"(B) is under 19 years of age;

"(C) has a serious mental illness or emotional disturbance or substance abuse disorder (as determined in accordance with standards established by the Secretary consistent with subsection (d)); and

"(D) has such an illness, disturbance, or disorder that is expected to last for not less than 1 year.

"(2) The individual—

"(A) is an eligible individual;

"(B) is 19 years of age or older;

"(C) has a serious mental illness or emotional disturbance or substance abuse disorder (as determined in accordance with standards established by the Secretary consistent with subsection (d));

"(D) has such an illness, disturbance, or disorder that is expected to last for not less than 1 year; and

"(E) has family income not greater than 200 percent of the official poverty line.

"(d) CRITERIA FOR STANDARDS FOR QUALIFIED INDIVIDUALS.—In establishing standards for purposes of subsection (c), the Secretary shall assure that Programs under this section focus services on adults with serious mental illness, children with serious emotional disturbance, and individuals with substance abuse disorder, as evidenced by a need for multiple services (either a past history, or prediction of future needs), and who have a disorder which is expected to last at least one year.

"(e) DEFINITIONS.—

"(1) MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES.—In this section, the term "mental health and substance abuse services" has the meaning given such term under section 1893(c) of the Social Security Act (as in effect on the date of the enactment of the Guaranteed Health Insurance Act of 1994).

"(2) OTHER DEFINITIONS.—In this section, the terms 'guaranteed national benefit package', 'medicare part C', 'medicare program', and 'certified health plan' have the meaning given such terms in the Guaranteed Health Insurance Act of 1994.

"SEC. 1982. GRANTS FOR DEVELOPMENT OF PROGRAMS.

"(a) IN GENERAL.—The Secretary may make grants to States for the initial operation of State programs under section 1981.

"(b) LIMITATION ON PERIOD OF GRANT.—A State may not receive funding from a grant awarded under this section for a period exceeding 5 years.

"(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for grants under this section $100,000,000 for each of the fiscal years 1996 through 1999.".

SEC. 7402. COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCES.

Section 565(f)(1) of the Public Health Service Act (42 U.S.C. 290ff–4(f)(1)) is amended by striking "for fiscal year 1994" and inserting "for each of the fiscal years 1994 through 1997".

Subtitle F—United States-Mexico Border Health Commission

SEC. 7501. AGREEMENT TO ESTABLISH BINATIONAL COMMISSION.

The President is authorized and encouraged to conclude an agreement with Mexico to establish a binational commission to be known as the United States-Mexico Border Health Commission.

SEC. 7502. DUTIES.

It should be the duty of the Commission—

(1) to conduct a comprehensive needs assessment in the United States-Mexico border area for the purposes of identify-

ing, evaluating, preventing, and resolving health problems that affect the general population of the area;

(2) to implement the actions recommended by the needs assessment by—

(A) assisting in the coordination of the efforts of public and private entities to prevent and resolve such health problems; and

(B) assisting in the coordination of the efforts of public and private entities to educate such population concerning such health problems; and

(3) to formulate recommendations to the Governments of the United States and Mexico concerning a fair and reasonable method by which the government of one country would reimburse a public or private entity in the other country for the cost of a health care service that the entity furnishes to a citizen of the first country who is unable, through insurance or otherwise, to pay for the service.

SEC. 7503. OTHER AUTHORIZED FUNCTIONS.

In addition to the duties described in section 7502, the Commission should be authorized to perform the following additional functions as the Commission determines to be appropriate:

(1) To conduct or sponsor investigations, research, or studies designed to identify, study, and monitor health problems that affect the general population in the United States-Mexico border area.

(2) To provide financial, technical, or administrative assistance to public or private entities who act to prevent, resolve, or educate such population concerning such health problems.

SEC. 7504. MEMBERSHIP.

(a) NUMBER AND APPOINTMENT OF UNITED STATES SECTION.—The United States section of the Commission should be composed of 13 members. The section should consist of the following members:

(1) The Secretary of Health and Human Services or such individual's delegate.

(2) The commissioners of health from the States of Texas, New Mexico, California, and Arizona or such individuals' delegates.

(3) 2 individuals from each of the States of Texas, New Mexico, California, and Arizona who are nominated by the chief executive officer of one of such States, and are appointed by the President from among individuals who have demonstrated ties to community-based organizations and have a demonstrated interest in health issues of the United States-Mexico border area.

(b) COMMISSIONER.—The Commissioner of the United States section of the Commission should be the Secretary of Health and Human Services or such individual's delegate to the Commission. The Commissioner should be the leader of the section.

SEC. 7505. REGIONAL OFFICES.

The Commission should establish no fewer than 2 regional border offices in locations selected by the Commission.

SEC. 7506. REPORTS.

Not later than February 1 of each year that occurs more than 1 year after the date of the establishment of the Commission, the Commission should submit an annual report to both the United States Government and the Government of Mexico regarding all activities of the Commission during the preceding calendar year.

SEC. 7507. DEFINITIONS.

For purposes of this subtitle:

(1) COMMISSION.—The term "Commission" means the United States-Mexico Border Health Commission authorized in section 7501.

(2) HEALTH PROBLEM.—The term "health problem" means a disease or medical ailment or an environmental condition that poses the risk of disease or medical ailment. The term includes diseases, ailments, or risks of disease or ailment caused by or related to environmental factors, control of animals and rabies, control of insect and rodent vectors, disposal of solid and hazardous waste, and control and monitoring of air and water quality.

(3) UNITED STATES-MEXICO BORDER AREA.—The term "United States-Mexico border area" means the area located in the United States and Mexico within 100 kilometers of the border between the United States and Mexico.

Subtitle G—Comprehensive School Health Education

PART 1—GENERAL PROVISIONS

SEC. 7601. PURPOSES.

Subject to the subsequent provisions of this subtitle, the purposes of this subtitle are as follows:

(1) To support the provision in kindergarten through grade 12 of sequential, age-appropriate, comprehensive health education programs that address locally-determined priorities developed with the active participation of parents, families, community organizations, and other appropriate entities.

(2) To establish a national framework within which State educational agencies, educational service agencies, and local education agencies can create comprehensive school health education programs that—

(A) target the health risk behaviors accounting for the majority of the morbidity and mortality among youth and adults, including the following: Alcohol and other drug abuse; sexual behaviors resulting in infection with the human immunodeficiency virus, in other sexually transmitted diseases or in unintended pregnancy; child abuse and neglect; behaviors resulting in intentional and unintentional injuries; dietary patterns resulting in disease; work hazards associated with preventable diseases and injuries and sedentary lifestyles; and

(B) are integrated with plans and programs in the State, if any, under title III of the Goals 2000: Educate America Act or any other State education reform plan and those targeting health promotion and disease prevention goals related to the national health objectives set forth in Healthy People 2000.

(3) To pay the initial costs of developing statewide comprehensive school health education programs that will be implemented and maintained with local, State, and other Federal resources.

(4) To support Federal activities such as research and demonstrations, evaluations, and training and technical assistance regarding comprehensive school health education.

(5) To motivate youth, especially low-achieving youth, to stay in school, avoid teen pregnancy, and strive for success by providing intensive, high-quality comprehensive health education programs that include peer-teaching, family, and community involvement.

(6) To improve the knowledge and skills of children and youth by integrating academic and experiential learning in comprehensive health education with other elements of a comprehensive school health program.

(7) To further the National Education Goals set forth in title I of the Goals 2000: Educate America Act and the national health objectives set forth in Healthy People 2000.

SEC. 7602. DEFINITIONS.

(a) COMPREHENSIVE SCHOOL HEALTH EDUCATION PROGRAM.—For purposes of this subtitle, the term "comprehensive school health education program" means a program that addresses locally determined priorities and is developed with the active involvement of parents, families, community organizations, and other appropriate entities, and that meets the following conditions:

(1) The program is sequential, and age and developmentally appropriate.

(2) The program is provided, in the area served by the program, every year for all students from kindergarten through grade 12.

(3) The program provides comprehensive health education, which covers a full range of topics relevant to human health, such as the following:

(A) Community health.

(B) Environmental health.

(C) Personal health (including physical fitness).

(D) Family life (including parenting and child development).

(E) Growth and development.

(F) Nutritional health.

(G) Emotional and mental health.

(H) Prevention and control of disease and disorders and such heath-risk behaviors as child abuse and neglect.

(I) Safety and prevention of injuries.

(J) Alcohol and drug abuse.

(K) Consumer health, including education to ensure that students understand the benefits and appropriate use of medical services, including immunizations and other clinical preventive services.

(4) The program is based upon current scientific knowledge of human health, fitness, and nutrition and does not provide medically false information.

(5) The program promotes personal responsibility for a healthy lifestyle and provides the knowledge and skills necessary to adopt a healthy lifestyle, including teaching the legal, social, mental, and health consequences of behaviors that pose health risks.

(6) To the extent practicable, the program is sensitive to cultural, gender, and ethnic issues in the content of instructional materials and approaches and addresses the needs of children with disabilities.

(7) The program includes activities that support instruction.

(8) The program includes activities to promote involvement by parents, families, community organizations, and other appropriate entities.

(9) The program is coordinated with other Federal, State, and local health education and prevention programs and with other Federal, State and local education programs, including those carried out under the Elementary and Secondary Education Act of 1965 (including the Drug-Free Schools and Communities Act of 1986) and the Individuals with Disabilities Education Act.

(10) The program focuses on the particular health concerns of the students, parents, and families in the State, school district, or school, as the case may be.

(11) The program utilizes existing professional resources and pupil services programs to prevent duplication and waste and to increase efficiency and coordination among education and prevention programs.

(b) OTHER DEFINITIONS.—For purposes of this subtitle:

(1) The term "educational service agency" means regional public multiservice agencies authorized by State statute to de-

velop, manage, and provide services and programs to local educational agencies.

(2) The term "local educational agency" has the meaning given such term in section 1471(12) of the Elementary and Secondary Education Act of 1965.

(3) The term "parent" includes a legal guardian or other person standing in loco parentis.

(4) The term "Secretary" means the Secretary of Health and Human Services, except as otherwise provided.

(5) The term "State educational agency" has the meaning given such term in section 1471(23) of the Elementary and Secondary Education Act of 1965.

SEC. 7603. PROHIBITION AGAINST FEDERAL CONTROL OF EDUCATION.

Nothing in this subtitle shall be construed to authorized any department, agency, officer, or employee of the United States to exercise any direction, supervision, or control over the curriculum, program of instruction, administration, or personnel of any educational institution, school, or school system, or over the selection of library resources, textbooks, or other printed or published instructional materials by any educational institution or school system.

SEC. 7604. PROHIBITION AGAINST DISTRIBUTION OF OBSCENE MATERIALS.

No entity receiving assistance under this subtitle may use such assistance to support the distribution of obscene materials to minors on school grounds.

PART 2—SCHOOL HEALTH EDUCATION; GENERAL PROVISIONS

SEC. 7611. AUTHORIZATIONS OF APPROPRIATIONS.

(a) FUNDING FOR SCHOOL HEALTH EDUCATION.—For the purpose of carrying out part 3, there are authorized to be appropriated $50,000,000 for fiscal year 1995, and such sums as may be necessary for each of the fiscal years 1996 through 2000.

(b) ALLOCATIONS.—Of the amounts appropriated under subsection (a) for a fiscal year—

(1) the Secretary may reserve not more than $5,000,000 to support national leadership activities, such as research and demonstration, evaluation, and training and technical assistance in comprehensive school health education; and

(2) the Secretary may reserve not more than 5 percent for administrative expenses regarding part 3.

(c) RELATION TO OTHER FUNDS.—The authorizations of appropriations established in subsection (a) are in addition to any other authorizations of appropriations that are available for the purpose described in such subsection.

SEC. 7612. WAIVERS OF STATUTORY AND REGULATORY REQUIREMENTS.

(a) IN GENERAL.—

(1) WAIVERS.—Except as provided in subsection (c), upon the request of an entity receiving funds under part 3 and under a program specified in paragraph (2), the Secretary of Education, upon the request of the Secretary of Health and Human Services, may grant to the entity a waiver of any requirement of such program regarding the use of funds, or of the regulations issued for the program by the Secretary of Education, if the following conditions are met with respect to such program:

(A) The Secretaries determine that the requirement of such program impedes the ability of the State educational agency or other recipient to achieve more effectively the purposes of part 3.

(B) The Secretaries determine that, with respect to the use of funds under such program, the requested use of the

funds by the entity would be consistent with the purposes of part 3.

(C) In the case of a request for a waiver submitted by a State educational agency, the State educational agency—

(i) provides all interested local educational agencies in the State with notice and an opportunity to comment on the proposal; and

(ii) submits the comments to the Secretary.

(D) In the case of a request for a waiver submitted by a local educational agency or other agency, institution, or organization that receives funds under part 3 from the State educational agency, such request has been reviewed by the State educational agency and is accompanied by the comments, if any, of such agency.

(2) RELEVANT PROGRAMS.—For purposes of paragraph (1), the programs specified in this paragraph are any program carried out under part B of the Drug-Free Schools and Communities Act of 1986.

(b) WAIVER PERIOD.—

(1) IN GENERAL.—A waiver under this section shall be for a period not to exceed three years.

(2) EXTENSIONS.—The Secretaries involved under subsection (a) may extend such period if the Secretaries determines that—

(A) the waiver has been effective in enabling the State or affected recipients to carry out the activities for which it was requested and has contributed to improved performance; and

(B) such extension is in the public interest.

(c) WAIVERS NOT AUTHORIZED.—The Secretaries involved under subsection (a) may not waive, under this section, any statutory or regulatory requirement relating to—

(1) comparability of services;

(2) maintenance of effort;

(3) the equitable participation of students attending private schools;

(4) parental participation and involvement;

(5) the distribution of funds to States or to local educational agencies or other recipients of funds under the programs specified in subsection (a)(2);

(6) maintenance of records;

(7) applicable civil rights requirements; or

(8) the requirements of sections 444 and 445 of the General Education Provisions Act.

(d) TERMINATION OF WAIVER.—The Secretaries involved under subsection (a) shall terminate a waiver under this section if the Secretary determines that the performance of the State or other recipient affected by the waiver has been inadequate to justify a continuation of the waiver or if it is no longer necessary to achieve its original purposes.

PART 3—SCHOOL HEALTH EDUCATION; GRANTS TO STATE EDUCATION AGENCIES

SEC. 7621. APPLICATION FOR GRANT.

(a) IN GENERAL.—Any State educational agency that wishes to receive a grant under this part shall submit an application to the Secretary of Health and Human Services and the Secretary of Education, at such time and in such manner as the Secretaries may require.

(b) APPLICATION; DEVELOPMENT; CONTENTS.—An application under subsection (a) shall be developed by the State educational agency in consultation with the State health agencies of the State involved, and shall describe the following:

(1) The State's need for comprehensive school health education based on an assessment, using goals that are estab-

lished by the Department of Health and Human Services and the Department of Education and that are integrated with the State's school improvement plan, if any, under title III of Goals 2000: Educate America Act or other State education reform plan.

(2) The State educational agency's goals and objectives for comprehensive school health education.

(3) How the State educational agency will collaborate with the State health agency in the planning and development of a comprehensive school health education and pupil services program in the State, including coordination of existing health education and pupil services programs and resources.

(4) A plan for evaluating the effectiveness of comprehensive school health education activities.

(5) How the State will allocate funds to local educational agencies in accordance with section 7625.

(6) How the State will coordinate programs under this part with other local, State and Federal health education and nutrition education programs.

(7) How comprehensive school health education programs will be coordinated and integrated with other local, State and Federal education programs, such as programs under the Elementary and Secondary Education Act of 1965 and the Individuals with Disabilities Education Act, with the State's school improvement plan, if any, under title III of the Goals 2000: Educate America Act, and with any similar programs.

(8) How the State will work with local education agencies, educational service agencies, and State and local health agencies to reduce barriers to implementing comprehensive school health education programs.

(9) How the State will monitor the implementation of such programs by local educational agencies.

(10) How the State will build capacity for professional development of school personnel.

(11) How the State will provide staff development (including curricula models and materials) and technical assistance to local educational agencies, including through the use of educational service agencies where such agencies exist.

(12) The respective roles of the State educational agency, local educational agencies, educational service agencies, the State health agency, and the local health agencies in developing and implementing such comprehensive school health education programs.

(13) How such school health education programs will be tailored, to the extent practicable, to be sensitive to gender, cultural, and linguistic differences and responsive to the various needs of the students served, including individuals with disabilities, and individuals from disadvantaged backgrounds (including racial and ethnic minorities).

(14) Such other information and assurances as the Secretary may reasonably require.

SEC. 7622. SELECTION OF GRANTEES.

(a) IN GENERAL.—The Secretary of Health and Human Services, in consultation with the Secretary of Education, shall establish criteria for the competitive selection of grantees under this part.

(b) EQUITABLE DISTRIBUTION.—The Secretary shall seek to ensure that assistance under this part is equitably distributed among the geographic regions of the United States, including both urban and rural areas.

SEC. 7623. AMOUNT OF GRANT.

(a) IN GENERAL.—For any fiscal year, the minimum grant to any State under this part is an amount determined by the Secretary to be necessary to enable the State to carry out the activities under this part.

(b) CRITERIA.—In determining the amount of any such grant, the Secretary may consider such factors as the number of children enrolled in schools in the State, the number or percentage of school-aged children living in poverty in the State, and the scope and quality of the State's plan.

SEC. 7624. AUTHORIZED ACTIVITIES; LIMITATION ON ADMINISTRATIVE COSTS.

(a) SUBGRANTS TO LOCAL EDUCATIONAL AGENCIES.—Each State that receives funds under this part for any fiscal year shall retain not more than 20 percent of those funds in the first year, and 10 percent of those funds in each succeeding year. Those funds not retained by the State shall be used to make grants to local educational agencies or educational service agencies in accordance with section 7625.

(b) STATE-LEVEL ACTIVITIES.—Each State shall use retained funds for any fiscal year for the following purposes:

(1) To conduct statewide or sub-State regional coordination and collaboration activities.

(2) To develop and provide technical assistance for the implementation of student learning objectives, instructional materials, and assessment instruments.

(3) To adapt, validate, or disseminate program models or strategies for comprehensive school health education.

(4) To build capacity to deliver staff development and technical assistance services to local educational agencies, and State and local health agencies.

(5) To promote program activities involving families and coordinating program activities with community groups and other public and private nonprofit agencies.

(6) To evaluate and report to the Secretary on the activities carried out with assistance under this part.

(7) To conduct such other activities to achieve the objectives of this part as the Secretary may by regulation authorize.

(c) STATE ADMINISTRATION.—Of the amounts received by a State for a fiscal year under this part and remaining after any grants to local educational agencies made from such amounts, the State may use up to 5 percent for the costs of administering such amounts, including monitoring the performance of local educational agencies.

SEC. 7625. SUBGRANTS TO LOCAL EDUCATIONAL AGENCIES.

(a) APPLICATION FOR GRANT.—Any local educational agency or educational service agency that wishes to receive a grant under this part shall submit an application to the State, containing such information and assurances as the State may require, including a description of the following:

(1) The local educational agency's goals and objectives for comprehensive school health education programs.

(2) How the local educational agency will concentrate funds in schools with the greatest need for comprehensive health education and provide sufficient funds to such schools to ensure the implementation of comprehensive programs.

(3) How the local educational agency will monitor the implementation of these programs.

(4) How the local educational agency will ensure that comprehensive school health education programs are tailored, to the extent practicable, to be sensitive to gender, cultural, and linguistic differences and responsive to the various needs of the students served, including individuals with disabilities, and individuals from disadvantaged backgrounds (including racial and ethnic minorities).

(5) How the local educational agency, in consultation with the local health agency, will evaluate and report on its progress toward attaining the goals and objectives described in paragraph (1).

(6) How the local educational agency, in consultation with the local health agency, will involve parents, teachers, school

health and pupil services personnel, and other education and health professionals in the design, instructional content, development, and implementation of the program.

(b) SELECTION OF SUBGRANTEES.—

(1) IN GENERAL.—Each State shall give priority to applications from local educational agencies serving areas with high needs, as indicated by objective, needs-based criteria developed by the State, using readily available public health and other data, which shall include, but need not be limited to, high rates of any of the following:

(A) Poverty among school-aged youth.

(B) Birth to adolescents.

(C) Sexually transmitted diseases among school-aged youth.

(D) Drug and alcohol use among school-aged youth.

(E) Violence among school-aged youth.

(F) Poor daily school attendance.

(2) EQUITABLE DISTRIBUTION.—Each State shall ensure that assistance under this part is equitably distributed among the geographic regions of the State, including both urban and rural areas.

