the wing's first Air Force inspection in July, 1995, the first ever for a composite wing and the largest in Air Force history; and

''Whereas, the opening of a training range near Mountain Home Air Force Base is essential to maintain the readiness and strike force capabilities of this unique military asset:

Now, therefore, be it ''*Resolved,* by the members of the Second Regular Session of the Fifty-third Idaho Legislature, the House of Representatives and the Senate concurring therein, That we urge the Congress of the United States to pass necessary legislation to establish and fund the training range at the Mountain Home Air Force Base, Idaho.

''*Be it further resolved,* That the Chief Clerk of the House of Representatives be, and she is hereby authorized and directed to forward a copy of this Memorial to the President of the Senate and the Speaker of the House of Representatives of Congress, and the congressional delegation representing the State of Idaho in the Congress of the United States.''

POM–579. A joint resolution adopted by the Legislature of the State of Alaska; to the Committee on Commerce, Science, and Transportation.

''RESOLVE NO. 39

''Whereas more fish were discarded in the federally managed fisheries of the North Pacific Ocean than were landed by American fishermen in the North Atlantic Ocean in 1992; and

''Whereas, in 1994, 25,881,596 kilograms of halibut and 1,866,272 kilograms of herring were discarded by fisheries in the North Pacific Ocean and the Bering Sea; and

''Whereas, in 1994, 15,459,253 crab were discarded by fisheries in the North Pacific Ocean and the Bering Sea; and

''Whereas, in 1994, 195,609 salmon were harvested in groundfish fisheries of the North Pacific Ocean and the Bering Sea; and

''Whereas these discarded herring, crab, and salmon are resources managed by the State of Alaska that were intercepted in offshore federal waters; and

''Whereas these resources are the economic and cultural lifeblood for many Alaskans who depend on the sea for their livelihoods and subsistence; and

''Whereas marine wildlife species in Alaska marine waters that depend on fish for food are faced with declining populations and a potential listing as endangered species; and

''Whereas this continued wanton waste undermines any long-term management strategy for sustained commercial, subsistence, and recreational fisheries, and places the rural communities of Alaska at risk; and

''Whereas efforts to implement severe penalties against vessels responsible for high bycatch and discard rates have failed; and

''Whereas minimizing the catch of undersized fish and reducing wanton waste will conserve fisheries resources for present and future generations of subsistence users, commercial and recreational fishermen, seafood industries, coastal communities, consumers, and the nation; and

''Whereas fisheries can technically or operationally reduce waste and the incidental taking of nontarget species if given economic incentives or if appropriate regulatory measures are applied; be it

''*Resolved,* by the Alaska State Legislature That the wanton waste now occurring in federal fisheries of the North Pacific Ocean and the Bering Sea is of utmost ecological, social, and economical importance; and be it

''*Further resolved,* That the Alaska State Legislature respectfully urges the Congress to amend the Magnuson Fishery Conservation and Management Act, or to enact other legislation, encompassing a broad range of measures to reduce wanton waste in North Pacific Ocean and Bering Sea fisheries, including harvest priority incentives for clean fishing practices and other management tools.''

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. SPECTER, from the Select Committee on Intelligence, with amendments:

S. 1745. An original bill to authorize appropriations for fiscal year 1997 for military activities of the Department of Defense, for military construction, and for defense activities of the Department of Energy, to prescribe personnel strengths for such fiscal year for the Armed Forces, and for other purposes (Rept. No. 104–278).

By Mr. STEVENS, from the Committee on Governmental Affairs, without amendment:

S. 1488. A bill to convert certain excepted service positions in the United States Fire Administration to competitive service positions, and for other purposes.

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second time by unanimous consent, and referred as indicated:

By Mr. DOLE (for himself, Mr. ROTH, Mr. SIMPSON, Mr. PRESSLER, Mr. HATCH, Mr. CHAFEE, Mr. MURKOWSKI, and Mr. COCHRAN):

S. 1856. A bill to establish a commission to study and provide recommendations on restoring solvency in the medicare program under title XVIII of the Social Security Act; to the Committee on Finance.

By Mr. DOLE:

S. 1857. A bill to establish a bipartisan commission on campaign practices and provide that its recommendations be given expedited consideration; to the Committee on Rules and Administration.

By Mr. GRAHAM (for himself, Mr. BAUCUS, and Mr. PRYOR):

S. 1858. A bill to provide for improved coordination, communication, and enforcement related to health care fraud, waste, and abuse; to the Committee on Finance.

By Mr. GRAHAM (for himself and Mr. BAUCUS):

S. 1859. A bill to create a point of order against legislation which diverts savings achieved through medicare waste, fraud, and abuse enforcement activities for purposes other than improving the solvency of the Federal Hospital Insurance Trust Fund under title XVIII of the Social Security Act, to ensure the integrity of such trust fund, and for other purposes; to the Committee on Rules and Administration.

By Mr. MCCONNELL (for himself, Mr. DOLE, Mr. MOYNIHAN, and Mr. LIEBERMAN):

S. 1860. A bill to provide for legal reform and consumer compensation relating to motor vehicle tort systems, and for other purposes; to the Committee on Commerce, Science, and Transportation.

S. 1861. A bill to provide for legal reform and consumer compensation, and for other purposes; to the Committee on the Judiciary.

By Mr. PRESSLER (for himself and Mr. HATCH):

S. 1862. A bill to permit the interstate distribution of state-inspected meat under appropriate circumstances; to the Committee on Agriculture, Nutrition, and Forestry.

By Mr. DASCHLE:

S. 1863. A bill to require the Secretary of the Army to acquire permanent flowage and saturation easements over land that is located within the 10-year floodplain of the James River, South Dakota, and for other purposes; to the Committee on Environment and Public Works.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. NICKLES (for himself, Mr. DASCHLE, Mr. LOTT, Mr. FORD, Mr. THURMOND, Mrs. KASSEBAUM, Mr. ABRAHAM, Mr. AKAKA, Mr. ASHCROFT, Mr. BAUCUS, Mr. BENNETT, Mr. BIDEN, Mr. BINGAMAN, Mr. BOND, Mrs. BOXER, Mr. BRADLEY, Mr. BREAUX, Mr. BROWN, Mr. BRYAN, Mr. BUMPERS, Mr. BURNS, Mr. BYRD, Mr. CAMPBELL, Mr. CHAFEE, Mr. COATS, Mr. COCHRAN, Mr. COHEN, Mr. CONRAD, Mr. COVERDELL, Mr. CRAIG, Mr. D'AMATO, Mr. DEWINE, Mr. DODD, Mr. DOMENICI, Mr. DORGAN, Mr. EXON, Mr. FAIRCLOTH, Mr. FEINGOLD, Mrs. FEINSTEIN, Mr. FRIST, Mr. GLENN, Mr. GORTON, Mr. GRAHAM, Mr. GRAMM, Mr. GRAMS, Mr. GRASSLEY, Mr. GREGG, Mr. HARKIN, Mr. HATCH, Mr. HATFIELD, Mr. HEFLIN, Mr. HELMS, Mr. HOLLINGS, Mrs. HUTCHISON, Mr. INHOFE, Mr. INOUYE, Mr. JEFFORDS, Mr. JOHNSTON, Mr. KEMPTHORNE, Mr. KENNEDY, Mr. KERREY, Mr. KERRY, Mr. KOHL, Mr. KYL, Mr. LAUTENBERG, Mr. LEAHY, Mr. LEVIN, Mr. LIEBERMAN, Mr. LUGAR, Mr. MACK, Mr. MCCAIN, Mr. MCCONNELL, Ms. MIKULSKI, Ms. MOSELEY-BRAUN, Mr. MOYNIHAN, Mr. MURKOWSKI, Mrs. MURRAY, Mr. NUNN, Mr. PELL, Mr. PRESSLER, Mr. PRYOR, Mr. REID, Mr. ROBB, Mr. ROCKEFELLER, Mr. ROTH, Mr. SANTORUM, Mr. SARBANES, Mr. SHELBY, Mr. SIMON, Mr. SIMPSON, Mr. SMITH, Ms. SNOWE, Mr. SPECTER, Mr. STEVENS, Mr. THOMAS, Mr. THOMPSON, Mr. WARNER, Mr. WELLSTONE, and Mr. WYDEN):

S. Res. 258. A resolution to designate the balcony adjacent to rooms S–230 and S–231 of the United States Capitol Building as the ''Robert J. Dole Balcony''; considered and agreed to.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. DOLE (for himself, Mr. ROTH, Mr. SIMPSON, Mr. PRESSLER, Mr. HATCH, Mr. CHAFEE, Mr. MURKOWSKI, and Mr. COCHRAN):

S. 1856. A bill to establish a commission to study and provide recommendations on restoring solvency in the Medicare program under title XVIII of the Social Security Act; to the Committee on Finance.

THE MEDICARE RESTORATION ACT

Mr. DOLE. Mr. President, last Wednesday the Medicare trustees released their report on the state of the Medicare trust fund, and the report was grim. Instead of going bankrupt in 2002, as they previously forecasted, the

trustees conclude that Medicare will go bankrupt in 2001—just 5 years from now.

For the past year and a half, this Republican Congress has attempted to deal honestly and forthrightly with the impending Medicare meltdown.

We put forward a budget that would protect, preserve, and strengthen Medicare by reducing its unsustainable rate of growth, while still allowing for a healthy growth rate.

We did not claim that our plan was perfect or that it solved the long-term problem. But it was a real attempt to alleviate a crisis that will immediately impact 37 million seniors and disabled Americans, and will have repercussions on tens of millions more.

In May 1995, I called for a bipartisan Commission to be set up to save Medicare similar to the one that saved Social Security. Unfortunately the White House dismissed the idea and decided to attack Republican plans to save the Medicare system.

That is why I rise today to introduce the Medicare Restoration Act to establish a blue-ribbon bipartisan advisory commission to help deal with this crisis.

In my view, leadership means more than just talking about problems. It also means doing something to solve them.

This Commission will be responsible for reviewing the current, short-term and long-term condition of the Medicare Trust funds. The Commission will be composed of 15 members appointed by the President, Senate, and House of Representatives. The members of this commission will be from both political parties, because it is clear to me that if we are to be successful we must put politics aside and work on a bipartisan basis.

Unfortunately, President Clinton has been unwilling to do that.

In February 1995, President Clinton submitted a budget that contained no provisions for saving Medicare.

In April 1995, the Medicare trustees—three of whom are members of his administration—issued their original report and urged ''prompt, effective and decisive action.'' The administration instead chose to attack Republican plans to save the system.

Last March, the President submitted a budget which, according to the Congressional Budget Office, would only stave off Medicare's bankruptcy for one more year.

It is an undeniable fact that the Republican proposal allowed Medicare spending per beneficiary to increase from $4,800 per person to $7,200 per person over 7 years.

It is also an undeniable fact that in their ill-fated health care reform proposal, the Clinton administration advocated slowing Medicare's rate of growth.

Despite these facts, however, the President vetoed our Medicare proposal, and we have heard nothing but attacks on Republicans for slashing and cutting Medicare.

And when the President was asked, not long ago at a news conference, why he continued to use these terms even though they are not true, his response was essentially that the media made him do it.

With the release of the trustee's report, the inescapable conclusion is that while the rhetoric flew, Medicare was put at further risk.

And those who say that talk is cheap should know that 18 months of misleading rhetoric may have gained one side points in the opinion polls, it also put Medicare another $90 billion-plus in the red.

The bottom line is that the 37 million Americans who depend on Medicare deserve better. Future generations of Americans who will need Medicare deserve better.

I call on the President to come forward and support this bipartisan commission so we can preserve the Medicare Program and to join with Republicans on a bipartisan basis, as I have proposed before, to address this very serious problem.

I send the bill to the desk and ask it be appropriately referred. It is cosponsored by Senators ROTH, SIMPSON, PRESSLER, HATCH, CHAFEE, and MURKOWSKI, who are on the Senate Finance Committee. I certainly welcome additional cosponsors on either side of the aisle. This will be a bipartisan commission.

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

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

S. 1856

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medicare Restoration Act of 1996''.

SEC. 2. ESTABLISHMENT.

There is established a commission to be known as the National Commission on Medicare Reform (referred to in this Act as the ''Commission'').

SEC. 3. FINDINGS.

The Congress finds that—

(1) the medicare program under title XVIII of the Social Security Act provides essential health care insurance to this Nation's senior citizens and to individuals with disabilities;

(2) the Federal Hospital Insurance Trust Fund will be bankrupt in the year 2001, and faces even greater solvency problems in the long-run with the aging of the baby boom generation;

(3) the trustees of the trust funds of the medicare program have reported that growth in spending within the Federal Supplementary Medical Insurance Trust Fund is unsustainable; and

(4) expeditious action is needed in order to restore the fiscal health of the medicare program and to maintain this Nation's commitment to senior citizens and to individuals with disabilities.

SEC. 4. DUTIES OF THE COMMISSION.

The Commission shall—

(1) review relevant analyses of the current, short-term, and long-term financial condition of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund under title XVIII of the Social Security Act;

(2) identify problems that threaten the solvency of such trust funds;

(3) analyze potential solutions to such problems that will both assure the financial integrity of the medicare program under such title and the provision of appropriate benefits under such program;

(4) make recommendations to restore the short-range and long-range solvency of the Federal Hospital Insurance Trust Fund, to provide for sustainable growth of the Supplementary Medical Insurance Trust Fund, and on related matters as the Commission deems appropriate; and

(5) review and analyze such other matters as the Commission deems appropriate.

SEC. 5. MEMBERSHIP.

(a) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members, of whom—

(1) five shall be appointed by the President, of whom not more than 3 shall be of the same political party;

(2) five shall be appointed by the Majority Leader of the Senate, in consultation with the Minority Leader of the Senate, of whom not more than 3 shall be of the same political party; and

(3) five shall be appointed by the Speaker of the House of Representatives, in consultation with the Minority Leader of the House of Representatives, of whom not more than 3 shall be of the same political party.

(b) COMPTROLLER GENERAL.—The Comptroller General of the United States shall advise the Commission on the methodology to be used in identifying problems and analyzing potential solutions in accordance with section 4.

(c) TERM OF APPOINTMENT.—The members shall serve on the Commission for the life of the Commission.

(d) MEETINGS.—The Commission shall locate its headquarters in the District of Columbia, and shall meet at the call of the Chairperson.

(e) QUORUM.—Ten members of the Commission shall constitute a quorum, but a lesser number may hold hearings.

(f) CHAIRPERSON AND VICE CHAIRPERSON.—Not later than 15 days after all the members of the Commission are appointed, such members shall designate a Chairperson and Vice Chairperson from among the members of the Commission.

(g) VACANCIES.—A vacancy on the Commission shall be filled in the manner in which the original appointment was made not later than 30 days after the Commission is given notice of the vacancy.

(h) COMPENSATION.—Members of the Commission shall receive no additional pay, allowances, or benefits by reason of their service on the Commission.

(i) EXPENSES.—Each member of the Commission shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

SEC. 6. STAFF AND SUPPORT SERVICES.

(a) DIRECTOR.—

(1) APPOINTMENT.—Upon consultation with the members of the Commission, the Chairperson shall appoint a Director of the Commission.

(2) COMPENSATION.—The Director shall be paid the rate of basic pay for level V of the Executive Schedule.

(b) STAFF.—With the approval of the Commission, the Director may appoint such personnel as the Director considers appropriate.

(c) APPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of

title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title relating to classification and General Schedule pay rates.

(d) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the Director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(e) STAFF OF FEDERAL AGENCIES.—Upon the request of the Commission, the head of any Federal agency may detail any of the personnel of such agency to the Commission to assist in carrying out the duties of the Commission.

(f) OTHER RESOURCES.—The Commission shall have reasonable access to materials, resources, statistical data, and other information from the Library of Congress and agencies and elected representatives of the executive and legislative branches of the Federal Government. The Chairperson of the Commission shall make requests for such access in writing when necessary.

(g) PHYSICAL FACILITIES.—The Administrator of the General Services Administration shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals required for the proper functioning of the Commission.

SEC. 7. POWERS OF COMMISSION.

(a) HEARINGS.—The Commission may conduct public hearings or forums at the discretion of the Commission, at any time and place the Commission is able to secure facilities and witnesses, for the purpose of carrying out the duties of the Commission.

(b) DELEGATION OF AUTHORITY.—Any member or agent of the Commission may, if authorized by the Commission, take any action the Commission is authorized to take by this section.

(c) GIFTS, BEQUESTS, AND DEVISES.—The Commission may accept, use, and dispose of gifts, bequests, or devises of services or property, both real and personal, for the purpose of aiding or facilitating the work of the Commission. Gifts, bequests, or devises of money and proceeds from sales of other property received as gifts, bequests, or devises shall be deposited in the Treasury and shall be available for disbursement upon order of the Commission.

(d) MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as other Federal agencies.

SEC. 8. REPORTS.

Not later than June 30, 1997, the Commission shall submit a report to the President and to the Congress on the findings and conclusions of the Commission.

SEC. 9. TERMINATION.

The Commission shall terminate on the date which is 30 days after the date the Commission submits its report to the President and to the Congress under section 8.

SEC. 10. FUNDING.

The Secretary of Health and Human Services shall provide to the Commission, out of funds otherwise available to such Secretary, such sums as are necessary to carry out the purposes of the Commission.

Mr. ROTH. Mr. President, I rise as a cosponsor of legislation introduced by the majority leader to establish a National Commission on Medicare Reform.

According to the Medicare trustees' report released last Wednesday, June 5, the Medicare hospital insurance trust fund will be bankrupt earlier than expected. In fact, the trustees, of which three of the six trustees are members of President Clinton's Cabinet, indicate that the trust fund may run out of money as early as calendar year 2000.

Senator DOLE's proposal is consistent with the recommendations of the Medicare trustees. The trustees recommend:

* * * the establishment of a national advisory group to examine the Medicare Program. The advisory group would collect and disseminate information and help develop recommendations for effective solutions to the long-term financing problem. This work will be of critical importance to the administration, the Congress and the American public in the extensive national discussion that any changes would require.

We are now 2 years closer to insolvency of the Medicare trust fund than we were at this time last year. We lost a year trying to address the problem, and the program is 1 more year closer to bankruptcy than we expected. Yet, I regret, we are miles away from reaching an agreement on a solution.

Given the very short time that Medicare will remain solvent, and given the large number of baby boomers who will be joining the Medicare Program in just a few years, we cannot afford more delay. It is time to put politics aside and find a solution.

What is happening to the Medicare trust fund is pretty basic. The program is paying out more than it is taking in. This simple dynamic, if left unchecked, will lead Medicare to bankruptcy in less than 5 years. And, simply put, bankruptcy of the trust fund means there will not be money to pay the hospital bills of our senior citizens and disabled individuals reliant on Medicare.

Again, I believe it is time to put politics aside. A Medicare Reform Commission is an important step in the right direction to bringing together a bipartisan, lasting agreement on resolving Medicare's fiscal crisis.

The 1983 National Commission on Social Security Reform was an essential catalyst to resolving the then-looming bankruptcy of Social Security. The 1983 Commission brought together people in a cooperative bipartisan spirit. Ultimately, the work of the Commission laid the ground for a solution to the solvency crisis. I believe a Medicare Reform Commission might be able to do the same today.

We are facing a crisis. A crisis requires action. We cannot be a government of empty promises. We must restore Medicare to robust health for our children and our grandchildren.

By Mr. DOLE:

S. 1857. A bill to establish a bipartisan commission on campaign practices and provide that its recommendations be given expedited consideration; to the Committee on Rules and Administration.

THE BIPARTISAN CAMPAIGN PRACTICES COMMISSION ACT OF 1996

Mr. DOLE. Mr. President, as I prepare to leave an institution in which I have served for over 35 years, I am mindful that in many ways the public has lost confidence in the ability of legislators to represent their interests, not special interests.

We should not allow this to continue. Representative Democracy, founded on fair and competitive elections, is at the core of what makes America great. Yet, concern over how we finance elections threatens to erode the trust the American people have in our elected officials.

As my colleagues know, Congress has tried repeatedly to grapple with this issue and largely failed. However, I continue to believe that the very nature of the problem makes it difficult to resolve in the normal give and take of the legislative process.

In 1990, for example, Senator Mitchell and I appointed a six-member commission of outside experts to look at this issue and report back to us, but the report was unfortunately ignored by Congress.

I suggested in 1994 and repeatedly since then that a similar commission be constituted to report back to Congress, but with an important difference. This time, the report should be in the form of recommended legislative language which provides a solution and Congress should have an opportunity for an up and down vote.

As my colleagues know, both President Clinton and Speaker GINGRICH endorsed a similar concept last year when they met in New Hampshire.

I therefore send to the desk a bill that establishes an eight-member commission of outside experts. They would have the broadest possible mandate to think through this problem, come up with solutions and report back to Congress not more than 30 days after the convening of the 105th Congress.

The commission will send Congress legislative language for those recommendations on which seven members agree. Congress will consider those recommendations under expedited procedures that mirror the fast-track authorities in our trade laws.

I know my colleagues will be grappling with this issue soon. However, I believe that it would be better to take this issue out of what is already a super-heated partisan atmosphere, and allow a bipartisan approach to be developed that Congress cannot ignore.

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

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

S. 1857

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Bipartisan Campaign Practices Commission Act of 1996''.

SEC. 2. ESTABLISHMENT.

There is established a commission to be known as the ''Bipartisan Commission on

Campaign Practices'' (referred to in this Act as the ''Commission'').

SEC. 3. DUTIES OF THE COMMISSION.

