employment discrimination based on race, color, religion, sex, national origin, age, or disability, and for other purposes.

S. 294

At the request of Mrs. HUTCHISON, the name of the Senator from New Jersey [Mr. TORRICELLI] was added as a cosponsor of S. 294, a bill to amend chapter 51 of title 18, United States Code, to establish Federal penalties for the killing or attempted killing of a law enforcement officer of the District of Columbia, and for other purposes.

S. 328

At the request of Mr. HUTCHINSON, the name of the Senator from Missouri [Mr. BOND] was added as a cosponsor of S. 328, a bill to amend the National Labor Relations Act to protect employer rights, and for other purposes.

S. 362

At the request of Mr. LEAHY, the name of the Senator from Louisiana [Ms. LANDRIEU] was added as a cosponsor of S. 362, a bill to deter and punish serious gang and violent crime, promote accountability in the juvenile justice system, prevent juvenile and youth crime, and for other purposes.

S. 385

At the request of Mr. CONRAD, the name of the Senator from Kentucky [Mr. FORD] was added as a cosponsor of S. 385, a bill to provide reimbursement under the medicare program for telehealth services, and for other purposes.

S. 397

At the request of Ms. MIKULSKI, the name of the Senator from Massachusetts [Mr. KENNEDY] was added as a cosponsor of S. 397, a bill to amend chapters 83 and 84 of title 5, United States Code, to extend the civil service retirement provisions of such chapter which are applicable to law enforcement officers, to inspectors of the Immigration and Naturalization Service, inspectors and canine enforcement officers of the United States Customs Service, and revenue officers of the Internal Revenue Service.

S. 460

At the request of Mr. BOND, the name of the Senator from Idaho [Mr. KEMPTHORNE] was added as a cosponsor of S. 460, a bill to amend the Internal Revenue Code of 1986 to increase the deduction for health insurance costs of self-employed individuals, to provide clarification for the deductibility of expenses incurred by a taxpayer in connection with the business use of the home, to clarify the standards used for determining that certain individuals are not employees, and for other purposes.

S. 587

At the request of Mr. CAMPBELL, the name of the Senator from Colorado [Mr. ALLARD] was added as a cosponsor of S. 587, a bill to require the Secretary of the Interior to exchange certain lands located in Hinsdale County, Colorado.

S. 589

At the request of Mr. CAMPBELL, the name of the Senator from Colorado [Mr. ALLARD] was added as a cosponsor of S. 589, a bill to provide for a boundary adjustment and land conveyance involving the Raggeds Wilderness, White River National Forest, Colorado, to correct the effects of earlier erroneous land surveys.

S. 590

At the request of Mr. CAMPBELL, the name of the Senator from Colorado [Mr. ALLARD] was added as a cosponsor of S. 590, a bill to provide for a land exchange involving certain land within the Routt National Forest in the State of Colorado.

S. 591

At the request of Mr. CAMPBELL, the name of the Senator from Colorado [Mr. ALLARD] was added as a cosponsor of S. 591, a bill to transfer the Dillon Ranger District in the Arapaho National Forest to the White River National Forest in the State of Colorado.

S. 597

At the request of Mr. BINGAMAN, the name of the Senator from South Dakota [Mr. JOHNSON] was added as a cosponsor of S. 597, a bill to amend title XVIII of the Social Security Act to provide for coverage under part B of the medicare program of medical nutrition therapy services furnished by registered dietitians and nutrition professionals.

S. 606

At the request of Mr. HUTCHINSON, the name of the Senator from Missouri [Mr. ASHCROFT] was added as a cosponsor of S. 606, a bill to prohibit discrimination in contracting on federally funded projects on the basis of certain labor policies of potential contractors.

S. 677

At the request of Ms. MOSELEY-BRAUN, the name of the Senator from Illinois [Mr. DURBIN] was added as a cosponsor of S. 677, a bill to amend the Immigration and Nationality Act of 1994, to provide the descendants of the children of female United States citizens born abroad before May 24, 1934, with the same rights to United States citizenship at birth as the descendants of children born of male citizens abroad.

S. 770

At the request of Mr. NICKLES, the name of the Senator from Wyoming [Mr. ENZI] was added as a cosponsor of S. 770, a bill to encourage production of oil and gas within the United States by providing tax incentives, and for other purposes.

S. 810

At the request of Mr. ABRAHAM, the name of the Senator from Georgia [Mr. COVERDELL] was added as a cosponsor of S. 810, a bill to impose certain sanctions on the People's Republic of China, and for other purposes.

S. 884

At the request of Mr. CLELAND, the name of the Senator from Georgia [Mr. COVERDELL] was added as a cosponsor of 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.

S. 885

At the request of Mr. D'AMATO, the name of the Senator from Vermont [Mr. JEFFORDS] was added as a cosponsor of 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.

S. 888

At the request of Mr. DOMENICI, the names of the Senator from Tennessee [Mr. FRIST], and the Senator from North Carolina [Mr. FAIRCLOTH] were added as cosponsors of S. 888, a bill to amend the Small Business Act to assist the development of small business concerns owned and controlled by women, and for other purposes.