(c) AUTHORIZED ACTIVITIES.—Each local educational agency that receives a grant under this part shall use the grant funds to implement comprehensive school health education programs, as defined in section 7602.

SEC. 7701. OCCUPATIONAL INJURY AND ILLNESS PREVENTION.

(a) IN GENERAL.—The Secretary of Health and Human Services and the Secretary of Labor shall collaborate to develop and implement a comprehensive program to expand and coordinate initiatives to prevent occupational injuries and illnesses.

(b) SECRETARY OF LABOR.—The Secretary of Labor, after consultation with the Secretary of Health and Human Services, shall directly or by grants or contracts—

(1) provided for training and education programs for employees and employers in the recognition and control of workplace hazards and methods and measures to prevent occupational injuries and illnesses;

(2) develop model educational materials for training and educating employees and employers on the recognition and control of workplace hazards, including a core curriculum for general safety and health training and materials related to specific safety and health hazards; and

(3) provide programs and services for technical assistance to employers and employees on the recognition and control of workplace safety and health hazards including programs for onsite consultation.

Nothing in this Act shall be construed to require adoption or implementation by any employer of materials or curricula funded by the Secretary of Labor pursuant to paragraph (2). Technical assistance and consultative services under paragraph (3) shall be provided in a manner that is separate from the enforcement programs conducted by the Secretary of Labor.

(c) SECRETARY OF HEALTH AND HUMAN SERVICES.—The Secretary of Health and Human Services, acting through the Director of the National Institute for Occupational Safety and Health and after consultation with the Secretary of Labor, shall directly or by grants or contracts—

(1) provide education programs for training occupational safety and health professionals including professionals in the fields of occupational medicine, occupational health nursing, industrial hygiene, safety engineering, toxicology, and epidemiology;

(2) provide education programs for other health professionals and health care providers and the public to improve the recognition, treatment, and prevention of occupationally related injuries and illnesses;

(3) conduct surveillance programs to identify patterns and to determine the prevalence of occupational illnesses, injuries and deaths related to exposure to particular safety and health hazards;

(4) conduct investigations and evaluations to determine if workplace exposures to toxic chemicals, harmful physical agents or potentially hazardous conditions pose a risk to exposed employees; and

(5) conduct research, demonstrations, and experiments relating to occupational safety and health to identify the causes of and major factors contributing to occupational illnesses and injuries.

In any case in which the Secretary of Health and Human Services conducts any activity under paragraph (3), (4), or (5) which includes a cohort study involving current or past employees of an employer, the Secretary shall provide prior notice to the employer and the employees (or employee representatives of the employees) in advance of the major steps of such activity, and shall provide the employer and the employees (or employee representatives) an opportunity to review the study and submit analysis or other comments prior to making the study publicly available.

(d) AUTHORIZATION OF APPROPRIATIONS.—For the purposes of carrying out this section, there are authorized to be appropriated $150,000,000 for each of the fiscal years 1995 through 2000.

Subtitle I—Miscellaneous Provisions

SEC. 7801. IDENTIFYING STRATEGIES FOR ASSESSING IMPACT OF HEALTH CARE REFORM.

(a) IN GENERAL.—Within 90 days after the date of the enactment of this Act, the Secretary shall seek to enter into an agreement with the Institute of Medicine of the National Academy of Sciences (or another nonprofit, nongovernmental organization or consortium of institutions) to study and report on the impact of this Act at the national, regional, and State levels.

(b) PURPOSE.—The purpose of the study under this section is to develop a detailed framework, using a prospective, longitudinal study design, to assess the impact of this Act on national goals, such as the goals of assuring security of coverage, promoting simplicity of administration, achieving health care savings, encouraging individual responsibility, improving quality of care, promoting choice, and improving health status.

(c) REPORT.—The Secretary shall require the organization conducting the study under this section to submit to the Secretary and the Congress a report within 18 months after the date of the enactment of this Act. The report shall include recommendations regarding each of the following:

(1) The appropriate indicators of national progress towards meeting the national goals referred to in subsection (b).

(2) The appropriate study designs that would assess the impact of this Act on these indicators and that could take into account different approaches to health care reform that may be used in different States and regions (or by different Federal agencies), as well as by foreign countries.

(3) The data elements and public and private sources of information for measuring such indicators, including—

(A) the special requirements or authorities needed to permit access to confidential data (and to assure continued confidentiality of such data) needed to measure such indicators;

(B) the methods for obtaining the elements that are not currently in use;

(C) approaches to establishing a core set of primary data as part of a national collection effort that could overlap with the evaluation of this Act; and

(D) the relationship between Federal, State, and local agencies in the gathering, reporting, and sharing of information on this Act and its assessment.

(4) The nature, scope, and frequency of reports that would best serve the Secretary and the Congress in the evaluation of this Act.

(5) The overall cost estimates associated with obtaining and evaluating information on the impact of this Act.

(6) The ways in which the findings contained in the report could be used by various groups, such as patients, providers, insurers, employers, taxpayers, and various government agencies.

SEC. 7802. STUDY OF WORKSITE WELLNESS PROGRAMS.

(a) IN GENERAL.—The Secretary of Health and Human Services, after consultation with the Secretary of Labor, shall conduct a study evaluating the effectiveness of health promotion programs in the worksite and analyzing the feasibility and desirability of providing incentives (including health plan premium discounts) to encourage employers to adopt such programs. In conducting the study, the Secretary shall assess the effect of programs of various size, scope, and type on health status, medical risk factors, life style, disability, morbidity, mortality, and productivity.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under subsection (a), and shall include in the report—

(1) information on the cost effectiveness, type, and amount of financial incentives (if any) provided under the programs studied; and

(2) such recommendations as the Secretary considers appropriate for providing incentives to encourage employers to adopt health promotion programs in the worksite.

TITLE VIII—MEDICARE AND MEDICAID

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Subtitle C—Cost Containment in the Medicare Programs

Subtitle D—Revisions to Medicare Part A and Part B

SEC. 8000. REFERENCES IN TITLE.

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

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

Subtitle A—Medicare Part C Program

SEC. 8001. ESTABLISHMENT OF MEDICARE PART C PROGRAM.

The Social Security Act is amended by adding after title XX the following new title:

"TITLE XXI—MEDICARE PART C

"SEC. 2100. ESTABLISHMENT OF PROGRAM.

"Not later than January 1, 1999, the Secretary shall establish and operate a Medicare Part C Program under this title to provide coverage for the guaranteed national benefit package for eligible individuals.

"PART A—ELIGIBILITY AND ENROLLMENT

"SEC. 2101. ELIGIBILITY.

"(a) ELIGIBILITY TO ENROLL FOR HEALTH INSURANCE BENEFITS.—Each medicare part C eligible individual (as defined in subsection (b)) is eligible to enroll in the program under this title.

"(b) MEDICARE PART C ELIGIBLE INDIVIDUAL DEFINED.—In this title, subject to subsection (c), the term 'medicare part C eligible individual' means any eligible individual (as defined in section 1001(c) of the Guaranteed Health Insurance Act of 1994) who meets any of the following requirements:

"(1) CERTAIN PART-TIME, TEMPORARY, AND SEASONAL EMPLOYEES.—The individual is an employee described in section 1102(c) of the Guaranteed Health Insurance Act of 1994 or a member of the family of such an individual (as defined in section 3 of such Act).

"(2) FULL-TIME EMPLOYEES OF SMALL EMPLOYERS.—The individual is a full-time employee (as defined in section 1106(a) of the Guaranteed Health Insurance Act of 1994) of an employer that is not a large employer (as defined in section 1106(b) of such Act) and the employee is not a qualified employer-covered employee of the employer (as defined in section 1104 of such Act), or a member of the family of such an individual (as defined in section 3 of such Act).

"(3) NON-WORKERS.—The individual is not an employee, or is a member of the family of an individual who is not an employee.

"(4) AFDC AND SSI RECIPIENTS.—The individual is an AFDC or SSI recipient.

"(5) EMPLOYED INDIVIDUALS WITH INCOME BELOW SPECIFIED PERCENTAGE OF INCOME THRESHOLD.—

"(A) IN GENERAL.—The individual—

"(i) is an employee of a small employer (as defined in section 1106(b) of the Guaranteed Health Insurance Act of 1994), and

"(ii) is determined, under part D of title XXII in the manner described in section 2251, to have projected modified adjusted gross income that is less than the applicable percentage (specified in subparagraph (B)) of the threshold amount (as defined in section 2122(c)(3)) applicable to the taxpayer involved.

"(B) APPLICABLE PERCENTAGE.—For purposes of subparagraph (A), the 'applicable percentage', for taxable years ending with or within—

"(i) 1999, 2000, or 2001, is 200 percent,

"(ii) 2002 or 2003, is 220 percent, and

"(iii) a year thereafter, is 240 percent.

"(c) INELIGIBLE INDIVIDUAL.—

"(1) IN GENERAL.—

"(A) IN GENERAL.—The term 'medicare part C eligible individual' does not include an eligible individual (as defined in section 1001 of the Guaranteed Health Insurance Act of 1994)—

"(i) who is covered under a certified health plan,

"(ii) subject to paragraph (2), who is entitled to benefits under part A of title XVIII,

"(iii) whose principal place of abode is in Puerto Rico, the Virgin Islands, Guam, American Samoa, or the Northern Mariana Islands, unless (and only so long as) such possession meets the requirements of paragraph (3)(A), or

"(iv) who is covered under a State single-payer system or a State managed competition program under subtitle A or B of title IV of the Guaranteed Health Insurance Act of 1994.

"(B) CONSTRUCTION.—Nothing in subparagraph (A)(i) shall prevent an individual described in such subparagraph from disenrolling from a plan in order to become a medicare part C eligible individual.

"(2) EXCEPTION FOR MEDICARE SECONDARY PAYER SITUATIONS.—Paragraph (1)(A)(ii) shall not apply to an individual to whom section 1862(b)(2) applies, if the program under this title would otherwise constitute the primary plan (as defined in section 1862(b)(2)(A)).

"(3) RULES RELATING TO POSSESSIONS.—

"(A) REQUIREMENTS.—The requirements of this subparagraph with respect to a possession are that an agreement is in effect between the United States and such possession pursuant to which—

"(i) the laws of such possession impose a qualified medicare part C premium individual share tax (as defined in subparagraph (B));

"(ii) nothing in any provision of law, including the law of such possession, permits such possession to reduce or remit in any way, directly or indirectly, any liability to such possession by reason of such individual share tax;

"(iii) any amount received in the Treasury of such possession by reason of such individual share tax shall be paid (at such time and in such manner as the Secretary of the Treasury shall prescribe) to the Treasury of the United States for credit to the Medicare Part C Trust Fund;

"(iv) such individual share tax is coordinated with the tax imposed by section 59B of the Internal Reve-

nue Code of 1986 such that, for any period, an individual would be required to pay (in the aggregate under both such taxes) not more than the appropriate applicable medicare part C premium for such period; and

"(v) the possession complies with such other requirements as may be prescribed by the Secretary and the Secretary of the Treasury to carry out the purposes of this paragraph, including requirements prescribing the information individuals to whom such individual share tax may apply shall furnish to the Secretary and the Secretary of the Treasury.

"(B) QUALIFIED MEDICARE PART C PREMIUM INDIVIDUAL SHARE TAX.—In subparagraph (A), the term 'qualified medicare part C premium individual share tax' means a tax imposed and collected by such a possession that is—

"(i) equivalent to the tax imposed under section 59B of the Internal Revenue Code of 1986 (and any tax subsequently enacted for the purpose of collecting the individual share of premiums for benefits under this title); and

"(ii) imposed on all individuals who are medicare part C eligible individuals (as determined without regard to paragraph (1)(A)(iii)) and who are bona fide residents of the possession, to the extent such individuals have not paid the tax imposed under such section 59B to the United States by reason of subsection (f)(4) of such section or otherwise paid the qualified medicare part C premium individual share tax imposed by another possession under this paragraph.

"SEC. 2102. ENROLLMENT PROCESS.

"(a) IN GENERAL.—The Secretary, through the Health Care Financing Administration, the Social Security Administration, and other appropriate agencies, shall establish a process in coordination with section 2184 for—

"(1) determining whether individuals are medicare part C eligible individuals,

"(2) enrolling medicare part C eligible individuals under this title if they seek such enrollment or are otherwise required to be enrolled or covered under this title, and

"(3) enrolling medicare part C eligible individuals described in section 2101(b)(2) whose employers do not enroll such individuals in a certified health plan.

"(b) PERIOD OF CONTINUOUS OPEN ENROLLMENT.—Any medicare part C eligible individual may enroll under this title at any time beginning July 1, 1998.

"(c) APPLICATION PROCESS.—

"(1) IN GENERAL.—The filing of an application for enrollment under this title shall (except as the Secretary may provide) constitute enrollment under this title. Such an application may be filed with the Secretary by mail or at such locations as the Secretary may specify.

"(2) AVAILABILITY OF APPLICATIONS.—The Secretary shall make applications for enrollment under this title available—

"(A) at local offices of the Social Security Administration,

"(B) at out-reach sites (such as provider and practitioner locations described in section 2103(c)), and

"(C) at other locations (including post offices) accessible to a broad cross-section of medicare part C eligible individuals.

"(3) COORDINATION WITH APPLICATION FOR PREMIUM SUBSIDIES AND WRAP-AROUND BENEFITS.—An application for enrollment under this title may (but need not) be accompanied by an application for wrap-around benefits under part B of title XXII.

"(c) CERTAIN INDIVIDUALS DEEMED ENROLLED.—Consistent with standards established under section 5501 of the Guaranteed Health Insurance Act of 1994—

"(1) TERMINATION OF ENROLLMENT UNDER CERTIFIED HEALTH PLAN.—The Secretary shall provide a process under which an eligible individual whose coverage under a certified health plan is terminated and who fails to establish continuous coverage under another certified health plan or the medicare program shall be deemed to be enrolled under this title as of the date of termination of such coverage.

"(2) COVERAGE AT BIRTH.—The Secretary shall provide that in the case of an individual born in the United States and who is not enrolled or otherwise covered under a certified health plan at the time of birth, the individual shall be deemed to have been enrolled under this title at the time of birth.

"(d) ISSUANCE OF HEALTH SECURITY CARD.—At the time an individual enrolls in the program under this title, the Secretary shall issue a health security card to the individual in accordance with the standards applicable to the issuance of such cards under subtitle B of title IX of the Guaranteed Health Insurance Act of 1994.

"SEC. 2103. FACILITATION OF ENROLLMENT.

"(a) IN GENERAL.—The Secretary shall establish procedures that facilitate enrollment under this title.

"(b) COORDINATION.—The Secretary shall coordinate with existing programs and agencies to streamline the enrollment process.

"(c) USE OF CERTAIN PROVIDERS.—

"(1) IN GENERAL.—In accordance with regulations promulgated by the Secretary, hospitals, rural primary care hospitals, federally qualified health centers, rural health clinics, and any essential community provider (as described in section 5012(c) of the Guaranteed Health Insurance Act of 1994) receiving Federal funds, shall—

"(A) assist in enrolling under this title individuals who (i) appear to be medicare part C eligible individuals, (ii) are provided services covered under the guaranteed national benefit package, and (iii) do not present a valid health security card, and

"(B) report to the Secretary such information as the Secretary may require to assist in the enrollment of such individuals.

"(2) ACCESS TO INFORMATION.—Such hospitals, centers, clinics, and providers shall have access to information, pertaining to the certified health plans (or the medicare program or medicare part C) in which individuals are enrolled, through the national enrollment verification system established under subtitle B of title IX of the Guaranteed Health Insurance Act of 1994.

"(d) OUTREACH.—The Secretary shall develop and implement outreach programs to ensure enrollment of all medicare part C eligible individuals (who are not enrolled in a certified health plan or the medicare program) under this title.

"SEC. 2104. COVERAGE PERIOD; TERMINATION OF ENROLLMENT.

"(a) BEGINNING OF COVERAGE.—In the case of an individual enrolled under this title, the benefits under this title shall first become available for services furnished beginning—

"(1) in the case of an individual who enrolls on or before January 1, 1999, on January 1, 1999; or

"(2) in the case of an individual who enrolls after such date, on the date of enrollment or such other date as the Secretary may specify, consistent with preventing eligible individuals from having any periods of noncoverage and consistent with rules established under section 5501 of the Guaranteed Health Insurance Act of 1994.

"(b) LIMITING TERMINATION OF ENROLLMENT.—An individual enrolled under this title may not terminate such enrollment unless—

"(A) the individual is no longer a medicare part C eligible individual because of a change of family, employment, or other relevant status; or

"(B) the individual demonstrates to the satisfaction of the Secretary that if the individual is an eligible individual the individual is enrolled under a certified health plan, is entitled to benefits under part A of title XVIII, is a noncovered, noncontributing individual (as defined in section 1004(b) of the Guaranteed Health Insurance Act of 1994), or is described in section 59B(g)(2)(A)(ii) of the Internal Revenue Code of 1986.

"PART B—BENEFITS AND PAYMENTS

"SEC. 2111. COVERAGE OF BENEFITS UNDER GUARANTEED NATIONAL BENEFIT PACKAGE.

"(a) IN GENERAL.—Subject to subsection (b), the health insurance benefits provided to an individual covered under this title shall consist of entitlement to the benefits (including cost-sharing) contained in the guaranteed national benefit package described in subtitle A of title III of the Guaranteed Health Insurance Act of 1994. Except in the case of enrollment with an organization under section 2132, the cost-sharing schedule shall be the standard cost-sharing schedule described in section 3013 of the Guaranteed Health Insurance Act of 1994 (determined without regard to subsection (a)(4) thereof).

"(b) REQUIRING COVERED SERVICES TO BE FURNISHED BY MEDICARE-ELIGIBLE PROVIDERS.—No benefits are payable under this title with respect to an individual or entity that provides items and services (other than services described in section 3002(d) of the Guaranteed Health Insurance Act of 1994) unless the individual or entity qualifies for payment with respect to such items or services under title XVIII (for individuals entitled to benefits under such title).

"SEC. 2112. PAYMENTS FOR HEALTH INSURANCE BENEFITS.

"(a) USE OF MEDICARE PAYMENT RULES.—

"(1) IN GENERAL.—Except as otherwise provided in this title, consistent with sections 5501(c)(3) and 8002(c) of the Guaranteed Health Insurance Act of 1994 and consistent with the cost-sharing described in section 2111(a)—

"(A) payment of health insurance benefits under this title with respect to services shall be made, subject to adjustment in payment rates under section 2113, in the same amounts and on the same basis as payment may be made with respect to such services under title XVIII (including pursuant to waiver authority), and

"(B) the provisions of sections 1814, 1815, 1833, 1834, 1835, 1842, 1848, 1850, 1886, 1887, and 1893 shall apply to payment of benefits (and provision of services and charges thereon) under this title in the same manner as they apply to benefits, services, and charges under title XVIII.

"(2) ESTABLISHMENT OF COMPARABLE PAYMENT METHODS FOR NEW SERVICES.—In the case of any service for which there is not a payment basis established under title XVIII, the Secretary shall establish payment rules that are similar to the payment rules for similar services under such title, in consultation with the Prospective Payment Assessment Commission, Physician Payment Review Commission, and the Prescription Drug Payment Review Commission.

"(3) LIMITATIONS ON ADMINISTRATIVE OR JUDICIAL REVIEW.—Administrative or judicial review of the payment rates or rules under this section (including adjustments made under section 2113) shall be available only to the extent such a review would be available with respect to such rates or rules (or similar rates or rules) under title XVIII.

"(4) USE OF TRUST FUND.—In applying the provisions described in paragraph (a)(1)(B) in carrying out this section, any reference in title XVIII to a trust fund shall be treated as a reference to the Medicare Part C Trust Fund established under section 2124.

"(b) PAYMENTS TO PROVIDERS FOR CERTAIN EMERGENCY CARE SERVICES FOR INELIGIBLE ALIENS.—

"(1) IN GENERAL.—In addition to amounts otherwise payable under this title, the Secretary shall make payments for care and services that are necessary for the treatment of an emergency medical condition (as defined in section 1903(v)(3)) of an alien who is not an eligible individual.

"(2) PAYMENT AMOUNT.—Notwithstanding any other provisions of this title, the amount of such payments—

"(A) shall not take into account any cost-sharing that may otherwise be imposed under this title, but

"(B) shall be reduced by the amount of any payment otherwise made (or that through the exercise of reasonable collection policies, would have been paid) with respect to such care and services.

"(3) EFFECTIVE DATE.—This subsection shall not apply to care and services furnished before January 1, 2002.

"SEC. 2113. ADJUSTMENTS TO MEDICARE RATES AND METHODOLOGIES.

