S. 883. A bill to amend the Internal Revenue Code of 1986 to encourage savings and investment through individual retirement accounts, to provide pension security, portability, and simplification, and for other purposes; to the Committee on Finance.

By Mr. CLELAND:

S. 884. A bill to amend the Appalachian Regional Development Act of 1965 to add Elbert County and Hart County, Georgia, to the Appalachian region; to the Committee on Environment and Public Works.

By Mr. D'AMATO (for himself, Mr. KERRY, Mrs. BOXER, Mr. BRYAN, Ms. MOSELEY-BRAUN, Mrs. MURRAY, and Mr. CHAFEE):

S. 885. A bill to amend the Electronic Fund Transfer Act to limit fees charged by financial institutions for the use of automatic teller machines, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

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

S. 886. A bill to reform the health care liability system and improve health care quality through the establishment of quality assurance programs, and for other purposes; to the Committee on Labor and Human Resources.

By Ms. MOSELEY-BRAUN (for herself and Mr. DEWINE):

S. 887. A bill to establish in the National Service the National Underground Railroad Network to Freedom program, and for other purposes; to the Committee on Energy and Natural Resources.

## STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. TORRICELLI:

S. 875. A bill to promote online commerce and communications, to protect consumers and service providers from the misuse of computer facilities by others sending bulk unsolicited electronic mail over such facilities, and for other purposes; to the Committee on Commerce, Science, and Transportation.

### THE ELECTRONIC MAILBOX PROTECTION ACT OF 1997

Mr. TORRICELLI. Mr. President, I rise today to introduce the Electronic Mailbox Protection Act of 1997, in the hopes of addressing an increasingly serious threat to online commerce and personal privacy rights—the distribution of unsolicited, bulk e-mail by unidentifiable senders.

It is an unfortunate side effect of the burgeoning and exciting world of online communication and commerce that more and more individuals are finding their electronic mailboxes filled to the cyber-brim with unsolicited messages. And many Internet service providers are facing slowdowns or even breakdowns of their systems due to uncontrollable and unaccountable senders of unidentifiable and unsolicited bulk e-mail.

Mr. President, some have suggested that we simply ban all unsolicited e-mail. But some people do want to receive these unsolicited messages, especially when they are tailored to their personal interests. And legitimate businesses and organizations are increasingly using unsolicited e-mail to recruit new customers, new members, or even financial assistance.

However, many people do not wish to receive unsolicited e-mail at all. And many new businesses are less than fully legitimate—all too frequently, unsolicited e-mail arrives with no return address, and no means of opting-out of future mailings. In fact, it is precisely because many bulk e-mailers know that their activities are going to meet massive opposition that they disguise their identities or alter their return addresses.

Newly developed software and increasingly brazen cyber-promoters have only exacerbated the problem. In some cases, these messages have slowed down or even crippled Internet service through local or national Internet service providers.

Many of these new cyber-promoters collect millions of addresses from service providers without consent, mail to those who have already expressed a desire to be kept off bulk e-mail lists, or purposefully disguise their identity or return address. They refuse to yield to public pressure, private suit or any other citizen action, and the more destructive of their tactics must be addressed before the situation overwhelms the Internet and paralyzes legitimate online commerce—something must be done.

As a result, I have been working for some time now with privacy groups, marketers, online service providers, and others to develop strong but reasonable legislation to put a stop to the most destructive e-mail practices, while protecting the first amendment rights of all who wish to send legitimate e-mail of any kind.

Mr. President, I have long been concerned about excessive—indeed any—Government regulation of the Internet. Many of the best qualities of American life are represented and enhanced by the Internet—the world's most democratic medium—and I do not wish to stifle speech or inhibit the freedom of commerce or expression. However, the problem of unaccountable junk e-mailers will not go away, and if we do not address this problem with legislation we risk the destruction of all legitimate expression and commerce on the information superhighway.

After a long back and forth process with a wide variety of interests, I believe we are all finally in agreement that the bill I introduce today represents the strongest and most balanced approach to this growing problem. Specifically, my bill includes the following key provisions.

First, and most simply, my bill will prohibit anyone from sending e-mail to a person who has asked not to receive such mail—either prior to receiving the first message or in response to an unsolicited message that made its way into the recipients mailbox. Mr. President, this provision requires no more than common courtesy and proper business sense. But unfortunately, this provision is sorely needed by the thousands—even millions—of recipients of repetitive and unsolicited e-mail.

And the bill also contains a pro-active provision which effectively defines prior notice as including either direct notice or notice through a standard method adopted by an Internet standard setting body, like the Internet Engineering Task Force. In other words, we allow the IETF or another community-recognized organization to discuss, develop, and adopt a method of preemptively informing all senders that certain recipients do not want to receive any unsolicited electronic mail. This could take the form of an opt-out system, an opt-in system, or even some sort of address labeling standard—whatever the Internet community chooses to adopt. But once the standard is in place, my bill will require that senders comply with that standard. We have given the Internet community the tools to enforce their own pro-active steps, and I believe this achieves a proper balance between Government action and self-regulation. As much as is possible, Congress should avoid dictating the details of Internet architecture.

Second, my bill will prohibit sending unsolicited e-mail from an unregistered, illegitimate, or fictitious Internet domain for the purpose of preventing an easy reply. Such tactics have become increasingly common in recent months, because the less responsible marketers know—they just know—that many of the recipients of their unsolicited junk will be unhappy and wish to respond. Rather than act responsibly and respond to complaints as they come in, these fly-by-night marketers prefer to make it impossible to respond. We have all heard from constituents who are simply fed up with these practices, and this bill will empower our constituents to do something about it.

Third, my bill will prohibit the use of procedures designed to defeat or circumvent mail filtering tools. Consumers and service providers are getting better at using mail filters to block out unwanted mail. But these filtering programs, still in relative infancy, are no match for cyber-promoters with sophisticated techniques and all the time in the world to work on skirting the filters and making it into your mailbox.

Next, my bill will prohibit anyone from using a computer program to harvest, or gather, a large number of e-mail addresses for the purpose of sending unsolicited e-mail to those addresses or selling the list to other senders of unsolicited e-mail—if such activity would be against the policy of the computer service from which the addresses are collected. In other words, if America Online or AT&T or Panix or Erols have policies against using a computer to harvest addresses of their subscribers, cyber-promoters would have to comply.

My bill also puts a stop to so-called hit and run spamming, which occurs when someone gets access to a temporary e-mail account, sends out thousands of unsolicited messages, and then

abandons the account and leaves the service provider to clean up the mess. Under my bill, registering an Internet domain or e-mail account for the purpose of sending unsolicited e-mail and avoiding replies would be prohibited.

Finally, Mr. President, my bill directs the FTC to pay close attention over the next 18 months to the affects that this bill has on the junk e-mail problem. At the end of that time, the FTC will submit a report to Congress detailing its findings, and we can determine whether or not new action is necessary.

And what will happen to those who break the rules we intend to set down in law? Well, there are two possibilities. First, there is a $5,000 civil penalty for each violation, to be imposed by the U.S. Government.

But more importantly, this bill empowers the individual recipient or service provider suffering the effects of a violation of this bill to sue for damages. These damages range from $500 for simple violations all the way up to $5,000 for particularly egregious or willful abuses. And if we think about the possibilities for class action suits, we can quickly see the deterrent effect of these provisions.

Mr. President, this bill will not prevent all unsolicited e-mail. Legitimate marketers, nonprofit organizations and others will still be able to send unsolicited e-mail, even in bulk. However, this legislation will make the senders of the e-mail accountable to the service providers and to the e-mail recipients. No longer will brazen promoters be able to disguise their identity and hide behind technology—from now on, they will be accountable for what they send and punished if their tactics are of the kind that merit such action.

Put simply, Mr. President, my bill will empower consumers and Internet service providers alike to block, filter, reply to, or prevent unwanted and unsolicited electronic mail.

We all recognize that we should not lightly enter into Internet regulation. But some practices are simply too destructive to ignore, and certain types of unsolicited e-mail must be stopped.

I hope you will join me in working to pass this fair but strong bill to protect individual privacy, preserve freedom of expression, and allow legitimate commerce on the Internet to flourish. I ask unanimous consent that the full text of the legislation be printed in the RECORD.

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

S. 875

*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 ''Electronic Mailbox Protection Act of 1997''.

**SEC. 2. FINDINGS.**

Congress makes the following findings:

(1) The Internet has increasingly become a critical mode of global communication and now presents unprecedented opportunities for the development and growth of global commerce and an integrated worldwide economy.

(2) In order for global commerce on the Internet to reach its full potential, individuals and entities using the Internet and other online services should be prevented from engaging in activities that prevent other users and Internet service providers from having a reasonably predictable, efficient, and economical online experience.

(3) Unsolicited electronic mail can be an important mechanism through which commercial vendors, nonprofit organizations, and other providers of services recruit members, advertise, and attract customers in the online environment.

(4) The receipt of unsolicited electronic mail may result in undue monetary costs to recipients who cannot refuse to accept such mail and who incur costs for the storage of such mail, or for the time spent accessing, reviewing, and discarding such mail, or for both.

(5) Unsolicited electronic mail sent in bulk may impose significant monetary costs on the Internet service providers, businesses, and educational and non-profit institutions that carry and receive such mail, as there is a finite volume of mail that such providers, businesses, and institutions can handle at any one point in time. The sending of such mail is increasingly and negatively affecting the quality of service provided to customers of Internet service providers.

(6) While many senders of bulk unsolicited electronic mail provide simple and reliable ways for recipients to reject (or ''opt-out'' of) receipt of unsolicited electronic mail from such senders in the future, other senders provide no such ''opt-out'' mechanism, or refuse to honor the requests of recipients not to receive electronic mail from such senders in the future, or both.

(7) An increasing number of senders of bulk unsolicited electronic mail purposefully disguise the source of such mail so as to prevent recipients from responding to such mail quickly and easily.

(8) Many senders of unsolicited electronic mail collect (or ''harvest'') electronic mail addresses of potential recipients without the knowledge of their intended recipients and in violation of the rules or terms of service of the fora from which such addresses are collected.

(9) Because recipients of unsolicited electronic mail are unable to avoid the receipt of such mail through reasonable means, such mail may threaten the privacy of recipients. This privacy threat is enhanced for recipients whose electronic mail software or server alerts them to new mail as it arrives, as unsolicited electronic mail thereby disrupts the normal operation of the recipient's computer.

(10) In legislating against certain abuses on the Internet, Congress and the States should be very careful to avoid infringing in any way upon constitutionally protected rights, including the rights of assembly, free speech, and privacy.

(11) In order to realize the full potential for online electronic commerce, senders of bulk unsolicited electronic mail should be required to abide by the requests of electronic mail recipients, Internet service providers, businesses, and educational and non-profit institutions to cease sending such mail to such recipients, providers, businesses, and educational and non-profit institutions.

**SEC. 3. PROHIBITION ON CERTAIN ACTIVITIES THAT MISAPPROPRIATE THE RESOURCES OF ONLINE SERVICE PROVIDERS.**

(a) IN GENERAL.—Whoever, in or affecting interstate or foreign commerce—

(1) initiates the transmission of an unsolicited electronic mail message from an unregistered or fictitious Internet domain, or an unregistered or fictitious electronic mail address, for the purpose of—

(A) preventing replies to such message through use of a standard reply mechanism in the recipient's electronic mail system; or

(B) preventing receipt of standard notices of non-delivery;

(2) uses a computer program or other technical mechanism or procedure to disguise the source of unsolicited electronic mail messages for the purpose of preventing recipients, or recipient interactive computer services, from implementing a mail filtering tool to block the messages from reaching the intended recipients;

(3) initiates the transmission of an unsolicited electronic mail message and fails to comply with the request of the recipient of the message, made to the sender or the listserver as appropriate, to cease sending electronic messages to the recipient in the future;

(4) distributes a collection or list of electronic mail addresses, having been given prior notice that one or more of the recipients identified by such addresses does not wish to receive unsolicited electronic mail and knowing that the recipient of such addresses intends to use such addresses for the purpose of sending unsolicited electronic mail;

(5) initiates the transmission of an unsolicited electronic mail message to a recipient despite having been given prior notice (either directly or through a standard method developed, adopted, or modified by an Internet standard setting organization (such as the Internet Engineering Task Force or the World Wide Web Consortium) to better facilitate pre-emptive consumer control over bulk unsolicited electronic mail) that the recipient does not wish to receive such messages;

(6) registers, creates, or causes to be created an Internet domain or applies for, registers, or otherwise obtains the use of an Internet electronic mail account for the sole or primary purpose of initiating the transmission of an unsolicited electronic mail message in contravention of paragraph (1) or (2);

(7) directs an unsolicited electronic mail message through the server of an interactive computer service to one or more subscribers of the interactive computer service, knowing that such action is in contravention of the rules of the interactive computer service with respect to bulk unsolicited electronic mail messages;

(8) knowing that such action is in contravention of the rules of the interactive computer service concerned, accesses the server of the interactive computer service and uses a computer program to collect electronic mail addresses of subscribers of the interactive computer service for the purpose of sending such subscribers unsolicited electronic mail or distributing such addresses knowing that the recipient of such addresses intends to use such addresses for the purpose of sending unsolicited electronic mail; or

(9) initiates the transmission of bulk unsolicited electronic mail messages and divides the mailing of such messages into smaller mailings for the purpose of circumventing another provision of this Act,

shall be subject to a civil penalty of not more than $5,000 per individual violation.

(b) ENFORCEMENT.—The Federal Trade Commission shall have the authority to commence civil actions under subsection (a).

**SEC. 4. RECOVERY OF CIVIL DAMAGES.**

(a) IN GENERAL.—Any person whose interactive computer service or electronic mailbox is intentionally misused or infiltrated,

or whose requests for cessation of electronic mail messages have been ignored, in violation of section 3 may in a civil action recover from the person or entity which engaged in that violation such relief as may be appropriate.

(b) RELIEF.—In an action under this section, appropriate relief includes—

(1) such preliminary and other equitable or declaratory relief as may be appropriate;

(2) actual monetary loss from a violation, statutory damages of not more than $500 for each violation, and, if the court finds that the defendant's actions were particularly egregious, willful, or knowing violations of section 3, the court may, in its discretion, increase the amount of an award to an amount equal to not more than 10 times the amount available hereunder; and

(3) a reasonable attorney's fee and other litigation costs reasonably incurred.

**SEC. 5. STATE LAW.**

Nothing in this Act shall be construed to prevent any State from enforcing any State law that is consistent with this Act. No cause of action may be brought and no liability may be imposed under any State or local law that is inconsistent with this Act.

**SEC. 6. FEDERAL TRADE COMMISSION STUDY INTO EFFECTS OF UNSOLICITED ELECTRONIC MAIL.**

Not later than 18 months after the date of enactment of this Act, the Federal Trade Commission shall submit to Congress a report detailing the effectiveness of, enforcement of, and the need, if any, for Congress to modify the provisions of this Act.

**SEC. 7. DEFINITIONS.**

In this Act:

(1) BULK UNSOLICITED ELECTRONIC MAIL MESSAGE.—The term ''bulk unsolicited electronic mail message'' means any substantially identical unsolicited electronic mail message with 25 or more intended recipients.

(2) ELECTRONIC MAIL ADDRESS.—

(A) IN GENERAL.—The term ''electronic mail address'' means a destination (commonly expressed as a string of characters) to which electronic mail can be sent or delivered.

(B) INCLUSION.—In the case of the Internet, the term ''electronic mail address'' may include an electronic mail address consisting of a user name or mailbox (commonly referred to as the ''local part'') and a reference to an Internet domain (commonly referred to as the ''domain part'').

(3) INITIATES THE TRANSMISSION.—The term ''initiates the transmission'', in the case an electronic mail message, refers to the action of the original sender of the message and not to any intervening computer service that may handle or retransmit the message, unless the intervening computer service retransmits the message with an intent to engage in activities prohibited by this Act.

(4) INTERACTIVE COMPUTER SERVICE.—The term ''interactive computer service'' has the meaning given that term in section 230(e)(2) of the Communications Act of 1934 (47 U.S.C. 230(e)(2)).

(5) INTERNET.—The term ''Internet'' has the meaning given that term in section 230(e)(1) of the Communications Act of 1934 (47 U.S.C. 230(e)(1)).

(6) INTERNET DOMAIN.—The term ''Internet domain'' refers to a specific computer system (commonly referred to as a ''host'') or collection of computer systems attached to or able to be referenced from the Internet which are assigned a specific reference point on the Internet (commonly referred to as the ''Internet domain name'') and registered with an organization recognized by the computer industry as a registrant of Internet domains.

(7) LISTSERVER.—The term ''listserver'' refers to a computer program that provides electronic mailing list management functions, including functions that allow individuals to subscribe and unsubscribe to and from electronic mailing lists.

(8) MAIL FILTERING TOOL.—The term ''mail filtering tool'' means any computer program, procedure, or mechanism used by an individual recipient or interactive computer service to block, return, reroute, or otherwise screen or sort incoming electronic mail messages.

(9) SERVER.—The term ''server'' refers to any computer that provides support or services of any kind, including electronic mailboxes, to other computers (commonly referred to as ''clients'').

(10) UNSOLICITED ELECTRONIC MAIL MESSAGE.—The term ''unsolicited electronic mail message'' means any electronic mail other than electronic mail sent by persons to others with whom they have a prior relationship, including a prior business relationship, or mail sent by a source to recipients where such recipients, or someone authorized by them, have at any time affirmatively requested to receive communications from that source.

**SEC. 8. EFFECTIVE DATE.**

This provisions of this Act shall take effect 45 days after the date of enactment of this Act.

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By Mr. GREGG (for himself, Mr. TORRICELLI, Mr. SMITH of New Hampshire, and Mr. JOHNSON):

S. 876. A bill to establish a nonpartisan commission on Federal election campaign practices and provide that the recommendations of the commission be given expedited consideration by Congress; to the Committee on Rules and Administration.

THE CLAREMONT COMMISSION ACT

Mr. GREGG. Mr. President, I rise today to announce the introduction of the Claremont Commission Act, which I am introducing, along with Senators BOB SMITH, TORRICELLI, and JOHNSON.

We chose this day because it is the anniversary of the historic event that prompted the introduction of this legislation. Two years ago on this very day, a concerned citizen from Newport, NH, Mr. Frank McConnell, stood up at a town meeting in Claremont, NH, and asked an insightful and thought-provoking question of Speaker GINGRICH and President Clinton: What are they going to do about reforming our campaign financing system? The two leaders, who were attending the meeting, promised to create a bipartisan commission to study campaign finance reform and then shook hands on the agreement. That handshake was a famous and short-lived moment of solidarity and bipartisanship. At this time, sadly, no such commission has been created.

The bill that I introduce today is a renewed effort to keep the promise made on that famous day 2 years ago. The Claremont Commission Act was introduced in a bipartisan manner to create an objective commission to look at the issues surrounding the reform of our Nation's campaign finance system. This legislation directs the commission to take important goals into consideration when making recommendations to the Congress with regard to reform legislation. These goals include: limiting the influence of money in Federal elections; increasing voter participation, creating a more equitable electoral system for both challengers and incumbents; and removing the negative aspects of financing of Federal elections. I believe that these are important goals to consider when Congress moves to make actual changes to our campaign financing laws.

The Claremont Commission Act specifically asks the commission to consider and respond to more than 14 questions regarding the most important issues surrounding the campaign finance reform debate. I am especially pleased that the issues of soft money contributions, independent expenditures, and the role of unions will be addressed. In particular, the role of unions and their use of mandatory union dues to make donations to political campaigns is of concern to me. The commission will address the serious issues surrounding how unions finance their political activities, as well as the considerable influence that these organizations wield over the outcome of elections. I am pleased that the creation of this commission can begin to address concerns, as well as other Members of Congress' questions regarding soft money contributions and independent expenditures.

The political infighting that has occurred over the years regarding the financing of our Federal elections will not cease unless a middle ground can be established. I believe that the Claremont Commission Act, by establishing a mechanism for a dispassionate analysis by a group of experts, can provide that middle ground. Hopefully, this bill will allow us to address the concerns of all Americans who have a growing sense of cynicism over our ability to resolve important campaign financing problems.

In closing, I urge my colleagues to take a serious look at this legislation and consider the merits of commissioning a bipartisan recommendation regarding campaign finance reform.

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By Mr. MCCAIN (by request):

S. 877. A bill to disestablish the National Oceanic and Atmospheric Administration Corps of Commissioned Officers; to the Committee on Commerce, Science, and Transportation.

NATIONAL OCEANIC AND ATMOSPHERIC ADMINISTRATION CORPS LEGISLATION

Mr. MCCAIN. Mr. President, on behalf of the administration, today I am introducing legislation to disestablish the National Oceanic and Atmospheric Administration Corps. This legislation is long overdue on the part of the administration, and I am pleased to be able to initiate a possible resolution on this issue.

In 1807, an organization known as the Coast Survey was established; this organization would later become NOAA. The Survey was responsible for charting the U.S. coastline, and its civilian employees were often augmented with military personnel. This interaction

between the Survey and the military continued, and, during World Wars I and II, members of the Survey served to defend our Nation. At the end of World War II, these members retained their military rank and compensation but returned to civilian duties as the NOAA Corps. Today, the corps numbers approximately 300 officers.

The corps operates the NOAA Fleet, flies the agency's hurricane research planes, and conducts a variety of activities essential for managing the Nation's natural resources. This bill seeks to maintain these services while improving the cost-effectiveness of the program. Under this legislation, civilian service positions would be created equivalent to existing NOAA Corps positions. Those officers with less than 15 years service would be eligible for these new civilian positions, while those with more than 15 years of service would be retired. Retired officers would still have an opportunity to compete for additional NOAA positions, as determined by the Under Secretary. The entire corps retirement program would be transferred to the Department of the Navy under this proposal.

Disestablishment of the corps has been recommended by the Vice President's National Performance Review, the Government Accounting Office, and the inspector general of the Department of Commerce. The GAO estimates that this bill would save $5 million over a 10-year period.

I am concerned that the NOAA Corps officers be treated fairly, and I understand that several of my colleagues have additional concerns about the impacts of this legislation. I look forward to addressing these issues through the committee process.

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By Mr. FEINGOLD:

S. 879. A bill to provide for home and community-based services for individuals with disabilities, and for other purposes; to the Committee on Finance.

LONG-TERM CARE REFORM AND DEFICIT REDUCTION ACT OF 1997

Mr. FEINGOLD. Mr. President, I am pleased to introduce S. 879, the Long-Term Care Reform and Deficit Reduction Act of 1997, legislation to reform fundamentally the way we provide long-term care in this country.

This legislation gives States the flexibility to establish a system of consumer-oriented, consumer-directed home and community-based long-term care services for individuals with disabilities of any age. It does so while reducing the deficit by $30.4 billion over the next 5 years, and $145.7 billion over the next 10 years with the potential for even greater savings.

Mr. President, the bill is based on Wisconsin's home and community-based long-term care program, the Community Options Program, called COP, which has been a national model of reform. COP was the keystone of Wisconsin's long-term care reforms that have saved Wisconsin taxpayers hundreds of millions of dollars.

The legislation is also similar, in large part, to the excellent bipartisan long-term care proposals developed by the Senate Committee on Labor and Human Resources as well as the Senate Committee on Finance during the 103d Congress, which in turn stemmed from the long-term care reforms included in President Clinton's health care reform proposal. Unlike so many other aspects of health care reform, the long-term care provisions that came out of the two Senate committees, that were included in the Mitchell compromise measure, and that were part of the proposals produced by the standing committees in the other body, received bipartisan support. It is somewhat remarkable that when there was so much controversy over so many issues relating to health care reform that there was so much agreement over the need to include long-term care reform.

Mr. President, the success of the Wisconsin program upon which this measure is based stems in large part from its flexibility, a flexibility that benefits both individual consumers of long-term care as well as local administrators.

This legislation reflects that same kind of flexibility. First and foremost, it does so by not creating a new, unfunded mandate. This program is entirely optional for States, and beyond four core services—assessment, care planning, personal assistance, and case management—those States choosing to participate will be free to decide what additional services, if any, they want to offer. States would be able but not required to offer such things as homemaker services, home modifications, respite, assistive devices, adult day care, supported employment, home health care, or any other service that would help keep a disabled individual at home or in the community.

Equally important, the measure provides both some initial funding, and the ability of States to recapture the bulk of the savings they can generate within the current long-term care system. The bill directs the Secretary of Health and Human Services to submit to Congress a proposal by which States could retain, in this new more flexible program, 75 percent of the Federal Medicaid long-term care savings they are able to generate. This not only provides a direct incentive for States to produce Medicaid savings, it also directly links the future of this reform to its ability to deliver results.

The legislation also creates a small hospital link pilot program based on our experiences in Wisconsin where such an initiative has helped direct individuals needing long-term care services out of hospitals, and back to their own homes and communities. The hospital discharge is a critical point of embarkation into the long-term care system for many, and this program helps ensure that those who leave a hospital in need of long-term care can receive needed services where they prefer them—in their own homes.

Mr. President, though I am convinced that long-term care reform can result in substantial savings to taxpayers—and this has been our experience in Wisconsin—this measure does not depend on hypothetical savings for funding. This measure includes funding provisions consisting of specific savings within the health care system. Those savings include extending and making permanent the Medicare secondary payer provisions; establishing a prospective payment system under Medicare for nursing homes; eliminating the technical errors in the reimbursement of certain outpatient hospital services, known as the formula-driven overpayments; and, reforming the way Medicare risk contractors are reimbursed.

Mr. President, this last provision, fixing the payment system for Medicare HMO's, deserves special notice. The current system of reimbursement is flawed, and results in grossly inequitable distribution of costs and benefits within Medicare. Because the risk contract reimbursement formula is driven by the average fee-for-service costs in an area, Medicare beneficiaries in States like Wisconsin, where Medicare's standard fee-for-service costs are kept low, are punished. By contrast, areas with higher costs, including costs driven by unnecessary utilization and even waste, fraud, and abuse, are rewarded with generous benefit packages and little or no copayments.

This system of incentives is backward, and I am pleased to include a proposal to bring some sense and equity to Medicare's reimbursement of risk contracts as part of this measure.

Mr. President, the offsetting reductions in this measure produce savings of $34.1 billion over 5 years, and $166.2 billion over 10 years. Altogether, including the long-term care reforms and grants to States, the bill produces net deficit reduction of $30.4 billion over 5 years, and $145.7 billion over 10 years.

This must be the approach we adopt, even for those proposals which experience shows will result in savings. By including funding provisions in this long-term care reform measure, we ensure that any additional savings produced by these reforms will only further reduce the budget deficit.

And there is strong evidence that there will be additional savings, as we have seen in Wisconsin. Between 1980 and 1993, while the rest of the country experienced increased Medicaid nursing home use of 35 percent, thanks to Wisconsin's long-term care reforms, Medicaid nursing home bed use actually dropped 16 percent in the State, saving Wisconsin taxpayers hundreds of millions of dollars.

Mr. President, aside from the immediate benefits of reducing the budget deficit, we need long-term care reform in its own right.

While the population of those needing long-term care is growing much

faster than those providing indirect support as taxpayers, informal care, which is largely provided by families, has been stretched to the limit by the economics of health care and the increasing age of the caregivers themselves.

The default system of formal long-term care, currently funded through the Medicaid Program, requires that individuals impoverish themselves before they can receive needed care, and it largely limits care to expensive institutional settings.

Failure to reform long-term care will inevitably lead to increased use of the Medicaid system—the most expensive long-term care alternative for taxpayers, and the least desirable for consumers.

Mr. President, there are few statistical forecasts as accurate as those dealing with our population, and estimates show that the population needing long-term care will explode during the next few decades. The elderly are the fastest growing segment of our population, with those over age 85—individuals most in need of long-term care—the fastest growing segment of the elderly. The over-85 population will triple in size between 1980 and 2030, and will be nearly seven times larger in 2050 than in 1980.

The growth in the population of elderly needing some assistance is expected to be equally dramatic. Activities of daily living, or ADL's, are a common measure of need for long-term care services. These activities include eating, transferring in and out of bed, toileting, dressing, and bathing. In 1988, approximately 6.9 million elderly could not perform all of these activities. By 2000, this population is expected to increase to 9 million, and by 2040 to 18 million.

Mr. President, that we have been able to stave off a long-term care crisis to date is due in large part to the direct caregiving provided by millions of families for their elderly and disabled family members. But here also we see that the demographic changes of the next several decades will result in increased strain on the current system.

While the number of people in need of care is increasing rapidly, the population supporting those individuals, either through direct caregiving, or indirectly through their taxes, is growing much more slowly, and thus is shrinking in comparison.

In 1900, there were about 7 elderly individuals for every 100 people of working age. As of 1990, the ratio was about 20 elderly for every 100, by 2020 the ratio will be 29 per 100, and after that it will rise to 38 per 100 by 2030.

These population differences will be further aggravated by the changing nature of the family and the work force. As the Alzheimer's Association has noted, smaller families, delayed childbearing, more women in the work force, higher divorce rates, and increased mobility all mean there will be fewer primary caregivers available, and far less informal support for those who do continue to provide care to family members in need of long-term care services.

Mr. President, while some elderly are relatively well off, thanks in part to programs like Social Security and Medicare that have kept many out of poverty, it is also true that too many seniors still find themselves living near or below the poverty line. This is especially true for those needing long-term care, who, on average, are poorer than those who do not need long-term care. In 1990, about 27 percent of people needing help with some activity of daily living survived on incomes below the poverty level, compared with 17 percent of all older people. About half of impaired elderly have income under 150 percent of poverty, compared with 35 percent of all elderly, and, according to Families USA, while 20 percent of the population as a whole had annual family income under $15,685 in 1992, nearly half of the disabled population had income under that level.

Further aggravating the problem is that informal family member caregivers are getting older. These caregivers are already an average of 57, with 36 percent of caregivers 65 or older. As the population ages, so will the average age of caregivers, and as the population of caregivers increases, their ability to provide adequate informal care diminishes.

Mr. President, all in all our country faces a rapidly growing population needing long-term care services, a population which is disproportionately poor. At the same time, the group of family caregivers, that has kept most of the population needing long-term care out of Government programs like Medicaid, is shrinking relative to those in need of services, and is becoming progressively older.

The inescapable result of these trends is substantial pressure on Government provided long-term care services—services that are inadequate in several fundamental ways.

First, with some exceptions, the current system fails to build effectively on the informal care provided by families.

Mr. President, most people with disabilities, even with severe disabilities, rely on care in their home from family and friends. The Alzheimer's Association estimates that families provide between 80 and 90 percent of all care at home, willingly and without pay. The association estimates that this informal off-budget care would cost $54 billion to replace.

This last figure can be only an estimate, not because it doesn't fairly represent the services currently being provided by family members, but because comparable services are largely unavailable from the long-term care system. The variety of home- and community-based services provided by family members simply do not exist in many areas.