S. 912

At the request of Mr. BOND, the name of the Senator from South Carolina [Mr. HOLLINGS] was added as a cosponsor of S. 912, a bill to provide for certain military retirees and dependents a special medicare part B enrollment period during which the late enrollment penalty is waived and a special medigap open period during which no under-writing is permitted.

AMENDMENTS SUBMITTED

THE BALANCED BUDGET ACT OF 1997

ROTH (AND MOYNIHAN) AMENDMENT NO. 431

Mr. ROTH (for himself and Mr. MOYNIHAN) proposed an amendment to the bill (S. 947) to provide for reconciliation pursuant to section 104(a) of the concurrent resolution on the budget for fiscal year 1998; as follows:

On page 169, between lines 24 and 25, insert:

''(5) SATISFACTION OF REQUIREMENT.—

''(A) IN GENERAL.—A MedicarePlus plan offered by a MedicarePlus organization satisfies paragraph (1)(A), with respect to benefits for items and services furnished other than through a provider that has a contract with the organization offering the plan, if the plan provides (in addition to any cost sharing provided for under the plan) for at least the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing permitted under such parts).

''(B) EXCEPTION FOR MSA PLANS AND UNRESTRICTED FEE-FOR-SERVICE PLANS.—Subparagraph (A) shall not apply to an MSA plan or an unrestricted fee-for-service plan.''

On page 188, between lines 18 and 19, insert:

''(k) TREATMENT OF SERVICES FURNISHED BY CERTAIN PROVIDERS.—

''(1) IN GENERAL.—A physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a MedicarePlus organization shall accept as payment in full for covered services under this title that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other

provision of law that applies to such a payment with respect to an individual entitled to benefits under this title (but not enrolled with a MedicarePlus organization under this part) also applies with respect to an individual so enrolled.

''(2) EXCEPTION FOR MSA PLANS AND UNRESTRICTED FEE-FOR-SERVICE PLANS.—Paragraph (1) shall not apply to an MSA plan or an unrestricted fee-for-service plan.''

On page 203, beginning with line 13, strike all through page 204, line 11, and insert:

''(8) ADJUSTMENTS TO MINIMUM AMOUNTS AND MINIMUM PERCENTAGE INCREASES.—After computing all amounts under this subsection (without regard to this paragraph) for any year, the Secretary shall—

''(A) redetermine the amount under paragraph (1)(C) for such year by substituting '100 percent' for '101 percent' each place it appears, and

''(B) increase the minimum amount under paragraph (1)(B) to an amount equal to the lesser of—

''(i) the amount the Secretary estimates will result in increased payments under such paragraph equal to the decrease in payments by reason of the redetermination under subparagraph (A), or

''(ii) an amount equal to 85 percent of the annual national Medicare Choice capitation rate determined under paragraph (4).''

On page 222, strike lines 18 through 21 and insert:

''(II) the date on which the Secretary determines that the State has in effect solvency standards identical to the standards established under section 1856(a).''

On page 226, beginning with line 17, strike all through page 227, line 3, and insert:

''(d) CERTIFICATION OF PROVISION AGAINST RISK OF INSOLVENCY FOR PSOS.—

''(1) IN GENERAL.—Each Medicare Choice organization that is a provider-sponsored organization with a waiver in effect under subsection (a)(2) shall meet the standards established under section 1856(a) with respect to the financial solvency and capital adequacy of the organization.''

On page 309, line 17, insert '', including the extent to which current medicare update indexes do not accurately reflect inflation'' after ''1395t)''.

On page 309, line 22, beginning with '', including'' strike all through ''inflation'' on line 24.

On page 335, beginning with line 24, strike through page 336, line 2, and insert:

(3) NONELDERLY MEDICARE BENEFICIARIES.—

(A) IN GENERAL.—The amendment made by subsection (c) shall apply to policies issued on and after July 1, 1998.

(B) TRANSITION RULE.—In the case of an individual who first became eligible for benefits under part A of title XVIII of the Social Security Act pursuant to section 226(b) of such Act and enrolled for benefits under part B of such title before July 1, 1998, the 6-month period described in section 1882(s)(2)(A) of such Act shall begin on July 1, 1998. Before July 1, 1998, the Secretary of Health and Human Services shall notify any individual described in the previous sentence of their rights in connection with medicare supplemental policies under section 1882 of such Act, by reason of the amendment made by subsection (c).

On page 340, between lines 21 and 22, insert:

PART I—IN GENERAL

On page 341, line 11, strike ''and''.

On page 341, between lines 11 and 12, insert:

''(3) applying the information and quality programs under part II; and''

On page 341, line 12, strike ''(3)'' and insert ''(4)''.

On page 357, between lines 2 and 3, insert:

PART II—INFORMATION AND QUALITY STANDARDS

Subpart A—Information

SEC. 5044. INFORMATION REQUIREMENTS.

(a) IN GENERAL.—The Secretary shall provide that in the case of a demonstration plan conducted under part I, the information and comparative reports described in this section shall be used in lieu of that provided under part C of title XVIII of the Social Security Act.