"(a) ADJUSTMENT OF MEDICARE PAYMENT RATES FOR INPATIENT HOSPITAL SERVICES.—

"(1) FOR PPS HOSPITALS.—For purposes of payment for inpatient hospital services for hospitals receiving payment under section 1886(d), the Secretary, by regulation and in accordance with this section—

"(A) shall adjust the standardized amounts otherwise established under title XVIII to reflect differences in the average cost of providing inpatient hospital services (included in the guaranteed national benefit package) between the program under part A of title XVIII and under this title, and

"(B) may develop separate diagnosis-related groups and weighting factors for such groups to reflect resource needs of individuals enrolled under this title and shall develop separate groups and factors for children.

"(2) REPORT BY PROSPECTIVE PAYMENT ASSESSMENT COMMISSION.—The Prospective Payment Assessment Commission, in its report to Congress under section 1886(e)(3)(A) in 1998, shall include its recommendations on the adjustments that should be made under paragraph (1) in the payment methodology for inpatient hospital services and data that should be collected in order to establish appropriate weighting factors for diagnosis-related groups used under this section. The Commission shall include, in its subsequent reports under such section, such recommendations with respect to payment for inpatient hospital services under this title as it deems appropriate.

"(3) SECRETARIAL PUBLICATIONS.—The Secretary shall provide for the publication, in the manner and time specified under section 1886(e)(5), of adjustments proposed to be made (and to be made) under this subsection for each fiscal year.

"(b) NEW PROCEDURE CODES AND RELATIVE VALUE UNITS FOR PHYSICIANS' SERVICES.—

"(1) NEW PROCEDURE CODES AND RELATIVE VALUE UNITS.—In applying section 2112 in the case of services for which relative value units have not been established under section 1848, the Secretary shall establish relative value units in the same manner as if payment for such services were made under part B of title XVIII.

"(2) REPORT BY PHYSICIAN PAYMENT REVIEW COMMISSION.—The Physician Payment Review Commission, in its recommendations to Congress under section 1845(b) in the year

before the first year in which this title is effective, shall include recommendations on adjustments to the relative value units that should be applied (under paragraph (1)) with respect to physicians' services furnished under this title. The Commission shall include, in its subsequent recommendations under such section, such recommendations with respect to the payment for physicians' services under this title as it deems appropriate.

"(3) SECRETARIAL PUBLICATION.—The Secretary shall cause to be published in the Federal Register—

"(A) before June 1 of the year before the first year in which this title is effective, the relative value units proposed to be applied during such first year under this title, and

"(B) after consideration of public comments submitted pursuant to such proposal and before October 1 before such first year, the relative value units to be applied during such first year under this title.

"(4) SECRETARIAL REVIEW AND REVISION.—The Secretary shall provide for the periodic review and adjustment of the relative value units to be applied under this title in the same manner and frequency as provided under section 1848(c)(2)(B), except that such review shall first be conducted each year during the first 3 years in which this title is in effect and not less often than every 5 years thereafter.

"(c) ADJUSTMENT TO AVERAGE PER CAPITA RATES FOR HEALTH MAINTENANCE ORGANIZATIONS.—For purposes of establishing per capita rates of payment for classes of individuals enrolled with an eligible organization under a risk-sharing contract under section 2132, the Secretary, by regulation and in accordance with this subsection, shall adjust the adjusted average per capita cost otherwise established under section 1876(a)(4) to take into account differences between the population served under title XVIII and the population receiving health insurance benefits under this title.

"SEC. 2114. EXCLUSIONS; COORDINATION.

"(a) EXCLUSIONS.—

"(1) IN GENERAL.—Section 1862 shall apply to expenses incurred for items and services provided under this title in the same manner as such section applies to items and services provided under title XVIII.

"(2) USE OF SAME NATIONAL COVERAGE DECISION REVIEW PROCESS.—The provisions of section 1869(b)(3) shall apply under this title in the same manner as they apply under title XVIII. Any determination under such title that, under paragraph (1), applies under this title shall not be subject to review under this paragraph.

"(b) TREATMENT AS LARGE GROUP HEALTH PLAN FOR PURPOSES OF MEDICARE SECONDARY PAYER.—For purposes of section 1862(b), this title shall be treated as a large group health plan (described in such section).

"PART C—PREMIUMS; MEDICARE PART C TRUST FUND

"SEC. 2121. COMPUTATION OF APPLICABLE MEDICARE PART C PREMIUM.

"(a) IN GENERAL.—The applicable medicare part C premium under this title, for health insurance benefits for any individual in a class of enrollment (as defined in section 3(b) of the Guaranteed Health Insurance Act of 1994) in a State (or outside the United States) for a month in a year, is equal to the product of—

"(1) the monthly national actuarial rate established under subsection (b) with respect to such class for months in the year, and

"(2) a State actuarial adjustment factor established under subsection (c) with respect to the State (or outside the United States).

The Secretary shall publish, for purposes of this title, sections 59B(c)(3)(D) and 3455(c)(4)(A) of the Internal Revenue Code of 1986, and part A of title XXII, tables of the monthly applicable medicare part C premium computed under this subsection.

"(b) MONTHLY NATIONAL ACTUARIAL RATES.—

"(1) INITIAL RATE.—Subject to the succeeding provisions of this subsection, the national monthly actuarial rates under this subsection for months in 1999 are as follows (expressed in 1994 dollars):

"(A) INDIVIDUAL ENROLLMENT.—$178.25 for the individual class of enrollment.

"(B) SINGLE PARENT ENROLLMENT.—$347.50 for the single parent class of enrollment.

"(C) FAMILY ENROLLMENT.—$472.60 for the family class of enrollment.

"(2) DETERMINATION OF RATES.—

"(A) ANNUAL DETERMINATION.—In September of each year (beginning with 1998) the Secretary shall determine and publish a national monthly actuarial rate for each class of enrollment for health insurance benefits under this title in the following year. Such rates for—

"(i) 1999 shall be the rates specified under paragraph (1), subject to adjustment under subparagraph (C), or

"(ii) a subsequent year, shall be the monthly actuarial rates estimated under paragraph (3).

"(B) PUBLIC STATEMENT.—Whenever the Secretary publishes monthly actuarial rates under this section, the Secretary shall, at the time of such publication, include a public statement setting forth the actuarial assumptions and bases employed in arriving at the amount of the actuarial rates.

"(C) RELATION TO SPECIFIED RATES.—If the Secretary finds that the rates specified under paragraph (1) are greater or less than the respective monthly actuarial rates estimated under paragraph (3), the Secretary shall adjust the specified rates to reflect such estimated actuarial rates and the national monthly actuarial rates under this subsection shall be treated for all purposes as the rates as so adjusted.

"(3) BASIS FOR MONTHLY ACTUARIAL RATES.—

"(A) IN GENERAL.—Subject to subparagraph (C), each such monthly actuarial rate established for a class of enrollment shall be an amount the Secretary estimates to be necessary so that, if payments were made on the basis of such rates for all individuals enrolled under this title in such class, the aggregate amount for the calendar year would equal the total of the benefits and administrative costs which the Secretary estimates will be payable from the Medicare Part C Trust Fund for services performed and related administrative costs incurred in such calendar year with respect to such enrollees. In calculating the monthly actuarial rates, the Secretary shall include an appropriate amount for a contingency margin.

"(B) ASSUMPTIONS FOR PREMIUM CALCULATION.—In determining actuarial rates under subparagraph (A)—

"(i) the Secretary shall not take into account any expenditures (including related administrative expenses) attributable to—

"(I) individuals enrolled for health insurance benefits under this title who are SSI recipients who have been determined to be disabled for purposes of the supplemental security income program (under title XVI); or

"(II) the operation of part B of this title; or

"(III) payments made pursuant to section 2112(b); and

"(ii) for months in 1999, 2000, 2001, and 2002, the Secretary shall assume that 3/4 of individuals who are medicare part C eligible individuals are enrolled under this title.

"(c) STATE ACTUARIAL ADJUSTMENT FACTORS.—

"(1) IN GENERAL.—The Secretary shall establish for each State a State actuarial adjustment factor. Such factor shall vary among the States based on the variation in the average level of costs for covered benefits and administration, described in subsection (b)(3)(B) and determined on a per capita basis, among such States.

"(2) CONDITIONS.—State actuarial adjustment factors shall be computed for each year in a manner so that the application of such adjustment factors shall not change the weighted average of the national monthly payment rates computed under this subsection.

"(3) SPECIAL RULE FOR INDIVIDUALS RESIDING OUTSIDE THE UNITED STATES.—In the case of an eligible individual who has a principal place of abode outside the United States, the State actuarial adjustment factor under this subsection is 1.

"(d) APPLICATION TO FAMILIES.—In the case of individuals enrolled under this title in a class of enrollment other than the individual class of enrollment, the premium rate established under this section applies collectively to all family members included within the class of enrollment.

"SEC. 2122. MEDICARE PART C PREMIUM LIABILITY.

"(a) IN GENERAL.—An individual's share of the medicare part C premium is the amount determined under section 59B of the Internal Revenue Code of 1986.

"(b) DESCRIPTION OF FACTORS TAKEN INTO ACCOUNT.—The amount of such individual share under such section—

"(1) is based on the sum of monthly premiums based on class of enrollment;

"(2) is fully or partially reduced for low-income individuals, as described in subsection (c); and

"(3) may be reduced by any employer payments.

"(c) REDUCTION FOR LOW-INCOME INDIVIDUALS.—

"(1) IN GENERAL.—An individual whose modified adjusted gross income (as defined in paragraph (4)) does not exceed the threshold amount (as defined in paragraph (3)) is not liable for payment of the individual share of the medicare part C premium.

"(2) PHASE-IN OF PREMIUM LIABILITY.—

"(A) IN GENERAL.—If the modified adjusted gross income of an individual for a taxable year exceeds the threshold amount by less than the phase-in amount (described in subparagraph (C)), the amount of the premium liability under subsection (a) for the year shall be the phase-in percentage (specified in subparagraph (B)) of the medicare part C premium liability of such individual for the taxable year.

"(B) PHASE-IN PERCENTAGE.—For purposes of subparagraph (A), the phase-in percentage shall be determined under tables prescribed by the Secretary of the Treasury under section 59B(b)(2)(B) of the Internal Revenue Code of 1986, which tables—

"(i) have income brackets of not more than $50, and

"(ii) provide for a ratable increase in the amount of premium imposed by subsection (a) for modified adjusted gross incomes between the threshold amount and the sum of the threshold amount and the phase-in amount.

"(C) PHASE-IN AMOUNT.—For purposes of subparagraphs (A) and (B), the phase-in amount is the amount equal to the applicable percentage (determined in accordance with the following table) of the threshold amount.

"In the case of taxable years ending with or within—	The applicable percentage is—
1999, 2000, or 2001	100 percent
2002 or 2003	120 percent
2004 or thereafter	140 percent.

"(3) THRESHOLD AMOUNT DEFINED.—For purposes of this subsection—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'threshold amount' means—

"(i) $7,400 in the case of a return with respect to which 1 personal exemption is allowable under section 151 of the Internal Revenue Code of 1986,

"(ii) $11,500 in the case of a return with respect to which 2 or 3 personal exemptions are allowable under such section, and

"(iii) $16,000 in the case of a return with respect to which 4 or more personal exemptions are allowable under such section.

"(B) CERTAIN SEPARATE RETURNS.—The threshold amount shall be zero in the case of a taxpayer who—

"(i) is married as of the close of the taxable year but does not file a joint return for such taxable year, and

"(ii) does not live apart from his spouse at all times during the last 6 months of the taxable year.

"(C) INFLATION ADJUSTMENTS.—In the case of a taxable year beginning in a calendar year after 1998, each dollar amount contained in subparagraph (A) shall be increased by an amount equal to—

"(i) such dollar amount, multiplied by

"(ii) the cost-of-living adjustment determined under section 1(f)(3) of the Internal Revenue Code of 1986 for the calendar year in which the taxable year begins, by substituting 'calendar year 1994' for 'calendar year 1992' in subparagraph (B) thereof.

"(4) MODIFIED ADJUSTED GROSS INCOME.—For purposes of this subsection, and pursuant to section 59B(e)(1) of the Internal Revenue Code of 1986, the term 'modified adjusted gross income' means adjusted gross income—

"(A) determined without regard to sections 911, 931, and 933 of the Internal Revenue Code of 1986, and

"(B) increased by the amount of interest received or accrued by the individual during the taxable year which is exempt from tax.

The determination under the preceding sentence shall be made without regard to any carryover or carryback.

"SEC. 2123. COLLECTION OF PREMIUMS.

"(a) IN GENERAL.—Except as provided in subsection (b), the amounts under section 2122 are payable pursuant to section 59B of the Internal Revenue Code of 1986.

"(b) DIRECT PAYMENT PROCESS.—

"(1) IN GENERAL.—The Secretary shall establish a process whereby individuals who are liable for payments under section 2122 (or section 59B of the Internal Revenue Code of 1986) may make such payments directly to the Secretary (or the Secretary's designee) in a manner specified by the Secretary.

"(2) INFORMATION.—Under the process, the Secretary shall provide such information return or other documentation that may be used to establish, for purposes of the Internal Revenue Code of 1986 or otherwise, the amounts paid on behalf of each

individual under this subsection and the period in which the individual was enrolled under this title.

"(3) DEPOSIT.—Amounts received under this subsection shall be deposited to the credit of the Medicare Part C Trust Fund (established under section 2124).

"SEC. 2124. MEDICARE PART C TRUST FUND.

"(a) ESTABLISHMENT.—

"(1) IN GENERAL.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Medicare Part C Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided pursuant to section 201(h) and such amounts as may be deposited in, or appropriated to, such Trust Fund as provided in this part.

"(2) DEPOSIT OF PREMIUM AMOUNTS AND CONTRIBUTIONS.—There are hereby appropriated to the Trust Fund amounts equivalent to 100 percent of—

"(A) the amounts received in the Treasury under section 59B and chapter 25 of the Internal Revenue Code of 1986 and section 2132,

"(B) the amount of payments made by States to the Secretary under sections 8111, 8121, and 8131 of the Guaranteed Health Insurance Act of 1994, and

"(C) amounts paid to the Treasury pursuant to agreements under section 2101(c)(3)(A).

The amounts appropriated by clauses (A) and (C) of the preceding sentence shall be transferred from time to time from the general fund in the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the amounts paid to or deposited into the Treasury; and proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the amounts specified in such clauses.

"(3) APPROPRIATIONS TO COVER BALANCE OF EXPENDITURES.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Medicare Part C Trust Fund a Government contribution equal to the amount by which the expenditures from the Trust Fund (including the payment of administrative expenses in accordance with section 201(g)(1)) exceed the other receipts of the Trust Fund.

"(b) INCORPORATION OF PROVISIONS.—

"(1) IN GENERAL.—Subject to paragraph (2), the provisions of subsections (b) through (e), (h), and (i) of section 1817 shall apply to the Trust Fund and this title in the same manner as they apply to the Federal Hospital Insurance Trust Fund and part A of title XVIII.

"(2) EXCEPTIONS.—In applying paragraph (1)—

"(A) the Board of Trustees and Managing Trustee of the Trust Fund shall be composed of the members of the Board of Trustees and the Managing Trustee, respectively, of the Federal Hospital Insurance Trust Fund; and

"(B) any reference in section 1817 to the Federal Hospital Insurance Trust Fund or to title XVIII (or part A thereof) is deemed a reference to the Trust Fund under this section and this title, respectively.

"(c) PAYMENTS FROM TRUST FUND.—

"(1) PAYMENTS FOR PART C PROGRAM.—Pursuant to authority described in section 1817(h) (as incorporated under subsection (b)(1)), the Managing Trustee of the Trust Fund shall pay from time to time from the Trust Fund such amounts as the Secretary certifies are necessary to carry out the medicare part C program under this title.

"(2) CERTAIN TRANSFERS.—The Managing Trustee of the Trust Fund shall also pay from time to time from the Trust Fund—

"(A) such amounts to the General Treasury as the Secretary certifies to be necessary to carry out parts A, B, and C of title XXII (including amounts for payments to States under subsections (a)(1)(B), (a)(2)(B), and (b)(2) of section 4004 of the Guaranteed Health Insurance Act of 1994).

"(B) such amounts to the General Treasury as the Secretary of the Treasury certifies to be payments for credits under section 3461 and 3462 of the Internal Revenue Code of 1986 that are not an offset to a liability in amounts otherwise payable under chapter 25 of such Code;

"(C) such amounts to the Secretary of Health and Human Services as are appropriated to the Trust Fund under subsection (a)(2)(B);

"(D) amounts equivalent to the amounts received in the Trust Fund by reason of section 3455(e) of the Internal Revenue Code of 1986 to the Indian Health Service to augment the appropriation for health programs of such Service; and

"(E) amounts equivalent to the amounts received in the Trust Fund by reason of section 3455(f) of the Internal Revenue Code of 1986 to the Secretary of Veterans Affairs to augment the appropriation for health programs of the Department of Veterans Affairs.

Amounts paid by a small employer (as defined in section 1106(b) of the Guaranteed Health Insurance Act of 1994) shall be taken into account under subparagraph (E) only if such employer offers coverage under a certified health plan.

"PART D—ADMINISTRATIVE PROVISIONS

"SEC. 2131. AGREEMENTS WITH HOSPITALS; PARTICIPATING PHYSICIANS; TREATMENT OF INDIAN HEALTH SERVICE FACILITIES.

"(a) REQUIREMENT.—Any hospital shall be qualified to participate under this title and shall be eligible for payments under this title if—

"(1) it has in effect a participation agreement under section 1866(a)(1), and

"(2) it files with the Secretary a participation agreement meeting the requirements of subsection (b).

"(b) ELEMENTS OF AGREEMENT.—

"(1) IN GENERAL.—Except as provided in this subsection, a participation agreement under this subsection shall provide terms, specified by the Secretary, that are the same terms as those required of hospital participation agreements under section 1866(a)(1).

"(2) MODIFIED COPAYMENTS.—Instead of the limitation on charges specified under paragraphs (1)(A) and (2) of section 1866(a), the agreement shall not permit the hospital to charge more than the applicable deductible and coinsurance permitted under this title.

"(c) PHYSICIAN PARTICIPATION AGREEMENTS.—The Secretary shall provide for participating physician agreements under this title in the same manner as such agreements are provided for under part B of title XVIII pursuant to section 1842(h).

"(d) INDIAN HEALTH SERVICE FACILITIES.—The provisions of section 1880 (relating to Indian health service facilities) shall apply to this title in the same manner as they apply under title XVIII.

"SEC. 2132. HEALTH MAINTENANCE ORGANIZATIONS.

"(a) IN GENERAL.—Except as provided in this section, section 1876 shall apply to individuals enrolled under this title in the same manner as such section applies to individuals entitled to benefits under part A, and enrolled under part B, of title XVIII.

"(b) APPLICATION.—In applying section 1876 under subsection (a)—

"(1) individuals who are enrolled in a class of enrollment under this title may enroll with an eligible organization only based on the same class of enrollment;

"(2) if an eligible organization imposes an additional premium for additional benefits, such a premium shall be adjusted to reflect the class of enrollment with the eligible organization;

"(3) the appropriate classes of members described in section 1876(a)(1)(B) applied under this section may be different from the classes applied for purposes of title XVIII;

"(4) the provisions of such section relating only to individuals enrolled under part B of title XVIII shall not apply;

"(5) any reference to a Trust Fund established under title XVIII and to benefits with respect to any services under such title is deemed a reference to the Medicare Part C Trust Fund and to the guaranteed national benefit package with respect to required health services under this title;

"(6) the adjusted average per capita cost shall be determined on the basis of benefits under this title;

"(7) subsection (h) shall not apply; and

"(8) in the case of a risk-sharing contract, the eligible organization may not require an enrollee to obtain a referral from a physician in order to obtain covered items and services from a physician who specializes in obstetrics and gynecology.

"SEC. 2133. USE OF FISCAL AGENTS.

"(a) USE OF FISCAL AGENTS.—

"(1) IN GENERAL.—Except as provided in this section, the Secretary shall provide for the administration of this title through the use of fiscal agents in the same manner as title XVIII is carried out through the use of fiscal intermediaries and carriers.

"(2) SEPARATE CONTRACTS.—Contracts with fiscal agents entered into pursuant to this subsection for an area need not be with the same fiscal intermediary or carrier with an agreement under section 1816 or a contract under section 1842 for the area. However, nothing in this section shall be construed as preventing such an organization with such an agreement or contract under such respective section from entering into a contract under this section.

"SEC. 2134. COMPLIANCE WITH INFORMATION STANDARDS; APPLICATION OF MEDICARE QUALITY ASSURANCE AND SURVEY AND CERTIFICATION REQUIREMENTS.

