section 458(b) and regulations of the Secretary), and" after "1994,"; and

(B) in each of subparagraphs (A) and (B), by striking "75" and inserting "90".

(2) Section 452(g)(2)(A) (42 U.S.C. 652(g)(2)(A)) is amended in the matter preceding clause (i)—

(A) by striking "paternity establishment percentage" and inserting "IV–D paternity establishment percentage"; and

(B) by striking "(or all States, as the case may be)".

(3) Section 452(g)(3) (42 U.S.C. 652(g)(3)) is amended—

(A) by striking subparagraph (A) and redesignating subparagraphs (B) and (C) as subparagraphs (A) and (B), respectively;

(B) in subparagraph (A) (as so redesignated), by striking "the percentage of children born out-of-wedlock in a State" and inserting "the percentage of children in a State

who are born out of wedlock or for whom support has not been established"; and

(C) in subparagraph (B) (as so redesignated)—

(i) by inserting "and overall performance in child support enforcement" after "paternity establishment percentages"; and

(ii) by inserting "and securing support" before the period.

(d) EFFECTIVE DATES.—

(1) INCENTIVE ADJUSTMENTS.—

(A) IN GENERAL.—The amendments made by subsections (a) and (b) shall become effective on the date of the enactment of this Act, except to the extent provided in subparagraph (B).

(B) EXCEPTION.—Section 458 of the Social Security Act, as in effect before the date of the enactment of this section, shall be effective for purposes of incentive payments to States for fiscal years before fiscal year 2000.

(2) PENALTY REDUCTIONS.—The amendments made by subsection (c) shall become effective with respect to calendar quarters beginning on and after the date of the enactment of this Act.

SEC. 7342. FEDERAL AND STATE REVIEWS AND AUDITS.

(a) STATE AGENCY ACTIVITIES.—Section 454 (42 U.S.C. 654) is amended—

(1) in paragraph (14), by striking "(14)" and inserting "(14)(A)";

(2) by redesignating paragraph (15) as subparagraph (B) of paragraph (14); and

(3) by inserting after paragraph (14) the following new paragraph:

"(15) provide for—

"(A) a process for annual reviews of and reports to the Secretary on the State program operated under the State plan approved under this part, including such information as may be necessary to measure State compliance with Federal requirements for expedited procedures, using such standards and procedures as are required by the Secretary, under which the State agency will determine the extent to which the program is operated in compliance with this part; and

"(B) a process of extracting from the automated data processing system required by paragraph (16) and transmitting to the Secretary data and calculations concerning the levels of accomplishment (and rates of improvement) with respect to applicable performance indicators (including IV–D paternity establishment percentages and overall performance in child support enforcement) to the extent necessary for purposes of sections 452(g) and 458.".

(b) FEDERAL ACTIVITIES.—Section 452(a)(4) (42 U.S.C. 652(a)(4)) is amended to read as follows:

"(4)(A) review data and calculations transmitted by State agencies pursuant to section 454(15)(B) on State program ac-

complishments with respect to performance indicators for purposes of subsection (g) of this section and section 458;

"(B) review annual reports submitted pursuant to section 454(15)(A) and, as appropriate, provide to the State comments, recommendations for additional or alternative corrective actions, and technical assistance; and

"(C) conduct audits, in accordance with the Government auditing standards of the Comptroller General of the United States—

"(i) at least once every 3 years (or more frequently, in the case of a State which fails to meet the requirements of this part concerning performance standards and reliability of program data) to assess the completeness, reliability, and security of the data, and the accuracy of the reporting systems, used in calculating performance indicators under subsection (g) of this section and section 458;

"(ii) of the adequacy of financial management of the State program operated under the State plan approved under this part, including assessments of—

"(I) whether Federal and other funds made available to carry out the State program are being appropriately expended, and are properly and fully accounted for; and

"(II) whether collections and disbursements of support payments are carried out correctly and are fully accounted for; and

"(iii) for such other purposes as the Secretary may find necessary;".

(c) EFFECTIVE DATE.—The amendments made by this section shall be effective with respect to calendar quarters beginning 12 months or more after the date of the enactment of this Act.

SEC. 7343. REQUIRED REPORTING PROCEDURES.

(a) ESTABLISHMENT.—Section 452(a)(5) (42 U.S.C. 652(a)(5)) is amended by inserting ", and establish procedures to be followed by States for collecting and reporting information required to be provided under this part, and establish uniform definitions (including those necessary to enable the measurement of State compliance with the requirements of this part relating to expedited processes) to be applied in following such procedures" before the semicolon.

(b) STATE PLAN REQUIREMENT.—Section 454 (42 U.S.C. 654), as amended by sections 7301(b), 7304(a), 7312(a), 7313(a), and 7333, is amended—

(1) by striking "and" at the end of paragraph (28);

(2) by striking the period at the end of paragraph (29) and inserting "; and"; and

(3) by adding after paragraph (29) the following new paragraph:

"(30) provide that the State shall use the definitions established under section 452(a)(5) in collecting and reporting information as required under this part.".

SEC. 7344. AUTOMATED DATA PROCESSING REQUIREMENTS.

(a) REVISED REQUIREMENTS.—

(1) IN GENERAL.—Section 454(16) (42 U.S.C. 654(16)) is amended—

(A) by striking ", at the option of the State,";

(B) by inserting "and operation by the State agency" after "for the establishment";

(C) by inserting "meeting the requirements of section 454A" after "information retrieval system";

(D) by striking "in the State and localities thereof, so as (A)" and inserting "so as";

(E) by striking "(i)"; and

(F) by striking "(including" and all that follows and inserting a semicolon.

(2) AUTOMATED DATA PROCESSING.—Part D of title IV (42 U.S.C. 651–669) is amended by inserting after section 454 the following new section:

"SEC. 454A. AUTOMATED DATA PROCESSING.

"(a) IN GENERAL.—In order for a State to meet the requirements of this section, the State agency administering the State program under this part shall have in operation a single statewide automated data processing and information retrieval system which has the capability to perform the tasks specified in this section with the frequency and in the manner required by or under this part.

"(b) PROGRAM MANAGEMENT.—The automated system required by this section shall perform such functions as the Secretary may specify relating to management of the State program under this part, including—

"(1) controlling and accounting for use of Federal, State, and local funds in carrying out the program; and

"(2) maintaining the data necessary to meet Federal reporting requirements under this part on a timely basis.

"(c) CALCULATION OF PERFORMANCE INDICATORS.—In order to enable the Secretary to determine the incentive and penalty adjustments required by sections 452(g) and 458, the State agency shall—

"(1) use the automated system—

"(A) to maintain the requisite data on State performance with respect to paternity establishment and child support enforcement in the State; and

"(B) to calculate the IV–D paternity establishment percentage and overall performance in child support enforcement for the State for each fiscal year; and

"(2) have in place systems controls to ensure the completeness and reliability of, and ready access to, the data described in paragraph (1)(A), and the accuracy of the calculations described in paragraph (1)(B).

"(d) INFORMATION INTEGRITY AND SECURITY.—The State agency shall have in effect safeguards on the integrity, accuracy, and completeness of, access to, and use of data in the automated system required by this section, which shall include the following (in addition to such other safeguards as the Secretary may specify in regulations):

"(1) POLICIES RESTRICTING ACCESS.—Written policies concerning access to data by State agency personnel, and sharing of data with other persons, which—

"(A) permit access to and use of data only to the extent necessary to carry out the State program under this part; and

"(B) specify the data which may be used for particular program purposes, and the personnel permitted access to such data.

"(2) SYSTEMS CONTROLS.—Systems controls (such as passwords or blocking of fields) to ensure strict adherence to the policies described in paragraph (1).

"(3) MONITORING OF ACCESS.—Routine monitoring of access to and use of the automated system, through methods such as audit trails and feedback mechanisms, to guard against and promptly identify unauthorized access or use.

"(4) TRAINING AND INFORMATION.—Procedures to ensure that all personnel (including State and local agency staff and contractors) who may have access to or be required to use confidential program data are informed of applicable requirements and penalties (including those in section 6103 of the Internal Revenue Code of 1986), and are adequately trained in security procedures.

"(5) PENALTIES.—Administrative penalties (up to and including dismissal from employment) for unauthorized access to, or disclosure or use of, confidential data.".

(3) REGULATIONS.—The Secretary of Health and Human Services shall prescribe final regulations for implementation of section 454A of the Social Security Act not later than 2 years after the date of the enactment of this Act.

(4) IMPLEMENTATION TIMETABLE.—Section 454(24) (42 U.S.C. 654(24)), as amended by sections 7304(a)(2) and 7312(a)(1), is amended to read as follows:

"(24) provide that the State will have in effect an automated data processing and information retrieval system—

"(A) by October 1, 1997, which meets all requirements of this part which were enacted on or before the date of enactment of the Family Support Act of 1988; and

"(B) by October 1, 1999, which meets all requirements of this part enacted on or before the date of the enactment of the Balanced Budget Reconciliation Act of 1995, except that such deadline shall be extended by 1 day for each day (if any) by which the Secretary fails to meet the deadline imposed by section 7344(a)(3) of the Balanced Budget Reconciliation Act of 1995.".

(b) SPECIAL FEDERAL MATCHING RATE FOR DEVELOPMENT COSTS OF AUTOMATED SYSTEMS.—

(1) IN GENERAL.—Section 455(a) (42 U.S.C. 655(a)) is amended—

(A) in paragraph (1)(B)—

(i) by striking "90 percent" and inserting "the percent specified in paragraph (3)";

(ii) by striking "so much of"; and

(iii) by striking "which the Secretary" and all that follows and inserting ", and"; and

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

"(3)(A) The Secretary shall pay to each State, for each quarter in fiscal years 1996 and 1997, 90 percent of so much of the State expenditures described in paragraph (1)(B) as the Secretary finds are for a system meeting the requirements specified in section 454(16) (as in effect on the day before the date of the enactment of the Balanced Budget Reconciliation Act of 1995), but limited to the amount approved for States in the advance planning documents of such States submitted on or before May 1, 1995.

"(B)(i) The Secretary shall pay to each State, for each quarter in fiscal years 1997 through 2001, the percentage specified in clause (ii) of so much of the State expenditures described in paragraph (1)(B) as the Secretary finds are for a system meeting the requirements of sections 454(16) and 454A.

"(ii) The percentage specified in this clause is the greater of—

"(I) 80 percent; or

"(II) the percentage otherwise applicable to Federal payments to the State under subparagraph (A) (as adjusted pursuant to section 458).".

(2) TEMPORARY LIMITATION ON PAYMENTS UNDER SPECIAL FEDERAL MATCHING RATE.—

(A) IN GENERAL.—The Secretary of Health and Human Services may not pay more than $260,000,000 in the aggregate under section 455(a)(3) of the Social Security Act for fiscal years 1996, 1997, 1998, 1999, and 2000.

(B) ALLOCATION OF LIMITATION AMONG STATES.—The total amount payable to a State under section 455(a)(3) of such Act for fiscal years 1996, 1997, 1998, 1999, and 2000 shall not exceed the limitation determined for the State by the Secretary of Health and Human Services in regulations.

(C) ALLOCATION FORMULA.—The regulations referred to in subparagraph (B) shall prescribe a formula for allocating the amount specified in subparagraph (A) among States with plans approved under part D of title IV of the Social Security Act, which shall take into account—

(i) the relative size of State caseloads under such part; and

(ii) the level of automation needed to meet the automated data processing requirements of such part.

(c) CONFORMING AMENDMENT.—Section 123(c) of the Family Support Act of 1988 (102 Stat. 2352; Public Law 100–485) is repealed.

SEC. 7345. TECHNICAL ASSISTANCE.

(a) FOR TRAINING OF FEDERAL AND STATE STAFF, RESEARCH AND DEMONSTRATION PROGRAMS, AND SPECIAL PROJECTS OF REGIONAL OR NATIONAL SIGNIFICANCE.—Section 452 (42 U.S.C. 652) is amended by adding at the end the following new subsection:

"(j) Out of any money in the Treasury of the United States not otherwise appropriated, there is hereby appropriated to the Secretary for each fiscal year an amount equal to 1 percent of the total amount paid to the Federal Government pursuant to section 457(a)

during the immediately preceding fiscal year (as determined on the basis of the most recent reliable data available to the Secretary as of the end of the 3rd calendar quarter following the end of such preceding fiscal year), to cover costs incurred by the Secretary for—

"(1) information dissemination and technical assistance to States, training of State and Federal staff, staffing studies, and related activities needed to improve programs under this part (including technical assistance concerning State automated systems required by this part); and

"(2) research, demonstration, and special projects of regional or national significance relating to the operation of State programs under this part.".

(b) OPERATION OF FEDERAL PARENT LOCATOR SERVICE.—Section 453 (42 U.S.C. 653), as amended by section 7316(f), is amended by adding at the end the following new subsection:

"(n) Out of any money in the Treasury of the United States not otherwise appropriated, there is hereby appropriated to the Secretary for each fiscal year an amount equal to 2 percent of the total amount paid to the Federal Government pursuant to section 457(a) during the immediately preceding fiscal year (as determined on the basis of the most recent reliable data available to the Secretary as of the end of the 3rd calendar quarter following the end of such preceding fiscal year), to cover costs incurred by the Secretary for operation of the Federal Parent Locator Service under this section, to the extent such costs are not recovered through user fees.".

SEC. 7346. REPORTS AND DATA COLLECTION BY THE SECRETARY.

(a) ANNUAL REPORT TO CONGRESS.—

(1) Section 452(a)(10)(A) (42 U.S.C. 652(a)(10)(A)) is amended—

(A) by striking "this part;" and inserting "this part, including—"; and

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

"(i) the total amount of child support payments collected as a result of services furnished during the fiscal year to individuals receiving services under this part;

"(ii) the cost to the States and to the Federal Government of so furnishing the services; and

"(iii) the number of cases involving families—

"(I) who became ineligible for assistance under State programs funded under part A during a month in the fiscal year; and

"(II) with respect to whom a child support payment was received in the month;".