(b) SECRETARY'S MATERIALS; CONTENTS.—The notice and informational materials mailed by the Secretary under this part shall be written and formatted in the most easily understandable manner possible, and shall include, at a minimum, the following:

(1) GENERAL INFORMATION.—General information with respect to coverage under this part during the next calendar year, including—

(A) the part B premium rates that will be charged for part B coverage, and a statement of the fact that enrollees in demonstration plans are not required to pay such premium,

(B) the deductible, copayment, and coinsurance amounts for coverage under the traditional medicare program,

(C) a description of the coverage under the traditional medicare program and any changes in coverage under the program from the prior year,

(D) a description of the individual's medicare payment area, and the standardized medicare payment amount available with respect to such individual,

(E) information and instructions on how to enroll in a demonstration plan,

(F) the right of each demonstration plan sponsor by law to terminate or refuse to renew its contract and the effect the termination or nonrenewal of its contract may have on individuals enrolled with the demonstration plan under this part,

(G) appeal rights of enrollees, including the right to address grievances to the Secretary or the applicable external review entity, and

(H) the benefits offered by plans in basic benefit plans under section 1895H(a), and how those benefits differ from the benefits offered under parts A and B.

(2) COMPARATIVE REPORT.—A copy of the most recent comparative report (as established by the Secretary under subsection (c)) for the demonstration plans in the individual's medicare payment area.

(c) COMPARATIVE REPORT.—

(1) IN GENERAL.—The Secretary shall develop an understandable standardized comparative report on the demonstration plans offered by demonstration plan sponsors, that will assist demonstration eligible individuals in their decisionmaking regarding medical care and treatment by allowing such individuals to compare the demonstration plans that such individuals are eligible to enroll with. In developing such report the Secretary shall consult with outside organizations, including groups representing the elderly, demonstration plan sponsors, providers of services, and physicians and other health care professionals, in order to assist the Secretary in developing the report.

(2) REPORT.—The report described in paragraph (1) shall include a comparison for each demonstration plan of—

(A) the plan's medicare service area;

(B) coverage by the plan of emergency services and urgently needed care;

(C) the amount of any deductibles, coinsurance, or any monetary limits on benefits;

(D) the number of individuals who disenrolled from the plan within 3 months of enrollment during the previous fiscal year (excluding individuals whose disenrollment was due to death or moving outside of the plan's service area) stated as percentages of the total number of individuals in the plan;

(E) process, outcome, and enrollee satisfaction measures, as recommended by the Quality Advisory Institute as established under section 5044B;

(F) information on access and quality of services obtained from the analysis described in section 5044B;

(G) the procedures used by the plan to control utilization of services and expenditures, including any financial incentives;

(H) the number of applications during the previous fiscal year requesting that the plan cover or pay for certain medical services that were denied by the plan (and the number of such denials that were subsequently reversed by the plan), stated as a percentage of the total number of applications during such period requesting that the plan cover such services;

(I) the number of times during the previous fiscal year (after an appeal was filed with the Secretary) that the Secretary upheld or reversed a denial of a request that the plan cover certain medical services;

(J) the restrictions (if any) on payment for services provided outside the plan's health care provider network;

(K) the process by which services may be obtained through the plan's health care provider network;

(L) coverage for out-of-area services;

(M) any exclusions in the types of health care providers participating in the plan's health care provider network;

(N) whether the plan is, or has within the past two years been, out-of-compliance with any requirements of this part (as determined by the Secretary);

(O) the plan's premium price for the basic benefit plan submitted under part C of title XVIII of the Social Security Act, an indication of the difference between such premium price and the standardized medicare payment amount, and the portion of the premium an individual must pay out of pocket;

(P) whether the plan offers any of the optional supplemental benefit plans, and if so, the plan's premium price for such benefits; and

(Q) any additional information that the Secretary determines would be helpful for demonstration eligible individuals to compare the demonstration plans that such individuals are eligible to enroll with.

(3) ADDITIONAL INFORMATION.—The comparative report shall also include—

(A) a comparison of each demonstration plan to the fee-for-service program under parts A and B of title XVIII of the Social Security Act;

(B) an explanation of medicare supplemental policies under section 1882 of such Act and how to obtain specific information regarding such policies; and

(C) a phone number for each demonstration plan that will enable demonstration eligible individuals to call to receive a printed listing of all health care providers participating in the plan's health care provider network.

(4) UPDATE.—The Secretary shall, not less than annually, update each comparative report.

(5) DEFINITIONS.—In this subsection—

(A) HEALTH CARE PROVIDER.—The term ''health care provider'' means anyone licensed under State law to provide health care services under part A or B.

(B) NETWORK.—The term ''network'' means, with respect to a demonstration plan sponsor, the health care providers who have entered into a contract or agreement with the plan sponsor under which such providers are obligated to provide items, treatment, and services under this section to individuals enrolled with the plan sponsor under this part.