The Commission shall study the laws and regulations that affect how campaigns for Federal office are conducted and may make recommendations for change. In studying Federal campaign practices, the Commission shall consider—

(1) whether too much or too little money is spent trying to influence campaigns for Federal office and whether the funds that are spent are sufficiently disclosed;

(2) whether the current laws (including regulations) governing campaigns for Federal office encourage or discourage those most qualified to hold office from seeking it;

(3) whether the existing system of financing campaigns for Federal office promotes trust and confidence in the political process among the electorate;

(4) whether the rules governing access to media ensure that the electorate has the greatest possible opportunity to be informed of candidates' positions on the issues; and

(5) such other matters as the Commission considers appropriate.

SEC. 4. MEMBERSHIP.

(a) COMPOSITION.—The Commission shall be composed of 9 members of the private sector, as follows:

(1) Two shall be appointed by the Majority Leader of the Senate.

(2) Two shall be appointed by the Speaker of the House of Representatives.

(3) Two shall be appointed by the President.

(4) One shall be appointed by the Minority Leader of the Senate.

(5) One shall be appointed by the Minority Leader of the House of Representatives.

(6) A chairperson shall be appointed in accordance with subsection (b).

(b) CHAIRPERSON.—

(1) SELECTION.—Within 7 days after all the members described in section 3(a) (1) through (5) are appointed, those members shall meet and by majority vote select a chairperson.

(2) FAILURE TO MAKE SELECTION.—If, by the date that is 30 days after the date of the meeting described in subsection (b), the office of chairperson is still vacant, all current members of the Commission shall be discharged from further service as members of the Commission.

(c) VACANCIES.—A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

(d) COMPENSATION.—Each member of the Commission shall each be entitled to receive the daily equivalent of the annual rate of basic pay in effect for level V of the Executive Schedule under section 5316 of title 5, United States Code, for each day during which the member is engaged in the actual performance of the duties of the Commission.

(e) QUORUM.—Six members of the Commission shall constitute a quorum, and any decision of the Commission shall require the affirmative vote of 6 members.

(f) MEETINGS.—The Commission shall meet at the call of the chairperson or at the request of 6 members of the Commission.

SEC. 5. STAFF OF COMMISSION; SERVICES.

Subject to such rules as may be adopted by the Commission, the chairperson, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service and without regard to the provisions of chapter 51 and subchapter III of chapter 53 of that title relating to classifications and General Schedule pay rates, may appoint such staff personnel as the chairperson considers necessary and procure temporary and intermittent services to the same extent as is authorized by section 3109(b) of title 5, United States Code.

SEC. 6. RECOMMENDATION; FAST TRACK PROCEDURES.

(a) REPORT.—Not later than 30 days after the convening of the 105th Congress, the Commission shall submit to Congress a report describing the study conducted under section 3.

(b) RECOMMENDATIONS.—The report under subsection (a) may include any recommendations for changes in the laws (including regulations) governing the conduct of Federal campaigns, including any changes in the rules of the Senate or the House of Representatives, to which 6 or more members of the Commission may agree.

(c) PREPARATION OF BILLS.—If 7 or more members concur on 1 or more recommendations for changes in the way campaigns for Federal office are conducted, the members agreeing on each such recommendation shall prepare for each a bill that would implement the recommendation, and the implementing bill shall be submitted with the report under subsection (a).

(d) CONSIDERATION BY CONGRESS.—Each implementing bill submitted with the report under subsection (a) shall be given expedited consideration under the same provisions and in the same way as an implementing bill for a trade agreement under section 151 of the Trade Act of 1974 (19 U.S.C. 2191).

SEC. 7. TERMINATION.

The Commission shall cease to exist 30 days after submission of the report under section 6.

SEC. 8. AUTHORIZATION OF APPROPRIATIONS.

There is authorized to be appropriated $750,000 to carry out this Act.

By Mr. GRAHAM (for himself, Mr. BAUCUS and Mr. PRYOR):

S. 1858. A bill to provide for improved coordination, communication, and enforcement related to health care fraud, waste, and abuse; to the Committee on Finance.

THE MEDICARE ANTI-FRAUD ACT OF 1996

By Mr. GRAHAM (for himself, and Mr. BAUCUS):

S. 1859. A bill to create a point of order against legislation which diverts savings achieved through medicare waste, fraud, and abuse enforcement activities for purposes other than improving the solvency of the Federal hospital insurance trust fund under title XVIII of the Social Security Act, to ensure the integrity of such trust fund, and for other purposes; to the Committee on Rules and Administration.

THE MEDICARE RESTORE TRUST ACT OF 1996

Mr. GRAHAM. Mr. President, I rise today to introduce timely legislation with Senators BAUCUS and PRYOR that addresses the problem of Medicare fraud and abuse. The two bills, entitled the ''Medicare Anti-Fraud Act of 1996'' and the ''Medicare Restore Trust Act of 1996,'' would undertake serious and strong anti-fraud efforts by the Federal Government based in large part on the success of the administration's recent Medicare and antifraud effort called Operation Restore Trust and ensure that savings achieved from such efforts are returned to the Medicare trust fund.

Mr. President, we have heard in the last few days some very troubling reports about the impending insolvency of the Medicare trust fund. This legislation would have two direct contributions to reversing that move toward insolvency.

First, it would suture a hemorrhage of funds out of the Medicare trust fund which today are going for fraudulent bills, and not for service to American citizens; and, second, it would assure that any funds that were recovered as a result of these more effective investigations and prosecutions would go directly back into the Medicare trust fund in order to restore its financial base.

Mr. President, unfortunately the phrase ''fraud, waste and abuse'' has become discredited. It has been used so often as an excuse for not dealing with the more difficult and fundamental problems. Unfortunately, the area of Medicare waste, fraud, and abuse is a part of the fundamental problem. It has been estimated that of the $180 billion spent last year on Medicare and on approximately 36 million Americans' health care—$180 billion—10 percent, or $18 billion, was wasted in fraudulent activities.

You might ask why is there such a high level of fraud in this program of Medicare? Some of the reasons include: The amount of money that is being expended is huge—$180 billion and growing; that it is being spent largely on populations which have groups within it that are vulnerable to these fraudulent schemes; that those people who wish to perpetrate those schemes are sophisticated shysters and there has been lax enforcement.

First and foremost, the General Accounting Office estimates that the Medicare waste, fraud and abuse rip-off rate is about 10 percent. With fraud pilfering the health systems' resources, losses to Medicare and the federal share of Medicaid could be $30 billion annually. Using the most conservative of estimates, we could cover an additional 2 million seniors a year with funds lost just to Medicare waste, fraud, and abuse.

Two million additional Americans could be covered if those funds could be properly directed.

Although it is increasingly unlikely that a Medicare reform package will pass this year in Congress, it would be unconscionable to not pass a Medicare waste, fraud and abuse this year. Rather than putting Medicare beneficiaries at risk of losing coverage or access with the cuts envisioned in some legislative proposals during this Congress, we should act instead to combat Medicare fraud to protect the health care of beneficiaries and the Medicare trust fund.

As the Citizens Against Government Waste wrote in their August 23, 1995, report entitled ''Medicare Fraud: Tales From the Gypped,'' ''Preserving, protecting, and strengthening Medicare must be the number one priority for Congress and the administration.'' The organization details 89 examples in its report and advises that waste, fraud,

and abuse is the first area of needed attack.

How did this get to be such a problem? According to the General Accounting Office in its February 1995 report entitled ''Medicare Claims,'' ''Physicians, supply companies, or diagnostic laboratories have about 3 chances out of 1,000 of having Medicare audit their billing practices in any given year. Moreover, Medicare pays more claims with less scrutiny today than at any other time over the past 5 years.'' The GAO continues, ''In fiscal year 1993, Medicare processed almost 700 million claims, about 250 million more than it processed 5 years earlier. Despite the rising volume of claims, per-claim funding for antifraud and antiabuse activities declined between 1989 and 1993 by over 20 percent.''

As a result, FBI Director Louis Freeh says cocaine distributors in south Florida and southern California are switching from drug dealing to health care fraud. The reason: more money with less risk. Drug dealers committing health care fraud know that law enforcement is not yet equipped with the laws needed to effectively attack the problem. With a program estimated by the Congressional Budget Office to be spending over $1.6 billion during the next 6 years and with lax laws to combat abuse, con artists, thieves, and opportunists know Medicare is where the easy money is.

As Republican Congressmen STEVEN SCHIFF and CHRIS SHAYS write, ''currently there is no Federal crime of health care fraud. It is difficult to prosecute health care-related offenses because law enforcement must rely on wire and mail fraud statutes for their investigations and prosecutions.''

Attacking fraud is crucial to the overall Medicare debate for the following reasons:

Fraud ought to be the first place we look when considering reductions in Medicare expenditures.

Fraud undermines public confidence in Medicare. We cannot ''fix'' Medicare while letting fraud erode the system.

One dollar spent against fraud and abuse can reduce Medicare Program costs by as much as 11 dollars, according to the Health Care Financing Administration [HCFA] and demonstrated by the administration's effort in Operation Restore Trust.

Solutions are available.

What can be done to solve this problem? To engage in a comprehensive assault on fraud, particularly within the Medicare Program, multiple agencies within the Federal Government will need additional resources. The Inspector General testified at a hearing before the Senate Finance Committee that ''now is the time to implement new legal remedies and reverse the downward trend of funding for efforts to combat health care fraud and abuse.'' The legislation that I am introducing today will achieve both of these goals.

Operation Restore Trust is an effort currently underway in five States which brings together the HHS Office of Inspector General, Health Care Financing Administration, the Department of Justice, State Medicaid agencies, and State Medicaid fraud control units to combat fraud and abuse. This legislation would institutionalize these efforts in all 50 States.

The Department of Health and Human Services recently released results from the first year of Operation Restore Trust. The program had $4.09 million to work with and has added $43.2 million to the Medicare trust fund and U.S. Treasury: an 11-to-1 return. This program has been a great success, but I agree with June Gibbs Brown that this is the ''tip of the iceberg.''

To provide adequate resources to go after the fraud and abuse, we establish a Medicare anti-fraud account for the Inspector General (IG) and an antifraud control account for other government agency's use. Funds for the Medicare account would be provided by and returned to the Medicare trust fund. For every $1 spent on prevention, the IG uncovers at least $7 in fraud. By using trust fund dollars to augment IG operations, the legislation assures that the IG will continue to have the resources necessary to combat fraud and abuse without worrying about discretionary spending cuts.

This legislation enacts a broad-based Federal statute aimed at suppressing Medicare fraud. This enhances the protection of fraud victims and prescribe stiff penalties against those convicted of fraud. It institutes a policy, ''one strike and you are out,'' one instance of Medicare fraud and you are out of the program for at least 5 years.

The second bill would establish a point of order against any piece of legislation that would divert savings from anti-fraud, waste and abuse enforcement activities for any other purpose—such as new Federal spending or tax breaks—other than saving the Medicare trust fund. This legislation would also ensure that any savings from antifraud, waste and abuse activities reimburse the up-front investment on enforcement and further strengthen the Medicare trust fund.

We have all promised to protect Medicare. We can do so by passing comprehensive Medicare waste, fraud, and abuse legislation and do it in 1996, thus ensuring savings achieved are used to protect Medicare and improve its solvency. The two bills we are introducing today—the Medicare Anti-Fraud Act of 1996 and the Medicare Restore Trust Act—would accomplish these goals.

Mr. President, I suggest these two pieces of legislation should get the immediate attention of this Senate. I am pleased to see that we have with us today the chairman of the Senate Finance Committee, which I assume will be the primary committee of reference for consideration of this legislation.

Every day that passes allows for further waste of Federal taxpayers money and further eroding of the solvency of the Medicare trust fund, further erosion of the confidence of the American people. We must take action now.

At the signing of the Medicare bill in Missouri 30 years ago, President Johnson said Medicare had been planted with ''the seed of compassion and duty which have today flowered into care for the sick and serenity for the fearful.'' Medicare has lived up to the promise of President Johnson and President Truman. But fraud is rotting away at the Medicare system. We have the prescriptions to combat fraud. Now is the time to employ them if we want to save the integrity of Medicare for future generations.

Mr. President, I ask unanimous consent that the text of the bills be printed in the RECORD.

There being no objection, the bills were ordered to be printed in the RECORD, as follows:

S. 1858

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

SECTION 1. SHORT TITLE; REFERENCES IN ACT; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Antifraud Act of 1996''.

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

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

TITLE I—FRAUD AND ABUSE CONTROL PROGRAM

SEC. 101. FRAUD AND ABUSE CONTROL PROGRAM.

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

''FRAUD AND ABUSE CONTROL PROGRAM

''SEC. 1128C. (a) ESTABLISHMENT OF PROGRAM.—

''(1) IN GENERAL.—Not later than January 1, 1997, the Secretary, acting through the Office of the Inspector General of the Department of Health and Human Services, and the Attorney General shall establish a program—

''(A) to coordinate Federal, State, and local law enforcement programs to control fraud and abuse with respect to health plans,

''(B) to conduct investigations, audits, evaluations, and inspections relating to the delivery of and payment for health care in the United States,

''(C) to facilitate the enforcement of the provisions of sections 1128, 1128A, and 1128B and other statutes applicable to health care fraud and abuse,

''(D) to provide for the modification and establishment of safe harbors and to issue advisory opinions and special fraud alerts pursuant to section 104 of the Medicare Antifraud Act of 1996, and

''(E) to provide for the reporting and disclosure of certain final adverse actions against health care providers, suppliers, or practitioners pursuant to the data collection system established under section 301 of such Act.

''(2) COORDINATION WITH HEALTH PLANS.—In carrying out the program established under paragraph (1), the Secretary and the Attorney General shall consult with, and arrange for the sharing of data with representatives of health plans.

''(3) GUIDELINES.—

''(A) IN GENERAL.—The Secretary and the Attorney General shall issue guidelines to carry out the program under paragraph (1). The provisions of sections 553, 556, and 557 of title 5, United States Code, shall not apply in the issuance of such guidelines.

''(B) INFORMATION GUIDELINES.—

''(i) IN GENERAL.—Guidelines issued under subparagraph (A) shall include guidelines relating to the furnishing of information by health plans, providers, and others to enable the Secretary and the Attorney General to carry out the program (including coordination with health plans under paragraph (2)).

''(ii) CONFIDENTIALITY.—Guidelines issued under subparagraph (A) shall include procedures to assure that such information is provided and utilized in a manner that appropriately protects the confidentiality of the information and the privacy of individuals receiving health care services and items.

''(iii) QUALIFIED IMMUNITY FOR PROVIDING INFORMATION.—The provisions of section 1157(a) (relating to limitation on liability) shall apply to a person providing information to the Secretary or the Attorney General in conjunction with their performance of duties under this section.

''(4) ENSURING ACCESS TO DOCUMENTATION.—The Inspector General of the Department of Health and Human Services is authorized to exercise such authority described in paragraphs (3) through (9) of section 6 of the Inspector General Act of 1978 (5 U.S.C. App.) as necessary with respect to the activities under the fraud and abuse control program established under this subsection.

''(5) AUTHORITY OF INSPECTOR GENERAL.—Nothing in this Act shall be construed to diminish the authority of any Inspector General, including such authority as is provided in the Inspector General Act of 1978 (5 U.S.C. App.).

''(b) ADDITIONAL USE OF FUNDS BY INSPECTOR GENERAL.—

''(1) REIMBURSEMENTS FOR INVESTIGATIONS.—The Inspector General of the Department of Health and Human Services is authorized to receive and retain for current use reimbursement for the costs of conducting investigations and audits and for monitoring compliance plans when such costs are ordered by a court, voluntarily agreed to by the payor, or otherwise.

''(2) CREDITING.—Funds received by the Inspector General under paragraph (1) as reimbursement for costs of conducting investigations shall be deposited to the credit of the appropriation from which initially paid, or to appropriations for similar purposes currently available at the time of deposit, and shall remain available for obligation for 1 year from the date of the deposit of such funds.

''(c) HEALTH PLAN DEFINED.—For purposes of this section, the term 'health plan' means a plan or program that provides health benefits, whether directly, through insurance, or otherwise, and includes—

''(1) a policy of health insurance;

''(2) a contract of a service benefit organization; and

''(3) a membership agreement with a health maintenance organization or other prepaid health plan.''.

(b) ESTABLISHMENT OF HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT IN FEDERAL HOSPITAL INSURANCE TRUST FUND.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

''(k) HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—

''(1) ESTABLISHMENT.—There is hereby established in the Trust Fund an expenditure account to be known as the 'Health Care Fraud and Abuse Control Account' (in this subsection referred to as the 'Account').

''(2) APPROPRIATED AMOUNTS TO TRUST FUND.—

''(A) IN GENERAL.—There are hereby appropriated to the Trust Fund—

''(i) such gifts and bequests as may be made as provided in subparagraph (B);

''(ii) such amounts as may be deposited in the Trust Fund as provided in title XI; and

''(iii) such amounts as are transferred to the Trust Fund under subparagraph (C).

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

''(C) TRANSFER OF AMOUNTS.—The Managing Trustee shall transfer to the Trust Fund, under rules similar to the rules in section 9601 of the Internal Revenue Code of 1986, an amount equal to the sum of the following:

''(i) Criminal fines recovered in cases involving a Federal health care offense (as defined in section 982(a)(6)(B) of title 18, United States Code).

''(ii) Civil monetary penalties and assessments imposed in health care cases, including amounts recovered under titles XI, XVIII, and XIX, and chapter 38 of title 31, United States Code (except as otherwise provided by law).

''(iii) Amounts resulting from the forfeiture of property by reason of a Federal health care offense.

''(iv) Penalties and damages obtained and otherwise creditable to miscellaneous receipts of the general fund of the Treasury obtained under sections 3729 through 3733 of title 31, United States Code (known as the False Claims Act), in cases involving claims related to the provision of health care items and services (other than funds awarded to a relator, for restitution or otherwise authorized by law).

''(3) APPROPRIATED AMOUNTS TO ACCOUNT FOR FRAUD AND ABUSE CONTROL PROGRAM, ETC.—

''(A) DEPARTMENTS OF HEALTH AND HUMAN SERVICES AND JUSTICE.—

''(i) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund such sums as the Secretary and the Attorney General certify are necessary to carry out the purposes described in subparagraph (C), to be available without further appropriation, in an amount not to exceed—

''(I) for fiscal year 1997, $104,000,000;

''(II) for each of the fiscal years 1998 through 2003, the limit for the preceding fiscal year, increased by 15 percent; and

''(III) for each fiscal year after fiscal year 2003, the limit for fiscal year 2003.

''(ii) MEDICARE AND MEDICAID ACTIVITIES.—For each fiscal year, of the amount appropriated in clause (i), the following amounts shall be available only for the purposes of the activities of the Office of the Inspector General of the Department of Health and Human Services with respect to the medicare and medicaid programs—

''(I) for fiscal year 1997, not less than $60,000,000 and not more than $70,000,000;

''(II) for fiscal year 1998, not less than $80,000,000 and not more than $90,000,000;

''(III) for fiscal year 1999, not less than $90,000,000 and not more than $100,000,000;

''(IV) for fiscal year 2000, not less than $110,000,000 and not more than $120,000,000;

''(V) for fiscal year 2001, not less than $120,000,000 and not more than $130,000,000;

''(VI) for fiscal year 2002, not less than $140,000,000 and not more than $150,000,000; and

''(VII) for each fiscal year after fiscal year 2002, not less than $150,000,000 and not more than $160,000,000.

''(B) FEDERAL BUREAU OF INVESTIGATION.—There are hereby appropriated from the general fund of the United States Treasury and hereby appropriated to the Account for transfer to the Federal Bureau of Investigation to carry out the purposes described in subparagraph (C), to be available without further appropriation—

''(i) for fiscal year 1997, $47,000,000;

''(ii) for fiscal year 1998, $56,000,000;

''(iii) for fiscal year 1999, $66,000,000;

''(iv) for fiscal year 2000, $76,000,000;

''(v) for fiscal year 2001, $88,000,000;

''(vi) for fiscal year 2002, $101,000,000; and

''(vii) for each fiscal year after fiscal year 2002, $114,000,000.

''(C) USE OF FUNDS.—The purposes described in this subparagraph are to cover the costs (including equipment, salaries, benefits, travel, and training) of the administration and operation of the health care fraud and abuse control program established under section 1128C(a), including the costs of—

''(i) prosecuting health care matters (through criminal, civil, and administrative proceedings);

''(ii) investigations;

''(iii) financial and performance audits of health care programs and operations;

''(iv) inspections and other evaluations; and

''(v) provider and consumer education regarding compliance with the provisions of title XI.

''(4) APPROPRIATED AMOUNTS TO ACCOUNT FOR MEDICARE BENEFIT INTEGRITY SYSTEM.—

''(A) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund for each fiscal year such amounts as are necessary to carry out the Medicare Benefit Integrity System under section 1889, subject to subparagraph (B), to be available without further appropriation.

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

''(i) For fiscal year 1997, such amount shall be not less than $430,000,000 and not more than $440,000,000.

''(ii) For fiscal year 1998, such amount shall be not less than $490,000,000 and not more than $500,000,000.

''(iii) For fiscal year 1999, such amount shall be not less than $550,000,000 and not more than $560,000,000.

''(iv) For fiscal year 2000, such amount shall be not less than $620,000,000 and not more than $630,000,000.

''(v) For fiscal year 2001, such amount shall be not less than $670,000,000 and not more than $680,000,000.

''(vi) For fiscal year 2002, such amount shall be not less than $690,000,000 and not more than $700,000,000.