"(a) IN GENERAL.—The Secretary, with respect to the program under this title, shall comply with the applicable provisions of subtitle B of title IX of the Guaranteed Health Insurance Act of 1994 (relating to information systems and administrative simplification).

"(b) SURVEY AND CERTIFICATION; QUALITY ASSURANCE.—In accordance with rules of the Secretary, the survey and certification requirements of title XVIII, and the quality assurance provisions of such title and part B of title XI (relating to professional review organizations), insofar as they relate to providers of services and other health care providers under title XVIII, shall apply to such providers under this title in the same manner as they apply to providers under title XVIII.

"SEC. 2135. PROGRAM INTEGRITY.

Sections 1124, 1124A, 1126, 1128 through 1128B (relating to fraud and abuse), 1145 (relating to restrictions on the disclosure of health information), and section 1877 (relating to limitation on certain physician referrals) shall apply to this title in the same manner as they apply to title XVIII.

"SEC. 2136. GENERAL ADMINISTRATION; MISCELLANEOUS PROVISIONS.

"(a) HEALTH SECURITY ADMINISTRATION.—

"(1) IN GENERAL.—Except as otherwise provided in this title, this title shall be administered by the Health Security Administration.

"(2) RENAMING HEALTH CARE FINANCING ADMINISTRATION AS HEALTH SECURITY ADMINISTRATION.—Any reference in law to the 'Health Care Financing Administration' is hereby deemed a reference to the 'Health Security Administration'.

"(b) REGULATIONS; TITLE II PROVISIONS; ADMINISTRATION.—The provisions of sections 1871, 1872, and 1874 (relating to regulations, application of certain provisions of title II, and administration) shall apply to this title in the same manner as they apply to title XVIII.

"(c) DETERMINATIONS; APPEALS; PROVIDER REIMBURSEMENT REVIEW BOARD.—

"(1) IN GENERAL.—The determination of whether an individual is entitled to benefits under this title, the determination of the amount of benefits under this title, and appeals from such determinations shall be made in accordance with the same procedures applicable to determinations under title XVIII.

"(2) PROVIDER REIMBURSEMENT REVIEW BOARD.—The provisions of section 1878 (relating to the Provider Reimbursement Review Board) shall apply under this title in the same manner as they apply under title XVIII.

"(d) REPORTING OF INFORMATION TO SECRETARY OF TREASURY.—The Secretary shall submit to the Secretary of the Treasury such information on individuals enrolled under this title as the Secretary of the Treasury may require for purposes of carrying out section 59B and chapter 25, and related provisions, of the Internal Revenue Code of 1986.

"PART E—DEFINITIONS AND MISCELLANEOUS

"SEC. 2161. DEFINITIONS.

"In this title—

"(1) the definitions contained in section 1861 apply for purposes of this title in the same manner as they apply for purposes of title XVIII;

"(2) the definitions contained in sections 2 and 3 (relating to general definitions and definitions relating to families) of the Guaranteed Health Insurance Act of 1994 apply for purposes of this title in the same manner as they apply for purposes of such Act.

"SEC. 2162. REFERENCES TO MEDICARE PROVISIONS.

"In this title, except as otherwise specifically provided, any references to provisions of title XVIII of the Social Security Act are deemed to be references to such provisions as in effect on the day after the date of the enactment of the Guaranteed Health Insurance Act of 1994, taking into account the amendments made to such title by such Act.".

SEC. 8002. CONFORMING AMENDMENTS.

(a) IN GENERAL.—Effective January 1, 1999, section 1876(f) (42 U.S.C. 1395mm(f)) is amended by striking "under a State plan approved under title XIX" and inserting "under title XXI" each place it appears.

(b) RENAMING OF HEALTH CARE FINANCING ADMINISTRATION.—Section 1117 (42 U.S.C. 1317) is amended—

(1) in the heading, by striking "HEALTH CARE FINANCING ADMINISTRATION" and inserting "HEALTH SECURITY ADMINISTRATION", and

(2) by striking "Health Care Financing Administration" and inserting "Health Security Administration".

(c) ADMINISTRATIVE EXPENSES.—Section 201 (42 U.S.C. 401) is amended—

(1) in subsection (g)(1)(A), by inserting "and the Medicare Part C Trust Fund established by title XXI" after "title XVIII" in the matter before clause (i);

(2) in subsection (g)(1), by striking "and XVIII" and "and title XVIII" each place either appears and inserting "XVIII, and XXI" and "title XVIII, and title XXI", respectively; and

(3) in subsection (h), by striking "and the Federal Supplementary Medical Insurance Trust Fund" and inserting "the Federal Supplementary Medical Insurance Trust Fund, and the Medicare Part C Trust Fund".

(d) DEFINITION OF STATE.—Section 1101(a)(1) (42 U.S.C. 1301(a)(1)) is amended by inserting "or title XXI" after "Such term when used in title XX".

SEC. 8003. EFFECTIVE DATE.

Title XXI of the Social Security Act, as added by section 8001, shall take effect on the date of the enactment of this Act, except that no benefits shall be provided under such title for services furnished before January 1, 1999.

Subtitle B—Benefits for Low-Income Individuals; State Maintenance of Effort

Subtitle C—Cost Containment in the Medicare Programs

PART 1—MEDICARE HEALTH EXPENDITURE ESTIMATES

PART 2—STATE HEALTH EXPENDITURE ESTIMATES

PART 3—ADMINISTRATIVE AND JUDICIAL REVIEW

PART 1—BENEFITS FOR LOW-INCOME INDIVIDUALS

SEC. 8101. ESTABLISHMENT OF BENEFITS.

The Social Security Act, as amended by section 8001, is amended by adding after title XXI the following new title:

"TITLE XXII—ASSISTANCE FOR LOW-INCOME INDIVIDUALS

"SEC. 2200. ESTABLISHMENT OF PROGRAMS.

"(a) IN GENERAL.—Not later than January 1, 1999, the Secretary shall establish and operate the following programs under this title:

"(1) A program of premium subsidies under part A for certain low-income individuals covered under a certified health plan (as defined in section 2 of the Guaranteed Health Insurance Act of 1994).

"(2) A program of wrap-around benefits under part B for certain low-income individuals.

"(3) A program of payment of medicare cost-sharing under part C for qualified medicare beneficiaries.

"(b) DIRECT SPENDING FOR PROGRAMS.—

"(1) IN GENERAL.—There are hereby appropriated to the Secretary such amount as the Secretary determines is necessary enable the Secretary to make all required expenditures under this title.

"(2) DIRECT SPENDING.—Amounts appropriated pursuant to this subsection are available each fiscal year to the Secretary for carrying out this title.

"PART A—PREMIUM CERTIFICATE PROGRAM

"Subpart 1—Certificates for Low-Income Individuals Covered Under Certified Health Plans

"SEC. 2201. ELIGIBILITY.

"(a) IN GENERAL.—Each premium certificate eligible individual is entitled to be issued a premium certificate in accordance with this part.

"(b) PREMIUM CERTIFICATE ELIGIBLE INDIVIDUAL.—

"(1) IN GENERAL.—In this part, the term 'premium certificate eligible individual' means an eligible individual who—

"(A) with respect to premiums for a taxable year ending in a year, is determined, in the manner described in section 2251, to have projected modified adjusted gross income that is less than the applicable percentage (specified in section 2101(b)(5)(B)) of the threshold amount (as defined in section 2122(c)(3)) applicable to the taxpayer involved; or

"(B) with respect to a premium for a month, is an AFDC or SSI recipient (as defined in section 2 of the Guaranteed Health Insurance Act of 1994) in the month.

"(2) EXCEPTION.—

"(A) IN GENERAL.—Such term does not include an individual—

"(i) who is enrolled under the medicare part C program under title XXI;

"(ii) who is entitled to benefits under part A of title XVIII;

"(iii) subject to subparagraph (B), who is covered under a State single-payer system approved under subtitle A of title IV of the Guaranteed Health Insurance Act of 1994 or a State managed competition system approved under subtitle B of title IV of such Act; or

"(iv) whose only enrollment in a certified health plan is in a plan that is a high deductible plan (as defined in section 5504(5)).

"(B) CONTINUED APPLICATION IN CASE OF CERTAIN ELECTION.—Subparagraph (A)(iii) shall not apply in the case of a State which has made the election described in section 4104(a)(1)(A)(ii) of the Guaranteed Health Insurance Act of 1994.

"SEC. 2202. VALUE OF PREMIUM CERTIFICATE.

"The value of the premium certificate issued under this part to an individual is equal to—

"(1) the amount of the reduction that would occur in the medicare part C premium liability under section 2122(c) for the individual if the individual were a medicare part C covered individual; or

"(2) if less in the case of an individual who is an employee and who is covered under a certified health plan of the employer, the employee's premium obligation under such certified health plan.

"SEC. 2203. ADMINISTRATION OF PROGRAM.

"(a) IN GENERAL.—The Secretary shall establish a program to provide for the issuance of premium certificates, in the amount described in section 2202, to premium certificate eligible individuals. Under the program the Secretary shall—

"(1) determine if individuals are premium certificate eligible individuals, and

"(2) provide for issuance of premium certificates to individuals determined to be premium certificate eligible individuals.

"(b) APPLICATION FOR CERTIFICATE.—

"(1) IN GENERAL.—Any eligible individual may apply for a premium certificate under this part by filing an application with the Secretary (either in person or by mail) through a local office of the Social Security Administration. An eligible Indian under section 902(a) of the Indian Health Care Improvement Act may apply for a certificate through the Indian Health Service in the same manner as an individual applying through a local office of the Social Security Administration.

"(2) ATTACHMENTS.—The Secretary shall require attachments to the application of such documentation (such as prior year tax forms and pay stubs) as may be needed to determine the individual's eligibility and the value of any premium certificate.

"(c) DETERMINATIONS.—

"(1) IN GENERAL.—The Secretary shall provide for—

"(A) prompt determination, on each application made under subsection (b), of eligibility of an applicant and the value of any premium certificate for the applicant, and

"(B) prompt notification of the applicant of such determinations (including an explanation of the reasons for the determination)

"(2) CONDITION OF CERTIFICATE.—Each certificate issued to an individual under this section is conditioned upon the individual reporting to the Secretary (in a form and manner specified by the Secretary) any change in status that would affect the individual's eligibility for such a certificate or the amount of the certificate.

"(3) HEARINGS; APPEALS.—The provisions of section 2136(c) shall apply with respect to determinations of eligibility for and the value of a premium certificate under this part in the same manner as such provisions apply to determinations of entitlement to and the amount of benefits under title XXI.

"(d) ISSUANCE AND USE OF CERTIFICATES.—

"(1) ISSUANCE.—The Secretary shall issue a premium certificate to each individual determined to be a premium certificate eligible individual under this section.

"(2) TREATMENT OF EMPLOYEES.—

"(A) IN GENERAL.—If an individual who is entitled to a premium certificate under this part is an employee and eligible to be enrolled under a certified health plan offered by an employer of the individual, the premium certificate may only be applied against the premiums for a certified health plan offered by the employer.

"(B) SUBMISSION TO SECRETARY; AND REMISSION OF VALUE TO EMPLOYER.—The Secretary shall make payments (in a manner specified by the Secretary) to each employer who tenders such a certificate to the Secretary in the value of the certificate so tendered.

"(3) TREATMENT OF OTHER INDIVIDUALS.—

"(A) IN GENERAL.—If an individual who is entitled to a premium certificate under this part is not described in paragraph (2)(A)—

"(i) the premium certificate may be applied against the premiums for the certified health plan in which the individual is enrolled, and

"(ii) upon the tender of such certificate by the individual to the applicable carrier, the carrier is required to reduce the amount of premiums required to be paid by the individual.

"(B) APPLICABLE CARRIER DESCRIBED.—In subparagraph (A), the term 'applicable carrier' means, with respect to an individual enrolled in a certified health plan,—

"(i) the Office of Universal FEHBP, in the case of an individual who pays premiums through such office;

"(ii) the consumer purchasing cooperative under subtitle E of title V of the Guaranteed Health Insurance Act of 1994, in the case of an individual who pays premiums through the cooperative);

"(iii) the program of the Indian Health Service (as used in section 901 of the Indian Health Care Improvement Act), in the case of an individual enrolled in a health program of the Indian Health Service; or§

"(iv) the Secretary of Veterans Affairs, in the case of an individual enrolled in a health program of the Department of Veterans Affairs.

"(4) DIRECT PAYMENT OF CERTAIN ASSISTANCE.—The Secretary shall provide for a payment directly to an individual whose application is approved of an amount equal to the amount of the reduction in premium that would have been provided with respect to the individual for the month in which the application was filed if the certificate had been issued (and tendered to the individual's employer or plan, as the case may be) on the first day of such month.

"(e) VERIFICATION.—

"(1) IN GENERAL.—The Secretary shall periodically verify information reported on applications under this section, using any or all of the following:

"(A) The national enrollment verification system established under subtitle B of title IX of the Guaranteed Health Insurance Act of 1994.

"(B) Information reported pursuant to section 1137.

"(C) Other information deemed to be necessary.

"(2) RECONCILIATION.—

"(A) EXCESS PAYMENTS.—If the Secretary determines, based upon information described in paragraph (1), that the value of a certificate issued exceeded the correct value of the certificate or that an individual who was issued a certificate was not a premium certificate eligible individual, the Secretary shall—

"(i) adjust the value of the certificate to recoup, over a reasonable period of time, the amount of the overpayment, or

"(ii) if the individual is no longer a premium certificate eligible individual, bill the individual for the amount of the excess value and for interest on any amount so billed that is not repaid on a timely basis.

"(B) DEFICIT PAYMENTS.—If the Secretary determines, based upon the information described in paragraph (1), that the value of a certificate issued was less than the correct value of the certificate, the Secretary shall—

"(i) pay directly to the individual the amount of the underpayment, or

"(ii) if the individual continues to be a premium certificate eligible individual, adjust the value of the certificate, as appropriate.

"(f) PENALTIES FOR MISREPRESENTATION.—Any individual who knowingly makes a material misrepresentation of information in an application for a premium certificate under this section would

be liable for excess payments made based upon such misrepresentation and interest on such excess payments, at a rate specified by the Secretary. In addition, such individuals would be subject to a civil monetary penalty of $1,000, or, if greater, three times the amount of excess payments made based on such misrepresentations. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under this subsection in the same manner as they apply to a penalty or proceeding under section 1128A(a).

"Subpart 2—Premium Assistance for Qualified Retirees

"SEC. 2211. ELIGIBILITY FOR PREMIUM CERTIFICATE FOR CERTAIN RETIREES.

"(a) IN GENERAL.—A qualified retiree (or qualified spouse or child of such a retiree) is eligible for a premium certificate in accordance with this subpart if—

"(1) the total amount paid by the individual for premiums for enrollment in a health benefit plan during months in a year, exceeds

"(2) the product of (A) the individual's projected modified adjusted gross income for the year, and (B) the applicable percentage established under section 2212(c).

"(b) HEALTH BENEFIT PLAN DEFINED.—In subsection (a), the term 'health benefit plan' has the meaning given such term in section 5504(3) of the Guaranteed Health Insurance Act of 1994.

"SEC. 2212. ELIGIBILITY.

"(a) QUALIFIED RETIREE AND QUALIFIED SPOUSE OR CHILD DEFINED.—For purposes of this subpart—

"(1) QUALIFIED RETIREE DEFINED.—The term 'qualified retiree' means, with respect to a month in a calendar year, an eligible individual who meets the income requirements specified in subsection (b) for the year and who as of the first day of the month—

"(A) has attained age 55 but not age 65 (as of January 1, 1994),

"(B) is not a full-time employee, and

"(C) is not entitled to benefits under part A of title XVIII.

"(2) QUALIFIED SPOUSE OR CHILD DEFINED.—The term 'qualified spouse or child' means, in relation to a qualified retiree, an eligible individual who meets the income requirements specified in subsection (b) for the year and with respect to whom the requirements in one of the following clauses is met (with respect to the first day of a month):

"(A) The individual (i) is under 65 years of age, is not a full-time employee, and is (and has been for a period of at least one year) married to a qualified retiree or (ii) is a young dependent (as described in section 1003(b)(1)(B) of the Guaranteed Health Insurance Act of 1994) of the qualified retiree.

"(B) In the case of a person who was a qualified retiree at the time of the person's death—

"(i) the individual was (and had for a period of at least one year been) married to the retiree at the time of the person's death,

"(ii) the individual is under 65 years of age,

"(iii) the individual is not a full-time employee,

"(iv) the individual is not remarried, and

"(v) the deceased spouse would still be a qualified retiree if such spouse had not died.

"(C) The individual is a young dependent (as described in section 1003(b)(1)(B) of the Guaranteed Health Insurance Act of 1994) of an individual described in subparagraph (B).

"(b) MAXIMUM AMOUNT OF INCOME.—

"(1) IN GENERAL.—An individual meets the income requirements of this subsection if (for a calendar year ending in 1994)—

"(A) in the case of a married individual whose spouse is a qualified retiree or qualified spouse or child under subsection (a), the combined income of the individual and the individual's spouse for the year does not exceed $40,000, or

"(B) in the case of any other individual, the individual's income for the year does not exceed $30,000.

"(2) INFLATION ADJUSTMENTS.—In the case of a year after 1997, each dollar amount contained in paragraph (1) shall be increased by an amount equal to—

"(A) such dollar amount, multiplied by

"(B) the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the previous calendar year.

"(c) APPLICABLE PERCENTAGE.—For purposes of subsection (a), the applicable percentage specified in this paragraph for a year is determined in accordance with the following table:

"In the case of calendar years ending with or within—	The applicable percentage is—
1997	7 percent
1998	7 percent
1999	6 percent
2000	5 percent
2001 or thereafter	4 percent

"(d) PRORATION.—In the case of an individual described in subsection (a) who is not a qualified retiree or qualified spouse or child for all months in the calendar year, the amount of any premium certificate under subsection (a) shall be prorated to reflect the ratio of the number of months in the year in which the individual is a qualified retiree or qualified spouse or child to 12 months.

"SEC. 2213. VALUE OF PREMIUM CERTIFICATE.

"(a) IN GENERAL.—The amount of the premium certificate provided to an individual under this subpart for a year is equal to the amount by which—

"(1) the total amount paid by the individual for premiums for enrollment in a health benefit plan during months in the year; exceeds

"(2) the product of (A) the individual's projected modified adjusted gross income for the year, and (B) the applicable percentage established under section 2212(c).

"(b) LIMITATION FOR YEARS AFTER 1998.—With respect to years beginning with 1999, the amount of the premium certificate provided to an individual under this subpart for the year is equal to the lesser of—

"(1) the amount determined in accordance with subsection (a); or

"(2) an amount equal to the amount by which—

"(A) the total amount that would have been paid by the individual for premiums during the year if the individual had been enrolled in medicare part C during the year, exceeds

"(B) the amount described in subsection (a)(2).

"SEC. 2214. ADMINISTRATION OF PREMIUM CERTIFICATES FOR RETIREES.

"The provisions of section 2203 shall apply to this subpart in the same manner as they apply to subpart 1.

"Subpart 3—Maintenance of Effort Offset for Retiree Premium Contributions

"SEC. 2221. OFFSET OF PREMIUM OBLIGATIONS FOR RETIREES.

"The Secretary shall make a per capita payment to each employer who meets the requirements of section 1113 of the Guaranteed Health Insurance Act of 1994 (relating to maintenance of effort for premiums for certain retirees, spouses, and dependents) during a year in the amount determined under section 2222 with respect to each eligible individual for whom the employer meets such requirement.

"SEC. 2222. AMOUNT OF OFFSET.

"The amount of the payment made to an employer with respect to an individual for a year is equal to 50 percent of the employer's share of the premium that would be applicable to the individual based on the individual's class of enrollment during the year if the individual were enrolled in medicare part C during the year.

"SEC. 2223. PROCEDURES FOR OBTAINING OFFSET.

"The Secretary shall establish procedures under which employers may submit information necessary for the Secretary to make payment to the employer under this subpart.

"PART B—WRAP-AROUND BENEFITS FOR LOW-INCOME INDIVIDUALS

"SEC. 2231. ELIGIBILITY.

"(a) IN GENERAL.—Subject to subsection (c), each individual who applies for benefits under this part and is determined under this part to be a wrap around eligible individual described in subsection (b) is entitled to wrap-around benefits in accordance with this part, without regard to whether the individual is enrolled under medicare part C under title XXI.

"(b) WRAP AROUND ELIGIBLE INDIVIDUAL.—

"(1) IN GENERAL.—In this part, the term 'wrap around eligible individual' means any of the following individuals:

"(A) INDIVIDUALS WITH INCOME BELOW POVERTY LEVEL.—An individual who is determined under this part to have projected modified adjusted gross income that is less than the threshold amount (as defined in section 2122(c)(3)) applicable to the individual involved.