(2) Section 452(a)(10)(C) (42 U.S.C. 652(a)(10)(C)) is amended—

(A) in the matter preceding clause (i)—

(i) by striking "with the data required under each clause being separately stated for cases" and inserting "separately stated for (1) cases";

(ii) by striking "cases where the child was formerly receiving" and inserting "or formerly received";

(iii) by inserting "or 2136" after "471(a)(17)"; and

(iv) by inserting "(2)" before "all other";

(B) in each of clauses (i) and (ii), by striking ", and the total amount of such obligations";

(C) in clause (iii), by striking "described in" and all that follows and inserting "in which support was collected during the fiscal year;";

(D) by striking clause (iv); and

(E) by redesignating clause (v) as clause (vii), and inserting after clause (iii) the following new clauses:

"(iv) the total amount of support collected during such fiscal year and distributed as current support;

"(v) the total amount of support collected during such fiscal year and distributed as arrearages;

"(vi) the total amount of support due and unpaid for all fiscal years; and".

(3) Section 452(a)(10)(G) (42 U.S.C. 652(a)(10)(G)) is amended by striking "on the use of Federal courts and".

(4) Section 452(a)(10) (42 U.S.C. 652(a)(10)) is amended—

(A) in subparagraph (H), by striking "and";

(B) in subparagraph (I), by striking the period and inserting "; and"; and

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

"(J) compliance, by State, with the standards established pursuant to subsections (h) and (i).".

(5) Section 452(a)(10) (42 U.S.C. 652(a)(10)) is amended by striking all that follows subparagraph (J), as added by paragraph (4).

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall be effective with respect to fiscal year 1996 and succeeding fiscal years.

CHAPTER 6—ESTABLISHMENT AND MODIFICATION OF SUPPORT ORDERS

SEC. 7351. NATIONAL CHILD SUPPORT GUIDELINES COMMISSION.

(a) ESTABLISHMENT.—There is hereby established a commission to be known as the National Child Support Guidelines Commission (in this section referred to as the "Commission").

(b) GENERAL DUTIES.—

(1) IN GENERAL.—The Commission shall determine—

(A) whether it is appropriate to develop a national child support guideline for consideration by the Congress or for adoption by individual States; or

(B) based on a study of various guideline models, the benefits and deficiencies of such models, and any needed improvements.

(2) DEVELOPMENT OF MODELS.—If the Commission determines under paragraph (1)(A) that a national child support guideline is needed or under paragraph (1)(B) that improvements to guideline models are needed, the Commission shall develop such national guideline or improvements.

(c) MATTERS FOR CONSIDERATION BY THE COMMISSION.—In making the recommendations concerning guidelines required under subsection (b), the Commission shall consider—

(1) the adequacy of State child support guidelines established pursuant to section 467;

(2) matters generally applicable to all support orders, including—

(A) the feasibility of adopting uniform terms in all child support orders;

(B) how to define income and under what circumstances income should be imputed; and

(C) tax treatment of child support payments;

(3) the appropriate treatment of cases in which either or both parents have financial obligations to more than 1 family, including the effect (if any) to be given to—

(A) the income of either parent's spouse; and

(B) the financial responsibilities of either parent for other children or stepchildren;

(4) the appropriate treatment of expenses for child care (including care of the children of either parent, and work-related or job-training-related child care);

(5) the appropriate treatment of expenses for health care (including uninsured health care) and other extraordinary expenses for children with special needs;

(6) the appropriate duration of support by 1 or both parents, including—

(A) support (including shared support) for postsecondary or vocational education; and

(B) support for disabled adult children;

(7) procedures to automatically adjust child support orders periodically to address changed economic circumstances, including changes in the Consumer Price Index or either parent's income and expenses in particular cases;

(8) procedures to help noncustodial parents address grievances regarding visitation and custody orders to prevent such parents from withholding child support payments until such grievances are resolved; and

(9) whether, or to what extent, support levels should be adjusted in cases in which custody is shared or in which the noncustodial parent has extended visitation rights.

(d) MEMBERSHIP.—

(1) NUMBER; APPOINTMENT.—

(A) IN GENERAL.—The Commission shall be composed of 12 individuals appointed not later than January 15, 1997, of which—

(i) 2 shall be appointed by the Chairman of the Committee on Finance of the Senate, and 1 shall be appointed by the ranking minority member of the Committee;

(ii) 2 shall be appointed by the Chairman of the Committee on Ways and Means of the House of Representatives, and 1 shall be appointed by the ranking minority member of the Committee; and

(iii) 6 shall be appointed by the Secretary of Health and Human Services.

(B) QUALIFICATIONS OF MEMBERS.—Members of the Commission shall have expertise and experience in the

evaluation and development of child support guidelines. At least 1 member shall represent advocacy groups for custodial parents, at least 1 member shall represent advocacy groups for noncustodial parents, and at least 1 member shall be the director of a State program under part D of title IV of the Social Security Act.

(2) TERMS OF OFFICE.—Each member shall be appointed for a term of 2 years. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

(e) COMMISSION POWERS, COMPENSATION, ACCESS TO INFORMATION, AND SUPERVISION.—The 1st sentence of subparagraph (C), the 1st and 3rd sentences of subparagraph (D), subparagraph (F) (except with respect to the conduct of medical studies), clauses (ii) and (iii) of subparagraph (G), and subparagraph (H) of section 1886(e)(6) of the Social Security Act shall apply to the Commission in the same manner in which such provisions apply to the Prospective Payment Assessment Commission.

(f) REPORT.—Not later than 2 years after the appointment of members, the Commission shall submit to the President, the Committee on Ways and Means of the House of Representatives, and the Committee on Finance of the Senate, a recommended national child support guideline and a final assessment of issues relating to such a proposed national child support guideline.

(g) TERMINATION.—The Commission shall terminate 6 months after the submission of the report described in subsection (e).

SEC. 7352. SIMPLIFIED PROCESS FOR REVIEW AND ADJUSTMENT OF CHILD SUPPORT ORDERS.

Section 466(a)(10) (42 U.S.C. 666(a)(10)) is amended to read as follows:

"(10) Procedures under which the State shall review and adjust each support order being enforced under this part upon the request of either parent or the State if there is an assignment. Such procedures shall provide the following:

"(A) The State shall review and, as appropriate, adjust the support order every 3 years, taking into account the best interests of the child involved.

"(B)(i) The State may elect to review and, if appropriate, adjust an order pursuant to subparagraph (A) by—

"(I) reviewing and, if appropriate, adjusting the order in accordance with the guidelines established pursuant to section 467(a) if the amount of the child support award under the order differs from the amount that would be awarded in accordance with the guidelines; or

"(II) applying a cost-of-living adjustment to the order in accordance with a formula developed by the State and permit either party to contest the adjustment, within 30 days after the date of the notice of the adjustment, by making a request for review and, if appropriate, adjustment of the order in accordance with the child support guidelines established pursuant to section 467(a).

"(ii) Any adjustment under clause (i) shall be made without a requirement for proof or showing of a change in circumstances.

"(C) The State may use automated methods (including automated comparisons with wage or State income tax data) to identify orders eligible for review, conduct the review, identify orders eligible for adjustment, and apply the appropriate adjustment to the orders eligible for adjustment under the threshold established by the State.

"(D)(i) The State shall, at the request of either parent subject to such an order or of any State child support enforcement agency, review and, if appropriate, adjust the order in accordance with the guidelines established pursuant to section 467(a) based upon a substantial change in the circumstances of either parent.

"(ii) The State shall provide notice to the parents subject to such an order informing them of their right to request the State to review and, if appropriate, adjust the order pursuant to clause (i). The notice may be included in the order.".

SEC. 7353. FURNISHING CONSUMER REPORTS FOR CERTAIN PURPOSES RELATING TO CHILD SUPPORT.

Section 604 of the Fair Credit Reporting Act (15 U.S.C. 1681b) is amended by adding at the end the following new paragraphs:

"(4) In response to a request by the head of a State or local child support enforcement agency (or a State or local government official authorized by the head of such an agency), if the person making the request certifies to the consumer reporting agency that—

"(A) the consumer report is needed for the purpose of establishing an individual's capacity to make child support payments or determining the appropriate level of such payments;

"(B) the paternity of the consumer for the child to which the obligation relates has been established or acknowledged by the consumer in accordance with State laws under which the obligation arises (if required by those laws);

"(C) the person has provided at least 10 days' prior notice to the consumer whose report is requested, by certified or registered mail to the last known address of the consumer, that the report will be requested; and

"(D) the consumer report will be kept confidential, will be used solely for a purpose described in subparagraph (A), and will not be used in connection with any other civil, administrative, or criminal proceeding, or for any other purpose.

"(5) To an agency administering a State plan under section 454 of the Social Security Act (42 U.S.C. 654) for use to set an initial or modified child support award.".

SEC. 7354. NONLIABILITY FOR DEPOSITORY INSTITUTIONS PROVIDING FINANCIAL RECORDS TO STATE CHILD SUPPORT ENFORCEMENT AGENCIES IN CHILD SUPPORT CASES.

(a) IN GENERAL.—Notwithstanding any other provision of Federal or State law, a depository institution shall not be liable under any Federal or State law to any person for disclosing any financial record of an individual to a State child support enforcement agency attempting to establish, modify, or enforce a child support obligation of such individual.

(b) PROHIBITION OF DISCLOSURE OF FINANCIAL RECORD OBTAINED BY STATE CHILD SUPPORT ENFORCEMENT AGENCY.—A State child support enforcement agency which obtains a financial record of an individual from a financial institution pursuant to subsection (a) may disclose such financial record only for the purpose of, and to the extent necessary in, establishing, modifying, or enforcing a child support obligation of such individual.

(c) CIVIL DAMAGES FOR UNAUTHORIZED DISCLOSURE.—

(1) DISCLOSURE BY STATE OFFICER OR EMPLOYEE.—If any person knowingly, or by reason of negligence, discloses a financial record of an individual in violation of subsection (b), such individual may bring a civil action for damages against such person in a district court of the United States.

(2) NO LIABILITY FOR GOOD FAITH BUT ERRONEOUS INTERPRETATION.—No liability shall arise under this subsection with respect to any disclosure which results from a good faith, but erroneous, interpretation of subsection (b).

(3) DAMAGES.—In any action brought under paragraph (1), upon a finding of liability on the part of the defendant, the defendant shall be liable to the plaintiff in an amount equal to the sum of—

(A) the greater of—

(i) $1,000 for each act of unauthorized disclosure of a financial record with respect to which such defendant is found liable; or

(ii) the sum of—

(I) the actual damages sustained by the plaintiff as a result of such unauthorized disclosure; plus

(II) in the case of a willful disclosure or a disclosure which is the result of gross negligence, punitive damages; plus

(B) the costs (including attorney's fees) of the action.

(d) DEFINITIONS.—For purposes of this section:

(1) The term "depository institution" means—

(A) a depository institution, as defined in section 3(c) of the Federal Deposit Insurance Act (12 U.S.C. 1813(c));

(B) an institution-affiliated party, as defined in section 3(u) of such Act (12 U.S.C. 1813(v)); and

(C) any Federal credit union or State credit union, as defined in section 101 of the Federal Credit Union Act (12 U.S.C. 1752), including an institution-affiliated party of such a credit union, as defined in section 206(r) of such Act (12 U.S.C. 1786(r)).

(2) The term "financial record" has the meaning given such term in section 1101 of the Right to Financial Privacy Act of 1978 (12 U.S.C. 3401).

(3) The term "State child support enforcement agency" means a State agency which administers a State program for establishing and enforcing child support obligations.

CHAPTER 7—ENFORCEMENT OF SUPPORT ORDERS

SEC. 7361. INTERNAL REVENUE SERVICE COLLECTION OF ARREARAGES.

(a) AMENDMENT TO INTERNAL REVENUE CODE.—Section 6305(a) of the Internal Revenue Code of 1986 (relating to collection of certain liability) is amended—

(1) by striking "and" at the end of paragraph (3);

(2) by striking the period at the end of paragraph (4) and inserting ", and";

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

"(5) no additional fee may be assessed for adjustments to an amount previously certified pursuant to such section 452(b) with respect to the same obligor."; and

(4) by striking "Secretary of Health, Education, and Welfare" each place it appears and inserting "Secretary of Health and Human Services".

(b) EFFECTIVE DATE.—The amendments made by this section shall become effective October 1, 1997.

SEC. 7362. AUTHORITY TO COLLECT SUPPORT FROM FEDERAL EMPLOYEES.

(a) CONSOLIDATION AND STREAMLINING OF AUTHORITIES.—Section 459 (42 U.S.C. 659) is amended to read as follows:

"SEC. 459. CONSENT BY THE UNITED STATES TO INCOME WITHHOLDING, GARNISHMENT, AND SIMILAR PROCEEDINGS FOR ENFORCEMENT OF CHILD SUPPORT AND ALIMONY OBLIGATIONS.

"(a) CONSENT TO SUPPORT ENFORCEMENT.—Notwithstanding any other provision of law (including section 207 of this Act and section 5301 of title 38, United States Code), effective January 1, 1975, moneys (the entitlement to which is based upon remuneration for employment) due from, or payable by, the United States or the District of Columbia (including any agency, subdivision, or instrumentality thereof) to any individual, including members of the Armed Forces of the United States, shall be subject, in like manner and to the same extent as if the United States or the District of Columbia were a private person, to withholding in accordance with State law enacted pursuant to subsections (a)(1) and (b) of section 466 and regulations of the Secretary under such subsections, and to any other legal process brought, by a State agency administering a program under a State plan approved under this part or by an individual obligee, to enforce the legal obligation of the individual to provide child support or alimony.