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

''(5) ANNUAL REPORT.—The Secretary and the Attorney General shall submit jointly an annual report to Congress on the amount of revenue which is generated and disbursed, and the justification for such disbursements, by the Account in each fiscal year.''.

SEC. 102. MEDICARE BENEFIT INTEGRITY SYSTEM.

Part C of title XVIII (42 U.S.C. 1395 et seq.) is amended by inserting after section 1888 the following new section:

''MEDICARE BENEFIT INTEGRITY CONTRACTS

''SEC. 1889. (a) AUTHORITY TO CONTRACT.—

''(1) IN GENERAL.—In order to improve the effectiveness of benefit quality assurance activities relating to programs under this title, and to enhance the Secretary's capability of carrying out program safeguard functions and related education activities to avoid the improper expenditure of assets of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, the Secretary shall enter into contracts with organizations or other entities having demonstrated the capability to carry out one or more benefit quality assurance activities. The provisions of sections 1816 and 1842 shall be inapplicable to contracts under this section.

''(2) NUMBER OF CONTRACTS.—The Secretary shall determine the number of separate contracts which are necessary to achieve, with the maximum degree of efficiency and cost-effectiveness, the objectives of this section. The Secretary may enter into contracts under this section at such time or times as are appropriate so long as not later than the fiscal year beginning October 1, 1998, and for each fiscal year thereafter, there are in effect contracts that, considered collectively, provide for benefit quality assurance activities with respect to all payments under this title.

''(b) CONTRACT REQUIREMENTS.—A benefit quality assurance contract entered into under subsection (a) must provide for one or more benefit quality assurance program activities. Each such contract shall include an agreement by the contractor to cooperate with the Inspector General of the Department of Health and Human Services, and the Attorney General, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this title and in other cases arising out of the activities described in such section, and shall contain such other provisions as the Secretary finds necessary or appropriate to achieve the purposes of this part. The provisions of section 1153(e)(1) shall apply to contracts and contracting authority under this section, except that competitive procedures must be used when entering into new contracts under this section, or at any other time when it is in the best interests of the United States. A contract under this section may be renewed from term to term without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

''(c) LIMITATIONS.—

''(1) IN GENERAL.—In carrying out this section, the Secretary may not enter into a contract with an organization or other entity if the Secretary determines that such organization's or entity's financial holdings, interests, or relationships would interfere with its ability to perform the functions to be required by the contract in an effective and impartial manner.

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

SEC. 103. APPLICATION OF CERTAIN HEALTH ANTIFRAUD AND ABUSE SANCTIONS TO FRAUD AND ABUSE AGAINST FEDERAL HEALTH PROGRAMS.

(a) CRIMES.—

(1) SOCIAL SECURITY ACT.—Section 1128B (42 U.S.C. 1320a–7b) is amended as follows:

(A) In the heading, by striking ''MEDICARE OR STATE HEALTH CARE PROGRAMS'' and inserting ''FEDERAL HEALTH CARE PROGRAMS''.

(B) In subsection (a)(1), by striking ''a program under title XVIII or a State health care program (as defined in section 1128(h))'' and inserting ''a Federal health care program (as defined in subsection (f))''.

(C) In subsection (a)(5), by striking ''a program under title XVIII or a State health care program'' and inserting ''a Federal health care program (as defined in subsection (f))''.

(D) In the second sentence of subsection (a)—

(i) by striking ''a State plan approved under title XIX'' and inserting ''a Federal health care program (as defined in subsection (f))''; and

(ii) by striking ''the State may at its option (notwithstanding any other provision of that title or of such plan)'' and inserting ''the administrator of such program may at its option (notwithstanding any other provision of such program)''.

(E) In subsection (b)—

(i) by striking ''and willfully'' each place it appears;

(ii) by striking ''$25,000'' each place it appears and inserting ''$50,000'';

(iii) by striking ''title XVIII or a State health care program'' each place it appears and inserting ''Federal health care program (as defined in subsection (f))'';

(iv) in paragraph (1) in the matter preceding subparagraph (A), by striking ''kind—'' and inserting ''kind with intent to be influenced—'';

(v) in paragraph (1)(A), by striking ''in return for referring'' and inserting ''to refer'';

(vi) in paragraph (1)(B), by striking ''in return for purchasing, leasing, ordering, or arranging for or recommending'' and inserting ''to purchase, lease, order, or arrange for or recommend'';

(vii) in paragraph (2) in the matter preceding subparagraph (A), by striking ''to induce such person'' and inserting ''with intent to influence such person'';

(viii) by adding at the end of paragraphs (1) and (2) the following sentence: ''A violation exists under this paragraph if one or more purposes of the remuneration is unlawful under this paragraph.'';

(ix) by redesignating paragraph (3) as paragraph (4);

(x) in paragraph (4) (as redesignated) in the matter preceding subparagraph (A), by striking ''Paragraphs (1) and (2)'' and inserting ''Paragraphs (1), (2), and (3)''; and

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

''(3)(A) The Attorney General may bring an action in the district courts to impose upon any person who carries out any activity in violation of this subsection a civil penalty of not less than $25,000 and not more than $50,000 for each such violation, plus three times the total remuneration offered, paid, solicited, or received.

''(B) A violation exists under this paragraph if one or more purposes of the remuneration is unlawful, and the damages shall be the full amount of such remuneration.

''(C) Section 3731 of title 31, United States Code, and the Federal Rules of Civil Procedure shall apply to actions brought under this paragraph.

''(D) The provisions of this paragraph do not affect the availability of other criminal and civil remedies for such violations.''.

(F) In subsection (c), by inserting ''(as defined in section 1128(h))'' after ''a State health care program''.

(G) By adding at the end the following new subsections:

''(f) For purposes of this section, the term 'Federal health care program' means—

''(1) any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded, in whole or in part, by the United States Government; or

''(2) any State health care program, as defined in section 1128(h).

''(g)(1) The Inspector General of the departments and agencies with a Federal health care program may conduct an investigation or audit relating to violations of this section and claims within the jurisdiction of other Federal departments or agencies if the following conditions are satisfied:

''(A) The investigation or audit involves primarily claims submitted to the Federal health care programs of the department or agency conducting the investigation or audit.

''(B) The Inspector General of the department or agency conducting the investigation or audit gives notice and an opportunity to participate in the investigation or audit to the Inspector General of the department or agency with primary jurisdiction over the Federal health care programs to which the claims were submitted.

''(2) If the conditions specified in paragraph (1) are fulfilled, the Inspector General of the department or agency conducting the investigation or audit may exercise all powers granted under the Inspector General Act of 1978 (5 U.S.C. App.) with respect to the claims submitted to the other departments or agencies to the same manner and extent as provided in that Act with respect to claims submitted to such departments or agencies.''.

(2) IDENTIFICATION OF COMMUNITY SERVICE OPPORTUNITIES.—Section 1128B (42 U.S.C. 1320a–7b), as amended by paragraph (1), is amended by adding at the end the following new subsection:

''(h) The Secretary may—

''(1) in consultation with State and local health care officials, identify opportunities for the satisfaction of community service obligations that a court may impose upon the conviction of an offense under this section; and

''(2) make information concerning such opportunities available to Federal and State law enforcement officers and State and local health care officials.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1997.

SEC. 104. HEALTH CARE FRAUD AND ABUSE PROVIDER GUIDANCE.

(a) SOLICITATION AND PUBLICATION OF MODIFICATIONS TO EXISTING SAFE HARBORS AND NEW SAFE HARBORS.—

(1) IN GENERAL.—

(A) SOLICITATION OF PROPOSALS FOR SAFE HARBORS.—Not later than January 1, 1997, and not less than annually thereafter, the Secretary shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for—

(i) modifications to existing safe harbors issued pursuant to section 14(a) of the Medicare Patient and Program Protection Act of 1987 (42 U.S.C. 1320a–7b note);

(ii) additional safe harbors specifying payment practices that shall not be treated as a criminal offense under section 1128B(b) of the Social Security Act (42 U.S.C. 1320a–7b(b)) and shall not serve as the basis for an exclusion under section 1128(b)(7) of such Act (42 U.S.C. 1320a–7(b)(7));

(iii) interpretive rulings to be issued pursuant to subsection (b); and

(iv) special fraud alerts to be issued pursuant to subsection (c).

(B) PUBLICATION OF PROPOSED MODIFICATIONS AND PROPOSED ADDITIONAL SAFE HARBORS.—After considering the proposals described in clauses (i) and (ii) of subparagraph (A), the Secretary, in consultation with the Attorney General, shall publish in the Federal Register proposed modifications to existing safe harbors and proposed additional safe harbors, if appropriate, with a 60-day comment period. After considering any public comments received during this period, the Secretary shall issue final rules modifying the existing safe harbors and establishing new safe harbors, as appropriate.

(C) REPORT.—The Inspector General of the Department of Health and Human Services (in this section referred to as the ''Inspector General'') shall, in an annual report to Congress or as part of the year-end semiannual report required by section 5 of the Inspector General Act of 1978 (5 U.S.C. App.), describe the proposals received under clauses (i) and (ii) of subparagraph (A) and explain which proposals were included in the publication described in subparagraph (B), which proposals were not included in that publication, and the reasons for the rejection of the proposals that were not included.

(2) CRITERIA FOR MODIFYING AND ESTABLISHING SAFE HARBORS.—In modifying and establishing safe harbors under paragraph (1)(B), the Secretary may consider the extent to which providing a safe harbor for the specified payment practice may result in any of the following:

(A) An increase or decrease in access to health care services.

(B) An increase or decrease in the quality of health care services.

(C) An increase or decrease in patient freedom of choice among health care providers.

(D) An increase or decrease in competition among health care providers.

(E) An increase or decrease in the ability of health care facilities to provide services in medically underserved areas or to medically underserved populations.

(F) An increase or decrease in the cost to Federal health care programs (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f)).

(G) An increase or decrease in the potential overutilization of health care services.

(H) The existence or nonexistence of any potential financial benefit to a health care professional or provider which may vary based on their decisions of—

(i) whether to order a health care item or service; or

(ii) whether to arrange for a referral of health care items or services to a particular practitioner or provider.

(I) Any other factors the Secretary deems appropriate in the interest of preventing fraud and abuse in Federal health care programs (as so defined).

(b) INTERPRETIVE RULINGS.—

(1) IN GENERAL.—

(A) REQUEST FOR INTERPRETIVE RULING.—Any person may present, at any time, a request to the Inspector General for a statement of the Inspector General's current interpretation of the meaning of a specific aspect of the application of sections 1128A and 1128B of the Social Security Act (42 U.S.C. 1320a–7a and 1320a–7b) (in this section referred to as an ''interpretive ruling'').

(B) ISSUANCE AND EFFECT OF INTERPRETIVE RULING.—

(i) IN GENERAL.—If appropriate, the Inspector General shall in consultation with the Attorney General, issue an interpretive ruling not later than 120 days after receiving a request described in subparagraph (A). Interpretive rulings shall not have the force of law and shall be treated as an interpretive rule within the meaning of section 553(b) of title 5, United States Code. All interpretive rulings issued pursuant to this clause shall be published in the Federal Register or otherwise made available for public inspection.

(ii) REASONS FOR DENIAL.—If the Inspector General does not issue an interpretive ruling in response to a request described in subparagraph (A), the Inspector General shall notify the requesting party of such decision not later than 120 days after receiving such a request and shall identify the reasons for such decision.

(2) CRITERIA FOR INTERPRETIVE RULINGS.—

(A) IN GENERAL.—In determining whether to issue an interpretive ruling under paragraph (1)(B), the Inspector General may consider—

(i) whether and to what extent the request identifies an ambiguity within the language of the statute, the existing safe harbors, or previous interpretive rulings; and

(ii) whether the subject of the requested interpretive ruling can be adequately addressed by interpretation of the language of the statute, the existing safe harbor rules, or previous interpretive rulings, or whether the request would require a substantive ruling (as defined in section 552 of title 5, United States Code) not authorized under this subsection.

(B) NO RULINGS ON FACTUAL ISSUES.—The Inspector General shall not give an interpretive ruling on any factual issue, including the intent of the parties or the fair market value of particular leased space or equipment.

(c) SPECIAL FRAUD ALERTS.—

(1) IN GENERAL.—

(A) REQUEST FOR SPECIAL FRAUD ALERTS.—Any person may present, at any time, a request to the Inspector General for a notice which informs the public of practices which the Inspector General considers to be suspect or of particular concern under section 1128B(b) of the Social Security Act (42 U.S.C. 1320a–7b(b)) (in this subsection referred to as a ''special fraud alert'').

(B) ISSUANCE AND PUBLICATION OF SPECIAL FRAUD ALERTS.—Upon receipt of a request described in subparagraph (A), the Inspector General shall investigate the subject matter of the request to determine whether a special fraud alert should be issued. If appropriate, the Inspector General shall issue a special fraud alert in response to the request. All special fraud alerts issued pursuant to this subparagraph shall be published in the Federal Register.

(2) CRITERIA FOR SPECIAL FRAUD ALERTS.—In determining whether to issue a special fraud alert upon a request described in paragraph (1), the Inspector General may consider—

(A) whether and to what extent the practices that would be identified in the special fraud alert may result in any of the consequences described in subsection (a)(2); and

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

SEC. 105. MEDICARE/MEDICAID BENEFICIARY PROTECTION PROGRAM.

(a) ESTABLISHMENT OF PROGRAM.—Not later than January 1, 1997, the Secretary (through the Administrator of the Health Care Financing Administration and the Inspector General of the Department of Health and Human Services) shall establish the Medicare/Medicaid Beneficiary Protection Program. Under such program the Secretary shall—

(1) educate medicare and medicaid beneficiaries regarding—

(A) medicare and medicaid program coverage;

(B) fraudulent and abusive practices;

(C) medically unnecessary health care items and services; and

(D) substandard health care items and services;

(2) identify and publicize fraudulent and abusive practices with respect to the delivery of health care items and services; and

(3) establish a procedure for the reporting of fraudulent and abusive health care providers, practitioners, claims, items, and services to appropriate law enforcement and payer agencies.

(b) RECOGNITION AND PUBLICATION OF CONTRIBUTIONS.—The program established by the Secretary under this section shall recognize and publicize significant contributions made by individual health care patients toward the combating of health care fraud and abuse.

(c) DISSEMINATION OF INFORMATION.—The Secretary shall provide for the broad dissemination of information regarding the Medicare/Medicaid Beneficiary Protection Program.

SEC. 106. ENSURING THE INTEGRITY OF THE FEDERAL HOSPITAL INSURANCE TRUST FUND.

(a) DETERMINATION.—Prior to the end of each fiscal year, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') and the Attorney General shall jointly determine—

(1) the portion of the costs charged during such fiscal year to any account established within the Federal Hospital Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to combat health care waste, fraud, and abuse, which do not relate to the administration of the medicare program; and

(2) the amount of funds deposited into such account of such trust fund during such fiscal year that were attributable to enforcement activities that were intended to combat health care waste, fraud, and abuse, which do not relate to the administration of the medicare program.

(b) CERTIFICATION.—If the portion determined under paragraph (1) of subsection (a) exceeds the amount determined under paragraph (2) of such subsection, the Secretary and the Attorney General shall certify to the Secretary of the Treasury the amount, which shall be equal to the amount of such excess, which should be transferred from the General Fund of the Treasury to such trust fund, in order to ensure that such trust fund is fully reimbursed for any expenditures made from the account described in subsection (a) that are not related to the administration of the medicare program under title XVIII of the Social Security Act.

(c) TRANSFER OF FUNDS.—The Secretary of the Treasury shall transfer to such trust fund from the General Fund of the Treasury, out of any funds in the General Fund that are not otherwise appropriated, an amount equal to the amount certified under subsection (b).

TITLE II—REVISIONS TO CURRENT SANCTIONS FOR FRAUD AND ABUSE

SEC. 201. MANDATORY EXCLUSION FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS.

(a) INDIVIDUAL CONVICTED OF FELONY RELATING TO HEALTH CARE FRAUD.—

(1) IN GENERAL.—Section 1128(a) (42 U.S.C. 1320a–7(a)) is amended by adding at the end the following new paragraph:

''(3) FELONY CONVICTION RELATING TO HEALTH CARE FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Medicare Antifraud Act of 1996, under Federal or State law, in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program (other than those specifically described in paragraph (1)) operated by or financed in whole or in part by any Federal, State, or local government agency, of a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct.''.

(2) CONFORMING AMENDMENT.—Paragraph (1) of section 1128(b) (42 U.S.C. 1320a–7(b)) is amended to read as follows:

''(1) CONVICTION RELATING TO FRAUD.—Any individual or entity that has been convicted after the date of the enactment of the Medicare Antifraud Act of 1996, under Federal or State law—

''(A) of a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct—

''(i) in connection with the delivery of a health care item or service, or

''(ii) with respect to any act or omission in a health care program (other than those specifically described in subsection (a)(1)) operated by or financed in whole or in part by any Federal, State, or local government agency; or

''(B) of a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program (other than a health care program) operated by or financed in whole or in part by any Federal, State, or local government agency.''.

(b) INDIVIDUAL CONVICTED OF FELONY RELATING TO CONTROLLED SUBSTANCE.—

(1) IN GENERAL.—Section 1128(a) (42 U.S.C. 1320a–7(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

''(4) FELONY CONVICTION RELATING TO CONTROLLED SUBSTANCE.—Any individual or entity that has been convicted after the date of the enactment of the Medicare Antifraud Act of 1996, under Federal or State law, of a criminal offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.''.

(2) CONFORMING AMENDMENT.—Section 1128(b)(3) (42 U.S.C. 1320a–7(b)(3)) is amended—

(A) in the heading, by striking ''CONVICTION'' and inserting ''MISDEMEANOR CONVICTION''; and

(B) by striking ''criminal offense'' and inserting ''criminal offense consisting of a misdemeanor''.

SEC. 202. ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION FROM MEDICARE AND STATE HEALTH CARE PROGRAMS.

Section 1128(c)(3) (42 U.S.C. 1320a–7(c)(3)) is amended by adding at the end the following new subparagraphs:

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

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

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

SEC. 203. PERMISSIVE EXCLUSION OF INDIVIDUALS WITH OWNERSHIP OR CONTROL INTEREST IN SANCTIONED ENTITIES.

Section 1128(b) (42 U.S.C. 1320a–7(b)) is amended by adding at the end the following new paragraph:

''(15) INDIVIDUALS CONTROLLING A SANCTIONED ENTITY.—Any individual who has a direct or indirect ownership or control interest of 5 percent or more, or an ownership or control interest (as defined in section 1124(a)(3)) in, or who is an officer or managing employee (as defined in section 1126(b)) of, an entity—

''(A) that has been convicted of any offense described in subsection (a) or in paragraph (1), (2), or (3) of this subsection; or

''(B) that has been excluded from participation under a program under title XVIII or under a State health care program (as defined in subsection (h)).''.

SEC. 204. SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.

(a) MINIMUM PERIOD OF EXCLUSION FOR PRACTITIONERS AND PERSONS FAILING TO MEET STATUTORY OBLIGATIONS.—

(1) IN GENERAL.—The second sentence of section 1156(b)(1) (42 U.S.C. 1320c–5(b)(1)) is amended by striking ''may prescribe)'' and inserting ''may prescribe, except that such period may not be less than 1 year)''.

(2) CONFORMING AMENDMENT.—Section 1156(b)(2) (42 U.S.C. 1320c–5(b)(2)) is amended by striking ''shall remain'' and inserting ''shall (subject to the minimum period specified in the second sentence of paragraph (1)) remain''.

(b) REPEAL OF ''UNWILLING OR UNABLE'' CONDITION FOR IMPOSITION OF SANCTION.—Section 1156(b)(1) (42 U.S.C. 1320c–5(b)(1)) is amended—

(1) in the second sentence, by striking ''and determines'' and all that follows through ''such obligations,''; and

(2) by striking the third sentence.

SEC. 205. SANCTIONS AGAINST PROVIDERS FOR EXCESSIVE FEES OR PRICES.

Section 1128(b)(6)(A) (42 U.S.C. 1320a–7(b)(6)(A)) is amended—

(1) by inserting ''(as specified by the Secretary in regulations)'' after ''substantially in excess of such individual's or entity's usual charges''; and

(2) by striking ''(or, in applicable cases, substantially in excess of such individual's or entity's costs)'' and inserting '', costs or fees''.

SEC. 206. APPLICABILITY OF THE BANKRUPTCY CODE TO PROGRAM SANCTIONS.

(a) EXCLUSION OF INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN FEDERAL HEALTH CARE PROGRAMS.—Section 1128 (42 U.S.C. 1320a–7) is amended by adding at the end the following new subsection:

''(j) APPLICABILITY OF BANKRUPTCY PROVISIONS.—An exclusion imposed under this section is not subject to the automatic stay imposed under section 362 of title 11, United States Code.''.

(b) CIVIL MONETARY PENALTIES.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended by adding at the end the following sentence: ''An exclusion imposed under this subsection is not subject to the automatic stay imposed under section 362 of title 11, United States Code, and any penalties and assessments imposed under this section shall be nondischargeable under the provisions of such title.''.

(c) OFFSET OF PAYMENTS TO INDIVIDUALS.—Section 1892(a)(4) (42 U.S.C. 1395ccc(a)(4)) is amended by adding at the end the following

sentence: ''An exclusion imposed under paragraph (2)(C)(ii) or paragraph (3)(B) is not subject to the automatic stay imposed under section 362 of title 11, United States Code.''.