"(B) AFDC AND SSI RECIPIENTS.—An AFDC recipient or SSI recipient.

"(C) CHILDREN AND PREGNANT WOMEN WITH INCOME BELOW 200 PERCENT OF POVERTY LEVEL.—Any of the following individuals if the individual is determined under this part to have projected modified adjusted gross income that is less than twice the threshold amount (as defined in section 2122(c)(3)) applicable to the individual involved:

"(i) A child under 19 years of age.

"(ii) A pregnant woman.

For purposes of clause (ii), a woman shall be deemed to be a pregnant woman during the period ending on the first day of the first month that begins more than 60 days after the date of the termination of the pregnancy.

"(2) EXCEPTIONS.—

"(A) IN GENERAL.—Such term does not include an individual—

"(i) who is entitled to benefits under part A of title XVIII,

"(ii) subject to subparagraph (B), who is covered under a State single-payer system approved under subtitle A of title IV of the Guaranteed Health Insurance Act of 1994 or a State managed competition system approved under subtitle B of title IV of such Act, or

"(iii) whose only enrollment in a certified health plan is in a plan that is a high deductible plan (as defined in section 5504(5)).

"(B) SPECIAL RULE.—Subparagraph (A)(ii) shall not apply in the case of a State which has made the election described in section 4104(b)(1)(B) of the Guaranteed Health Insurance Act of 1994.

"(c) SPECIAL RULES FOR CASH ASSISTANCE RECIPIENTS.—

"(1) IN GENERAL.—An individual who is an AFDC recipient or SSI recipient is deemed to be entitled to benefits under this part, without the need to file an application under this part, for items and services furnished during the period in which the individual is receiving assistance.

"(2) COORDINATION.—The Secretary shall provide for a method under which individuals who are determined to be AFDC recipients or SSI recipients are notified of the benefits to which they are entitled under this part and any applicable procedures for obtaining evidence of their entitlement.

"(d) PERIOD OF ENTITLEMENT.—

"(1) BEGINNING OF BENEFITS.—Benefits under this part shall be available with respect to expenses incurred for items and services furnished after the date the individual is determined to be a wrap around eligible individual.

"(2) TERMINATION OF PERIOD.—

"(A) IN GENERAL.—Subject to subparagraph (C) and section 2251(c), an individual who is determined to be entitled to benefits under this part shall remain so entitled for a period of 12 months beginning on the date on which the determination takes effect. Such period may be extended upon the filing of an application under this part before the end of the 12-month period.

"(B) NOTICE OF REQUIREMENT.—The Secretary shall provide for appropriate written notice of the requirement of subparagraph (A) (relating to reapplying annually in order to continue to be entitled to benefits under this part) to each family a member of which is entitled to benefits under this part at least 60 days before the expiration of the 12-month period described in such subparagraph.

"(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply with respect to an individual whose entitlement to benefits under this part is based solely on the grounds that the individual is an AFDC recipient or an SSI recipient.

"(e) AFDC RECIPIENT AND SSI RECIPIENT DEFINED.—In this part, the terms 'AFDC recipient' and 'SSI recipient' have the meanings given such terms in section 2 of the Guaranteed Health Insurance Act of 1994.

"SEC. 2232. WRAP-AROUND BENEFITS.

"(a) BENEFITS.—The benefits provided to a wrap around eligible individual under this part consist of the following (subject to subsection (e)):

"(1) WAIVER OF COST-SHARING.—The payment for any cost sharing (described in part B of title XXI) otherwise applicable to items and services covered under the guaranteed national benefit package (described in subtitle A of title III of the Guaranteed Health Insurance Act of 1994).

"(2) EARLY AND PERIODIC SCREENING, DIAGNOSTIC, AND TREATMENT SERVICES.—For individuals under 19 years of age, payment for those early and periodic screening, diagnostic, and treatment services (as defined in section 1905(r)) that are not covered under the guaranteed national benefit package.

"(3) VISION AND HEARING CARE.—For individuals 19 years of age or older, payment for vision and hearing care of the same scope as provided under paragraph (2), including eyeglasses and hearing aids, that are not covered under the guaranteed national benefit package.

"(b) PAYMENT AMOUNTS.—

"(1) COST-SHARING.—Payments for cost-sharing under subsection (a)(1) for an item or service shall be based upon the cost-sharing amounts that would apply to the item or service if the individual were enrolled under medicare part C under title XXI, without regard to whether the individual is enrolled under such part.

"(2) ADDITIONAL SERVICES.—Payments for items and services described in paragraph (2) or (3) of subsection (a)—

"(A) for which there are payment amounts established under title XXI shall be based on the payment amounts established under such title; or

"(B) for which there are not such payment amounts established, shall be based on payment amounts established by the Secretary, in consultation with the Prospective Payment Assessment Commission and the Physician Payment Review Commission, taking into account the payment rules established for similar items and services under part A of title XVIII.

"(c) SECONDARY PAYER TO CERTIFIED HEALTH PLANS.—Section 1862(b) shall apply to expenses incurred for items and services provided under this part in the same manner as such section applies to items and services provided under title XVIII.

"(d) USE OF MEDICARE PART C CLAIMS PROCESS.—

"(1) COST-SHARING FOR INDIVIDUALS ENROLLED UNDER MEDICARE PART C.—In the case of individuals entitled to benefits under this part and enrolled under title XXI, the benefits for cost-sharing under subsection (a)(1) with respect to an item or service shall be provided simultaneous with the payment of benefits with respect to such item or service under such part.

"(2) OTHER BENEFITS.—Except as provided in paragraph (1), claims for payment for benefits under this part shall be made and processed in the same manner as claims for payment for benefits under title XXI.

"(3) EXTENSION OF AGREEMENTS WITH FISCAL AGENTS.—The Secretary may provide for the administration of this part through agreements with fiscal agents meeting the requirements applicable to such agents under title XXI.

"(e) SPECIAL RULES FOR INDIVIDUALS ENROLLED IN MANAGED MENTAL HEALTH AND SUBSTANCE ABUSE PROGRAMS.—

"(1) COVERAGE OF SERVICES THROUGH THE PROGRAM.—In the case of a wrap around eligible individual who is enrolled in a managed mental health and substance abuse program of a State or an Indian tribe or tribal organization approved under section 1981 of the Public Health Service Act for a month—

"(A) the individual is considered to have waived the right to benefits described in paragraph (3) under this part in consideration of receipt of benefits for mental health and substance abuse services through such program;

"(B) the Secretary shall make a per capita payment to the State or Indian tribe or tribal organization, in the amount specified in paragraph (2), on behalf of the individual; and

"(C) no other payment may be made under this part with respect to such services furnished to the individual during the month.

Payments under subparagraph (B) shall be made not less frequently than monthly.

"(2) CAPITATED PAYMENTS AMOUNTS.—The amount of the per capita payment provided under paragraph (1)(B) shall be an amount determined in accordance with a methodology established by the Secretary (similar to the methodology used under section 1893(b) to determine capitated payments to States or Indian tribes or tribal organizations on behalf of medicare beneficiaries enrolled in such programs) that reflects the costs associated with the benefits described in paragraph

(3) that would be provided to the individual under this part if the individual were not enrolled in the managed mental health and substance abuse program.

"(3) MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS DESCRIBED.—The benefits described in this paragraph are as follows:

"(A) MENTAL HEALTH AND SUBSTANCE ABUSE COST SHARING.—Payment of cost sharing described in subsection (a)(1) with respect to mental health and substance abuse services (as defined in section 1893(c)) covered under the guaranteed national benefit package.

"(B) MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES INCLUDED IN EPSDT.—Benefits under subsection (a)(2) with respect to such mental health and substance abuse services.

"SEC. 2233. APPLICATION FOR BENEFITS.

"(a) FORM.—

"(1) IN GENERAL.—An application for benefits under this part shall be made in such form and manner as the Secretary shall specify consistent with this section.

"(2) INFORMATION.—The application shall require—

"(A) the provision of information necessary to determine eligibility for benefits under this part, and

"(B) the provision of information respecting whether the individual is enrolled under medicare part C and the certified health plan (if any) in which the individual is enrolled.

"(b) AVAILABILITY OF APPLICATIONS.—The Secretary shall make applications for benefits under this part available in the same manner as the Secretary makes available applications for enrollment under title XXI.

"(c) COORDINATION WITH PART C AND PREMIUM CERTIFICATE ENROLLMENT APPLICATION.—An application for benefits under this part may (but need not) be accompanied by an application for enrollment under medicare part C or for a premium certificate under part A on the basis of being a low-income individual.

"(d) FACILITATION OF APPLICATIONS FOR BENEFITS.—The provisions of section 2103 shall apply to wrap around eligible individuals and applications for benefits under this part in the same manner as such provisions apply to medicare part C eligible individuals and applications for enrollment under title XXI.

"(e) TIMING OF APPLICATION.—An application for benefits under this part may be filed at any time during the year.

"SEC. 2234. REFERENCES TO MEDICARE PROVISIONS.

"In this part, except as otherwise specifically provided, any references to provisions of title XVIII of the Social Security Act are deemed to be references to such provisions as in effect on the day after the date of the enactment of the Guaranteed Health Insurance Act of 1994, taking into account the amendments made to such title by such Act.

"PART C—PAYMENT OF MEDICARE COST-SHARING FOR CERTAIN LOW-INCOME INDIVIDUALS

"SEC. 2241. PAYMENT OF COST-SHARING FOR CERTAIN INDIVIDUALS.

"Subject to section 2242, the Secretary shall make payments as follows:

"(1) QUALIFIED MEDICARE BENEFICIARIES WITH INCOME BELOW 100 PERCENT OF POVERTY LEVEL.—In the case of an individual who is determined by the Secretary to be a qualified medicare beneficiary (as defined in section 2243(a)), the Secretary shall make payment for all medicare cost-sharing described in section 2242(a).

"(2) QUALIFIED MEDICARE BENEFICIARIES WITH INCOME BELOW 120 PERCENT OF POVERTY LEVEL.—In the case of an individual who would be such a qualified medicare beneficiary but

for the fact the individual's family income exceeds 100 percent but is less than 120 percent of the official poverty line (as described in section 2243(d)), the Secretary shall make payment for the medicare cost-sharing described in section 2242(a)(1)(B).

"(3) QUALIFIED DISABLED AND WORKING INDIVIDUALS.—In the case of an individual who is determined by the Secretary to be a qualified disabled and working individual (as defined in section 2243(d)(2)), the Secretary shall make payment for the medicare cost-sharing described in section 2242(a)(1)(A).

"SEC. 2242. MEDICARE COST-SHARING DEFINED.

"(a) IN GENERAL.—In this section, the term 'medicare cost-sharing' means the following costs incurred with respect to a qualified medicare beneficiary or a qualified disabled and working individual:

"(1)(A) Premiums under section 1818 or 1818A, and

"(B) premiums under section 1839.

"(2) Coinsurance under title XVIII (including coinsurance described in section 1813).

"(3) Deductibles established under title XVIII (including those described in section 1813, 1833(b), and 1834(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'.

"(b) ENROLLMENT WITH ELIGIBLE ORGANIZATIONS.—Under rules established by the Secretary for an individual described in section 2241(1), 'medicare cost-sharing' under this section may include premiums for the enrollment of the individual with an eligible organization under section 1876.

"SEC. 2243. INDIVIDUALS DEFINED.

"(a) QUALIFIED MEDICARE BENEFICIARY.—In this part, the term 'qualified medicare beneficiary' means an individual—

"(1) who is entitled to benefits under part A of title XVIII (other than an individual entitled to such benefits only pursuant to an enrollment under section 1818A);

"(2) whose income (as determined under section 1612 for purposes of the supplemental security income program, except as provided in subsection (c)) does not exceed 100 percent of the official poverty line applicable to a family of the size involved; and

"(3) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program.

"(b) QUALIFIED DISABLED AND WORKING INDIVIDUAL.—The term 'qualified disabled and working individual' means an individual—

"(1) who is entitled to enroll for hospital insurance benefits under part A of title XVIII under section 1818A;

"(2) whose income (as determined under section 1612 for purposes of the supplemental security income program, except as provided in subsection (c)) does not exceed 200 percent of the official poverty line applicable to a family of the size involved;

"(3) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual or a couple (in the case of an individual with a spouse) may have and obtain benefits under that program; and

"(4) who is not eligible for medical assistance under the State plan for medical assistance under title XIX for the State in which the individual resides.

"(c) EXCLUSION OF CERTAIN TRANSITION INCOME.—In determining under this section the income of an individual who is entitled to monthly insurance benefits under title II for a transition month

in a year, such income shall not include any amounts attributable to an increase in the level of monthly insurance benefits payable under such title which have occurred pursuant to section 215(i) for benefits payable for months beginning with December of the previous year. In the previous sentence, the term 'transition month' means each month in a year through the month following the month in which the annual revision of the official poverty line (as described in subsection (d)) is published.

"(d) OFFICIAL POVERTY LINE DESCRIBED.—In this section, the 'official poverty line' is the line defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981.

"(e) USE OF ALTERNATIVE METHODOLOGIES.—

"(1) IN GENERAL.—The methodology to be employed in determining income and resource eligibility under this section may be less restrictive, and shall be no more restrictive, than the methodology—

"(A) in the case of groups consisting of aged, blind, or disabled individuals, under the supplemental security income program under title XVI, or

"(B) in the case of other groups, under the State plan most closely categorically related.

"(2) MORE RESTRICTIVE METHODOLOGY DESCRIBED.—For purposes of this subsection, a methodology is considered to be 'no more restrictive' if, using the methodology, additional individuals may be eligible for treatment as qualified medicare beneficiaries or qualified disabled and working individuals and no individuals who are otherwise eligible to be so treated are made ineligible for such treatment.

"SEC. 2244. TIMING.

"If an individual is determined to be a qualified medicare beneficiary or a qualified disabled and working individual under this part, such determination shall apply to items and services furnished after the end of the month in which the determination first occurs.

"PART D—ADMINISTRATIVE PROVISIONS

"SEC. 2251. DETERMINATION OF ELIGIBILITY; APPEALS.

"(a) PROCESS.—The Secretary, through the Social Security Administration and other appropriate agencies, shall establish a process for determining whether individuals are eligible for benefits under this title. Such process shall be coordinated with the enrollment process described in section 2102.

"(b) DETERMINATION OF PROJECTED INCOME FOR PURPOSES OF MEDICARE PART C AND WRAP-AROUND.—

"(1) IN GENERAL.—In determining the amount of an individual's projected modified adjusted gross income for purposes of part A or part B, the income for a year shall be projected on an annual basis based on evidence of the current (and projected) modified adjusted gross income over a period of at least 3 months, as determined under a uniform, national methodology established by the Secretary.

"(2) MODIFIED ADJUSTED GROSS INCOME DEFINED.—In this title, the term 'modified adjusted gross income' has the meaning given such term in section 59B(e)(2) of the Internal Revenue Code of 1986 (as in effect on the date of the enactment of the Guaranteed Health Insurance Act of 1994). The parenthetical in the preceding sentence shall not apply to the determination of adjusted gross income.

"(c) REQUIREMENT TO PROVIDE NOTICE OF MATERIAL CHANGE AFFECTING ELIGIBILITY FOR BENEFITS.—

"(1) IN GENERAL.—Each individual who has been determined to be entitled to benefits under this title (including under section 2231(c)) shall notify the Secretary (in a form and manner specified by the Secretary) of any material change in

status that would affect the individual's eligibility for benefits under this title.

"(2) CONSTRUCTION.—Nothing in this section shall be construed as authorizing reconciliation of benefits provided with respect to deductibles and coinsurance.

"(d) NOTICE AND APPEALS.—

"(1) NOTICE.—If the Secretary determines that an individual is not entitled to benefits under this title, the Secretary shall notify the individual of the determination (and an explanation of the reasons for the determination).

"(2) APPEALS.—The provisions of section 2136(c) shall apply with respect to determinations of entitlement to and the amount of benefits under this title in the same manner as such provisions apply to determinations of entitlement to and the amount of benefits under title XXI.

"SEC. 2252. VERIFICATION OF ELIGIBILITY.

"(a) IN GENERAL.—The Secretary, in consultation with the Secretary of the Treasury, shall provide for such verification of eligibility, including verification of income, as the Secretary deems appropriate. Such verification may be based upon information provided under the national enrollment verification system established under subtitle B of title IX of the Guaranteed Health Insurance Act of 1994 and information provided under section 1137, and may be made on a sample or other basis.

"(b) MONITORING CHANGES IN STATUS.—

"(1) IN GENERAL.—The Secretary periodically shall verify, using the national enrollment verification system established under subtitle B of title IX of the Guaranteed Health Insurance Act of 1994 and other means, the status of individuals who are receiving benefits under this title in order to identify changes of employment or other status that may affect their eligibility for such benefits.

"(2) INFORMATION ON CASH ASSISTANCE RECIPIENTS.—In order to carry out paragraph (1), the Secretary shall require States administering plans under parts A or E of title IV and the entity responsible for administering the supplemental security income program under title XVI to report to the Secretary, on a semiannual basis, such information as may be necessary to verify an individual's status as an AFDC or SSI recipient.

"SEC. 2253. PENALTIES FOR MISREPRESENTATION.

"Any individual that knowingly misrepresents income or family status for the purpose of obtaining benefits under this title to which the individual is not entitled is subject to a civil money penalty not to exceed $1,000 for each such misrepresentation, or, if greater, three times the amount of the benefits obtained as a result of the misrepresentation. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under this section in the same manner as they apply to a penalty or proceeding under section 1128A(a).".

SEC. 8102. EFFECTIVE DATES.

(a) PREMIUM CERTIFICATES.—No premium certificate or other assistance under title XXII of the Social Security Act (as added by subsection (a)) shall be made available—

(1) under subpart 1 or subpart 3 of part A of such title for premiums or assistance for months before January 1999; or

(2) under subpart 2 of part A of such title for premiums for months before January 1997.

(b) WRAP-AROUND BENEFITS.—No wrap-around benefits are available under part B of title XXII of the Social Security Act, added by subsection (a), with respect to any items or services furnished before January 1, 1999.

(c) MEDICARE COST-SHARING.—No medicare cost-sharing is available under part C of title XXII of the Social Security Act (as added by section 8001) with respect to items or services furnished in a State before January 1999.

PART 2—STATE MAINTENANCE OF EFFORT

Subpart A—Payments for Cash Assistance Recipients

SEC. 8111. STATE RESPONSIBILITY FOR PAYMENTS.

(a) IN GENERAL.—Subject to section 8133, each State shall provide in each year (beginning with 1999) for payment to the Secretary, to the credit of the Medicare Part C Trust Fund, of an amount equal to the State medical assistance percentage (as defined in subsection (b)) of the State maintenance of effort percentage (as defined in section 8134) for the year of the sum of the following products:

(1) AFDC PORTION.—The product of—

(A) the sum of—

(i) the AFDC, non-DSH per capita amount for the State for the year (determined under section 8112(a)(1)), and

(ii) the AFDC, DSH per capita amount for the State for the year (determined under section 8112(a)(2)); and

(B) the number of AFDC recipients residing in the State in the year (as determined under section 8114).

(2) SSI PORTION.—The product of—

(A) the sum of—

(i) the SSI, non-DSH per capita amount for the State for the year (determined under section 8113), and

(ii) the SSI, DSH per capita amount for the State for the year (determined under section 8113); and

(B) the number of SSI recipients residing in the State in the year (as determined under section 8114).

(b) STATE MEDICAL ASSISTANCE PERCENTAGE DEFINED.—In subsection (a), the term "State medical assistance percentage" means, for a State for a quarter in a fiscal year, 100 percent minus the Federal medical assistance percentage (as defined in section 1905(b) of the Social Security Act) for the State for the fiscal year.

(c) BENEFIT PACKAGE FOR LOW-INCOME INDIVIDUALS.—In this subtitle, the term "benefit package for low-income individuals" means the benefits, including the guaranteed national benefit package and the wrap-around benefits made available for low-income individuals under part A and subpart 2 of part B of title XXI of the Social Security Act, as added by the previous provisions of this title.

SEC. 8112. DETERMINATION OF AFDC PER CAPITA AMOUNTS FOR STATES.

(a) DETERMINATIONS.—

(1) IN GENERAL.—For each State for each year, the Secretary shall determine an AFDC, non-DSH per capita amount in accordance with paragraph (2) and an AFDC, DSH per capita amount in accordance with paragraph (3).