Mr. President, the prevalence of family-provided caregiving affirms that, in reforming our long-term care system, it is vital that we build on top of the existing informal care that is being provided, not try to substitute for that care by imposing a new system. The goal of long-term care reform is first to enable family caregivers to continue to provide the care they currently give and that their family members prefer.

Mr. President, another weakness of the current long-term care system is the lack of a home and community service capacity. This is due in part to the inadequacies of the Medicaid Program. Enacted in 1965, Medicaid was primarily a response to the acute care needs of the poor. Though Congress did not envision Medicaid as a long-term care program, it quickly became the primary source of Government funds for long-term care services.

For many years, those long-term services provided under Medicaid were almost exclusively institutionally based. Not until institutional services, such as nursing homes, had become well established were community- and home-based services funded.

The result of the head start given institutional long-term care services has been a continuing bias toward institutions in our long-term care programs. The rate of nursing home use by the elderly since the advent of Medicare and Medicaid has doubled, while the community and home-based alternatives to institutional care are considered exceptions to institutional care. A State must get a waiver from the Federal Government in order to qualify for community and home-based nonmedical service alternatives under Medicaid and, in many cases, an individual must otherwise be headed to an institution in order to qualify for those Medicaid funded community and home-based alternative programs.

More significantly, there remains an absolute entitlement to institutional care that does not exist for the home and community-based waiver alternatives.

Mr. President, many families have been able to provide long-term care services themselves to their elderly and disabled family members, but the lack of even partial support services makes it increasingly difficult for families to choose to keep their family members at home.

According to a 1991 Alzheimer's Association study, the family caregiving alternative to Government funded long-term care is likely to disappear not because of the increasing impairment of the long-term care consumer, but because of the physical, emotional, or financial exhaustion of the caregiver:

> Family caregivers suffer more stress-related illness, resulting from exhaustion, lowered immune functions, and injuries, than the general population . . . Depression among caregivers of the frail elderly is as high as 43 to 46 percent, nearly three times the norm. . . . The likelihood of health problems is heightened by the relatively high age of caregivers: the average is 57. Thirty-six percent of caregivers are 65 or older.

Mr. President, the impact on the economy of the family caregiver is also

significant. Beyond the obvious strain on the personal economy of those families with members needing long-term care services, there is also a significant effect on employers.

One-quarter of American workers over the age of 30 care for an elderly parent, and this percentage is expected to increase with 40 percent of workers expecting to be caring for aging parents in the next 5 years.

These are impressive statistics when one considers that caregivers report missing a week and a half of work each year in order to provide care, and nearly one-third of working caregivers have either quit their job or reduced their work hours because of their caregiving responsibilities.

For those working 20 hours or fewer a week, over half have reduced their work hours because of caregiving responsibilities.

Mr. President, long-term care is very much a woman's issue. Women live longer than men, and make up a greater portion of the population needing care. And women are much more likely to be the family member that is providing care to a loved one who needs long-term care. One in five women have a parent living in their home, and nearly half of adult daughters who are caregivers are unemployed. Over a quarter of these women said they either quit their jobs or retired early just to provide care for an older person.

In addition to the impact on caregivers as employees, workers, and family breadwinners, there is also a measurable impact on their personal health. As the Alzheimer's Association study noted, caregivers are more likely to be in poor health than the general population, and are three times more likely to suffer from depression, a condition that raises the risk of other ailments such as exhaustion, lowered immune function, stress-related illness, and injury related to their caregiving responsibilities.

Compounding both the work-related and health-related problems, the burden of this kind of caregiving can increase over time. The Alzheimer's Association study noted that unlike caring for a child, which diminishes over time as the child matures and becomes more independent, caregiving responsibilities for an aging parent often increase as they become more dependent and require more care.

Mr. President, failure to reform long-term care will also lead to cost shifting and will undermine our efforts both to contain acute care costs and further reduce the deficit.

Thanks in large part to the lack of universal coverage and the attendant shared responsibility, the health care system has become expert at shifting costs. Federal and State policymakers, in attempting to control costs, have often only created bigger incentives to shift costs as they try to clamp down in one area only to see utilization jump in another. All too often, no real savings are achieved in the end.

This was seen, for example, when the Federal Government changed several aspects of Medicare reimbursements. Patients were discharged from hospitals quicker and sicker than they had been before with a resulting increase in utilization in other areas, including long-term care services such as skilled nursing facilities.

This example is particularly appropriate. As efforts are made to limit costs in the acute care system, it is precisely this kind of shifting, from the acute care side to the long-term care side, that will occur unless long-term care reforms are pursued.

A grandmother who is discharged from a hospital by an HMO seeking to lower its costs, may have little alternative but to enter a nursing home. Long-term care reform could provide her family with sufficient additional supports to be able to care for that grandmother in her own home, and at significantly lower cost to the family and the system as a whole.

But, Mr. President, as important as it is to gain control of our health care costs, long-term care reform is needed first and foremost as a matter of humanity.

In my own State of Wisconsin, long-term care has been the focus of significant reforms since the early 1980's.

One long-term care administrator, Chuck McLaughlin of Black River Falls, WI, testified before a field hearing of the Senate Aging Committee in the 103d Congress that prior to those reforms, he saw an almost complete absence of community or home-based long-term care services for people in need of support.

This was especially visible for older disabled individuals. Except for those seniors with sufficient resources to create their own system of in-home supports, he saw many forced to enter nursing homes who would have liked to have remained in their own home or community.

McLaughlin noted that though some eventually adjusted to leaving their home and entering the nursing home, others never did.

> I saw people who simply willed their own death because they saw no reason to continue living. These were people who were literally torn from familiar places and familiar people. People who had lost the continuity of their lives and the history that so richly made them into who they were now. People who had nurtured and sustained their communities which in turn provided them with positive status in that community. These people were truly uprooted and adrift in an alien environment lacking familiar sights, sounds, and smells. Many of them simply chose not to live any longer. While the medical care they received was excellent, they were more than just their physical bodies. Modern medicine has no treatment for a broken spirit.

Mr. President, for many, the current long-term care system continues to be so inflexible as to be inhumane.

Mr. President, there are many reasons for pursuing long-term care reform—certainly more than are addressed here. But the one which may be the most meaningful for those actually needing long-term care is the ability to make their own choice about what kinds of services they will receive. In particular, this will mean the chance to remain as independent as possible, living at home or in the community or, if they choose, in an institution.

Survey after survey reveal the overwhelming preference for home-based care, and these findings are consistent with the anecdotal evidence available from just about every family facing some kind of long-term care need.

Ann Hauser, a 74-year-old woman who retired after 30 years as a ward clerk in a Milwaukee hospital, offered testimony at a May 9, 1994, field hearing of the Senate Special Committee on Aging that is typical of what many have said over the years.

Now living at home with help from Wisconsin's home and community-based long-term care program, the Community Options Program [COP], Ms. Hauser related a number of problems she had experienced while in different nursing homes.

> While at this nursing home and the others, I was to continue on IV antibiotics and needed some, but not total assistance for chair transfers. Before much time had passed, I was assisted in moving around so seldom that I lost muscle tone. Within 5 months, I became bedridden. The Heuer lift became a cop-out, and I learned that I was better to refuse it so that I would keep the use of some of my muscles. The less active I became, the more depressed I became. I was going downhill fast.
>
> How could I be happy in places that allowed the aides to switch the TV station on my television to their favorite soap operas (when I don't even like shows like that)? Furthermore, when I would remind them that I was at their mercy to finish my bed bath as they stopped to watch just one more minute, they would take away my remote control while I shivered and waited.

The particulars of Ms. Hauser's experience are less important than the overall loss of control and independence that she experienced, something that is common for many in nursing homes. As Ms. Hauser noted:

> How could I thrive in an environment that counted on my remaining inactive when I had been so active until now?

Dorothy Freund also gave testimony at the May 9 field hearing. At the time, she was a nursing home resident. Ms. Freund, who received her B.A. from Ohio State University, majored in English, and later received an additional degree from Maclean College of Drama, Speech, and Voice in Chicago.

After a brief stay in a hospital for treatment to her ankle, she came to a nursing home for further treatment. She gave up her apartment, because it was not designed for maneuvering in a wheelchair, and she has been on the COP waiting list for a year and a half.

Ms. Freund testified that she enjoys helping people, and this was obvious to those at the hearing as she related her efforts to tutor a nursing assistant who had worked at the nursing home. The aide decided that she would like to become a nurse, to get her LPN, but

needed to get her high school diploma. Ms. Freund helped her with English, geometry, government, and geography, and, thanks in large part to Ms. Freund's efforts, the nursing assistant did receive her high school diploma.

Ms. Freund spoke about her experience and her thoughts on living in a nursing home:

> Then why not stay at the nursing home and help others in the same way? It is not an atmosphere of peace and quiet for any length of time. I'm not deprecating the nursing home and its quality of care. They are always looking for ways to improve situations and to solve problems that arise. Nor am I downgrading those who are trying their best to give that care. But when the shouting, moaning, screaming, and babbling all go on at the same time it can be bedlam. It may erupt at any moment. . . . The frustrations of being stuffed in a nursing home, the struggle to ride out the storms, and keep one's head above the turbulent waters, can seem overwhelming when there's not even a gleam at the end of the tunnel. But I just can't resign myself to a life of Bingo and Roll-a-ball. ''Don't give up; there must be a way,'' I keep telling myself.

Ms. Freund's testimony, again, is typical of the experiences of many needing long-term care. And it bears emphasizing that the desire to live in one's own home, and to be able to function as independently as possible, exists despite the high quality of care that is provided in most nursing homes.

Mr. President, this should come as no surprise in a society that values independence so highly. We cannot expect an individual's value system to change the instant they require some long-term care, though this is precisely how our current long-term care system is structured.

If for no other reason, we need to reform our long-term care system to reflect the values we cherish as a nation, to live, as we wish, independently, in our own homes and communities.

Mr. President, during the debate over comprehensive health care reform in the 103d Congress, I issued a report reviewing the long-term care provisions in President Clinton's health care reform legislation and offering some modifications to those provisions based on our experience in Wisconsin. In that report, I noted that Chuck McLaughlin's eloquent comments on the importance of community were not only relevant, even central, to the discussion of long-term care, but that community must also be the focus of our efforts in many other areas of our lives as Americans and citizens of the world.

More often than not, the critical problems we face stem from a failure of community or a lack of adequate community-based supports—for example jobs and economic development, housing, crime, and education. These and other important issues are usually confronted by policymakers at a distance—from Washington, DC or from State capitals—essentially from the top down.

Too often we have tried to solve these challenges, including the challenge of long-term care, by imposing a superior vision from above. This approach has led to inflexible systems that cannot react to individual needs, but rather end up trying to fit the problem to their own structure.

This fundamental weakness is often enough to undermine even the sometimes huge amounts of money that we send along to implement the problem solving. It also limits the kinds of creative approaches those who are ''on the ground'' may see as useful and necessary.

Mr. President, just as we have a need to reinvent government to respond more efficiently to our country's needs and our national deficit, we need also to reinvent community to allow flexible approaches to problems, and to allow those in the community to exercise their judgment as to how best to solve problems.

A great strength of the Wisconsin long-term care reforms, and especially the home and community-based benefit on which this legislation is based, is that it is focused on the needs of the individual. Eligibility is based on disability, not age, and services are centered around the particular needs of an individual rather than the perceived needs of a group.

The approach this legislation takes is not only appropriate, but integral to the nature of long-term care.

Mr. President, the population needing long-term care services is a diverse group with widely differing needs.

Of the many misconceptions about long-term care, and about programs providing long-term care services, the most common may be that long-term care is purely an elderly issue. Though it is true that the elderly make up the largest part of the population needing long-term care services, long-term care is an issue facing millions of younger Americans. Approximately 1 million children have severe disabilities that require long-term care services.

Beyond the wide difference in the ages of those needing long-term care services, there is a diversity of needs, including the needs of the caregiving family members who may need a variety of different long-term care services.

From individuals with cerebral palsy to families that have a loved one afflicted with Alzheimer's disease, however well intentioned, no one set of services will address the individual needs of long-term care consumers.

Rather than trying to fit all of those needing long-term care services into one set of services, this legislation lets case managers, working with long-term care consumers and their families, determine just what services are needed and preferred.

Mr. President, the failure to enact comprehensive reform will not interrupt my own efforts to advocate and push individual reforms that respond to the needs of people and that can help save our health care system money.

In home and community-based long-term care reform, we can achieve both.

For taxpayers in Wisconsin, COP has saved hundreds of millions of dollars that would otherwise have been spent on more expensive institutional care.

At the same time, COP has provided an alternative that allows the consumer to participate in determining the plan of care and in the execution of that plan.

But, Mr. President, at the Federal level we are behind Wisconsin and other States in reforming long-term care. Despite the creation of community-based Medicaid waiver programs, consumers are, for the most part, faced with few alternatives. This proposal will begin to provide the flexibility State government needs to provide consumer-oriented and consumer-directed services.

Mr. President, I ask unanimous consent that a summary of the measure, followed by the complete text of the legislation, be printed in the RECORD.

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

S. 879

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

**SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

(a) SHORT TITLE.—This Act may be cited as the ''Long-Term Care Reform and Deficit Reduction Act of 1997''.

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

Sec. 1. Short title; table of contents.

TITLE I—HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DISABILITIES

Sec. 101. State programs for home and community-based services for individuals with disabilities.
Sec. 102. State plans.
Sec. 103. Individuals with disabilities defined.
Sec. 104. Home and community-based services covered under State plan.
Sec. 105. Cost sharing.
Sec. 106. Quality assurance and safeguards.
Sec. 107. Advisory groups.
Sec. 108. Payments to States.
Sec. 109. Appropriations; allotments to States.
Sec. 110. Federal evaluations.
Sec. 111. Information and technical assistance grants relating to development of hospital linkage programs.

TITLE II—PROSPECTIVE PAYMENT SYSTEM FOR NURSING FACILITIES

Sec. 201. Definitions.
Sec. 202. Payment objectives.
Sec. 203. Powers and duties of the Secretary.
Sec. 204. Relationship to title XVIII of the Social Security Act.
Sec. 205. Establishment of resident classification system.
Sec. 206. Cost centers for nursing facility payment.
Sec. 207. Resident assessment.
Sec. 208. The per diem rate for nursing service costs.
Sec. 209. The per diem rate for administrative and general costs.
Sec. 210. Payment for fee-for-service ancillary services.
Sec. 211. Reimbursement of selected ancillary services and other costs.

Sec. 212. Per diem payment for property costs.
Sec. 213. Mid-year rate adjustments.
Sec. 214. Exception to payment methods for new and low volume nursing facilities.
Sec. 215. Appeal procedures.
Sec. 216. Transition period.
Sec. 217. Effective date; inconsistent provisions.

TITLE III—ADDITIONAL MEDICARE PROVISIONS

Sec. 301. Elimination of formula-driven overpayments for certain outpatient hospital services.
Sec. 302. Permanent extension of certain secondary payer provisions.
Sec. 303. Financing and quality modernization and reform.

## TITLE I—HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DISABILITIES

### SEC. 101. STATE PROGRAMS FOR HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH DISABILITIES.

(a) IN GENERAL.—Each State that has a plan for home and community-based services for individuals with disabilities submitted to and approved by the Secretary under section 102(b) may receive payment in accordance with section 108.

(b) ENTITLEMENT TO SERVICES.—Nothing in this title shall be construed to create a right to services for individuals or a requirement that a State with an approved plan expend the entire amount of funds to which it is entitled under this title.

(c) DESIGNATION OF AGENCY.—Not later than 6 months after the date of enactment of this Act, the Secretary shall designate an agency responsible for program administration under this title.

### SEC. 102. STATE PLANS.

(a) PLAN REQUIREMENTS.—In order to be approved under subsection (b), a State plan for home and community-based services for individuals with disabilities must meet the following requirements:

(1) STATE MAINTENANCE OF EFFORT.—

(A) IN GENERAL.—A State plan under this title shall provide that the State will, during any fiscal year that the State is furnishing services under this title, make expenditures of State funds in an amount equal to the State maintenance of effort amount for the year determined under subparagraph (B) for furnishing the services described in subparagraph (C) under the State plan under this title or under the State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(B) STATE MAINTENANCE OF EFFORT AMOUNT.—

(i) IN GENERAL.—The maintenance of effort amount for a State for a fiscal year is an amount equal to—

(I) for fiscal year 1999, the base amount for the State (as determined under clause (ii)) updated through the midpoint of fiscal year 1999 by the estimated percentage change in the index described in clause (iii) during the period beginning on October 1, 1997, and ending at that midpoint; and

(II) for succeeding fiscal years, an amount equal to the amount determined under this clause for the previous fiscal year updated through the midpoint of the year by the estimated percentage change in the index described in clause (iii) during the 12-month period ending at that midpoint, with appropriate adjustments to reflect previous underestimations or overestimations under this clause in the projected percentage change in such index.

(ii) STATE BASE AMOUNT.—The base amount for a State is an amount equal to the total expenditures from State funds made under the State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) during fiscal year 1997 with respect to medical assistance consisting of the services described in subparagraph (C).

(iii) INDEX DESCRIBED.—For purposes of clause (i), the Secretary shall develop an index that reflects the projected increases in spending for services under subparagraph (C), adjusted for differences among the States.

(C) MEDICAID SERVICES DESCRIBED.—The services described in this subparagraph are the following:

(i) Personal care services (as described in section 1905(a)(24) of the Social Security Act (42 U.S.C. 1396d(a)(24))).

(ii) Home or community-based services furnished under a waiver granted under subsection (c), (d), or (e) of section 1915 of such Act (42 U.S.C. 1396n).

(iii) Home and community care furnished to functionally disabled elderly individuals under section 1929 of such Act (42 U.S.C. 1396t).

(iv) Community supported living arrangements services under section 1930 of such Act (42 U.S.C. 1396u).

(v) Services furnished in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other institutional setting specified by the Secretary.

(2) ELIGIBILITY.—

(A) IN GENERAL.—Within the amounts provided by the State and under section 108 for such plan, the plan shall provide that services under the plan will be available to individuals with disabilities (as defined in section 103(a)) in the State.

(B) INITIAL SCREENING.—The plan shall provide a process for the initial screening of an individual who appears to have some reasonable likelihood of being an individual with disabilities. Any such process shall require the provision of assistance to individuals who wish to apply but whose disability limits their ability to apply. The initial screening and the determination of disability (as defined under section 103(b)(1)) shall be conducted by a public agency.

(C) RESTRICTIONS.—

(i) IN GENERAL.—The plan may not limit the eligibility of individuals with disabilities based on—

(I) income;

(II) age;

(III) residential setting (other than with respect to an institutional setting, in accordance with clause (ii)); or

(IV) other grounds specified by the Secretary;

except that through fiscal year 2007, the Secretary may permit a State to limit eligibility based on level of disability or geography (if the State ensures a balance between urban and rural areas).

(ii) INSTITUTIONAL SETTING.—The plan may limit the eligibility of individuals with disabilities based on the definition of the term ''institutional setting'', as determined by the State.

(D) CONTINUATION OF SERVICES.—The plan must provide assurances that, in the case of an individual receiving medical assistance for home and community-based services under the State medicaid plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) as of the date a State's plan is approved under this title, the State will continue to make available (either under this plan, under the State medicaid plan, or otherwise) to such individual an appropriate level of assistance for home and community-based services, taking into account the level of assistance provided as of such date and the individual's need for home and community-based services.

(3) SERVICES.—

(A) NEEDS ASSESSMENT.—Not later than the end of the second year of implementation, the plan or its amendments shall include the results of a statewide assessment of the needs of individuals with disabilities in a format required by the Secretary. The needs assessment shall include demographic data concerning the number of individuals within each category of disability described in this title, and the services available to meet the needs of such individuals.

(B) SPECIFICATION.—Consistent with section 104, the plan shall specify—

(i) the services made available under the plan;

(ii) the extent and manner in which such services are allocated and made available to individuals with disabilities; and

(iii) the manner in which services under the plan are coordinated with each other and with health and long-term care services available outside the plan for individuals with disabilities.

(C) TAKING INTO ACCOUNT INFORMAL CARE.—A State plan may take into account, in determining the amount and array of services made available to covered individuals with disabilities, the availability of informal care. Any individual plan of care developed under section 104(b)(1)(B) that includes informal care shall be required to verify the availability of such care.

(D) ALLOCATION.—The State plan—

(i) shall specify how services under the plan will be allocated among covered individuals with disabilities;

(ii) shall attempt to meet the needs of individuals with a variety of disabilities within the limits of available funding;

(iii) shall include services that assist all categories of individuals with disabilities, regardless of their age or the nature of their disabling conditions;

(iv) shall demonstrate that services are allocated equitably, in accordance with the needs assessment required under subparagraph (A); and

(v) shall ensure that—

(I) the proportion of the population of low-income individuals with disabilities in the State that represents individuals with disabilities who are provided home and community-based services either under the plan, under the State medicaid plan, or under both, is not less than

(II) the proportion of the population of the State that represents individuals who are low-income individuals.

(E) LIMITATION ON LICENSURE OR CERTIFICATION.—The State may not subject consumer-directed providers of personal assistance services to licensure, certification, or other requirements that the Secretary finds not to be necessary for the health and safety of individuals with disabilities.

(F) CONSUMER CHOICE.—To the extent feasible, the State shall follow the choice of an individual with disabilities (or that individual's designated representative who may be a family member) regarding which covered services to receive and the providers who will provide such services.

(4) COST SHARING.—The plan may impose cost sharing with respect to covered services in accordance with section 105.

(5) TYPES OF PROVIDERS AND REQUIREMENTS FOR PARTICIPATION.—The plan shall specify—

(A) the types of service providers eligible to participate in the program under the plan, which shall include consumer-directed providers of personal assistance services, except that the plan—

(i) may not limit benefits to services provided by registered nurses or licensed practical nurses; and

(ii) may not limit benefits to services provided by agencies or providers certified

under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.); and

(B) any requirements for participation applicable to each type of service provider.

(6) PROVIDER REIMBURSEMENT.—

(A) PAYMENT METHODS.—The plan shall specify the payment methods to be used to reimburse providers for services furnished under the plan. Such methods may include retrospective reimbursement on a fee-for-service basis, prepayment on a capitation basis, payment by cash or vouchers to individuals with disabilities, or any combination of these methods. In the case of payment to consumer-directed providers of personal assistance services, including payment through the use of cash or vouchers, the plan shall specify how the plan will assure compliance with applicable employment tax and health care coverage provisions.

(B) PAYMENT RATES.—The plan shall specify the methods and criteria to be used to set payment rates for—

(i) agency administered services furnished under the plan; and

(ii) consumer-directed personal assistance services furnished under the plan, including cash payments or vouchers to individuals with disabilities, except that such payments shall be adequate to cover amounts required under applicable employment tax and health care coverage provisions.

(C) PLAN PAYMENT AS PAYMENT IN FULL.—The plan shall restrict payment under the plan for covered services to those providers that agree to accept the payment under the plan (at the rates established pursuant to subparagraph (B)) and any cost sharing permitted under section 105 as payment in full for services furnished under the plan.

(7) QUALITY ASSURANCE AND SAFEGUARDS.—The State plan shall provide for quality assurance and safeguards for applicants and beneficiaries in accordance with section 106.

(8) ADVISORY GROUP.—The State plan shall—

(A) assure the establishment and maintenance of an advisory group in accordance with section 107(b); and

(B) include the documentation prepared by the group under section 107(b)(4).

(9) ADMINISTRATION AND ACCESS.—

(A) STATE AGENCY.—The plan shall designate a State agency or agencies to administer (or to supervise the administration of) the plan.

(B) COORDINATION.—The plan shall specify how it will—

(i) coordinate services provided under the plan, including eligibility prescreening, service coordination, and referrals for individuals with disabilities who are ineligible for services under this title with the State medicaid plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), titles V and XX of such Act (42 U.S.C. 701 et seq. and 1397 et seq.), programs under the Older Americans Act of 1965 (42 U.S.C. 3001 et seq.), programs under the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6000 et seq.), programs under the Individuals with Disabilities Education Act (20 U.S.C. 1400 et seq.), and any other Federal or State programs that provide services or assistance targeted to individuals with disabilities; and

(ii) coordinate with health plans.

(C) ADMINISTRATIVE EXPENDITURES.—Effective beginning with fiscal year 2007, the plan shall contain assurances that not more than 10 percent of expenditures under the plan for all quarters in any fiscal year shall be for administrative costs.

(D) INFORMATION AND ASSISTANCE.—The plan shall provide for a single point of access to apply for services under the State program for individuals with disabilities. Notwithstanding the preceding sentence, the plan may designate separate points of access to the State program for individuals under 22 years of age, for individuals 65 years of age or older, or for other appropriate classes of individuals.

(10) REPORTS AND INFORMATION TO SECRETARY; AUDITS.—The plan shall provide that the State will furnish to the Secretary—

(A) such reports, and will cooperate with such audits, as the Secretary determines are needed concerning the State's administration of its plan under this title, including the processing of claims under the plan; and

(B) such data and information as the Secretary may require in a uniform format as specified by the Secretary.

(11) USE OF STATE FUNDS FOR MATCHING.—The plan shall provide assurances that Federal funds will not be used to provide for the State share of expenditures under this title.

(12) HEALTH CARE WORKER REDEPLOYMENT.—The plan shall provide for the following:

(A) Before initiating the process of implementing the State program under such plan, negotiations will be commenced with labor unions representing the employees of the affected hospitals or other facilities.

(B) Negotiations under subparagraph (A) will address the following:

(i) The impact of the implementation of the program upon the workforce.

(ii) Methods to redeploy workers to positions in the proposed system, in the case of workers affected by the program.

(C) The plan will provide evidence that there has been compliance with subparagraphs (A) and (B), including a description of the results of the negotiations.

(13) TERMINOLOGY.—The plan shall adhere to uniform definitions of terms, as specified by the Secretary.

(b) APPROVAL OF PLANS.—The Secretary shall approve a plan submitted by a State if the Secretary determines that the plan—

(1) was developed by the State after a public comment period of not less than 30 days; and

(2) meets the requirements of subsection (a).

The approval of such a plan shall take effect as of the first day of the first fiscal year beginning after the date of such approval (except that any approval made before October 1, 1998, shall be effective as of such date). In order to budget funds allotted under this title, the Secretary shall establish a deadline for the submission of such a plan before the beginning of a fiscal year as a condition of its approval effective with that fiscal year. Any significant changes to the State plan shall be submitted to the Secretary in the form of plan amendments and shall be subject to approval by the Secretary.

(c) MONITORING.—The Secretary shall annually monitor the compliance of State plans with the requirements of this title according to specified performance standards. In accordance with section 108(e), States that fail to comply with such requirements may be subject to a reduction in the Federal matching rates available to the State under section 108(a) or the withholding of Federal funds for services or administration until such time as compliance is achieved.

(d) TECHNICAL ASSISTANCE.—The Secretary shall ensure the availability of ongoing technical assistance to States under this section. Such assistance shall include serving as a clearinghouse for information regarding successful practices in providing long-term care services.

(e) REGULATIONS.—The Secretary shall issue such regulations as may be appropriate to carry out this title on a timely basis.

**SEC. 103. INDIVIDUALS WITH DISABILITIES DEFINED.**

(a) IN GENERAL.—For purposes of this title, the term ''individual with disabilities'' means any individual within 1 or more of the following categories:

(1) INDIVIDUALS REQUIRING HELP WITH ACTIVITIES OF DAILY LIVING.—An individual of any age who—

(A) requires hands-on or standby assistance, supervision, or cueing (as defined in regulations) to perform 3 or more activities of daily living (as defined in subsection (d)); and

(B) is expected to require such assistance, supervision, or cueing for a chronic condition that will last at least 180 days.

(2) INDIVIDUALS WHO REQUIRE SUPERVISION DUE TO COGNITIVE OR OTHER MENTAL IMPAIRMENTS.—An individual of any age—

(A) who requires supervision to protect himself or herself from threats to health or safety due to impaired judgment, or who requires supervision due to symptoms of 1 or more serious behavioral problems (that is on a list of such problems specified by the Secretary); and

(B) who is expected to require such supervision for a chronic condition that will last at least 180 days.

Not later than 2 years after the date of enactment of this Act, the Secretary shall make recommendations regarding the most appropriate duration of disability under this paragraph.

(3) INDIVIDUALS WITH SEVERE OR PROFOUND MENTAL RETARDATION.—An individual of any age who has severe or profound mental retardation (as determined according to a protocol specified by the Secretary).

(4) INDIVIDUALS WITH MEDICAL MANAGEMENT NEEDS.—An individual of any age who due to a physical cognitive or other mental impairment requires assistance to manage his or her medical or nursing care (as determined by the Secretary).

(5) YOUNG CHILDREN WITH SEVERE DISABILITIES.—An individual under 6 years of age who—

(A) has a severe disability or chronic medical condition that limits functioning in a manner that is comparable in severity to the standards established under paragraphs (1), (2), or (3); and

(B) is expected to have such a disability or condition for at least 180 days.

The Secretary shall elaborate the criteria for children under 6 years of age based on an analysis of Phase I (1994) and II (1996) of the National Disability Survey.

(6) STATE OPTION WITH RESPECT TO INDIVIDUALS WITH COMPARABLE DISABILITIES.—Not more than 5 percent of a State's allotment for services under this title may be expended for the provision of services to individuals with severe disabilities and long-term medical or nursing needs that are comparable in severity to the criteria described in paragraphs (1) through (5), but who fail to meet the criteria in any single category under such paragraphs.

(b) DETERMINATION.—

(1) IN GENERAL.—In formulating eligibility criteria under subsection (a), the Secretary shall establish criteria for assessing the functional level of disability among all categories of individuals with disabilities that are comparable in severity, regardless of the age or the nature of the disabling condition of the individual. The determination of whether an individual is an individual with disabilities shall be made by a public or nonprofit agency that is specified under the State plan and that is not a provider of home and community-based services under this title and by using a uniform protocol consisting of an initial screening and a determination of disability specified by the Secretary. A State may not impose cost sharing with respect to a determination of disability. A State may collect additional information,

at the time of obtaining information to make such determination, in order to provide for the assessment and plan described in section 104(b) or for other purposes.

(2) PERIODIC REASSESSMENT.—The determination that an individual is an individual with disabilities shall be considered to be effective under the State plan for a period of not more than 6 months (or for such longer period in such cases as a significant change in an individual's condition that may affect such determination is unlikely). A reassessment shall be made if there is a significant change in an individual's condition that may affect such determination.

(c) ELIGIBILITY CRITERIA.—The Secretary shall reassess the validity of the eligibility criteria described in subsection (a) as new knowledge regarding the assessments of functional disabilities becomes available. The Secretary shall report to the Congress on its findings under the preceding sentence as determined appropriate by the Secretary.

(d) ACTIVITY OF DAILY LIVING DEFINED.—In this title, the term ''activity of daily living'' means any of the following: eating, toileting, dressing, bathing, and transferring.