SEC. 207. INTERMEDIATE SANCTIONS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

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

(1) IN GENERAL.—Section 1876(i)(1) (42 U.S.C. 1395mm(i)(1)) is amended by striking ''the Secretary may terminate'' and all that follows and inserting ''in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—

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

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

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

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

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

''(i) Civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

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

''(iii) Suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.''.

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

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

''(A) the Secretary first provides the organization with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1) and the organization fails to develop or implement such a plan;

''(B) in deciding whether to impose sanctions, the Secretary considers aggravating factors such as whether an entity has a history of deficiencies or has not taken action to correct deficiencies the Secretary has brought to their attention;

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

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

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

(b) AGREEMENTS WITH PEER REVIEW ORGANIZATIONS.—

(1) REQUIREMENT FOR WRITTEN AGREEMENT.—Section 1876(i)(7)(A) (42 U.S.C. 1395mm(i)(7)(A)) is amended by striking ''an agreement'' and inserting ''a written agreement''.

(2) DEVELOPMENT OF MODEL AGREEMENT.—Not later than July 1, 1997, the Secretary shall develop a model of the agreement that an eligible organization with a risk-sharing contract under section 1876 of the Social Security Act (42 U.S.C. 1395mm) must enter into with an entity providing peer review services with respect to services provided by the organization under section 1876(i)(7)(A) of such Act (42 U.S.C. 1395mm(i)(7)(A)).

(3) REPORT BY GAO.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study of the costs incurred by eligible organizations with risk-sharing contracts under section 1876 of such Act (42 U.S.C. 1395mm(b)) of complying with the requirement of entering into a written agreement with an entity providing peer review services with respect to services provided by the organization, together with an analysis of how information generated by such entities is used by the Secretary to assess the quality of services provided by such eligible organizations.

(B) REPORT TO CONGRESS.—Not later than July 1, 1998, the Comptroller General shall submit a report to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance and the Special Committee on Aging of the Senate on the study conducted under subparagraph (A).

SEC. 208. LIABILITY OF MEDICARE CARRIERS AND FISCAL INTERMEDIARIES AND STATES FOR CLAIMS SUBMITTED BY EXCLUDED PROVIDERS.

(a) REIMBURSEMENT TO THE SECRETARY FOR AMOUNTS PAID TO EXCLUDED PROVIDERS.—

(1) REQUIREMENTS FOR FISCAL INTERMEDIARIES.—

(A) IN GENERAL.—Section 1816 (42 U.S.C. 1395h), is amended by adding at the end the following new subsection:

''(*l*) An agreement with an agency or organization under this section shall require that such agency or organization reimburse the Secretary for any amounts paid for a service under this title which is furnished, directed, or prescribed by an individual or entity during any period for which the individual or entity is excluded pursuant to section 1128, 1128A, or 1156, from participation in the program under this title, if the amounts are paid after the Secretary notifies the agency or organization of the exclusion.''.

(B) CONFORMING AMENDMENT.—Section 1816(i) (42 U.S.C. 1395h(i)) is amended by adding at the end the following new paragraph:

''(4) Nothing in this subsection shall be construed to prohibit reimbursement by an agency or organization under subsection (*l*).''.

(2) REQUIREMENTS FOR CARRIERS.—Section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended—

(A) by striking ''and'' at the end of subparagraph (I); and

(B) by inserting after subparagraph (I) the following new subparagraph:

''(J) will reimburse the Secretary for any amounts paid for an item or service under this part which is furnished, directed, or prescribed by an individual or entity during any period for which the individual or entity is excluded pursuant to section 1128, 1128A, or 1156 from participation in the program under this title, if the amounts are paid after the Secretary notifies the carrier of the exclusion; and''.

(3) REQUIREMENTS FOR STATES.—Section 1902(a)(39) (42 U.S.C. 1396a(a)(39)) is amended by striking the semicolon at the end and inserting '', and provide further for reimbursement to the Secretary of any payments made under the plan for any item or service furnished, directed, or prescribed by the excluded individual or entity during such period, after the Secretary notifies the State of such exclusion;''.

(b) CONFORMING REPEAL OF MANDATORY PAYMENT RULE.—Section 1862(e)(2) (42 U.S.C. 1395y(e)(2)) is amended to read as follows:

''(2) No individual or entity may bill (or collect any amount from) any individual for any item or service for which payment is denied under paragraph (1). No person is liable for payment of any amounts billed for such an item or service in violation of the previous sentence.''.

SEC. 209. EFFECTIVE DATE.

The amendments made by this title shall take effect January 1, 1997.

TITLE III—ADMINISTRATIVE AND MISCELLANEOUS PROVISIONS

SEC. 301. ESTABLISHMENT OF THE HEALTH CARE FRAUD AND ABUSE DATA COLLECTION PROGRAM.

(a) GENERAL PURPOSE.—Not later than January 1, 1997, the Secretary shall establish a national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements in which no findings of liability have been made) against health care providers, suppliers, or practitioners as required by subsection (b), with access as set forth in subsection (c), and shall maintain a database of the information collected under this section.

(b) REPORTING OF INFORMATION.—

(1) IN GENERAL.—Each Government agency and health plan shall report any final adverse action (not including settlements in which no findings of liability have been made) taken against a health care provider, supplier, or practitioner.

(2) INFORMATION TO BE REPORTED.—The information to be reported under paragraph (1) includes the following:

(A) The name and TIN (as defined in section 7701(a)(41) of the Internal Revenue Code of 1986) of any health care provider, supplier, or practitioner who is the subject of a final adverse action.

(B) The name (if known) of any health care entity with which a health care provider, supplier, or practitioner, who is the subject of a final adverse action, is affiliated or associated.

(C) The nature of the final adverse action and whether such action is on appeal.

(D) A description of the acts or omissions and injuries upon which the final adverse action was based, and such other information as the Secretary determines by regulation is required for appropriate interpretation of information reported under this section.

(3) CONFIDENTIALITY.—In determining what information is required, the Secretary shall include procedures to assure that the privacy of individuals receiving health care services is appropriately protected.

(4) TIMING AND FORM OF REPORTING.—The information required to be reported under this subsection shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') prescribes. Such information shall first be required to be reported on a date specified by the Secretary.

(5) TO WHOM REPORTED.—The information required to be reported under this subsection shall be reported to the Secretary.

(c) DISCLOSURE AND CORRECTION OF INFORMATION.—

(1) DISCLOSURE.—With respect to the information about final adverse actions (not including settlements in which no findings of liability have been made) reported to the Secretary under this section with respect to a health care provider, supplier, or practitioner, the Secretary shall, by regulation, provide for—

(A) disclosure of the information, upon request, to the health care provider, supplier, or licensed practitioner, and

(B) procedures in the case of disputed accuracy of the information.

(2) CORRECTIONS.—Each Government agency and health plan shall report corrections of information already reported about any final adverse action taken against a health care provider, supplier, or practitioner, in such form and manner that the Secretary prescribes by regulation.

(d) ACCESS TO REPORTED INFORMATION.—

(1) AVAILABILITY.—The information in the database maintained under this section shall be available to Federal and State government agencies, health plans, and the public pursuant to procedures that the Secretary shall provide by regulation.

(2) FEES FOR DISCLOSURE.—The Secretary may establish or approve reasonable fees for the disclosure of information in such database (other than with respect to requests by Federal agencies). The amount of such a fee may be sufficient to recover the full costs of carrying out the provisions of this section, including reporting, disclosure, and administration. Such fees shall be available to the Secretary or, in the Secretary's discretion to the agency designated under this section to cover such costs.

(e) PROTECTION FROM LIABILITY FOR REPORTING.—No person or entity shall be held liable in any civil action with respect to any report made as required by this section, without knowledge of the falsity of the information contained in the report.

(f) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

(1) FINAL ADVERSE ACTION.—

(A) IN GENERAL.—The term ''final adverse action'' includes the following:

(i) Civil judgments against a health care provider or practitioner in Federal or State court related to the delivery of a health care item or service.

(ii) Federal or State criminal convictions related to the delivery of a health care item or service.

(iii) Actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers, and licensed health care practitioners, including—

(I) formal or official actions, such as revocation or suspension of a license (and the length of any such suspension), reprimand, censure, or probation,

(II) any other loss of license, or the right to apply for or renew a license of the provider, supplier, or practitioner, whether by operation of law, voluntary surrender, nonrenewability, or otherwise, or

(III) any other negative action or finding by such Federal or State agency that is publicly available information.

(iv) Exclusion from participation in Federal or State health care programs (as defined in section 1128B(f) and 1128(h), respectively).

(v) Any other adjudicated actions or decisions that the Secretary shall establish by regulation.

(B) EXCLUSION.—The term does not include any action with respect to a malpractice claim.

(C) SPECIAL RULE.—For purposes of this paragraph, the existence of a conviction shall be determined under section 1128(i) of the Social Security Act (42 U.S.C. 1320a–7(i)).

(2) LICENSED HEALTH CARE PRACTITIONER.—The terms ''licensed health care practitioner'', ''licensed practitioner'', and ''practitioner'' mean, with respect to a State, an individual who is licensed or otherwise authorized by the State to provide health care services (or any individual who, without authority holds himself or herself out to be so licensed or authorized).

(3) HEALTH CARE PROVIDER.—The term ''health care provider'' means a provider of services as defined in section 1861(u) of the Social Security Act (42 U.S.C. 1395x(u)), and any person or entity, including a health maintenance organization, group medical practice, or any other entity listed by the Secretary in regulation, that provides health care services.

(4) SUPPLIER.—The term ''supplier'' means a supplier of health care items and services described in subsections (a) and (b) of section 1819, and section 1861 of the Social Security Act (42 U.S.C. 1395i–3 (a) and (b), and 1395x).

(5) GOVERNMENT AGENCY.—The term ''Government agency'' shall include the following:

(A) The Department of Justice.

(B) The Department of Health and Human Services.

(C) Any other Federal agency that either administers or provides payment for the delivery of health care services, including, but not limited to the Department of Defense and the Veterans' Administration.

(D) State law enforcement agencies.

(E) State medicaid fraud and abuse units.

(F) Federal or State agencies responsible for the licensing and certification of health care providers and licensed health care practitioners.

(6) HEALTH PLAN.—The term ''health plan'' has the meaning given such term by section 1128C(c) of the Social Security Act, as added by section 101(a) of this Act.

(g) CONFORMING AMENDMENT.—Section 1921(d) (42 U.S.C. 1396r–2(d)) is amended by inserting ''and section 301 of the Medicare Antifraud Act of 1996'' after ''section 422 of the Health Care Quality Improvement Act of 1986''.

SEC. 302. INSPECTOR GENERAL ACCESS TO NATIONAL PRACTITIONER DATA BANK.

Section 427 of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11137) is amended—

(1) in subsection (a), by adding at the end the following sentence: ''Information reported under this part shall also be made available, upon request, to the Inspector General of the Departments of Health and Human Services, Defense, and Labor, the Office of Personnel Management, and the Railroad Retirement Board.''; and

(2) by amending subsection (b)(4) to read as follows:

''(4) FEES.—The Secretary may impose fees for the disclosure of information under this part sufficient to recover the full costs of carrying out the provisions of this part, including reporting, disclosure, and administration, except that a fee may not be imposed for requests made by the Inspector General of the Department of Health and Human Services. Such fees shall remain available to the Secretary (or, in the Secretary's discretion, to the agency designated in section 424(b)) until expended.''.

SEC. 303. CORPORATE WHISTLEBLOWER PROGRAM.

Title XI (42 U.S.C. 1301 et seq.), as amended by section 101(a), is amended by inserting after section 1128C the following new section:

''CORPORATE WHISTLEBLOWER PROGRAM

''SEC. 1128D. (a) ESTABLISHMENT OF PROGRAM.—The Secretary, through the Inspector General of the Department of Health and Human Services, shall establish a procedure whereby corporations, partnerships, and other legal entities specified by the Secretary, may voluntarily disclose instances of unlawful conduct and seek to resolve liability for such conduct through means specified by the Secretary.

''(b) LIMITATION.—No person may bring an action under section 3730(b) of title 31, United States Code, if, on the date of filing—

''(1) the matter set forth in the complaint has been voluntarily disclosed to the United States by the proposed defendant and the defendant has been accepted into the voluntary disclosure program established pursuant to subsection (a); and

''(2) any new information provided in the complaint under such section does not add substantial grounds for additional recovery beyond those encompassed within the scope of the voluntary disclosure.''.

SEC. 304. HOME HEALTH BILLING, PAYMENT, AND COST LIMIT CALCULATION TO BE BASED ON SITE WHERE SERVICE IS FURNISHED.

(a) CONDITIONS OF PARTICIPATION.—Section 1891 (42 U.S.C. 1395bbb) is amended by adding at the end the following new subsection:

''(g) A home health agency shall submit claims for payment of home health services under this title only on the basis of the geographic location at which the service is furnished, as determined by the Secretary.''.

(b) WAGE ADJUSTMENT.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by striking ''agency is located'' and inserting ''service is furnished''.

SEC. 305. APPLICATION OF INHERENT REASONABLENESS.

(a) IN GENERAL.—Section 1834(a)(10)(B) (42 U.S.C. 1395m(a)(10)(B)) is amended—

(1) in the first sentence, by striking ''apply the provisions'' and all that follows through the period and inserting ''describe by regulation the factors to be used in determining the cases (or particular items) in which the application of this subsection results in the determination of an amount that, by reason of its being grossly excessive or grossly deficient, is not inherently reasonable, and to provide in such cases for the factors that will be considered in establishing an amount that is realistic and equitable.''; and

(2) in the second sentence, by striking ''applying such provisions'' and inserting ''applying the previous provisions of this subsection''.

(b) CONFORMING AMENDMENT.—Section 1834(i) (42 U.S.C. 1395m(i)) is amended by adding at the end the following new paragraph:

''(3) ADJUSTMENT FOR INHERENT REASONABLENESS.—The provisions of subsection (a)(10)(B) shall apply to payment for surgical dressings under this subsection.''.

SEC. 306. CLARIFICATION OF TIME AND FILING LIMITATIONS.

(a) IN GENERAL.—Section 1862(b)(2)(B) (42 U.S.C. 1395y(b)(2)(B)) is amended by adding at the end the following new clause:

''(v) TIME, FILING, AND RELATED PROVISIONS UNDER PRIMARY PLAN.—Requirements under a primary plan as to the filing of a claim, time limitations for the filing of a claim, information not maintained by the Secretary, or notification or pre-admission review, shall not apply to a claim by the United States under clause (ii) or (iii).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to items and services furnished after 1990.

SEC. 307. CLARIFICATION OF LIABILITY OF THIRD PARTY ADMINISTRATORS.

(a) IN GENERAL.—Section 1862(b)(2)(B)(ii) (42 U.S.C. 1395y(b)(2)(B)(ii)) is amended by inserting '', or which determines claims under the primary plan'' after ''primary plan''.

(b) CLAIMS BETWEEN PARTIES OTHER THAN THE UNITED STATES.—Section 1862(b)(2)(B) (42 U.S.C. 1395y(b)(2)(B)), as amended by section 306(a) of this Act, is amended by adding at the end the following new clause:

''(vi) CLAIMS BETWEEN PARTIES OTHER THAN THE UNITED STATES.—A claim by the United States under clause (ii) or (iii) shall not preclude claims between other parties.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished after 1990.

SEC. 308. CLARIFICATION OF PAYMENT AMOUNTS TO MEDICARE.

(a) IN GENERAL.—Section 1862(b)(2)(B)(i) (42 U.S.C. 1395y(b)(2)(B)(i)) is amended to read as follows:

''(i) REPAYMENT REQUIRED.—

''(I) IN GENERAL.—Any payment under this title, with respect to any item or service for which payment by a primary plan is required under the preceding provisions of this subsection, shall be conditioned on reimbursement to the appropriate Trust Fund established by this title when notice or other information is received that payment for that item or service has been or should have been made under those provisions. If reimbursement is not made to the appropriate Trust Fund before the expiration of the 60-day period that begins on the date such notice or other information is received, the Secretary may charge interest (beginning with the date on which the notice or other information is received) on the amount of the reimbursement until reimbursement is made (at a rate determined by the Secretary in accordance with regulations of the Secretary of the Treasury applicable to charges for late payments).

''(II) DETERMINATION OF AMOUNT OWED.—The amount owed by a primary plan under the first sentence of subclause (I) is the lesser of the full primary payment required (if that amount is readily determinable) and the amount paid under this title for that item or service.''.

(b) CONFORMING AND TECHNICAL AMENDMENTS.—

(1) Subparagraphs (A)(i)(I) and (B)(i) of section 1862(b)(1) (42 U.S.C. 1395y(b)(1)) are each amended by inserting ''(or eligible to be covered)'' after ''covered''.

(2) Section 1862(b)(1)(C)(ii) (42 U.S.C. 1395y(b)(1)(C)(ii)) is amended by striking ''covered by such plan''.

(3) The matter in section 1862(b)(2)(A) (42 U.S.C. 1395y(b)(2)(A)) preceding clause (i) is amended by striking '', except as provided in subparagraph (B),''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished after 1990.

SEC. 309. INCREASED FLEXIBILITY IN CONTRACTING FOR MEDICARE CLAIMS PROCESSING.

(a) CARRIERS TO INCLUDE ENTITIES THAT ARE NOT INSURANCE COMPANIES.—The matter in section 1842(a) (42 U.S.C. 1395u(a)) preceding paragraph (1) is amended by striking ''with carriers'' and inserting ''with agencies and organizations (referred to as carriers)''.

(b) REPEAL.—Section 1842(f) (42 U.S.C. 1395u(f)) is repealed.

TITLE IV—CIVIL MONETARY PENALTIES

SEC. 401. SOCIAL SECURITY ACT CIVIL MONETARY PENALTIES.

(a) GENERAL CIVIL MONETARY PENALTIES.—Section 1128A (42 U.S.C. 1320a–7a) is amended as follows:

(1) In the third sentence of subsection (a), by striking ''programs under title XVIII'' and inserting ''Federal health care programs (as defined in section 1128B(f))''.

(2) In subsection (f)—

(A) by redesignating paragraph (3) as paragraph (4); and

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

''(3) With respect to amounts recovered arising out of a claim under a Federal health care program (as defined in section 1128B(f)), the portion of such amounts as is determined to have been paid by the program shall be repaid to the program, and the portion of such amounts attributable to the amounts recovered under this section by reason of the amendments made by the Medicare Antifraud Act of 1996 (as estimated by the Secretary) shall be deposited into the Health Care Fraud and Abuse Control Account established under section 101(b) of such Act.''.

(3) In subsection (i)—

(A) in paragraph (2), by striking ''title V, XVIII, XIX, or XX of this Act'' and inserting ''a Federal health care program (as defined in section 1128B(f))'';

(B) in paragraph (4), by striking ''a health insurance or medical services program under title XVIII or XIX of this Act'' and inserting ''a Federal health care program (as so defined)''; and

(C) in paragraph (5), by striking ''title V, XVIII, XIX, or XX'' and inserting ''a Federal health care program (as so defined)''.

(4) By adding at the end the following new subsection:

''(m)(1) For purposes of this section, with respect to a Federal health care program not contained in this Act, references to the Secretary in this section shall be deemed to be references to the Secretary or Administrator of the department or agency with jurisdiction over such program and references to the Inspector General of the Department of Health and Human Services in this section shall be deemed to be references to the Inspector General of the applicable department or agency.

''(2)(A) The Secretary and Administrator of the departments and agencies referred to in paragraph (1) may include in any action pursuant to this section, claims within the jurisdiction of other Federal departments or agencies as long as the following conditions are satisfied:

''(i) The case primarily involves claims submitted to the Federal health care programs of the department or agency initiating the action.

''(ii) The Secretary or Administrator of the department or agency initiating the action gives notice and an opportunity to participate in the investigation to the Inspector General of the department or agency with primary jurisdiction over the Federal health care programs to which the claims were submitted.

''(B) If the conditions specified in subparagraph (A) are fulfilled, the Inspector General of the department or agency initiating the action is authorized to exercise all powers granted under the Inspector General Act of 1978 (5 U.S.C. App.) with respect to the claims submitted to the other departments or agencies to the same manner and extent as provided in that Act with respect to claims submitted to such departments or agencies.''.

(b) EXCLUDED INDIVIDUAL RETAINING OWNERSHIP OR CONTROL INTEREST IN PARTICIPATING ENTITY.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(1) by striking ''or'' at the end of paragraph (1)(D);

(2) by striking '', or'' at the end of paragraph (2) and inserting a semicolon;

(3) by striking the semicolon at the end of paragraph (3) and inserting ''; or''; and

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

''(4) in the case of a person who is not an organization, agency, or other entity, is excluded from participating in a program under title XVIII or a State health care program in accordance with this subsection or under section 1128 and who, at the time of a violation of this subsection, retains a direct or indirect ownership or control interest of 5 percent or more, or an ownership or control interest (as defined in section 1124(a)(3)) in, or who is an officer or managing employee (as defined in section 1126(b)) of, an entity that is participating in a program under title XVIII or a State health care program;''.

(c) EMPLOYER BILLING FOR SERVICES FURNISHED, DIRECTED, OR PRESCRIBED BY AN EXCLUDED EMPLOYEE.—Section 1128A(a)(1) (42 U.S.C. 1320a–7a(a)(1)), as amended by subsection (b), is amended—

(1) by striking ''or'' at the end of subparagraph (C);

(2) by striking the semicolon at the end of subparagraph (D) and inserting '', or''; and

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

''(E) is for a medical or other item or service furnished, directed, or prescribed by an individual who is an employee or agent of the person during a period in which such employee or agent was excluded from the program under which the claim was made on any of the grounds for exclusion described in subparagraph (D);''.