(2) AFDC, NON-DSH PER CAPITA AMOUNT.—The AFDC, non-DSH per capita amount is equal to the per capita, non-DSH State medicaid expenditures (under subsection (b)(1)) for the benefit package for low-income individuals (as defined in section 8111(c)) for AFDC recipients for the State for the year (as determined under subsection (b)(1)).

(3) AFDC, DSH PER CAPITA AMOUNT.—The AFDC, DSH per capita amount is equal to the per capita DSH State medicaid expenditures (under subsection (b)(2)) for the benefit package for low-income individuals (as defined in section 8111(c)) for AFDC recipients for the State for the year (as determined under subsection (b)(2)).

(b) PER CAPITA STATE MEDICAID EXPENDITURES DEFINED.—For purposes of subsection (a)—

(1) PER CAPITA NON-DSH STATE MEDICAID EXPENDITURES.—The "per capita non-DSH State medicaid expenditures" for the benefit package for low-income individuals for a State for a year is equal to the base per capita non-DSH expenditures (described in subsection (c)(1)), updated to the year involved under subsection (d)).

(2) PER CAPITA DSH STATE MEDICAID EXPENDITURES.—The "per capita DSH State medicaid expenditures" for the benefit package for low-income individuals for a State for a year is equal to the base per capita DSH expenditures (described in subsection (c)(2)), updated to the year involved under subsection (d)).

(c) MEDICAID EXPENDITURES.—

(1) BASE PER CAPITA NON-DSH EXPENDITURES.—The "base per capita non-DSH expenditures" described in this paragraph, for a State for a year, is—

(A) the baseline non-DSH medicaid expenditures (as defined in subsection (e)(1)(A)) for the State, divided by

(B) the number of AFDC recipients enrolled in the State medicaid plan in fiscal year 1993, as determined under section 8114(a).

(2) BASE PER CAPITA DSH EXPENDITURES.—The "base per capita DSH expenditures" described in this paragraph, for a State for a year, is—

(A) the baseline DSH medicaid expenditures (as defined in subsection (e)(1)(B)) for the State; divided by

(B) the number of AFDC recipients enrolled in the State medicaid plan in fiscal year 1993, as determined under section 8114(a).

(d) UPDATING.—

(1) INITIAL UPDATE THROUGH 1998.—

(A) IN GENERAL.—

(i) BASE PER CAPITA NON-DSH EXPENDITURES.—The Secretary shall update the base per capita non-DSH expenditures described in subsection (c)(1) for each State from fiscal year 1993 through 1998, by 57.6 percent.

(ii) BASE PER CAPITA DSH EXPENDITURES.—The Secretary shall update the base per capita DSH expenditures described in subsection (c)(2) for each State from fiscal year 1993 through 1998, by 39.7 percent.

(B) ADJUSTMENT AUTHORIZED TO TAKE INTO ACCOUNT CASH FLOW VARIATIONS.—In determining the update under paragraph (1), the Secretary may provide for an adjustment in a manner similar to the adjustment permitted under section 8122(b)(3).

(2) UPDATE FOR SUBSEQUENT YEARS.—For each State for 1999 and for each subsequent year the Secretary shall update the base per capita non-DSH expenditures described in subsection (c)(1) (as previously updated under this subsection) and the base per capita DSH expenditures described in subsection (c)(2) (as previously updated under this subsection) by a factor equal to the national medicare growth factor (under section 8201(c) for the year.

(e) DETERMINATION OF BASELINE MEDICAID EXPENDITURES.—

(1) IN GENERAL.—

(A) BASELINE NON-DSH MEDICAID EXPENDITURES.—For purposes of subsection (c)(1)(A), the "baseline non-DSH medicaid expenditures" for a State is the gross amount of payments under the State medicaid plan with respect to medical assistance furnished, for items and services included in the benefit package for low-income individuals, for AFDC recipients for calendar quarters in fiscal year 1993, but does not include such expenditures for which no Federal financial participation is provided under such plan and does not include any payments made under section

1923 of the Social Security Act (relating to DSH payments).

(B) BASELINE DSH MEDICAID EXPENDITURES.—For purposes of subsection (c)(2)(A), the term "baseline DSH medicaid expenditures" for a State is payments made under section 1923 of the Social Security Act in fiscal year 1993 multiplied by the proportion of payments for medical assistance for hospital services (including psychiatric hospital services) under the State medicaid plan in fiscal year 1993 that is attributable to AFDC recipients.

(2) TREATMENT OF DISALLOWANCES.—The amount determined under this subsection shall take into account amounts (or an estimate of amounts) disallowed.

(f) APPLICATION TO PARTICULAR ITEMS AND SERVICES IN BENEFIT PACKAGE FOR LOW-INCOME INDIVIDUALS.—For purposes of this section, in determining the per capita State non-DSH medicaid expenditures and the per capita State DSH medicaid expenditures for a category of items and services (within the benefit package for low-income individuals) furnished in a State, there shall be counted only that proportion of such expenditures (determined only with respect to medical assistance furnished to AFDC recipients) that were attributable to items and services included in the benefit package for low-income individuals (taking into account any limitation on amount, duration, or scope of items and services included in such package).

SEC. 8113. DETERMINATION OF SSI PER CAPITA AMOUNT FOR STATES.

For State for each year, the Secretary shall determine an SSI per capita amount in accordance with this section. Such amount shall be determined in the same manner as the AFDC per capita amount for the State is determined under section 8112 except that, for purposes of this section—

(1) any reference in such section (or in sections referred to in such section) to an "AFDC recipient" is deemed a reference to an "SSI recipient"; and

(2)(A) 25.8 percent shall be substituted for 57.6 percent in section 8112(d)(1)(A)(i), and

(B) 11.5 percent shall be substituted for 39.7 percent in section 8112(d)(1)(A)(ii).

SEC. 8114. DETERMINATION OF NUMBER OF AFDC AND SSI RECIPIENTS.

(a) BASELINE.—For purposes of section 8112 and section 8113, the number of AFDC recipients and SSI recipients for a State for fiscal year 1993 shall be determined based on actual reports submitted by the State to the Secretary. In the case of individuals who were not recipients for the entire fiscal year, the number shall take into account only the portion of the year in which they were such recipients. The Secretary may audit such reports.

(b) SUBSEQUENT YEARS.—For purposes of section 8111(a), the number of AFDC and SSI recipients residing in a State shall be determined on a monthly basis based on the actual number of such recipients.

Subpart B—Payments for Non-Cash Assistance Recipients

SEC. 8121. STATE RESPONSIBILITY FOR PAYMENTS.

(a) PAYMENT.—Each State shall provide for each year (beginning with 1999) for payment to the Secretary, to the credit of the Medicare Part C Trust Fund, of the amounts specified in subsection (b).

(b) AMOUNT.—Subject to section 8133, the total amount of such payment for a year shall be equal to the State maintenance of effort percentage (as defined in section 8134) for the year of the sum of—

(1) the State non-cash, non-DSH baseline amount for the State, determined under section 8122(a)(1) and updated to the year involved under section 8123, and

(2) the State non-cash, DSH baseline amount for the State, determined under section 8122(a)(2) and updated to the year involved under section 8123.

SEC. 8122. DETERMINATION OF BASELINE AMOUNTS.

(a) BASELINE AMOUNTS.—

(1) NON-DSH AMOUNT.—The Secretary shall determine for each State a non-cash, non-DSH baseline amount which is equal to the aggregate State medicaid expenditures in fiscal year 1993 (as defined in subsection (c)(1)) for the benefit package for low-income individuals for non-cash assistance recipients (as defined in subsection (b)).

(2) DSH AMOUNT.—The Secretary shall determine for each State a non-cash, DSH baseline amount which is equal to the DSH expenditures in fiscal year 1993 (as defined in subsection (c)(2)) multiplied by proportion of payments for medical assistance for hospital services (including psychiatric hospital services) under the State medicaid plan in fiscal year 1993 that is attributable to non-cash assistance recipients.

(b) NON-CASH ASSISTANCE RECIPIENT.—In this part, the term "non-cash assistance recipient" means an eligible individual who is not an AFDC or SSI recipient or a medicare part A beneficiary.

(c) STATE MEDICAID EXPENDITURES AND DSH EXPENDITURES DEFINED.—

(1) AGGREGATE STATE MEDICAID EXPENDITURES.—

(A) IN GENERAL.—In this section, the term "aggregate State medicaid expenditures" means, with respect to a State in fiscal year 1993, the amount of payments under the State medicaid plan with respect to medical assistance furnished for non-cash assistance recipients for calendar quarters in fiscal year 1993, less the amount of Federal financial participation paid to the State with respect to such assistance, and not including any DSH expenditures (as defined in paragraph (2)).

(B) LIMITED TO PAYMENTS FOR SERVICES.—In applying subparagraph (A), payments under the State medicaid plan shall not be included unless Federal financial participation is provided with respect to such payments under section 1903(a)(1) of the Social Security Act and such payments shall not include payments for medicare cost-sharing (as defined in section 1905(p)(3) of the Social Security Act).

(2) DSH EXPENDITURES.—In this section, the term "DSH expenditures" means payments made under section 1923 of the Social Security Act in fiscal year 1993.

(3) ADJUSTMENT AUTHORIZED TO TAKE INTO ACCOUNT CASH FLOW VARIATIONS.—If the Secretary finds that a State took an action that had the effect of shifting the timing of medical assistance payments under the State medicaid plan between quarters or fiscal years in a manner so that the payments made in fiscal year 1993 do not accurately reflect the value of the medical assistance provided with respect to items and services furnished in that fiscal year, the Secretary may provide for such adjustment in the amounts computed under this subsection as may be necessary so that the non-cash, non-DSH baseline amount and the non-cash, DSH baseline amount determined under this section accurately reflect such value.

(4) TREATMENT OF DISALLOWANCES.—The amounts determined under this subsection shall take into account amounts (or an estimate of amounts) disallowed.

(d) APPLICATION TO PARTICULAR ITEMS AND SERVICES IN THE BENEFIT PACKAGE FOR LOW-INCOME INDIVIDUALS.—For purposes of subsection (a), in determining the aggregate State medicaid expenditures for a category of items and services (within the benefit

package for low-income individuals) furnished in a State, there shall be counted only that proportion of such expenditures that were attributable to items and services included in such package (taking into account any limitation on amount, duration, or scope of items and services included in such package).

SEC. 8123. UPDATING OF BASELINE AMOUNT.

(a) UPDATE FOR YEARS THROUGH 1998.—

(1) NON-CASH, NON-DSH BASELINE AMOUNT.—The Secretary shall update the non-cash, non-DSH baseline amount determined under section 8122(a)(1) for each State for years from fiscal year 1993 through 1998 by 66.2 percent.

(2) NON-CASH, DSH BASELINE AMOUNT.—The Secretary shall update the non-cash, DSH baseline amount determined under section 8122(a)(2) for each State for years from fiscal year 1993 through 1998 by 47.3 percent.

(3) ADJUSTMENT AUTHORIZED TO TAKE INTO ACCOUNT CASH FLOW VARIATIONS.—In determining the updates under paragraph (1), the Secretary may provide for an adjustment in a manner similar to the adjustment permitted under section 8122(b)(3).

(b) UPDATE FOR SUBSEQUENT YEARS.—For each State for each year after 1998, the Secretary shall update the non-cash, non-DSH baseline amount (as previously updated under this section) and the non-cash, DSH baseline amount (as previously updated under this section) by the product of—

(1) 1 plus the national medicare growth factor (under section 8201(c)) for the year, and

(2) 1 plus the annual percentage increase in the population of the United States of individuals who are under 65 years of age (as estimated by the Secretary based on projections made by the Bureau of Labor Statistics of the Department of Labor) for the year.

Subpart C—General and Miscellaneous Provisions

SEC. 8131. TIMING AND MANNER OF PAYMENTS.

(a) IN GENERAL.—Amounts required to be paid under this part shall be paid on a periodic basis specified by the Secretary, taking into account the benefits provided under part B of title XXI of the Social Security Act and taking into account the manner in which States provide for payments under agreements under section 1843 of such Act.

(b) PERIODIC PROVISION OF INFORMATION.—Each State shall periodically transmit to the Secretary such information as the Secretary may require to verify the amounts payable.

(c) RECONCILIATION.—

(1) PRELIMINARY.—At such time after the end of each year as the Secretary shall specify, the State shall submit to the Secretary such information as the Secretary may require to do a preliminary reconciliation of the amounts paid under this part and the amounts due.

(2) FINAL.—No later than June 30 of each year, the Secretary shall provide for a final reconciliation for such payments for quarters in the previous year. Amounts subsequently payable are subject to adjustment to reflect the results of such reconciliation.

(3) AUDIT.—Payments under this part are subject to audits by the Secretary in accordance with rules established by the Secretary.

SEC. 8132. SPECIAL RULES FOR PUERTO RICO AND OTHER TERRITORIES.

(a) COMPUTATION OF BASELINES AS IF COMMONWEALTHS AND TERRITORIES WERE STATES.—

(1) IN GENERAL.—For purposes of determining payment amounts by the Commonwealths and territories under subpart

A and subpart B of this part, subject to paragraph (2), the Secretary, in consultation with such Commonwealths and territories and using data on expenditures reported to the Secretary by the Commonwealths and territories, shall compute—

(A) the base per capita non-DSH expenditures and base per capita DSH expenditures, under section 8112(c), and

(B) the non-cash, non-DSH baseline amount and the non-cash, DSH baseline amount, under section 8122(a),

in the same manner as if the Commonwealths and territories had been one of the 50 States of the United States.

(2) REDUCTION OF MAINTENANCE OF EFFORT PAYMENTS BY AMOUNT OF TOBACCO TAXES IN PUERTO RICO.—The payment amounts otherwise payable under subparts A and B of this part by each of the Commonwealths and territories for a year shall be ratably reduced by ratio of—

(A) the amount of additional revenues in the year which the Secretary of the Treasury estimates to be attributable to section 5701(h) of the Internal Revenue Code of 1986 (as added by section 11101(h) of this Act), to

(B) the total payment amounts otherwise payable under such subparts by all of the Commonwealths and territories for the year.

(b) TREATMENT OF CERTAIN SSI RECIPIENTS.—With respect to the Commonwealths and territories insofar as they are not covered under the supplementary security income program, in this part, the term "SSI recipient" includes an individual receiving aid under a territorial program for the aged, blind, or disabled under the Social Security Act.

(c) COMMONWEALTHS AND TERRITORIES.—In this section, the term "Commonwealths and territories" means Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

SEC. 8133. SANCTIONS FOR FAILURE TO MAKE TIMELY PAYMENTS.

(a) REDUCTION OF FEDERAL MATCHING PAYMENTS.—To the extent that a State that fails to make the payments required under this part in a timely manner, the Secretary shall, in addition to withholding payments pursuant to section 1903(x) of the Social Security Act (as added by section 8502(b)), withhold the required amounts from Federal matching payments that would otherwise be paid to the State for the following programs:

(1) The program under part A of title IV of the Social Security Act.

(2) The program under title XVI of such Act.

(3) The program under title XX of such Act.

(b) CONSTRUCTION.—Nothing in this section shall be construed as affecting payments made directly to individuals, whether or not such payments are administered by a State agency.

SEC. 8134. STATE MAINTENANCE OF EFFORT PERCENTAGE.

For purposes of sections 8111(a) and 8121(b), the term "State maintenance of effort percentage" means—

(1) 100 percent for 1999, 2000, and 2001

(2) 96 percent for 2002 and 2003, and

(3) 86 percent for each year thereafter.

PART 3—ANALYSIS OF IMPACT OF ACT ON FEDERAL EXPENDITURES AND STATES

SEC. 8141. IMPACT OF HEALTH CARE REFORM ON FEDERAL BUDGET.

(a) STUDY.—The Director of the Congressional Budget Office shall conduct a study of the impact of this Act on the budget of the Federal Government (including the impact on receipts, spending, and other obligations) with respect to each fiscal year (beginning with fiscal year 1996).

(b) REPORT.—Not later than March 1 of each year (beginning with 1997), the Director shall submit a report to Congress on the study conducted under subsection (a) for the previous fiscal year, and shall include in the report—

(1) a comparison of the actual impact of this Act on the Federal budget with the projected impact of this Act on Federal receipts, spending, and obligations, as first estimated by the Director after the date of the enactment of this Act; and

(2) to the extent that the actual impact of this Act on the Federal budget is not in accordance with the Director's estimate, an explanation for the differences.

SEC. 8142. IMPACT OF HEALTH CARE REFORM ON STATES.

(a) STUDY.—The Director of the Congressional Budget Office shall conduct a State-by-State study for each fiscal year (beginning with fiscal year 1996) of the impact of this Act on State spending for health care services and the overall economy of the State during the fiscal year. Such study shall include an analysis of the impact of this Act on the following:

(1) The number of individuals in the State with health insurance coverage.

(2) Health-related expenditures by the State, including—

(A) maintenance of effort paid under part 2;

(B) payments under the State plan under title XIX of the Social Security Act;

(C) support for uninsured and low-income individuals (including undocumented aliens);

(D) payments for medical education and other public health programs;

(E) payments for health insurance coverage for State and local government employees.

(3) Health-related payments by the Federal government to individuals and providers in the State, including—

(A) premium certificates under part A of title XXII of the Social Security Act and other premium assistance for low-income individuals;

(B) credits for small employers and retirees;

(C) payments to providers under the medicare program and medicare part C; and

(D) other Federal assistance to providers and programs (including capital assistance, payments under the Public Health Service Act, and payments for graduate medical education) under this Act and other Federal laws.

(b) REPORT.—Not later than March 1 of each year (beginning with 1997), the Director shall submit a report to Congress on the study conducted under subsection (a) for the previous fiscal year.

(c) RECOMMENDATIONS TO ASSIST ADVERSELY AFFECTED STATES.—If, with respect to a State for a fiscal year, the Director finds that this Act resulted in an adverse impact on State revenues and the overall State economy during the year, the Director shall report such information to the Secretary. The Secretary shall submit recommendations to Congress for a legislative proposal to assure that the State is held harmless as a result of this Act (including recommendations relating to adjustments in the State maintenance of effort payments required under part 2, other revenues contained in this Act, and other provisions).

Subtitle C—Cost Containment in the Medicare Programs

PART 1—MEDICARE HEALTH EXPENDITURE ESTIMATES

SEC. 8201. NATIONAL MEDICARE PER CAPITA HEALTH EXPENDITURE ESTIMATE.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—For each calendar year (beginning with 1996), there is established a national medicare per capita health expenditure estimate (in this subtitle referred to as the "national medicare per capita estimate") determined under paragraph (2).

(2) AMOUNT.—Subject to subsection (e)—

(A) NATIONAL MEDICARE PER CAPITA ESTIMATE.—

(i) 1996, 1997, AND1998.—The national medicare per capita estimate for 1996, 1997, and 1998 is equal to the national medicare A/B per capita estimate for the respective year.

(ii) SUBSEQUENT YEARS.—The national medicare per capita estimate for a year after 1998 is equal to the average, weighted by the estimated number of enrollees in the respective programs, of the national medicare A/B per capita estimate and the national medicare C per capita estimate for the year.

(B) NATIONAL MEDICARE A/B PER CAPITA AMOUNT.—

(i) 1996.—Subject to the special rule provided under subsection (e)(4), the national medicare A/B per capita estimate for 1996 is equal to the medicare per capita budget baseline for 1995 (as determined under subsection (b)) multiplied by the sum of 1 plus the national medicare growth factor (specified under subsection (c)) for 1996.

(ii) SUBSEQUENT YEARS.—Subject to the special rule provided under subsection (e)(4), the total amount of the national medicare A/B per capita estimate for each year after 1996 is equal to the national medicare A/B per capita estimate determined under this subparagraph for the previous year multiplied by the national medicare growth factor (specified under subsection (c)) for the year involved.

(C) NATIONAL MEDICARE C PER CAPITA AMOUNT.—

(i) 1999.—The Secretary shall estimate the national medicare C per capita estimate for 1999 by using the payment rates under the medicare part C program in 1999 and taking into account the average characteristics of the population expected to be enrolled in such program and their projected use of covered services (including wrap around services covered under subpart 2 of part B of title XXIII of the Social Security Act).

(ii) SUBSEQUENT YEARS.—The total amount of the national medicare C per capita estimate for each year after 1999 is equal to the national medicare C per capita estimate determined under this subparagraph for the previous year multiplied by the sum of 1 plus the national medicare growth factor (specified under subsection (c)) for the year involved.

(3) PUBLICATION.—The Secretary of Health and Human Services shall publish in the Federal Register and report to the Congress—

(A) by not later than April 1 before each year, an initial estimate of the per capita estimates under this subsection for the year; and

(B) by not later than October 1 before each year, a final determination of such per capita estimates for such year.

