United States of America to Brunei Darussalam.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee: Sylvia Gaye Stanfield.

Post: Brunei Darussalam.

Contributions, amount, date, and donee:

1. Self, none beyond $1 check-off on income tax return.
2. Spouse, none.
3. Children and spouses, N/A.
4. Parents, Mrs. J.A. (Nadine Roberts) Stanfield, none; Mr. J.A. Stanfield, deceased for 20 years.
5. Grandparents, deceased for over 20 years.
6. Brothers and spouses, none.
7. Sisters and spouses, Eunice F. Stanfield, M.D., none.

William B. Taylor, Jr., of Virginia, for the Rank of Ambassador during tenure of service as Coordinator of U.S. Assistance for the New Independent States.

(The above nominations were reported with the recommendation that they be confirmed, subject to the nominees' commitment to respond to requests to appear and testify before any duly constituted committee of the Senate).

Mr. HELMS. Mr. President, for the Committee on Foreign Relations, I report favorably a nomination list which was printed in the RECORD of July 1, 1999, and ask unanimous consent, to save the expense of reprinting on the Executive Calendar, that these nominations lie at the Secretary's desk for information of Senators.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The nominations ordered to lie on the Secretary's desk were printed in the RECORD of July 1, 1999, at the end of the Senate proceedings.)

In the Foreign Service nominations beginning Susan Garrison, and ending Richard Tsutomu Yoneoka, which nominations were received by the Senate and appeared in the Congressional Record of July 1, 1999.

By Mr. JEFFORDS, for the Committee on Health, Education, Labor, and Pensions:

A. E. Dick Howard, of Virginia, to be a Member of the Board of Trustees of the James Madison Memorial Fellowship Foundation for a term of six years.

James Roger Angel, of Arizona, to be a Member of the Board of Trustees of the Barry Goldwater Scholarship and Excellence in Education Foundation for a term expiring February 4, 2002.

Edward B. Montgomery, of Maryland, to be an Assistant Secretary of Labor.

Richard M. McGahey, of the District of Columbia, to be an Assistant Secretary of Labor.

Jack E. Hightower, of Texas, to be a Member of the National Commission on Libraries and Information Science for a term expiring July 19, 1999.

Christopher C. Gallagher, of New Hampshire, to be a Member of the Board of Directors of the Corporation for National and Community Service for a term expiring October 6, 2003. (Reappointment)

Jerry D. Florence, of California, to be a Member of the National Museum Services Board for a term expiring December 6, 2002.

(The above nominations were reported with the recommendations that they be confirmed, subject to the nominees' commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.)

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

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

By Mr. WELLSTONE (for himself, Mr. KENNEDY, Mr. INOUYE, Mr. DASCHLE, and Mr. MOYNIHAN):

S. 1447. A bill to amend the Public Health Service Act, Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to provide for nondiscriminatory coverage for substance abuse treatment service under private group and individual health coverage; to the Committee on Health, Education, Labor, and Pensions.

By Mr. HUTCHINSON (for himself, Mrs. LINCOLN, Mr. DEWINE, Mr. ASHCROFT, Mr. SESSIONS, Mr. FRIST, Mr. BREAUX, Mr. MOYNIHAN, Mrs. FEINSTEIN, and Mrs. BOXER):

S. 1448. A bill to amend the Food Security Act of 1985 to authorize the annual enrollment of land in the wetlands reserve program, to extend the program through 2005, and for other purposes; to the Committee on Agriculture, Nutrition, and Forestry.

By Mr. CONRAD (for himself, Mr. FRIST, Mr. ROBB, Mr. INOUYE, Mr. THOMPSON, Mr. MURKOWSKI, and Mr. DEWINE):

S. 1449. A bill to amend title XVIII of the Social Security Act to increase the payment amount for renal dialysis services furnished under the medicare program; to the Committee on Finance.

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

S. 1450. A bill to authorize the Secretary of Transportation to convey a National Defense Reserve Fleet vessel to the Glacier Society, Inc., of Bridgeport, Connecticut; to the Committee on Commerce, Science, and Transportation.