"(b) CONSENT TO REQUIREMENTS APPLICABLE TO PRIVATE PERSON.—With respect to notice to withhold income pursuant to subsection (a)(1) or (b) of section 466, or any other order or process to enforce support obligations against an individual (if the order or process contains or is accompanied by sufficient data to permit

prompt identification of the individual and the moneys involved), each governmental entity specified in subsection (a) shall be subject to the same requirements as would apply if the entity were a private person, except as otherwise provided in this section.

"(c) DESIGNATION OF AGENT; RESPONSE TO NOTICE OR PROCESS—

"(1) DESIGNATION OF AGENT.—The head of each agency subject to this section shall—

"(A) designate an agent or agents to receive orders and accept service of process in matters relating to child support or alimony; and

"(B) annually publish in the Federal Register the designation of the agent or agents, identified by title or position, mailing address, and telephone number.

"(2) RESPONSE TO NOTICE OR PROCESS.—If an agent designated pursuant to paragraph (1) of this subsection receives notice pursuant to State procedures in effect pursuant to subsection (a)(1) or (b) of section 466, or is effectively served with any order, process, or interrogatory, with respect to an individual's child support or alimony payment obligations, the agent shall—

"(A) as soon as possible (but not later than 15 days) thereafter, send written notice of the notice or service (together with a copy of the notice or service) to the individual at the duty station or last-known home address of the individual;

"(B) within 30 days (or such longer period as may be prescribed by applicable State law) after receipt of a notice pursuant to such State procedures, comply with all applicable provisions of section 466; and

"(C) within 30 days (or such longer period as may be prescribed by applicable State law) after effective service of any other such order, process, or interrogatory, respond to the order, process, or interrogatory.

"(d) PRIORITY OF CLAIMS.—If a governmental entity specified in subsection (a) receives notice or is served with process, as provided in this section, concerning amounts owed by an individual to more than 1 person—

"(1) support collection under section 466(b) must be given priority over any other process, as provided in section 466(b)(7);

"(2) allocation of moneys due or payable to an individual among claimants under section 466(b) shall be governed by section 466(b) and the regulations prescribed under such section; and

"(3) such moneys as remain after compliance with paragraphs (1) and (2) shall be available to satisfy any other such processes on a 1st-come, 1st-served basis, with any such process being satisfied out of such moneys as remain after the satisfaction of all such processes which have been previously served.

"(e) NO REQUIREMENT TO VARY PAY CYCLES.—A governmental entity that is affected by legal process served for the enforcement of an individual's child support or alimony payment obligations

shall not be required to vary its normal pay and disbursement cycle in order to comply with the legal process.

"(f) RELIEF FROM LIABILITY.—

"(1) Neither the United States, nor the government of the District of Columbia, nor any disbursing officer shall be liable with respect to any payment made from moneys due or payable from the United States to any individual pursuant to legal process regular on its face, if the payment is made in accordance with this section and the regulations issued to carry out this section.

"(2) No Federal employee whose duties include taking actions necessary to comply with the requirements of subsection (a) with regard to any individual shall be subject under any law to any disciplinary action or civil or criminal liability or penalty for, or on account of, any disclosure of information made by the employee in connection with the carrying out of such actions.

"(g) REGULATIONS.—Authority to promulgate regulations for the implementation of this section shall, insofar as this section applies to moneys due from (or payable by)—

"(1) the United States (other than the legislative or judicial branches of the Federal Government) or the government of the District of Columbia, be vested in the President (or the designee of the President);

"(2) the legislative branch of the Federal Government, be vested jointly in the President pro tempore of the Senate and the Speaker of the House of Representatives (or their designees), and

"(3) the judicial branch of the Federal Government, be vested in the Chief Justice of the United States (or the designee of the Chief Justice).

"(h) MONEYS SUBJECT TO PROCESS.—

"(1) IN GENERAL.—Subject to paragraph (2), moneys paid or payable to an individual which are considered to be based upon remuneration for employment, for purposes of this section—

"(A) consist of—

"(i) compensation paid or payable for personal services of the individual, whether the compensation is denominated as wages, salary, commission, bonus, pay, allowances, or otherwise (including severance pay, sick pay, and incentive pay);

"(ii) periodic benefits (including a periodic benefit as defined in section 228(h)(3)) or other payments—

"(I) under the insurance system established by title II;

"(II) under any other system or fund established by the United States which provides for the payment of pensions, retirement or retired pay, annuities, dependents' or survivors' benefits, or similar amounts payable on account of personal services performed by the individual or any other individual;

"(III) as compensation for death under any Federal program;

"(IV) under any Federal program established to provide 'black lung' benefits; or

"(V) by the Secretary of Veterans Affairs as pension, or as compensation for a service-connected disability or death (except any compensation paid by the Secretary to a member of the Armed Forces who is in receipt of retired or retainer pay if the member has waived a portion of the retired pay of the member in order to receive the compensation); and

"(iii) workers' compensation benefits paid under Federal or State law; but

"(B) do not include any payment—

"(i) by way of reimbursement or otherwise, to defray expenses incurred by the individual in carrying out duties associated with the employment of the individual; or

"(ii) as allowances for members of the uniformed services payable pursuant to chapter 7 of title 37, United States Code, as prescribed by the Secretaries concerned (defined by section 101(5) of such title) as necessary for the efficient performance of duty.

"(2) CERTAIN AMOUNTS EXCLUDED.—In determining the amount of any moneys due from, or payable by, the United States to any individual, there shall be excluded amounts which—

"(A) are owed by the individual to the United States;

"(B) are required by law to be, and are, deducted from the remuneration or other payment involved, including Federal employment taxes, and fines and forfeitures ordered by court-martial;

"(C) are properly withheld for Federal, State, or local income tax purposes, if the withholding of the amounts is authorized or required by law and if amounts withheld are not greater than would be the case if the individual claimed all dependents to which he was entitled (the withholding of additional amounts pursuant to section 3402(i) of the Internal Revenue Code of 1986 may be permitted only when the individual presents evidence of a tax obligation which supports the additional withholding);

"(D) are deducted as health insurance premiums;

"(E) are deducted as normal retirement contributions (not including amounts deducted for supplementary coverage); or

"(F) are deducted as normal life insurance premiums from salary or other remuneration for employment (not including amounts deducted for supplementary coverage).

"(i) DEFINITIONS.—As used in this section:

"(1) UNITED STATES.—The term 'United States' includes any department, agency, or instrumentality of the legislative, judicial, or executive branch of the Federal Government, the United States Postal Service, the Postal Rate Commission, any

Federal corporation created by an Act of Congress that is wholly owned by the Federal Government, and the governments of the territories and possessions of the United States.

"(2) CHILD SUPPORT.—The term 'child support', when used in reference to the legal obligations of an individual to provide such support, means periodic payments of funds for the support and maintenance of a child or children with respect to which the individual has such an obligation, and (subject to and in accordance with State law) includes payments to provide for health care, education, recreation, clothing, or to meet other specific needs of such a child or children, and includes attorney's fees, interest, and court costs, when and to the extent that the same are expressly made recoverable as such pursuant to a decree, order, or judgment issued in accordance with applicable State law by a court of competent jurisdiction.

"(3) ALIMONY.—The term 'alimony', when used in reference to the legal obligations of an individual to provide the same, means periodic payments of funds for the support and maintenance of the spouse (or former spouse) of the individual, and (subject to and in accordance with State law) includes separate maintenance, alimony pendente lite, maintenance, and spousal support, and includes attorney's fees, interest, and court costs when and to the extent that the same are expressly made recoverable as such pursuant to a decree, order, or judgment issued in accordance with applicable State law by a court of competent jurisdiction. Such term does not include any payment or transfer of property or its value by an individual to the spouse or a former spouse of the individual in compliance with any community property settlement, equitable distribution of property, or other division of property between spouses or former spouses.

"(4) PRIVATE PERSON.—The term 'private person' means a person who does not have sovereign or other special immunity or privilege which causes the person not to be subject to legal process.

"(5) LEGAL PROCESS.—The term 'legal process' means any writ, order, summons, or other similar process in the nature of garnishment—

"(A) which is issued by—

"(i) a court of competent jurisdiction in any State, territory, or possession of the United States;

"(ii) a court of competent jurisdiction in any foreign country with which the United States has entered into an agreement which requires the United States to honor the process; or

"(iii) an authorized official pursuant to an order of such a court of competent jurisdiction or pursuant to State or local law; and

"(B) which is directed to, and the purpose of which is to compel, a governmental entity which holds moneys which are otherwise payable to an individual to make a payment from the moneys to another party in order to satisfy a legal obligation of the individual to provide child support or make alimony payments.".

(b) CONFORMING AMENDMENTS.—

(1) TO PART D OF TITLE IV.—Sections 461 and 462 (42 U.S.C. 661 and 662) are repealed.

(2) TO TITLE 5, UNITED STATES CODE.—Section 5520a of title 5, United States Code, is amended, in subsections (h)(2) and (i), by striking "sections 459, 461, and 462 of the Social Security Act (42 U.S.C. 659, 661, and 662)" and inserting "section 459 of the Social Security Act (42 U.S.C. 659)".

(c) MILITARY RETIRED AND RETAINER PAY.—

(1) DEFINITION OF COURT.—Section 1408(a)(1) of title 10, United States Code, is amended—

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

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

(C) by adding after subparagraph (C) the following new subparagraph:

"(D) any administrative or judicial tribunal of a State competent to enter orders for support or maintenance (including a State agency administering a program under a State plan approved under part D of title IV of the Social Security Act), and, for purposes of this subparagraph, the term 'State' includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.".

(2) DEFINITION OF COURT ORDER.—Section 1408(a)(2) of such title is amended by inserting "or a court order for the payment of child support not included in or accompanied by such a decree or settlement," before "which—".

(3) PUBLIC PAYEE.—Section 1408(d) of such title is amended—

(A) in the heading, by inserting "(OR FOR BENEFIT OF)" before "SPOUSE OR"; and

(B) in paragraph (1), in the 1st sentence, by inserting "(or for the benefit of such spouse or former spouse to a State disbursement unit established pursuant to section 454B of the Social Security Act or other public payee designated by a State, in accordance with part D of title IV of the Social Security Act, as directed by court order, or as otherwise directed in accordance with such part D)" before "in an amount sufficient".

(4) RELATIONSHIP TO PART D OF TITLE IV.—Section 1408 of such title is amended by adding at the end the following new subsection:

"(j) RELATIONSHIP TO OTHER LAWS.—In any case involving an order providing for payment of child support (as defined in section 459(i)(2) of the Social Security Act) by a member who has never been married to the other parent of the child, the provisions of this section shall not apply, and the case shall be subject to the provisions of section 459 of such Act.".

(d) EFFECTIVE DATE.—The amendments made by this section shall become effective 6 months after the date of the enactment of this Act.

SEC. 7363. ENFORCEMENT OF CHILD SUPPORT OBLIGATIONS OF MEMBERS OF THE ARMED FORCES.

(a) AVAILABILITY OF LOCATOR INFORMATION.—

(1) MAINTENANCE OF ADDRESS INFORMATION.—The Secretary of Defense shall establish a centralized personnel locator service that includes the address of each member of the Armed Forces under the jurisdiction of the Secretary. Upon request of the Secretary of Transportation, addresses for members of the Coast Guard shall be included in the centralized personnel locator service.

(2) TYPE OF ADDRESS.—

(A) RESIDENTIAL ADDRESS.—Except as provided in subparagraph (B), the address for a member of the Armed Forces shown in the locator service shall be the residential address of that member.

(B) DUTY ADDRESS.—The address for a member of the Armed Forces shown in the locator service shall be the duty address of that member in the case of a member—

(i) who is permanently assigned overseas, to a vessel, or to a routinely deployable unit; or

(ii) with respect to whom the Secretary concerned makes a determination that the member's residential address should not be disclosed due to national security or safety concerns.

(3) UPDATING OF LOCATOR INFORMATION.—Within 30 days after a member listed in the locator service establishes a new residential address (or a new duty address, in the case of a member covered by paragraph (2)(B)), the Secretary concerned shall update the locator service to indicate the new address of the member.

(4) AVAILABILITY OF INFORMATION.—The Secretary of Defense shall make information regarding the address of a member of the Armed Forces listed in the locator service available, on request, to the Federal Parent Locator Service established under section 453 of the Social Security Act.

(b) FACILITATING GRANTING OF LEAVE FOR ATTENDANCE AT HEARINGS.—

(1) REGULATIONS.—The Secretary of each military department, and the Secretary of Transportation with respect to the Coast Guard when it is not operating as a service in the Navy, shall prescribe regulations to facilitate the granting of leave to a member of the Armed Forces under the jurisdiction of that Secretary in a case in which—

(A) the leave is needed for the member to attend a hearing described in paragraph (2);

(B) the member is not serving in or with a unit deployed in a contingency operation (as defined in section 101 of title 10, United States Code); and

(C) the exigencies of military service (as determined by the Secretary concerned) do not otherwise require that such leave not be granted.

(2) COVERED HEARINGS.—Paragraph (1) applies to a hearing that is conducted by a court or pursuant to an administra-

tive process established under State law, in connection with a civil action—

(A) to determine whether a member of the Armed Forces is a natural parent of a child; or

(B) to determine an obligation of a member of the Armed Forces to provide child support.

(3) DEFINITIONS.—For purposes of this subsection:

(A) The term "court" has the meaning given that term in section 1408(a) of title 10, United States Code.

(B) The term "child support" has the meaning given such term in section 459(i) of the Social Security Act (42 U.S.C. 659(i)).