(C) OUT-OF-NETWORK.—The term ''out-of-network'' means services provided by health

care providers who have not entered into a contract agreement with the demonstration plan sponsor under which such providers are obligated to provide items, treatment, and services under this section to individuals enrolled with the plan sponsor under this part.

(6) COST SHARING.—Each demonstration plan sponsor shall pay to the Secretary its pro rata share of the estimated costs incurred by the Secretary in carrying out the requirements of this section and section 4360 of the Omnibus Reconciliation Act of 1990. There are hereby appropriated to the Secretary the amount of the payments under this paragraph for purposes of defraying the cost described in the preceding sentence. Such amounts shall remain available until expended.

Subpart B—Quality in Demonstration Plans

SEC. 5044A. DEFINITIONS.

In this subpart:

(1) COMPARATIVE REPORT.—The term ''comparative report'' means the comparative report developed under section 5044.

(2) DIRECTOR.—The term ''Director'' means the Director of the Office of Competition within the Department of Health and Human Services as established under part I.

(3) MEDICARE PROGRAM.—The term ''medicare program'' means the program of health care benefits provided under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(4) DEMONSTRATION PLAN.—The term ''demonstration plan'' means a plan established under part I.

(5) DEMONSTRATION PLAN SPONSOR.—The term ''demonstration plan sponsor'' means a sponsor of a demonstration plan.

SEC. 5044B. QUALITY ADVISORY INSTITUTE.

(a) ESTABLISHMENT.—There is established an Institute to be known as the ''Quality Advisory Institute'' (in this subpart referred to as the ''Institute'') to make recommendations to the Director concerning licensing and certification criteria and comparative measurement methods under this subpart.

(b) MEMBERSHIP.—

(1) COMPOSITION.—The Institute shall be composed of 5 members to be appointed by the Director from among individuals who have demonstrable expertise in—

(A) health care quality measurement;

(B) health plan certification criteria setting;

(C) the analysis of information that is useful to consumers in making choices regarding health coverage options, health plans, health care providers, and decisions regarding health treatments; and

(D) the analysis of health plan operations.

(2) TERMS AND VACANCIES.—The members of the Institute shall be appointed for 5-year terms with the terms of the initial members staggered as determined appropriate by the Director. Vacancies shall be filled in a manner provided for by the Director.

(c) DUTIES.—The Institute shall—

(1) not later than 1 year after the date on which all members of the Institute are appointed under subsection (b)(2), provide advice to the Director concerning the initial set of criteria for the certification of demonstration plans;

(2) analyze the use of the criteria for the certification of demonstration plans implemented by the Director under this subpart and recommend modifications in such criteria as needed;

(3) analyze the use of the comparative measurements implemented by the Director in developing comparative reports and recommend modifications in such measurements as needed;

(4) perform, or enter into contracts with other entities for the performance of, an analysis of access to services and clinical outcomes based on patient encounter data;

(5) enter into contracts with other entities for the development of such criteria and measurements and to otherwise carry out its duties under this section; and

(6) carry out any other activities determined appropriate by the Institute to carry out its duties under this section.

The analysis described in paragraph (4) should focus on conditions and procedures of significance to beneficiaries under the medicare program, as determined by the Institute, and should be designed, and the results summarized, in a manner that facilitates comparisons across health plans.

SEC. 5044C. DUTIES OF DIRECTOR.

(a) IN GENERAL.—The Director shall—

(1) adopt, adapt, or develop criteria in accordance with sections 5044F through 5044I to be used in the licensing of certifying entities and in the certification of demonstration plans, including any minimum criteria needed for the operation of demonstration plans during the transition period described in section 5044F(c);

(2) issue licenses to certifying entities that meet the criteria developed under paragraph (1) for the purpose of enabling such entities to certify demonstration plans in accordance with this subpart;

(3) develop comparative health care measures in addition to those implemented by the Director in developing comparative reports in order to guide consumer choice under the medicare program and to improve the delivery of quality health care under such program;

(4) develop procedures, consistent with section 5044A, for the dissemination of certification and comparative quality information provided to the Director;

(5) contract with an independent entity for the conduct of audits concerning certification and quality measurement and require that as part of the certification process performed by licensed certification entities that there include an onsite evaluation, using performance-based standards, of the providers of items and services under a demonstration plan;

(6) at least quarterly, meet jointly with the Agency for Health Care Policy and Research to review innovative health outcomes measures, new measurement processes, and other matters determined appropriate by the Director;

(7) at least annually, meet with the Institute concerning certification criteria;

(8) not later than January 1, 1999, and each January 1 thereafter, prepare and submit to demonstration plan sponsors and to Congress, a report concerning the activities of the Director for the previous year;

(9) advise the President and Congress concerning health insurance and health care provided under demonstration plans and make recommendations concerning measures that may be implemented to protect the health of all enrollees in demonstration plans; and

(10) carry out other activities determined appropriate by the Director.

(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to limit the authority of the Director or the Secretary of Health and Human Services with respect to requirements other than those applied under this subpart with respect to demonstration plans.

SEC. 5044D. COMPLIANCE.

(a) IN GENERAL.—Not later than January 1, 1999, the Director shall ensure that a demonstration plan may not be offered unless it has been certified in accordance with this subpart.