(d) CIVIL MONEY PENALTIES FOR ITEMS OR SERVICES FURNISHED, DIRECTED, OR PRESCRIBED BY AN EXCLUDED INDIVIDUAL.—Section 1128A(a)(1)(D) (42 U.S.C. 1320a–7a(a)(1)(D)) is amended by inserting '', directed, or prescribed'' after ''furnished''.

(e) MODIFICATIONS OF AMOUNTS OF PENALTIES AND ASSESSMENTS.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by subsection (b), is amended in the matter following paragraph (4)—

(1) by striking ''$2,000'' and inserting ''$10,000'';

(2) by inserting ''; in cases under paragraph (4), $10,000 for each day the prohibited relationship occurs'' after ''false or misleading information was given''; and

(3) by striking ''twice the amount'' and inserting ''3 times the amount''.

(f) CLAIM FOR ITEM OR SERVICE BASED ON INCORRECT CODING OR MEDICALLY UNNECESSARY SERVICES.—Section 1128A(a)(1) (42 U.S.C. 1320a–7a(a)(1)), as amended by subsection (c), is amended—

(1) in subparagraph (A) by striking ''claimed,'' and inserting ''claimed, including any person who engages in a pattern or practice of presenting or causing to be presented a claim for an item or service that is based on a code that the person knows or has reason to know will result in a greater payment to the person than the code the person knows or has reason to know is applicable to the item or service actually provided,'';

(2) in subparagraph (D), by striking ''or'' at the end; and

(3) in subparagraph (E), by striking the semicolon and inserting'', or''; and

(4) by inserting after subparagraph (E) the following new subparagraph:

''(F) is for a medical or other item or service that a person knows or has reason to know is not medically necessary;''.

(g) PERMITTING SECRETARY TO IMPOSE CIVIL MONETARY PENALTY FOR KICKBACK VIOLATIONS.—Section 1128A(b) (42 U.S.C. 1320a–7a(a)) is amended by adding the following new paragraph:

''(3) Any person (including any organization, agency, or other entity, but excluding a beneficiary as defined in subsection (i)(5)) who the Secretary determines has violated section 1128B(b) of this title shall be subject to a civil monetary penalty of not more than $10,000 for each such violation. In addition,

such person shall be subject to an assessment of not more than twice the total amount of the remuneration offered, paid, solicited, or received in violation of section 1128B(b). The total amount of remuneration subject to an assessment shall be calculated without regard to whether some portion thereof also may have been intended to serve a purpose other than one proscribed by section 1128B(b).''.

(h) SANCTIONS AGAINST PRACTITIONERS AND PERSONS FOR FAILURE TO COMPLY WITH STATUTORY OBLIGATIONS.—Section 1156(b)(3) (42 U.S.C. 1320c–5(b)(3)) is amended by striking ''the actual or estimated cost'' and inserting ''up to $10,000 for each instance''.

(i) PROCEDURAL PROVISIONS.—Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)), as amended by section 207(a)(2), is amended by adding at the end the following new subparagraph:

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

(j) PROHIBITION AGAINST OFFERING INDUCEMENTS TO INDIVIDUALS ENROLLED UNDER PROGRAMS OR PLANS.—

(1) OFFER OF REMUNERATION.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), as amended by subsection (b), is amended—

(A) by striking '', or'' at the end of paragraph (3) and inserting a semicolon;

(B) by striking the semicolon at the end of paragraph (4) and inserting ''; or''; and

(C) by inserting after paragraph (4) the following new paragraph:

''(5) offers to or transfers remuneration to any individual eligible for benefits under title XVIII of this Act, or under a State health care program (as defined in section 1128(h)) that such person knows or should know is likely to influence such individual to order or receive from a particular provider, practitioner, or supplier any item or service for which payment may be made, in whole or in part, under title XVIII, or a State health care program (as so defined);''.

(2) REMUNERATION DEFINED.—Section 1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by adding the following new paragraph:

''(6) The term 'remuneration' includes the waiver of coinsurance and deductible amounts (or any part thereof), and transfers of items or services for free or for other than fair market value. The term 'remuneration' does not include—

''(A) the waiver of coinsurance and deductible amounts by a person, if—

''(i) the waiver is not offered as part of any advertisement or solicitation;

''(ii) the person does not routinely waive coinsurance or deductible amounts; and

''(iii) the person—

''(I) waives the coinsurance and deductible amounts after determining in good faith that the individual is in financial need;

''(II) fails to collect coinsurance or deductible amounts after making reasonable collection efforts; or

''(III) provides for any permissible waiver as specified in section 1128B(b)(3) or in regulations issued by the Secretary;

''(B) differentials in coinsurance and deductible amounts as part of a benefit plan design as long as the differentials have been disclosed in writing to all beneficiaries, third party payors, and providers, to whom claims are presented and as long as the differentials meet the standards as defined in regulations promulgated by the Secretary not later than 180 days after the date of the enactment of the Medicare Antifraud Act of 1996; or

''(C) incentives given to individuals to promote the delivery of preventive care as determined by the Secretary in regulations so promulgated.''.

(k) EFFECTIVE DATE.—The amendments made by this section shall take effect January 1, 1997.

TITLE V—AMENDMENTS TO CRIMINAL LAW

SEC. 501. HEALTH CARE FRAUD.

(a) IN GENERAL.—

(1) FINES AND IMPRISONMENT FOR HEALTH CARE FRAUD VIOLATIONS.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following new section:

''§ 1347. Health care fraud

''(a) Whoever knowingly and willfully executes, or attempts to execute, a scheme or artifice—

''(1) to defraud any health plan or other person, in connection with the delivery of or payment for health care benefits, items, or services; or

''(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any health plan, or person in connection with the delivery of or payment for health care benefits, items, or services;

shall be fined under this title or imprisoned not more than 10 years, or both. If the violation results in serious bodily injury (as defined in section 1365(g)(3) of this title), such person may be imprisoned for any term of years.

''(b) For purposes of this section, the term 'health plan' has the same meaning given such term in section 1128C(c) of the Social Security Act.''.

(2) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 63 of title 18, United States Code, is amended by adding at the end the following:

''1347. Health care fraud.''.

(b) CRIMINAL FINES DEPOSITED IN THE HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—The Secretary of the Treasury shall deposit into the Health Care Fraud and Abuse Control Account established under section 101(b) an amount equal to the criminal fines imposed under section 1347 of title 18, United States Code (relating to health care fraud).

SEC. 502. FORFEITURES FOR FEDERAL HEALTH CARE OFFENSES.

(a) IN GENERAL.—Section 982(a) of title 18, United States Code, is amended by adding after paragraph (5) the following new paragraph:

''(6)(A) The court, in imposing sentence on a person convicted of a Federal health care offense, shall order the person to forfeit property, real or personal, that constitutes or is derived, directly or indirectly, from proceeds traceable to the commission of the offense.

''(B) For purposes of this paragraph, the term 'Federal health care offense' means a violation of, or a criminal conspiracy to violate—

''(i) section 1347 of this title;

''(ii) section 1128B of the Social Security Act;

''(iii) section 287, 371, 664, 666, 1001, 1027, 1341, 1343, 1920, or 1954 of this title if the violation or conspiracy relates to health care fraud; and

''(iv) section 501 or 511 of the Employee Retirement Income Security Act of 1974, if the violation or conspiracy relates to health care fraud.''.

(b) PROPERTY FORFEITED DEPOSITED IN HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.—The Secretary of the Treasury shall deposit into the Health Care Fraud and Abuse Control Account established under section 101(b) an amount equal to amounts resulting from forfeiture of property by reason of a Federal health care offense pursuant to section 982(a)(6) of title 18, United States Code.

SEC. 503. INJUNCTIVE RELIEF RELATING TO FEDERAL HEALTH CARE OFFENSES.

(a) IN GENERAL.—Section 1345(a)(1) of title 18, United States Code, is amended—

(1) by striking ''or'' at the end of subparagraph (A);

(2) by inserting ''or'' at the end of subparagraph (B); and

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

''(C) committing or about to commit a Federal health care offense (as defined in section 982(a)(6)(B) of this title);''.

(b) FREEZING OF ASSETS.—Section 1345(a)(2) of title 18, United States Code, is amended by inserting ''or a Federal health care offense (as defined in section 982(a)(6)(B))'' after ''title)''.

SEC. 504. GRAND JURY DISCLOSURE.

Section 3322 of title 18, United States Code, is amended—

(1) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(2) by inserting after subsection (b) the following new subsection:

''(c) A person who is privy to grand jury information concerning a Federal health care offense (as defined in section 982(a)(6)(B))—

''(1) received in the course of duty as an attorney for the Government; or

''(2) disclosed under rule 6(e)(3)(A)(ii) of the Federal Rules of Criminal Procedure;

may disclose that information to an attorney for the Government to use in any investigation or civil proceeding relating to health care fraud.''.

SEC. 505. FALSE STATEMENTS.

(a) IN GENERAL.—Chapter 47, of title 18, United States Code, is amended by adding at the end the following new section:

''§ 1035. False statements relating to health care matters

''(a) Whoever, in any matter involving a health plan, knowingly and willfully falsifies, conceals, or covers up by any trick, scheme, or device a material fact, or makes any false, fictitious, or fraudulent statements or representations, or makes or uses any false writing or document knowing the same to contain any false, fictitious, or fraudulent statement or entry, shall be fined under this title or imprisoned not more than 5 years, or both.

''(b) For purposes of this section, the term 'health plan' has the same meaning given such term in section 1128C(c) of the Social Security Act.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 47 of title 18, United States Code, in amended by adding at the end the following:

''1035. False statements relating to health care matters.''.

SEC. 506. OBSTRUCTION OF CRIMINAL INVESTIGATIONS, AUDITS, OR INSPECTIONS OF FEDERAL HEALTH CARE OFFENSES.

(a) IN GENERAL.—Chapter 73 of title 18, United States Code, is amended by adding at the end the following new section:

''§ 1518. Obstruction of criminal investigations, audits, or inspections of Federal health care offenses

''(a) IN GENERAL.—Whoever willfully prevents, obstructs, misleads, delays or attempts to prevent, obstruct, mislead, or delay the communication of information or records relating to a Federal health care offense to a Federal agent or employee involved in an investigation, audit, inspection, or other activity related to such an offense, shall be fined under this title or imprisoned not more than 5 years, or both.

''(b) FEDERAL HEALTH CARE OFFENSE.—As used in this section the term 'Federal health

care offense' has the same meaning given such term in section 982(a)(6)(B) of this title.

''(c) CRIMINAL INVESTIGATOR.—As used in this section the term 'criminal investigator' means any individual duly authorized by a department, agency, or armed force of the United States to conduct or engage in investigations for prosecutions for violations of health care offenses.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 73 of title 18, United States Code, is amended by adding at the end the following:

''1518. Obstruction of criminal investigations, audits, or inspections of Federal health care offenses.''.

SEC. 507. THEFT OR EMBEZZLEMENT.

(a) IN GENERAL.—Chapter 31 of title 18, United States Code, is amended by adding at the end the following new section:

''§ 669. Theft or embezzlement in connection with health care

''(a) IN GENERAL.—Whoever willfully embezzles, steals, or otherwise without authority willfully and unlawfully converts to the use of any person other than the rightful owner, or intentionally misapplies any of the moneys, funds, securities, premiums, credits, property, or other assets of a health plan, shall be fined under this title or imprisoned not more than 10 years, or both.

''(b) HEALTH PLAN.—As used in this section the term 'health plan' has the same meaning given such term in section 1128C(c) of the Social Security Act.''.

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of chapter 31 of title 18, United States Code, is amended by adding at the end the following:

''669. Theft or embezzlement in connection with health care.''.

SEC. 508. LAUNDERING OF MONETARY INSTRUMENTS.

Section 1956(c)(7) of title 18, United States Code, is amended by adding at the end the following new subparagraph:

''(F) Any act or activity constituting an offense involving a Federal health care offense as that term is defined in section 982(a)(6)(B) of this title.''.

SEC. 509. AUTHORIZED INVESTIGATIVE DEMAND PROCEDURES.

(a) IN GENERAL.—Chapter 233 of title 18, United States Code, is amended by adding after section 3485 the following new section:

''§ 3486. Authorized investigative demand procedures

''(a) AUTHORIZATION.—

''(1) In any investigation relating to functions set forth in paragraph (2), the Attorney General or designee may issue in writing and cause to be served a subpoena compelling production of any records (including any books, papers, documents, electronic media, or other objects or tangible things), which may be relevant to an authorized law enforcement inquiry, that a person or legal entity may possess or have care, custody, or control. A custodian of records may be required to give testimony concerning the production and authentication of such records. The production of records may be required from any place in any State or in any territory or other place subject to the jurisdiction of the United States at any designated place, except that such production shall not be required more than 500 miles distant from the place where the subpoena is served. Witnesses summoned under this section shall be paid the same fees and mileage that are paid witnesses in the courts of the United States. A subpoena requiring the production of records shall describe the objects required to be produced and prescribe a return date within a reasonable period of time within which the objects can be assembled and made available.

''(2) Investigative demands utilizing an administrative subpoena are authorized for any investigation with respect to any act or activity constituting or involving health care fraud, including a scheme or artifice—

''(A) to defraud any health plan or other person, in connection with the delivery of or payment for health care benefits, items, or services; or

''(B) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control or, any health plan, or person in connection with the delivery of or payment for health care benefits, items, or services.

''(b) SERVICE.—A subpoena issued under this section may be served by any person designated in the subpoena to serve it. Service upon a natural person may be made by personal delivery of the subpoena to such person. Service may be made upon a domestic or foreign association which is subject to suit under a common name, by delivering the subpoena to an officer, to a managing or general agent, or to any other agent authorized by appointment or by law to receive service of process. The affidavit of the person serving the subpoena entered on a true copy thereof by the person serving it shall be proof of service.

''(c) ENFORCEMENT.—In the case of contumacy by or refusal to obey a subpoena issued to any person, the Attorney General may invoke the aid of any court of the United States within the jurisdiction of which the investigation is carried on or of which the subpoenaed person is an inhabitant, or in which such person carries on business or may be found, to compel compliance with the subpoena. The court may issue an order requiring the subpoenaed person to appear before the Attorney General to produce records, if so ordered, or to give testimony touching the matter under investigation. Any failure to obey the order of the court may be punished by the court as a contempt thereof. All process in any such case may be served in any judicial district in which such person may be found.

''(d) IMMUNITY FROM CIVIL LIABILITY.—Notwithstanding any Federal, State, or local law, any person, including officers, agents, and employees, receiving a subpoena under this section, who complies in good faith with the subpoena and thus produces the materials sought, shall not be liable in any court of any State or the United States to any customer or other person for such production or for nondisclosure of that production to the customer.

''(e) USE IN ACTION AGAINST INDIVIDUALS.—

''(1) Health information about an individual that is disclosed under this section may not be used in, or disclosed to any person for use in, any administrative, civil, or criminal action or investigation directed against the individual who is the subject of the information unless the action or investigation arises out of and is directly related to receipt of health care or payment for health care or action involving a fraudulent claim related to health, or if authorized by an appropriate order of a court of competent jurisdiction, granted after application showing good cause therefore.

''(2) In assessing good cause, the court shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services.

''(3) Upon the granting of such order, the court, in determining the extent to which any disclosure of all or any part of any record is necessary, shall impose appropriate safeguards against unauthorized disclosure.

''(f) HEALTH PLAN.—As used in this section, the term 'health plan' has the same meaning given such term in section 1128C(c) of the Social Security Act.''.

(b) CLERICAL AMENDMENT.—The table of sections for chapter 223 of title 18, United States Code, is amended by inserting after the item relating to section 3485 the following new item:

''3486. Authorized investigative demand procedures.''.

(c) CONFORMING AMENDMENT.—Section 1510(b)(3)(B) of title 18, United States Code, is amended by inserting ''or a Department of Justice subpoena (issued under section 3486),'' after ''subpoena''.

TITLE VI—STATE HEALTH CARE FRAUD CONTROL UNITS

SEC. 601. STATE HEALTH CARE FRAUD CONTROL UNITS.

(a) EXTENSION OF CONCURRENT AUTHORITY TO INVESTIGATE AND PROSECUTE FRAUD IN OTHER FEDERAL PROGRAMS.—Section 1903(q)(3) (42 U.S.C. 1396b(q)(3)) is amended—

(1) by inserting ''(A)'' after ''in connection with''; and

(2) by striking ''title.'' and inserting ''title; and (B) in cases where the entity's function is also described by subparagraph (A), and upon the approval of the relevant Federal agency, any aspect of the provision of health care services and activities of providers of such services under any Federal health care program (as defined in section 1128B(b)(1)).''.

(b) EXTENSION OF AUTHORITY TO INVESTIGATE AND PROSECUTE PATIENT ABUSE IN NON-MEDICAID BOARD AND CARE FACILITIES.—Section 1903(q)(4) (42 U.S.C. 1396b(q)(4)) is amended to read as follows:

''(4)(A) The entity has—

''(i) procedures for reviewing complaints of abuse or neglect of patients in health care facilities which receive payments under the State plan under this title;

''(ii) at the option of the entity, procedures for reviewing complaints of abuse or neglect of patients residing in board and care facilities; and

''(iii) procedures for acting upon such complaints under the criminal laws of the State or for referring such complaints to other State agencies for action.

''(B) For purposes of this paragraph, the term 'board and care facility' means a residential setting which receives payment from or on behalf of two or more unrelated adults who reside in such facility, and for whom one or both of the following is provided:

''(i) Nursing care services provided by, or under the supervision of, a registered nurse, licensed practical nurse, or licensed nursing assistant.

''(ii) Personal care services that assist residents with the activities of daily living, including personal hygiene, dressing, bathing, eating, toileting, ambulation, transfer, positioning, self-medication, body care, travel to medical services, essential shopping, meal preparation, laundry, and housework.''.

TITLE VII—MEDICARE/MEDICAID BILLING ABUSE PREVENTION

SEC. 701. UNIFORM MEDICARE/MEDICAID APPLICATION PROCESS.

Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services (in this title referred to as the ''Secretary'') shall establish procedures and a uniform application form for use by any individual or entity that seeks to participate in the programs under titles XVIII and XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 42 U.S.C. 1396 et seq.). The procedures established shall include the following:

(1) Execution of a standard authorization form by all individuals and entities prior to submission of claims for payment which shall include the social security number of

the beneficiary and the TIN (as defined in section 7701(a)(41) of the Internal Revenue Code of 1986) of any health care provider, supplier, or practitioner providing items or services under the claim.

(2) Assumption of responsibility and liability for all claims submitted.

(3) A right of access by the Secretary to provider records relating to items and services rendered to beneficiaries of such programs.

(4) Retention of source documentation.

(5) Provision of complete and accurate documentation to support all claims for payment.

(6) A statement of the legal consequences for the submission of false or fraudulent claims for payment.

SEC. 702. STANDARDS FOR UNIFORM CLAIMS.

(a) ESTABLISHMENT OF STANDARDS.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall establish standards for the form and submission of claims for payment under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and the medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.).

(b) ENSURING PROVIDER RESPONSIBILITY.—In establishing standards under subsection (a), the Secretary, in consultation with appropriate agencies including the Department of Justice, shall include such methods of ensuring provider responsibility and accountability for claims submitted as necessary to control fraud and abuse.

(c) USE OF ELECTRONIC MEDIA.—The Secretary shall develop specific standards which govern the submission of claims through electronic media in order to control fraud and abuse in the submission of such claims.

SEC. 703. UNIQUE PROVIDER IDENTIFICATION CODE.

(a) ESTABLISHMENT OF SYSTEM.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall establish a system which provides for the issuance of a unique identifier code for each individual or entity furnishing items or services for which payment may be made under title XVIII or XIX of the Social Security (42 U.S.C. 1395 et seq.; 1396 et seq.), and the notation of such unique identifier codes on all claims for payment.

(b) APPLICATION FEE.—The Secretary shall require an individual applying for a unique identifier code under subsection (a) to submit a fee in an amount determined by the Secretary to be sufficient to cover the cost of investigating the information on the application and the individual's suitability for receiving such a code.

SEC. 704. USE OF NEW PROCEDURES.

No payment may be made under either title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq.; 42 U.S.C. 1396 et seq.) for any item or service furnished by an individual or entity unless the requirements of sections 702 and 703 are satisfied.

SEC. 705. NONDISCHARGEABILITY OF CERTAIN MEDICARE DEBTS.

(a) PAYMENT TO PROVIDERS.—Section 1815(d) (42 U.S.C. 1395g(d)) is amended by adding at the end thereof the following new sentence: ''Notwithstanding any other provision of law, amounts due to the program under this subsection are not dischargeable under any provision of title 11, United States Code.''.

(b) PAYMENT OF BENEFITS.—Section 1833(j) (42 U.S.C. 1395l(j)) is amended by adding at the end thereof the following new sentence: ''Notwithstanding any other provision of law, amounts due to the program under this subsection are not dischargeable under any provision of title 11, United States Code.''.

S. 1859

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medicare Restore Trust Act of 1996''.

SEC. 2. PROHIBITION ON CONSIDERATION OF LEGISLATION THAT DIVERTS SAVINGS ACHIEVED THROUGH MEDICARE WASTE, FRAUD, AND ABUSE ENFORCEMENT ACTIVITIES FOR PURPOSES OTHER THAN IMPROVING THE SOLVENCY OF THE FEDERAL HOSPITAL INSURANCE TRUST FUND.