(c) PAYMENT OF MILITARY RETIRED PAY IN COMPLIANCE WITH CHILD SUPPORT ORDERS.—

(1) DATE OF CERTIFICATION OF COURT ORDER.—Section 1408 of title 10, United States Code, as amended by section 7362(c)(4), is amended—

(A) by redesignating subsections (i) and (j) as subsections (j) and (k), respectively; and

(B) by inserting after subsection (h) the following new subsection:

"(i) CERTIFICATION DATE.—It is not necessary that the date of a certification of the authenticity or completeness of a copy of a court order for child support received by the Secretary concerned for the purposes of this section be recent in relation to the date of receipt by the Secretary.".

(2) PAYMENTS CONSISTENT WITH ASSIGNMENTS OF RIGHTS TO STATES.—Section 1408(d)(1) of such title is amended by inserting after the 1st sentence the following: "In the case of a spouse or former spouse who assigns to a State the rights of the spouse or former spouse to receive support, the Secretary concerned may make the child support payments referred to in the preceding sentence to that State in amounts consistent with that assignment of rights.".

(3) ARREARAGES OWED BY MEMBERS OF THE UNIFORMED SERVICES.—Section 1408(d) of such title is amended by adding at the end the following new paragraph:

"(6) In the case of a court order for which effective service is made on the Secretary concerned on or after the date of the enactment of this paragraph and which provides for payments from the disposable retired pay of a member to satisfy the amount of child support set forth in the order, the authority provided in paragraph (1) to make payments from the disposable retired pay of a member to satisfy the amount of child support set forth in a court order shall apply to payment of any amount of child support arrearages set forth in that order as well as to amounts of child support that currently become due.".

(4) PAYROLL DEDUCTIONS.—The Secretary of Defense shall begin payroll deductions within 30 days after receiving notice of withholding, or for the 1st pay period that begins after such 30-day period.

SEC. 7364. VOIDING OF FRAUDULENT TRANSFERS.

Section 466 (42 U.S.C. 666), as amended by section 7321, is amended by adding at the end the following new subsection:

"(g) In order to satisfy section 454(20)(A), each State must have in effect—

"(1)(A) the Uniform Fraudulent Conveyance Act of 1981;

"(B) the Uniform Fraudulent Transfer Act of 1984; or

"(C) another law, specifying indicia of fraud which create a prima facie case that a debtor transferred income or property to avoid payment to a child support creditor, which the Secretary finds affords comparable rights to child support creditors; and

"(2) procedures under which, in any case in which the State knows of a transfer by a child support debtor with respect to which such a prima facie case is established, the State must—

"(A) seek to void such transfer; or

"(B) obtain a settlement in the best interests of the child support creditor.".

SEC. 7365. WORK REQUIREMENT FOR PERSONS OWING CHILD SUPPORT.

Section 466(a) (42 U.S.C. 666(a)), as amended by sections 7301(a), 7315, 7317(a), and 7323, is amended by adding at the end the following new paragraph:

"(15) Procedures requiring the State, in any case in which an individual owes support with respect to a child receiving services under this part, to seek a court order or administrative order that requires the individual to—

"(A) pay such support in accordance with a plan approved by the court; or

"(B) if the individual is not working and is not incapacitated, participate in work activities (including, at State option, work activities as defined in section 482) as the court deems appropriate.".

SEC. 7366. DEFINITION OF SUPPORT ORDER.

Section 453 (42 U.S.C. 653) as amended by sections 7316 and 7345(b), is amended by adding at the end the following new subsection:

"(o) As used in this part, the term 'support order' means a judgment, decree, or order, whether temporary, final, or subject to modification, issued by a court or an administrative agency of competent jurisdiction, for the support and maintenance of a child, including a child who has attained the age of majority under the law of the issuing State, or a child and the parent with whom the child is living, which provides for monetary support, health care, arrearages, or reimbursement, and which may include related costs and fees, interest and penalties, income withholding, attorneys' fees, and other relief.".

SEC. 7367. REPORTING ARREARAGES TO CREDIT BUREAUS.

Section 466(a)(7) (42 U.S.C. 666(a)(7)) is amended to read as follows:

"(7)(A) Procedures (subject to safeguards pursuant to subparagraph (B)) requiring the State to report periodically to consumer reporting agencies (as defined in section 603(f) of the Fair Credit Reporting Act (15.U.S.C. 1681a(f)) the name of any

absent parent who is delinquent in the payment of support, and the amount of overdue support owed by such parent.

"(B) Procedures ensuring that, in carrying out subparagraph (A), information with respect to an absent parent is reported—

"(i) only after such parent has been afforded all due process required under State law, including notice and a reasonable opportunity to contest the accuracy of such information; and

"(ii) only to an entity that has furnished evidence satisfactory to the State that the entity is a consumer reporting agency.".

SEC. 7368. LIENS.

Section 466(a)(4) (42 U.S.C. 666(a)(4)) is amended to read as follows:

"(4) Procedures under which—

"(A) liens arise by operation of law against real and personal property for amounts of overdue support owed by an absent parent who resides or owns property in the State; and

"(B) the State accords full faith and credit to liens described in subparagraph (A) arising in another State, without registration of the underlying order.".

SEC. 7369. STATE LAW AUTHORIZING SUSPENSION OF LICENSES.

Section 466(a) (42 U.S.C. 666(a)), as amended by sections 7315, 7317(a), 7323, and 7365, is amended by adding at the end the following new paragraph:

"(16) Procedures under which the State has (and uses in appropriate cases) authority to withhold or suspend, or to restrict the use of, driver's licenses, professional and occupational licenses, and recreational licenses of individuals owing overdue support or failing, after receiving appropriate notice, to comply with subpoenas or warrants relating to paternity or child support proceedings.".

SEC. 7370. DENIAL OF PASSPORTS FOR NONPAYMENT OF CHILD SUPPORT.

(a) HHS CERTIFICATION PROCEDURE.—

(1) SECRETARIAL RESPONSIBILITY.—Section 452 (42 U.S.C. 652), as amended by section 7345, is amended by adding at the end the following new subsection:

"(k)(1) If the Secretary receives a certification by a State agency in accordance with the requirements of section 454(31) that an individual owes arrearages of child support in an amount exceeding $5,000, the Secretary shall transmit such certification to the Secretary of State for action (with respect to denial, revocation, or limitation of passports) pursuant to section 7370(b) of the Balanced Budget Reconciliation Act of 1995.

"(2) The Secretary shall not be liable to an individual for any action with respect to a certification by a State agency under this section.".

(2) STATE CSE AGENCY RESPONSIBILITY.—Section 454 (42 U.S.C. 654), as amended by sections 7301(b), 7304(a), 7312(b), 7313(a), 7333, and 7343(a), is amended—

(A) by striking "and" at the end of paragraph (29);

(B) by striking the period at the end of paragraph (30) and inserting "; and"; and

(C) by adding after paragraph (30) the following new paragraph:

"(31) provide that the State agency will have in effect a procedure (which may be combined with the procedure for tax refund offset under section 464) for certifying to the Secretary, for purposes of the procedure under section 452(k) (concerning denial of passports), determinations that individuals owe arrearages of child support in an amount exceeding $5,000, under which procedure—

"(A) each individual concerned is afforded notice of such determination and the consequences thereof, and an opportunity to contest the determination; and

"(B) the certification by the State agency is furnished to the Secretary in such format, and accompanied by such supporting documentation, as the Secretary may require.".

(b) STATE DEPARTMENT PROCEDURE FOR DENIAL OF PASSPORTS.—

(1) IN GENERAL.—The Secretary of State shall, upon certification by the Secretary of Health and Human Services transmitted under section 452(k) of the Social Security Act, refuse to issue a passport to such individual, and may revoke, restrict, or limit a passport issued previously to such individual.

(2) LIMIT ON LIABILITY.—The Secretary of State shall not be liable to an individual for any action with respect to a certification by a State agency under this section.

(c) EFFECTIVE DATE.—This section and the amendments made by this section shall become effective October 1, 1996.

SEC. 7371. INTERNATIONAL CHILD SUPPORT ENFORCEMENT.

The Secretary of State is authorized to negotiate reciprocal agreements with foreign nations on behalf of the States, territories, and possessions of the United States regarding the international enforcement of child support obligations and designating the Department of Health and Human Services as the central authority for such enforcement.

SEC. 7372. DENIAL OF MEANS-TESTED FEDERAL BENEFITS TO NONCUSTODIAL PARENTS WHO ARE DELINQUENT IN PAYING CHILD SUPPORT.

(a) IN GENERAL.—Notwithstanding any other provision of law, a non-custodial parent who is more then 2 months delinquent in paying child support shall not be eligible to receive any means-tested Federal benefits.

(b) EXCEPTION.—

(1) IN GENERAL.—Subsection (a) shall not apply to an unemployed non-custodial parent who is more then 2 months delinquent in paying child support if such parent—

(A) enters into a schedule of repayment for past due child support with the entity that issued the underlying child support order; and

(B) meets all of the terms of repayment specified in the schedule of repayment as enforced by the appropriate disbursing entity.

(2) 2-YEAR EXCLUSION.—(A) A non-custodial parent who becomes delinquent in child support a second time or any subsequent time shall not be eligible to receive any means-tested Federal benefits for a 2-year period beginning on the date that such parent failed to meet such terms.

(B) At the end of that two-year period, paragraph (A) shall once again apply to that individual.

(c) MEANS-TESTED FEDERAL BENEFITS.— For purposes of this section, the term "means-tested Federal benefits" means benefits under any program of assistance, funded in whole or in part, by the Federal Government, for which eligibility for benefits is based on need.

SEC. 7373. CHILD SUPPORT ENFORCEMENT FOR INDIAN TRIBES.

(a) CHILD SUPPORT ENFORCEMENT AGREEMENTS.—Section 454 (42 U.S.C. 654), as amended by sections 7301(b), 7304(a), 7312(b), 9313(a), 7333, 7343(a), and 7370(a)(2) is amended—

(1) by striking "and" at the end of paragraph (30);

(2) by striking the period at the end of paragraph (31) and inserting "; and"; and

(3) by adding after paragraph (31) the following new paragraph:

"(32) provide that a State that receives funding pursuant to section 429 and that has within its borders Indian country (as defined in section 1151 of title 18, United States Code) shall, through the State administering agency, make reasonable efforts to enter into cooperative agreements with an Indian tribe or tribal organization (as defined in paragraphs (1) and (2) of section 428(c)), if the Indian tribe or tribal organization demonstrates that such tribe or organization has an established tribal court system or a Court of Indian Offenses with the authority to establish paternity, establish and enforce support orders, and to enter support orders in accordance with child support guidelines established by such tribe or organization, under which the State and tribe or organization shall provide for the cooperative delivery of child support enforcement services in Indian country and for the forwarding of all funding collected pursuant to the functions performed by the tribe or organization to the State agency, or conversely, by the State agency to the tribe or organization, which shall distribute such funding in accordance with such agreement.".

(b) DIRECT FEDERAL FUNDING TO INDIAN TRIBES AND TRIBAL ORGANIZATIONS.—Section 455 (42 U.S.C. 655) is amended by adding at the end the following new subsection:

"(b) The Secretary may, in appropriate cases, make direct payments under this part to an Indian tribe or tribal organization which has an approved child support enforcement plan under this title. In determining whether such payments are appropriate, the Secretary shall, at a minimum, consider whether services are being provided to eligible Indian recipients by the State agency through an agreement entered into pursuant to section 454(32). The Secretary shall provide for an appropriate adjustment to the State allotment under this section to take into account any payments made under this subsection to Indian tribes or tribal organizations located within such State.

(c) COOPERATIVE ENFORCEMENT AGREEMENTS.—Paragraph (7) of section 454 (42 U.S.C. 654) is amended by inserting "and Indian tribes or tribal organizations (as defined in section 450(b) of title 25, United States Code)" after "law enforcement officials".

SEC. 7374. FINANCIAL INSTITUTION DATA MATCHES.

Section 466(a) (42 U.S.C. 666(a)), as amended by sections 7315, 7317(a), 7323, 7365, and 7369, is amended by adding at the end the following new paragraph:

"(17) Procedures under which the State agency shall enter into agreements with financial institutions doing business within the State to develop and operate a data match system, using automated data exchanges to the maximum extent feasible, in which such financial institutions are required to provide for each calendar quarter the name, record address, social security number, and other identifying information for each absent parent identified by the State who maintains an account at such institution and, in response to a notice of lien or levy, to encumber or surrender, as the case may be, assets held by such institution on behalf of any absent parent who is subject to a child support lien pursuant to paragraph (4). For purposes of this paragraph, the term 'financial institution' means Federal and State commercial savings banks, including savings and loan associations and cooperative banks, Federal and State chartered credit unions, benefit associations, insurance companies, safe deposit companies, money-market mutual funds, and any similar entity authorized to do business in the State, and the term 'account' means a demand deposit account, checking or negotiable withdrawal order account, savings account, time deposit account, or money-market mutual fund account.

SEC. 7375. CHILD SUPPORT ENFORCEMENT FEES FOR NON-ASSISTANCE FAMILIES.

(a) IN GENERAL.—Part D of title IV (42 U.S.C. 651–669), as amended by sections 7312(b) and 7344(a)(2), is amended by inserting after section 454B the following new section:

"SEC. 454C. COLLECTION OF CHILD SUPPORT ENFORCEMENT COSTS AND FEES FOR NON-ASSISTANCE FAMILIES.

"(a) MANDATORY ENFORCEMENT FEES.—

"(1) IN GENERAL.—With respect to individuals described in section 454(6)(B) for services described in section 454(4), the State, under the State plan, shall impose and collect an amount equal to the sum of the following fees:

"(A) APPLICATION FEES.—An application fee of $25 per applicant.