(b) CONTRACTS OR REIMBURSEMENTS.—In carrying out subsection (a), the Director—

(1) may not enter into a contract with a demonstration plan sponsor for the provision of a demonstration plan unless the demonstration plan is certified in accordance with this subpart;

(2) may not reimburse a demonstration plan sponsor for items and services provided under a demonstration plan unless the demonstration plan is certified in accordance with this subpart; and

(3) shall, after providing notice to the demonstration plan sponsor operating a demonstration plan and an opportunity for such demonstration plan to be certified, and in accordance with any applicable grievance and appeals procedures under section 5044I, terminate any contract with a demonstration plan sponsor for the operation of a demonstration plan if such demonstration plan is not certified in accordance with this subpart.

SEC. 5044E. PAYMENTS FOR VALUE.

(a) ESTABLISHMENT OF PROGRAM.—The Director shall establish a program under which payments are made to various demonstration plans to reward such plans for meeting or exceeding quality targets.

(b) PERFORMANCE MEASURES.—In carrying out the program under subsection (a), the Director shall establish broad categories of quality targets and performance measures. Such targets and measures shall be designed to permit the Director to determine whether a demonstration plan is being operated in a manner consistent with this subpart.

(c) USE OF FUNDS.—

(1) IN GENERAL.—The Secretary shall withhold 0.50 percent from any payment that a demonstration plan sponsor receives with respect to an individual enrolled with such plan under part I.

(2) PAYMENTS.—The Director shall use amounts collected under paragraph (1) to make annual payments to those demonstration plans that have been determined by the Director to meet or exceed the quality targets and performance measures established under subsection (b). Any amounts collected under such paragraph for a fiscal year and remaining available after payments are made under subsection (d), shall be used for deficit reduction.

(d) AMOUNT OF PAYMENT.—

(1) FORMULA.—The amount of any payment made to a demonstration plan under this section shall be determined in accordance with a formula to be developed by the Director. The formula shall ensure that a payment made to a demonstration plan under this section be in an amount equal to—

(A) with respect to a demonstration plan that is determined to be in the first quintile, 1 percent of the amount allocated to the plan under this subpart;

(B) with respect to a demonstration plan that is determined to be in the second quintile, 0.75 percent of the amount allocated to the plan under this subpart;

(C) with respect to a demonstration plan that is determined to be in the third quintile, 0.50 percent of the amount allocated by the plan under this subpart; and

(D) with respect to a demonstration plan that is determined to be in the fourth quintile, 0.25 percent of the amount allocated by the plan under this subpart.

(2) NO PAYMENT.—A demonstration plan that is determined by the Director to be in the fifth quintile shall not be eligible to receive a payment under this section.

(3) DETERMINATION OF QUINTILES.—Not later than April 30 of each calendar year, the Director shall rank each demonstration plan based on the performance of the plan during the preceding year as determined using the quality targets and performance measures established under subsection (b). Such rankings shall be divided into quintiles with the first quintile containing the highest ranking plans and the fifth quintile containing the lowest ranking plans. Each such

quintile shall contain plans that in the aggregate cover an equal number of beneficiaries as compared to another quintile.

SEC. 5044F. CERTIFICATION REQUIREMENT.

(a) IN GENERAL.—To be eligible to enter into a contract with the Director to enroll individuals in a demonstration plan, a demonstration plan sponsor shall participate in the certification process and have the demonstration plans offered by such plan sponsor certified in accordance with this subpart.

(b) EFFECT OF MERGERS OR PURCHASE.—

(1) CERTIFIED PLANS.—Where 2 or more demonstration plan sponsors offering certified demonstration plans are merged or where 1 such plan sponsor is purchased by another plan sponsor, the resulting plan sponsor may continue to operate and enroll individuals for coverage under the demonstration plan as if the demonstration plan involved were certified. The certification of any resulting demonstration plan shall be reviewed by the applicable certifying entity to ensure the continued compliance of the contract with the certification criteria.

(2) NONCERTIFIED PLANS.—The certification of a demonstration plan shall be terminated upon the merger of the demonstration plan sponsor involved or the purchase of the plan sponsor by another entity that does not offer any certified demonstration plans. Any demonstration plans offered through the resulting plan sponsor may reapply for certification after the completion of the merger or purchase.

(c) TRANSITION FOR NEW PLANS.—

(1) IN GENERAL.—A demonstration plan that has not provided health insurance coverage to individuals prior to the effective date of this Act shall be permitted to contract with the Director and operate and enroll individuals under a demonstration plan without being certified for the 2-year period beginning on the date on which such demonstration plan sponsor enrolls the first individual in the demonstration plan. Such demonstration plan must be certified in order to continue to provide coverage under the contract after such period.

(2) LIMITATION.—A new demonstration plan described in paragraph (1) shall, during the period referred to in paragraph (1) prior to certification, comply with the minimum criteria developed by the Director under section 5044F(a)(1).

SEC. 5044G. LICENSING OF CERTIFICATION ENTITIES.