(a) POINT OF ORDER.—It shall not be in order in the Senate to consider any bill, conference report, or any other legislation that would use savings achieved through enforcement activities that are intended to combat waste, fraud, and abuse under the medicare program under title XVIII of the Social Security Act as offsets for purposes other than to improve the solvency of the Federal Hospital Insurance Trust Fund established under section 1817 of such Act (42 U.S.C. 1395i) (in this Act referred to as the ''trust fund'').

(b) WAIVER.—The point of order described in subsection (a) may be waived or suspended in the Senate by a ⅗ majority vote of the Senators duly chosen and sworn, or by the unanimous consent of the Senate.

(c) APPEALS.—

(1) IN GENERAL.—Appeals in the Senate from decisions of the Chair relating to this section shall be limited to 1 hour, to be equally divided between and controlled by, the appellant and the manager of the bill, conference report, or other legislation, as the case may be.

(2) WAIVER.—An affirmative ⅗ majority vote of the Senators duly chosen and sworn, or a unanimous consent agreement of the Senate shall be required to sustain an appeal of the ruling of the Chair on a point of order raised under this section.

SEC. 3. ENSURING THE INTEGRITY OF THE FEDERAL HOSPITAL INSURANCE TRUST FUND.

(a) DETERMINATION.—Prior to the end of each fiscal year, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') and the Attorney General shall jointly determine—

(1) the portion of the costs charged during such fiscal year to any account established within the Federal Hospital Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to combat health care waste, fraud, and abuse, which do not relate to the administration of the medicare program; and

(2) the amount of funds deposited into such account of such trust fund during such fiscal year that were attributable to enforcement activities that were intended to combat health care waste, fraud, and abuse, which do not relate to the administration of the medicare program.

(b) CERTIFICATION.—If the portion determined under paragraph (1) of subsection (a) exceeds the amount determined under paragraph (2) of such subsection, the Secretary and the Attorney General shall certify to the Secretary of the Treasury the amount, which shall be equal to the amount of such excess, which should be transferred from the General Fund of the Treasury to such trust fund, in order to ensure that such trust fund is fully reimbursed for any expenditures made from the account described in subsection (a) that are not related to the administration of the medicare program under title XVIII of the Social Security Act.

(c) TRANSFER OF FUNDS.—The Secretary of the Treasury shall transfer to such trust fund from the General Fund of the Treasury, out of any funds in the General Fund that are not otherwise appropriated, an amount equal to the amount certified under subsection (b).

By Mr. MCCONNELL (for himself, Mr. DOLE, Mr. LIEBERMAN, and Mr. MOYNIHAN):

S. 1860. A bill to provide for legal reform and consumer compensation relating to motor vehicle tort systems, and for other purposes; to the Committee on Commerce, Science, and Transportation.

THE AUTO CHOICE REFORM ACT OF 1996

By Mr. MCCONNELL (for himself and Mr. DOLE):

S. 1861. A bill to provide for legal reform and consumer compensation, and for other purposes; to the Committee on the Judiciary.

THE LEGAL REFORM AND CONSUMER COMPENSATION ACT OF 1996

● Mr. MCCONNELL. Mr. President, several weeks ago, I was disappointed, but not surprised, when the President vetoed the bipartisan product liability reform bill. The bill would have curbed runaway punitive damage awards—which the Supreme Court endorsed in its recent BMW versus Gore decision—and offered some protection to those needlessly dragged into lawsuits. The President, erroneously, in my view, charged that the product liability reform bill, offered too many benefits to business and unfairly burdened the injured.

The President missed an opportunity to correct some of the defects in the legal system. The fact is the system is too costly and fails to provide prompt and fair relief to those who are injured. Less than half of every dollar spent on lawsuits goes to the injured.

And, spiraling legal costs exact a toll on every American family and business owner in the form of higher insurance premiums and ever-increasing costs for medical care. FBI Director Louis Freeh estimates that fraudulent medical claims arising out of phony car accidents cost every American household $200 a year.

Moreover, economic growth is impeded when new American-made products, technology, medicines, and medical devices aren't brought to worldwide markets because of too many lawsuits.

This mess-of-a-legal system can be turned around with reforms that will ensure those who are injured get fairly and quickly compensated without resort to expensive and protracted litigation. The two bills I am introducing today take aim at the unnecessary costs of personal injury lawsuits. The result will be more money in the hands of the injured more quickly, and a massive savings to American consumers.

The Joint Economic Committee estimates that the Auto Choice Reform Act will save the driving public $40 billion annually in insurance costs. Savings would be progressive, resulting in savings to low-income drivers of about 45 percent on their insurance premiums.

The Legal Reform and Consumer Compensation Act, designed to change the monopolistic and anticompetitive contingent fee system and to provide a rapid recovery mechanism for personal injury victims, would save more than $45 billion a year.

These dramatic savings are achieved without capping punitive damages, or limiting the rights of victims. Rather, these bills expand consumer options. By adding a new type of auto insurance, new ways of paying victims fairly for their injuries, and breaking the contingent fee hold, Americans will be begin to be relieved of the litigation burden that threatens to strangle every family and burdens the overall economy.

The changes proposed in these bills will require a major rethinking about the current zero-sum, adversarial legal system. Occasionally, the legal system rewards a persistent plaintiff with a windfall damage award—like the woman who won a multi-million-dollar verdict from McDonald's for spilling hot coffee on herself. But odds of winning in the legal system are about as good as hitting a jackpot in Las Vegas.

The perverse incentive structure—the one-in-a-million chance of winning the lottery—discourages settlement and rewards a piling on of claims. If a jury will award an injured party 3 times his or her out-of-pocket losses, then 10 trips to the doctor are better than 2. The Rand Corp., in a study released earlier this year, estimates that excess medical claiming connected with lawsuits consumed some $4 billion of health care resources.

But the fault for the runaway legal system does not lie exclusively with the injured and their lawyers. Defendants and their lawyers know that the multimillion-dollar jury award is a rare occurrence. Yet, most cases are fought as if every case results in $1 million verdict. Every dollar spent on defense buys delay and precludes early and reasonable resolution.

In the meantime, every American pays the price—through higher car insurance premiums, spiraling medical bills, and soaring prices at the checkout counter. And the economy suffers from slow growth and through products, inventions, and technologies withheld from the world's markets because of the cost of lawsuits. It's time we cut the tort tax and give every American relief from the costly legal system.

I am pleased that Senator DOLE is joining this effort. His sponsorship of this ambitious effort to overhaul the legal system will probably be one of his last legislative initiatives. I am honored to have his support.

I ask unanimous consent that a copy of the two bills and a summary of the bills be printed in the RECORD.

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

S.1860

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Auto Choice Reform Act of 1996''.

SEC. 2. FINDINGS.

The Congress finds that—

(1) the costs of operating a motor vehicle are excessive due to the legal and administrative costs associated with the processing of claims under the tort system;

(2) the costly fault and liability insurance system often fails to provide compensation commensurate with loss, takes too long to pay benefits and wastes too many dollars on legal fees;

(3) the distorted incentives of the tort system for motor vehicles produce—

(A) significant fraud in the claiming process, thereby dangerously exacerbating the national distrust felt by many Americans toward the legal process in general and the rule of law itself;

(B) significant wasteful, fraudulent, and costly overuse and abuse of scarce health care resources and services, thereby increasing the problems of affordability and accessibility in the health care system;

(C) significant and unbearable cost burdens on low-income Americans, which impose on them the Hobson's choice of driving on an unlawful, uninsured basis or compelling them to forego essential needs;

(D) significant reductions in access to, and purchases of, motor vehicles, thereby damaging the economic well-being of many low-income Americans, while also unnecessarily harming a critical component of the American economy;

(E) significant deterioration of the economic well-being of most major American cities through the imposition of a massive, differentially greater ''tort tax'' on urban residents, thereby contributing to the abandonment of cities by many American taxpayers able to achieve substantial after-tax savings on automobile insurance premiums by the sole act of moving to adjacent suburban communities; and

(F) significant inability to achieve market-based discounts in insurance rates for owners of safer cars, thereby powerfully contributing to the lesser safety of American drivers and passengers;

(4) a system that allows consumers the opportunity to self-insure and separates economic and non-economic damages for the purpose of purchasing insurance would provide enormous cost savings to drivers;

(5) consumer choice in selection of motor vehicle insurance would be greatly enhanced if each consumer could decide upon the form of insurance that best suits the individual needs of the consumer;

(6) insurance to indemnify individuals for personal injury arising from motor vehicle collisions is frequently unavailable at reasonable cost because of the potential for third-party claims;

(7) a system enabling individuals to select the form of motor vehicle insurance coverage that best suits individual needs would enhance individual freedom and reduce the costs of motor vehicle insurance for consumers; and

(8) a system which targets and emphasizes the scourge of those who drive under the influence of drugs or alcohol will further deter such dangerous and unlawful conduct.

SEC. 3. PURPOSE.

The purpose of this Act is to authorize consumers of motor vehicle insurance to choose between their present tort remedies under State law and a system which combines first-party insurance and the right to sue negligent drivers for all further uncompensated economic losses.

SEC. 4. DEFINITIONS.

For the purposes of this Act, the term—

(1) ''accident'' means unforeseen or unplanned event causing loss or injury;

(2) ''economic loss'' means any objectively verifiable pecuniary loss resulting from the harm suffered, including past and future medical expenses, loss of past and future earnings, burial costs, costs of repair, or replacement costs of replacement services in the home, including child care, transportation, food preparation, and household care, costs of making reasonable accommodations to a personal residence, loss of employment, and loss of business or employment opportunities, to the extent recovery for such losses is allowed under applicable State law;

(3) ''financial responsibility law'' means a statute (including one requiring compulsory coverage) penalizing motorists for failing to carry defined limits of tort liability insurance covering motor vehicle accidents;

(4) ''insurer'' includes a person who is self-insured within the meaning of applicable State law;

(5) ''intentional misconduct'' means conduct whereby harm is intentionally caused or attempted to be caused by one who acts or fails to act for the purpose of causing harm or with knowledge that harm is substantially certain to follow when such conduct caused or substantially contributed to the harm claimed for, except a person does not intentionally cause or attempt to cause harm—

(A) merely because his or her act or failure to act is done with the realization that it creates a grave risk of causing harm; or

(B) if the act or omission causing bodily harm is for the purpose of averting bodily harm to oneself or another person;

(6) ''motor vehicle'' means a vehicle of any kind required to be registered under the provisions of the applicable State law relating to motor vehicles;

(7) ''net economic loss''—

(A) means economic loss, including when payable based on fault, a reasonable attorney's fee calculated on the basis of the value of the attorney's efforts as reflected in payment to the attorney's client; and

(B) excludes amounts paid or payable under—

(i) Federal, State, or private disability or sickness programs;

(ii) Federal, State, or private health insurance programs;

(iii) employer wage continuation programs;

(iv) workers' compensation or similar occupational compensation acts; and

(v) any other source of payment intended to compensate such individual for injuries resulting from a motor vehicle accident, including amounts paid under personal protection insurance or tort maintenance coverage;

(8) ''no-fault motor vehicle law'' means a statute under which those injured in motor vehicle accidents are paid without regard to fault for their pecuniary losses as a result of personal injury, in return for which claims based on fault including for nonpecuniary losses, are to a defined extent limited;

(9) ''noneconomic loss'' means subjective, nonmonetary losses including pain, suffering, inconvenience, mental suffering, emotion distress, loss of society and companionship, loss of consortium, hedonic damages, injury to reputation, and humiliation;

(10) ''person'' means any individual, corporation, company, association, firm, partnership, society, joint stock company, or any other entity (including any governmental entity);

(11) ''personal protection'' means an insurance contract payable without regard to

fault for net economic loss due to personal injury resulting from a motor vehicle accident, along with waiver of tort claims pursuant to this Act;

(12) ''replacement service loss'' means expenses reasonably incurred in obtaining ordinary and necessary services from others, not members of the injured person's household, in lieu of the services the injured person would have performed for the benefit of the household;

(13) ''resident relative or dependent'' means a person related to the owner of a motor vehicle by blood, marriage, adoption, or otherwise (including a dependent receiving financial services or support from such owner), and residing in the same household at the time of accidental personal injury, and a person resides in the same household if he or she usually makes his or her home in the same family unit, even though temporarily living elsewhere;

(14) ''serious bodily injury'' means bodily injury which results in death, dismemberment, significant and permanent loss of an important bodily function, or significant and permanent scarring or disfigurement;

(15) ''State'' means any State of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, the Virgin Islands, American Samoa, the Northern Mariana Islands, the Trust Territories of the Pacific Islands, and any other territory or possession of the United States;

(16) ''tort liability'' means the legal obligation for payment of damages caused by one adjudged to have committed a tort;

(17) ''tort liability insurance'' means insurance by the terms of which an insurer agrees to pay, on behalf of an insured, damages the latter is obligated to pay a third person because of his or her liability to that third person;

(18) ''tort maintenance coverage'' means coverage under which a tort liability insured, when involved in an accident with a personal protection insured, retains his or her right to claim for personal injury under State law without modification by any provision of this Act, except that responsibility for payment for any such claim is assumed by his or her own insurer to the extent of such coverage under section 5(b)(1); and

(19) ''uninsured motorist'' means the owner of a motor vehicle, including his or her resident relatives, uninsured for either personal protection or tort liability insurance at the limits prescribed by the applicable State's financial responsibility law or higher under section 5(a)(2)(A).

SEC. 5. MOTOR VEHICLE PERSONAL PROTECTION INSURANCE.

(a) INSURANCE POLICY PROVISIONS.—(1) An insurance policy that includes provisions that entitle the insured to receive, without regard to fault or lack of fault, the insured's net economic losses caused by an injury along with an express, specific waiver of tort rights as provided in the insurance policy shall be valid notwithstanding any contrary provisions of State law.

(2) In order for a personal protection insurance policy to be covered by this Act, a motor vehicle insurance policy issued by an insurer shall, at a minimum—

(A) provide personal protection coverage of the greater of—

(i) up to the minimum limits of liability insurance for personal injury under the State's financial responsibility law; or

(ii) in a State covered by a no-fault motor vehicle insurance law, up to the minimum level of insurance required for no-fault benefits; and

(B) contain provisions under the State's financial responsibility law, including those related to liability for property damage, except to the extent State law would bar contractual provisions giving effect to personal protection authorizations set forth in this Act, or to the extent that State law would be contrary to other provisions of this Act.

(3) A personal protection insurer is authorized to contract to pay personal protection benefits periodically as losses accrue. Unless the treatment or expenses related thereto are in reasonable dispute, an insurer who does not pay a claim for net economic loss covered by a personal protection insurance under this Act within 30 days after payment is due, shall pay the loss compounded at a rate of 50 percent per annum, as liquidated damages and in lieu of any penalty or exemplary damages.

(b) OPERATION OF THE RIGHT TO CHOOSE.—(1) Under this Act, in lieu of buying traditional tort liability insurance for personal injury to protect third parties, motorists have the right to choose personal protection which will be available to themselves and their family members in the event of a motor vehicle accident, including the amount of financial protection they deem appropriate and affordable for themselves and such others. As an alternative, motorists have the right to elect traditional tort liability coverage for personal injury at the minimum limits (or higher) under the State's financial responsibility law.

(2)(A) A motorist who chooses traditional tort liability has automatically included in such coverage tort maintenance coverage at least at the equivalent of the minimum levels of insurance under the higher of—

(i) the State's financial responsibility law for personal injury; or

(ii) the State's no-fault motor vehicle law, if applicable.

(B) A motorist described under subparagraph (A) who is involved in an accident with another motorist remains subject to tort law for personal injury except that, based on fault, such motorist—

(i) may be claimed against by those covered by personal protection insurance or tort maintenance coverage only for net economic loss; and

(ii) may not claim against those covered by personal protection insurance or tort maintenance coverage except for net economic loss.

(C)(i) With respect to a claim under subparagraph (B)(ii), a deduction is made against the recovery equal to the limits of tort maintenance coverage applicable to the economic loss of the claimant.

(ii) One-half of any amount paid under tort maintenance coverage referred to under clause (i) shall be deemed payable for economic loss.

(3) A motorist who chooses personal protection coverage and who is involved in an accident with another such motorist is compensated under his or her own policy for net economic loss only without regard to fault. But if the motorist sustains net economic loss in excess of his or her policy's benefit levels, that person retains the right to claim and sue for net economic loss based on fault.

(4) If a motorist who has chosen personal protection coverage is involved in an accident with an uninsured motorist, the personal protection insured is compensated for net economic loss without regard to fault according to the terms of his or her personal protection policy, and has the right to claim against the uninsured motorist for net economic loss based on fault. The uninsured motorist forfeits the right to claim for noneconomic loss against the motorist who has chosen the personal protection policy.

(5)(A) A motorist who chooses either personal protection insurance or tort liability insurance also binds by such choice his or her resident relatives, provided that—

(i) an adult resident relative shall not be bound without his or her consent, which, in the absence of express consent, shall be implied when the relative is present in a motor vehicle operated by the motorist; and

(ii) insurers are authorized to specify reasonable terms and conditions governing the commencement, duration, and application of the chosen coverage depending on the number of motor vehicles and owners thereof in a household.

(B) In order to minimize conflict between the two options under subparagraph (A), insurers are authorized to maintain underwriting rules that encourage uniformity within a household.

(6) A personal protection insured retains the right to claim, and remains subject to a claim, for driving under the influence of alcohol or illegal drugs, both as defined by State law, or for intentional misconduct.

(7) A personal protection insured claims personal protection benefits in the following priority:

(A) The personal protection of an employer if the person injured is an employee of the employer and the accident occurs while the employee is acting within the scope of the employee's employment.

(B) The personal protection under which the injured person is or was an insured.

(C) The personal protection covering a motor vehicle involved in the accident, if the person injured was an occupant or was struck by such motor vehicle at the time of the accident.

(8) A personal protection insurer is authorized to write personal protection coverage—

(A) without any deductible or subject to a reasonable deductible not to exceed $1,000; and

(B) with an exclusion of coverage for persons driving under the influence of alcohol or illegal drugs.

(9) A personal protection insurer is subrogated, to the extent of its obligations, to all of the rights of its personal protection insured with respect to an accident caused in whole or in part, as determined by applicable State law, by the negligence of an uninsured motorist or driving under the influence of alcohol or illegal drugs, or caused in whole or in part by intentional misconduct or any person who is not affected by the limitations on tort rights and liabilities under this Act.

(10) Any person lawfully uninsured under the terms of State law for either personal protection or tort liability insurance retains his or her tort rights in a form unaffected by this Act.

(c) RENEWAL OR CANCELLATION.—An insurer shall not cancel, fail to renew, or increase the premium of its insured solely on account of the insured or any other injured person making a claim for personal protection benefits or, where there is no basis for ascribing fault to the insured or one for whom the insured is vicariously liable, for tort maintenance coverage.

(d) IMMUNITY.—No insurer or any agent or employee of such insurer, no insurance producer representing a motor vehicle insurer or any automobile residual market plan, and no attorney licensed to practice law within this State shall be liable in an action for damages on account of an election of the tort liability option, an election of the personal protection option, or a failure to make a required election, unless such person has willfully misrepresented the available choices or has fraudulently induced the election of one system over the other.

(e) RULE OF CONSTRUCTION.—Nothing in this Act shall be construed—

(1) to waive or affect any defense of sovereign immunity asserted by any State under any law or by the United States;

(2) to preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation;

(3) to affect the right of any court to transfer venue, to apply the law of a foreign nation, or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum;

(4) subject to paragraph (1), to create or vest jurisdiction in the district courts of the United States over any motor vehicle accident liability or damages action subject to this Act which is not otherwise properly in the United States District Court;

(5) to prevent insurers and insureds from contracting to limit recovery for lost wages and income under personal protection coverage such that only 60 percent or more of lost wages or income is covered, or to offset death benefits under personal protection coverage by amounts paid for lost wages and replacement service losses;

(6) to prevent an insurer from contracting with personal protection insureds, as permitted by State law, to have submitted to arbitration any dispute with respect to payment of personal protection benefits;

(7) to relieve a motorist of the obligations imposed by State law to purchase tort liability insurance for personal injury to protect third parties who are not affected by the immunities of subsection (b); and

(8) to preclude a State from enacting, for all motor vehicle accident cases including cases covered by this Act, a minimum dollar value for defined classes of cases involving death or serious bodily injury.

SEC. 6. APPLICABILITY TO STATES; CHOICE OF LAW; JURISDICTION; AND CONSTRUCTION.

(a) ELECTION OF NONAPPLICABILITY BY STATES.—This Act shall not apply in a State if such State enacts a statute that—

(1) cites the authority of this subsection; and

(2) declares the election of such State that this Act shall not apply.

(b) NONAPPLICABILITY TO STATE BY STATE FINDING.—(1) This Act shall not apply in a State, if—

(A) the State official charged with jurisdiction over insurance rates for motor vehicles makes a finding that the statewide average motor vehicle premiums in effect immediately before the effective date of this Act for personal injury will not be reduced by an average of at least 30 percent for persons choosing personal protection coverage in lieu of traditional tort liability pursuant to this Act (without including any cost for uninsured or underinsured or medical payments coverages);

(B) the finding described under subparagraph (A) is supported by evidence adduced in public hearing and reviewable under the State's administrative procedure law; and

(C) the finding described under subparagraph (A) and any review of such finding described under subparagraph (B) occurs no later than 60 days after the date of the enactment of this Act.