(b) MEDICARE PER CAPITA BUDGET BASELINE.—The Secretary shall compute a medicare per capita budget baseline under this subsection for 1995 as follows:

(1) 1993 ACTUAL EXPENDITURES.—The Secretary shall determine (on the basis of the best data available) the amount of the medicare per capita expenditures (as determined under subsection (d)) for 1993.

(2) PROJECTION FOR 1995.—The Secretary shall increase such amount by the Secretary's estimate of the percentage increase in the national medicare per capita estimate between the midpoint of 1993 and the midpoint of 1995.

(c) NATIONAL MEDICARE GROWTH FACTOR.—The national medicare growth factor under this subsection for each year is the sum (expressed as a fraction) of—

(1) the average annual percentage increase in the per capita gross domestic product (in current dollars, as published by the Secretary of Commerce) during the 5-year period ending with the second previous year; and

(2)(A) for 1996, 1.8 percentage points,

(B) for 1997, 1.4 percentage points,

(C) for 1998, 0.5 percentage points,

(D) for 1999, 0.1 percentage points, and

(E) for each year thereafter, 0 percentage points.

(d) DETERMINATION OF NATIONAL MEDICARE PER CAPITA EXPENDITURES FOR 1993.—

(1) IN GENERAL.—The Secretary shall determine for 1993 the national medicare per capita expenditures equal to—

(A) total covered health care expenditures (described in paragraph (2)), divided by

(B) the estimated average number of medicare beneficiaries in 1993 for whom such expenditures were determined.

(2) COVERED HEALTH CARE EXPENDITURES.—For purposes of paragraph (1)(A), the Secretary shall determine covered health care expenditures for 1993 as follows:

(A) DETERMINATION OF TOTAL EXPENDITURES.—The Secretary shall first determine the amount of total payments made for items and services under title XVIII of the Social Security Act (determined without regard to cost sharing) in 1993.

(B) REMOVAL OF CERTAIN EXPENDITURES NOT INCLUDED IN MEDICARE.—The amount so determined shall be decreased by the proportion of such amount that is attributable to expenditures which are paid for items and services excluded from classes of services under section 8202(a)(4).

(e) ADJUSTMENTS.—

(1) IN GENERAL.—Except as provided in this subsection, the Secretary is not authorized to adjust the medicare A/B per capita estimate or the medicare C per capita estimate under this section for a year once they are published before October of the previous year.

(2) RECOMMENDATIONS FOR CHANGES.—Except as permitted under paragraphs (3) and (4), the Secretary may submit to Congress recommendations for changes in the medicare A/B per capita estimate or the medicare C per capita estimate, but may not implement such recommendations without the approval of Congress.

(3) CORRECTION PERMITTED FOR ESTIMATION ERRORS IN MEDICARE PER CAPITA BUDGET BASELINE.—Insofar as the Secretary determines that the amounts used in estimating initially the medicare per capita budget baseline described in subsection (b) did not accurately reflect the actual amount described in subsection (b)(1) and the actual percentage increase described in subsection (b)(2), the Secretary shall adjust the national medicare per capita estimate to correct for such estimation errors.

(4) SPECIAL RULES.—

(A) MEDICARE A/B PER CAPITA ESTIMATE.—The Secretary shall adjust the national medicare A/B per capita estimate for each year (beginning with 1996) in order to reflect the changes in expenditures under parts A and B of the medicare program attributable to amendments made

by subtitle B of title III or subtitle D of this title, including the addition of an outpatient prescription drug benefit.

(B) MEDICARE C PER CAPITA ESTIMATE.—The Secretary shall adjust the national medicare C per capita estimate for each year (beginning with 1999) in order to reflect the changes in expenditures under medicare part C attributable to the addition of benefits not included in the previous year.

SEC. 8202. CLASSES OF HEALTH CARE SERVICES.

(a) ESTABLISHMENT OF CLASSES.—

(1) IN GENERAL.—

(A) SPECIFIED SERVICES.—

(i) IN GENERAL.—Subject to subparagraph (B)(ii), in the case of items and services specified in a subparagraph under paragraph (2), all of the items and services described in that subparagraph shall be considered to be a "separate" class of health care services.

(ii) OVERLAPPING SERVICES.—Except as the Secretary may provide, items and services specified in a subparagraph of paragraph (2) shall be considered to be excluded from the subsequent subparagraphs of that paragraph.

(B) OTHER ITEMS AND SERVICES.—

(i) IN GENERAL.—In the case of items and services included as health care services under paragraph (3), the Secretary shall group such items and services into such class or classes of health care services as may be appropriate.

(ii) INCLUSION IN CLASSES OF SPECIFIED HEALTH CARE SERVICES.—In carrying out clause (i), the Secretary may include an item or service described in paragraph (3) within a class of services established under subparagraph (A).

(2) SPECIFIED HEALTH CARE SERVICES.—Subject to paragraph (4), the items and services specified in this paragraph are as follows:

(A) Inpatient hospital services, other than mental health services.

(B) Outpatient hospital services and ambulatory facility services (including renal dialysis facility services), other than mental health services.

(C) Diagnostic testing services (including clinical laboratory services and x-ray services).

(D) Physicians' services and other professional medical services, other than mental health services.

(E) Home health services and hospice care.

(F) Rehabilitation services, such as physical therapy, occupational and speech therapy.

(G) Durable medical equipment and supplies.

(H) Prescription drugs and biologicals and insulin.

(I) Nursing facility services, including skilled nursing facility services and intermediate care facility services, other than mental health services.

(J) Mental health services.

(3) CLASSIFICATION OF ADDITIONAL ITEMS AND SERVICES.—Subject to paragraph (4), with respect to items and services (not described in paragraph (2)) which are included under the medicare program (including wrap around benefits under subpart 2 of part B of title XXIII of the Social Security Act), the Secretary may classify them either within a class specified in paragraph (2) or within a new class established by the Secretary for such an item or service.

(4) EXCLUSIONS.—The following items and services shall not be considered to be health care services and shall not be included in a class of services under paragraph (1) or (3), except as provided in paragraph (5):

(A) Over-the-counter medications and medical equipment and devices.

(B) Homemaker and home health aide services and personal care services, and other services described in section 1915(c)(4)(B), section 1929(a), or section 1930(a) of the Social Security Act.

(C) Inpatient mental health services of a custodial nature.

(5) INCLUSION OF MEDICARE SERVICES.—Paragraph (4) shall not apply to items and services covered under the medicare program.

(b) PUBLICATION.—

(1) IN GENERAL.—The Secretary shall publish—

(A) by not later than April 1, 1995, proposed regulations defining the health care services and establishing the classes of services under this section, and

(B) by not later than October 1, 1995, final regulations defining the health care services and establishing such classes.

(2) ITEMS INCLUDED IN REGULATIONS.—In such regulations, the Secretary shall define—

(A) the class or classes to be established under subsection (a)(1),

(B) the services to be included within each class, and

(C) the methods and sources of data for computing, for purposes of this subtitle, the national medicare per capita estimate within the class.

(3) CHANGES.—

(A) NO CHANGES AUTHORIZED.—After the Secretary has established classes of services under paragraph (1)(B), the Secretary may not change such classes (or the services included in such classes), except in the case of services not previously classified. Any such services not previously classified shall be classified within one of the classes previously established.

(B) RECOMMENDED CHANGES.—If the Secretary determines that a change in the classification established under this section may be appropriate, the Secretary shall submit to the Congress a report proposing such change. The Secretary shall include in the report an explanation of—

(i) the rationale for such change, and

(ii) the impact of such change on the per capita estimates under this part and on medicare expenditures permitted for classes of services that would be affected by the change.

(4) COMMISSION REPORTS.—

(A) INITIAL REPORTS.—With respect to the establishment of classes of services under this section, each applicable Commission (as defined in subsection (c)), by not later than June 1, 1995, shall report to the Congress its comments concerning the classification proposed by the Secretary under paragraph (1)(A).

(B) PERIODIC REPORTS.—Each applicable Commission shall periodically report to Congress on changes in the system of classification under this section that should be made to promote the more efficient provision of medically appropriate health care services.

(c) APPLICABLE COMMISSION DEFINED.—In this subtitle, the term "applicable Commission" means—

(1) with respect to services included in a class of services furnished by a hospital, other institutional provider, or home health provider, the Prospective Payment Assessment Commission (established under section 1886(e)(2) of the Social Security Act);

(2) with respect to prescription drugs, biologicals, and insulin, the Prescription Drug Payment Review Commission (pro-

vided for under section 1847 of the Social Security Act, as added by section 3104 of this Act),

(3) with respect to physicians' services, the Physician Payment Review Commission (provided for under section 1845 of the Social Security Act), and

(4) with respect to mental health and substance abuse services, the Advisory Commission on Mental Health and Substance Abuse Services (provided for under section 3025(a)).

SEC. 8203. ALLOCATION OF PER CAPITA ESTIMATES BY CLASS OF SERVICE FOR MEDICARE A/B.

(a) ALLOCATION.—

(1) IN GENERAL.—The Secretary shall allocate the medicare A/B per capita estimate under section 8201 for a year among classes of services specified under section 8202.

(2) PROPORTIONAL ALLOCATION BASED ON PROJECTED EXPENDITURES.—The amount allocated to each class for a year shall be equal to the medicare A/B per capita estimate for the year multiplied by the ratio (expressed as a percentage) of—

(A) the projected medicare A/B expenditures for the class for the year (as determined under subsection (b)(2)), to

(B) the sum of such projected medicare A/B expenditures for all the classes for the year.

(3) PUBLICATION.—

(A) IN GENERAL.—The Secretary shall, in conjunction with the publication of the initial estimate and final determination of the per capita estimates under section 8201(a)(3) for a year, publish in the Federal Register and report to the Congress the allocation of the per capita estimates among the classes of services under this subsection.

(B) EXCEPTION FOR 1996.—For 1996, the Secretary shall publish and report the allocation of the medicare A/B per capita estimate among the classes of services under this subsection not later than August 1, 1995.

(b) PROJECTED MEDICARE A/B EXPENDITURES.—

(1) IN GENERAL.—

(A) DETERMINATION.—For purposes of subsection (a)—

(i) FOR 1995.—The projected medicare A/B expenditures for a class of services for 1995 is equal to the portion of the national medicare per capita expenditures during 1993 (as determined under section 8201(d)) which is attributable to the class of services, multiplied twice by the medicare A/B trend factor (described in subparagraph (B)) for the class and multiplied by the adjustment factor described in subparagraph (C) for 1995. In computing such portion for classes, the Secretary shall take into account the allocation of expenditures by health maintenance organizations among the different classes of services.

(ii) SUBSEQUENT YEARS.—The projected medicare A/B expenditures for a class of services for a year after 1995 is equal to the amount of the allocation for the class under clause (i) for the preceding year multiplied by the medicare A/B trend factor (described in subparagraph (B)) for the class and multiplied by the adjustment factor described in subparagraph (C) for the year.

(B) MEDICARE A/B TREND FACTOR.—In subparagraph (A), subject to subparagraph (D), the "medicare A/B trend factor", is 1 plus the following amount for the class of services involved:

(i) INPATIENT HOSPITAL SERVICES.—For the class described in section 8202(a)(2)(A), 8.6 percent.

(ii) OUTPATIENT HOSPITAL SERVICES.—For the class described in section 8202(a)(2)(B), 15.7 percent.

(iii) DIAGNOSTIC TESTING SERVICES.—For the class described in section 8202(a)(2)(C), 12.2 percent.

(iv) PHYSICIANS' SERVICES.—For the class described in section 8202(a)(2)(D), 9.1 percent.

(v) HOME HEALTH AND HOSPICE.—For the class described in section 8202(a)(2)(E), 13.9 percent.

(vi) REHABILITATION SERVICES.—For the class described in section 8202(a)(2)(F), 12.3 percent.

(vii) DURABLE MEDICAL EQUIPMENT.—For the class described in section 8202(a)(2)(G), 10.2 percent.

(viii) PRESCRIPTION DRUGS.—For the class described in section 8202(a)(2)(H), 8.2 percent.

(ix) NURSING FACILITY SERVICES.—For the class described in section 8202(a)(2)(I), 11.5 percent.

(x) MENTAL HEALTH SERVICES.—For the class described in section 8202(a)(2)(J), 15.7 percent.

(C) ADJUSTMENT FACTOR (NORMALIZATION).—The adjustment factor described in this subparagraph for a year is equal to the ratio of—

(i) the national medicare A/B per capita estimate for the year (as determined under section 8201(a)(2)(B)) or, for 1995, the medicare per capita budget baseline for 1995 (as determined under section 8201(b)(2)), to

(ii) the sum of the projected medicare A/B expenditures projected for all the classes for the year (determined under subparagraph (A) without regard to this subparagraph).

(D) SPECIAL RULE.—The Secretary shall adjust the projected medicare A/B expenditures for each year (beginning with 1996) in order to reflect the changes in expenditures under parts A and B of the medicare program attributable to amendments made by subtitle B of title III or subtitle D of this title, including the addition of an outpatient prescription drug benefit. Such adjustment shall be consistent with the adjustment described in section 8201(e)(4)(A).

(2) PUBLICATION OF TREND FACTORS.—The Secretary shall publish, by not later than August 1, 1995, the medicare A/B trend factors for the different classes of services.

(c) REVIEW AND CHANGES IN ALLOCATION.—

(1) IN GENERAL.—

(A) NO ADMINISTRATIVE AUTHORITY TO CHANGE.—Except as specifically provided in this paragraph, the Secretary has no authority to change the allocation or medicare A/B trend factors from the allocation and medicare A/B trend factors provided under this section.

(B) RECOMMENDED CHANGES.—Subject to subparagraph (C), if the Secretary determines that a change in the allocation of an estimate among classes is appropriate, the Secretary shall submit to the Congress a report proposing such change. The Secretary shall include in the report an explanation of—

(i) the rationale for such change, and

(ii) the impact of such change on the per capita estimates permitted for classes of services that would be affected by the change.

(C) CORRECTION PERMITTED FOR ESTIMATION ERRORS.—Insofar as the Secretary determines that the amounts used in estimating initially the projected medicare A/B expenditures under this subsection did not accurately reflect the actual portions described in subsection (b)(1)(A)(i), the Secretary shall adjust the allocation of the medicare A/B per capita estimate among classes of services to correct for such estimation errors.

(2) COMMISSION REVIEW.—Each applicable Commission shall annually review and report to Congress, in its report submitted under section 8202(b)(4), on the effect of the medicare trend factors used in the allocation of the medicare A/B per capita estimate among classes of services. Such report shall include such recommendations for appropriate adjustments in the medicare trend factors as the applicable Commission considers appropriate to properly take into account at least—

(A) changes in health care technology,

(B) changes in the patterns and practices relating to health care delivery found to be appropriate,

(C) changes in the distribution of health care services, and

(D) the special health care needs of underserved rural and inner city populations.

SEC. 8204. ALLOCATION OF PER CAPITA ESTIMATES BY CLASS OF SERVICE FOR MEDICARE C.

(a) ALLOCATION.—

(1) IN GENERAL.—The Secretary shall allocate the medicare C per capita estimate under section 8201 for a year among classes of services specified under section 8202.

(2) PROPORTIONAL ALLOCATION BASED ON PROJECTED EXPENDITURES.—The amount allocated to each class for a year shall be equal to the medicare C per capita estimate allocated for the year multiplied by the ratio (expressed as a percentage) of—

(A) the projected medicare C expenditures for the class for the year (as determined under subsection (b)(2)), to

(B) the sum of such projected medicare C expenditures for all the classes for the year.

(3) PUBLICATION.—The Secretary shall, in conjunction with the publication of the initial estimate and final determination of the per capita estimates under section 8201(a)(3) for a year, publish in the Federal Register and report to the Congress the allocation of the per capita estimates among the classes of services under this subsection.

(b) PROJECTED MEDICARE PART C EXPENDITURES.—

(1) IN GENERAL.—

(A) DETERMINATION.—For purposes of subsection (a)—

(i) FOR 1999.—The projected medicare part C expenditures for a class of services for 1999 is equal to the portion of the national medicare C per capita estimate during 1999 (as determined under section 8201(a)(2)(C)) which is attributable to each class of services, as estimated by the Secretary based upon the best data available, consistent with data used in determining the applicable medicare part C premiums under section 2121 of the Social Security Act.

(ii) SUBSEQUENT YEARS.—The projected medicare C expenditures for a class of services for a year after 1999 is equal to the amount of the allocation for the class under clause (i) for the preceding year multiplied by the medicare C trend factor (described in subparagraph (B)) for the class for the year involved and multiplied by the adjustment factor described in subparagraph (C) for the year.

(B) MEDICARE C TREND FACTOR.—

(i) IN GENERAL.—In subparagraph (A), subject to clause (ii), the "medicare C trend factor", for a class of services, the private trend factor for the class of services, as determined under section 6003(b)(1)(B).

(ii) MODIFICATION.—Based upon data from the medicaid program and such other data as the Secretary determines to be appropriate, the Secretary may modify the trend factors described in clause (i) to

reflect the rate of growth in services for the classes under medicare part C.

(C) ADJUSTMENT FACTOR (NORMALIZATION).—The adjustment factor described in this subparagraph for a year is equal to the ratio of—

(i) the national medicare C per capita estimate for the year (as determined under section 8201(a)(2)(C)), to

(ii) the sum of the projected medicare C expenditures projected for all the classes for the year (determined under subparagraph (A) without regard to this subparagraph).

(D) SPECIAL RULE.—The Secretary shall adjust the projected medicare C expenditures for each year (beginning with 2000) in order to reflect the changes in expenditures under medicare part C to reflect the changes in expenditures under medicare part C attributable to the addition of benefits not included in the previous year. Such adjustment shall be consistent with the adjustment described in section 8201(e)(4)(B).

(2) PUBLICATION OF TREND FACTORS.—The Secretary shall publish, by not later than April 1, 1998, the medicare C trend factors for the different classes of services.

(c) REVIEW AND CHANGES IN ALLOCATION.—

(1) IN GENERAL.—

(A) NO ADMINISTRATIVE AUTHORITY TO CHANGE.—Except as specifically provided in this paragraph, subsection (b)(1)(B)(ii), and sections 8201(e)(4)(B) and 8203(b)(1)(D), the Secretary has no authority to change the allocation or medicare C trend factors from the allocation and medicare C trend factors provided under this section.

(B) RECOMMENDED CHANGES.—If the Secretary determines that a change in the allocation of an estimate among classes is appropriate, the Secretary shall submit to the Congress a report proposing such change. The Secretary shall include in the report an explanation of—

(i) the rationale for such change, and

(ii) the impact of such change on the per capita estimates permitted for classes of services that would be affected by the change.

(2) COMMISSION REVIEW.—Each applicable Commission shall annually review and report to Congress, in its report submitted under section 8202(b)(4), on the effect of the medicare trend factors used in the allocation of the medicare C per capita estimate among classes of services. Such report shall include such recommendations for appropriate adjustments in the medicare trend factors as the applicable Commission considers appropriate to properly take into account at least—

(A) changes in health care technology,

(B) changes in the patterns and practices relating to health care delivery found to be appropriate,

(C) changes in the distribution of health care services, and

(D) the special health care needs of underserved rural and inner city populations.

SEC. 8205. COMBINED MEDICARE PER CAPITA ALLOCATIONS FOR CLASSES OF SERVICES.

(a) FOR 1996, 1997, AND 1998.—For 1996, 1997, and 1998, the Secretary shall compute a combined medicare per capita allocation for each class of services equal to the per capita amount allocated to the class for medicare A/B for the year under section 8203.

(b) SUBSEQUENT YEARS.—For each year after 1998, the Secretary shall compute a combined medicare per capita allocation for each class of services equal to the average of—

(1) the per capita amount allocated to the class for medicare A/B for the year under section 8203, and

(2) the per capita amount allocated to the class for medicare C for the year under section 8204,

weighted to reflect the relative average number of enrollees in the medicare program and in medicare part C, respectively, for the year.

SEC. 8206. COMPUTATION OF MEDICARE ANNUAL COMBINED RATE OF INCREASE FOR CLASSES OF SERVICES; APPLICATION TO MEDICARE PAYMENT RATES.

(a) COMBINED RATES.—

(1) DETERMINATION.—For each year (beginning with 1996) for services within each class of services, the Secretary shall determine a uniform percentage increase. The uniform percentage increase shall be such an increase as the Secretary determines will result in aggregate expenditures under the medicare program and medicare part C consistent with the combined medicare per capita allocation for such class for such year, as determined under section 8205.

(2) APPLICATION TO MEDICARE PAYMENT RATES.—Notwithstanding any provision of title XVIII or title XXIII of the Social Security Act, subject to section 4004(c)(1)(B), the amount of payment under such titles for items and services included in a class of services for a year (after 1995) shall be based on the amount of payment for such items and services under such titles in the previous year increased by the uniform percentage increase determined under paragraph (1) for such class of services for the year.