By Mr. HARKIN (for himself, Mr. HOLLINGS, Mr. BIDEN, and Mr. GRAHAM):

S. 1451. A bill to amend titles XI and XVIII of the Social Security Act to improve efforts to combat medicare fraud, waste, and abuse; to the Committee on Finance.

By Mr. SHELBY (for himself, Mr. BAYH, Mr. BRYAN, Mr. ROCKEFELLER, and Mr. BINGAMAN):

S. 1452. A bill to modernize the requirements under the National Manufactured Housing Construction and Safety Standards of 1974 and to establish a balanced consensus process for the development, revision, and interpretation of Federal construction and safety standards for manufactured homes; to the Committee on Banking, Housing, and Urban Affairs.

By Mr. FRIST (for himself, Mr. FEINGOLD, Mr. BROWNBACK, and Mr. LIEBERMAN):

S. 1453. A bill to facilitate relief efforts and a comprehensive solution to the war in Sudan; to the Committee on Foreign Relations.

By Mr. ROBB (for himself, Mr. LAUTENBERG, Mr. CONRAD, Mr. HARKIN, Mr. KENNEDY, Mr. DASCHLE, Mr. REID, Mrs. MURRAY, Mr. LEVIN, Mr. CLELAND, Mr. DODD, Mr. TORRICELLI, Mr. SCHUMER, Mrs. LINCOLN, Mr. JOHNSON, Mr. WELLSTONE, Mr. KERRY, Mr. KERREY, and Mr. AKAKA):

S. 1454. A bill to amend the Internal Revenue Code of 1986 to expand the incentives for the construction and renovation of public schools and to provide tax incentives for corporations to participate in cooperative agreements with public schools in distressed areas; to the Committee on Finance.

By Mr. ABRAHAM (for himself and Mr. FEINGOLD):

S. 1455. A bill to enhance protections against fraud in the offering of financial assistance for college education, and for other purposes; to the Committee on the Judiciary.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

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

By Mr. HELMS (for himself and Mr. BIDEN):

S. Res. 168. A resolution paying a gratuity to Mary Lyda Nance; considered and agreed to.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. WELLSTONE (for himself, Mr. KENNEDY, Mr. INOUYE, Mr. DASCHLE, and Mr. MOYNIHAN):

S. 1447. A bill to amend the Public Health Service Act, Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to provide for nondiscriminatory coverage for substance abuse treatment service under private group and individual health coverage; to the Committee on Health, Education, Labor, and Pensions.

FAIRNESS IN TREATMENT—THE DRUG AND ALCOHOL ADDICTION RECOVERY ACT OF 1999

● Mr. WELLSTONE. Mr. President, I rise today to introduce legislation that will ensure that private health insurance companies cover the costs for drug and alcohol addiction treatment services at the same level that they pay for treatment for other diseases. The purpose of this bill is to end discrimination in insurance coverage for drug and alcohol addiction treatment. This bill, entitled Fairness in Treatment: The Drug and Alcohol Addiction Recovery Act of 1999, offers the necessary provisions to provide this assurance.

For too long, the problem of drug and alcohol addiction has been viewed as a moral issue, rather than as a disease. Too often, a cloak of secrecy has surrounded this problem, causing people who have this disease to feel ashamed and afraid to seek treatment for their symptoms for fear that they will be seen as admitting to a moral failure, or a weakness in character. We have all seen portrayals of alcoholics and addicts that are intended to be humorous or derogatory, and only reinforce the biases against people who have problems with drug and alcohol addiction. I cannot imagine this type of portrayal of someone who has another kind of chronic illness, a heart problem, or who happens to carry a gene that predisposes them to diabetes.