(2) Premiums for personal injury referred to under paragraph (1)(A) include premiums for—

(A) personal injury liability, uninsured and underinsured motorists' liability, and medical payments coverage; and

(B) if applicable—

(i) no fault benefits under no fault motor vehicle law; or

(ii) similar benefits under a law not limiting claims based on fault for nonpecuniary losses.

(c) CHOICE OF LAW.—In disputes between citizens of States that elect nonapplicability under subsection (a) and citizens of States that do not so elect, ordinary choice of law principles shall apply.

(d) JURISDICTION.—This section shall not confer jurisdiction on the district courts of the United States under section 1331 or 1337 or title 28, United States Code.

(e) CONSTRUCTION.—Nothing in this Act shall alter or diminish the authority or obligation of the Federal courts to construe the terms of this Act.

SEC. 7. EFFECTIVE DATE.

This Act shall take effect 60 days after the date of the enactment of this Act.

S. 1861

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Legal Reform and Consumer Compensation Act of 1996''.

SEC. 2. TABLE OF CONTENTS.

The table of contents for this Act is as follows:

SEC. 3. FINDINGS.

The Congress finds that—

(1) the current liability system is, all too often, a frustrating experience for many personal injury claimants, resulting in a time-consuming process which provides inadequate compensation for their injuries;

(2) for other personal injury claimants, the system can provide a windfall of financial gain, greatly in excess of their actual losses;

(3) the unpredictable and erratic system is a product of a perverse incentive structure in which the magnitude of noneconomic damages is directly linked to, and is a multiple of, the out-of-pocket expenses incurred by the claimant;

(4) the incentives of the litigation system perpetuate the overuse and abuse of the medical system, costing the economy billions of dollars and costing every United States family hundreds of dollars in unnecessary insurance premiums and health care expenses;

(5) the system as it has recently developed—

(A) is highly regressive;

(B) is often duplicative of and inconsistent with Federal regulatory and social welfare programs for the protection of injured parties;

(C) is burdened by an administrative cost structure that causes a disproportionate amount of its dollars to go to lawyers rather than to injured parties;

(D) is particularly prejudicial to the competitive position of the American small business community;

(E) is a major and increasing threat to the economic viability of American cities;

(F) imposes a major burden on the American economy and if reformed would significantly enhance American productivity and consumer wealth;

(G) is replete with incentives that reward abusive claiming and defensive behavior; and

(H) is therefore a major cause of the dangerous disesteem increasingly felt by increasing numbers of Americans toward the legal system and, indeed, the rule of law itself; and

(6) there is a need for a system of early offer, rapid recovery and consumer choice to enable claimants to be made whole and recover all economic losses without resort to complex and protracted litigation.

TITLE I—EARLY OFFER AND RAPID RECOVERY

SEC. 101. EARLY OFFER AND RAPID RECOVERY MECHANISMS.

(a) PURPOSE.—The purpose of this title is to establish a system of early offer and rapid recovery to permit personal injury claimants to recover their economic losses from a responsible party in a timely manner.

(b) IN GENERAL.—Chapter 111 of title 28, United States Code, is amended by adding at the end the following new section:

''§ 1660. Early offer and rapid recovery mechanisms

''(a) For purposes of this section:

''(1) The term 'allegedly responsible party' means a person, partnership, or corporation, and an insurer thereof, alleged by the claimant to be responsible for at least some portion of an injury alleged by a claimant.

''(2) The term 'claimant' means an individual who, in his or her own right, or vicariously as otherwise permitted by law, is seeking compensation for personal injury.

''(3) The term 'clear and convincing evidence' means that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established. The level of proof required to satisfy such standard shall be more than that required under preponderance of the evidence, and less than that required for proof beyond a reasonable doubt.

''(4) The term 'collateral benefits' means all benefits and advantages received or entitled to be received (regardless of the right of recoupment of any other entity, through subrogation, trust agreement, lien, or otherwise) by an injured individual (or other entity) as reimbursement of loss because of personal injury—

''(A) payable or required to be paid by—

''(i) Federal, State, or other governmental disability, unemployment, or sickness programs;

''(ii) under the terms of any Federal, State, or other governmental or private health insurance, accident insurance, wage or salary continuation plan, or disability income insurance; or

''(iii) any other program or compensation system, if the payment is intended to compensate the claimant for the same injury or disability which is the subject of the claim; minus

''(B) the amount paid by such individual (or by the spouse, parent, child, or legal guardian of such individual) to secure the payments described in subparagraph (A).

''(5) The term 'economic loss' means any objectively verifiable pecuniary loss resulting from the harm suffered, including past and future medical expenses, loss of past and future earnings, burial costs, property damage accompanying bodily injury, costs of replacement services in the home, including child care, transportation, food preparation, and household care, costs of making reasonable accommodations to a personal residence, loss of employment, and loss of business or employment opportunities, to the extent recovery for such losses is allowed under applicable State law.

''(6) The term 'entity' includes an individual or person.

''(7) The term 'intentional misconduct' means conduct whereby harm is intentionally caused or attempted to be caused by one who acts or fails to act for the purpose of causing harm or with knowledge that harm is substantially certain to follow when such conduct caused or substantially contributed to the harm claimed for, except a person does not intentionally cause or attempt to cause harm—

''(A) merely because his or her act or failure to act is intentional or done with the realization that it creates a risk of harm; or

''(B) if the act or omission causing bodily harm is for the purpose of averting bodily harm to oneself or another person.

''(8) The term 'liability claim' means a demand for compensation by certified mail to an allegedly responsible party, which shall set forth the material facts relevant to the claim including—

''(A) the name, address, age, marital status, and occupation of claimant, which term for the purposes of this section includes the injured party if claimant is operating in a representative capacity;

''(B) a brief description of how the injury occurred;

''(C) the names, and, if known, the addresses, telephone numbers, and occupations of all known witnesses to the injury;

''(D) copies of photographs in claimant's possession that relate to the injury;

''(E) the basis for claiming that the party to whom the claim is addressed is at least partially responsible for causing the injury;

''(F) a description of the nature of the injury, the names and addresses of all physicians, other health care providers, and hospitals, clinics, or other medical service entities that provided medical care to the claimant or the injured party including the date and nature of the service;

''(G) a copy of the medical records relating to the injury and those involving a prior injury or preexisting medical condition which an allegedly responsible party would be able to introduce into evidence in a trial or, in lieu of either or both, executed releases authorizing the allegedly responsible party to obtain such records directly from health care providers that produced or possess them; and

''(H) relevant documents, including records of earnings if a claimant is self-employed and employer records of earnings if a claimant is employed, and any medical expenses, wages lost, or other pertinent damages suffered as a consequence of the injury.

''(9) The term 'noneconomic loss' means nonmonetary losses including punitive damage claims and further including without being limited to pain, suffering, inconvenience, mental suffering, emotional distress, loss of society and companionship, loss of consortium, hedonic damages, injury to reputation, and humiliation.

''(10) The term 'punitive damages' means damages awarded against any person or entity to punish such persons or entity or to deter such person or entity, or others, from engaging in similar behavior in the future.

''(11) The term 'reasonable attorney's fee' means an hourly fee for services rendered subsequent to the execution of a written agreement establishing an attorney-client relationship that bears a reasonable relation to the attorney's actual efforts on the client's behalf. Fees shall not be deemed reasonable to the extent that services provided by an attorney are attributable to any failure to provide reasonably prompt notice pursuant to subsection (b)(1)(A)(ii).

''(12) The term 'serious bodily injury' means bodily injury which results in death, dismemberment, significant and permanent loss of an important bodily function, or significant and permanent scarring or disfigurement.

''(13) The term 'wanton misconduct' means conduct that the allegedly responsible party realized was excessively dangerous, done heedlessly and recklessly, and with a conscious disregard of the consequences to or rights and safety of the claimant.

''(b)(1)(A) After an occurrence that may give rise to a civil action or claim against any person, in any Federal or State court based on any cause of action to recover damages for personal injury, any potentially allegedly responsible party has the option to offer, not later than the later of—

''(i) 120 days after the injury; or

''(ii) 120 days after the initiation of the liability claim,

to compensate a claimant for reasonable economic loss, including future economic loss, less collateral benefits, and including a reasonable attorney's fee for the claimant.

''(B) If within 30 days of receipt of a liability claim an allegedly responsible party notifies an unrepresented claimant or a claimant's attorney of a request for a medical examination of the claimant, and the claimant is not made available for such examination within 10 days of receipt of the request, the time provided by this section for issuing a response is extended by 1 day for each day that the request is not honored after the expiration of 10 days from the date of the request. Any such extension shall also include a further period of 10 days from the date of the completion of the medical examination.

''(C) The claimant may extend the time for receiving the offer specified in subparagraph (A).

''(2) States may establish for all cases, including cases covered by this title, a minimum dollar value for defined classes involving death or serious bodily injury. A claimant shall have the option of accepting such minimum dollar value payable in lump sum, or accepting the benefit specified in paragraph (1)(A).

''(c) An offer under subsection (b) may include other allegedly responsible parties, individuals, or entities that were involved in the events which gave rise to the civil action, regardless of the theory of liability on which the claim is based, upon their request or consent.

''(d) Future economic losses shall be payable to an individual under this section as such losses occur.

''(e) If, after an offer is made under subsection (b), the participants in the offer dispute their relative contributions to the payments to be made to the individual, such disputes shall be resolved through binding arbitration in accordance with applicable rules and procedures established by the Attorney General of the United States.

''(f)(1) The claimant may reject an offer of compensation made under subsection (b) and elect to bring or maintain a civil action. Upon rejection of the offer, the claimant may recover economic loss, including future economic loss, less collateral benefits. The amount of collateral benefits shall be determined by the court in a pretrial proceeding. In any subsequent proceeding in the action, no evidence shall be admitted as to the amount of economic loss for which collateral benefits have been paid to, or will be paid to, the claimant. The claimant may recover for noneconomic loss to the extent authorized by other applicable law only if the claimant proves each element of the claim for noneconomic loss by clear and convincing evidence, that the allegedly responsible party caused the injury by intentional or wanton misconduct.

''(2) A notice of such a rejection is required to be made not later than 90 days after the date on which the offer of compensation benefits is made. A failure to accept the offer within the 90-day period is deemed a rejection.

''(g) Rejected offers may not be disclosed in any subsequent action brought by the claimant.

''(h) Nothing in this section shall be construed to—

''(1) waive or affect any defense of sovereign immunity asserted by any State under any law;

''(2) waive or affect any defense of sovereign immunity asserted by the United States;

''(3) affect the applicability of any provision of chapter 97;

''(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation;

''(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum;

''(6) affect any applicable statute of limitations of any State or of the United States, except as expressly provided in this title; or

''(7) impair any right of a provider of collateral benefits to seek reimbursement outside of the claimant's cause of action where permitted by State law, other than by a lien on the recovery of the claimant.

''(i)(1) This section shall not apply to accidental bodily injury caused by the operation or the use of a motor vehicle in claims in which an uninsured motorist or a personal protection insured is involved.

''(2) For purposes of this subsection the term 'operation or use'—

''(A) means operation or use of a motor vehicle as a motor vehicle, including, incident to its operation or use as a vehicle, the occupation of the vehicle;

''(B) does not cover conduct within the course of a business of manufacturing, selling, or maintaining a motor vehicle, including repairing, servicing, washing, loading, or unloading; and

''(C) does not include such conduct not within the course of such a business unless such conduct occurs while occupying a motor vehicle.''.

(c) TECHNICAL AND CONFORMING AMENDMENTS.—The table of sections for chapter 111 of title 28, United States Code, is amended by adding at the end the following new item:

''1660. Early offer and rapid recovery mechanisms.''.

TITLE II—FAIRNESS IN LEGAL FEES

SEC. 201. FINDINGS AND PURPOSE.

(a) FINDINGS.—The Congress finds that contingency fees play a useful and often critical role in ensuring access to counsel and the courts on the part of those who would otherwise be unable to afford such access, but that—

(1) personal injury claimants are often subjected to unnecessary costs, delays, and inefficiencies in processing their compensation claims;

(2) virtually all such claimants who are represented by attorneys are charged contingent fees;

(3) the ethical and legal validity of a contingent fee is dependent upon an attorney undertaking risk in exchange for sharing proportionately in the proceeds of a claim;

(4) the perverse incentives of the existing system often encourage and reward defendants who take intransigent settlement positions and otherwise unethically add to the costs and delays of settling meritorious claims for, among other reasons, the purpose of reducing the marginal rates of compensation received by claimants' counsel;

(5) many deserving claimants receive inequitable compensation because—

(A) such claimants are required to pay attorneys approximately one-third or more of any recovery even when there is little or no issue of liability or damages and therefore little or no assumption of risk by the attorney; and

(B) when a defendant or its insurer has made a substantial settlement offer before the attorney's retention or shortly thereafter and the attorney has added little or nothing to the value of the claim to that point, payment of a substantial contingent fee is nonetheless generally required;

(6) the current compensation system often fails to provide sufficient financial incentives to effectuate prompt and adequate compensation to deserving claimants, resulting in—

(A) delays in adjudications and case settlements often caused by intransigent defendant conduct that the present system perversely rewards and thereby deprives claimants of prompt compensation;

(B) a substantial burden on Federal and State courts contributing to very high case backlogs; and

(C) regressive cost burdens and substantial avoidable costs imposed on all parties resulting from the long delays in resolving many claims;

(7) the current tort compensation system which results in delays in resolving claims and which effectively provides for increased noneconomic damages and, therefore, increased legal fees as medical care costs increase, provides perverse financial incentives for both more intensive and unnecessary use of medical care providers and the fraudulent incurrence of medical care expenses, thereby adding materially to the Nation's health care costs and burdens;

(8) delays in resolving claims often result in more intensive and unnecessary use of medical care providers, thereby adding to the Nation's health care burden;

(9) the claims process gives rise to substantial, avoidable transaction costs because of the lack of adequate incentives for defendants and their insurers to offer prompt and equitable settlements to meritorious claimants and because claimants' attorneys exact a significant share of any settlement even when their efforts do not generate or augment the settlement offer;

(10) contingency fee practices, as described in the preceding paragraphs, expose a clear and impermissible gap between (A) the ethical standards established and promulgated by courts and professed by the Bar, and (B) the actual practices of the Bar;

(11) contingency fee practices, as described in the preceding paragraphs, bring substantial disrepute to the Bar and to the legal system as a whole and loss of confidence in the rule of law itself, not the least because they create and expose broad gaps between the stated ethical principles of the legal profession and its real world practices;

(12) the inability of the Bar and the courts to curb contingency fee abuses has led to higher settlement costs, lowered compensation to injured persons, excessive medical care costs and delayed claims processing; and

(13) there is a need for adopting a procedure to implement appropriate ethical and legal standards and to resolve personal injury claims more fairly and promptly.

(b) PURPOSES.—The purposes of this title are to—

(1) enforce more efficiently and effectively ethical standards governing the reasonableness of lawyers' fees and correspondingly to implement the stricter scrutiny that courts are obliged to apply to contingent fees;

(2) reverse systemic incentives now in effect so as to reward, and not to penalize, defendants who make substantial early settlement offers;

(3) compensate claimants' attorneys more rationally by calculating their compensation in relation to the value of services rendered and risks undertaken;

(4) compensate more fairly those seeking redress for injuries by giving them a larger share of promptly achieved settlements;

(5) further enhance the likelihood of early settlement of claims by preserving a larger share of early settlement offers for claimants;

(6) lower the costs of the personal injury tort compensation system including unnecessary medical and defense costs;

(7) remove the burdens on interstate commerce and the Nation's health care programs that are imposed by the current tort compensation system;

(8) create a simple, self-enforcing system, controlled by the parties, which forms an early basis for establishing the sums and issues that are in dispute;

(9) reduce unworkable burdens now placed on courts and bar grievance boards presently charged with enforcing ethical standards through ex post facto, case-by-case fact finding processes that pose difficult burdens of proof and impose disproportionate transaction costs on both parties and fact finders; and

(10) provide alternatives to across-the-board fee cap reforms, which often provide defendants with unearned advantages and further encourage many defendants in unethical protraction of settlement of meritorious claims.

SEC. 202. DEFINITIONS.

For purposes of this title:

(1) The term ''allegedly responsible party'' means a person, partnership, corporation, and an insurer thereof, alleged by a claimant to be responsible for at least some portion of a personal injury alleged by claimant.

(2) The term ''claim'' means an assertion of entitlement to compensation for personal injury from an allegedly responsible party and, to the extent subject to a contingent fee agreement, to all other related claims arising from such injury.

(3) The term ''claimant'' means an individual who, in his or her own right, or vicariously as otherwise permitted by law, is seeking compensation for personal injury.

(4) The term ''contingent fee'' means the fee negotiated in a contingent fee agreement that is payable in fact or in effect only from the proceeds of any recovery on behalf of claimant.

(5) The term ''contingent fee agreement'' means a fee agreement between an attorney and claimant wherein the attorney agrees to bear the risk of no or inadequate compensation in exchange for a proportionate share of any recovery by settlement or verdict obtained for claimant.

(6) The term ''contingent fee attorney'' means an attorney who agrees to represent claimant in exchange for a contingent fee.

(7) The term ''fixed fee'' means an agreement between an attorney and claimant whereby the attorney agrees to perform a specific legal task in exchange for a specified sum to be paid by claimant.

(8) The term ''hourly rate fee'' means the fee generated by an agreement, or otherwise by operation of law, between an attorney and claimant providing that claimant pay the attorney a fee determined by multiplying the hourly rate negotiated, or otherwise set by law, between the attorney and claimant, by the number of hours that the attorney has worked on behalf of claimant in furtherance of claimant's interest. An hourly rate fee may also be a contingent fee to the extent it is only payable in fact or in effect from the proceeds of any recovery on behalf of claimant.

(9) The term ''injury'' means personal injury.

(10) The term ''personal injury'' means an occurrence resulting from any act giving rise to a tort claim, including, without limitation, bodily injury, sickness, disease, death, or property damage accompanying bodily injury.

(11) The term ''post-retention offer'' means an offer of settlement in response to a demand for compensation made within the time constraints, and conforming to the provisions of this title, made to a claimant who is represented by a contingent fee attorney.

(12) The term ''pre-retention offer'' means an offer to settle a claim for compensation made to a claimant not represented by an attorney at the time of the offer.

(13) The term ''response'' means a written communication by claimant or an allegedly responsible party or the attorney for either, deposited into the United States mail and sent certified mail or delivered by an overnight delivery service.

(14) The term ''settlement offer'' means a written offer of settlement set forth in a response within the time limits set forth in this title.

SEC. 203. CREATION OF A FIDUCIARY RELATIONSHIP.

For purposes of this title, a fiduciary relationship commences when a claimant consults a contingent fee attorney to seek professional services.

SEC. 204. WRITTEN HOURLY RATE FEE AGREEMENT.

Contingent fee agreements for the representation of parties with claims shall also include alternate hourly rate fees. If a contingent fee attorney has not entered into a written agreement with claimant at the time of retention setting forth the attorney's hourly rate, then a reasonable hourly rate is payable, subject to the limitations set forth in this title.

SEC. 205. NATURE OF DEMAND FOR COMPENSATION.

(a) IN GENERAL.—At any time after retention, a contingent fee attorney pursuing a claim shall send a demand for compensation by certified mail to an allegedly responsible party, which shall set forth the material facts relevant to the claim including—

(1) the name, address, age, marital status, and occupation of claimant, which term for the purposes of this title includes the injured party if claimant is operating in a representative capacity;

(2) a brief description of how the injury occurred;

(3) the names, and, if known, the addresses, telephone numbers, and occupations of all known witnesses to the injury;

(4) copies of photographs in claimant's possession that relate to the injury;

(5) the basis for claiming that the party to whom the claim is addressed is at least partially responsible for causing the injury;

(6) a description of the nature of the injury, the names and addresses of all physicians, other health care providers, and hospitals, clinics, or other medical service entities that provide medical care to claimant or the injured party including the date and nature of the service;

(7) medical records relating to the injury and those involving a prior injury or pre-existing medical condition which an allegedly responsible party would be able to introduce into evidence in a trial or, in lieu of either or both, executed releases authorizing the allegedly responsible party to obtain such records directly from health care providers that produced or possess them; and

(8) relevant documentation, including records of earnings if a claimant is self-employed and employer records of earnings if a claimant is employed, or any medical expenses, wages lost, or other pertinent damages suffered as a consequence of the injury.

(b) MAILING OF COPIES.—At the time of the mailing of the demand for compensation, a claimant's attorney shall mail copies of each such demand to the claimant and to every other allegedly responsible party.

(c) LIMITATION ON FEE.—A fee received by or contracted for by a contingent fee attorney that exceeds 10 percent of any settlement or judgment received by his or her client after reasonable expenses have been deducted is unreasonable and excessive if the attorney has sent a timely demand for compensation but has omitted information of a material nature that is required by this section which he or she had in his or her possession or which was readily available to him or her at the time of filing.

SEC. 206. TIME LIMIT FOR, AND REQUISITE CONTENTS OF, RESPONSE SETTING FORTH SETTLEMENT OFFER.

(a) POST-RETENTION OFFER.—To qualify its response as a post-retention offer under this title, an allegedly responsible party shall—

(1) issue a response stating a settlement offer within 60 days from receipt of a demand for compensation;

(2) send the response to claimant's attorney with a copy to claimant;

(3) state that the offer is open for acceptance for a minimum of 30 days from the time of its receipt by claimant's attorney and further state whether it expires at the end of this period or remains open for acceptance for a longer period or until notice of withdrawal is given; and

(4) include with the offer copies of materials in its or its attorney's possession concerning the alleged injury upon which the allegedly responsible party relied in making the settlement offer except material that such party or its attorney believes in good faith would not be discoverable by claimant during the course of litigation.