(a) IN GENERAL.—The Director shall develop procedures for the licensing of entities to certify demonstration plans under this subpart.

(b) REQUIREMENTS.—The procedures developed under subsection (a) shall ensure that—

(1) to be licensed under this section a certification entity shall apply the requirements of this subpart to demonstration plans seeking certification;

(2) a certification entity has procedures in place to suspend or revoke the certification of a demonstration plan that is failing to comply with the certification requirements; and

(3) the Director will give priority to licensing entities that are accrediting health plans that contract with the Director on the date of enactment of this Act.

SEC. 5044H. CERTIFICATION CRITERIA.

(a) ESTABLISHMENT.—The Director shall establish minimum criteria under this section to be used by licensed certifying entities in the certification of demonstration plans under this subpart.

(b) REQUIREMENTS.—Criteria established by the Director under subsection (a) shall require that, in order to be certified, a demonstration plan shall comply at a minimum with the following:

(1) QUALITY IMPROVEMENT PLAN.—The demonstration plan shall implement a total quality improvement plan that is designed to improve the clinical and administrative processes of the demonstration plan on an ongoing basis and demonstrate that improvements in the quality of items and services provided under the demonstration plan have occurred as a result of such improvement plan.

(2) PROVIDER CREDENTIALS.—The demonstration plan shall compile and annually provide to the licensed certifying entity documentation concerning the credentials of the hospitals, physicians, and other health care professionals reimbursed under the demonstration plan.

(3) COMPARATIVE INFORMATION.—The demonstration plan shall compile and provide, as requested by the Secretary of Health and Human Services, to the such Secretary the information necessary to develop a comparative report.

(4) ENCOUNTER DATA.—The demonstration plan shall maintain patient encounter data in accordance with standards established by the Institute, and shall provide these data, as requested by the Institute, to the Institute in support of conducting the analysis described in section 5044B(c)(4).

(5) OTHER REQUIREMENTS.—The demonstration plan shall comply with other requirements authorized under this subpart and implemented by the Director.

SEC. 5044I. GRIEVANCE AND APPEALS.

The Director shall develop grievance and appeals procedures under which a demonstration plan that is denied certification under this subpart may appeal such denial to the Director.

On page 434, line 17, insert ''county in a'' after ''residing in a''.

On page 434, line 21, insert ''or a rural county that is not adjacent to a Metropolitan Statistical Area'' after ''254e(a)(1)(A))''.

On page 515, strike line 5 through 7, and insert the following:

SEC. 5331. EXTENSION OF COST LIMITS.

On page 515, line 14, beginning with '', increased by'' strike all through ''data'' on line 18.

On page 519, line 7, strike ''October'' and insert ''July''.

On page 527, lines 22 and 23, strike '', PERCENTAGE, AND HISTORICAL TREND FACTOR'' and insert '' AND PERCENTAGE''.

On page 578, line 20, insert ''V66.2,'' after ''V66.1,''.

On page 636, strike lines 1 and 2, and insert:

SEC. 5505. IMPLEMENTATION OF RESOURCE-BASED METHODOLOGIES.

On page 636, lines 18 through 20, strike ''primary care services provided in an office setting'' and insert ''office visit procedure codes''.

On page 637, beginning with line 19, strike all through page 638, line 14, and insert:

(b) DELAY OF IMPLEMENTATION TO 1999; PHASEIN OF IMPLEMENTATION.—Section 1848(c)(2) (42 U.S.C. 1395w–4(c)(2)), as amended by subsection (a), is amended—

(1) in subparagraph (C)(ii)—

(A) by striking ''1998'' each place it appears and inserting ''1999'', and

(B) by inserting '', to the extent provided under subparagraph (H),'' after ''based'' in the matter following subclause (II), and

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

''(H) 3-YEAR ADDITIONAL PHASEIN OF RESOURCE-BASED PRACTICE EXPENSE UNITS.—Notwithstanding subparagraph (C)(ii), the Secretary shall implement the resource-based practice expense unit methodology described in such subparagraph ratably over the 3-year period beginning with 1999 such that such methodology is fully implemented for 2001 and succeeding years.''.

On page 640, between lines 12 and 13, insert:

(e) APPLICATION OF RESOURCE-BASED METHODOLOGY TO MALPRACTICE RELATIVE VALUE UNITS.—Section 1848(c)(2)(C)(iii) (42 U.S.C. 1395w–4(c)(2)(C)(iii)) is amended—

(1) by inserting ''for years before 1999'' before ''equal'', and

(2) by striking the period at the end and inserting a comma and by adding at the end the following flush matter:

''and for years beginning with 1999 based on the malpractice expense resources involved in furnishing the service''.

On page 640, line 13, strike lines 13 through 15, and insert:

(f) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by this section shall apply to years beginning on and after January 1, 1998.

(2) MALPRACTICE.—The amendments made by subsection (e) shall apply to years beginning on and after January 1, 1999.

On page 647, beginning with line 6, strike all through page 653, line 19.