It has been shown that some forms of addiction have a genetic basis, and yet we still try to deny the serious medical nature of this disease. We think of those with this disease as somehow different from us. We forget that someone who has a problem with drugs or alcohol can look just like the person we see in the mirror, or the person who is sitting next to us at work or on the subway, or like someone in our own family. In fact, it is likely that most of us know someone who has experienced drug and alcohol addiction, within our families or our circle of friends or coworkers.

Alcoholism and drug addiction are painful, private struggles with staggering public costs. A study prepared by The Lewin Group for the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism, estimated that the total economic cost of alcohol and drug abuse to be $246 billion for 1992. Of this cost, $98 billion was due to drug addiction to illicit drugs and other drugs taken for non-medical purposes. This estimate includes addiction treatment and prevention costs, as well as costs associated with related illnesses, reduced job productivity or lost earnings, and other costs to society such as crime and social welfare programs. The study also determined that these costs are borne primarily by governments (46 percent), followed by those who abuse drugs and members of their households (44 percent). According to this same study, private health and life insurance companies bear only 3.2 percent of the costs of drug abuse and 10.2 percent of the costs of alcohol abuse.

The health effects resulting from alcohol addiction can be very serious, even fatal. A 1996 article in Scientific American estimated that excessive alcohol consumption causes more than 100,000 deaths in the U.S. each year. Of these deaths, twenty-four per cent are due to drunken driving, eleven percent are homicides, and eight percent are suicides. Alcohol contributes to cancers of the esophagus, larynx, and oral cavity, which account for seventeen percent of these deaths. Strokes related to alcohol use account for another nine percent of deaths. Alcohol causes several other ailments, such as cirrhosis of the liver. These ailments account for eighteen percent of the deaths.

We know that addiction to alcohol and other drugs contribute to other problems as well. Addictive substances have the potential for destroying the person who is addicted, their family, and their other relationships. We know, for example, that fetal alcohol syndrome is the leading known cause of mental retardation. If the woman who was addicted to alcohol could receive proper treatment, fetal alcohol syndrome for her baby would be 100 percent preventable, and more than 12,000 infants born in the U.S. each year would not suffer from fetal alcohol syndrome, with its irreversible physical and mental damage. We know too of the devastation caused by addiction when violence between people is one of the consequences. A 1998 SAMHSA report outlined the links between domestic violence and substance abuse. We know from clinical reports that 25–50% of men who commit acts of domestic violence also have substance abuse problems. The report recognized the link between the victim of abuse and use of alcohol and drugs, and recommended that after the woman's safety has been addressed, the next step would be to help with providing treatment for her addiction as a step toward independence and health, and toward the prevention of the consequences for the children who suffer the same abuse either directly, or indirectly by witnessing spousal violence.

People who have the disease of addiction can be found throughout our society. According to the 1997 National Household Survey on Drug Abuse published by SAMHSA, nearly 73 percent of all illegal drug users in the United States are employed. This number represents 6.7 million full-time workers and 1.6 million part-time workers. Although many of these workers could and should have insurance benefits that would cover treatment for this disease, they do not.

In addition to the health problems resulting from the failure to treat the illness, there are other serious consequences affecting the workplace, such as lost productivity, high employee turnover, low employee morale, mistakes, accidents, and increased worker's compensation insurance and health insurance premiums—all results of untreated addiction problems. Whether you are a corporate CEO or a small business owner, there are simple, effective steps that can be taken—including providing insurance coverage for this disease, ready access to treatment, and workplace policies that support treatment—that can reduce these human and economic costs.

We know from the outstanding research conducted at NIH, through the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism, that treatment for drug and alcohol addiction can be effective. That is the major finding from a NIDA-sponsored nationwide study of drug abuse treatment outcomes. The Drug Abuse Treatment Outcome Study (DATOS) tracked 10,000 people in nearly 100 treatment programs in 11 cities who entered treatment for addiction between 1991 and 1993. Results showed that for all four treatment types studied, there were reductions in the use of cocaine, heroin, and marijuana after treatment. Moreover, treatment resulted in other positive changes in behavior, such as fewer psychological symptoms and increased work productivity.