(b) PERCENTAGE INCREASE IN COMBINED ALLOCATION FOR CLASS OF PRESCRIPTION DRUGS.—For each year beginning after 1997, for purposes of sections 1834(d) of the Social Security Act and sections 3012(d) and 3013(a), the Secretary shall compute the percentage by which—

(1) the combined medicare per capita allocation for the class of services that includes prescription drugs for the year, exceeds

(2) the combined medicare per capita allocation for such class of services for the preceding year.

SEC. 8207. NATIONAL HEALTH EXPENDITURES REPORTING SYSTEM.

(a) IN GENERAL.—The Secretary shall establish a national health expenditures reporting system (in this section referred to as the "system") for purposes of—

(1) establishing per capita estimates,

(2) allocating the medicare per capita estimates among classes of services,

(3) determining medicare payment rates,

(4) monitoring of any State cost containment and benefit management programs established by States pursuant to title IV, and

(5) otherwise carrying out this subtitle.

(b) INFORMATION REPORTING.—

(1) ANNUAL REPORT BY PROVIDERS.—

(A) IN GENERAL.—Under the system, providers of health care services (including such providers within provider networks) shall submit (by not later than April 15 of each year, beginning with 1997) a report.

(B) CONTENTS.—Such a report shall include such information as the Secretary specifies relating to the provision of health care services in the previous year, including—

(i) the volume and receipts for such services,

(ii) cost and revenue data for hospitals and other institutional providers and revenue data for other providers, and

(iii) information by class of service, type of payer, and State of residence of individual provided the services.

Information on revenues for activities not related to the provision of direct patient care, such as teaching or re-

search or for services that are explicitly excluded from the system of national health expenditures estimates, shall be reported separately.

(C) FORM.—The report shall be submitted in such form and manner (including the use of electronic transmission) as the Secretary shall specify in regulation. Such form shall permit the reporting of information by health plans on behalf of providers who are in provider networks in the plan.

(D) USE OF REPORTING MECHANISMS.—To the maximum extent practicable and appropriate, reporting under such system shall be done through reporting mechanisms (such as uniform hospital reports provided under section 9105) and using data bases otherwise in use.

(E) USE OF SURVEYS.—The Secretary may, where appropriate, provide for the collection of information under the system through surveys of a sample of health care providers or with respect to a sample of information with respect to such providers.

(2) CONFIDENTIALITY.—Information gathered pursuant to the authority provided under this section shall not be disclosed in a manner that identifies individual providers of services.

(3) TRANSITION.—Before April 15, 1997, for purposes of this subtitle, the Secretary may use such other data collection and estimation techniques as may be appropriate for purposes described in subsection (a).

(c) ENFORCEMENT.—If a provider of health services is required, under the system under this section, to report information and refuses, after being requested by the Secretary, to provide the information required, or deliberately provides information that is false, the Secretary may impose a civil money penalty of not to exceed $10,000 for each such refusal or provision of false information. The provisions of section 1128A of the Social Security Act (other than subsections (a) and (b)) shall apply to civil money penalties under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a) of such Act.

PART 2—STATE HEALTH EXPENDITURE ESTIMATES

SEC. 8211. STATE MEDICARE PER CAPITA HEALTH EXPENDITURE ESTIMATE.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—For each calendar year (beginning with 1996), the Secretary shall establish a State medicare per capita health expenditure estimate (in this subtitle referred to as a "State medicare per capita estimate") for each State under paragraph (2).

(2) AMOUNT.—Subject to subsection (e), the State medicare per capita estimate for a State for a year is equal to the national medicare per capita estimate for the year, established under section 8201, multiplied by the applicable State adjustment factor (specified under subsection (b)) for the State.

(3) PUBLICATION.—The Secretary shall publish in the Federal Register and report to the Congress and to each State—

(A) by not later than April 1 before each year, an initial estimate of the State medicare per capita estimate for each State for the year; and

(B) by not later than October 1 before each year, a final determination of the State medicare per capita estimate for each State for the year.

(4) PERIODIC COMMISSION REPORTS ON STATE ESTIMATES.—Each applicable Commission shall periodically review and report to Congress on the State medicare per capita estimates established under this section. Such a report shall include such

recommendations as the respective Commission deems appropriate.

(b) STATE ADJUSTMENT FACTORS.—

(1) IN GENERAL.—The Secretary shall compute a State adjustment factor for each State consistent with this subsection.

(2) BASIS FOR COMPUTATION.—Subject to adjustment under paragraphs (3) and (4), the State adjustment factor for a State shall be equal to the ratio of the State's medicare per capita expenditures (that would be computed for the State under section 8201(d) if computations under such section were made for that State rather than for the United States) to the national medicare per capita expenditures determined under such section.

(3) ADJUSTMENT TO REFLECT HEALTH CARE EXPENDITURES FOR STATE RESIDENTS.—The Secretary shall provide for an adjustment to take into account differences among States in the in-State, and out-of-State, use of services by residents and nonresidents of the State, in order that the per capita amount reflects the medicare per capita health care expenditures for residents of the State for services provided anywhere in the United States.

(4) AVERAGE.—The Secretary shall establish the State adjustment factors in such a manner as assures that the population weighted average of such factors is 1.

(c) ADJUSTMENT.—

(1) IN GENERAL.—Subject to paragraph (3), the provisions of section 8201(e) shall apply to the State medicare per capita estimates under this section in the same manner as they apply to the national medicare per capita estimate.

(2) ADJUSTMENT TO CORRECT ESTIMATION ERRORS.—Insofar as the Secretary determines that the amounts used in estimating initially the State medicare per capita estimates did not accurately reflect the correct values for the factors used in computing State adjustments factors under subsection (b), the Secretary shall adjust the State medicare per capita estimates to correct for such estimation errors.

(3) ADJUSTMENTS IN 1996 and subsequent years.—

(A) ADJUSTMENT FOR CHANGES IN BENEFITS IN 1996.—In applying section 8201(e)(4) under paragraph (1), the adjustment for each State medicare per capita estimate shall be the same as the adjustment to the national medicare per capita estimate under such section.

(B) ADJUSTMENT FOR IMPLEMENTATION OF MEDICARE PART C.—The Secretary shall adjust the State medicare per capita estimates for each State for each year (beginning with 1999) to reflect variations among States in the estimated number of residents of the State who are enrolled in medicare part C for the year.

PART 3—ADMINISTRATIVE AND JUDICIAL REVIEW

SEC. 8221. LIMITATION ON ADMINISTRATIVE AND JUDICIAL REVIEW.

There shall be no administrative or judicial review of any of the following determinations:

(1) The national medicare per capita estimate and the State medicare per capita estimate for each State.

(2) Allocation of the national medicare per capita estimate or a State medicare per capita estimate to a class of health services.

Subtitle D—Revisions to Medicare Part A and Part B

PART 1—ADDITIONAL MEDICARE SAVINGS

SEC. 8301. REDUCTION IN PAYMENTS FOR INDIRECT COSTS OF MEDICAL EDUCATION.

(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 January 1, 1999, 'c' is equal to 1.89;

"(II) January 1, 1999, and before October 1, 1999, 'c' is equal to 1.68;

"(III) October 1, 1999, and before October 1, 2000, 'c' is equal to 1.48; and

"(IV) October 1, 2000, 'c' is equal to 1.28.".

(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 8301(a) of the Guaranteed Health Insurance Act of 1994".

SEC. 8302. REDUCTIONS IN DISPROPORTIONATE SHARE ADJUSTMENTS.

(a) IN GENERAL.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(1) in clause (ii), by striking "The amount" and inserting "Subject to clause (ix), the amount"; and

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

"(ix) Notwithstanding any other provision of this subparagraph, the Secretary shall reduce the amount of any additional payment made to a hospital under this subparagraph—

"(I) for discharges occurring on or after January 1, 1999, and before October 1, 2000, by 25 percent (or, in the case of an urban hospital that has more than 100 beds and a disproportionate patient percentage equal to or greater than 30 percent or a hospital described in the second sentence of clause (v), by 10 percent); and

"(II) for discharges occurring on or after October 1, 2000 by 50 percent (or, in the case of an urban hospital that has more than 100 beds and a disproportionate patient percentage equal to or greater than 30 percent or a hospital described in the second sentence of clause (v), by 25 percent).".

(b) RECOMMENDATIONS ON ADJUSTMENTS TO FORMULA.—

(1) RECOMMENDATIONS OF SECRETARY.—Not later than October 1, 1995, the Secretary shall submit recommendation to Congress on methods to adjust the definition of disproportionate patient percentage used to determine the amount of payment adjustments made under section 1886(d)(5)(F) of the Social Security Act to hospitals serving a significantly disproportionate number of low-income patients to take into account the provisions of this Act, including the establishment of the health insurance benefit program under part A of title XXIII of the Social Security Act and the repeal of coverage of inpatient hospital services under State plans for medical assistance under title XIX of such Act.

(2) REPORT BY PROPAC.—The Prospective Payment Assessment Commission shall review the Secretary's report under paragraph (2) and include recommendations relating to the report in the report submitted pursuant to section 1886(e)(3) of the Social Security Act on March 1, 1996.

SEC. 8303. REDUCTIONS IN PAYMENTS FOR CAPITAL-RELATED COSTS OF INPATIENT HOSPITAL SERVICES FOR PPS HOSPITALS.

Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended by adding at the end the following new sentence: "In addition to the reduction described in the preceding sentence, for discharges occurring after September 30, 1995, the Secretary shall reduce by 7.31 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 Guaranteed Health Insurance Act of 1994) and shall reduce by 10.41 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 the Guaranteed Health Insurance Act of 1994).".

SEC. 8304. LIMITATIONS ON PAYMENT FOR PHYSICIANS' SERVICES FURNISHED BY HIGH-COST HOSPITAL MEDICAL STAFFS.

(a) IN GENERAL.—

(1) LIMITATIONS DESCRIBED.—Part B of title XVIII, as amended by [*Review:* section 3103(a)], is amended by inserting after section 1848 the following new section:

"LIMITATIONS ON PAYMENT FOR PHYSICIANS' SERVICES FURNISHED BY HIGH-COST HOSPITAL MEDICAL STAFFS

"SEC. 1849. (a) SERVICES SUBJECT TO REDUCTION.—

"(1) DETERMINATION OF HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUE.—Not later than October 1 of each year (beginning with 1997), the Secretary shall determine for each hospital—

"(A) the hospital-specific per admission relative value under subsection (b)(2) for the following year; and

"(B) whether such hospital-specific relative value is projected to exceed the allowable average per admission relative value applicable to the hospital for the following year under subsection (b)(1).

"(2) REDUCTION FOR SERVICES AT HOSPITALS EXCEEDING ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE.—If the Secretary determines (under paragraph (1)) that a medical staff's hospital-specific per admission relative value for a year (beginning with 1998) is projected to exceed the allowable average per admission relative value applicable to the medical staff for the year, the Secretary shall reduce (in accordance with subsection (c)) the amount of payment otherwise determined under this part for each physician's service furnished during the year to an inpatient of the hospital by an individual who is a member of the hospital's medical staff.

"(3) TIMING OF DETERMINATION; NOTICE TO HOSPITALS AND CARRIERS.—Not later than October 1 of each year (beginning with 1997), the Secretary shall notify the medical executive committee of each hospital (as set forth in the Standards of the Joint Commission on the Accreditation of Health Organizations) of the determinations made with respect to the medical staff under paragraph (1).

"(b) DETERMINATION OF ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE AND HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUES.—

"(1) ALLOWABLE AVERAGE PER ADMISSION RELATIVE VALUE.—

"(A) URBAN HOSPITALS.—In the case of a hospital located in an urban area, the allowable average per admission relative value established under this subsection for a year is equal to 125 percent (or 120 percent for years after 1999) of the median of 1996 hospital-specific per admission relative values determined under paragraph (2) for all hospital medical staffs.

"(B) RURAL HOSPITALS.—In the case of a hospital located in a rural area, the allowable average per admission relative value established under this subsection for 1998 and each succeeding year, is equal to 140 percent of the

median of the 1996 hospital-specific per admission relative values determined under paragraph (2) for all hospital medical staffs.

"(2) HOSPITAL-SPECIFIC PER ADMISSION RELATIVE VALUE.—

"(A) IN GENERAL.—The hospital-specific per admission relative value projected for a hospital (other than a teaching hospital) for a calendar year, shall be equal to the average per admission relative value (as determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding such calendar year, adjusted for variations in case-mix and disproportionate share status among hospitals (as determined by the Secretary under subparagraph (C)).

"(B) SPECIAL RULE FOR TEACHING HOSPITALS.—The hospital-specific relative value projected for a teaching hospital in a calendar year shall be equal to the sum of—

"(i) the average per admission relative value (as determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by the hospital's medical staff (excluding interns and residents) during the second year preceding such calendar year; and

"(ii) the equivalent per admission relative value (as determined under section 1848(c)(2)) for physicians' services furnished to inpatients of the hospital by interns and residents of the hospital during the second year preceding such calendar year, adjusted for variations in case-mix, disproportionate share status, and teaching status among hospitals (as determined by the Secretary under subparagraph (C)). The Secretary shall determine such equivalent relative value unit per admission for interns and residents based on the best available data for teaching hospitals and may make such adjustment in the aggregate.

"(C) ADJUSTMENT FOR TEACHING AND DISPROPORTIONATE SHARE HOSPITALS.—The Secretary shall adjust the allowable per admission relative values otherwise determined under this paragraph to take into account the needs of teaching hospitals and hospitals receiving additional payments under subparagraphs (F) and (G) of section 1886(d)(5). The adjustment for teaching status or disproportionate share shall not be less than zero.

"(c) AMOUNT OF REDUCTION.—The amount of payment otherwise made under this part for a physician's service that is subject to a reduction under subsection (a) during a year shall be reduced 15 percent, in the case of a service furnished by a member of the medical staff of the hospital for which the Secretary determines under subsection (a)(1) that the hospital medical staff's projected relative value per admission exceeds the allowable average per admission relative value.

"(d) RECONCILIATION OF REDUCTIONS BASED ON HOSPITAL-SPECIFIC RELATIVE VALUE PER ADMISSION WITH ACTUAL RELATIVE VALUES.—

"(1) DETERMINATION OF ACTUAL AVERAGE PER ADMISSION RELATIVE VALUE.—Not later than October 1 of each year (beginning with 1999), the Secretary shall determine the actual average per admission relative value (as determined pursuant to section 1848(c)(2)) for the physicians' services furnished by members of a hospital's medical staff to inpatients of the hospital during the previous year, on the basis of claims for payment for such services that are submitted to the Secretary not later than 90 days after the last day of such previous year. The actual average per admission shall be adjusted by the appropriate case-mix, disproportionate share factor, and teaching factor for the hospital medical staff (as determined by the Sec-

retary under subsection (b)(2)(C)). Notwithstanding any other provision of this title, no payment may be made under this part for any physician's service furnished by a member of a hospital's medical staff to an inpatient of the hospital during a year unless the hospital submits a claim to the Secretary for payment for such service not later than 90 days after the last day of the year.

"(2) RECONCILIATION WITH REDUCTIONS TAKEN.—In the case of a hospital for which the payment amounts for physicians' services furnished by members of the hospital's medical staff to inpatients of the hospital were reduced under this section for a year—

"(A) if the actual average per admission relative value for such hospital's medical staff during the year (as determined by the Secretary under paragraph (1)) did not exceed the allowable average per admission relative value applicable to the hospital's medical staff under subsection (b)(1) for the year, the Secretary shall reimburse the fiduciary agent for the medical staff by the amount by which payments for such services were reduced for the year under subsection (c), including interest at an appropriate rate determined by the Secretary;

"(B) if the actual average per admission relative value for such hospital's medical staff during the year is less than 15 percentage points above the allowable average per admission relative value applicable to the hospital's medical staff under subsection (b)(1) for the year, the Secretary shall reimburse the fiduciary agent for the medical staff, as a percent of the total allowed charges for physicians' services performed in such hospital (prior to the withhold), the difference between 15 percentage points and the actual number of percentage points that the staff exceeds the limit allowable average per admission relative value, including interest at an appropriate rate determined by the Secretary; and

"(C) if the actual average per admission relative value for such hospital's medical staff during the year exceeded the allowable average per admission relative value applicable to the hospital's medical staff by 15 percentage points or more, none of the withhold is paid to the fiduciary agent for the medical staff.

"(3) MEDICAL EXECUTIVE COMMITTEE OF A HOSPITAL.—Each medical executive committee of a hospital whose medical staff is projected to exceed the allowable relative value per admission for a year, shall have one year from the date of notification that such medical staff is projected to exceed the allowable relative value per admission to designate a fiduciary agent for the medical staff to receive and disburse any appropriate withhold amount made by the carrier.

"(4) ALTERNATIVE REIMBURSEMENT TO MEMBERS OF STAFF.—At the request of a fiduciary agent for the medical staff, if the fiduciary agent for the medical staff is owed the reimbursement described in paragraph (2)(B) for excess reductions in payments during a year, the Secretary shall make such reimbursement to the members of the hospital's medical staff, on a pro-rata basis according to the proportion of physicians' services furnished to inpatients of the hospital during the year that were furnished by each member of the medical staff.

"(e) DEFINITIONS.—In this section, the following definitions apply:

"(1) MEDICAL STAFF.—An individual furnishing a physician's service is considered to be on the medical staff of a hospital—

"(A) if (in accordance with requirements for hospitals established by the Joint Commission on Accreditation of Health Organizations)—

"(i) the individual is subject to bylaws, rules, and regulations established by the hospital to provide a framework for the self-governance of medical staff activities;

"(ii) subject to such bylaws, rules, and regulations, the individual has clinical privileges granted by the hospital's governing body; and

"(iii) under such clinical privileges, the individual may provide physicians' services independently within the scope of the individual's clinical privileges, or

"(B) if such physician provides at least one service to a medicare beneficiary in such hospital.

"(2) RURAL AREA; URBAN AREA.—The terms 'rural area' and 'urban area' have the meaning given such terms under section 1886(d)(2)(D).

"(3) TEACHING HOSPITAL.—The term 'teaching hospital' means a hospital which has a teaching program approved as specified in section 1861(b)(6).".

(2) CONFORMING AMENDMENTS.—(A) Section 1833(a)(1)(N) (42 U.S.C. 1395l(a)(1)(N)) is amended by inserting "(subject to reduction under section 1849)" after "1848(a)(1)".

(B) Section 1848(a)(1)(B) (42 U.S.C. 1395w-4(a)(1)(B)) is amended by striking "this subsection," and inserting "this subsection and section 1849,".

(b) REQUIRING PHYSICIANS TO IDENTIFY HOSPITAL AT WHICH SERVICE FURNISHED.—Section 1848(g)(4)(A)(i) (42 U.S.C. 1395w-4(g)(4)(A)(i)) is amended by striking "beneficiary," and inserting "beneficiary (and, in the case of a service furnished to an inpatient of a hospital, report the hospital identification number on such claim form),".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 1998.

SEC. 8305. MEDICARE SECONDARY PAYER.

(a) EXTENSION OF DATA MATCH.—

(1) Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

(b) REPEAL OF SUNSET ON APPLICATION TO DISABLED EMPLOYEES OF EMPLOYERS WITH MORE THAN 100 EMPLOYEES.—Section 1862(b)(1)(B)(iii) (42 U.S.C. 1395y(b)(1)(B)(iii)) is amended—

(1) in the heading, by striking "SUNSET" and inserting "EFFECTIVE DATE"; and

(2) by striking ", and before October 1, 1998".

(c) PROVISIONS RELATING TO END STAGE RENAL DISEASE BENEFICIARIES.—

(1) EXTENSION OF PERIOD.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended in the second sentence by striking "and on or before October 1, 1998,".

(2) CLARIFICATION OF SECONDARY PAYER FOR BENEFICIARIES COVERED UNDER GROUP HEALTH PLANS.—Effective as if included in the enactment of OBRA-1993, section 1862(b)(1)(C)(i) (42 U.S.C. 1395y(b)(1)(C)(i)) is amended—

(A) by inserting "(or a member of the individual's family) who is covered under the plan by virtue of the individual's current employment status with an employer" after "an individual"; and

(B) by inserting "solely" after "this title".

(d) PENALTY FOR LATE PAYMENT.—Section 1862(b)(2)(B)(i) (42 U.S.C. 1395y(b)(2)(B)(i)) is amended by adding at the end the following: "If a primary plan fails to make such reimbursement during the 60-day period that begins on the date such notice or other information is received, the amount required to be reimbursed