On page 668, beginning with line 24, strike all through page 669, line 3, and insert:

''(2)(A) In the case of a drug or biological for which payment was under this part on May 1, 1997, the amount determined under paragraph (1) for any drug or biological shall not exceed—

''(i) in the case of 1998, the amount of the payment under this part on May 1, 1997, and

''(ii) in the case of 1999 and each succeeding year, the amount determined under this subparagraph for the previous year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

''(B) In the case of a drug or biological not described in subparagraph (A), the amount determined under paragraph (1) for any year following the first year for which payment is made under this part for such drug or biological shall not exceed the amount payable under this part (after application of this subparagraph) for the previous year, increased by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.''

On page 669, line 9, strike the end quotation marks.

On page 669, between lines 9 and 10, insert:

''(4) The Secretary shall conduct such studies or surveys as are necessary to determine the average wholesale price (and such other price as the Secretary determines appropriate) of any drug or biological for purposes of paragraph (1). The Secretary shall, not later than 6 months after the date of the enactment of this subsection, report to the appropriate committees of Congress the results of the studies and surveys conducted under this paragraph.''

On page 669, line 12, strike ''1999'' and insert ''1998''.

On page 768, line 2, strike ''the provider'' and insert ''a provider or managed care entity (as defined in section 1950(a)(1)''.

On page 768, line 5, insert ''or managed care entity (as defined in section 1950(a)(1)'' after ''a provider''.

On page 771, line 9, insert '', and as approved by the Secretary'' after ''DSH''.

On page 771, line 14, strike ''services provided by'' and insert ''payments to''.

On page 771, line 18, insert '', and as approved by the Secretary'' after ''DSH''.

On page 773, line 9, insert '', and as approved by the Secretary'' after ''DSH''.

On page 773, line 17, strike ''services provided by'' and insert ''payments to''.

On page 773, line 22, insert '', and as approved by the Secretary'' after ''DSH''.

On page 775, line 2, strike ''services provided by'' and insert ''payments to''.

On page 775, line 6, insert ", and as approved by the Secretary" after "health DSH".

On page 777, line 13, strike "during fiscal year 1995" and insert "that are attributable to the fiscal year 1995 DSH allotment,".

On page 778, strike lines 14 through 18 and insert the following:

"(A) the total State DSH expenditures that are attributable to fiscal year 1995 for payments to institutions for mental diseases and other mental health facilities (based on reporting data specified by the State on HCFA Form 64 as mental health DSH, and as approved by the Secretary); or"

On page 778, line 24, strike "services provided by" and insert "payments to".

On page 779, line 3, insert ", and as approved by the Secretary" after "DSH".

On page 779, line 20, strike "services provided by" and insert "payments to".

On page 820, strike lines 21 through 24 and insert the following:

"(6) Any cost-sharing imposed under this subsection may not be included in determining the amount of the State percentage required for reimbursement of expenditures under a State plan under this title.

"(7) In this subsection, the term 'cost-sharing' includes copayments, deductibles, coinsurance, enrollment fees, premiums, and other charges for the provision of health care services.".

On page 846, line 2, strike "and".

On page 846, line 13, strike the period and insert "; and".

On page 846, between lines 13 and 14, insert the following:

"(C) satisfies the maintenance of effort requirement described in section 2105(c)(5).".

On page 849, strike lines 13 through 15, and insert the following:

"(B) for each of fiscal years 1999 and 2000, $3,200,000,000;

"(C) for fiscal year 2001, $3,600,000,000;

"(D) for fiscal year 2002, $3,500,000,000;"

On page 849, line 17, strike "(D)" and insert "(E)".

On page 856, line 11, insert "Federal and State incurred" after "the".

On page 856, line 18, insert "Federal and State incurred" after "the".

On page 856, line 20, insert "children covered at State option among" after "for".

On page 856, line 23, insert "Federal and State incurred" after "the".

On page 856, line 25, insert "children covered at State option among" after "for".

On page 860, strike lines 1 through 10 and insert the following:

"(c) PROHIBITION ON USE OF FUNDS.—No funds provided under this title may be used to provide health insurance coverage for—

"(1) families of State public employees; or

"(2) children who are committed to a penal institution."

On page 860, line 14, strike "title." and insert "title (as described in section 2101), and any health insurance coverage provided with such funds may include coverage of abortion only if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest."

On page 863, strike lines 1 through 23 and insert the following:

"(4) Section 1128 (relating to exclusion from individuals and entities from participation in State health care plans).

"(5) Section 1128A (relating to civil monetary penalties).

"(6) Section 1128B (relating to criminal penalties for certain additional charges).

"(7) Section 1132 (relating to periods within which claims must be filed).

"(8) Section 1902(a)(4)(C) (relating to conflict of interest standards).

"(9) Section 1903(i) (relating to limitations on payment).

"(10) Section 1903(w) (relating to limitations on provider taxes and donations).

"(11) Subparagraph (B) in the matter following section 1905(a)(25) (relating to the exclusion of care or services for any individual who has not attained 65 years of age and who is a patient in an institution for mental diseases from the definition of medical assistance).

"(12) Section 1921 (relating to state licensure authorities).