If reproduction costs under paragraph (4) would be significant relative to the size of the offer, the allegedly responsible party may, in the alternative, offer other forms of access to the materials convenient and at reasonable cost to claimant's attorney.

(b) TIME LIMITATIONS.—If within 30 days of receipt of a claimant's demand for compensation an allegedly responsible party notifies an unrepresented claimant or a claimant's attorney that it seeks to have a medical examination of claimant, and claimant is not made available for such examination within 10 days of receipt of the request, the time herein provided for issuing a response is extended by 1 day for each day that the request is not honored after the expiration of 10 days from the date of the request. Any such extension also includes a further period of 10 days from the date of the completion of the medical examination.

(c) INCREASE IN OFFER.—The settlement offer may be increased during the 60-day period set forth in subsection (a)(1) by issuing an additional offer stating that the time for acceptance is 10 days after receipt of the additional offer by claimant's attorney or 30 days from receipt of the initial response, whichever is longer, unless the additional response specifies a longer period of time for acceptance as set forth in subsection (a)(3).

SEC. 207. CONSEQUENCES OF FAILURE TO INCLUDE PRESCRIBED MATERIAL WITH SETTLEMENT OFFER.

(a) IN GENERAL.—If an allegedly responsible party or its attorney willfully fails to include the material required by section 206(a)(4) with a response stating a settlement offer or does not otherwise make such material available—

(1) a claimant may revoke its acceptance of such settlement offer within 2 years of having accepted it; and

(2) any fees and costs reasonably incurred by a claimant in revoking its acceptance of such settlement offer and reinstating its claim is recoverable from the allegedly responsible party, including the losses suffered by a claimant who is precluded from reinstating its claim by operation of a statute of limitations.

(b) SANCTIONS FOR PARTY.—Willful failure of an allegedly responsible party to comply with section 206(a)(4) shall subject such party to the sanctions applicable to a party who fails to comply with requests for the production of documents.

(c) SANCTIONS FOR ATTORNEY.—Willful failure of an attorney for an allegedly responsible party to comply with section 206(a)(4) shall subject that attorney to the same sanctions applicable to attorneys who improperly counsel their clients not to produce documents for which there has been a discovery request.

SEC. 208. NO OBLIGATION TO ISSUE RESPONSE; INADMISSIBILITY OF DEMANDS, RESPONSES, AND FAILURE TO RESPOND.

(a) NO OBLIGATION TO RESPOND.—Nothing in this title imposes on an allegedly responsible party an obligation to issue a response to a demand for compensation.

(b) INADMISSIBILITY OF OFFER.—Demands for compensation, early settlement offers, or the failure of an allegedly responsible party to issue same, are inadmissible in any subsequent litigation, proceeding, or arbitration, to the extent that evidence of settlement negotiations is inadmissible in the jurisdiction where the case is brought.

SEC. 209. EFFECT OF PRE-DEMAND SETTLEMENT OFFER.

A settlement offer to an injured party represented by a contingent fee counsel made before receipt of a demand for compensation, which is open for acceptance for 60 days or more from the time of its receipt and which conforms to the requirements of section 206, is deemed a post-retention offer and has the same effect under this title as if it were a response to a demand for compensation.

SEC. 210. PRE-RETENTION OFFER.

(a) PROHIBITION OF PERCENTAGE FEE OF PRE-RETENTION OFFER.—It is a violation of this title for an attorney retained after claimant has received a pre-retention offer to enter into an agreement with claimant to receive a contingent fee based upon or payable from the proceeds of the pre-retention offer, provided that the pre-retention offer remains in effect or is renewed until the time has elapsed for issuing a response containing a settlement offer as defined under section 206.

(b) UNREASONABLE AND EXCESSIVE FEE.—An attorney entering into a fee agreement that would effectively result in payment of a percentage of a pre-retention offer to a claimant has charged an unreasonable and excessive fee.

(c) PRESUMPTIVE REASONABLE FEE.—An attorney who contracts with a claimant for a reasonable hourly rate or a reasonable fixed fee, or who is paid such a fee for advising claimant regarding the fairness of the pre-retention offer, has charged a presumptively reasonable fee.

SEC. 211. POST-RETENTION OFFER WHEN A PRE-RETENTION OFFER HAS BEEN MADE.

(a) REASONABLE FEE BASED ON HOURLY FEE.—A fee paid or contracted to be paid to a contingent fee attorney by a claimant who has rejected a pre-retention offer and who later accepts a post-retention offer of a greater amount is an unreasonable and excessive fee unless it is an hourly rate fee that does not exceed 25 percent of the excess of the post-retention offer over the pre-retention offer.

(b) REASONABLE FEE BASED ON PERCENTAGE.—If the accepted post-retention offer is less than the pre-retention offer, a total fee for all services rendered that is greater than 10 percent of the first $100,000 of the post-retention offer plus 5 percent of any amount that exceeds $100,000 after all reasonable expenses have been deducted is an unreasonable and excessive fee.

SEC. 212. POST-RETENTION OFFER WHEN NO PRE-RETENTION OFFER HAS BEEN MADE.

A fee paid or contracted to be paid to a contingent fee attorney by a claimant who has not received a pre-retention offer and who has accepted a post-retention offer is an unreasonable and excessive fee unless it is an hourly rate fee that does not exceed 10 percent of the first $100,000 of the offer plus 5 percent of any amount that exceeds $100,000 after all reasonable expenses have been deducted.

SEC. 213. CALCULATION OF ATTORNEY'S FEE WHEN THERE IS A SUBSEQUENT RESOLUTION OF THE CLAIM.

Irrespective of any pre-retention offer, the provisions of section 212 regarding maximum allowable fees remain in effect if a post-retention offer is not accepted by claimant within the time provided by this title. Contingent fees are unreasonable and excessive unless charged against the difference between an unaccepted post-retention offer and the judgment or settlement ultimately obtained by claimant. When such judgment or settlement is lower than the unaccepted offer, the fee limitations of section 212 apply against the judgment or settlement.

SEC. 214. PROVISION OF CLOSING STATEMENT.

Upon receipt of any settlement or judgment, and prior to disbursement thereof, a contingent fee attorney shall provide claimant with a written statement detailing how the proceeds are to be distributed, including the amount of the expenses paid out or to be paid out of the proceeds, the amount of the fee, how the fee amount is calculated, and the amount due claimant.

SEC. 215. EFFECT OF CONTRAVENING AGREEMENTS.

(a) VIOLATION.—A contingent fee attorney who charges a fee that contravenes this title has charged an unreasonable and excessive fee.

(b) EXCESSIVE AND UNREASONABLE FEES.—If the fee violates subsection (a), then it is also excessive and unreasonable to the extent that it has not been reduced by any reasonable fees and costs incurred by claimant in establishing that the fee agreement contravened this title.

(c) UNENFORCEABLE FEE AGREEMENTS.—Fee agreements between claimants and contingent fee attorneys who have charged fees defined under this title as unreasonable or excessive are illegal and unenforceable except to the extent provided in this title.

SEC. 216. INAPPLICABILITY.

(a) EVALUATIONS AND COLLECTIONS.—Except for the provisions of section 203, nothing in

this title applies to an agreement between a claimant and an attorney to retain the attorney—

(1) on an hourly rate fee or fixed fee basis solely to evaluate a pre-retention offer; or

(2) to collect overdue amounts from an accepted pre-retention or post-retention settlement offer.

(b) AGREEMENTS IN WHICH CERTAIN OFFERS NOT MADE.—The provisions of this title prohibiting the charging of contingency fees in the absence of assuming meaningful risk and defining reasonable and unreasonable fees, shall have no effect on contingent fee agreements in cases in which neither a pre-retention nor a post-retention offer of settlement is made.

(c) MOTOR VEHICLE ACCIDENTAL BODILY INJURY.—(1) This title shall not apply to accidental bodily injury caused by the operation or the use of a motor vehicle in claims in which an uninsured motorist or personal protection insured is involved.

(2) For purposes of this subsection the term ''operation or use''—

(A) means operation or use of a motor vehicle as a motor vehicle, including, incident to its operation or use as a vehicle, the occupation of the vehicle;

(B) does not cover conduct within the course of a business of manufacturing, selling, or maintaining a motor vehicle, including repairing, servicing, washing, loading, or unloading; and

(C) does not include such conduct not within the course of such a business unless such conduct occurs while occupying a motor vehicle.

TITLE III—APPLICABILITY AND RULE OF CONSTRUCTION

SEC. 301. APPLICABILITY TO STATES; CHOICE OF LAW; JURISDICTION; AND CONSTRUCTION.

(a) APPLICABILITY TO STATES.—Title I or II of this Act shall not apply in a State if such State enacts a statute that—

(1) cites the authority of this subsection; and

(2) declares the election of such State that the title shall not apply.

(b) CHOICE OF LAW.—In disputes between citizens of States that elect nonapplicability under subsection (a) and citizens of States that do not so elect, ordinary choice of law principles shall apply.

(c) JURISDICTION.—This section shall not confer jurisdiction on the district courts of the United States under section 1331 or 1337 or title 28, United States Code.

(d) CONSTRUCTION.—Nothing in this Act shall alter or diminish the authority or obligation of the Federal courts to construe the terms of this Act.

SEC. 302. EFFECTIVE DATE.

This Act shall take effect on the date of enactment of this Act.

SUMMARY OF DOLE-MCCONNELL LEGAL REFORM PROPOSALS

1. ''CHOICE'' IN AUTO INSURANCE

The principal feature of this proposal is the unbundling of economic losses and noneconomic (''pain & suffering'') losses and enabling individuals to self-insure for non-economic losses.

Without changing substantive state law of negligence, the proposal would offer drivers two choices for motor vehicle insurance:

a. Traditional tort coverage—the injured collects against his/her own policy for economic and non-economic losses, upon a showing that another party was at fault, pursuant to relevant state law. If the injured's economic losses exceed his/her policy limits, the injured will be able to sue the negligent party for those remaining losses and to collect a reasonable attorney's fee; or

b. Personal Injury Protection—the injured collects against his/her policy for economic losses, regardless of fault. As in the traditional tort coverage, if the injured's economic loses exceed his/her policy limits, the injured will be able to sue the negligent party for remaining economic losses, including a reasonable attorney's fee.

In all cases of intentional injury or injury that occurs as a result of drug or alcohol use, the injured retains the ability to sue for both economic and non-economic losses in accordance with applicable state law.

The Joint Economic Committee estimates that this proposal will save consumers $40 billion annually in reduced premiums for automobile insurance.

2. CONTINGENT FEE REFORM

This provision limits traditional contingent fee arrangements in order to ensure that more of the proceeds of a settlement or award will more often go to the insured party.

First, an attorney would be required to offer all clients an hourly rate and an hourly rate is presumed, if the attorney does not have a specific contingent fee agreement.

Where an injured party hires a lawyer to evaluate a settlement offer (pre-retention offer), the attorney is prohibited from receiving a percentage of the offer. The attorney may collect an hourly fee or a fixed fee.

In a case where an injured party retains a lawyer to engage in settlement negotiations on his behalf, and the injured party accepts a settlement offer, the lawyer is restricted to a fee of 10% of the first $100,000 and 5% of amounts above $10,000, after all reasonable expenses have been deducted.

If the settlement offer is not accepted and the case goes to trial, the lawyer may take a contingent only out of that portion of the award which exceeds the settlement offer. If the judgment is lower than the settlement offer, then the lawyer's fee is limited to the 10%/5% formula above.

3. EARLY OFFER/RAPID RECOVERY

This provision, originally sponsored a decade ago by Congressmen Richard Gephardt and Henson Moore, will encourage an injured individual to receive an offer of full compensation for economic losses, including future losses, without a lawsuit. In order to encourage this offer, an injured individual will be required, in making a claim against the allegedly responsible party, to provide all relevant information, including medical records. The allegedly responsible party will have 120 days to provide such economic compensation (the time may be extended by the claimant), and the allegedly responsible party can verify the information, including requesting the injured to get a medical examination.

The claimant retains the right to reject such early offer and may sue to recover all losses. However, noneconomic losses, including any punitive damages may only be recovered if the injured party proves, by clear and convincing evidence, that the injury was caused intentionally or by wanton misconduct.

In the event of more than one responsible party, relative fault and proportionate contribution will be assessed by an arbitrator.

And, the states can establish a minimum payment for serious bodily injury (for example, a loss of a limb which may not result in significant economic losses) that will have to be paid to the injured party under early offer.

To satisfy the federalism concerns raised by some, the bill will allow states to ''opt out'' of any of these provisions.●

By Mr. DASCHLE:

S. 1863. A bill to require the Secretary of the Army to acquire permanent flowage and saturation easements over land that is located within the 10-year flood plain of the James River, SD, and for other purposes; to the Committee on Environment and Public Works.

EASEMENT ACQUISITIONS LEGISLATION

Mr. DASCHLE. Mr. President, since 1993 the James River has flooded nearly 3 million acres of valuable farmland in my State resulting in billions of dollars of lost revenue for South Dakota producers and greatly diminishing the value of their land by washing away valuable top soil.

Clearly, the extreme wet conditions of the last 4 years have contributed to these floods. However, Mother Nature does not bear sole responsibility for the flooding. The problem has been affected by the James River management policy of the U.S. Army Corps of Engineers.

For producers to be asked to continue to bear these losses is unfair and unacceptable. Downstream landowners in South Dakota should not be required to accept financial losses directly influenced by the corps' river management policy.

Mr. President, today I am introducing legislation that will provide landowners along the James River with a measure of security against future high water flows and help ensure that the Federal Government assumes greater responsibility for the damaging effects of its river management policies. This bill gives the U.S. Army Corps of Engineers authority to purchase from willing sellers easements over land that is located within the 10-year flood plain of the James River. Local producers who wish to grant these easements not only will be reimbursed for the loss of productivity on their flooded land, but also will retain their haying and grazing rights. Thus, the land will continue to provide value to farmers in relatively dry years. Those who do not wish to grant the corps these easements will be under no obligation to do so.

This legislation will provide some relief to landowners affected by the frequent flooding of the James River in South Dakota and represents part of the long-term solution to this troublesome problem. However, the overall management of the Jamestown Dam also needs to be examined, and I will continue to urge the corps to take seriously the concerns of South Dakotans as the operations manual for that dam is written.

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

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

S. 1863

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

SECTION 1. ACQUISITION OF EASEMENTS OVER LAND NEAR JAMES RIVER, SOUTH DAKOTA.

(a) IN GENERAL.—The Secretary of the Army shall acquire, from willing sellers, permanent flowage and saturation easements over land that is located within the 10-year floodplain of the James River, South Dakota.

(b) SCOPE.—

(1) IN GENERAL.—The easements acquired by the Secretary of the Army under subsection (a) shall include the right, power, and privilege of the Federal Government to submerge, overflow, percolate, and saturate the surface and subsurface of the land and such other terms and conditions as the Secretary of the Army considers appropriate.

(2) HAYING AND GRAZING.—The Secretary of the Army shall permit haying and grazing on the land subject to the easements.

(c) PAYMENT.—In acquiring the easements under subsection (a), the Secretary of the Army shall pay an amount based on the unaffected fee value of the land subject to the easements. For the purpose of this subsection, the unaffected fee value of the land is the value that the land would have if the land were unaffected by rising ground water and surface flooding associated with the James River.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $40,000,000, to remain available until expended.

ADDITIONAL COSPONSORS

S. 94

At the request of Mr. COVERDELL, the name of the Senator from Oklahoma [Mr. INHOFE] was added as a cosponsor of S. 94, a bill to amend the Congressional Budget Act of 1974 to prohibit the consideration of retroactive tax increases.

S. 684

At the request of Mr. INHOFE, his name was added as a cosponsor of S. 684, a bill to amend the Public Health Service Act to provide for programs of research regarding Parkinson's disease, and for other purposes.

S. 969

At the request of Mr. BRADLEY, the name of the Senator from Florida [Mr. GRAHAM] was added as a cosponsor of S. 969, a bill to require that health plans provide coverage for a minimum hospital stay for a mother and child following the birth of the child, and for other purposes.

S. 1166

At the request of Mr. LUGAR, the name of the Senator from Iowa [Mr. GRASSLEY] was added as a cosponsor of S. 1166, a bill to amend the Federal Insecticide, Fungicide, and Rodenticide Act, to improve the registration of pesticides, to provide minor use crop protection, to improve pesticide tolerances to safegaurd infants and children, and for other purposes.

S. 1199

At the request of Mrs. BOXER, the name of the Senator from Louisiana [Mr. JOHNSTON] was added as a cosponsor of S. 1199, a bill to amend the Internal Revenue Code of 1986 to permit tax-exempt financing of certain transportation facilities.

S. 1578

At the request of Ms. MOSELEY-BRAUN, her name was added as a cosponsor of S. 1578, a bill to amend the Individuals With Disabilities Education Act to authorize appropriations for fiscal years 1997 through 2002, and for other purposes.

S. 1610

At the request of Mr. BOND, the name of the Senator from New Mexico [Mr. DOMENICI] was added as a cosponsor of S. 1610, a bill to amend the Internal Revenue Code of 1986 to clarify the standards used for determining whether individuals are not employees.

S. 1628

At the request of Mr. BROWN, the names of the Senator from Idaho [Mr. CRAIG] and the Senator from Kansas [Mrs. KASSEBAUM] were added as cosponsors of S. 1628, a bill to amend title 17, United States Code, relating to the copyright interests of certain musical performances, and for other purposes.

S. 1639

At the request of Mr. DOLE, the name of the Senator from New Hampshire [Mr. GREGG] was added as a cosponsor of S. 1639, a bill to require the Secretary of Defense and the Secretary of Health and Human Services to carry out a demonstration project to provide the Department of Defense with reimbursement from the Medicare Program for health care services provided to Medicare-eligible beneficiaries under TRICARE.

S. 1714

At the request of Mr. BURNS, the names of the Senator from North Carolina [Mr. HELMS] and the Senator from Virginia [Mr. WARNER] were added as cosponsors of S. 1714, a bill to amend title 49, United States Code, to ensure the ability of utility providers to establish, improve, operate and maintain utility structures, facilities, and equipment for the benefit, safety, and well-being of consumers, by removing limitations on maximum driving and on-duty time pertaining to utility vehicle operators and drivers, and for other purposes.

S. 1726

At the request of Mr. BURNS, the names of the Senator from California [Mrs. BOXER], the Senator from Wyoming [Mr. SIMPSON], and the Senator from Mississippi [Mr. LOTT] were added as cosponsors of S. 1726, a bill to promote electronic commerce by facilitating the use of strong encryption, and for other purposes.

S. 1731

At the request of Mr. CRAIG, the name of the Senator from Mississippi [Mr. COCHRAN] was added as a cosponsor of S. 1731, A bill to reauthorize and amend the National Geologic Mapping Act of 1992, and for other purposes.

S. 1752

At the request of Mr. SIMPSON, the name of the Senator from Idaho [Mr. CRAIG] was added as a cosponsor of S. 1752, a bill to amend title 38, United States Code, to exempt full-time registered nurses, physician assistants, and expanded-function dental auxiliaries from restrictions on remunerated outside professional activities.

S. 1755

At the request of Mr. DOMENICI, the name of the Senator from Idaho [Mr. CRAIG] was added as a cosponsor of S. 1755, a bill to amend the Federal Agriculture Improvement and Reform Act of 1996 to provide that assistance shall be available under the noninsured crop assistance program for native pasture for livestock, and for other purposes.

S. 1781

At the request of Mr. CRAIG, the name of the Senator from Utah [Mr. HATCH] was added as a cosponsor of S. 1781, a bill to amend the Harmonized Tariff Schedule of the United States to provide for duty free treatment for epoxide resins.

S. 1782

At the request of Mr. CRAIG, the name of the Senator from Utah [Mr. HATCH] was added as a cosponsor of S. 1782, a bill to amend the Harmonized Tariff Schedule of the United States to provide for duty free treatment for certain injection molding machines.

S. 1783

At the request of Mr. CRAIG, the name of the Senator from Utah [Mr. HATCH] was added as a cosponsor of S. 1783, a bill to amend the Harmonized Tariff Schedule of the United States to provide for duty free treatment for certain semi-manufactured forms of gold.

S. 1786

At the request of Mr. WELLSTONE, the name of the Senator from Nevada [Mr. REID] was added as a cosponsor of S. 1786, a bill to require the Secretary of Veterans Affairs and the Secretary of Health and Human Resources to carry out a demonstration project to provide the Department of Veterans Affairs with reimbursement from the medicare program for health care services provided to certain medicare-eligible veterans.

S. 1794

At the request of Mr. FAIRCLOTH, his name was added as a cosponsor of S. 1794, a bill to amend chapter 83 of title 5, United States Code, to provide for the forfeiture of retirement benefits in the case of any Member of Congress, congressional employee, or Federal justice or judge who is convicted of an offense relating to official duties of that individual, and for the forfeiture of the retirement allowance of the President for such a conviction.

S. 1848

At the request of Mrs. BOXER, the name of the Senator from Vermont [Mr. JEFFORDS] was added as a cosponsor of S. 1848, a bill to amend the Internal Revenue Code of 1986 to encourage the production and use of clean-fuel vehicles, and for other purposes.

S. 1853

At the request of Mr. FAIRCLOTH, the names of the Senator from Alabama