(e) INDIVIDUALS WITH COGNITIVE OR OTHER MENTAL IMPAIRMENTS DEFINED.—In this title, the term ''individuals with cognitive or other mental impairments'' means an individual with Alzheimer's disease, dementia, autism, mental illness, mental retardation, congenital or acquired brain injury, or any other severe mental condition.

**SEC. 104. HOME AND COMMUNITY-BASED SERVICES COVERED UNDER STATE PLAN.**

(a) SPECIFICATION.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, the State plan under this title shall specify—

(A) the home and community-based services available under the plan to individuals with disabilities (or to such categories of such individuals); and

(B) any limits with respect to such services.

(2) FLEXIBILITY IN MEETING INDIVIDUAL NEEDS.—Subject to subsection (e)(2), such services may be delivered in an individual's home, a range of community residential arrangements, or outside the home.

(b) REQUIREMENT FOR NEEDS ASSESSMENT AND PLAN OF CARE.—

(1) IN GENERAL.—The State plan shall provide for home and community-based services to an individual with disabilities only if the following requirements are met:

(A) COMPREHENSIVE ASSESSMENT.—

(i) IN GENERAL.—A comprehensive assessment of an individual's need for home and community-based services (regardless of whether all needed services are available under the plan) shall be made in accordance with a uniform, comprehensive assessment tool that shall be used by a State under this paragraph with the approval of the Secretary. The comprehensive assessment shall be made by a public or nonprofit agency that is specified under the State plan and that is not a provider of home and community-based services under this title.

(ii) EXCEPTION.—The State may elect to waive the provisions of clause (i) if—

(I) with respect to any area of the State, the State has determined that there is an insufficient pool of entities willing to perform comprehensive assessments in such area due to a low population of individuals eligible for home and community-based services under this title residing in the area; and

(II) the State plan specifies procedures that the State will implement in order to avoid conflicts of interest.

(B) INDIVIDUALIZED PLAN OF CARE.—

(i) IN GENERAL.—An individualized plan of care based on the assessment made under subparagraph (A) shall be developed by a public or nonprofit agency that is specified under the State plan and that is not a provider of home and community-based services under this title, except that the State may elect to waive the provisions of this sentence if, with respect to any area of the State, the State has determined there is an insufficient pool of entities willing to develop individualized plans of care in such area due to a low population of individuals eligible for home and community-based services under this title residing in the area, and the State plan specifies procedures that the State will implement in order to avoid conflicts of interest.

(ii) REQUIREMENTS WITH RESPECT TO PLAN OF CARE.—A plan of care under this subparagraph shall—

(I) specify which services included under the individual plan will be provided under the State plan under this title;

(II) identify (to the extent possible) how the individual will be provided any services specified under the plan of care and not provided under the State plan;

(III) specify how the provision of services to the individual under the plan will be coordinated with the provision of other health care services to the individual; and

(IV) be reviewed and updated every 6 months (or more frequently if there is a change in the individual's condition).

The State shall make reasonable efforts to identify and arrange for services described in subclause (II). Nothing in this subsection shall be construed as requiring a State (under the State plan or otherwise) to provide all the services specified in such a plan.

(C) INVOLVEMENT OF INDIVIDUALS.—The individualized plan of care under subparagraph (B) for an individual with disabilities shall—

(i) be developed by qualified individuals (specified in subparagraph (B));

(ii) be developed and implemented in close consultation with the individual (or the individual's designated representative); and

(iii) be approved by the individual (or the individual's designated representative).

(c) REQUIREMENT FOR CARE MANAGEMENT.—

(1) IN GENERAL.—The State shall make available to each category of individuals with disabilities care management services that at a minimum include—

(A) arrangements for the provision of such services; and

(B) monitoring of the delivery of services.

(2) CARE MANAGEMENT SERVICES.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the care management services described in paragraph (1) shall be provided by a public or private entity that is not providing home and community-based services under this title.

(B) EXCEPTION.—A person who provides home and community-based services under this title may provide care management services if—

(i) the State determines that there is an insufficient pool of entities willing to provide such services in an area due to a low population of individuals eligible for home and community-based services under this title residing in such area; and

(ii) the State plan specifies procedures that the State will implement in order to avoid conflicts of interest.

(d) MANDATORY COVERAGE OF PERSONAL ASSISTANCE SERVICES.—The State plan shall include, in the array of services made available to each category of individuals with disabilities, both agency-administered and consumer-directed personal assistance services (as defined in subsection (h)).

(e) ADDITIONAL SERVICES.—

(1) TYPES OF SERVICES.—Subject to subsection (f), services available under a State plan under this title may include any (or all) of the following:

(A) Homemaker and chore assistance.

(B) Home modifications.

(C) Respite services.

(D) Assistive technology devices, as defined in section 3(2) of the Technology-Related Assistance for Individuals With Disabilities Act of 1988 (29 U.S.C. 2202(2)).

(E) Adult day services.

(F) Habilitation and rehabilitation.

(G) Supported employment.

(H) Home health services.

(I) Transportation.

(J) Any other care or assistive services specified by the State and approved by the Secretary that will help individuals with disabilities to remain in their homes and communities.

(2) CRITERIA FOR SELECTION OF SERVICES.—The State electing services under paragraph (1) shall specify in the State plan—

(A) the methods and standards used to select the types, and the amount, duration, and scope, of services to be covered under the plan and to be available to each category of individuals with disabilities; and

(B) how the types, and the amount, duration, and scope, of services specified, within the limits of available funding, provide substantial assistance in living independently to individuals within each of the categories of individuals with disabilities.

(f) EXCLUSIONS AND LIMITATIONS.—A State plan may not provide for coverage of—

(1) room and board;

(2) services furnished in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other institutional setting specified by the Secretary; or

(3) items and services to the extent coverage is provided for the individual under a health plan or the medicare program.

(g) PAYMENT FOR SERVICES.—In order to pay for covered services, a State plan may provide for the use of—

(1) vouchers;

(2) cash payments directly to individuals with disabilities;

(3) capitation payments to health plans; and

(4) payment to providers.

(h) PERSONAL ASSISTANCE SERVICES.—

(1) IN GENERAL.—For purposes of this title, the term ''personal assistance services'' means those services specified under the State plan as personal assistance services and shall include at least hands-on and standby assistance, supervision, cueing with activities of daily living, and such instrumental activities of daily living as deemed necessary or appropriate, whether agency-administered or consumer-directed (as defined in paragraph (2)). Such services shall include services that are determined to be necessary to help all categories of individuals with disabilities, regardless of the age of such individuals or the nature of the disabling conditions of such individuals.

(2) CONSUMER-DIRECTED.—For purposes of this title:

(A) IN GENERAL.—The term ''consumer-directed'' means, with reference to personal assistance services or the provider of such services, services that are provided by an individual who is selected and managed (and, at the option of the service recipient, trained) by the individual receiving the services.

(B) STATE RESPONSIBILITIES.—A State plan shall ensure that where services are provided in a consumer-directed manner, the State shall create or contract with an entity, other than the consumer or the individual provider, to—

(i) inform both recipients and providers of rights and responsibilities under all applicable Federal labor and tax law; and

(ii) assume responsibility for providing effective billing, payments for services, tax

withholding, unemployment insurance, and workers' compensation coverage, and act as the employer of the home care provider.

(C) RIGHT OF CONSUMERS.—Notwithstanding the State responsibilities described in subparagraph (B), service recipients, and, where appropriate, their designated representative, shall retain the right to independently select, hire, terminate, and direct (including manage, train, schedule, and verify services provided) the work of a home care provider.

(3) AGENCY ADMINISTERED.—For purposes of this title, the term ''agency-administered'' means, with respect to such services, services that are not consumer-directed.

**SEC. 105. COST SHARING.**

(a) NO COST SHARING FOR POOREST.—

(1) IN GENERAL.—The State plan may not impose any cost sharing for individuals with income (as determined under subsection (d)) less than 150 percent of the official poverty level applicable to a family of the size involved (referred to in paragraph (2)).

(2) OFFICIAL POVERTY LEVEL.—For purposes of paragraph (1), the term ''official poverty level applicable to a family of the size involved'' means, for a family for a year, the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)) applicable to a family of the size involved.

(b) SLIDING SCALE FOR REMAINDER.—The State plan may impose cost sharing for individuals not described in subsection (a) in such form and manner as the State determines is appropriate.

(c) RECOMMENDATION OF THE SECRETARY.—The Secretary shall make recommendations to the States as to how to reduce cost-sharing for individuals with extraordinary out-of-pocket costs for whom the imposition of cost-sharing could jeopardize their ability to take advantage of the services offered under this title. The Secretary shall establish a methodology for reducing the cost-sharing burden for individuals with exceptionally high out-of-pocket costs under this title.

(d) DETERMINATION OF INCOME FOR PURPOSES OF COST SHARING.—The State plan shall specify the process to be used to determine the income of an individual with disabilities for purposes of this section. Such standards shall include a uniform Federal definition of income and any allowable deductions from income.

**SEC. 106. QUALITY ASSURANCE AND SAFEGUARDS.**

(a) QUALITY ASSURANCE.—

(1) IN GENERAL.—The State plan shall specify how the State will ensure and monitor the quality of services, including—

(A) safeguarding the health and safety of individuals with disabilities;

(B) setting the minimum standards for agency providers and how such standards will be enforced;

(C) setting the minimum competency requirements for agency provider employees who provide direct services under this title and how the competency of such employees will be enforced;

(D) obtaining meaningful consumer input, including consumer surveys that measure the extent to which participants receive the services described in the plan of care and participant satisfaction with such services;

(E) establishing a process to receive, investigate, and resolve allegations of neglect or abuse;

(F) establishing optional training programs for individuals with disabilities in the use and direction of consumer directed providers of personal assistance services;

(G) establishing an appeals procedure for eligibility denials and a grievance procedure for disagreements with the terms of an individualized plan of care;

(H) providing for participation in quality assurance activities; and

(I) specifying the role of the Long-Term Care Ombudsman (under the Older Americans Act of 1965 (42 U.S.C. 3001 et seq.)) and the protection and advocacy system (established under section 142 of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6042)) in assuring quality of services and protecting the rights of individuals with disabilities.

(2) ISSUANCE OF REGULATIONS.—Not later than 1 year after the date of enactment of this Act, the Secretary shall issue regulations implementing the quality provisions of this subsection.

(b) FEDERAL STANDARDS.—The State plan shall adhere to Federal quality standards in the following areas:

(1) Case review of a specified sample of client records.

(2) The mandatory reporting of abuse, neglect, or exploitation.

(3) The development of a registry of provider agencies or home care workers and consumer directed providers of personal assistance services against whom any complaints have been sustained, which shall be available to the public.

(4) Sanctions to be imposed on States or providers, including disqualification from the program, if minimum standards are not met.

(5) Surveys of client satisfaction.

(6) State optional training programs for informal caregivers.

(c) CLIENT ADVOCACY.—

(1) IN GENERAL.—The State plan shall provide that the State will expend the amount allocated under section 109(b)(2) for client advocacy activities. The State may use such funds to augment the budgets of the Long-Term Care Ombudsman (under the Older Americans Act of 1965 (42 U.S.C. 3001 et seq.) and the protection and advocacy system (established under section 142 of the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 6042)) or may establish a separate and independent client advocacy office in accordance with paragraph (2) to administer a new program designed to advocate for client rights.

(2) CLIENT ADVOCACY OFFICE.—

(A) IN GENERAL.—A client advocacy office established under this paragraph shall—

(i) identify, investigate, and resolve complaints that—

(I) are made by, or on behalf of, clients; and

(II) relate to action, inaction, or decisions, that may adversely affect the health, safety, welfare, or rights of the clients (including the welfare and rights of the clients with respect to the appointment and activities of guardians and representative payees), of—

(aa) providers, or representatives of providers, of long-term care services;

(bb) public agencies; or

(cc) health and social service agencies;

(ii) provide services to assist the clients in protecting the health, safety, welfare, and rights of the clients;

(iii) inform the clients about means of obtaining services provided by providers or agencies described in clause (i)(II) or services described in clause (ii);

(iv) ensure that the clients have regular and timely access to the services provided through the office and that the clients and complainants receive timely responses from representatives of the office to complaints; and

(v) represent the interests of the clients before governmental agencies and seek administrative, legal, and other remedies to protect the health, safety, welfare, and rights of the clients with regard to the provisions of this title.

(B) CONTRACTS AND ARRANGEMENTS.—

(i) IN GENERAL.—Except as provided in clause (ii), the State agency may establish and operate the office, and carry out the program, directly, or by contract or other arrangement with any public agency or nonprofit private organization.

(ii) LICENSING AND CERTIFICATION ORGANIZATIONS; ASSOCIATIONS.—The State agency may not enter into the contract or other arrangement described in clause (i) with an agency or organization that is responsible for licensing, certifying, or providing long-term care services in the State.

(d) SAFEGUARDS.—

(1) CONFIDENTIALITY.—The State plan shall provide safeguards that restrict the use or disclosure of information concerning applicants and beneficiaries to purposes directly connected with the administration of the plan.

(2) SAFEGUARDS AGAINST ABUSE.—The State plans shall provide safeguards against physical, emotional, or financial abuse or exploitation (specifically including appropriate safeguards in cases where payment for program benefits is made by cash payments or vouchers given directly to individuals with disabilities). All providers of services shall be required to register with the State agency.

(3) REGULATIONS.—Not later than October 1, 1998, the Secretary shall promulgate regulations with respect to the requirements on States under this subsection.

(e) SPECIFIED RIGHTS.—The State plan shall provide that in furnishing home and community-based services under the plan the following individual rights are protected:

(1) The right to be fully informed in advance, orally and in writing, of the care to be provided, to be fully informed in advance of any changes in care to be provided, and (except with respect to an individual determined incompetent) to participate in planning care or changes in care.

(2) The right to—

(A) voice grievances with respect to services that are (or fail to be) furnished without discrimination or reprisal for voicing grievances;

(B) be told how to complain to State and local authorities; and

(C) prompt resolution of any grievances or complaints.

(3) The right to confidentiality of personal and clinical records and the right to have access to such records.

(4) The right to privacy and to have one's property treated with respect.

(5) The right to refuse all or part of any care and to be informed of the likely consequences of such refusal.

(6) The right to education or training for oneself and for members of one's family or household on the management of care.

(7) The right to be free from physical or mental abuse, corporal punishment, and any physical or chemical restraints imposed for purposes of discipline or convenience and not included in an individual's plan of care.

(8) The right to be fully informed orally and in writing of the individual's rights.

(9) The right to a free choice of providers.

(10) The right to direct provider activities when an individual is competent and willing to direct such activities.

**SEC. 107. ADVISORY GROUPS.**

(a) FEDERAL ADVISORY GROUP.—

(1) ESTABLISHMENT.—The Secretary shall establish an advisory group, to advise the Secretary and States on all aspects of the program under this title.

(2) COMPOSITION.—The group shall be composed of individuals with disabilities and

their representatives, providers, Federal and State officials, and local community implementing agencies. A majority of its members shall be individuals with disabilities and their representatives.

(b) STATE ADVISORY GROUPS.—

(1) IN GENERAL.—Each State plan shall provide for the establishment and maintenance of an advisory group to advise the State on all aspects of the State plan under this title.

(2) COMPOSITION.—Members of each advisory group shall be appointed by the Governor (or other chief executive officer of the State) and shall include individuals with disabilities and their representatives, providers, State officials, and local community implementing agencies. A majority of its members shall be individuals with disabilities and their representatives. The members of the advisory group shall be selected from those nominated as described in paragraph (3).

(3) SELECTION OF MEMBERS.—Each State shall establish a process whereby all residents of the State, including individuals with disabilities and their representatives, shall be given the opportunity to nominate members to the advisory group.

(4) PARTICULAR CONCERNS.—Each advisory group shall—

(A) before the State plan is developed, advise the State on guiding principles and values, policy directions, and specific components of the plan;

(B) meet regularly with State officials involved in developing the plan, during the development phase, to review and comment on all aspects of the plan;

(C) participate in the public hearings to help assure that public comments are addressed to the extent practicable;

(D) report to the Governor and make available to the public any differences between the group's recommendations and the plan;

(E) report to the Governor and make available to the public specifically the degree to which the plan is consumer-directed; and

(F) meet regularly with officials of the designated State agency (or agencies) to provide advice on all aspects of implementation and evaluation of the plan.

**SEC. 108. PAYMENTS TO STATES.**

(a) IN GENERAL.—Subject to section 102(a)(9)(C) (relating to limitation on payment for administrative costs), the Secretary, in accordance with the Cash Management Improvement Act of 1990 (31 U.S.C. 6501 note), shall authorize payment to each State with a plan approved under this title, for each quarter (beginning on or after October 1, 1998), from its allotment under section 109(b), an amount equal to—

(1)(A) with respect to the amount demonstrated by State claims to have been expended during the year for home and community-based services under the plan for individuals with disabilities that does not exceed 20 percent of the amount allotted to the State under section 109(b), 100 percent of such amount; and

(B) with respect to the amount demonstrated by State claims to have been expended during the year for home and community-based services under the plan for individuals with disabilities that exceeds 20 percent of the amount allotted to the State under section 109(b), the Federal home and community-based services matching percentage (as defined in subsection (b)) of such amount; plus

(2) an amount equal to 90 percent of the amount demonstrated by the State to have been expended during the quarter for quality assurance activities under the plan; plus

(3) an amount equal to 90 percent of the amount expended during the quarter under the plan for activities (including preliminary screening) relating to determinations of eligibility and performance of needs assessment; plus

(4) an amount equal to 90 percent (or, beginning with quarters in fiscal year 2007, 75 percent) of the amount expended during the quarter for the design, development, and installation of mechanical claims processing systems and for information retrieval; plus

(5) an amount equal to 50 percent of the remainder of the amounts expended during the quarter as found necessary by the Secretary for the proper and efficient administration of the State plan.

(b) FEDERAL HOME AND COMMUNITY-BASED SERVICES MATCHING PERCENTAGE.—In subsection (a), the term ''Federal home and community-based services matching percentage'' means, with respect to a State, the State's Federal medical assistance percentage (as defined in section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b))) increased by 15 percentage points, except that the Federal home and community-based services matching percentage shall in no case be more than 95 percent.

(c) PAYMENTS ON ESTIMATES WITH RETROSPECTIVE ADJUSTMENTS.—The method of computing and making payments under this section shall be as follows:

(1) The Secretary shall, prior to the beginning of each quarter, estimate the amount to be paid to the State under subsection (a) for such quarter, based on a report filed by the State containing its estimate of the total sum to be expended in such quarter, and such other information as the Secretary may find necessary.

(2) From the allotment available therefore, the Secretary shall provide for payment of the amount so estimated, reduced or increased, as the case may be, by any sum (not previously adjusted under this section) by which the Secretary finds that the estimate of the amount to be paid the State for any prior period under this section was greater or less than the amount that should have been paid.

(d) APPLICATION OF RULES REGARDING LIMITATIONS ON PROVIDER-RELATED DONATIONS AND HEALTH CARE-RELATED TAXES.—The provisions of section 1903(w) of the Social Security Act (42 U.S.C. 1396b(w)) shall apply to payments to States under this section in the same manner as they apply to payments to States under section 1903(a) of such Act (42 U.S.C. 1396b(a)).

(e) FAILURE TO COMPLY WITH STATE PLAN.—If a State furnishing home and community-based services under this title fails to comply with the State plan approved under this title, the Secretary may either reduce the Federal matching rates available to the State under subsection (a) or withhold an amount of funds determined appropriate by the Secretary from any payment to the State under this section.

**SEC. 109. APPROPRIATIONS; ALLOTMENTS TO STATES.**

(a) APPROPRIATIONS.—

(1) FISCAL YEARS 1999 THROUGH 2007.—Subject to paragraph (5)(C), for purposes of this title, the appropriation authorized under this title for each of fiscal years 1999 through 2007 is the following:

(A) For fiscal year 1999, $500,000,000.

(B) For fiscal year 2000, $750,000,000.

(C) For fiscal year 2001, $1,000,000,000.

(D) For fiscal year 2002, $1,500,000,000.

(E) For fiscal year 2003, $2,000,000,000.

(F) For fiscal year 2004, $2,500,000,000.

(G) For fiscal year 2005, $3,250,000,000.

(H) For fiscal year 2006, $4,000,000,000.

(I) For fiscal year 2007, $5,000,000,000.

(2) SUBSEQUENT FISCAL YEARS.—For purposes of this title, the appropriation authorized for State plans under this title for each fiscal year after fiscal year 2007 is the appropriation authorized under this subsection for the preceding fiscal year multiplied by—

(A) a factor (described in paragraph (3)) reflecting the change in the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics for the fiscal year; and

(B) a factor (described in paragraph (4)) reflecting the change in the number of individuals with disabilities for the fiscal year.

(3) CPI MEDICAL CARE EXPENDITURE INCREASE FACTOR.—For purposes of paragraph (2)(A), the factor described in this paragraph for a fiscal year is the ratio of—

(A) the percentage increase or decrease, respectively, in the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics, for the preceding fiscal year, to—

(B) such increase or decrease, as so measured, for the second preceding fiscal year.

(4) DISABLED POPULATION FACTOR.—For purposes of paragraph (2)(B), the factor described in this paragraph for a fiscal year is 100 percent plus (or minus) the percentage increase (or decrease) change in the disabled population of the United States (as determined for purposes of the most recent update under subsection (b)(3)(D)).

(5) LEGISLATIVE PROPOSAL FOR ADDITIONAL FUNDS DUE TO MEDICAID OFFSETS.—

(A) IN GENERAL.—Not later than January 1, 1998, the Secretary shall submit to the appropriate committees of Congress a legislative proposal that, during the period beginning on October 1, 1998, and ending on September 30, 2007, for each fiscal year during such period, allocates among the States with plans approved under this title an amount equal to 75 percent of the Federal medicaid long-term care savings. The legislative proposal shall provide that funds shall be allocated to such States without requiring any State matching payments in order to receive such funds.

(B) FEDERAL MEDICAID LONG-TERM CARE SAVINGS DEFINED.—In subparagraph (A), the term 'Federal medicaid long-term care savings' means with respect to a fiscal year, the amount equal to the amount of Federal outlays that would have been made under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) during such fiscal year but for the provision of home and community-based services under the program under this title.

(b) ALLOTMENTS TO STATES.—

(1) IN GENERAL.—The Secretary shall allot the amounts available under the appropriation authorized for the fiscal year under paragraph (1) of subsection (a), to the States with plans approved under this title in accordance with an allocation formula developed by the Secretary that takes into account—

(A) the percentage of the total number of individuals with disabilities in all States that reside in a particular State;

(B) the per capita costs of furnishing home and community-based services to individuals with disabilities in the State; and

(C) the percentage of all individuals with incomes at or below 150 percent of the official poverty line (as described in section 105(a)(2)) in all States that reside in a particular State.

(2) ALLOCATION FOR CLIENT ADVOCACY ACTIVITIES.—Each State with a plan approved under this title shall allocate ½ of 1 percent of the State's total allotment under paragraph (1) for client advocacy activities as described in section 106(c).

(3) NO DUPLICATE PAYMENT.—No payment may be made to a State under this section for any services provided to an individual to the extent that the State received payment for such services under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)).

(4) REALLOCATIONS.—Any amounts allotted to States under this subsection for a year that are not expended in such year shall remain available for State programs under this title and may be reallocated to States as the Secretary determines appropriate.

(c) STATE ENTITLEMENT.—This title constitutes budget authority in advance of appropriations Acts, and represents the obligation of the Federal Government to provide for the payment to States of amounts described in subsection (a).

**SEC. 110. FEDERAL EVALUATIONS.**

Not later than December 31, 2004, December 31, 2007, and each December 31 thereafter, the Secretary shall provide to Congress analytical reports that evaluate—

(1) the extent to which individuals with low incomes and disabilities are equitably served;

(2) the adequacy and equity of service plans to individuals with similar levels of disability across States;

(3) the comparability of program participation across States, described by level and type of disability; and

(4) the ability of service providers to sufficiently meet the demand for services.

**SEC. 111. INFORMATION AND TECHNICAL ASSISTANCE GRANTS RELATING TO DEVELOPMENT OF HOSPITAL LINKAGE PROGRAMS.**

(a) FINDINGS.—Congress finds that—

(1) demonstration programs and projects have been developed to offer care management to hospitalized individuals awaiting discharge who are in need of long-term health care services that meet individual needs and preferences in home and community-based settings as an alternative to long-term nursing home care or institutional placement; and

(2) there is a need to disseminate information and technical assistance to hospitals and State and local community organizations regarding such programs and projects and to provide incentive grants to State and local public and private agencies, including area agencies on aging, to establish and expand programs that offer care management to individuals awaiting discharge from acute care hospitals who are in need of long-term care so that services to meet individual needs and preferences can be arranged in home and community-based settings as an alternative to long-term placement in nursing homes or other institutional settings.

(b) DISSEMINATION OF INFORMATION, TECHNICAL ASSISTANCE, AND INCENTIVE GRANTS TO ASSIST IN THE DEVELOPMENT OF HOSPITAL LINKAGE PROGRAMS.—Part C of title III of the Public Health Service Act (42 U.S.C. 248 et seq.) is amended by adding at the end the following:

**"SEC. 327B. DISSEMINATION OF INFORMATION, TECHNICAL ASSISTANCE AND INCENTIVE GRANTS TO ASSIST IN THE DEVELOPMENT OF HOSPITAL LINKAGE PROGRAMS.**

''(a) DISSEMINATION OF INFORMATION.—The Secretary shall compile, evaluate, publish, and disseminate to appropriate State and local officials and to private organizations and agencies that provide services to individuals in need of long-term health care services, such information and materials as may assist such entities in replicating successful programs that are aimed at offering care management to hospitalized individuals who are in need of long-term care so that services to meet individual needs and preferences can be arranged in home and community-based settings as an alternative to long-term nursing home placement. The Secretary may provide technical assistance to entities seeking to replicate such programs.

''(b) INCENTIVE GRANTS TO ASSIST IN THE DEVELOPMENT OF HOSPITAL LINKAGE PROGRAMS.—The Secretary shall establish a program under which incentive grants may be awarded to assist private and public agencies, including area agencies on aging, and organizations in developing and expanding programs and projects that facilitate the discharge of individuals in hospitals or other acute care facilities who are in need of long-term care services and placement of such individuals into home and community-based settings.

''(c) ADMINISTRATIVE PROVISIONS.—

''(1) ELIGIBLE ENTITIES.—To be eligible to receive a grant under subsection (b) an entity shall be—

''(A)(i) a State agency as defined in section 102(43) of the Older Americans Act of 1965 (42 U.S.C. 3002(43)); or

''(ii) a State agency responsible for administering home and community care programs under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.); or

''(B) if no State agency described in subparagraph (A) applies with respect to a particular State, a public or nonprofit private entity.

''(2) APPLICATIONS.—To be eligible to receive an incentive grant under subsection (b), an entity shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including—

''(A) an assessment of the need within the community to be served for the establishment or expansion of a program to facilitate the discharge of individuals in need of long-term care who are in hospitals or other acute care facilities into home and community-care programs that provide individually planned, flexible services that reflect individual choice or preference rather than nursing home or institutional settings;

''(B) a plan for establishing or expanding a program for identifying individuals in hospital or acute care facilities who are in need of individualized long-term care provided in home and community-based settings rather than nursing homes or other institutional settings and undertaking the planning and management of individualized care plans to facilitate discharge into such settings;

''(C) assurances that nongovernmental case management agencies funded under grants awarded under this section are not direct providers of home and community-based services;

''(D) satisfactory assurances that adequate home and community-based long term care services are available, or will be made available, within the community to be served so that individuals being discharged from hospitals or acute care facilities under the proposed program can be served in such home and community-based settings, with flexible, individualized care that reflects individual choice and preference;

''(E) a description of the manner in which the program to be administered with amounts received under the grant will be continued after the termination of the grant for which such application is submitted; and

''(F) a description of any waivers or approvals necessary to expand the number of individuals served in federally funded home and community-based long term care programs in order to provide satisfactory assurances that adequate home and community-based long term care services are available in the community to be served.

''(3) AWARDING OF GRANTS.—

''(A) PREFERENCES.—In awarding grants under subsection (b), the Secretary shall give preference to entities submitting applications that—

''(i) demonstrate an ability to coordinate activities funded using amounts received under the grant with programs providing individualized home and community-based case management and services to individuals in need of long term care with hospital discharge planning programs; and

''(ii) demonstrate that adequate home and community-based long term care management and services are available, or will be made available to individuals being served under the program funded with amounts received under subsection (b).

''(B) DISTRIBUTION.—In awarding grants under subsection (b), the Secretary shall ensure that such grants—

''(i) are equitably distributed on a geographic basis;

''(ii) include projects operating in urban areas and projects operating in rural areas; and

''(iii) are awarded for the expansion of existing hospital linkage programs as well as the establishment of new programs.

''(C) EXPEDITED CONSIDERATION.—The Secretary shall provide for the expedited consideration of any waiver application that is necessary under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) to enable an applicant for a grant under subsection (b) to satisfy the assurance required under paragraph (1)(D).

''(4) USE OF GRANTS.—An entity that receives amounts under a grant under subsection (b) may use such amounts for planning, development and evaluation services and to provide reimbursements for the costs of one or more case mangers to be located in or assigned to selected hospitals who would—

''(A) identify patients in need of individualized care in home and community-based long-term care;

''(B) assess and develop care plans in cooperation with the hospital discharge planning staff; and

''(C) arrange for the provision of community care either immediately upon discharge from the hospital or after any short term nursing-home stay that is needed for recuperation or rehabilitation;

''(5) DIRECT SERVICES SUBJECT TO REIMBURSEMENTS.—None of the amounts provided under a grant under this section may be used to provide direct services, other than case management, for which reimbursements are otherwise available under title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq. and 1396 et seq.).

''(6) LIMITATIONS.—

''(A) TERM.—Grants awarded under this section shall be for terms of less than 3 years.

''(B) AMOUNT.—Grants awarded to an entity under this section shall not exceed $300,000 per year. The Secretary may waive the limitation under this subparagraph where an applicant demonstrates that the number of hospitals or individuals to be served under the grant justifies such increased amounts.

''(C) SUPPLANTING OF FUNDS.—Amounts awarded under a grant under this section may not be used to supplant existing State funds that are provided to support hospital link programs.

''(d) EVALUATION AND REPORTS.—

''(1) BY GRANTEES.—An entity that receives a grant under this section shall evaluate the effectiveness of the services provided under the grant in facilitating the placement of individuals being discharged from hospitals or acute care facilities into home and community-based long term care settings rather than nursing homes. Such entity shall prepare and submit to the Secretary a report containing such information and data concerning the activities funded under the grant as the Secretary determines appropriate.

''(2) BY SECRETARY.—Not later than the end of the third fiscal year for which funds are

appropriated under subsection (e), the Secretary shall prepare and submit to the appropriate committees of Congress, a report concerning the results of the evaluations and reports conducted and prepared under paragraph (1).