"(B) COLLECTION FEES.—In addition to any child support collected, a collection fee in an amount equal to the applicable percentage of the amount of child support collected.

"(2) RULES REGARDING ENFORCEMENT FEES.—

"(A) IN GENERAL.—At the option of the State, the fees described in paragraph (1) may be—

"(i) paid by individuals applying for the services described in section 454(4);

"(ii) recovered from absent parents; or

"(iii) paid by the State out of its own funds, the payment of which from State funds shall not be considered as an administrative cost of the State for the operation of the plan, and shall be considered income to the program.

"(B) LIMITATION OF COLLECTION FEES APPLIED TO CERTAIN CUSTODIAL PARENTS.—With respect to any individual to whom such services are made available—

"(i) whose family income is below 185 percent of the poverty line applicable to the size of the family involved (as defined in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section), no fee under paragraph (1)(B) may be collected from such individual;

"(ii) whose family income is not less than 185 percent nor more than 300 percent of such poverty line, such fee collected from such individual may not exceed 2 percent of the amount of child support collected; and

"(iii) whose family income is more than 300 percent of such poverty line, such fee collected from such individual may not exceed the amount of such fee collected from the absent parent.

"(C) MEANS-TESTED.—The State at its option may vary the amount of the fees under paragraph (1) among individuals on the basis of ability to pay.

"(D) APPLICABLE PERCENTAGE.—For purposes of paragraph (1)(B), the applicable percentage for any State shall equal such percentage as is required, after taking into account subparagraphs (B) and (C), to provide an amount of total fees under paragraph (1) which equals the amount which would be provided by imposing the fee under paragraph (1)(A) and a 6.6 percent fee under paragraph (1)(B) without regard to such subparagraphs.

"(E) DISPOSITION OF COLLECTION FEES.—Notwithstanding any other provision of this part, 100 percent of any amount representing collection fees under paragraph (1)(B) shall be remitted to the Federal Government.

"(b) PERMISSIVE FEES.—With respect to any individual described in section 454(6)(B), the State may impose—

"(1) a fee of not more than $25 in any case where the State requests the Secretary of the Treasury to withhold past-due support owed to or on behalf of such individual from a tax refund pursuant to section 464(a)(2), and

"(2) a fee (in accordance with regulations of the Secretary) for performing genetic tests.

"(c) COLLECTION OF EXCESS COSTS OF ENFORCEMENT.—With respect to any individual described in section 454(6)(B), any costs of enforcement under this part in excess of the fees imposed under this section may be collected—

"(1) from the parent who owes the child or spousal support obligation involved, or

"(2) at the option of the State, from the individual to whom such services are made available, but only if such State has in

effect a procedure whereby all persons in such State having authority to order child or spousal support are informed that such costs are to be collected from the individual to whom such services were made available.".

(b) SENSE OF THE SENATE.—It is the sense of the Senate that although States have the overall choice as to how to collect enforcement costs under part D of title IV of the Social Security Act, such States should pursue such collection from—

(1) any noncustodial parent who denies paternity and is later determined to be the father; and

(2) any noncustodial parent who does not voluntarily comply with judicial or administrative enforcement orders under such part.

SEC. 7376. ENFORCEMENT OF ORDERS AGAINST PATERNAL GRANDPARENTS IN CASES OF MINOR PARENTS.

Section 466(a) (42 U.S.C. 666(a)), as amended by sections 7315, 7317(a), 7323, 7365, 7369, and 7374, is amended by adding at the end the following new paragraph:

"(18) Procedures under which any child support order enforced under this part with respect to a child of minor parents, if the mother of such child is receiving assistance under the State grant under part A, shall be enforceable, jointly and severally, against the paternal grandparents of such child.".

SEC. 7377. SENSE OF THE SENATE REGARDING THE INABILITY OF THE NON-CUSTODIAL PARENT TO PAY CHILD SUPPORT.

It is the sense of the Senate that—

(a) States should diligently continue their efforts to enforce child support payments by the non-custodial parent to the custodial parent, regardless of the employment status or location of the non-custodial parent; and

(b) States are encouraged to pursue pilot programs in which the parents of a non-adult, non-custodial parent who refuses to or is unable to pay child support must—

(1) pay or contribute to the child support owed by the non-custodial parent; or

(2) otherwise fulfill all financial obligations and meet all conditions imposed on the non-custodial parent, such as participation in a work program or other related activity.

CHAPTER 8—MEDICAL SUPPORT

SEC. 7378. TECHNICAL CORRECTION TO ERISA DEFINITION OF MEDICAL CHILD SUPPORT ORDER.

(a) IN GENERAL.—Section 609(a)(2)(B) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1169(a)(2)(B)) is amended—

(1) by striking "issued by a court of competent jurisdiction";

(2) by striking the period at the end of clause (ii) and inserting a comma; and

(3) by adding, after and below clause (ii), the following:

"if such judgment, decree, or order (I) is issued by a court of competent jurisdiction or (II) is issued through an ad-

ministrative process established under State law and has the force and effect of law under applicable State law.".

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall take effect on the date of the enactment of this Act.

(2) PLAN AMENDMENTS NOT REQUIRED UNTIL JANUARY 1, 1996.—Any amendment to a plan required to be made by an amendment made by this section shall not be required to be made before the 1st plan year beginning on or after January 1, 1996, if—

(A) during the period after the date before the date of the enactment of this Act and before such 1st plan year, the plan is operated in accordance with the requirements of the amendments made by this section; and

(B) such plan amendment applies retroactively to the period after the date before the date of the enactment of this Act and before such 1st plan year.

A plan shall not be treated as failing to be operated in accordance with the provisions of the plan merely because it operates in accordance with this paragraph.

SEC. 7379. ENFORCEMENT OF ORDERS FOR HEALTH CARE COVERAGE.

Section 466(a) (42 U.S.C. 666(a)), as amended by sections 7315, 7317(a), 7323, 7365, 7369, 7374, and 7376, is amended by adding at the end the following new paragraph:

"(19) Procedures under which all child support orders enforced under this part shall include a provision for the health care coverage of the child, and in the case in which an absent parent provides such coverage and changes employment, and the new employer provides health care coverage, the State agency shall transfer notice of the provision to the employer, which notice shall operate to enroll the child in the absent parent's health plan, unless the absent parent contests the notice.".

CHAPTER 9—ENHANCING RESPONSIBILITY AND OPPORTUNITY FOR NONRESIDENTIAL PARENTS

SEC. 7381. GRANTS TO STATES FOR ACCESS AND VISITATION PROGRAMS.

Part D of title IV (42 U.S.C. 651–669) is amended by adding at the end the following new section:

"SEC. 469A. GRANTS TO STATES FOR ACCESS AND VISITATION PROGRAMS.

"(a) IN GENERAL.—The Administration for Children and Families shall make grants under this section to enable States to establish and administer programs to support and facilitate absent parents' access to and visitation of their children, by means of activities including mediation (both voluntary and mandatory), counseling, education, development of parenting plans, visitation enforcement (including monitoring, supervision and neutral drop-off and pickup), and development of guidelines for visitation and alternative custody arrangements.

"(b) AMOUNT OF GRANT.—The amount of the grant to be made to a State under this section for a fiscal year shall be an amount equal to the lesser of—

"(1) 90 percent of State expenditures during the fiscal year for activities described in subsection (a); or

"(2) the allotment of the State under subsection (c) for the fiscal year.

"(c) ALLOTMENTS TO STATES.—

"(1) IN GENERAL.—The allotment of a State for a fiscal year is the amount that bears the same ratio to the amount appropriated for grants under this section for the fiscal year as the number of children in the State living with only 1 biological parent bears to the total number of such children in all States.

"(2) MINIMUM ALLOTMENT.—The Administration for Children and Families shall adjust allotments to States under paragraph (1) as necessary to ensure that no State is allotted less than—

"(A) $50,000 for fiscal year 1996 or 1997; or

"(B) $100,000 for any succeeding fiscal year.

"(d) NO SUPPLANTATION OF STATE EXPENDITURES FOR SIMILAR ACTIVITIES.—A State to which a grant is made under this section may not use the grant to supplant expenditures by the State for activities specified in subsection (a), but shall use the grant to supplement such expenditures at a level at least equal to the level of such expenditures for fiscal year 1995.

"(e) STATE ADMINISTRATION.—Each State to which a grant is made under this section—

"(1) may administer State programs funded with the grant, directly or through grants to or contracts with courts, local public agencies, or nonprofit private entities;

"(2) shall not be required to operate such programs on a statewide basis; and

"(3) shall monitor, evaluate, and report on such programs in accordance with regulations prescribed by the Secretary.".

CHAPTER 10—EFFECT OF ENACTMENT

SEC. 7391. EFFECTIVE DATES.

(a) IN GENERAL.—Except as otherwise specifically provided (but subject to subsections (b) and (c))—

(1) the provisions of this subtitle requiring the enactment or amendment of State laws under section 466 of the Social Security Act, or revision of State plans under section 454 of such Act, shall be effective with respect to periods beginning on and after October 1, 1996; and

(2) all other provisions of this subtitle shall become effective upon the date of the enactment of this Act.

(b) GRACE PERIOD FOR STATE LAW CHANGES.—The provisions of this subtitle shall become effective with respect to a State on the later of—

(1) the date specified in this subtitle, or

(2) the effective date of laws enacted by the legislature of such State implementing such provisions,

but in no event later than the 1st day of the 1st calendar quarter beginning after the close of the 1st regular session of the State leg-

islature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

(c) GRACE PERIOD FOR STATE CONSTITUTIONAL AMENDMENT.—A State shall not be found out of compliance with any requirement enacted by this subtitle if the State is unable to so comply without amending the State constitution until the earlier of—

(1) 1 year after the effective date of the necessary State constitutional amendment; or

(2) 5 years after the date of the enactment of this subtitle.

Subtitle F—Noncitizens

SEC. 7401. STATE OPTION TO PROHIBIT ASSISTANCE FOR CERTAIN ALIENS.

(a) IN GENERAL.—A State may, at its option, prohibit the use of any Federal funds received for the provision of assistance under any means-tested public assistance program for any individual who is a noncitizen of the United States.

(b) EXCEPTIONS.—Subsection (a) shall not apply to—

(1) any individual who is described in subclause (II), (III), or (IV) of section 1614(a)(1)(B)(i) of the Social Security Act (42 U.S.C. 1382c(a)(1)(B)(i)); and

(2) any program described in section 7402(f)(2).

SEC. 7402. DEEMED INCOME REQUIREMENT FOR FEDERAL AND FEDERALLY FUNDED PROGRAMS.

(a) DEEMING REQUIREMENT FOR FEDERAL AND FEDERALLY FUNDED PROGRAMS.—Subject to subsection (d), for purposes of determining the eligibility of an individual (whether a citizen or national of the United States or an alien) for assistance and the amount of assistance, under any Federal program of assistance provided or funded, in whole or in part, by the Federal Government for which eligibility is based on need, the income and resources described in subsection (b) shall, notwithstanding any other provision of law, be deemed to be the income and resources of such individual.

(b) DEEMED INCOME AND RESOURCES.—The income and resources described in this subsection include the following:

(1) The income and resources of any person who, as a sponsor of such individual's entry into the United States, or in order to enable such individual lawfully to remain in the United States, executed an affidavit of support or similar agreement with respect to such individual.

(2) The income and resources of the sponsor's spouse.

(c) LENGTH OF DEEMING PERIOD.—The requirement of subsection (a) shall apply for the period for which the sponsor has agreed, in such affidavit or agreement, to provide support for such individual, or for a period of 5 years beginning on the date such individual was first lawfully in the United States after the execution of such affidavit or agreement, whichever period is longer.

(d) LIMITATION ON MEASUREMENT OF DEEMED INCOME AND RESOURCES.—

(1) IN GENERAL.—If a determination described in paragraph (2) is made, the amount of income and resources of the sponsor or the sponsor's spouse which shall be attributed to the sponsored individual shall not exceed the amount actually provided, for a period beginning on the date of such determination and lasting 12 months or, if the address of the sponsor is unknown to the sponsored individual on the date of such determination, for 12 months after the address becomes known to the sponsored individual or to the agency (which shall inform such individual within 7 days).

(2) DETERMINATION.—The determination described in this paragraph is a determination by an agency that a sponsored

individual would, in the absence of the assistance provided by the agency, be unable to obtain food and shelter, taking into account the individual's own income, plus any cash, food, housing, or other assistance provided by other individuals, including the sponsor.

(e) DEEMING AUTHORITY TO STATE AND LOCAL AGENCIES.—

(1) IN GENERAL.—Notwithstanding any other provision of law, but subject to an exception equivalent to that in subsection (d), the State or local government may, for purposes of determining the eligibility of an individual (whether a citizen or national of the United States or an alien) for assistance, and the amount of assistance, under any State or local program of assistance for which eligibility is based on need, or any need-based program of assistance administered by a State or local government other than a program described in subsection (a), require that the income and resources described in paragraph (2) be deemed to be the income and resources of such individual.

(2) DEEMED INCOME AND RESOURCES.—The income and resources described in this paragraph include the following:

(A) The income and resources of any person who, as a sponsor of such individual's entry into the United States, or in order to enable such individual lawfully to remain in the United States, executed an affidavit of support or similar agreement with respect to such individual.

(B) The income and resources of the sponsor's spouse.

(3) LENGTH OF DEEMED INCOME PERIOD.—Subject to an exception equivalent to subsection (d), a State or local government may impose a requirement described in paragraph (1) for the period for which the sponsor has agreed, in such affidavit or agreement, to provide support for such individual, or for a period of 5 years beginning on the date such individual was first lawfully in the United States after the execution of such affidavit or agreement, whichever period is longer.