"(13) Sections 1902(a)(25), 1912(a)(1)(A), and 1903(o) (insofar as such sections relate to third party liability)."

Section 403(a)(5) of the Social Security Act, as added by section 5821, is amended—

(1) by striking "amounts reserved pursuant to subparagraphs (F) and (G)" each place it appears and inserting "amounts reserved pursuant to subparagraphs (E), (F), and (G)"; and

(2) in subparagraph (A)(i), by adding at the end the following flush sentence:

"The Secretary shall make pro rata reductions in the amounts otherwise payable to States under this paragraph as necessary so that grants under this paragraph do not exceed the available amount, as defined in clause (iv)."

On page 834, strike "and" on lines 6, 18 and 25, and strike lines 7 and 19.

On page 835, strike lines 1, 9 and 17, and strike "and" on lines 8 and 16.

KERREY AMENDMENT NO. 432

(Ordered to lie on the table.)

Mr. KERREY submitted an amendment intended to be proposed by him to the bill, S. 947, supra; as follows:

At the appropriate place in the bill insert the following:

SEC. . RESERVE PRICE.

In any auction conducted or supervised by the Federal Communications Commission (hereinafter the Commission) for any license, permit or right which has value, a reasonable reserve price shall be set by the Commission for each unit in the auction. The reserve price shall establish a minimum bid for the unit to be auctioned. If no bid is received above the reserve price for a unit, the unit shall be retained. The Commission shall reassess the reserve price for that unit and place the unit in the next scheduled or next appropriate auction.

THE CIVIL RIGHTS ACT OF 1997

MCCONNELL (AND OTHERS) AMENDMENT NO. 433

(Ordered referred to the Committee on the Judiciary.)

Mr. MCCONNELL (for himself, Mr. HATCH, Mr. KYL, and Mr. SESSIONS) submitted an amendment intended to be proposed by them to the bill (S. 952) to establish a Federal cause of action for discrimination and preferential treatment in Federal actions on the basis of race, color, national origin, or sex, and for other purposes; as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Civil Rights Act of 1997".

SEC. 2. FINDINGS AND PURPOSE.

(a) FINDINGS.—Congress finds that—

(1) the fifth and fourteenth amendments to the Constitution guarantee that all individuals are entitled to equal protection of the laws, regardless of race, color, national origin, or sex;

(2) the Supreme Court, in Adarand Constructors, Inc. v. Pena, 515 U.S. 200 (1995), recently affirmed that this guarantee of equality applies to Federal actions;

(3) the Federal Government currently conducts over 150 programs, including contracting programs, that grant preferences based on race, color, national origin, or sex; and

(4) the Federal Government also grants preferences in employment based on race, color, national origin, or sex.

(b) PURPOSE.—The purpose of this Act is to provide for equal protection of the laws and to prohibit discrimination and preferential treatment in the Federal Government on the basis of race, color, national origin, or sex.

SEC. 3. PROHIBITION AGAINST DISCRIMINATION AND PREFERENTIAL TREATMENT.

Notwithstanding any other provision of law, neither the Federal Government nor any officer, employee, or agent of the Federal Government shall—

(1) intentionally discriminate against, or grant a preference to, any person or group based in whole or in part on race, color, national origin, or sex, in connection with—

(A) a Federal contract or subcontract;

(B) Federal employment; or

(C) any other federally conducted program or activity; or

(2) require or encourage a Federal contractor or subcontractor, or the recipient of a license or financial assistance, to discriminate intentionally against, or grant a preference to, any person or group based in whole or in part on race, color, national origin, or sex, in connection with any Federal contract or subcontract or Federal license or financial assistance.

SEC. 4. AFFIRMATIVE ACTION PERMITTED.

This Act does not prohibit or limit any effort by the Federal Government or any officer, employee, or agent of the Federal Government—

(1) to encourage businesses owned by women and minorities to bid for Federal contracts or subcontracts, to recruit qualified women and minorities into an applicant pool for Federal employment, or to encourage participation by qualified women and minorities in any other federally conducted program or activity, if such recruitment or encouragement does not involve granting a preference, based in whole or in part on race, color, national origin, or sex, in selecting any person for the relevant employment, contract or subcontract, benefit, opportunity, or program; or

(2) to require or encourage any Federal contractor, subcontractor, or recipient of a Federal license or Federal financial assistance to recruit qualified women and minorities into an applicant pool for employment, or to encourage businesses owned by women and minorities to bid for Federal contracts or subcontracts, if such requirement or encouragement does not involve granting a preference, based in whole or in part on race, color, national origin, or sex, in selecting any individual for the relevant employment, contract or subcontract, benefit, opportunity, or program.

SEC. 5. CONSTRUCTION.

(a) HISTORICALLY BLACK COLLEGES AND UNIVERSITIES.—Nothing in this Act shall be construed to prohibit or limit any act that is designed to benefit an institution that is an historically Black college or university on the basis that the institution is an historically Black college or university.

(b) INDIAN TRIBES.—This Act does not prohibit any action taken—

(1) pursuant to a law enacted under the constitutional powers of Congress relating to the Indian tribes; or