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section, $5,000,000 for each of the fiscal years 1998 through 2000.''.

## TITLE II—PROSPECTIVE PAYMENT SYSTEM FOR NURSING FACILITIES

### SEC. 201. DEFINITIONS.

In this title:

(1) ACUITY PAYMENT.—The term ''acuity payment'' means a fixed amount that will be added to the facility-specific prices for certain resident classes designated by the Secretary as requiring heavy care.

(2) AGGREGATED RESIDENT INVOICE.—The term ''aggregated resident invoice'' means a compilation of the per resident invoices of a nursing facility which contain the number of resident days for each resident and the resident class of each resident at the nursing facility during a particular month.

(3) ALLOWABLE COSTS.—The term ''allowable costs'' means costs which HCFA has determined to be necessary for a nursing facility to incur according to the Provider Reimbursement Manual (in this title referred to as ''HCFA-Pub. 15'').

(4) BASE YEAR.—The term ''base year'' means the most recent cost reporting period (consisting of a period which is 12 months in length, except for facilities with new owners, in which case the period is not less than 4 months and not more than 13 months) for which cost data of nursing facilities is available to be used for the determination of a prospective rate.

(5) CASE MIX WEIGHT.—The term ''case mix weight'' means the total case mix score of a facility calculated by multiplying the resident days in each resident class by the relative weight assigned to each resident class, and summing the resulting products across all resident classes.

(6) COMPLEX MEDICAL EQUIPMENT.—The term ''complex medical equipment'' means items such as ventilators, intermittent positive pressure breathing machines, nebulizers, suction pumps, continuous positive airway pressure devices, and bead beds such as air fluidized beds.

(7) DISTINCT PART NURSING FACILITY.—The term ''distinct part nursing facility'' means an institution which has a distinct part that is certified under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and meets the requirements of section 201.1 of the Skilled Nursing Facility Manual published by HCFA (in this title referred to as ''HCFA-Pub. 12'').

(8) EFFICIENCY INCENTIVE.—The term ''efficiency incentive'' means a payment made to a nursing facility in recognition of incurring costs below a prespecified level.

(9) FIXED EQUIPMENT.—The term ''fixed equipment'' means equipment which meets the definition of building equipment in section 104.3 of HCFA-Pub. 15, including attachments to buildings such as wiring, electrical fixtures, plumbing, elevators, heating systems, and air conditioning systems.

(10) GEOGRAPHIC CEILING.—The term ''geographic ceiling'' means a limitation on payments in any given cost center for nursing facilities in 1 of no fewer than 8 geographic regions, further subdivided into rural and urban areas, as designated by the Secretary.

(11) HCFA.—The term ''HCFA'' means the Health Care Financing Administration.

(12) HEAVY CARE.—The term ''heavy care'' means an exceptionally high level of care which the Secretary has determined is required for residents in certain resident classes.

(13) INDEXED FORWARD.—The term ''indexed forward'' means an adjustment made to a per diem rate to account for cost increases due to inflation or other factors during an intervening period following the base year and projecting such cost increases for a future period in which the rate applies. Indexing forward under this title shall be determined from the midpoint of the base year to the midpoint of the rate year.

(14) MDS.—The term ''MDS'' means a resident assessment instrument, currently recognized by HCFA, any extensions to MDS, and any extensions to accommodate subacute care which contain an appropriate core of assessment items with definitions and coding categories needed to comprehensively assess a nursing facility resident.

(15) MAJOR MOVABLE EQUIPMENT.—The term ''major movable equipment'' means equipment that meets the definition of major movable equipment in section 104.4 of HCFA-Pub. 15.

(16) NURSING FACILITY.—The term ''nursing facility'' means an institution that meets the requirements of a ''skilled nursing facility'' under section 1819(a) of the Social Security Act (42 U.S.C. 1395i–3(a)) and of a ''nursing facility'' under section 1919(a) of that Act (42 U.S.C. 1396r(a)).

(17) PER BED LIMIT.—The term ''per bed limit'' means a per-bed ceiling on the fair asset value of a nursing facility for 1 of the geographic regions designated by the Secretary.

(18) PER DIEM RATE.—The term ''per diem rate'' refers to a rate of payment for the costs of covered services for a resident day.

(19) RELATIVE WEIGHT.—The term ''relative weight'' means the index of the value of the resources required for a given resident class relative to the value of resources of either a base resident class or the average of all the resident classes.

(20) R.S. MEANS INDEX.—The term ''R.S. Means Index'' means the index of the R. S. Means Company, Inc., specific to commercial or industrial institutionalized nursing facilities, that is based upon a survey of prices of common building materials and wage rates for nursing facility construction.

(21) REBASE.—The term ''rebase'' means the process of updating nursing facility cost data for a subsequent rate year using a more recent base year.

(22) RENTAL RATE.—The term ''rental rate'' means a percentage that will be multiplied by the fair asset value of property to determine the total annual rental payment in lieu of property costs.

(23) RESIDENT CLASSIFICATION SYSTEM.—The term ''resident classification system'' means a system that categorizes residents into different resident classes according to similarity of their assessed condition and required services of the residents.

(24) RESIDENT DAY.—The term ''resident day'' means the period of services for 1 resident, regardless of payment source, for 1 continuous 24 hours of services. The day of admission of the resident constitutes a resident day but the day of discharge does not constitute a resident day. Bed hold days are not to be considered resident days, and bed hold day revenues are not to be offset.

(25) RESOURCE UTILIZATION GROUPS, VERSION III.—The term ''Resource Utilization Groups, Version III'' (in this title referred to as ''RUG–III'') refers to a category-based resident classification system used to classify nursing facility residents into mutually exclusive RUG–III groups. Residents in each RUG–III group utilize similar quantities and patterns of resources.

(26) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(27) SUBACUTE CARE.—The term ''subacute care'' means comprehensive inpatient care designed for an individual that has an acute illness, injury, or exacerbation of a disease process. The care is goal oriented treatment rendered immediately after, or instead of, acute hospitalization to treat 1 or more specific active complex medical conditions or to administer 1 or more technically complex treatments, in the context of a person's underlying long-term conditions and overall situation. In most cases, the individual's condition is such that the care does not depend heavily on high technology monitoring or complex diagnostic procedures. Subacute care requires the coordinated services of an interdisciplinary team including physicians, nurses, and other relevant professional disciplines, who are trained and knowledgeable to assess and manage these specific conditions and perform the necessary procedures. Subacute care is given as part of a specifically defined program, regardless of the site. Subacute care is generally more intensive than traditional nursing facility care and less than acute care. It requires frequent (daily to weekly) recurrent patient assessment and review of the clinical course and treatment plan for a limited (several days to several months) time period, until the condition is stabilized or a predetermined treatment course is completed.

### SEC. 202. PAYMENT OBJECTIVES.

Payment rates under the Prospective Payment System for nursing facilities shall reflect the following objectives:

(1) To maintain an equitable and fair balance between cost containment and quality of care in nursing facilities.

(2) To encourage nursing facilities to admit residents without regard to such residents' source of payment.

(3) To provide an incentive to nursing facilities to admit and provide care to persons in need of comparatively greater care, including those in need of subacute care.

(4) To maintain administrative simplicity, for both nursing facilities and the Secretary.

(5) To encourage investment in buildings and improvements to nursing facilities (capital formation) as necessary to maintain quality and access.

### SEC. 203. POWERS AND DUTIES OF THE SECRETARY.

(a) RULES AND REGULATIONS.—The Secretary shall establish by regulation all rules and regulations necessary for implementation of this title. The rates determined under this title shall be determined in a budget neutral manner and shall reflect the objectives described in section 202 of this title.

(b) FILING REQUIREMENTS.—The Secretary may require that each nursing facility file such data, statistics, schedules, or information as required to enable the Secretary to implement this title.

### SEC. 204. RELATIONSHIP TO TITLE XVIII OF THE SOCIAL SECURITY ACT.

(a) IN GENERAL.—No provision in this title shall replace, or otherwise affect, the skilled nursing facility benefit under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(b) PROVISIONS OF HCFA–15.—The provisions of HCFA-Pub. 15 shall apply to the determination of allowable costs under this title except to the extent that such provisions conflict with any other provision in this title.

### SEC. 205. ESTABLISHMENT OF RESIDENT CLASSIFICATION SYSTEM.

(a) IN GENERAL.—

(1) ESTABLISHMENT.—The Secretary shall establish a resident classification system which shall group residents into classes according to similarity of their assessed condition and required services.

(2) MODEL FOR SYSTEM.—The resident classification system shall be modelled after the RUG-III system and all updated versions of that system, and shall be expanded into subacute categories and costs of care.

(3) REFLECTIVE OF CERTAIN TIME AND COSTS.—The resident classification system shall reflect of the necessary professional and paraprofessional nursing staff time and costs required to address the care needs of nursing facility residents.

(b) RELATIVE WEIGHT FOR EACH RESIDENT CLASS.—

(1) IN GENERAL.—The Secretary shall assign a relative weight for each resident class based on the relative value of the resources required for each resident class. If the Secretary determines it to be appropriate, the assignment of relative weights for resident classes shall be developed for each geographic region as determined in accordance with subsection (c).

(2) UTILIZATION OF MDSS.—In assigning the relative weights of the resident classes in a geographic region, the Secretary shall utilize information derived from the most recent MDSs of all the nursing facilities in a geographic region.

(3) RECALIBRATED EVERY 3 YEARS.—Every 3 years the Secretary shall recalibrate the relative weights of the resident classes in each geographic region based on any changes in the cost or amount of resources required for the care of a resident in the resident class.

(c) GEOGRAPHIC REGIONS; PEER GROUPINGS.—

(1) GEOGRAPHIC REGIONS.—The Secretary shall designate at least 3 geographic regions for the total United States. Within each geographic region, the Secretary shall take appropriate account of variations in cost between urban and rural areas.

(2) PEER GROUPING.—The Secretary shall ensure that there are no peer grouping of nursing facilities based on facility size or whether the nursing facilities are hospital-based or not.

**SEC. 206. COST CENTERS FOR NURSING FACILITY PAYMENT.**

(a) PAYMENT RATES.—Consistent with the objectives described in section 202 of this title, the Secretary shall determine payment rates for nursing facilities using the following cost/service groupings:

(1) The nursing service cost center shall include salaries and wages for the Director of Nursing, quality assurance nurses, registered nurses, licensed practical nurses, nurse aides (including wages related to initial and ongoing nurse aid training and other ongoing or periodic training costs incurred by nursing personnel), contract nursing, fringe benefits and payroll taxes associated therewith, medical records, and nursing supplies.

(2) The administrative and general cost center shall include all expenses (including salaries, benefits, and other costs) related to administration, plant operation, maintenance and repair, housekeeping, dietary (excluding raw food), central services and supply (excluding medical or nursing supplies), laundry, and social services, excluding overhead allocations to ancillary services.

(3) Ancillary services that are paid on a fee-for-service basis shall include physical therapy, occupational therapy, speech therapy, respiratory therapy, and hyperalimentation. The fee-for-service ancillary service payments under part A of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) shall not affect the reimbursement of ancillary services under part B of title XVIII of that Act (42 U.S.C. 1395j et seq.).

(4) The cost center for selected ancillary services and other costs shall include drugs, raw food, IV therapy, x-ray services, laboratory services, property tax, property insurance, and all other costs not included in the other 4 cost-of-service groupings.

(5) The property cost center shall include depreciation on the buildings and fixed equipment, major movable equipment, motor vehicles, land improvements, amortization of leasehold improvements, lease acquisition costs, capital leases, interest on capital indebtedness, mortgage interest, lease costs, and equipment rental expense.

(b) PER DIEM RATE.—The Secretary shall pay nursing facilities a prospective, facility-specific, per diem rate based on the sum of the per diem rates established for the nursing service, administrative and general, and property cost centers.

(c) FACILITY-SPECIFIC PROSPECTIVE RATE.—The Secretary shall pay nursing facilities a facility-specific prospective rate for each unit of the fee-for-service ancillary services as determined in accordance with section 210 of this title.

(d) REIMBURSEMENT FOR SELECTIVE ANCILLARY SERVICES.—Nursing facilities shall be reimbursed by the Secretary for selected ancillary services and other costs on a retrospective basis in accordance with section 211 of this title.

**SEC. 207. RESIDENT ASSESSMENT.**

(a) IN GENERAL.—In order to be eligible for payments under this title, a nursing facility shall perform a resident assessment in accordance with section 1819(b)(3) of the Social Security Act (42 U.S.C. 1395i–3(b)(3)) within 14 days of admission of the resident and at such other times as required by that section.

(b) RESIDENT CLASS.—The resident assessment shall be used to determine the resident class of each resident in the nursing facility for purposes of determining the per diem rate for the nursing service cost center in accordance with section 208 of this title.

**SEC. 208. THE PER DIEM RATE FOR NURSING SERVICE COSTS.**

(a) IN GENERAL.—

(1) NURSING SERVICE COST CENTER RATE.—The Secretary shall calculate the nursing service cost center rate using a prospective, facility-specific per diem rate based on the nursing facility's case-mix weight and nursing service costs during the base year.

(2) CASE-MIX WEIGHT.—For purposes of paragraph (1), the case-mix weight of a nursing facility shall be obtained by multiplying the number of resident days in each resident class at a nursing facility during the base year by the relative weight assigned to each resident class in the appropriate geographic region. Once this calculation is performed for each resident class in the nursing facility, the sum of these products shall constitute the case-mix weight for the nursing facility.

(3) FACILITY NURSING UNIT VALUE.—A facility nursing unit value for the nursing facility for the base year shall be obtained by dividing the nursing service costs for the base year, which shall be indexed forward from the midpoint of the base period to the midpoint of the rate period using the DRI McGraw-Hill HCFA Nursing Home Without Capital Market Basket, by the case-mix weight of the nursing facility for the base year.

(4) FACILITY-SPECIFIC NURSING SERVICES PRICE.—A facility-specific nursing services price for each resident class shall be obtained my multiplying the lower of the indexed facility unit value of the nursing facility during the base year or the geographic ceiling, as determined in accordance with subsection (b), by the relative weight of the resident class.

(5) PATIENT CLASSIFICATIONS.—For patient classifications associated with the use of complex medical equipment and other specialized, noncustomary equipment (particularly subacute classifications), the Secretary shall provide for a daily allowance for such equipment based upon the amortized value of such equipment over the life of the equipment.

(6) SELECTED RESIDENT CLASSIFICATIONS.—For selected resident classifications (particularly subacute classifications) requiring additional or specialized medical administrative staff, the Secretary shall provide for a daily allowance to cover these costs.

(7) DESIGNATION OF CERTAIN RESIDENT CLASSES.—The Secretary shall designate certain resident classes, such as subacute resident classes, as requiring heavy care. An acuity payment of 3 percent of the facility-specific nursing services price shall be added to the facility-specific price for each resident that the Secretary has designated as requiring heavy care.

(8) PER DIEM RATE.—The per diem rate for the nursing service cost center for each resident in a resident class shall constitute the facility-specific price, plus the acuity payment where appropriate.

(9) PER DIEM RATE REBASED ANNUALLY.—The Secretary shall annually rebate the per diem rate for the nursing service cost center, including the facility-specific price and the acuity payment.

(10) PAYMENT.—To determine the payment amount to a nursing facility for the nursing service cost center, the Secretary shall multiply the per diem rate (including the acuity payment) for a resident class by the number of resident days for each resident class based on aggregated resident invoices which each nursing facility shall submit on a monthly basis.

(b) GEOGRAPHIC CEILING.—

(1) FACILITY UNIT VALUE.—The facility unit value identified in subsection (a)(3) shall be subjected to geographic ceilings established for the geographic regions designated by the Secretary in section 205 of this title.

(2) DETERMINATION.—

(A) IN GENERAL.—The Secretary shall determine the geographic ceiling by creating an array of indexed facility unit values in a geographic region from lowest to highest. Based on this array, the Secretary shall identify a fixed proportion between the indexed facility unit value of the nursing facility which contained the medianth resident day in the array (except as provided in subsection (b)(4) of this section) and the indexed facility unit value of the nursing facility which contained the 95th percentile resident day in that array during the first year of operation of the Prospective Payment System for nursing facilities. The fixed proportion shall remain the same in subsequent years.

(B) SUBSEQUENT YEARS.—To obtain the geographic ceiling on the indexed facility unit value for nursing facilities in a geographic region in each subsequent year, the fixed proportion identified pursuant to subparagraph (A) shall be multiplied by the indexed facility unit value of the nursing facility which contained the medianth resident day in the array of facility unit values for the geographic region during the base year.

(3) EXCLUSIONS FROM DETERMINATION.—For purposes of determining the geographic ceiling for a nursing service cost center, the Secretary shall exclude low volume and new nursing facilities (as defined in section 214 of this title).

(c) EXCEPTIONS TO GEOGRAPHIC CEILING.—The Secretary shall establish by regulation procedures for allowing exceptions to the geographic ceiling imposed on a nursing service cost center. The procedure shall permit exceptions based on the following factors:

(1) Local supply or labor shortages which substantially increase costs to specific nursing facilities.

(2) Higher per resident day usage of contract nursing personnel, if utilization of contract nursing personnel is warranted by local circumstances and the provider has taken all reasonable measures to minimize contract personnel expense.

(3) Extraordinarily low proportion of distinct part nursing facilities in a geographic region resulting in a geographic ceiling that unfairly restricts the reimbursement of distinct part facilities.

(4) Regulatory changes that increase costs to only a subset of the nursing facility industry.

(5) The offering of a new institutional health service or treatment program by a nursing facility (in order to account for initial startup costs).

(6) Disproportionate usage of part-time employees, where adequate numbers of full-time employees cannot reasonably be obtained.

(7) Other cost producing factors specified by the Secretary in regulations that are specific to a subset of facilities in a geographic region (except case-mix variation).

**SEC. 209. THE PER DIEM RATE FOR ADMINISTRATIVE AND GENERAL COSTS.**

(a) IN GENERAL.—

(1) PAYMENT.—The Secretary shall make payments for the administrative and general cost center by using a facility-specific, prospective, per diem rate.

(2) STANDARDS FOR PER DIEM RATE.—The Secretary shall assign a per diem rate to a nursing facility by applying 2 standards that is calculated as follows:

(A) STANDARD A.—The Secretary shall determine a Standard A for each geographic region by creating an array of indexed nursing facility administrative and general per diem costs from lowest to highest. The Secretary shall then identify a fixed proportion by dividing the indexed administrative and general per diem costs of the nursing facility that contains the medianth resident day of the array (except as provided in subsection (a)(4)) into the indexed administrative and general per diem costs of the nursing facility that contains the 75th percentile resident day in that array. Standard A for each base year shall constitute the product of this fixed proportion and the administrative and general indexed per diem costs of the nursing facility that contains the medianth resident day in the array of such costs during the base year.

(B) STANDARD B.—The Secretary shall determine a Standard B for each geographic region by using the same calculation as in subparagraph (A) except that the fixed proportion shall use the indexed administrative and general costs of the nursing facility containing the 85th percentile, rather than the 75th percentile, resident day in the array of such costs.

(3) GEOGRAPHIC REGIONS.—The Secretary shall use the geographic regions identified in section 205(c) of this title for purposes of determining Standards A and B.

(4) EXCLUSION.—The Secretary shall exclude low volume and new nursing facilities (as defined in section 214 of this title) for purposes of determining Standard A and Standard B.

(5) PER DIEM RATE.—To determine a nursing facility's per diem rate for the administrative and general cost center, Standards A and B shall be applied to a nursing facility's administrative and general per diem costs, indexed forward using the DRI McGraw-Hill HCFA Nursing Home Without Capital Market Basket, as follows:

(A) Each nursing facility having indexed costs which are below the median shall be assigned a rate equal to their individual indexed costs plus an ''efficiency incentive'' equal to ½ of the difference between the median and Standard A.

(B) Each nursing facility having indexed costs which are below Standard A but are equal to or exceed the median shall be assigned a per diem rate equal to their individual indexed costs plus an ''efficiency incentive'' equal to ½ of the difference between the nursing facility's indexed costs and Standard A.

(C) Each nursing facility having indexed costs which are between Standard A and Standard B shall be assigned a rate equal to Standard A plus ½ of the difference between the nursing facility's indexed costs and Standard A.

(D) Each nursing facility having indexed costs which exceed Standard B shall be assigned a rate as if their costs equaled Standard B. These nursing facilities shall be assigned a per diem rate equal to Standard A plus ½ of the difference between Standard A and Standard B.

(E) For purposes of subparagraphs (A) through (D), the median represents the indexed administrative and general per diem costs of a nursing facility that contains the medianth resident day in the array of such costs during the base year in the geographic region.

(b) REBASING.—Not less than annually, the Secretary shall rebase the payment rates for administrative and general costs.

**SEC. 210. PAYMENT FOR FEE-FOR-SERVICE ANCILLARY SERVICES.**

(a) IN GENERAL.—The Secretary shall make payments for the ancillary services described in section 206(a)(3) on a prospective fee-for-service basis.

(b) PAYMENT METHODOLOGY.—The Secretary shall identify the fee for each of the fee-for-service ancillary services for a particular nursing facility by dividing the nursing facility's reasonable costs, including overhead allocated through the cost finding process, of providing each particular service, indexed forward using the DRI McGraw-Hill HCFA Nursing Home Without Capital Market Basket, by the units of the particular service provided by the nursing facility during the cost year.

(c) COMPUTATION PERIOD.—The fee for each of the fee-for-service ancillary services shall be calculated by the Secretary under this title at least once a year for each facility and ancillary service.

**SEC. 211. REIMBURSEMENT OF SELECTED ANCILLARY SERVICES AND OTHER COSTS.**

(a) IN GENERAL.—Reimbursement of selected ancillary services and other costs identified in section 206(a)(4) of this title shall be reimbursed by the Secretary on a retrospective basis as pass-through costs, including overhead allocated through the cost-finding process.

(b) CHARGE-BASED INTERIM RATES.—The Secretary shall set charge-based interim rates for selected ancillary services and other costs for each nursing facility providing such services. Any overpayments or underpayments resulting from the difference between the interim and final settlement rates shall be either refunded by the nursing facility or paid to the nursing facility following submission of a timely filed medicare cost report.

**SEC. 212. PER DIEM PAYMENT FOR PROPERTY COSTS.**

(a) IN GENERAL.—The Secretary shall make a per diem payment for property costs based on a gross rental system. The amount of the payment shall be determined as follows:

(1) BUILDING AND FIXED EQUIPMENT VALUE.—In the case of a new facility in any geographic region, the cost for building and fixed equipment used in determining the gross rental shall be equivalent to the median cost of home construction in the region (as measured by RS Means). Such cost shall then be multiplied by the factor 1.2 to account for land and the value of movable equipment. The resulting value shall be indexed each year using the RS Means Construction Cost Index.

(2) AGE.—

(A) IN GENERAL.—The gross rental system establishes a facility's value based on its age. The older the facility, the less its value. Additions, replacements, and renovations shall be recognized by lowering the age of the facility and, thus, increasing the facility's value. Existing facilities, 1 year or older, shall be valued at the new bed value less 2 percent per year according to the ''age'' of the facility. Facilities shall not be depreciated to an amount less than 50 percent of the new construction bed value.

(B) ADDITION OF BEDS.—The addition of beds shall require a computation by the Secretary of the weighted average age of the facility based on the construction dates of the original facility and the additions.

(C) REPLACEMENT OF BEDS.—The replacement of existing beds shall result in an adjustment to the age of the facility. A weighted average age shall be calculated by the Secretary according to the year of initial construction and the year of bed replacement. If a facility has a series of additions or replacements, the Secretary shall assume that the oldest beds are the ones being replaced when computing the average facility age.

(D) RENOVATIONS OR MAJOR IMPROVEMENTS.—Renovations or major improvements shall be calculated by the Secretary as a bed replacement, except that the value of the bed prior to renovation shall be taken into consideration. To qualify as a bed replacement, the bed being renovated must be at least 10 years old and the renovation or improvements cost must be equal to or greater than the difference between the existing bed value and the value of a new bed. To determine the new adjusted facility age, the number of renovated beds assigned a ''new'' age is determined by dividing the total cost of renovation by the difference between the existing bed value and the value of the new bed.

(E) STARTUP OF GROSS RENTAL SYSTEM.—To start up the fair rental system, each facility's bed values shall be determined by the Secretary based on the age of the facility. The determination shall include setting a value for the original beds with adjustments for any additions, bed replacements, and major renovations. For determination of bed values for use in determining the initial rate, the procedures described above for determining the values of original beds, additions, and replacements shall be used.

(3) TOTAL CURRENT VALUE.—The Secretary shall multiply the per bed value by the number of beds in the facility to estimate the facility's total current value.

(4) RENTAL FACTOR.—The Secretary shall apply a rental factor to the facility's total current value to estimate its annual gross rental value. The Secretary shall determine the rental factor by using the Treasury Bond Composite Yield (greater than 10 years) as published in the Federal Reserve Bulletin plus a risk premium. A risk premium in the amount of 3 percentage points shall be added to the Treasury Yield. The rental factor is multiplied by the facility's total value, as determined in paragraph (3), to determine the annual gross rental value.

(5) PER DIEM PROPERTY PAYMENT.—The annual gross rental value shall be divided by the Secretary by 90 percent of the facility's annual licensed bed days during the cost report period to arrive at the per diem property payment.

(6) PER RESIDENT DAY RENTAL RATE.—The per resident day rental rate for a newly constructed facility during its first year of operation shall be based on the total annual rental divided by the greater of 50 percent of available resident days or actual annualized resident days up to 90 percent of annual licensed bed days during the first year of operation.

(b) Facilities in operation prior to the effective date of this Act shall receive the per resident day rental or actual costs, as determined in accordance with HCFA-Pub. 15, whichever is greater, except that a nursing facility shall be reimbursed the per resident day rental on and after the earliest of the following dates:

(1) the date upon which the nursing facility changes ownership;

(2) the date the nursing facility accepts the per resident day rental; or

(3) the date of the renegotiation of the lease for the land or buildings, not including the exercise of optional extensions specifically included in the original lease agreement or valid extensions thereof.

**SEC. 213. MID-YEAR RATE ADJUSTMENTS.**

(a) MID-YEAR ADJUSTMENTS.—The Secretary shall establish by regulation a procedure for granting mid-year rate adjustments for the nursing service, administrative and general, and fee-for-service ancillary services cost centers.

(b) INDUSTRY-WIDE BASIS.—The mid-year rate adjustment procedure shall require the Secretary to grant adjustments on an industry-wide basis, without the need for nursing facilities to apply for such adjustments, based on the following circumstances:

(1) Statutory or regulatory changes affecting nursing facilities.

(2) Changes to the Federal minimum wage.

(3) General labor shortages with high regional wage impacts.

(c) APPLICATION FOR ADJUSTMENT.—The mid-year rate adjustment procedure shall permit specific facilities or groups of facilities to apply to the Secretary for an adjustment based on the following factors:

(1) Local labor shortages.

(2) Regulatory changes that apply to only a subset of the nursing facility industry.

(3) Economic conditions created by natural disasters or other events outside of the control of the provider.

(4) Other cost producing factors, except case-mix variation, to be specified by the Secretary in regulations.

(d) REQUIREMENTS FOR APPLICATION FOR ADJUSTMENT.—

(1) IN GENERAL.—A nursing facility which applies for a mid-year rate adjustment pursuant to this section shall be required to show that the adjustment will result in a greater than 2 percent deviation in the per diem rate for any individual cost service center or a deviation of greater than $5,000 in the total projected and indexed costs for the rate year, whichever is less.

(2) COST EXPERIENCE DATA.—A nursing facility application for a mid-year rate adjustment must be accompanied by recent cost experience data and budget projections.

**SEC. 214. EXCEPTION TO PAYMENT METHODS FOR NEW AND LOW VOLUME NURSING FACILITIES.**

(a) DEFINITION OF LOW VOLUME NURSING FACILITY.—In this title, the term ''low volume nursing facility'' means a nursing facility having fewer than 2,500 medicare part A resident days per year.

(b) DEFINITION OF NEW NURSING FACILITY.—In this title, the term ''new nursing facility'' means a newly constructed, licensed, and certified nursing facility or a nursing facility that is in its first 3 years of operation as a provider of services under part A of the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). A nursing facility that has operated for more than 3 years but has a change of ownership shall not constitute a new facility.

(c) OPTION FOR LOW VOLUME NURSING FACILITIES.—A Low volume nursing facility shall have the option of submitting a cost report to the Secretary to receive retrospective payment for all of the cost centers, other than the property cost center, or accepting a per diem rate which shall be based on the sum of—

(1) the median indexed resident day facility unit value for the appropriate geographic region for the nursing service cost center during the base year as identified in section 208(b)(2) of this title;

(2) the median indexed resident day administrative and general per diem costs of all nursing facilities in the appropriate geographic region as identified in section 209(a)(5)(E) of this title;

(3) the median indexed resident day costs per unit of service for fee-for-service ancillary services obtained using the cost information from the nursing facilities in the appropriate geographic region during the base year, excluding low volume and new nursing facilities, and based on an array of such costs from lowest to highest; and

(4) the median indexed resident day per diem costs for selected ancillary services and other costs obtained using information from the nursing facilities in the appropriate geographic region during the base year, excluding low volume and new nursing facilities, and based on an array of such costs from lowest to highest.

(d) OPTION FOR NEW NURSING FACILITIES.—New nursing facilities shall have the option of being paid by the Secretary on a retrospective cost pass-through basis for all costs centers, or in accordance with subsection (c).

**SEC. 215. APPEAL PROCEDURES.**

(a) IN GENERAL.—

(1) APPEAL.—Any person or legal entity aggrieved by a decision of the Secretary under this title, and which results in an amount in controversy of $10,000 or more, shall have the right to appeal such decision directly to the Provider Reimbursement Review Board (in this section referred to as ''the Board'') authorized under section 1878 of the Social Security Act (42 U.S.C. 1395oo).

(2) AMOUNT IN CONTROVERSY.—The $10,000 amount in controversy referred to in paragraph (1) shall be computed in accordance with 42 C.F.R. 405.1839.

(b) HEARINGS.—Any appeals to and any hearings before the Board under this title shall follow the procedures under section 1878 of the Social Security Act (42 U.S.C. 1395oo) and the regulations contained in (42 C.F.R. 405.1841–1889), except to the extent that they conflict with, or are inapplicable on account of, any other provision of this title.

**SEC. 216. TRANSITION PERIOD.**

The Prospective Payment System described in this title shall be phased in over a 3 year period using the following blended rate:

(1) For the first year that the provisions of this title are in effect, 25 percent of the payment rates will be based on the Prospective Payment System under this title and 75 percent will remain based upon reasonable cost reimbursement.

(2) For the second year that the provisions of this title are in effect, 50 percent of the payment rates will be based on the Prospective Payment System under this title and 50 percent based upon reasonable cost reimbursement.