(f) APPLICABILITY OF SECTION.—

(1) INDIVIDUALS.—The provisions of this section shall not apply to the eligibility of any individual who is described in subclause (II), (III), or (IV) of section 1614(a)(1)(B)(i) of the Social Security Act (42 U.S.C. 1382c(a)(1)(B)(i)).

(2) PROGRAMS.—The provisions of this section shall not apply to eligibility for—

(A) emergency medical services under title XXI of the Social Security Act;

(B) short-term emergency disaster relief;

(C) assistance or benefits under the National School Lunch Act;

(D) assistance or benefits under the Child Nutrition Act of 1966;

(E) public health assistance for immunizations with respect to immunizable diseases and for testing and treatment for communicable diseases if the Secretary of Health and Human Services determines that such testing and treatment is necessary;

(F) the Head Start program (42 U.S.C. 9801); and

(G) programs specified by the Attorney General, in the Attorney General's sole and unreviewable discretion after consultation with appropriate Federal agencies and departments, which (i) deliver services at the community level, including through public or private nonprofit agencies; (ii) do not condition the provision of assistance, the amount of assistance provided, or the cost of assistance provided on the individual recipient's income or resources; and (iii) are necessary for the protection of life, safety, or public health.

(g) CONFORMING AMENDMENTS.—

(1) Section 1621 (42 U.S.C. 1382j) is repealed.

(2) Section 1614(f)(3) (42 U.S.C. 1382c(f)(3)) is amended by striking "section 1621" and inserting "section 7402 of the Balanced Budget Reconciliation Act of 1995".

SEC. 7403. REQUIREMENTS FOR SPONSOR'S AFFIDAVIT OF SUPPORT.

(a) ENFORCEABILITY.—No affidavit of support may be relied upon by the Attorney General or by any consular officer to establish that an alien is not excludable as a public charge under section 212(a)(4) of the Immigration and Nationality Act unless such affidavit is executed as a contract—

(1) which is legally enforceable against the sponsor by the sponsored individual, by the Federal Government, and by any State, district, territory, or possession of the United States (or any subdivision of such State, district, territory, or possession of the United States) which provides any benefit under a program described in subsection (d)(2), but not later than 10 years after the sponsored individual last receives any such benefit;

(2) in which the sponsor agrees to financially support the sponsored individual, so that he or she will not become a public charge, until the sponsored individual has worked in the United States for 40 qualifying quarters; and

(3) in which the sponsor agrees to submit to the jurisdiction of any Federal or State court for the purpose of actions brought under subsection (d)(4).

(b) FORMS.—Not later than 90 days after the date of the enactment of this Act, the Secretary of State, the Attorney General, and the Secretary of Health and Human Services shall jointly formulate the affidavit of support described in this section.

(c) NOTIFICATION OF CHANGE OF ADDRESS.—

(1) IN GENERAL.—The sponsor shall notify the Attorney General and the State, district, territory, or possession in which the sponsored individual is currently resident within 30 days of any change of address of the sponsor during the period specified in subsection (a)(1).

(2) PENALTY.—Any person subject to the requirement of paragraph (1) who fails to satisfy such requirement shall be subject to a civil penalty of—

(A) not less than $250 or more than $2,000, or

(B) if such failure occurs with knowledge that the sponsored individual has received any benefit described in section 241(a)(5)(C) of the Immigration and Nationality Act, not less than $2,000 or more than $5,000.

(d) REIMBURSEMENT OF GOVERNMENT EXPENSES.—

(1) IN GENERAL.—Upon notification that a sponsored individual has received any benefit under a program described in paragraph (2), the appropriate Federal, State, or local official shall request reimbursement by the sponsor in the amount of such assistance.

(2) PROGRAMS DESCRIBED.—The programs described in this paragraph include the following:

(A) Assistance under a State program funded under part A of title IV of the Social Security Act.

(B) The medicaid program under title XXI of the Social Security Act.

(C) The food stamp program under the Food Stamp Act of 1977.

(D) The supplemental security income program under title XVI of the Social Security Act.

(E) Any State general assistance program.

(F) Any other program of assistance funded, in whole or in part, by the Federal Government or any State or local government entity, for which eligibility for benefits is based on need, except the programs specified in section 7402(f)(2).

(3) REGULATIONS.—The Commissioner of Social Security shall prescribe such regulations as may be necessary to carry out paragraph (1). Such regulations shall provide for notification to the sponsor by certified mail to the sponsor's last known address.

(4) REIMBURSEMENT.—If within 45 days after requesting reimbursement, the appropriate Federal, State, or local agency has not received a response from the sponsor indicating a willingness to commence payments, an action may be brought against the sponsor pursuant to the affidavit of support.

(5) ACTION IN CASE OF FAILURE.—If the sponsor fails to abide by the repayment terms established by such agency, the agency may, within 60 days of such failure, bring an action against the sponsor pursuant to the affidavit of support.

(6) STATUTE OF LIMITATIONS.—No cause of action may be brought under this subsection later than 10 years after the sponsored individual last received any benefit under a program described in paragraph (2).

(e) JURISDICTION.—For purposes of this section, no State court shall decline for lack of jurisdiction to hear any action brought against a sponsor for reimbursement of the cost of any benefit under a program described in subsection (d)(2) if the sponsored individual received public assistance while residing in the State.

(f) DEFINITIONS.—For the purposes of this section—

(1) the term "sponsor" means an individual who—

(A) is a United States citizen or national or an alien who is lawfully admitted to the United States for permanent residence;

(B) is 18 years of age or over;

(C) is domiciled in any of the several States of the United States, the District of Columbia, or any territory or possession of the United States; and

(D) demonstrates the means to maintain an annual income equal to at least 200 percent of the poverty line for the individual and the individual's family (including the sponsored individual), through evidence that shall include a copy of the individual's Federal income tax returns for his or her most recent two taxable years and a written statement, executed under oath or as permitted under penalty of perjury under section 1746 of title 28, United States Code, that the copies are true copies of such returns;

(2) the term "poverty line" has the same meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)); and

(3) the term "qualifying quarter" means a three-month period in which the sponsored individual has—

(A) earned at least the minimum necessary for the period to count as one of the 40 calendar quarters required to qualify for social security retirement benefits;

(B) not received need-based public assistance; and

(C) had income tax liability for the tax year of which the period was part.

SEC. 7404. LIMITED ELIGIBILITY OF NONCITIZENS FOR SSI BENEFITS.

(a) IN GENERAL.—Paragraph (1) of section 1614(a) (42 U.S.C. 1382c(a)) is amended—

(1) in subparagraph (B)(i), by striking "either" and all that follows through ", or" and inserting "(I) a citizen; (II) a noncitizen who is granted asylum under section 208 of the Immigration and Nationality Act or whose deportation has been withheld under section 243(h) of such Act for a period of not more than 5 years after the date of arrival into the United States; (III) a noncitizen who is admitted to the United States as a refugee under section 207 of such Act for not more than such 5-year period; (IV) a noncitizen, lawfully present in any State (or any territory or possession of the United States), who is a veteran (as defined in section 101 of title 38, United States Code) with a discharge characterized as an honorable discharge and not on account of alienage or who is the spouse or unmarried dependent child of such veteran; or (V) a noncitizen who has worked sufficient calendar quarters of coverage to be a fully insured individual for benefits under title II, or"; and

(2) by adding at the end the following new flush sentence: "For purposes of subparagraph (B)(i)(IV), the determination of whether a noncitizen is lawfully present in the United States shall be made in accordance with regulations of the Attorney General. A noncitizen shall not be considered to be lawfully present in the United States for purposes of this title merely because the noncitizen may be considered to be permanently residing in the United States under color of law for purposes of any particular program.".

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by subsection (a) shall apply to applicants for benefits for months beginning on or after the date of the enactment of this Act, without regard to whether regulations have been issued to implement such amendments.

(2) APPLICATION TO CURRENT RECIPIENTS.—

(A) APPLICATION AND NOTICE.—Notwithstanding any other provision of law, in the case of an individual who is receiving supplemental security income benefits under title XVI of the Social Security Act as of the date of the enactment of this Act and whose eligibility for such benefits would terminate by reason of the amendments made by subsection (a), such amendments shall apply with respect to the benefits of such individual for months beginning on or after January 1, 1997, and the Commissioner of Social Security shall so notify the individual not later than 90 days after the date of the enactment of this Act.

(B) REAPPLICATION.—

(i) IN GENERAL.—Not later than 120 days after the date of the enactment of this Act, each individual notified pursuant to subparagraph (A) who desires to reapply for benefits under title XVI of the Social Security Act shall reapply to the Commissioner of Social Security.

(ii) DETERMINATION OF ELIGIBILITY.—Not later than 1 year after the date of the enactment of this Act, the Commissioner of Social Security shall determine the eligibility of each individual who reapplies for benefits under clause (i) pursuant to the procedures of such title XVI.

SEC. 7405. TREATMENT OF NONCITIZENS.

(a) IN GENERAL.—Notwithstanding any other provision of law, a noncitizen who has entered into the United States on or after the date of the enactment of this Act shall not, during the 5-year period beginning on the date of such noncitizen's entry into the United States, be eligible to receive any benefits under any program of assistance provided, or funded, in whole or in part, by the Federal Government, for which eligibility for benefits is based on need.

(b) EXCEPTIONS.—Subsection (a) shall not apply to—

(1) any individual who is described in subclause (II), (III), (IV), or (V) of section 1614(a)(1)(B)(i) of the Social Security Act (42 U.S.C. 1382c(a)(1)(B)(i));

(2) any program described in section 7402(f)(2); and

(3) payments for foster care and adoption assistance under part E of title IV of the Social Security Act for a child who would, in the absence of this section, be eligible to have such payments made on the child's behalf under such part, but only if the foster or adoptive parent or parents of such child are not noncitizens described in subsection (a).

SEC. 7406. INFORMATION REPORTING.

(a) TITLE IV OF THE SOCIAL SECURITY ACT.—Section 405 of the Social Security Act, as added by section 7201(b), is amended by adding at the end the following new subsection:

"(g) STATE REQUIRED TO PROVIDE CERTAIN INFORMATION.—Each State to which a grant is made under section 403 shall, at least 4 times annually and upon request of the Immigration and Naturalization Service, furnish the Immigration and Naturalization Service with the name and address of, and other identifying

information on, any individual who the State knows is unlawfully in the United States.".

(b) SSI.—Section 1631(e) (42 U.S.C. 1383(e)) is amended—

(1) by redesignating the paragraphs (6) and (7) inserted by sections 206(d)(2) and 206(f)(1) of the Social Security Independence and Programs Improvement Act of 1994 (Public Law 103–296; 108 Stat. 1514, 1515) as paragraphs (7) and (8), respectively; and

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

"(9) Notwithstanding any other provision of law, the Commissioner shall, at least 4 times annually and upon request of the Immigration and Naturalization Service (hereafter in this paragraph referred to as the 'Service'), furnish the Service with the name and address of, and other identifying information on, any individual who the Commissioner knows is unlawfully in the United States, and shall ensure that each agreement entered into under section 1616(a) with a State provides that the State shall furnish such information at such times with respect to any individual who the State knows is unlawfully in the United States.".

(c) HOUSING PROGRAMS.—Title I of the United States Housing Act of 1937 (42 U.S.C. 1437 et seq.) is amended by adding at the end the following new section:

"SEC. 27. PROVISION OF INFORMATION TO LAW ENFORCEMENT AND OTHER AGENCIES.

"(a) NOTICE TO IMMIGRATION AND NATURALIZATION SERVICE OF ILLEGAL ALIENS.—Notwithstanding any other provision of law, the Secretary shall, at least 4 times annually and upon request of the Immigration and Naturalization Service (hereafter in this subsection referred to as the 'Service'), furnish the Service with the name and address of, and other identifying information on, any individual who the Secretary knows is unlawfully in the United States, and shall ensure that each contract for assistance entered into under section 6 or 8 of this Act with a public housing agency provides that the public housing agency shall furnish such information at such times with respect to any individual who the public housing agency knows is unlawfully in the United States.".

SEC. 7407. PROHIBITION ON PAYMENT OF FEDERAL BENEFITS TO CERTAIN PERSONS.

(a) IN GENERAL.—Notwithstanding any other provision of law and except as provided in subsection (b), Federal benefits shall not be paid or provided to any person who is not a person lawfully present within the United States.

(b) EXCEPTIONS.—Subsection (a) shall not apply with respect to the following benefits:

(1) Emergency medical services under title XXI of the Social Security Act.

(2) Short-term emergency disaster relief.

(3) Assistance or benefits under the National School Lunch Act.

(4) Assistance or benefits under the Child Nutrition Act of 1966.

(5) Public health assistance for immunizations and, if the Secretary of Health and Human Services determines that it is

necessary to prevent the spread of a serious communicable disease, for testing and treatment of such disease.

(c) DEFINITIONS.—For purposes of this section:

(1) FEDERAL BENEFIT.—The term "Federal benefit" means—

(A) the issuance of any grant, contract, loan, professional license, or commercial license provided by an agency of the United States or by appropriated funds of the United States; and

(B) any retirement, welfare, Social Security, health, disability, public housing, post-secondary education, food stamps, unemployment benefit, or any other similar benefit for which payments or assistance are provided by an agency of the United States or by appropriated funds of the United States.

(2) PERSON LAWFULLY PRESENT WITHIN THE UNITED STATES.—The term "person lawfully present within the United States" means a person who, at the time the person applies for, receives, or attempts to receive a Federal benefit, is a United States citizen, a permanent resident alien, an alien whose deportation has been withheld under section 243(h) of the Immigration and Nationality Act (8 U.S.C. 1253(h)), an asylee, a refugee, a parolee who has been paroled for a period of at least 1 year, a national, or a national of the United States for purposes of the immigration laws of the United States (as defined in section 101(a)(17) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(17)).