(3) For the third year that the provisions of this title are in effect, 75 percent of the payment rates will be based on the Prospective Payment System under this title and 25 percent based upon reasonable cost reimbursement.

(4) For the fourth year that the provisions of this title are in effect and for all subsequent years, the payment rates will be based solely on the Prospective Payment System under this title.

**SEC. 217. EFFECTIVE DATE; INCONSISTENT PROVISIONS.**

(a) EFFECTIVE DATE.—The provisions of this title shall take effect on October 1, 1998.

(b) INCONSISTENT PROVISIONS.—The provisions contained in this title shall supersede any other provisions of title XVIII or XIX of the Social Security Act (42 U.S.C. 1395 et seq. 1396 et seq.) which are inconsistent with such provisions.

## TITLE III—ADDITIONAL MEDICARE PROVISIONS

**SEC. 301. ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS FOR CERTAIN OUTPATIENT HOSPITAL SERVICES.**

(a) AMBULATORY SURGICAL CENTER PROCEDURES.—Section 1833(i)(3)(B)(i)(II) of the Social Security Act (42 U.S.C. 13951(i)(3)(B)(i)(II)) is amended—

(1) by striking ''of 80 percent''; and

(2) by striking the period at the end and inserting the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).''.

(b) RADIOLOGY SERVICES AND DIAGNOSTIC PROCEDURES.—Section 1833(n)(1)(B)(i)(II) of the Social Security Act (42 U.S.C. 13951(n)(1)(B)(i)(II)) is amended—

(1) by striking ''of 80 percent''; and

(2) by striking the period at the end and inserting the following: '', less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished during portions of cost reporting periods occurring on or after July 1, 1997.

**SEC. 302. PERMANENT EXTENSION OF CERTAIN SECONDARY PAYER PROVISIONS.**

(a) WORKING DISABLED.—Section 1862(b)(1)(B) of the Social Security Act (42 U.S.C. 1395y(b)(1)(B)) is amended by striking clause (iii).

(b) INDIVIDUALS WITH END STAGE RENAL DISEASE.—Section 1862(b)(1)(C) of the Social Security Act (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the first sentence, by striking ''12-month'' each place it appears and inserting ''18-month'', and

(2) by striking the second sentence.

(c) IRS-SSA-HCFA DATA MATCH.—

(1) SOCIAL SECURITY ACT.—Section 1862(b)(5)(C) of the Social Security Act (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) INTERNAL REVENUE CODE.—Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

**SEC. 303. FINANCING AND QUALITY MODERNIZATION AND REFORM.**

(a) PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS.—Section 1876(a) of the Social Security Act (42 U.S.C. 1395mm(a)) is amended to read as follows:

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

''(i) a per capita rate of payment for individuals who are enrolled under this section with an eligible organization which has entered into a risk-sharing contract and who are entitled to benefits under part A and enrolled under part B, and

''(ii) a per capita rate of payment for individuals who are so enrolled with such an organization and who are enrolled under part B only.

For purposes of this section, the term 'risk-sharing contract' means a contract entered into under subsection (g) and the term 'reasonable cost reimbursement contract' means a contract entered into under subsection (h).

''(B)(i) The annual per capita rate of payment for each medicare payment area (as defined in paragraph (5)) shall be equal to 95 percent of the adjusted average per capita cost (as defined in paragraph (4)), adjusted by the Secretary for—

''(I) individuals who are enrolled under this section with an eligible organization which has entered into a risk-sharing contract and who are enrolled under part B only; and

''(II) such risk factors as age, disability status, gender, institutional status, and such other factors as the Secretary determines to be appropriate so as to ensure actuarial equivalence.

The Secretary may add to, modify, or substitute for such factors, if such changes will improve the determination of actuarial equivalence.

''(ii) The Secretary shall reduce the annual per capita rate of payment by a uniform percentage (determined by the Secretary for a year, subject to adjustment under subparagraph (G)(v)) so that the total reduction is estimated to equal the amount to be paid under subparagraph (G).

''(C) In the case of an eligible organization with a risk-sharing contract, the Secretary shall make monthly payments in advance and in accordance with the rate determined under subparagraph (B) and except as provided in subsection (g)(2), to the organization for each individual enrolled with the organization under this section.

''(D) The Secretary shall establish a separate rate of payment to an eligible organization with respect to any individual determined to have end-stage renal disease and enrolled with the organization. Such rate of payment shall be actuarially equivalent to rates paid to other enrollees in the payment area (or such other area as specified by the Secretary).

''(E)(i) The amount of payment under this paragraph may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled in the plan under this section and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

''(ii)(I) Subject to subclause (II), the Secretary may make retroactive adjustments under clause (i) to take into account individuals enrolled during the period beginning on the date on that the individual enrolls with an eligible organization (that has a risk-sharing contract under this section) under a health benefit plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the plan under this section, except that for purposes of making such retroactive adjustments under this clause, such period may not exceed 90 days.

''(II) No adjustment may be made under subclause (I) with respect to any individual who does not certify that the organization provided the individual with the explanation described in subsection (c)(3)(E) at the time the individual enrolled with the organization.

''(F)(i) At least 45 days before making the announcement under subparagraph (A) for a year, the Secretary shall provide for notice to eligible organizations of proposed changes to be made in the methodology or benefit coverage assumptions from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

''(ii) In each announcement made under subparagraph (A), the Secretary shall include an explanation of the assumptions (including any benefit coverage assumptions) and changes in methodology used in the announcement in sufficient detail so that eligible organizations can compute per capita rates of payment for individuals located in each county (or equivalent medicare payment area) which is in whole or in part within the service area of such an organization.

''(2) With respect to any eligible organization that has entered into a reasonable cost reimbursement contract, payments shall be made to such plan in accordance with subsection (h)(2) rather than paragraph (1).

''(3) Subject to subsection (c) (2)(B)(ii) and (7), payments under a contract to an eligible organization under paragraph (1) or (2) shall be instead of the amounts that (in the absence of the contract) would be otherwise payable, pursuant to sections 1814(b) and 1833(a), for services furnished by or through the organization to individuals enrolled with the organization under this section.

''(4)(A) For purposes of this section, the 'adjusted average per capita cost' for a medicare payment area (as defined in paragraph (5)) is equal to the greatest of the following:

''(i) The sum of—

''(I) the area-specific percentage for the year (as specified under subparagraph (B) for the year) of the area-specific adjusted average per capita cost for the year for the medicare payment area, as determined under subparagraph (C), and

''(II) the national percentage (as specified under subparagraph (B) for the year) of the input-price-adjusted national adjusted average per capita cost for the year, as determined under subparagraph (D),

multiplied by a budget neutrality adjustment factor determined under subparagraph (E).

''(ii) An amount equal to—

''(I) in the case of 1998, 85 percent of the average annual per capita cost under parts A and B of this title for 1997;

''(II) in the case of 1999, 85 percent of the average annual per capita cost under parts A and B of this title for 1998; and

''(III) in the case of a succeeding year, the amount specified in this clause for the preceding year increased by the national average per capita growth percentage specified under subparagraph (F) for that succeeding year.

''(B) For purposes of subparagraph (A)(i)—

''(i) for 1998, the 'area-specific percentage' is 75 percent and the 'national percentage' is 25 percent,

''(ii) for 1999, the 'area-specific percentage' is 60 percent and the 'national percentage' is 40 percent,

''(iii) for 2000, the 'area-specific percentage' is 40 percent and the 'national percentage' is 60 percent,

''(iv) for 2001, the 'area-specific percentage' is 25 percent and the 'national percentage' is 75 percent, and

''(v) for 2002 and each subsequent year, the 'area-specific percentage' is 10 percent and the 'national percentage' is 90 percent.

''(C) For purposes of subparagraph (A)(i), the area-specific adjusted average per capita cost for a medicare payment area—

''(i) for 1998, is the annual per capita rate of payment for 1997 for the medicare payment area (determined under this subsection, as in effect the day before the date of enactment of the Long-Term Care Reform and Deficit Reduction Act of 1997), increased by the national average per capita growth percentage for 1998 (as defined in subparagraph (F)); or

''(ii) for a subsequent year, is the area-specific adjusted average per capita cost for the previous year determined under this subparagraph for the medicare payment area, increased by the national average per capita growth percentage for such subsequent year.

''(D)(i) For purposes of subparagraph (A)(i), the input-price-adjusted national adjusted average per capita cost for a medicare payment area for a year is equal to the sum, for all the types of medicare services (as classified by the Secretary), of the product (for each such type of service) of—

''(I) the national standardized adjusted average per capita cost (determined under clause (ii)) for the year,

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

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

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

''(ii) In clause (i)(I), the 'national standardized adjusted average per capita cost' for a year is equal to—

''(I) the sum (for all medicare payment areas) of the product of (aa) the area-specific adjusted average per capita cost for that year for the area under subparagraph (C), and (bb) the average number of medicare beneficiaries residing in that area in the year; divided by

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

''(iii) In applying this subparagraph for 1998—

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

''(II) the proportions described in clause (i)(II) for such types of services shall be—

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

''(bb) for part B services, 100 percent minus the ratio described in item (aa);

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

''(IV) for part B services—

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

''(bb) of the remaining 34 percent of the amount of such payments, 70 percent shall be adjusted by the index described in subclause (III); and

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

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

''(E) For each year, the Secretary shall compute a budget neutrality adjustment factor so that the aggregate of the payments

under this section shall not exceed the aggregate payments that would have been made under this section if the area-specific percentage for the year had been 100 percent and the national percentage had been 0 percent.

''(F) In this section, the 'national average per capita growth percentage' for a year is equal to the Secretary's estimate (after consultation with the Secretary of the Treasury) of the 3-year average (ending with the year involved) of the annual rate of growth in the national average wage index (as defined in section 209(k)(1)) for each year in the period.

''(5)(A) In this section the term 'medicare payment area' means a county, or equivalent area specified by the Secretary.

''(B) In the case of individuals who are determined to have end-stage renal disease, the medicare payment area shall be each State.

''(6) The payment to an eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A and enrolled under part B shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The portion of that payment to the organization for a month to be paid by each trust fund shall be determined as follows:

''(A) In regard to expenditures by eligible organizations having risk-sharing contracts, the allocation shall be determined each year by the Secretary based on the relative weight that benefits from each fund contribute to the adjusted average per capita cost.

''(B) In regard to expenditures by eligible organizations operating under a reasonable cost reimbursement contract, the initial allocation shall be based on the plan's most recent budget, such allocation to be adjusted, as needed, after cost settlement to reflect the distribution of actual expenditures.

The remainder of that payment shall be paid by the former trust fund.

''(7) Subject to paragraphs (2)(B)(ii) and (7) of subsection (c), if an individual is enrolled under this section with an eligible organization having a risk-sharing contract, only the eligible organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.''.

(b) EFFECTIVE DATE.—The amendment made by this section takes effect on October 1, 1997.

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SUMMARY OF FEINGOLD LONG-TERM CARE REFORM BILL

LONG-TERM CARE SERVICES

*Overall*

This proposal would give States incentives to provide home and community-based long-term care services through a voluntary, capped grant for severely disabled persons, regardless of age or income. No entitlement to individuals would be created. States would be given greater flexibility and an enhanced federal match relative to the current Medicaid program.

*Eligibility*

Those meeting any of the following criteria would be eligible for the program:

Individuals requiring assistance, supervision or cuing with three or more activities of daily living.

Individuals with severe mental retardation.

Individuals with severe cognitive or mental impairment.

Children under 6, with severe disabilities.

In addition, States could set aside funds for individuals who may not meet any one of the above criteria, but who have a disability of comparable level of severity.

*Services*

States participating in the program would be required to provide assessment, plan of care, personal assistance, and case management services. Beyond that, States may also offer any other service that would help keep a disabled individual at home or in the community. (Such services might include homemaker services, home modifications, respite, assistive devices, adult day care, habilitation/rehabilitation, supported employment, home health care, etc.)

*Financing*

States choosing to participate in the program would receive capped grants, and would match the Federal funding with State funding. The State match rate would be 15% lower than their current Medicaid State match rate.

States would be allowed to charge copayments and establish deductibles for services based on income, except that no such payments could be charged to individuals with income below 150% of poverty.

Total grant funding of the Federal share of the long-term care grants would be $3.75 billion over 5 years, and $20.5 billion over 10 years.

In addition to the specific grants outlined in the new version, the measure also includes a directive to the Secretary of HHS to submit a proposal to Congress whereby States can retain 75% of the Federal Medicaid long-term care savings they achieve through this program (e.g., reduced institutional utilization).

*Offsetting Savings*

Extend Medicare Secondary Payer Program—savings of $7.2 billion over 5 years, and $18.1 billion over 10 years.

Eliminate Formula-Driven Overpayments—savings of $9.1 billion over 5 years, and $30.1 billion over 10 years.

Establish Prospective Payment System for Skilled Nursing Facilities—savings of $7.7 billion over 5 years, and $24.5 billion over 10 years.

Reform Medicare HMO Reimbursement Formula—savings of $10.1 billion over 5 years, and $93.5 billion over 10 years.

Total offsets: $34.1 billion over 5 years, and $166.2 billion over 10 years.

Net deficit reduction: $30.4 billion over 5 years, and $145.7 billion over 10 years.

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By Mr. GORTON:

S. 880. A bill to authorize the Secretary of Transportation to issue a certificate of documentation with appropriate endorsement for employment in the coastwise trade for the vessel *Dusken IV*; to the Committee on Commerce, Science, and Transportation.

JONES ACT WAIVER

Mr. GORTON. Mr. President, I ask unanimous consent that S. 880 be printed in the RECORD.

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

S. 880

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled*, That notwithstanding sections 12106 and 12108 of title 46, United States Code, and section 27 of the Merchant Marine Act, 1920 (46 U.S.C. App. 883), as applicable on the date of enactment of this Act, the Secretary of Transportation may issue a certificate of documentation with appropriate endorsement for employment in the coastwise trade for the vessel *Dusken IV* (United States official Number 952645).

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By Mr. WYDEN (for himself and Mr. SMITH of Oregon):

S. 881. A bill to provide for a land exchange involving the Warner Canyon Ski Area and other land in the State of Oregon; to the Committee on Energy and Natural Resources.

THE WARNER CANYON SKI HILL LAND EXCHANGE ACT OF 1997

Mr. WYDEN. Mr. President, I am pleased to introduce legislation authorizing an exchange of lands between the U.S. Forest Service, the U.S. Fish and Wildlife Service, and Lake County, OR. I believe that this exchange project is a win-win proposition for both the Federal Government and Lake County.

Under my bill, the U.S. Forest Service will deed about 290 acres of national forest land, comprising the Warner Canyon ski hill, to Lake County. In exchange, Lake County will deed roughly 320 acres of land within the Hart Mountain National Antelope Refuge to the Federal Government. The refuge is managed by the U.S. Fish and Wildlife Service.

The specific acreage offered by the county will be determined upon a specific appraisal of all the lands in order to provide for an equal value land trade.

While there is a commonly held notion that western ski areas resemble Oregon's Mt. Bachelor or Colorado's Vail, the fact is that there are many dozens of very small, financially marginal ski hills in the backyards of many small western towns. Warner Canyon is one of them.

The Warner Canyon ski hill has been operated by the nonprofit Fremont Highlanders Ski Club since 1938. It's one of America's last nonprofit ski hills. It has one lift—a T bar. It has 780 vertical feet of skiing. The ski area is about 5 miles from the town of Lakeview, which has a population of roughly 2,500.

The people of Lakeview believe that this legislation is necessary to keep the ski area viable. The Federal requirements for managing ski areas are more in tune with the Vails than the Warner Canyons. I'm told that under county ownership the liability expense alone should be reduced tenfold. The forest supervisor tells us that it costs the Forest Service about $10,000 per year to administer the ski area permit, yet the area generates just more than $400 per year in ski fee revenues to the U.S. Treasury.

I also want to emphasize the benefits of this bill to the Hart Mountain Antelope Refuge. As my colleagues well understand, too many of our national wildlife refuges contain private land inholdings over which the Federal Government has essentially no control. These lands can be sold or developed at any time. If Lake County were ever strapped for cash, it would certainly be their prerogative to sell these parcels to the highest bidder. With this acquisition we move closer to the permanent protection of this important Oregon wildlife refuge.

I am pleased to be joined in this effort by Senator GORDON SMITH.

At this time, Mr. President, I ask unanimous consent to be printed in the RECORD the bill and my statement, a document from the Lake County Board of Commissioners entitled ''Reasons to support Warner Canyon Ski Hill Ownership Transfer,'' and letters of support from the Fremont Highlanders Ski Club, Inc., and the Lake County Chamber of Commerce.

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

S. 881

*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 ''Warner Canyon Ski Hill Land Exchange Act of 1997''.

**SEC. 2. LAND EXCHANGE INVOLVING WARNER CANYON SKI AREA AND OTHER LAND IN OREGON.**

(a) AUTHORIZATION OF EXCHANGE.—If title acceptable to the Secretary for non-Federal land described in subsection (b) is conveyed to the United States, the Secretary of Agriculture shall convey to Lake County, Oregon, subject to valid existing rights of record, all right, title, and interest of the United States in and to a parcel of Federal land consisting of approximately 295 acres within the Warner Canyon Ski Area of the Freemont National Forest, as generally depicted on the map entitled ''Warner Canyon Ski Hill Land Exchange'', dated June 1997.

(b) NON-FEDERAL LAND.—The non-Federal land referred to in subsection (a) consists of—

(1) approximately 320 acres within the Hart Mountain National Wildlife Refugee, as generally depicted on the map referred to in subsection (a); and

(2) such other parcels of land owned by Lake County, Oregon, within the Refuge as are necessary to ensure that the values of the Federal land and non-Federal land to be exchanged under this section are approximately equal in value, as determined by appraisals.

(c) ACCEPTABLE TITLE.—Title to the non-Federal land conveyed to the United States under subsection (a) shall be such title as is acceptable to the Secretary of the Interior, in conformance with title approval standards applicable to Federal land acquisitions.

(d) VALID EXISTING RIGHTS.—The conveyance shall be subject to such valid existing rights of record as may be acceptable to the Secretary of the Interior.

(e) APPLICABILITY OF OTHER LAWS.—Except as otherwise provided in this section, the Secretary of the Interior shall process the land exchange authorized by this section in the manner provided in subpart 2200 of title 43, Code of Federal Regulations (as in effect on the date of enactment of this Act).

(f) MAP.—The map referred to in subsection (a) shall be on file and available for inspection in one or more local offices of the Department of the Interior and the Department of Agriculture.

(g) ADDITIONAL TERMS AND CONDITIONS.—The Secretary of the Interior or the Secretary of Agriculture may require such additional terms and conditions in connection with the conveyances under this section as either Secretary considers appropriate to protect the interests of the United States.

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LAKE COUNTY BOARD OF COMMISSIONERS

Robert M. Pardue, Chairman; Jane O'Keeffe, Kathleen Collins

REASONS TO SUPPORT WARNER CANYON SKI HILL OWNERSHIP TRANSFER

Lake County agrees to accept the ownership of 280+-acres of land which is the location of the Warner Canyon Ski Hill with all encumbrance.

Lake County offers 320+-acres of land in the Hart Mountain National Antelope Refuge as the mechanism to equalize the value for the Federal Government.

Lake County desires to have the proposal completed by November 1, 1997 to allow this winter season to come under our ownership.

The exchange will benefit the U.S. Forest Service, Fremont National Forest by removing management costs that exceed return generated by the Special Use Permit to the Fremont Highlanders.

U.S. Fish and Wildlife Service benefits by having ownership of 320+-acres of inholdings within the existing refuge boundary. (Lake County owns additional land within the refuge that can be sued to facilitate this proposal if necessary.)

The Fremont Highlanders Ski Club, operator of the ski area, benefits from lower cost of liability insurance, no cost operating permit and possible supplemental funding from special county recreation funds.

The Lakeview community benefits from the long term stable operation of the ski hill to provide family winter recreation opportunities, facilities for high school ski race team, part time seasonal employment opportunities during high unemployment periods.

Lake County acquires a parcel of land that is adjacent to an existing 40 acres of county land over which the ski lift crosses. This is an opportunity for the county do demonstrate its desire to support the recreation and tourism industry and possibly enhance and expand winter recreation potential. The county receives R.V. registration fee rebates from the State of Oregon for use at county owned park or recreation areas. The Warner Canyon Ski area will be eligible for supplemental funding from these funds.

ROBERT M. PARDUE, *Chairman*.

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FREMONT HIGHLANDERS SKI CLUB, INC.,
*Lakeview, OR, June 5, 1997.*

CHARLES GRAHAM,
*Forest Supervisor, U.S. Forest Service, Lake County Commissioners.*

DEAR MR. GRAHAM AND LAKE COUNTY COMMISSIONERS: The Fremont Highlanders Ski Club is in full support of the land trade involving Warner Canyon Ski Area between Lake County, the U.S. Forest Service and the U.S. Fish and Wildlife Service. Warner Canyon Ski Area is one of the few remaining non-profit ski areas in the United States. The Fremont Highlanders have operated this ski area for over 50 years. However, increasing regulations, fees, and insurance costs have severely impacted our ability to operate. We believe the land trade will reduce our costs of operating our ski area and will allow us to better serve our communities recreational interests.

Sincerely,

MICHAEL SABIN,
*President.*

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LAKE COUNTY,
CHAMBER OF COMMERCE,
*Lakeview, OR, June 6, 1997.*

BOB PARDUE,
*Chairman, Lake County Commissioners, Courthouse, Lakeview, OR.*

DEAR BOB. On behalf of the Lake County Chamber of Commerce Board of Directors, we would like to congratulate you on your recent decision to make a land trade with the Fremont National Forest, regarding the Warner Canyon Ski Area.

Maintaining the level of operation, to provide a quality skiing experience for recreational skiers in Southeast Oregon, has been a difficult challenge for the Fremont Highlanders Ski Club. Liability Insurance has been a real obstacle, as well as sporadic snow conditions. Thanks to Collins McDonald Trust Fund, as well as other generous Lake County businesses and citizens, we have been able to financially survive.

Three years ago the chamber received a grant to promote winter recreation in Lake County. The success of Warner Canyon Ski Area is an important component to that promotion, which impacts the local economy during the usual slow months.

We are very supportive of this trade and look forward to many successful ski seasons in the future.

Sincerely,

BARB GOVER,
*Director, Lake County Chamber of Commerce.*

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By Mrs. BOXER:

S. 882. A bill to improve academic and social outcomes for students by providing productive activities during after school hours; to the Committee on Labor and Human Resources.

THE AFTER SCHOOL EDUCATION AND SAFETY ACT OF 1997

Mrs. BOXER. Mr. President, I rise to introduce the After School Education and Safety Act of 1997. This bill creates after school enrichment programs for kindergarten, elementary, and secondary school-aged students. Today's youth face far greater social risks than did their parents and grandparents. According to the Federal Bureau of Investigation, youth between the ages of 12 and 17 are most at risk of committing violent acts and being victims of violent crimes between 3 p.m. and 6 p.m.—a time when they are not in school.

My bill will help schools expand their capacity to address the needs of school-aged children between these critical hours. Since juvenile crime peeks at the close of the schoolday—we need to give children a safe and supervised place where they can use those hours to their best advantage. Education is a key component of success. This bill seeks to increase the academic success of students while working to improve their intellectual, social, physical, and cultural skills. For older students, programs will be available to prepare them for work force participation.

Schools receiving grants under the act must provide at least two of the following programs: Mentoring, academic assistance, recreational activities, or technology training. It is critical that we work with our Nation's children during their school years to create strong foundations in academics, technology, and other fields which will carry them into adulthood.

Schools will be able to work within their communities to design programs that meet the needs of the area. Activities authorized by the bill are to take place in a school building or another public facility designated by the school.

Mr. President, the best investment we can make in this country is in our children. I urge my colleagues to review this legislation and join me in making after school a safe time for our Nation's children.

I ask unanimous consent that the text of the legislation be included in the RECORD.

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

S. 882

*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 "After School Education and Safety Act of 1997".

**SEC. 2. PURPOSE.**

The purpose of this Act is to improve academic and social outcomes for students by providing productive activities during after school hours.

**SEC. 3. FINDINGS.**

Congress makes the following findings:

(1) Today's youth face far greater social risks than did their parents and grandparents.

(2) Students spend more of their waking hours alone, without supervision, companionship, or activity than the students spend in school.

(3) Law enforcement statistics show that youth who are ages 12 through 17 are most at risk of committing violent acts and being victims of violent acts between 3 p.m. and 6 p.m.

(4) Greater numbers of students are failing in school and the consequences of academic failure are more dire in 1997 than ever before.

**SEC. 4. GOALS.**

The goals of this Act are as follows:

(1) To increase the academic success of students.

(2) To improve the intellectual, social, physical, and cultural skills of students.

(3) To promote safe and healthy environments for students.

(4) To prepare students for workforce participation.

(5) To provide alternatives to drug, alcohol, tobacco, and gang activity.

**SEC. 5. DEFINITIONS.**

In this Act:

(1) SCHOOL.—The term "school" means a public kindergarten, or a public elementary school or secondary school, as defined in section 14101 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 8801).

(2) SECRETARY.—The term "Secretary" means the Secretary of Education.

**SEC. 6. PROGRAM AUTHORIZED.**

The Secretary is authorized to carry out a program under which the Secretary awards grants to schools to enable the schools to carry out the activities described in section 7(a).

**SEC. 7. AUTHORIZED ACTIVITIES; REQUIREMENTS.**

(a) AUTHORIZED ACTIVITIES.—

(1) REQUIRED.—Each school receiving a grant under this Act shall carry out at least 2 of the following activities:

(A) Mentoring programs.

(B) Academic assistance.

(C) Recreational activities.

(D) Technology training.

(2) PERMISSIVE.—Each school receiving a grant under this Act may carry out any of the following activities:

(A) Drug, alcohol, and gang, prevention activities.

(B) Health and nutrition counseling.

(C) Job skills preparation activities.

(b) TIME.—A school shall provide the activities described in subsection (a) only after regular school hours during the school year.

(c) SPECIAL RULE.—Each school receiving a grant under this Act shall carry out activities described in subsection (a) in a manner that reflects the specific needs of the population, students, and community to be served.

(d) LOCATION.—A school shall carry out the activities described in subsection (a) in a school building or other public facility designated by the school.

(e) ADMINISTRATION.—In carrying out the activities described in subsection (a), a school is encouraged—

(1) to request volunteers from the business and academic communities to serve as mentors or to assist in other ways;

(2) to request donations of computer equipment; and

(3) to work with State and local park and recreation agencies so that activities that are described in subsection (a) and carried out prior to the date of enactment of this Act are not duplicated by activities assisted under this Act.

**SEC. 8 APPLICATIONS.**

Each school desiring a grant under this Act shall submit an application to the Secretary at such time, in such manner, and accompanied by such information as the Secretary may require. Each such application shall—

(1) identify how the goals set forth in section 4 shall be met by the activities assisted under this Act;

(2) provide evidence of collaborative efforts by students, parents, teachers, site administrators, and community members in the planning and administration of the activities;

(3) contain a description of how the activities will be administered;

(4) demonstrate how the activities will utilize or cooperate with publicly or privately funded programs in order to avoid duplication of activities in the community to be served;

(5) contain a description of the funding sources and in-kind contributions that will support the activities; and

(6) contain a plan for obtaining non-Federal funding for the activities.

**SEC. 9 AUTHORIZATION OF APPROPRIATIONS.**

There is authorized to be appropriated to carry out this ACt $50,000,000 for each of the fiscal years 1998 through 2002.

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By Mr. GREGG (for himself, Mr. ROTH, Mr. FAIRCLOTH, Mrs. HUTCHISON, Mr. MURKOWSKI, Mr. SANTORUM, and Ms. COLLINS):

S. 883. A bill to amend the Internal Revenue Code of 1986 to encourage savings and investment through individual retirement accounts, to provide pension security, portability, and simplification, and for other purposes; to the Committee on Finance.

THE RETIREMENT INCOME SECURITY AND SAVINGS ACT OF 1997

Mr. GREGG. Mr. President, I am extremely pleased to rise to introduce the Retirement Income, Security, and Savings Act of 1997.

Mr. President, this bill represents the culmination of literally months of work by the Republican Retirement Security Task Force, which I chair. It embodies a collection of policies which would, if enacted, do a tremendous amount for a critical national need—to increase retirement saving and ultimately, therefore, retirement income for all Americans.

It has become almost axiomatic to state that America is in dire need of a qualitative increase in its level of retirement saving. None of the three legs of the metaphorical retirement stool—Social Security, employer-provided pensions, and individual saving—are saving an adequate amount for 21st century retirement needs. Social Security is not really a savings program at all, but is rather funded on a pay-as-you-go basis, the surplus loaned to the Government, to be paid back from general revenues at a future date. Employer-provided pensions only reach half of the working population, and there are problems of underfunding facing even the portion that are covered. And, as a general rule, only a few Americans are putting away sufficient saving on their own initiative to meet their future retirement income needs.

I would like to take a few moments to describe the current details with respect to retirement income in America, and then how our package addresses those needs. Only then, I believe, can my colleagues fully appreciate the quality and importance of the policy recommendations that we are making.

The typical retired American today receives retirement income from a variety of sources. On average, 41.7 percent comes from Social Security, 20.5 percent from asset income, 20.1 percent from pensions, 14.8 percent is annually earned, and the remaining 3 percent comes from a variety of other sources, including welfare programs such as SSI and unemployment compensation.

I would stress that this is only an average picture. The reality varies greatly from American to American. We need to look at the oldest of Americans to see the future of an aging nation. Americans currently 80 and older receive 52.6 percent of their income from Social Security, whereas their pensions provide proportionally less—down to 15.3 percent. And, of course, they are less able to earn money at this age, thus earnings make up only 3.9 percent of their income.

I describe this situation because it dramatizes our future. Americans continue to have longer and longer life expectancies. The population aged 80 and older is growing faster than any other age group, proportionally. This are group currently receives inadequate pension and individual savings income, and has needed to rely more heavily on Social Security. The plain fact is that as America grows older, this group of Americans simply must have access to more in the areas of pension coverage and personal savings if they are to maintain a dignified standard of living.

The current national picture is also not equitable with regard to the treatment of women. Currently, women are almost twice as likely as men to live in poverty in their retirement years—a 15.7 percent poverty rate versus an 8.9 percent poverty rate for men. For women who are widowed or divorced, the picture is worse still—widows suffer a poverty rate of 21.5 percent, divorcees 29.1 percent. Thus, the task force placed high priority on including provisions designed to help women generate saving in their own name.

Also of note are the discrepancies in income sources between high-income

and low-income Americans. Among elderly Americans in the lowest quintile, Social Security constitutes 82.6 percent of their income. Their next biggest source is public assistance—SSI, unemployment compensation, and other such sources—which make up 9.1 percent of their income stream. Thus, poorest Americans would benefit the most from expansions of existing pension coverage.

Mr. President, it is, therefore, essential that this Nation pursue policies that increase pension and individual savings in the private sector. One added reason for this is the plight of Social Security. Thus far, Congress has not been willing to address Social Security's enormous unfunded liability. Under current practices, we will continue to pour the annual Social Security surplus into current Government consumption. We have no method to pay for Social Security's trillions in unfunded liability other than the promise of future Government taxation.

Although few are willing to admit it, it is clear from the projections that Social Security in the 21st century will not be able to deliver as large a share of the income of retired Americans as it does today. That is simply not possible when the projected worker-to-collector ratios for the program will hit only 2 to 1 within a generation. When the program is brought into balance, as it must be, what will happen to the millions of Americans who rely on Social Security for the majority of their retirement income? The answer, Mr. President, depends on how successful we are in providing for retirement income via other means.

Our task force approached these problems in as objective a fashion as we could. We decided early on that the problem was one of inadequate saving, instead of one of inadequate regulation, or inequitable distribution. Indeed, many existing regulations and distribution requirements have actually worked against the aim of expanded pension coverage, because they deter employers from providing it. The result is that many small business owners do not believe that they can afford to offer pension coverage. Mr. President, we must begin to make it easier—in fact, we must begin to make it attractive—for employers to offer pensions.

There is a single common theme that runs through the Republican approach to retirement security: Retirement income comes from retirement saving. It comes from nowhere else. Everything in our package aims at generating additional retirement saving in a reasonably direct way. Government must do more to encourage saving, and in many ways this is best done by doing less to discourage it. We have produced a package that would make it easier for additional retirement saving to occur, by facilitating saving via a broad variety of measures.

That is not to say that we did not identify areas of the law where there were simply technical adjustments to be made. Often there are absurd regulatory inconsistencies in our pension structures. We penalize employers who do not properly fund pension plans, but on the other hand, we prevent others from funding the full amount of liabilities that they know are coming. Or we will treat employer contributions one way, but the contributions of the self-employed another way. There is a host of confusing, sometimes inconsistent, regulations in effect. We did our best to identify and to rectify such problems and inconsistencies in existing law.

This package seeks to increase saving through individual savings incentives, through employer funding of pension plans, through simplification, through expanded portability, through defined contribution plans, and through defined benefit plans. We attempted to increase savings on every front. We cast our net wide. Thus, we have a package that is a veritable smorgasbord of reforms, more than Congress could possibly enact this year. But we have produced a host of proposals that are each candidates for at least partial inclusion in budget reconciliation, and I believe that Congress would do well to favorably consider them.

Because we attempted to approach our task with this specific policy objective in mind—increasing savings—we did not set ourselves up to oppose every idea that originated in another place. The centerpiece proposals of our package—full IRA deductibility for every American, the WISE women's equity package, and the new SAFE defined benefit plan—are not included in the package of pension proposals offered by the minority party. But we did not reject some good technical corrections merely because they have appeared in the work of others. I believe that there is a basis for Congress to review the proposals offered separately by Republicans, and by Democrats, and to pursue many initiatives on which there is a broad area of common ground.

I would like to thank Majority Leader LOTT for convening the task force and for selecting me to be its chairman. I also wish to thank Senator LARRY CRAIG for his helpful coordination of the various Republican task force efforts. I wish to thank each of the members of the Senate Republican Retirement Security Task Force—Senators BOND, COLLINS, HUTCHISON, JEFFORDS, MURKOWSKI, ROBERTS, SANTORUM, FAIRCLOTH—but most especially Finance Committee Chairman Senator WILLIAM ROTH, whose work was absolutely instrumental to this drafting effort. I would like to single out Doug Fisher of Senator ROTH's staff for the technical advice and assistance that he provided to me and to my staff at every stage of this process.

It would be appropriate at this point to say a word of appreciation to Senator GRAHAM of Florida as well, for his parallel work in fashioning a bipartisan package of pension reforms that I understand will be introduced later this week. Our Republican task force has communicated in open and good faith with his bipartisan group, and there have been times when we have found ourselves working on overlapping ground. Senator GRAHAM and his staff have made important and original contributions to a bipartisan effort to promote retirement security, and I believe that we can work with Senator GRAHAM and others in this coalition, throughout the reconciliation process and beyond, to pursue reforms of common interest.

Let me now turn to the specific provisions of our legislation.

Title I would establish a fully deductible IRA for every American. The IRA is becoming a cornerstone of national retirement policy, and the Federal Government should not deter anyone from participating by limiting or eliminating the tax deductibility of the option. We endorse the Roth/Breaux schedule of phasing out the limits on IRA deductibility by 2001, and of indexing the contribution limits for inflation. We would also create the option of the back-loaded IRA—in which contributions are taxed when they are made, instead of upon withdrawal—in order to mitigate the revenue implications in the near-term. Stimulating personal saving—making it attractive for every American to adopt the habit of contributing to an IRA each year—is an important first step toward meeting tomorrow's retirement income needs.

Title II is the WISE bill introduced earlier this year. Already this important piece of legislation has 25 co-sponsors. These women's equity initiatives include a strengthening of the homemaker IRA, permitting a homemaker to make a fully deductible IRA contribution, regardless of whether his or her spouse receives an employer-provided pension. In addition, we would permit individuals who take maternity or paternity leave to make catch-up contributions to their 401–(k) or similar plans for the time missed from work. And—the most creative part of our legislation—we would permit individuals who are absent from pension plan participation for an extended period to raise a child—to make additional contributions upon return, and to catch up for up to 18 years of absence.

The WISE legislation is extremely popular, and I do not need to describe it at length here. However, I would say that it recognizes an important principle too frequently unrecognized in our pension law: That individuals do not have the same opportunities to save at every stage of their lives. Frequently, the financial pressures of raising a child prevent parents from attending to their own retirement saving. WISE attempts to give some flexibility, to permit individuals to put away more money when, at last, they have the surplus income to do so.

Title III of our bill is targeted at expanding pension coverage in small

business. This, Mr. President, is a title of our legislation that is just as vital as the first two, for a number of important reasons. First, it is those individuals who work for small businesses who are most likely to lack pension coverage. Second, we felt it was very important in this legislation to do something to make defined benefit plans more attractive to employers. The task force concluded that removing impediments to defined contribution saving was extremely important, but we could not stop there: We needed to pursue parallel methods with respect to establishing pension coverage for individuals who do not have discretionary income to put into retirement savings.

Title III of our legislation begins with the SAFE plan—a fully portable, fully funded, defined benefit plan designed for small business. This legislation attempts to make defined benefit plans a more realistic option for small businesses, just as the SIMPLE plan did last year for defined contribution plans. Because SAFE is a method of creating a defined benefit plan without running into the problems with funding and complex regulation that have deterred small businesses from offering other defined benefit plans, it is good for employers. And because it offers a defined benefit funded by the employer, rather than dependent upon employee contributions, it is good for lower income employees.

In essence, the way SAFE works is this: An employer can choose to establish a SAFE plan that accrues at either a 1-percent, a 2-percent, or a 3-percent rate. What this means is that for every year the employee works, they get either 1 percent, 2 percent, or 3 percent of their salary as their defined benefit upon retirement. If, for example, the employee works for 25 years in a plan that accrues at 3 percent, then their retirement benefit will be 75 percent of working income. Everyone in the plan accrues at the same rate. So the employer can make a choice: If they fund at the lower rate—say, 1 percent—then they will diminish the size of their own pension benefits as well as that of their employees. By treating all employees equally, across the board, SAFE bypasses the need for complex nondiscrimination requirements. Fair treatment is assured by the basic construction of the plan.

SAFE plans are fully funded by the employer. The employer must fund the benefits such that, when a 5 percent interest rate is assumed, enough will be present at time of retirement to pay the defined benefit. If the employer is able to do better, in managing the plan, then that 5 percent interest rate, then the extra goes back into the pension benefits. Annually, the plan is monitored to ensure that the employer has kept pace with that 5 percent rate. If not, then the employer must make a makeup contribution at year's end. So, in all events, the pension benefits are protected. It is annually assured that the promised benefits are fully funded, and it is also possible that the beneficiary will receive more. Moreover, because each individual's pension benefit is fully funded in advance by a defined amount, it is fully portable—the benefit can travel with the employee easily when they switch jobs.

The SAFE plan gives a small business owner the opportunity to create a simple defined benefit plan that has the potential to provide large pension benefits—for both the employees and the employer. Because of that potential and its resulting incentive, and because of the protection from messy discrimination rules, SAFE plans will be an attractive alternative for small businesses. And by creating this alternative, we increase the opportunities for lower income individuals to receive defined benefit pension coverage that they might not be able to fund via a defined contribution system.

It will take too much of the Senate's time to list every aspect of our comprehensive legislation, but I invite Senators to review this and other provisions we have created to make pensions more attractive to small business owners in title III of the bill.

Title IV contains assorted measures to ensure pension portability. This is essential in a mobile society such as ours, in which pension coverage is lowest among short-tenured young workers, moving from job to job. We do not generate retirement saving if these pension benefits simply turn into a cash-out every time one changes jobs. Our legislation would protect plans that accept rollovers from disqualification, and also specifically facilitate rollovers between a large variety of plans—government plans, nonprofit plans, and others.

Title V of the legislation deals with pension security. We felt it was important to highlight our finding that pension managers have an obligation to comply with the intent of ERISA, which directs that they manage these plans with an eye solely toward maximizing the accumulation of pension assets, not pursuing an external purpose, whether social, political, or any other. Accordingly, we would eliminate the promotion of the Department of Labor's Economically Targeted Investments Program. The last thing that we want, Mr. president, is for pension managers to feel pressured into investing in any vehicles that they do not believe meet the best interests of future pension beneficiaries. To the extent that these economically targeted investments produce healthy, sound investments, they do not need promotion by the Department of Labor. To the extent that they do not, pension managers should not invest in them.

Also in title V, Mr. President, is an important provision that gradually increases the current limitation on full employer funding of pension liabilities. Right now, employers may fund for no more than 150 percent of current liability, even when they may know that future liabilities are accruing and must be funded. This is short-sighted policy by the Federal Government, undertaken solely to protect the Federal balance sheet, by limiting the tax deductibility of pension contributions. I would argue that this existing policy, in the long run, does not even protect the Federal balance sheet, because ultimately, these liabilities must be funded, and the deduction therefore taken. It is better to permit employers to invest the money now, and to let that investment compound to meet future liabilities, rather than to forbid them from doing so, and thereby force them to make a larger contribution later—and then claim an even larger deduction. We must take a far-sighted approach to funding pensions, and not discourage proper pension funding simply because we are looking at a short-term budget window here in the Federal Government. Our provision would gradually increase the 150 percent limit, by 5 percent every 2 years.

Finally, title VI deals with another vital area of pension reform—pension simplification. In this title, Mr. President, Senators will find a host of changes that eliminate existing inconsistencies within law and regulation, as well as facilitating the use of electronic technology to replace cumbersome paperwork. I would draw the attention of the Senate to one particular provision here that would exempt Government plans from existing nondiscrimination rules. These nondiscrimination rules, Mr. President, were not designed for Government plans, and it has proved very vexatious to determine how to apply them in cases when the employer is a government body. I believe that many Senators have probably heard from administrators of State government retirement plans regarding the need to make this exemption permanent, and our bill would do so. This is one provision, Mr. President, that I believe we should seek to include in budget reconciliation this year.

Mr. President, I am very proud to introduce this legislation. Tax law in this area is complicated and dry—I have become too familiar with that these last months—but it is imperative that we shoulder the burden of reforming it to make it work more simply, and more effectively, to encourage greater retirement income saving. I have worked long and hard to create this legislation, and I believe that it represents a good comprehensive effort to enhance the future retirement security of millions of Americans. I thank the rest of the task force, and the majority leader, for this opportunity to lead in this important work, and I commend this legislation to the Senate for its favorable consideration.

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By Mr. D'AMATO (for himself, Mr. KERRY, Mrs. BOXER, Mr. BRYAN, Ms. MOSELEY-BRAUN, Mrs. MURRAY, and Mr. CHAFEE):

S. 885. A bill to amend the Electronic Fund Transfer Act to limit fees charged by financial institutions for

the use of automatic teller machines, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

THE FAIR ATM FEES FOR CONSUMERS ACT

Mr. D'AMATO. Mr. President, I rise today with Senator KERRY as my primary cosponsor to reintroduce legislation to protect consumers from excessive and redundant fees imposed by automated teller machine [ATM] operators. I am also pleased that Senators BOXER, BRYAN, MOSELEY-BRAUN, MURRAY, and CHAFEE have chosen to join with me once again in cosponsoring this important initiative.

Mr. President, last year, I introduced legislation to eliminate ATM fees. At that time, some of my colleagues argued that consumers could always choose to go to an ATM that does not double-charge. I predicted then that if we permit this practice, eventually every bank will double-charge consumers would have no choice but to pay through the nose.

Last fall, I asked the General Accounting Office to examine ATM fees. I want to know how many banks are double charging and how much consumers are being forced to pay.

This morning the Banking Committee heard GAO's results. Their results detail the spread of the anticonsumer, anticompetitive, and anti-free-market practice—double ATM fees.

In a nutshell, this abusive practice is spreading like wildfire and consumers across the country are getting burned. When I received the GAO report, I was shocked to find that, in just over a year, the number of ATM's that double charge consumers has risen 320 percent since the end of 1995. That means that consumers have less and less of a choice when they need to use an ATM.

The GAO study also reveals that 54 percent of the ATM's in the United States are now double-charging. Soon consumers will have nowhere to turn. For that reason, I am reintroducing my bill, the Fair ATM Fees for Consumers Act.

Until April of last year, most consumers paid a fee, usually about $1, to their own bank each time they used another bank's ATM. This fee was intended to cover the cost of the transaction. Now, in addition to that fee, the ATM operator may charge these consumers a second fee. This second fee can run as high as $3 per transaction. Many consumers are forced to pay a total of $3 or more just to take $20 of their own money out of the bank. That's outrageous.

Double-charging was prohibited in most of the country until April 1, 1996, when Visa and MasterCard, which operate the two largest ATM networks, endorsed this practice. When the Banking Committee held a hearing on double ATM charges last summer Visa and MasterCard refused to appear. I intend to hold further hearings on this issue and I fully expect Visa and MasterCard to testify as to why they suddenly permitted this double charge which hurts consumers and community banks.

Recent estimates show that the average consumer is paying a whopping $155 per year to use automated teller machines or ATM's. The average family will pay several times that amount. That's outrageous. The banks are making windfall profits from working people.

A transaction conducted at an ATM costs about 25 cents while the same transaction conducted by a teller in a bank branch costs well over a dollar. Realizing this, banks strongly encouraged their customers to use ATM's. ATM's appeared everywhere as banks cut bank on branches and teller service. ATM networks were formed when individual banks joined together and agreed to let each other's customers use any ATM in the network without paying any extra charges.

Now, banks are suddenly claiming that ATM's are no longer cost effective. They have decided to soak consumers with multiple fees every time they need to take money out of their accounts.

Banks report record profits in part by slapping customers and noncustomers with ever-increasing convenience fees. In many cases, consumers are forced to pay multiple fees for a single ATM transaction. Imagine, working men and women are paying two separate fees for the privilege of getting their own money.

This is a windfall for the banks. The consumer receives no additional benefit and the bank provides no additional service. A recent study by the U.S. Public Interest Research Group [U.S. PIRG] reported that banks will profit $1.9 billion from ATM surcharges alone this year. This double charge is a free lunch for the banks and consumers are footing the bill. I am not opposed to banks making a profit, but double ATM fees unfairly exploit the consumer.

Banks argue that consumers have the freedom to go to an ATM that doesn't double-charge. But working people on their lunch hours, or late at night, have no time to hunt for a free ATM when they need cash. As the GAO reported, those free ATM's are getting very hard to find.

The people who are getting hit the hardest are the ones who can least afford it. While many Americans can simply choose to avoid extra fees by taking $100 or $200 every time they go to an ATM, many families struggling to make ends meet don't have that option. Senior citizens on fixed incomes and students with little money to space are being forced to pay $2 or $3 just to take out $20. A $3 fee on a $200 withdrawal is a nuisance, but taking a $3 bite out of a $20 withdrawal is outrageous.

Mr. President, double-charging is a monopolistic practice that eliminates competition and distorts the free market. Banks are using double ATM fees to squeeze small competitors out of business. Community banks, thrifts, and credit unions have customers who depend on access to other institutions' ATM's. These customers now pay twice whenever they use an ATM. Large banks with many ATM's are exploiting this situation to lure away small bank customers. Eventually, small banks will not be able to survive. That's not competition, that's a monopoly.

When ATM's were first introduced, banks claimed that these machines would give consumers more choices and greater convenience. ATM's were supposed to reduce costs and the savings could be passed on to consumers. Today, when bank profits are at record highs, it is astonishing that banks cannot resist the temptation to squeeze consumers a little harder by doubling ATM fees,

I look forward to holding additional hearings on ATM fees during this Congress to provide opponents and proponents of the bill, including representatives of various States that are attempting to enact bans, an opportunity to participate in this debate. I hope may colleagues will join me in taking a stand against this predatory banking practice.

Mr. President, I ask unanimous consent that the full 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. 885

*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 "Fair ATM Fees for Consumers Act".

**SEC. 2 DEFINITION.**

Section 903 of the Electronic Fund Transfer Act (15 U.S.C. 1693a) is amended—

(1) in paragraph (10), by striking "and" at the end;

(2) in paragraph (11), by striking the period at the end and inserting a semicolon; and

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

"(12) the term 'electronic terminal surcharge' means a transaction fee assessed by a financial institution that is the owner or operator of the electronic terminal; and

"(13) the term 'electronic banking network' means a communications system linking financial institutions through electronic terminals.".

**SEC. 3. CERTAIN FEES PROHIBITED.**

Section 905 of the Electronic Fund Transfer Act (12 U.S.C. 1693c) is amended by adding at the end the following new subsection:

"(d) LIMITATION ON FEES.—With respect to a transaction conducted at an electronic terminal, an electronic terminal surcharge may not be assessed against a consumer if the transaction—

"(1) does not relate to or affect an account held by the consumer with the financial institution that is the owner or operator of the electronic terminal; and

"(2) is conducted through a national or regional electronic banking network.".

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Mr. KERRY. Mr. President, I am pleased to join my colleague, the chairman of the Banking Committee, in introducing the Fair ATM Fees for Consumers Act of 1997.

Today, in the Banking Committee, representatives of the U.S. General Accounting Office discussed the findings

of their report on the growth of ATM surcharges. It is a fascinating report, and I recommend our colleagues take a look at it. I will highlight some of the findings, especially as they pertain to my home State.

I will tell you, Mr. President, it is not often in the Banking Committee that passions run this high on a financial services issue. I have heard from officials of large banks who tell me that prohibiting ATM surcharges is tantamount to nationalizing our banking industry.

Mr. President, I do not believe that it is the business of the U.S. Senate to set prices and fees at banks and other financial institutions. I am a great believer in the free market—not the Federal Government—dictating fee structures. But there is a general sense of fairness that is being violated in this surcharge.

When a depositor opens an account, he or she knows the fees associated with transactions. It is current federal law—found in statutes like the Electronic Funds Transfer Act, the Truth-in-Savings Act, and the Truth-in-Lending Act—that mandates fees to be disclosed to the consumer. So, when we open a bank account, we know how much each transaction will cost.

But now, with this new surcharge, we are left in the dark. In the absence of disclosure law dealing with surcharges, we don't find out, in many cases, how much it will cost to use an ATM machine not associated with our particular bank until our statement appears in the mail, long after the ATM transaction is completed.

That is bad for consumers and it is bad precedent. And, as the GAO report testifies, the trend is not favorable. Historic mergers, consolidations, and acquisitions have taken place in the financial service industry. Bank lobby hours have been curtailed so drastically, and so many human tellers replaced by machines, that we are forced to use ATM's. This is the undeniable direction of the industry.

Mr. President, some of the biggest banks argue that ATM fees are an outgrowth of the convenience consumers derive from using ATM's. But I suspect that other forces are at play. Commercial banks posted record profits last year, surpassing the previous record-breaking year. This new fee is not needed to ensure that banks are profitable.

Mr. President, last year, a constituent of mine from Dorchester, MA, testified before the Banking Committee on this issue. He owns a profitable bank with one ATM machine. He runs the bank well and serves the community. But his small bank is no match for far bigger competitors. He contends that these surcharges are designed by the big banks to draw customers away from community banks. This may not be an issue of establishing prices and fees; this has all the coloration of an antitrust issue. I want to set the marker down clearly—the Congress needs to do a better job in monitoring and preventing the trend of consolidation from running the smaller banks out of business.

In Massachusetts, the two largest banks own more than 62 percent of the ATM's in the Commonwealth. The GAO report tells us that, nationally, one-third of all ATM's are owned by large banks. So, Massachusetts has double the national concentration. And that is a critical measure, Mr. President. The GAO report found that ATM surcharges are more prevalent among larger banks, 98 percent of which own ATM's. Fifty-four percent of large institutions assessed a surcharge as opposed to 32 percent of smaller institutions. That is the static measure, which is significant enough, but the trend is even more disturbing. The number of ATM's assessing a surcharge has risen 320 percent in the past 13 months. The highest surcharge found was $3 and the average surcharge is $1.14, up from 99 cents last year.

I will say that I appreciate the fact that BankBoston—one of the two large banks in Massachusetts—does not impose surcharges at all. I also know that the Massachusetts Bankers Association is grappling with this issue, trying to find some accommodation, and I am willing to listen to its arguments on this issue. My mind is certainly open to alternatives to the current draft of our legislation. But, Mr. President, I must say that the findings of the GAO report do little to dissuade me that we must move forward to prohibit these surcharges.

I thank my friend, the chairman of the Banking Committee, for his leadership.

Ms. MOSELEY-BRAUN. Mr. President, I would like to congratulate my colleague, the Senator from New York, Senator D'AMATO, for his leadership on this bill, the Fair ATM Fees for Consumers Act.

Few Americans will quarrel with the issue this bill addresses: surcharging, or double charging consumers for a single ATM transaction, is unfair and unnecessary.

Many banks charge their customers for using foreign ATM's—those ATM's not owned by the customer's bank. These fees are disclosed to the customer in advance, allowing consumers to shop for and choose banks that offer the best package of services at the best price.

I don't have a problem with that kind of fee. Customers have that information well in advance, and at a time they can use it. If the services offered by banks fail to meet the customer's satisfaction, customers can take their business elsewhere.

Surcharging, however, undermines all that. Last April, the major computer networks allowed ATM owners to begin charging fees to customers using foreign ATM's. From that day, the floodgates opened, and now customers nationwide are being charged twice for the same transaction—first by their own institution, and by the institution owning the ATM machine.

These costs are spreading. According to a recent General Accounting Office report commissioned by the Senator from New York, ATM surcharges have ballooned 320 percent since 1995.

One example of the surcharge boom is in my hometown of Chicago. Earlier this month, First Chicago NBD instituted surcharges, affecting 710 ATM's in the area. That decision, coupled with the 1,550 ATM's in the region already levying surcharges, now means that more than half of the 4,400 ATM's in the Chicago area have a surcharge.

Mr. President, if current trends continue, few ATM's will remain that have no surcharge, and consumers, despite surcharge warnings posted on the computer screen or on the machine, will truly have no alternative but to be charged twice for the same transaction.

I am aware that there are some costs to convenience. There are more than 122,000 ATM's around the Nation, almost 5 times the number in place a decade ago. Americans used ATM machines more than 9 billion times last year, accessing their bank accounts and other financial services 24 hours a day, 7 days a week. I know there are costs associated with deploying these new machines, handling increased transactions, and other maintenance and safety issues.

It should not be forgotten, however, that banks moved customers to ATM's because, compared to teller transactions, ATM's were cheaper. According to a Mentis Corp. study, an ATM cash withdrawal from an in-branch ATM costs an average of 22 to 28 cents, while the cost of a teller transaction is 90 cents to $1.15. And in some cases, banks charge customers for completing transactions with a teller if those transactions could have been completed at an ATM.

Certainly ATM's are a convenience for customers, but the truth is that banks have deployed more ATM's because it means lower costs to banks.

I remember when banks paid their customers for the use of their money. Today, however, it's increasingly expensive for the average working family to manage even a simple banking account. Americans who make timely credit card payments, or no payments at all, face higher fees. Americans who avoid special banking services are considered unprofitable customers, and face higher fees.

Now, with ATM surcharges, Americans are discovering that they must pay banks an additional $155 each year simply to access their own money.

The market is out of whack. The pubic knows this is unfair, and their visceral reaction is a response to market excess.

I am hopeful that the financial industry will take the necessary steps to remedy this problem. Otherwise, the Government has a duty to correct the abuse of double and triple charging

people for accessing their own hard-earned dollars.

It is time to stop nickel and diming the American pocket. That's why I'm pleased to be a cosponsor of this bill, and I urge its swift approval by the U.S. Senate.

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By Mr. McCONNELL (for himself and Mr. LIEBERMAN):

S. 886. A bill to reform the health care liability system and improve health care quality through the establishment of quality assurance programs, and for other purposes; to the Committee on Labor and Human Resources.

THE HEALTH CARE LIABILITY REFORM AND QUALITY ASSURANCE ACT OF 1997

Mr. McCONNELL. Mr. President, I am pleased to introduce the Health Care Liability Reform and Quality Assurance Act of 1997. This is virtually the same legislation as S. 454 that I introduced in the last Congress with Senators LIEBERMAN and Kassebaum. That bill was reported out of the Labor Committee and received the support of 53 Senators when it was added as an amendment to the product liability legislation. Ultimately, however, the amendment was withdrawn under the threat of a filibuster. I am very happy to, once again, be joining with Senator LIEBERMAN in this effort.

Health care liability is one issue on which there has been some bipartisan consensus about the need to make significant changes. This bill which I am introducing today with the cosponsorship and assistance of Senator LIEBERMAN represents this bipartisan effort.

The purpose of our bill is to promote patient safety, compensate those who suffer injuries fully and fairly, without enriching lawyers and bureaucrats, make health care more accessible, gain some cost containment in health care, strengthen the doctor-patient relationship and encourage medical innovation. Our present system, unfortunately, does none of the above.

First of all, patients don't get compensated. The Rand Corp. has reported that only 43 cents of every dollar spent in the liability system goes to the injured party. That means lawyers, experts, and court fees eat up a significant percentage of every dollar spent in the liability system.

Second, the prohibitive cost of liability insurance means some doctors won't provide care to those in our society who need it most. Half-a-million rural women can't get an obstetrician to deliver their babies. This problem, however, is not limited to rural areas. High malpractice premiums force doctors to avoid the practice of medicine in urban areas as well, making it more difficult for minority communities to get necessary care.

Third, companies that invent new products are discouraged under the current system from putting them on the market. Medical device manufacturers are finding it more difficult to get raw materials to produce life saving devices because of the risk of lawsuits.

Fourth, doctors are less likely to explore risky treatment because of the proliferation of lawsuits. A doctor has a better than 1 in 3 chance of being sued during his practice years. And the likelihood of suit has nothing to do with whether the doctor was negligent. The General Accounting Office reports that almost 60 percent of all suits are dismissed without a verdict or even a settlement.

So, something is very wrong with our liability system, and our bill will help solve the problem. I have included a summary of the bill's provisions, and I ask unanimous consent that the full text of the bill and the summary be printed in the RECORD.

Mr. President, I am hopeful that health care liability will get full consideration and action in this Congress. It is very important that we tackle this issue, and I look forward to prompt action.

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

S. 886

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

**SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

(a) SHORT TITLE.—This Act may be cited as the ''Health Care Liability Reform and Quality Assurance Act of 1997''.

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

Sec. 1. Short title; table of contents.

TITLE I—HEALTH CARE LIABILITY REFORM

Subtitle A—Liability Reform

Sec. 101. Findings and purpose.
Sec. 102. Definitions.
Sec. 103. Applicability.
Sec. 104. Statute of limitations.
Sec. 105. Reform of punitive damages.
Sec. 106. Periodic payments.
Sec. 107. Scope of liability.
Sec. 108. Mandatory offsets for damages paid by a collateral source.
Sec. 109. Treatment of attorneys' fees and other costs.
Sec. 110. Obstetric cases.
Sec. 111. State-based alternative dispute resolution mechanisms.
Sec. 112. Requirement of certificate of merit.

Subtitle B—Biomaterials Access Assurance

Sec. 121. Short title.
Sec. 122. Findings.
Sec. 123. Definitions.
Sec. 124. General requirements; applicability; preemption.
Sec. 125. Liability of biomaterials suppliers.
Sec. 126. Procedures for dismissal of civil actions against biomaterials suppliers.
Sec. 127. Applicability.

Subtitle C—Applicability

Sec. 131. Applicability.

TITLE II—PROTECTION OF THE HEALTH AND SAFETY OF PATIENTS

Sec. 201. Additional resources for State health care quality assurance and access activities.
Sec. 202. Quality assurance, patient safety, and consumer information.

TITLE III—SEVERABILITY

Sec. 301. Severability.

**TITLE I—HEALTH CARE LIABILITY REFORM**

**Subtitle A—Liability Reform**

**SEC. 101. FINDINGS AND PURPOSE.**

(a) FINDINGS.—Congress finds the following:

(1) EFFECT ON HEALTH CARE ACCESS AND COSTS.—The civil justice system of the United States is a costly and inefficient mechanism for resolving claims of health care liability and compensating injured patients and the problems associated with the current system are having an adverse impact on the availability of, and access to, health care services and the cost of health care in the United States.

(2) EFFECT ON INTERSTATE COMMERCE.—The health care and insurance industries are industries affecting interstate commerce and the health care liability litigation systems existing throughout the United States affect interstate commerce by contributing to the high cost of health care and premiums for health care liability insurance purchased by participants in the health care system.

(3) EFFECT ON FEDERAL SPENDING.—The health care liability litigation systems existing throughout the United States have a significant effect on the amount, distribution, and use of Federal funds because of—

(A) the large number of individuals who receive health care benefits under programs operated or financed by the Federal Government;

(B) the large number of individuals who benefit because of the exclusion from Federal taxes of the amounts spent to provide such individuals with health insurance benefits; and

(C) the large number of health care providers who provide items or services for which the Federal Government makes payments.

(b) PURPOSE.—It is the purpose of this Act to implement reasonable, comprehensive, and effective health care liability reform that is designed to—

(1) ensure that individuals with meritorious health care injury claims receive fair and adequate compensation;

(2) improve the availability of health care service in cases in which health care liability actions have been shown to be a factor in the decreased availability of services; and

(3) improve the fairness and cost-effectiveness of the current health care liability system of the United States to resolve disputes over, and provide compensation for, health care liability by reducing uncertainty and unpredictability in the amount of compensation provided to injured individuals.

**SEC. 102. DEFINITIONS.**

As used in this subtitle:

(1) CLAIMANT.—The term ''claimant'' means any person who commences a health care liability action, and any person on whose behalf such an action is commenced, including the decedent in the case of an action brought through or on behalf of an estate.