(d) STATE OBLIGATION.—Notwithstanding any other provision of law, a State that administers a program that provides a Federal benefit (described in subsection (c)(1)) or provides State benefits pursuant to such a program shall not be required to provide such benefit to a person who is not a person lawfully present within the United States (as defined in subsection (c)(2)) through a State agency or with appropriated funds of such State.

(e) VERIFICATION OF ELIGIBILITY.—

(1) IN GENERAL.—Not later than 18 months after the date of the enactment of this Act, the Attorney General of the United States, after consultation with the Secretary of Health and Human Services, shall promulgate regulations requiring verification that a person applying for a Federal benefit, including a benefit described in subsection (b), is a person lawfully present within the United States and is eligible to receive such benefit. Such regulations shall, to the extent feasible, require that information requested and exchanged be similar in form and manner to information requested and exchanged under section 1137 of the Social Security Act.

(2) STATE COMPLIANCE.—Not later than 24 months after the date the regulations described in paragraph (1) are adopted, a State that administers a program that provides a Federal benefit described in such paragraph shall have in effect a verification system that complies with the regulations.

(3) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the purpose of this section.

(f) SEVERABILITY.—If any provision of this section or the application of such provision to any person or circumstance is held to be unconstitutional, the remainder of this section and the application of the provisions of such to any person or circumstance shall not be affected thereby.

Subtitle G—Additional Provisions Relating to Welfare Reform

CHAPTER 1—REDUCTIONS IN FEDERAL GOVERNMENT POSITIONS

SEC. 7411. REDUCTIONS.

(a) DEFINITIONS.—As used in this section:

(1) APPROPRIATE EFFECTIVE DATE.—The term "appropriate effective date", used with respect to a Department referred to in this section, means the date on which all provisions of subtitle D of title I, this subtitle, or subtitles C, D, E, and F of this title that the Department is required to carry out, and amendments and repeals made by such titles and subtitles to provisions of Federal law that the Department is required to carry out, are effective.

(2) COVERED ACTIVITY.—The term "covered activity", used with respect to a Department referred to in this section, means an activity that the Department is required to carry out under—

(A) a provision of subtitle D of title I, this subtitle, or subtitle C, D, E, or F of this title; or

(B) a provision of Federal law that is amended or repealed by any such title or subtitles.

(b) REPORTS.—

(1) CONTENTS.—Not later than December 31, 1995, each Secretary referred to in paragraph (2) shall prepare and submit to the relevant committees described in paragraph (3) a report containing—

(A) the determinations described in subsection (c);

(B) appropriate documentation in support of such determinations; and

(C) a description of the methodology used in making such determinations.

(2) SECRETARY.—The Secretaries referred to in this paragraph are—

(A) the Secretary of Agriculture;

(B) the Secretary of Education;

(C) the Secretary of Labor;

(D) the Secretary of Housing and Urban Development; and

(E) the Secretary of Health and Human Services.

(3) RELEVANT COMMITTEES.—The relevant Committees described in this paragraph are the following:

(A) With respect to each Secretary described in paragraph (2), the Committee on Government Reform and

Oversight of the House of Representatives and the Committee on Governmental Affairs of the Senate.

(B) With respect to the Secretary of Agriculture, the Committee on Agriculture and the Committee on Economic and Educational Opportunities of the House of Representatives and the Committee on Agriculture, Nutrition, and Forestry of the Senate.

(C) With respect to the Secretary of Education, the Committee on Economic and Educational Opportunities of the House of Representatives and the Committee on Labor and Human Resources of the Senate.

(D) With respect to the Secretary of Labor, the Committee on Economic and Educational Opportunities of the House of Representatives and the Committee on Labor and Human Resources of the Senate.

(E) With respect to the Secretary of Housing and Urban Development, the Committee on Banking and Financial Services of the House of Representatives and the Committee on Banking, Housing, and Urban Affairs of the Senate.

(F) With respect to the Secretary of Health and Human Services, the Committee on Economic and Educational Opportunities of the House of Representatives, the Committee on Labor and Human Resources of the Senate, the Committee on Ways and Means of the House of Representatives, and the Committee on Finance of the Senate.

(4) REPORT ON CHANGES.—Not later than December 31, 1996, and each December 31 thereafter, each Secretary referred to in paragraph (2) shall prepare and submit to the relevant Committees described in paragraph (3), a report concerning any changes with respect to the determinations made under subsection (c) for the year in which the report is being submitted.

(c) DETERMINATIONS.—Not later than December 31, 1995, each Secretary referred to in subsection (b)(2) shall determine—

(1) the number of full-time equivalent positions required by the Department headed by such Secretary to carry out the covered activities of the Department, as of the day before the date of enactment of this Act;

(2) the number of such positions required by the Department to carry out the activities, as of the appropriate effective date for the Department; and

(3) the difference obtained by subtracting the number referred to in paragraph (2) from the number referred to in paragraph (1).

(d) ACTIONS.—Not later than 30 days after the appropriate effective date for the Department involved, each Secretary referred to in subsection (b)(2) shall take such actions as may be necessary, including reduction in force actions, consistent with sections 3502 and 3595 of title 5, United States Code, to reduce the number of positions of personnel of the Department by at least the difference referred to in subsection (c)(3).

(e) CONSISTENCY.—

(1) EDUCATION.—The Secretary of Education shall carry out this section in a manner that enables the Secretary to meet the requirements of this section.

(2) LABOR.—The Secretary of Labor shall carry out this section in a manner that enables the Secretary to meet the requirements of this section.

(3) HEALTH AND HUMAN SERVICES.—The Secretary of Health and Human Services shall carry out this section in a manner that enables the Secretary to meet the requirements of this section and section 7412.

(f) CALCULATION.—In determining, under subsection (c), the number of full-time equivalent positions required by a Department to carry out a covered activity, a Secretary referred to in subsection (b)(2), shall include the number of such positions occupied by personnel carrying out program functions or other functions (including budgetary, legislative, administrative, planning, evaluation, and legal functions) related to the activity.

(g) GENERAL ACCOUNTING OFFICE REPORT.—Not later than July 1, 1996, the Comptroller General of the United States shall prepare and submit to the committees described in subsection (b)(3), a report concerning the determinations made by each Secretary under subsection (c). Such report shall contain an analysis of the determinations made by each Secretary under subsection (c) and a determination as to whether further reductions in full-time equivalent positions are appropriate.

SEC. 7412. REDUCTIONS IN FEDERAL BUREAUCRACY.

(a) IN GENERAL.—The Secretary of Health and Human Services shall reduce the Federal workforce within the Department of Health and Human Services by an amount equal to the sum of—

(1) 75 percent of the full-time equivalent positions at such Department that relate to any direct spending program, or any program funded through discretionary spending, that has been converted into a block grant program under subtitle D of title I, this subtitle, or subtitle C, D, E, or F of this title and the amendments made by such title or subtitles; and

(2) an amount equal to 75 percent of that portion of the total full-time equivalent departmental management positions at such Department that bears the same relationship to the amount appropriated for the programs referred to in paragraph (1) as such amount relates to the total amount appropriated for use by such Department.

(b) REDUCTIONS IN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—Notwithstanding any other provision of this Act, the Secretary of Health and Human Services shall take such actions as may be necessary, including reductions in force actions, consistent with sections 3502 and 3595 of title 5, United States Code, to reduce the full-time equivalent positions within the Department of Health and Human Services—

(1) by 245 full-time equivalent positions related to the program converted into a block grant under the amendment made by section 7201(b); and

(2) by 60 full-time equivalent managerial positions in the Department.

SEC. 7413. REDUCING PERSONNEL IN WASHINGTON, D.C. AREA.

In making reductions in full-time equivalent positions, the Secretary of Health and Human Services is encouraged to reduce personnel in the Washington, DC, area office (agency headquarters) before reducing field personnel.

CHAPTER 2—BLOCK GRANTS FOR SOCIAL SERVICES

SEC. 7421. REDUCTION IN BLOCK GRANTS FOR SOCIAL SERVICES.

Section 2003(c) (42 U.S.C. 1397b) is amended—

(1) by striking "and" at the end of paragraph (4); and

(2) by striking paragraph (5) and inserting the following:

"(5) $2,800,000,000 for each of the fiscal years 1990 through 1996; and

"(6) $2,240,000,000 for each fiscal year after fiscal year 1996.".

SEC. 7422. ESTABLISHING NATIONAL GOALS TO PREVENT TEENAGE PREGNANCIES.

(a) IN GENERAL.—Not later than January 1, 1997, the Secretary of Health and Human Services shall establish and implement a strategy for—

(1) preventing an additional 2 percent of out-of-wedlock teenage pregnancies a year, and

(2) assuring that at least 25 percent of the communities in the United States have teenage pregnancy prevention programs in place.

(b) REPORT.—Not later than June 30, 1998, and annually thereafter, the Secretary shall report to the Congress with respect to the progress that has been made in meeting the goals described in paragraphs (1) and (2) of subsection (a).

(c) OUT-OF-WEDLOCK AND TEENAGE PREGNANCY PREVENTION PROGRAMS.—Section 2002 (42 U.S.C. 1397a) is amended by adding at the end the following new subsection:

"(f)(1) The Secretary shall conduct a study with respect to State programs that have been implemented to determine the relative effectiveness of the different approaches for reducing out-of-wedlock pregnancies and preventing teenage pregnancy and the approaches that can be best replicated by other States.

"(2) Each State shall provide to the Secretary, in such form and with such frequency as the Secretary requires, data from the programs the State has implemented. The Secretary shall report to the Congress annually on the progress of the programs and shall, not later than June 30, 1998, submit to the Congress a report on the study required under paragraph (1).".

CHAPTER 3—FOSTER CARE MAINTENANCE PAYMENTS PROGRAM

SEC. 7431. LIMITATION ON GROWTH OF ADMINISTRATIVE EXPENSES FOR FOSTER CARE MAINTENANCE PAYMENTS PROGRAM.

Section 474(b) (42 U.S.C. 674) is amended by adding at the end the following new paragraph:

"(5) Notwithstanding the provisions of subparagraphs (D) and (E) of subsection (a)(3), the total amount of the payment under such subparagraphs with respect to the foster care maintenance payments program for any fiscal year beginning with fiscal year 1996 shall not exceed 110 percent of the total amount of such payment for the preceding fiscal year.".

CHAPTER 4—MISCELLANEOUS PROVISIONS

SEC. 7441. EXEMPTION OF BATTERED INDIVIDUALS FROM CERTAIN REQUIREMENTS.

(a) IN GENERAL.—Notwithstanding any other provision of, or amendment made by, subtitle D of title I of this Act, this subtitle, or subtitle C, D, E, or F of this title, the applicable administering authority of any specified provision may exempt from (or modify) the application of such provision to any individual who was battered or subjected to extreme cruelty if the physical, mental, or emotional well-being of the individual would be endangered by the application of such provision to such individual. The applicable administering authority may take into consideration the family circumstances and the counseling and other supportive service needs of the individual.

(b) SPECIFIED PROVISIONS.—For purposes of this section, the term "specified provision" means any requirement, limitation, or penalty under any of the following:

(1) Sections 404, 405 (a) and (b), 406 (b), (c), and (d), 414(d), 453(c), 469A, and 1614(a)(1) of the Social Security Act.

(2) Sections 5(i) (other than paragraph (3) thereof) and 6 (d) and (j), and the provision relating to work requirements in section 6 of the Food Stamp Act of 1977.

(3) Sections 7401(a) and 7402 of this Act.

(c) DEFINITIONS AND SPECIAL RULES.—For purposes of this section—

(1) BATTERED OR SUBJECTED TO EXTREME CRUELTY.—The term "battered or subjected to extreme cruelty" includes, but is not limited to—

(A) physical acts resulting in, or threatening to result in, physical injury;

(B) sexual abuse, sexual activity involving a dependent child, forcing the caretaker relative of a dependent child to engage in nonconsensual sexual acts or activities, or threats of or attempts at physical or sexual abuse;

(C) mental abuse; and

(D) neglect or deprivation of medical care.

(2) CALCULATION OF PARTICIPATION RATES.—An individual exempted from the work requirements under section 404 of the Social Security Act by reason of subsection (a) shall not be included for purposes of calculating the State's participation rate under such section.

SEC. 7442. SENSE OF THE SENATE ON LEGISLATIVE ACCOUNTABILITY FOR UNFUNDED MANDATES IN WELFARE REFORM LEGISLATION.

(a) FINDINGS.—The Senate finds that the purposes of the Unfunded Mandates Reform Act of 1995 are—

(1) to strengthen the partnership between the Federal Government and State, local and tribal governments;

(2) to end the imposition, in the absence of full consideration by Congress, of Federal mandates on State, local and tribal governments without adequate Federal funding, in a manner that may displace other essential State, local and tribal governmental priorities;

(3) to assist Congress in its consideration of proposed legislation establishing or revising Federal programs containing Federal mandates affecting State, local and tribal governments, and the private sector by—

(A) providing for the development of information about the nature and size of mandates in proposed legislation; and

(B) establishing a mechanism to bring such information to the attention of the Senate and the House of Representatives before the Senate and the House of Representatives vote on proposed legislation;

(4) to promote informed and deliberate decisions by Congress on the appropriateness of Federal mandates in any particular instance; and

(5) to require that Congress consider whether to provide funding to assist State, local and tribal governments in complying with Federal mandates.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that prior to the Senate acting on the conference report on either H.R. 4 or any other legislation including welfare reform provisions, the Congressional Budget Office shall prepare an analysis of the conference report to include—

(1) estimates, over each of the next 7 fiscal years, by State and in total, of—

(A) the costs to States of meeting all work requirements in the conference report, including those for single-parent families, two-parent families, and those who have received cash assistance for 2 years;

(B) the resources available to the States to meet these work requirements, defined as Federal appropriations authorized in the conference report for this purpose in addition to what States are projected to spend under current welfare law; and

(C) the amount of any additional revenue needed by the States to meet the work requirements in the conference report, beyond resources available as defined under subparagraph (B);

(2) an estimate, based on the analysis in paragraph (1), of how many States would opt to pay any penalty provided for by the conference report rather than raise the additional revenue needed to meet the work requirements in the conference report; and

(3) estimates, over each of the next 7 fiscal years, of the costs to States of any other requirements imposed on them by such legislation.