(2) CLEAR AND CONVINCING EVIDENCE.—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, except that such measure or degree of proof is more than that required under preponderance of the evidence, but less than that required for proof beyond a reasonable doubt.

(3) COLLATERAL SOURCE RULE.—The term ''collateral source rule'' means a rule, either statutorily established or established at common law, that prevents the introduction of evidence regarding collateral source benefits or that prohibits the deduction of collateral source benefits from an award of damages in a health care liability action.

(4) CONTINGENCY FEE.—The term ''contingency fee'' means any fee for professional legal services which is, in whole or in part, contingent upon the recovery of any amount of damages, whether through judgment or settlement.

(5) ECONOMIC LOSSES.—The term ''economic losses'' means objectively verifiable monetary losses incurred as a result of the provision of (or failure to provide or pay for) health care services or the use of a medical product, including past and future medical expenses, loss of past and future earnings, cost of obtaining replacement services in the home (including child care, transportation, food preparation, and household care), cost of making reasonable accommodations to a personal residence, loss of employment, and loss of business or employment opportunities. Economic losses are neither noneconomic losses nor punitive damages.

(6) HEALTH CARE LIABILITY ACTION.—The term ''health care liability action'' means a civil action against a health care provider, health care professional, health plan, or other defendant, including a right to legal or equitable contribution, indemnity, subrogation, third-party claims, cross claims, or counter-claims, in which the claimant alleges injury related to the provision of, payment for, or the failure to provide or pay for, health care services or medical products, regardless of the theory of liability on which the action is based. Such term does not include a product liability action, except where such an action is brought as part of a broader health care liability action.

(7) HEALTH PLAN.—The term ''health plan'' means any person or entity which is obligated to provide or pay for health benefits under any health insurance arrangement, including any person or entity acting under a contract or arrangement to provide, arrange for, or administer any health benefit.

(8) HEALTH CARE PROFESSIONAL.—The term ''health care professional'' means any individual who provides health care services in a State and who is required by Federal or State laws or regulations to be licensed, registered or certified to provide such services or who is certified to provide health care services pursuant to a program of education, training and examination by an accredited institution, professional board, or professional organization.

(9) HEALTH CARE PROVIDER.—The term ''health care provider'' means any organization or institution that is engaged in the delivery of health care items or services in a State and that is required by Federal or State laws or regulations to be licensed, registered or certified to engage in the delivery of such items or services.

(10) HEALTH CARE SERVICES.—The term ''health care services'' means any services provided by a health care professional, health care provider, or health plan or any individual working under the supervision of a health care professional, that relate to the diagnosis, prevention, or treatment of any disease or impairment, or the assessment of the health of human beings.

(11) INJURY.—The term ''injury'' means any illness, disease, or other harm that is the subject of a health care liability action.

(12) MEDICAL PRODUCT.—The term ''medical product'' means a drug (as defined in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)) or a medical device as defined in section 201(h) of such Act (21 U.S.C. 321(h)), including any component or raw material used therein, but excluding health care services, as defined in paragraph (9).

(13) NONECONOMIC LOSSES.—The term ''noneconomic losses'' means losses for physical and emotional pain, suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of enjoyment of life, loss of consortium, loss of society or companionship (other than loss of domestic services), and other nonpecuniary losses incurred by an individual with respect to which a health care liability action is brought. Noneconomic losses are neither economic losses nor punitive damages.

(14) PUNITIVE DAMAGES.—The term ''punitive damages'' means damages awarded, for the purpose of punishment or deterrence, and not for compensatory purposes, against a health care professional, health care provider, or other defendant in a health care liability action. Punitive damages are neither economic nor noneconomic damages.

(15) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(16) STATE.—The term ''State'' means each of the several States of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

**SEC. 103. APPLICABILITY.**

(a) IN GENERAL.—Except as provided in subsection (c), this subtitle shall apply with respect to any health care liability action brought in any Federal or State court, except that this subtitle shall not apply to an action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act (42 U.S.C. 300aa-1) applies to the action.

(b) PREEMPTION.—

(1) IN GENERAL.—The provisions of this subtitle shall preempt any State law existing on, or enacted subsequent to, the date of enactment of this Act, only to the extent that such law is inconsistent with the limitations contained in such provisions and shall not preempt State law to the extent that such law—

(A) places greater restrictions on the amount of or standards for awarding noneconomic or punitive damages;

(B) places greater limitations on the awarding of attorneys fees for awards in excess of $150,000;

(C) permits a lower threshold for the periodic payment of future damages;

(D) establishes a shorter period during which a health care liability action may be initiated or a more restrictive rule with respect to the time at which the period of limitations begins to run; or

(E) implements collateral source rule reform that either permits the introduction of evidence of collateral source benefits or provides for the mandatory offset of collateral source benefits from damage awards.

(2) RULES OF CONSTRUCTION.—The provisions of this subtitle shall not be construed to preempt any State law that—

(A) permits State officials to commence health care liability actions as a representative of an individual;

(B) permits provider-based dispute resolution;

(C) places a maximum limit on the total damages in a health care liability action;

(D) places a maximum limit on the time in which a health care liability action may be initiated; or

(E) provides for defenses in addition to those contained in this Act.

(c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in this subtitle shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(4) preempt State choice-of-law rules with respect to actions 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 an action of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum; or

(6) supersede any provision of Federal law.

(d) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this subtitle shall be construed to establish any jurisdiction in the district courts of the United States over health care liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

**SEC. 104. STATUTE OF LIMITATIONS.**

A health care liability action that is subject to this Act may not be initiated unless a complaint with respect to such action is filed within the 2-year period beginning on the date on which the claimant discovered or, in the exercise of reasonable care, should have discovered the injury and its cause, except that such an action relating to a claimant under legal disability may be filed within 2 years after the date on which the disability ceases. If the commencement of a health care liability action is stayed or enjoined, the running of the statute of limitations under this section shall be suspended for the period of the stay or injunction.

**SEC. 105. REFORM OF PUNITIVE DAMAGES.**

(a) LIMITATION.—With respect to a health care liability action, an award for punitive damages may only be made, if otherwise permitted by applicable law, if it is proven by clear and convincing evidence that the defendant—

(1) intended to injure the claimant for a reason unrelated to the provision of health care services;

(2) understood the claimant was substantially certain to suffer unnecessary injury, and in providing or failing to provide health care services, the defendant deliberately failed to avoid such injury; or

(3) acted with a conscious, flagrant disregard of a substantial and unjustifiable risk of unnecessary injury which the defendant failed to avoid in a manner which constitutes a gross deviation from the normal standard of conduct in such circumstances.

(b) PUNITIVE DAMAGES NOT PERMITTED.—Notwithstanding the provisions of subsection (a), punitive damages may not be awarded against a defendant with respect to any health care liability action if no judgment for compensatory damages, including nominal damages (under $500), is rendered against the defendant.

(c) PROCEDURE FOR DETERMINING PUNITIVE DAMAGES.—

(1) IN GENERAL.—In any health care liability action subject to this subtitle in which punitive damages are recoverable, the trier of fact shall determine, concurrent with all other issues presented in such action, whether such damages shall be allowed. If the trier of fact determines that such damages are allowed, a separate proceeding shall be conducted by the court to determine the amount of such damages to be awarded.

(2) SEPARATE PROCEEDING.—At a separate proceeding to determine the amount of punitive damages to be awarded under paragraph (1), the court shall consider the following:

(A) The severity of the harm caused by the conduct of the defendant.

(B) The duration of the conduct or any concealment of such conduct by the defendant.

(C) The profitability of the conduct of the defendant.

(D) The number of products sold or medical procedures rendered for compensation, as the case may be, by the defendant of the kind

causing the harm complained of by the claimant.

(E) The total deterrent effect of other damages and punishment imposed upon the defendant as a result of the misconduct, including compensatory, exemplary and punitive damage awards to individuals in situations similar to those of the claimant and the severity of any criminal or administrative penalties, or civil fines, to which the defendant has been or may be subjected.

(3) DETERMINATION.—At the conclusion of a separate proceeding under paragraph (1), the court shall determine the amount of punitive damages to be awarded with respect to the health care liability action involved and shall enter judgment for that amount. The court shall clearly state its reasons for setting the amount of such award in findings of fact and conclusions of law, demonstrating consideration of each of the factors described in paragraph (2).

(d) LIMITATION AMOUNT.—The amount of damages that may be awarded as punitive damages in any health care liability action shall not exceed 3 times the amount awarded to the claimant for the economic injury on which such claim is based, or $250,000, whichever is greater. This subsection shall be applied by the court and shall not be disclosed to the jury.

(e) RESTRICTIONS PERMITTED.—Nothing in this Act shall be construed to imply a right to seek punitive damages where none exists under Federal or State law.

**SEC. 106. PERIODIC PAYMENTS.**

With respect to a health care liability action, if the award of future damages exceeds $100,000, the adjudicating body shall, at the request of either party, enter a judgment ordering that future damages be paid on a periodic basis in accordance with the guidelines contained in the Uniform Periodic Payments of Judgments Act, as promulgated by the National Conference of Commissioners on Uniform State Laws in July of 1990. The adjudicating body may waive the requirements of this section if such body determines that such a waiver is in the interests of justice.

**SEC. 107. SCOPE OF LIABILITY.**

(a) IN GENERAL.—With respect to punitive and noneconomic damages, the liability of each defendant in a health care liability action shall be several only and may not be joint. Such a defendant shall be liable only for the amount of punitive or noneconomic damages allocated to the defendant in direct proportion to such defendant's percentage of fault or responsibility for the injury suffered by the claimant.

(b) DETERMINATION OF PERCENTAGE OF LIABILITY.—With respect to punitive or noneconomic damages, the trier of fact in a health care liability action shall determine the extent of each party's fault or responsibility for injury suffered by the claimant, and shall assign a percentage of responsibility for such injury to each such party.

**SEC. 108. MANDATORY OFFSETS FOR DAMAGES PAID BY A COLLATERAL SOURCE.**

(a) IN GENERAL.—With respect to a health care liability action, the total amount of damages received by an individual under such action shall be reduced, in accordance with subsection (b), by any other payment that has been, or will be, made to an individual to compensate such individual for the injury that was the subject of such action.

(b) AMOUNT OF REDUCTION.—The amount by which an award of damages to an individual for an injury shall be reduced under subsection (a) shall be—

(1) the total amount of any payments (other than such award) that have been made or that will be made to such individual to pay costs of or compensate such individual for the injury that was the subject of the action; minus

(2) the amount paid by such individual (or by the spouse, parent, or legal guardian of such individual) to secure the payments described in paragraph (1).

(c) DETERMINATION OF AMOUNTS FROM COLLATERAL SERVICES.—The reductions required under subsection (b) shall be determined by the court in a pretrial proceeding. At the subsequent trial—

(1) no evidence shall be admitted as to the amount of any charge, payments, or damage for which a claimant—

(A) has received payment from a collateral source or the obligation for which has been assured by a third party; or

(B) is, or with reasonable certainty, will be eligible to receive payment from a collateral source of the obligation which will, with reasonable certainty be assumed by a third party; and

(2) the jury, if any, shall be advised that—

(A) except for damages as to which the court permits the introduction of evidence, the claimant's medical expenses and lost income have been or will be paid by a collateral source or third party; and

(B) the claimant shall receive no award for any damages that have been or will be paid by a collateral source or third party.

**SEC. 109. TREATMENT OF ATTORNEYS' FEES AND OTHER COSTS.**

(a) LIMITATION ON AMOUNT OF CONTINGENCY FEES.—An attorney who represents, on a contingency fee basis, a claimant in a health care liability action may not charge, demand, receive, or collect for services rendered in connection with such action in excess of the following amount recovered by judgment or settlement under such action:

(1) 33⅓ percent of the first $150,000 (or portion thereof) recovered, based on after-tax recovery, plus

(2) 25 percent of any amount in excess of $150,000 recovered, based on after-tax recovery.

(b) CALCULATION OF PERIODIC PAYMENTS.—In the event that a judgment or settlement includes periodic or future payments of damages, the amount recovered for purposes of computing the limitation on the contingency fee under subsection (a) shall be based on the cost of the annuity or trust established to make the payments. In any case in which an annuity or trust is not established to make such payments, such amount shall be based on the present value of the payments.

**SEC. 110. OBSTETRIC CASES.**

With respect to a health care liability action relating to services provided during labor or the delivery of a baby, if the health care professional against whom the action is brought did not previously treat the pregnant woman for the pregnancy, the trier of fact may not find that the defendant committed malpractice and may not assess damages against the health care professional unless the malpractice is proven by clear and convincing evidence.

**SEC. 111. STATE-BASED ALTERNATIVE DISPUTE RESOLUTION MECHANISMS.**

(a) ESTABLISHMENT BY STATES.—Each State is encouraged to establish or maintain alternative dispute resolution mechanisms that promote the resolution of health care liability claims in a manner that—

(1) is affordable for the parties involved in the claims;

(2) provides for the timely resolution of claims; and

(3) provides the parties with convenient access to the dispute resolution process.

(b) GUIDELINES.—The Attorney General, in consultation with the Secretary and the Administrative Conference of the United States, shall develop guidelines with respect to alternative dispute resolution mechanisms that may be established by States for the resolution of health care liability claims. Such guidelines shall include procedures with respect to the following methods of alternative dispute resolution:

(1) ARBITRATION.—The use of arbitration, a nonjury adversarial dispute resolution process which may, subject to subsection (c), result in a final decision as to facts, law, liability or damages. The parties may elect binding arbitration.

(2) MEDIATION.—The use of mediation, a settlement process coordinated by a neutral third party without the ultimate rendering of a formal opinion as to factual or legal findings.

(3) EARLY NEUTRAL EVALUATION.—The use of early neutral evaluation, in which the parties make a presentation to a neutral attorney or other neutral evaluator for an assessment of the merits, to encourage settlement. If the parties do not settle as a result of assessment and proceed to trial, the neutral evaluator's opinion shall be kept confidential.

(4) EARLY OFFER AND RECOVERY MECHANISM.—The use of early offer and recovery mechanisms under which a health care provider, health care organization, or any other alleged responsible defendant may offer to compensate a claimant for his or her reasonable economic damages, including future economic damages, less amounts available from collateral sources.

(5) NO FAULT.—The use of a no-fault statute under which certain health care liability actions are barred and claimants are compensated for injuries through their health plans or through other appropriate mechanisms.

(c) FURTHER REDRESS.—

(1) IN GENERAL.—The extent to which any party may seek further redress (subsequent to a decision of an alternative dispute resolution method) concerning a health care liability claim in a Federal or State court shall be dependent upon the methods of alternative dispute resolution adopted by the State.

(2) CLAIMANT.—With respect to further redress described in paragraph (1), if the party initiating such court action is the claimant and the claimant receives a level of damages that is at least 25 percent less under the decision of the court than under the State alternative dispute resolution method, such party shall bear the reasonable costs, including legal fees, incurred in the court action by the other party or parties to such action.

(3) PROVIDER OR OTHER DEFENDANT.—With respect to further redress described in paragraph (1), if the party initiating a court action is the health care professional, health care provider health plan, or other defendant in a health care liability action and the health care professional, health care provider, health plan or other defendant is found liable for a level of damages that is at least 25 percent more under the decision of the court than under the State alternative dispute resolution method, such party shall bear the reasonable costs, including legal fees, incurred in the court action by the other party or parties to such action.

(d) TECHNICAL ASSISTANCE AND EVALUATIONS.—

(1) TECHNICAL ASSISTANCE.—The Attorney General may provide States with technical assistance in establishing or maintaining alternative dispute resolution mechanisms under this section.

(2) EVALUATIONS.—The Attorney General, in consultation with the Secretary and the Administrative Conference of the United States, shall monitor and evaluate the effectiveness of State alternative dispute resolution mechanisms established or maintained under this section.

**SEC. 112. REQUIREMENT OF CERTIFICATE OF MERIT.**

(a) REQUIRING SUBMISSION WITH COMPLAINT.—Except as provided in subsection (b) and subject to the penalties of subsection (d), no health care liability action may be brought by any individual unless, at the time the individual commences such action, the individual or the individual's attorney submits an affidavit declaring that—

(1) the individual (or the individual's attorney) has consulted and reviewed the facts of the claim with a qualified specialist (as defined in subsection (c));

(2) the individual or the individual's attorney has obtained a written report by a qualified specialist that clearly identifies the individual and that includes the specialist's determination that, based upon a review of the available medical record and other relevant material, a reasonable medical interpretation of the facts supports a finding that the claim against the defendant is meritorious and based on good cause; and

(3) on the basis of the qualified specialist's review and consultation, the individual, and if represented, the individual's attorney, have concluded that the claim is meritorious and based on good cause.

(b) EXTENSION IN CERTAIN INSTANCES.—

(1) IN GENERAL.—Subject to paragraph (2), subsection (a) shall not apply with respect to an individual who brings a health care liability action without submitting an affidavit described in such subsection if—

(A) despite good faith efforts, the individual is unable to obtain the written report before the expiration of the applicable statute of limitations;

(B) despite good faith efforts, at the time the individual commences the action, the individual has been unable to obtain medical records or other information necessary, pursuant to any applicable law, to prepare the written report requested; or

(C) the court of competent jurisdiction determines that the affidavit requirement shall be extended upon a showing of good cause.

(2) DEADLINE FOR SUBMISSION WHERE EXTENSION APPLIES.—In the case of an individual who brings an action to which paragraph (1) applies, the action shall be dismissed unless the individual submits the affidavit described in subsection (a) not later than—

(A) in the case of an action to which subparagraph (A) of paragraph (1) applies, 90 days after commencing the action; or

(B) in the case of an action to which subparagraph (B) of paragraph (1) applies, 90 days after obtaining the information described in such subparagraph or when good cause for an extension no longer exists.

(c) QUALIFIED SPECIALIST DEFINED.—

(1) IN GENERAL.—As used in subsection (a), the term ''qualified specialist'' means, with respect to a health care liability action, a health care professional who has expertise in the same or substantially similar area of practice to that involved in the action.

(2) EVIDENCE OF EXPERTISE.—For purposes of paragraph (1), evidence of required expertise may include evidence that the individual—

(A) practices (or has practiced) or teaches (or has taught) in the same or substantially similar area of health care or medicine to that involved in the action; or

(B) is otherwise qualified by experience or demonstrated competence in the relevant practice area.

(d) SANCTIONS FOR SUBMITTING FALSE AFFIDAVIT.—Upon the motion of any party or on its own initiative, the court in a health care liability action may impose a sanction on a party, the party's attorney, or both, for—

(1) any knowingly false statement made in an affidavit described in subsection (a);

(2) making any false representations in order to obtain a qualified specialist's report; or

(3) failing to have the qualified specialist's written report in his or her custody and control;

and may require that the sanctioned party reimburse the other party to the action for costs and reasonable attorney's fees.

**Subtitle B—Biomaterials Access Assurance**

**SEC. 121. SHORT TITLE.**

This subtitle may be cited as the ''Biomaterials Access Assurance Act of 1997''.

**SEC. 122. FINDINGS.**

Congress finds that—

(1) each year millions of citizens of the United States depend on the availability of lifesaving or life enhancing medical devices, many of which are permanently implantable within the human body;

(2) a continued supply of raw materials and component parts is necessary for the invention, development, improvement, and maintenance of the supply of the devices;

(3) most of the medical devices are made with raw materials and component parts that—

(A) are not designed or manufactured specifically for use in medical devices; and

(B) come in contact with internal human tissue;

(4) the raw materials and component parts also are used in a variety of nonmedical products;

(5) because small quantities of the raw materials and component parts are used for medical devices, sales of raw materials and component parts for medical devices constitute an extremely small portion of the overall market for the raw materials and medical devices;

(6) under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.), manufacturers of medical devices are required to demonstrate that the medical devices are safe and effective, including demonstrating that the products are properly designed and have adequate warnings or instructions;

(7) notwithstanding the fact that raw materials and component parts suppliers do not design, produce, or test a final medical device, the suppliers have been the subject of actions alleging inadequate—

(A) design and testing of medical devices manufactured with materials or parts supplied by the suppliers; or

(B) warnings related to the use of such medical devices;

(8) even though suppliers of raw materials and component parts have very rarely been held liable in such actions, such suppliers have ceased supplying certain raw materials and component parts for use in medical devices because the costs associated with litigation in order to ensure a favorable judgment for the suppliers far exceeds the total potential sales revenues from sales by such suppliers to the medical device industry;

(9) unless alternate sources of supply can be found, the unavailability of raw materials and component parts for medical devices will lead to unavailability of lifesaving and life-enhancing medical devices;

(10) because other suppliers of the raw materials and component parts in foreign nations are refusing to sell raw materials or component parts for use in manufacturing certain medical devices in the United States, the prospects for development of new sources of supply for the full range of threatened raw materials and component parts for medical devices are remote;

(11) it is unlikely that the small market for such raw materials and component parts in the United States could support the large investment needed to develop new suppliers of such raw materials and component parts;

(12) attempts to develop such new suppliers would raise the cost of medical devices;

(13) courts that have considered the duties of the suppliers of the raw materials and component parts have generally found that the suppliers do not have a duty—

(A) to evaluate the safety and efficacy of the use of a raw material or component part in a medical device; and

(B) to warn consumers concerning the safety and effectiveness of a medical device;

(14) attempts to impose the duties referred to in subparagraphs (A) and (B) of paragraph (13) on suppliers of the raw materials and component parts would cause more harm than good by driving the suppliers to cease supplying manufacturers of medical devices; and

(15) in order to safeguard the availability of a wide variety of lifesaving and life-enhancing medical devices, immediate action is needed—

(A) to clarify the permissible bases of liability for suppliers of raw materials and component parts for medical devices; and

(B) to provide expeditious procedures to dispose of unwarranted suits against the suppliers in such manner as to minimize litigation costs.

**SEC. 123. DEFINITIONS.**

As used in this subtitle:

(1) BIOMATERIALS SUPPLIER.—

(A) IN GENERAL.—The term ''biomaterials supplier'' means an entity that directly or indirectly supplies a component part or raw material for use in the manufacture of an implant.

(B) PERSONS INCLUDED.—Such term includes any person who—

(i) has submitted master files to the Secretary for purposes of premarket approval of a medical device; or

(ii) licenses a biomaterials supplier to produce component parts or raw materials.

(2) CLAIMANT.—

(A) IN GENERAL.—The term ''claimant'' means any person who brings a civil action, or on whose behalf a civil action is brought, arising from harm allegedly caused directly or indirectly by an implant, including a person other than the individual into whose body, or in contact with whose blood or tissue, the implant is placed, who claims to have suffered harm as a result of the implant.

(B) ACTION BROUGHT ON BEHALF OF AN ESTATE.—With respect to an action brought on behalf of or through the estate of an individual into whose body, or in contact with whose blood or tissue the implant is placed, such term includes the decedent that is the subject of the action.

(C) ACTION BROUGHT ON BEHALF OF A MINOR OR INCOMPETENT.—With respect to an action brought on behalf of or through a minor or incompetent, such term includes the parent or guardian of the minor or incompetent.

(D) EXCLUSIONS.—Such term does not include—

(i) a provider of professional health care services, in any case in which—

(I) the sale or use of an implant is incidental to the transaction; and

(II) the essence of the transaction is the furnishing of judgment, skill, or services;

(ii) a person acting in the capacity of a manufacturer, seller, or biomaterials supplier; or

(iii) a person alleging harm caused by either the silicone gel or the silicone envelope utilized in a breast implant containing silicone gel, except that—

(I) neither the exclusion provided by this clause nor any other provision of this subtitle may be construed as a finding that silicone gel (or any other form of silicone) may or may not cause harm; and

(II) the existence of the exclusion under this clause may not—

(aa) be disclosed to a jury in any civil action or other proceeding; and

(bb) except as necessary to establish the applicability of this subtitle, otherwise be presented in any civil action or other proceeding.

(3) COMPONENT PART.—

(A) IN GENERAL.—The term ''component part'' means a manufactured piece of an implant.

(B) CERTAIN COMPONENTS.—Such term includes a manufactured piece of an implant that—

(i) has significant non-implant applications; and

(ii) alone, has no implant value or purpose, but when combined with other component parts and materials, constitutes an implant.

(4) HARM.—

(A) IN GENERAL.—The term ''harm'' means—

(i) any injury to or damage suffered by an individual;

(ii) any illness, disease, or death of that individual resulting from that injury or damage; and

(iii) any loss to that individual or any other individual resulting from that injury or damage.

(B) EXCLUSION.—The term does not include any commercial loss or loss of or damage to an implant.

(5) IMPLANT.—The term ''implant'' means—

(A) a medical device that is intended by the manufacturer of the device—

(i) to be placed into a surgically or naturally formed or existing cavity of the body for a period of at least 30 days; or

(ii) to remain in contact with bodily fluids or internal human tissue through a surgically produced opening for a period of less than 30 days; and

(B) suture materials used in implant procedures.

(6) MANUFACTURER.—The term ''manufacturer'' means any person who, with respect to an implant—

(A) is engaged in the manufacture, preparation, propagation, compounding, or processing (as defined in section 510(a)(1)) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(a)(1)) of the implant; and

(B) is required—

(i) to register with the Secretary pursuant to section 510 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360) and the regulations issued under such section; and

(ii) to include the implant on a list of devices filed with the Secretary pursuant to section 510(j) of such Act (21 U.S.C. 360(j)) and the regulations issued under such section.

(7) MEDICAL DEVICE.—The term ''medical device'' means a device, as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)) and includes any device component of any combination product as that term is used in section 503(g) of such Act (21 U.S.C. 353(g)).

(8) RAW MATERIAL.—The term ''raw material'' means a substance or product that—

(A) has a generic use; and

(B) may be used in an application other than an implant.

(9) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(10) SELLER.—

(A) IN GENERAL.—The term ''seller'' means a person who, in the course of a business conducted for that purpose, sells, distributes, leases, packages, labels, or otherwise places an implant in the stream of commerce.

(B) EXCLUSIONS.—The term does not include—

(i) a seller or lessor of real property;

(ii) a provider of professional services, in any case in which the sale or use of an implant is incidental to the transaction and the essence of the transaction is the furnishing of judgment, skill, or services; or

(iii) any person who acts in only a financial capacity with respect to the sale of an implant.

**SEC. 124. GENERAL REQUIREMENTS; APPLICABILITY; PREEMPTION.**

(a) GENERAL REQUIREMENTS.—

(1) IN GENERAL.—In any civil action covered by this subtitle, a biomaterials supplier may raise any defense set forth in section 125.

(2) PROCEDURES.—Notwithstanding any other provision of law, the Federal or State court in which a civil action covered by this subtitle is pending shall, in connection with a motion for dismissal or judgment based on a defense described in paragraph (1), use the procedures set forth in section 126.

(b) APPLICABILITY.—

(1) IN GENERAL.—Except as provided in paragraph (2), notwithstanding any other provision of law, this subtitle applies to any civil action brought by a claimant, whether in a Federal or State court, against a manufacturer, seller, or biomaterials supplier, on the basis of any legal theory, for harm allegedly caused by an implant.

(2) EXCLUSION.—A civil action brought by a purchaser of a medical device for use in providing professional services against a manufacturer, seller, or biomaterials supplier for loss or damage to an implant or for commercial loss to the purchaser—

(A) shall not be considered an action that is subject to this subtitle; and

(B) shall be governed by applicable commercial or contract law.

(c) SCOPE OF PREEMPTION.—

(1) IN GENERAL.—This subtitle supersedes any State law regarding recovery for harm caused by an implant and any rule of procedure applicable to a civil action to recover damages for such harm only to the extent that this subtitle establishes a rule of law applicable to the recovery of such damages.

(2) APPLICABILITY OF OTHER LAWS.—Any issue that arises under this subtitle and that is not governed by a rule of law applicable to the recovery of damages described in paragraph (1) shall be governed by applicable Federal or State law.

(d) STATUTORY CONSTRUCTION.—Nothing in this subtitle may be construed—

(1) to affect any defense available to a defendant under any other provisions of Federal or State law in an action alleging harm caused by an implant; or

(2) to create a cause of action or Federal court jurisdiction pursuant to section 1331 or 1337 of title 28, United States Code, that otherwise would not exist under applicable Federal or State law.

**SEC. 125. LIABILITY OF BIOMATERIALS SUPPLIERS.**

(a) IN GENERAL.—

(1) EXCLUSION FROM LIABILITY.—Except as provided in paragraph (2), a biomaterials supplier shall not be liable for harm to a claimant caused by an implant.

(2) LIABILITY.—A biomaterials supplier that—

(A) is a manufacturer may be liable for harm to a claimant described in subsection (b);

(B) is a seller may be liable for harm to a claimant described in subsection (c); and

(C) furnishes raw materials or component parts that fail to meet applicable contractual requirements or specifications may be liable for a harm to a claimant described in subsection (d).

(b) LIABILITY AS MANUFACTURER.—

(1) IN GENERAL.—A biomaterials supplier may, to the extent required and permitted by any other applicable law, be liable for harm to a claimant caused by an implant if the biomaterials supplier is the manufacturer of the implant.

(2) GROUNDS FOR LIABILITY.—The biomaterials supplier may be considered the manufacturer of the implant that allegedly caused harm to a claimant only if the biomaterials supplier—

(A)(i) has registered with the Secretary pursuant to section 510 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360) and the regulations issued under such section; and

(ii) included the implant on a list of devices filed with the Secretary pursuant to section 510(j) of such Act (21 U.S.C. 360(j)) and the regulations issued under such section;

(B) is the subject of a declaration issued by the Secretary pursuant to paragraph (3) that states that the supplier, with respect to the implant that allegedly caused harm to the claimant, was required to—

(i) register with the Secretary under section 510 of such Act (21 U.S.C. 360), and the regulations issued under such section, but failed to do so; or

(ii) include the implant on a list of devices filed with the Secretary pursuant to section 510(j) of such Act (21 U.S.C. 360(j)) and the regulations issued under such section, but failed to do so; or

(C) is related by common ownership or control to a person meeting all the requirements described in subparagraph (A) or (B), if the court deciding a motion to dismiss in accordance with section 126(c)(3)(B)(i) finds, on the basis of affidavits submitted in accordance with section 126, that it is necessary to impose liability on the biomaterials supplier as a manufacturer because the related manufacturer meeting the requirements of subparagraph (A) or (B) lacks sufficient financial resources to satisfy any judgment that the court feels it is likely to enter should the claimant prevail.

(3) ADMINISTRATIVE PROCEDURES.—

(A) IN GENERAL.—The Secretary may issue a declaration described in paragraph (2)(B) on the motion of the Secretary or on petition by any person, after providing—

(i) notice to the affected persons; and

(ii) an opportunity for an informal hearing.

(B) DOCKETING AND FINAL DECISION.—Immediately upon receipt of a petition filed pursuant to this paragraph, the Secretary shall docket the petition. Not later than 180 days after the petition is filed, the Secretary shall issue a final decision on the petition.

(C) APPLICABILITY OF STATUTE OF LIMITATIONS.—Any applicable statute of limitations shall toll during the period during which a claimant has filed a petition with the Secretary under this paragraph.

(c) LIABILITY AS SELLER.—A biomaterials supplier may, to the extent required and permitted by any other applicable law, be liable as a seller for harm to a claimant caused by an implant if—

(1) the biomaterials supplier—

(A) held title to the implant that allegedly caused harm to the claimant as a result of purchasing the implant after—

(i) the manufacture of the implant; and

(ii) the entrance of the implant in the stream of commerce; and

(B) subsequently resold the implant; or

(2) the biomaterials supplier is related by common ownership or control to a person meeting all the requirements described in paragraph (1), if a court deciding a motion to dismiss in accordance with section 126(c)(3)(B)(ii) finds, on the basis of affidavits submitted in accordance with section 126, that it is necessary to impose liability on the biomaterials supplier as a seller because the related seller meeting the requirements

of paragraph (1) lacks sufficient financial resources to satisfy any judgment that the court feels it is likely to enter should the claimant prevail.

(d) LIABILITY FOR VIOLATING CONTRACTUAL REQUIREMENTS OR SPECIFICATIONS.—A biomaterials supplier may, to the extent required and permitted by any other applicable law, be liable for harm to a claimant caused by an implant, if the claimant in an action shows, by a preponderance of the evidence, that—

(1) the raw materials or component parts delivered by the biomaterials supplier either—

(A) did not constitute the product described in the contract between the biomaterials supplier and the person who contracted for delivery of the product; or

(B) failed to meet any specifications that were—

(i) provided to the biomaterials supplier and not expressly repudiated by the biomaterials supplier prior to acceptance of delivery of the raw materials or component parts;

(ii)(I) published by the biomaterials supplier;

(II) provided to the manufacturer by the biomaterials supplier; or

(III) contained in a master file that was submitted by the biomaterials supplier to the Secretary and that is currently maintained by the biomaterials supplier for purposes of premarket approval of medical devices; or

(iii) included in the submissions for purposes of premarket approval or review by the Secretary under section 510, 513, 515, or 520 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360, 360c, 360e, or 360j), and received clearance from the Secretary if such specifications were provided by the manufacturer to the biomaterials supplier and were not expressly repudiated by the biomaterials supplier prior to the acceptance by the manufacturer of delivery of the raw materials or component parts; and

(2) such conduct was an actual and proximate cause of the harm to the claimant.

**SEC. 126. PROCEDURES FOR DISMISSAL OF CIVIL ACTIONS AGAINST BIOMATERIALS SUPPLIERS.**

(a) MOTION TO DISMISS.—In any action that is subject to this subtitle, a biomaterials supplier who is a defendant in such action may, at any time during which a motion to dismiss may be filed under an applicable law, move to dismiss the action against it on the grounds that—

(1) the defendant is a biomaterials supplier; and

(2)(A) the defendant should not, for the purposes of—

(i) section 125(b), be considered to be a manufacturer of the implant that is subject to such section; or

(ii) section 125(c), be considered to be a seller of the implant that allegedly caused harm to the claimant; or

(B)(i) the claimant has failed to establish, pursuant to section 125(d), that the supplier furnished raw materials or component parts in violation of contractual requirements or specifications; or

(ii) the claimant has failed to comply with the procedural requirements of subsection (b).

(b) MANUFACTURER OF IMPLANT SHALL BE NAMED A PARTY.—The claimant shall be required to name the manufacturer of the implant as a party to the action, unless—

(1) the manufacturer is subject to service of process solely in a jurisdiction in which the biomaterials supplier is not domiciled or subject to a service of process; or

(2) an action against the manufacturer is barred by applicable law.

(c) PROCEEDING ON MOTION TO DISMISS.—The following rules shall apply to any proceeding on a motion to dismiss filed under this section:

(1) AFFIDAVITS RELATING TO LISTING AND DECLARATIONS.—

(A) IN GENERAL.—The defendant in the action may submit an affidavit demonstrating that defendant has not included the implant on a list, if any, filed with the Secretary pursuant to section 510(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(j)).

(B) RESPONSE TO MOTION TO DISMISS.—In response to the motion to dismiss, the claimant may submit an affidavit demonstrating that—

(i) the Secretary has, with respect to the defendant and the implant that allegedly caused harm to the claimant, issued a declaration pursuant to section 125(b)(2)(B); or

(ii) the defendant who filed the motion to dismiss is a seller of the implant who is liable under section 125(c).

(2) EFFECT OF MOTION TO DISMISS ON DISCOVERY.—

(A) IN GENERAL.—If a defendant files a motion to dismiss under paragraph (1) or (2) of subsection (a), no discovery shall be permitted in connection to the action that is the subject of the motion, other than discovery necessary to determine a motion to dismiss for lack of jurisdiction, until such time as the court rules on the motion to dismiss in accordance with the affidavits submitted by the parties in accordance with this section.

(B) DISCOVERY.—If a defendant files a motion to dismiss under subsection (a)(2)(B)(i) on the grounds that the biomaterials supplier did not furnish raw materials or component parts in violation of contractual requirements or specifications, the court may permit discovery, as ordered by the court. The discovery conducted pursuant to this subparagraph shall be limited to issues that are directly relevant to—

(i) the pending motion to dismiss; or

(ii) the jurisdiction of the court.

(3) AFFIDAVITS RELATING STATUS OF DEFENDANT.—

(A) IN GENERAL.—Except as provided in clauses (i) and (ii) of subparagraph (B), the court shall consider a defendant to be a biomaterials supplier who is not subject to an action for harm to a claimant caused by an implant, other than an action relating to liability for a violation of contractual requirements or specifications described in subsection (d).

(B) RESPONSES TO MOTION TO DISMISS.—The court shall grant a motion to dismiss any action that asserts liability of the defendant under subsection (b) or (c) of section 125 on the grounds that the defendant is not a manufacturer subject to such section 125(b) or seller subject to section 125(c), unless the claimant submits a valid affidavit that demonstrates that—

(i) with respect to a motion to dismiss contending the defendant is not a manufacturer, the defendant meets the applicable requirements for liability as a manufacturer under section 125(b); or

(ii) with respect to a motion to dismiss contending that the defendant is not a seller, the defendant meets the applicable requirements for liability as a seller under section 125(c).

(4) BASIS OF RULING ON MOTION TO DISMISS.—

(A) IN GENERAL.—The court shall rule on a motion to dismiss filed under subsection (a) solely on the basis of the pleadings of the parties made pursuant to this section and any affidavits submitted by the parties pursuant to this section.

(B) MOTION FOR SUMMARY JUDGMENT.—Notwithstanding any other provision of law, if the court determines that the pleadings and affidavits made by parties pursuant to this section raise genuine issues as concerning material facts with respect to a motion concerning contractual requirements and specifications, the court may deem the motion to dismiss to be a motion for summary judgment made pursuant to subsection (d).

(d) SUMMARY JUDGMENT.—

(1) IN GENERAL.—

(A) BASIS FOR ENTRY OF JUDGMENT.—A biomaterials supplier shall be entitled to entry of judgment without trial if the court finds there is no genuine issue as concerning any material fact for each applicable element set forth in paragraphs (1) and (2) of section 125(d).

(B) ISSUES OF MATERIAL FACT.—With respect to a finding made under subparagraph (A), the court shall consider a genuine issue of material fact to exist only if the evidence submitted by claimant would be sufficient to allow a reasonable jury to reach a verdict for the claimant if the jury found the evidence to be credible.

(2) DISCOVERY MADE PRIOR TO A RULING ON A MOTION FOR SUMMARY JUDGMENT.—If, under applicable rules, the court permits discovery prior to a ruling on a motion for summary judgment made pursuant to this subsection, such discovery shall be limited solely to establishing whether a genuine issue of material fact exists as to the applicable elements set forth in paragraphs (1) and (2) of section 125(d).

(3) DISCOVERY WITH RESPECT TO A BIOMATERIALS SUPPLIER.—A biomaterials supplier shall be subject to discovery in connection with a motion seeking dismissal or summary judgment on the basis of the inapplicability of section 125(d) or the failure to establish the applicable elements of section 125(d) solely to the extent permitted by the applicable Federal or State rules for discovery against nonparties.

(e) STAY PENDING PETITION FOR DECLARATION.—If a claimant has filed a petition for a declaration pursuant to section 125(b)(3)(A) with respect to a defendant, and the Secretary has not issued a final decision on the petition, the court shall stay all proceedings with respect to that defendant until such time as the Secretary has issued a final decision on the petition.

(f) MANUFACTURER CONDUCT OF PROCEEDING.—The manufacturer of an implant that is the subject of an action covered under this subtitle shall be permitted to file and conduct a proceeding on any motion for summary judgment or dismissal filed by a biomaterials supplier who is a defendant under this section if the manufacturer and any other defendant in such action enter into a valid and applicable contractual agreement under which the manufacturer agrees to bear the cost of such proceeding or to conduct such proceeding.

(g) ATTORNEY FEES.—The court shall require the claimant to compensate the biomaterials supplier (or a manufacturer appearing in lieu of a supplier pursuant to subsection (f)) for attorney fees and costs, if—

(1) the claimant named or joined the biomaterials supplier; and

(2) the court found the claim against the biomaterials supplier to be without merit and frivolous.

**SEC. 127. APPLICABILITY.**

This subtitle shall apply to all civil actions covered under this subtitle that are commenced on or after the date of enactment of this Act, including any such action with respect to which the harm asserted in the action or the conduct that caused the harm occurred before the date of enactment of this Act.

**Subtitle C—Applicability**

**SEC. 131. APPLICABILITY.**

This title shall apply to all civil actions covered under this title that are commenced

on or after the date of enactment of this Act, including any such action with respect to which the harm asserted in the action or the conduct that caused the injury occurred before the date of enactment of this Act.

## TITLE II—PROTECTION OF THE HEALTH AND SAFETY OF PATIENTS

**SEC. 201. ADDITIONAL RESOURCES FOR STATE HEALTH CARE QUALITY ASSURANCE AND ACCESS ACTIVITIES.**

Each State shall require that not less than 50 percent of all awards of punitive damages resulting from all health care liability actions in that State, if punitive damages are otherwise permitted by applicable law, be used for activities relating to—

(1) the licensing, investigating, disciplining, and certification of health care professionals in the State; and

(2) the reduction of malpractice-related costs for health care providers volunteering to provide health care services in medically underserved areas.

**SEC. 202. QUALITY ASSURANCE, PATIENT SAFETY, AND CONSUMER INFORMATION.**

(a) ADVISORY PANEL.—

(1) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Administrator of the Agency for Health Care Policy and Research (hereafter referred to in this section as the ''Administrator'') shall establish an advisory panel to coordinate and evaluate, methods, procedures, and data to enhance the quality, safety, and effectiveness of health care services provided to patients.

(2) PARTICIPATION.—In establishing the advisory panel under paragraph (1), the Administrator shall ensure that members of the panel include representatives of public and private sector entities having expertise in quality assurance, risk assessment, risk management, patient safety, and patient satisfaction.

(3) OBJECTIVES.—In carrying out the duties described in this section, the Administrator, acting through the advisory panel established under paragraph (1), shall conduct a survey of public and private entities involved in quality assurance, risk assessment, patient safety, patient satisfaction, and practitioner licensing. Such survey shall include the gathering of data with respect to—

(A) performance measures of quality for health care providers and health plans;

(B) developments in survey methodology, sampling, and audit methods;

(C) methods of medical practice and patterns, and patient outcomes; and

(D) methods of disseminating information concerning successful health care quality improvement programs, risk management and patient safety programs, practice guidelines, patient satisfaction, and practitioner licensing.

(b) GUIDELINES.—Not later than 2 years after the date of enactment of this Act, the Administrator shall, in accordance with chapter 5 of title 5, United States Code, establish health care quality assurance, patient safety and consumer information guidelines. Such guidelines shall be modified periodically when determined appropriate by the Administrator. Such guidelines shall be advisory in nature and not binding.

(c) REPORTS.—

(1) INITIAL REPORT.—Not later than 6 months after the date of enactment of this Act, the Administrator shall prepare and submit to the Committee on Labor and Human Resources of the Senate and the Committee on Commerce of the House of Representatives, a report that contains—

(A) data concerning the availability of information relating to risk management, quality assessment, patient safety, and patient satisfaction;

(B) an estimation of the degree of consensus concerning the accuracy and content of the information available under subparagraph (A);

(C) a summary of the best practices used in the public and private sectors for disseminating information to consumers; and

(D) an evaluation of the National Practitioner Data Bank (as established under the Health Quality Improvement Act of 1986), for reliability and validity of the data and the effectiveness of the Data Bank in assisting hospitals and medical groups in overseeing the quality of practitioners.

(2) INTERIM REPORT.—Not later than 1 year after the date of enactment of this Act, the Administrator shall prepare and submit to the Committees referred to in paragraph (1) a report, based on the results of the advisory panel survey conducted under subsection (a)(3), concerning—

(A) the consensus of indicators of patient safety and risk;

(B) an assessment of the consumer perspective on health care quality that includes an examination of—

(i) the information most often requested by consumers;

(ii) the types of technical quality information that consumers find compelling;

(iii) the amount of information that consumers consider to be sufficient and the amount of such information considered overwhelming; and

(iv) the manner in which such information should be presented;

and recommendations for increasing the awareness of consumers concerning such information;

(C) proposed methods, building on existing data gathering and dissemination systems, for ensuring that such data is available and accessible to consumers, employers, hospitals, and patients;

(D) the existence of legal, regulatory, and practical obstacles to making such data available and accessible to consumers;

(E) privacy or proprietary issues involving the dissemination of such data;

(F) an assessment of the appropriateness of collecting such data at the Federal or State level;

(G) an evaluation of the value of permitting consumers to have access to information contained in the National Practitioner Data Bank and recommendations to improve the reliability and validity of the information; and

(H) the reliability and validity of data collected by the State medical boards and recommendations for developing investigation protocols.

(3) ANNUAL REPORT.—Not later than 1 year after the date of the submission of the report under paragraph (2), and each year thereafter, the Administrator shall prepare and submit to the Committees referred to in paragraph (1) a report concerning the progress of the advisory panel in the development of a consensus with respect to the findings of the panel and in the development and modification of the guidelines required under subsection (b).

(4) TERMINATION.—The advisory panel shall terminate on the date that is 3 years after the date of enactment of this Act.

## TITLE III—SEVERABILITY

**SEC. 301. SEVERABILITY.**

If any provision of this Act, an amendment made by this Act, or the application of such provision or amendment to any person or circumstance is held to be unconstitutional, the remainder of this Act, the amendments made by this Act, and the application of the provisions of such to any person or circumstance shall not be affected thereby.

HEALTH CARE LIABILITY REFORM AND QUALITY ASSURANCE ACT OF 1997

TITLE I—LIABILITY REFORM

SUBTITLE A—HEALTH CARE LIABILITY REFORM

*1. Scope*

The bill: Applies to any action, filed in federal or state court, against a health care provider, professional, payor, hmo, insurance company or any other defendant (except in cases based on vaccine-related injuries);

Preempts state law to the extent it is inconsistent with the provisions herein; no preemption for state laws which provide, among other things: a. additional defenses; b. greater limitations on attorneys' fees; c. greater restrictions on punitive or non-economic damages; d. maximum limit on the total damages.

Does not create federal jurisdiction for health care liability actions.

*2. Uniform statute of limitations*

Cases could be filed two years from the date that the injury was discovered or should have been discovered, except that any person under a legal disability may file within two years after the disability ceases.

*3. Limit on punitive damages*

Punitive damages will be awarded if it is proven by clear and convincing evidence that the defendant: a. intended to injure; b. understood claimant was substantially certain to suffer unnecessary injury and deliberately failed to avoid injury; or c. acted with conscious disregard of substantial and unjustifiable risk which defendant failed to avoid in a way which constitutes a gross deviation from the normal standard of conduct.

No punitive damages where compensatory damages of less than $500 are awarded.

Trier of fact determines if punitive damages are allowed. If so, then a separate proceeding is conducted by the court.

In determining the amount, court must consider only: a. severity of harm; b. duration of defendant's conduct and any concealment; c. profitability of defendant's conduct; d. number of products sold/procedures rendered which caused similar harm; e. similar awards of punitive damages in similar circumstances; f. criminal penalties imposed on defendant; g. civil fines imposed.

No award may exceed the greater of 3 times the amount of economic damages or $250,000.

*4. Periodic payment of future damages*

No more than $100,000 of future damages may be required to be paid in one single payment. The court will determine the schedule for payments, based on projection of future losses and reduced to present value. This requirement may be waived, in the interests of justice.

*5. Several, not joint, liability*

A defendant would be liable only for the amount of non-economic and punitive damages allocated to defendant's direct proportion of fault or responsibility. The trier of fact determines percentage of responsibility of each defendant.

*6. Collateral source*

Total damages must be reduced by payments from other sources to compensate individuals for injury that is the subject of the health care liability action. The offset is reduced by any amount paid by the injured party (or family member) to secure the payment. The reductions must be determined by the judge in a pretrial proceeding.

*7. Attorneys' fees*

This section limits attorney contingent fees to 33⅓% of the first $150,000 and 25% of any amount in excess of $150,000.

*8. Obstetric cases*

This section precludes a malpractice award against a health care professional relating to

delivery of a baby, if the health care professional did not previously treat the woman during the pregnancy, unless malpractice is proven by clear and convincing evidence.

*9. State-based alternative dispute resolution*

Prior to the filing, or immediately following the filing of the action, the parties are encouraged to participate in a state administered alternative dispute resolution system.

The Attorney General will develop adr methods for use by the states, including arbitration, mediation, early neutral evaluation, early offer and recovery. The parties may elect binding arbitration.

*10. Certificate of merit*

The certificate of merit provision requires that, prior to bringing a lawsuit, an individual (or his or her attorney) must submit an affidavit declaring that a qualified specialist reviewed the facts and concluded that the claim is meritorious.

A qualified specialist means a health care professional with expertise (the specialist practices or teaches or has experience or demonstrated competence) in the same or substantially similar area of practice as that involved in the case.

A court may impose sanctions for the submission of a false affidavit.

SUBTITLE B—BIOMATERIAL ACCESS ASSURANCE

*1. Summary*

The Biomaterial Access Assurance Act would allow suppliers of the raw materials (biomaterial) used to make medical implants, to obtain dismissal, without extensive discovery or other legal costs, in certain tort suits in which plaintiffs allege harm from a finished medical implant.

TITLE II—PROTECTION OF PATIENT HEALTH AND SAFETY

*1. Quality assurance*

The quality assurance section requires each state to establish a health care quality assurance program and fund, approved by the Secretary of HHS. It also allocates 50% of all punitive damage awards to be transferred to the fund for the purpose of licensing and certifying health professionals, implementing programs, including programs to reduce malpractice costs for volunteers serving under served areas.

*2. Risk management programs*

Finally, professionals and providers must participate in a risk management program to prevent and provide early warning of practices which may result in injuries. Insurers also must establish risk management programs and require participation, once every 3 years, as a condition of maintaining insurance.

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By Ms. MOSELEY-BRAUN (for herself and Mr. DEWINE):

S. 887. A bill to establish in the National Park Service the National Underground Railroad Network to Freedom Program, and for other purposes; to the Committee on Energy and Natural Resources.

THE NATIONAL UNDERGROUND RAILROAD NETWORK TO FREEDOM ACT OF 1997

Ms. MOSELEY-BRAUN. Mr. President, I am pleased to have the opportunity today to introduce the National Underground Railroad Network to Freedom Act of 1997.

The Underground Railroad, as my colleagues know, was among the most successful efforts in history in helping to undermine and destroy the institution of slavery in the United States. Beginning during the colonial period, this clandestine resistance movement reached its peak in the 19th century, helping hundreds of thousands of African-Americans flee servitude in the South and begin new lives in the North, and in Canada, Mexico, and the Caribbean.

Despite its historical significance, the Underground Railroad has not been officially recognized in any fashion. Consequently, in 1990, my distinguished former colleague, Senator Paul Simon, and former Congressman Pete Kostmayer of Pennsylvania, introduced legislation directing the National Park Service to explore and study options for commemorating the Underground Railroad. Congress passed that legislation later that year, and the National Park Service went to work gathering information on the routes and sites used by the Underground Railroad.

That study, completed in 1996, found that the Underground Railroad story was of national significance. The study documented over 380 sites, including 27 national park units, national historic landmarks, routes, privately owned buildings, and churches associated with this resistance movement. The study also found that many of these sites were in imminent danger of being lost or destroyed, and that despite a tremendous amount of interest in the Underground Railroad, little organized coordination and communication existed among interested individuals and organizations. The study reached a final recommendation that the U.S. Congress should authorize and fund a national initiative to support, preserve, and commemorate the sites and routes associated with the Underground Railroad.

Mr. President, the bill I am introducing today, along with my distinguished colleague from Ohio, Senator DEWINE, will enact many of the findings of that National Park Service study into law. Our bill, the National Underground Railroad Network to Freedom Act, will create within the National Park Service a nationwide network of historic buildings, routes, programs, projects, and museums that have certifiable thematic connections to the Underground Railroad. The bill will also allow the National Park Service to produce and disseminate educational and informational materials on the Underground Railroad, and enter into cooperative agreements with Federal agencies, State and local government, and historical societies to provide technical assistance and coordination among network participants. Participation in the network by private property owners is purely voluntary.

This bill does not create a new park unit in the traditional sense. In order to ensure the maximum safety and secrecy of its activities, the Underground Railroad was an amorphous and loosely organized system. No single site or route, therefore, completely characterizes the Underground Railroad, making it unfeasible that these sites could have boundaries and be operated as a traditional national park. Instead, it is the intent of this bill to create a network of cooperative partnerships, identified by an official or unifying symbol or device, at a limited annual operating cost.

Mr. President, we will never know how many individuals were freed from servitude, or how many Americans, black and white, women and men, mayors, ministers, businessmen, housewives, or former slaves endangered or sacrificed their lives in the defense of the belief that no American, and no human, should be bought, traded, or sold.

That's why I urge my colleagues to swiftly pass the Underground Railroad Network to Freedom Act. This bill grants Federal recognition to the Underground Railroad as a significant aspect of American history. This bill helps to preserve the structures and artifacts of an organized resistance movement for freedom. And finally, and most important, this bill commemorates those Americans whose efforts helped destroy the ugly legacy of slavery in this country.

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. 887

*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 ''National Underground Railroad Network to Freedom Act of 1997''.

**SEC. 2. FINDINGS AND PURPOSES.**

(a) FINDINGS.—Congress finds that—

(1) the Underground Railroad, which flourished from the end of the 18th century to the end of the Civil War, was 1 of the most significant expressions of the American civil rights movement during its evolution over more than 3 centuries;

(2) the Underground Railroad bridged the divides of race, religion, sectional differences, and nationality, spanned State lines and international borders, and joined the American ideals of liberty and freedom expressed in the Declaration of Independence and the Constitution to the extraordinary actions of ordinary men and women working in common purpose to free a people;

(3) pursuant to title VI of Public Law 101–628 (16 U.S.C. 1a–5 note; 104 Stat. 4495), the Underground Railroad Advisory Committee conducted a study of the appropriate means of establishing an enduring national commemorative Underground Railroad program of education, example, reflection, and reconciliation;

(4) the Underground Railroad Advisory Committee found that—

(A) although a few elements of the Underground Railroad story are represented in existing National Park Service units and other sites, many sites are in imminent danger of being lost or destroyed, and many important resource types are not adequately represented and protected;

(B) there are many important sites that have high potential for preservation and visitor use in 29 States, the District of Columbia, and the Virgin Islands;

(C) no single site or route completely reflects and characterizes the Underground

Railroad, since the Underground Railroad's story and associated resources involve networks and regions of the country rather than individual sites and trails; and

(D) establishment of a variety of partnerships between the Federal Government and other levels of government and the private sector would be most appropriate for the protection and interpretation of the Underground Railroad;

(5) the National Park Service can play a vital role in facilitating the national commemoration of the Underground Railroad; and

(6) the story and significance of the Underground Railroad can best engage the American people through a national program of the National Park Service that links historic buildings, structures, and sites, routes, geographic areas, and corridors, interpretive centers, museums, and institutions, and programs, activities, community projects, exhibits, and multimedia materials, in a manner that is both unified and flexible.

(b) PURPOSES.—The purposes of this Act are—

(1) to recognize the importance of—

(A) the Underground Railroad;

(B) the sacrifices made by slaves who used the Underground Railroad in search of freedom from tyranny and oppression; and

(C) the sacrifices made by the people who helped those slaves; and

(2) to authorize the National Park Service to coordinate and facilitate—

(A) Federal and non-Federal activities to commemorate, honor, and interpret the history of the Underground Railroad;

(B) the Underground Railroad's significance as a crucial element in the evolution of the national civil rights movement; and

(C) the Underground Railroad's relevance in fostering a spirit of racial harmony and national reconciliation.

**SEC. 3. NATIONAL UNDERGROUND RAILROAD NETWORK TO FREEDOM PROGRAM.**

(a) IN GENERAL.—The Secretary of the Interior (referred to in this Act as the ''Secretary'') shall establish in the National Park Service a program to be known as the ''National Underground Railroad Network to Freedom'' (referred to in this Act as the ''National Network''). Under the program, the Secretary shall—

(1) produce and disseminate appropriate educational materials, such as handbooks, maps, interpretive guides, or electronic information;

(2) enter into appropriate cooperative agreements and memoranda of understanding to provide technical assistance under subsection (c); and

(3) create and adopt an official and uniform symbol or device for the National Network and issue regulations for use of the symbol or device.

(b) ELEMENTS.—The National Network shall include—

(1) any unit or program of the National Park Service determined by the Secretary to pertain to the Underground Railroad;

(2) any other Federal, State, local, or privately owned property pertaining to the Underground Railroad that has a verifiable connection to the Underground Railroad and that is included on, or determined by the Secretary to be eligible for inclusion on, the National Register of Historic Places;

(3) any other governmental or nongovernmental facility or program of an educational, research, or interpretive nature that is directly related to the Underground Railroad.

(c) COOPERATIVE AGREEMENTS AND MEMORANDA OF UNDERSTANDING.—To achieve the purposes of this Act and to ensure effective coordination of the Federal and non-Federal elements of the National Network referred to in subsection (b) with National Park Service units and programs, the Secretary may enter into a cooperative agreement or memorandum of understanding with, and provide technical assistance to—

(1) the head of another Federal agency, a State, a locality, a regional governmental body, or a private entity; or

(2) in cooperation with the Secretary of State, the Government of Canada, Mexico, or any appropriate country in the Caribbean.

(d) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this Act—

(1) $500,000 for fiscal year 1998; and

(2) $1,000,000 for each fiscal year thereafter.

## ADDITIONAL COSPONSORS

S. 20

At the request of Mr. DASCHLE, the name of the Senator from Illinois [Mr. DURBIN] was added as a cosponsor of S. 20, a bill to amend the Internal Revenue Code of 1986 to increase the rate and spread the benefits of economic growth, and for other purposes.

S. 28

At the request of Mr. THURMOND, the name of the Senator from Indiana [Mr. COATS] was added as a cosponsor of S. 28, a bill to amend title 17, United States Code, with respect to certain exemptions from copyright, and for other purposes.

S. 387

At the request of Mr. HATCH, the name of the Senator from Colorado [Mr. CAMPBELL] was added as a cosponsor of S. 387, a bill to amend the Internal Revenue Code of 1986 to provide equity to exports of software.

S. 411

At the request of Mrs. HUTCHISON, the name of the Senator from Connecticut [Mr. LIEBERMAN] was added as a cosponsor of S. 411, a bill to amend the Internal Revenue Code of 1986 to provide a tax credit for investment necessary to revitalize communities within the United States, and for other purposes.

S. 419

At the request of Mr. BOND, the name of the Senator from Massachusetts [Mr. KENNEDY] was added as a cosponsor of S. 419, a bill to provide surveillance, research, and services aimed at prevention of birth defects, and for other purposes.

S. 496

At the request of Mr. SPECTER, his name was added as a cosponsor of S. 496, a bill to amend the Internal Revenue Code of 1986 to provide a credit against income tax to individuals who rehabilitate historic homes or who are the first purchasers of rehabilitated historic homes for use as a principal residence.

S. 555

At the request of Mr. ALLARD, the names of the Senator from South Carolina [Mr. HOLLINGS], the Senator from Oklahoma [Mr. INHOFE], the Senator from North Carolina [Mr. FAIRCLOTH], the Senator from Kansas [Mr. ROBERTS], and the Senator from Colorado [Mr. CAMPBELL] were added as cosponsors of S. 555, a bill to amend the Solid Waste Disposal Act to require that at least 85 percent of funds appropriated to the Environmental Protection Agency from the Leaking Underground Storage Tank Trust Fund be distributed to States to carry out cooperative agreements for undertaking corrective action and for enforcement of subtitle I of that Act.

S. 561

At the request of Mr. SHELBY, the name of the Senator from Alaska [Mr. STEVENS] was added as a cosponsor of S. 561, a bill to require States receiving prison construction grants to implement requirements for inmates to perform work and engage in educational activities, to eliminate certain sentencing inequities for drug offenders, and for other purposes.

S. 622

At the request of Mr. HATCH, the name of the Senator from South Dakota [Mr. JOHNSON] was added as a cosponsor of S. 622, a bill to amend the Internal Revenue Code of 1986 to modify the application of the pension nondiscrimination rules to governmental plans.

S. 627

At the request of Mr. JEFFORDS, the name of the Senator from California [Mrs. BOXER] was added as a cosponsor of S. 627, a bill to reauthorize the African Elephant Conservation Act.

S. 720

At the request of Mr. GRASSLEY, the names of the Senator from California [Mrs. FEINSTEIN] and the Senator from Virginia [Mr. ROBB] were added as cosponsors of S. 720, a bill to amend titles XVIII and XIX of the Social Security Act to expand and make permanent the availablity of cost-effective, comprehensive acute and long-term care services to frail elderly persons through Programs of All-inclusive Care for the Elderly (PACE) under the medicare and medicaid programs.

S. 725

At the request of Mr. CAMPBELL, the name of the Senator from Colorado [Mr. ALLARD] was added as a cosponsor of S. 725, a bill to direct the Secretary of the Interior to convey the Collbran Reclamation Project to the Ute Water Conservancy District and the Collbran Conservancy District.

S. 757

At the request of Mr. GRASSLEY, the names of the Senator from Nebraska [Mr. KERREY], the Senator from Nebraska [Mr. HAGEL], the Senator from Arkansas [Mr. HUTCHINSON], the Senator from Virginia [Mr. ROBB], the Senator from Maine [Ms. COLLINS], and the Senator from Mississippi [Mr. COCHRAN] were added as cosponsors of S. 757, a bill to amend the Employee Retirement Savings Act of 1974 to promote retirement income savings through the establishment of an outreach program in the Department of Labor and periodic National Summits on Retirement Savings.