SEC. 7443. SENSE OF THE SENATE REGARDING ENFORCEMENT OF STATUTORY RAPE LAWS.

It is the sense of the Senate that States and local jurisdictions should aggressively enforce statutory rape laws.

SEC. 7444. SANCTIONING FOR TESTING POSITIVE FOR CONTROLLED SUBSTANCES.

Notwithstanding any other provision of law, States shall not be prohibited by the Federal Government from sanctioning welfare recipients who test positive for use of controlled substances.

SEC. 7445. ABSTINENCE EDUCATION.

(a) INCREASES IN FUNDING.—Section 501(a) (42 U.S.C. 701(a)) is amended in the matter preceding paragraph (1) by striking "fiscal year 1994 and each fiscal year thereafter" and inserting "fiscal years 1994 and 1995 and $761,000,000 for fiscal year 1996 and each fiscal year thereafter".

(b) ABSTINENCE EDUCATION.—Section 501(a)(1) (42 U.S.C. 701(a)(1)) is amended—

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

(2) by inserting "and" at the end of subparagraph (D); and

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

"(E) to provide abstinence education, and at the option of the State, where appropriate, mentoring, counseling, and adult supervision to promote abstinence from sexual activity, with a focus on those groups which are most likely to bear children out-of-wedlock;".

(c) ABSTINENCE EDUCATION DEFINED.—Section 501(b) (42 U.S.C. 701(b)) is amended by adding at the end the following new paragraph:

"(5) ABSTINENCE EDUCATION.—The term 'abstinence education' means an educational or motivational program which—

"(A) has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;

"(B) teaches abstinence from sexual activity outside marriage as the expected standard for all school age children;

"(C) teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;

"(D) teaches that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity;

"(E) teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;

"(F) teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;

"(G) teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and

"(H) teaches the importance of attaining self-sufficiency before engaging in sexual activity.".

(d) SET-ASIDE.—

(1) IN GENERAL.—Section 502(c) (42 U.S.C. 702(c)) is amended in the matter preceding paragraph (1) by striking "From" and inserting "Except as provided in subsection (e), from".

(2) SET-ASIDE.—Section 502 (42 U.S.C. 702) is amended by adding at the end the following new subsection:

"(e) Of the amounts appropriated under section 501(a) for any fiscal year, the Secretary shall set aside $75,000,000 for abstinence education in accordance with section 501(a)(1)(E).".

SEC. 7446. FRAUD UNDER MEANS-TESTED WELFARE AND PUBLIC ASSISTANCE PROGRAMS.

(a) IN GENERAL.—If an individual's benefits under a Federal, State, or local law relating to a means-tested welfare or a public assistance program are reduced because of an act of fraud by the individual under the law or program, the individual may not, for the duration of the reduction, receive an increased benefit under any other means-tested welfare or public assistance program for which Federal funds are appropriated as a result of a decrease in the income of the individual (determined under the applicable program) attributable to such reduction.

(b) WELFARE OR PUBLIC ASSISTANCE PROGRAMS FOR WHICH FEDERAL FUNDS ARE APPROPRIATED.—For purposes of subsection (a), the term "means-tested welfare or public assistance program for which Federal funds are appropriated" shall include the food stamp program under the Food Stamp Act of 1977 (7 U.S.C. 2011 et seq.), any program of public or assisted housing under title I of the United States Housing Act of 1937 (42 U.S.C. 1437 et seq.), and State programs funded under part A of title IV of the Social Security Act (42 U.S.C. 601 et seq.).

Subtitle H—Reform of the Earned Income Tax Credit

SEC. 7460. AMENDMENT OF 1986 CODE.

Except as otherwise expressly provided, whenever in this subtitle an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of the Internal Revenue Code of 1986.

SEC. 7461. EARNED INCOME CREDIT DENIED TO INDIVIDUALS NOT AUTHORIZED TO BE EMPLOYED IN THE UNITED STATES.

(a) IN GENERAL.—Section 32(c)(1) (relating to individuals eligible to claim the earned income tax credit) is amended by adding at the end the following new subparagraph:

"(F) IDENTIFICATION NUMBER REQUIREMENT.—The term 'eligible individual' does not include any individual who does not include on the return of tax for the taxable year—

"(i) such individual's taxpayer identification number, and

"(ii) if the individual is married (within the meaning of section 7703), the taxpayer identification number of such individual's spouse."

(b) SPECIAL IDENTIFICATION NUMBER.—Section 32 is amended by adding at the end the following new subsection:

"(l) IDENTIFICATION NUMBERS.—Solely for purposes of subsections (c)(1)(F) and (c)(3)(D), a taxpayer identification number means a social security number issued to an individual by the Social Security Administration (other than a social security number issued pursuant to clause (II) (or that portion of clause (III) that relates to clause (II)) of section 205(c)(2)(B)(i) of the Social Security Act)."

(c) EXTENSION OF PROCEDURES APPLICABLE TO MATHEMATICAL OR CLERICAL ERRORS.—Section 6213(g)(2) (relating to the definition of mathematical or clerical errors) is amended by striking "and" at the end of subparagraph (D), by striking the period at the end of subparagraph (E) and inserting a comma, and by inserting after subparagraph (E) the following new subparagraphs:

"(F) an omission of a correct taxpayer identification number required under section 32 (relating to the earned income tax credit) to be included on a return, and

"(G) an entry on a return claiming the credit under section 32 with respect to net earnings from self-employment described in section 32(c)(2)(A) to the extent the tax imposed by section 1401 (relating to self-employment tax) on such net earnings has not been paid."

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

SEC. 7462. REPEAL OF EARNED INCOME CREDIT FOR INDIVIDUALS WITHOUT CHILDREN.

(a) IN GENERAL.—Subparagraph (A) of section 32(c)(1) (defining eligible individual) is amended to read as follows:

"(A) IN GENERAL.—The term 'eligible individual' means any individual who has a qualifying child for the taxable year."

(b) CONFORMING AMENDMENTS.—Each of the tables contained in paragraphs (1) and (2) of section 32(b) are amended by striking the items relating to no qualifying children.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

SEC. 7463. MODIFICATION OF EARNED INCOME CREDIT AMOUNT AND PHASEOUT.

(a) DECREASE IN CREDIT RATE.—

(1) IN GENERAL.—Subsection (b) of section 32, as amended by section 7462(b), is amended to read as follows:

"(b) PERCENTAGES AND AMOUNTS.—

"(1) IN GENERAL.—The credit percentage shall be determined as follows:

"In the case of an eligible individual with:	The credit percentage is:
1 qualifying child	34
2 or more qualifying children	36

"(2) AMOUNTS.—The earned income amount and the phaseout amount shall be determined as follows:

"In the case of an eligible individual with:	The earned income amount is:	The phaseout amount is:
1 qualifying child	$6,000	$11,000
2 or more qualifying children	$8,425	$11,000."

(2) CONFORMING AMENDMENT.—Paragraph (1) of section 32(j) is amended by striking "subsection (b)(2)(A)" and inserting "subsection (b)(2)".

(b) PHASEOUT.—Paragraph (2) of section 32(a) (relating to limitation) is amended to read as follows:

"(2) LIMITATION.—The amount of the credit allowable to a taxpayer under paragraph (1) for any taxable year shall be reduced by 0.66 percent (0.86 percent if only 1 qualifying child) for each $100 or fraction thereof by which the taxpayer's adjusted gross income (or, if greater, earned income) for the taxable year exceeds the phaseout amount."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

SEC. 7464. RULES RELATING TO DENIAL OF EARNED INCOME CREDIT ON BASIS OF DISQUALIFIED INCOME.

(a) DEFINITION OF DISQUALIFIED INCOME.—Paragraph (2) of section 32(i) (defining disqualified income) is amended by striking "and" at the end of subparagraph (B), by striking the period at the end of subparagraph (C) and inserting ", and", and by adding at the end the following new subparagraphs:

"(D) capital gain net income, and

"(E) the excess (if any) of—

"(i) the aggregate income from all passive activities for the taxable year (determined without regard to any amount described in a preceding subparagraph), over

"(ii) the aggregate losses from all passive activities for the taxable year (as so determined).

For purposes of subparagraph (E), the term 'passive activity' has the meaning given such term by section 469."

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

SEC. 7465. MODIFICATION OF ADJUSTED GROSS INCOME DEFINITION FOR EARNED INCOME CREDIT.

(a) IN GENERAL.—Subsections (a)(2), (c)(1)(C), and (f)(2)(B) of section 32 are each amended by striking "adjusted gross income" and inserting "modified adjusted gross income".

(b) MODIFIED ADJUSTED GROSS INCOME DEFINED.—Section 32(c) (relating to definitions and special rules) is amended by adding at the end the following new paragraph:

"(5) MODIFIED ADJUSTED GROSS INCOME.—

"(A) IN GENERAL.—The term 'modified adjusted gross income' means adjusted gross income—

"(i) increased by the sum of the amounts described in subparagraph (B), and

"(ii) determined without regard to—

"(I) the amounts described in subparagraph (C), or

"(II) the deduction allowed under section 172.

"(B) NONTAXABLE INCOME TAKEN INTO ACCOUNT.—Amounts described in this subparagraph are—

"(i) social security benefits (as defined in section 86(d)) received by the taxpayer during the taxable year to the extent not included in gross income,

"(ii) amounts which—

"(I) are received during the taxable year by (or on behalf of) a spouse pursuant to a divorce or separation instrument (as defined in section 71(b)(2)), and

"(II) under the terms of the instrument are fixed as payable for the support of the children of the payor spouse (as determined under section 71(c)),

but only to the extent such amounts exceed $6,000,

"(iii) interest received or accrued during the taxable year which is exempt from tax imposed by this chapter, and

"(iv) amounts received as a pension or annuity, and any distributions or payments received from an individual retirement plan, by the taxpayer during the taxable year to the extent not included in gross income.

Clause (iv) shall not include any amount which is not includible in gross income by reason of section 402(c), 403(a)(4), 403(b)(8), 408(d) (3), (4), or (5), or 457(e)(10).

"(C) CERTAIN AMOUNTS DISREGARDED.—An amount is described in this subparagraph if it is—

"(i) the amount of losses from sales or exchanges of capital assets in excess of gains from such sales or exchanges to the extent such amount does not exceed the amount under section 1211(b)(1),

"(ii) the net loss from the carrying on of trades or businesses, computed separately with respect to—

"(I) trades or businesses (other than farming) conducted as sole proprietorships,

"(II) trades or businesses of farming conducted as sole proprietorships, and

"(III) other trades or business,

"(iii) the net loss from estates and trusts, and

"(iv) the excess (if any) of amounts described in subsection (i)(2)(C)(ii) over the amounts described in subsection (i)(2)(C)(i) (relating to nonbusiness rents and royalties).

For purposes of clause (ii), there shall not be taken into account items which are attributable to a trade or business which consists of the performance of services by the taxpayer as an employee."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1995.

SEC. 7466. PROVISIONS TO IMPROVE TAX COMPLIANCE.

(a) INCREASE IN PENALTIES FOR RETURN PREPARERS.—

(1) UNDERSTATEMENT PENALTY.—Section 6694 (relating to understatement of income tax liability by income tax return preparer) is amended—

(A) by striking "$250" in subsection (a) and inserting "$500", and

(B) by striking "$1,000" in subsection (b) and inserting "$2,000".

(2) OTHER ASSESSABLE PENALTIES.—Section 6695 (relating to other assessable penalties) is amended—

(A) by striking "$50" and "$25,000" in subsections (a), (b), (c), (d), and (e) and inserting "$100" and "$50,000", respectively, and

(B) by striking "$500" in subsection (f) and inserting "$1,000".

(b) AIDING AND ABETTING PENALTY.—Section 6701(b) (relating to amount of penalty) is amended—

(1) by striking "$1,000" in paragraph (1) and inserting "2,000", and

(2) by striking "10,000" in paragraph (2) and inserting "20,000".

(c) REVIEW OF ELECTRONIC FILING OF EARNED INCOME CREDIT CLAIMS.—The Secretary of the Treasury shall use the maximum review process that is administratively feasible to ensure that originators of electronic returns involving the earned income credit under section 32 of the Internal Revenue Code of 1986 comply with the law.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to penalties with respect to taxable years beginning after December 31, 1995.

Subtitle I—Increase in Public Debt

SEC. 7471. INCREASE IN PUBLIC DEBT.

Subsection (b) of section 3101 of title 31, United States Code, is amended by striking the dollar amount contained therein and inserting "$5,500,000,000,000".

Subtitle J—Correction of Cost of Living Adjustments

SEC. 7481. SENSE OF THE SENATE REGARDING CORRECTION OF COST OF LIVING ADJUSTMENTS.

(a) FINDINGS.—The Senate finds that—

(1) the Consumer Price Index overstates the cost of living in the United States; and

(2) overstatement of the cost of living undermines the equitable administration of Federal benefit and tax policies.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that all cost of living adjustments required by Federal law should be corrected as soon as possible to accurately reflect future changes in the cost of living.

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