We must do more to prevent this illness and to treat those who are addicted to drugs and alcohol. Over the past few years, the principle of parity in insurance coverage for alcohol and drug rehabilitation and treatment has received the strong support of the White House, ONDCP Director General Barry McCaffrey, Former Surgeon General C. Everett Koop, Former President and Mrs. Gerald Ford, the U.S. Conference of Mayors, Kaiser Permanente Health Plans, and many leading figures in medicine, business, government, journalism, and entertainment who have successfully fought the battle of addiction with the help of treatment. Hearings held last year by the Senate Appropriations Committee and the Committee on Health, Education, Labor, and Pensions highlighted the recent major advances in scientific information about the disease; the biological causes of addiction; the effectiveness and low cost of treatment; and many painful, personal stories of people, including children, who have been denied treatment.

We know that the failure of insurance companies to provide treatment can sometimes have devastating results. The New York Times recently highlighted the tragic suicide of a young man who desperately sought inpatient treatment care for his drug addiction and fought for 8 months to have the plan authorize the treatment that was in fact included in as part of his benefits. The authorization came through—but too late—he had died three weeks earlier from a drug overdose. This kind of denial of care for addiction treatment is not at all unique—the 1998 Hay Group Report on Employer Health Care Dollars Spent on Substance Abuse showed that from 1988 through 1998 the value of substance abuse treatment benefits decreased by 74.5%, as compared to a 11.5% decrease for overall health care benefits.

Addiction to alcohol and drugs is a disease that affects the brain, the body, and the spirit. We must provide adequate opportunities for the treatment of addiction in order to help those who are suffering and to prevent the health and social problems that it causes. This legislation will take an important step in this direction by requiring that health insurance plans eliminate discrimination for addiction treatment. The costs for this are very low. A 1999 study by the Rand Corporation found that the cost to managed care health plans is now only about $5 per person per year for unlimited substance abuse treatment benefits to employees of big companies. A 1997 Milliman and Robertson study found that complete substance abuse treatment parity would increase per capita health insurance premiums by only one half of one percent, or less than $1 per member per month—without even considering any of the obvious savings that will result from treatment. Several studies have shown that for every $1 spent on treatment, more than $7 is saved in other health care expenses, and that these savings are in addition to the financial and other benefits of increased productivity, as well as participation in family and community life. Providing

treatment for addiction also saves millions of dollars in the criminal justice system. But for treatment to be effective and helpful throughout our society all systems of care—including private insurance plans—must share this responsibility.

This legislation does not mandate that health insurers offer substance addiction treatment benefits. What it does is prohibit discrimination by health plans who offer substance addiction treatment from placing unfair and life-threatening limitations on caps, access, or financial requirements for addiction treatment that are different from other medical and surgical services.

We must move forward now to vigorously address the serious and life-threatening problem of drug and alcohol addiction in our country. It is long past time that insurance companies do their fair share in bearing the responsibility for treating this disease.

I ask that the full text of the bill be printed in the RECORD.

The bill follows:

S. 1447

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 ''Fairness in Treatment: The Drug and Alcohol Addiction Recovery Act of 1999''.

SEC. 2. PARITY IN SUBSTANCE ABUSE TREATMENT BENEFITS.

(a) GROUP HEALTH PLANS.—

(1) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—

(A) IN GENERAL.—Subpart 2 of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–4 et seq.) is amended by adding at the end the following:

''SEC. 2707. PARITY IN THE APPLICATION OF TREATMENT LIMITATIONS AND FINANCIAL REQUIREMENTS TO SUBSTANCE ABUSE TREATMENT BENEFITS.

''(a) IN GENERAL.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and substance abuse treatment benefits, the plan or coverage shall not impose treatment limitations or financial requirements on the substance abuse treatment benefits unless similar limitations or requirements are imposed for medical and surgical benefits.

''(b) CONSTRUCTION.—Nothing in this section shall be construed—

''(1) as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any substance abuse treatment benefits; or

''(2) to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

''(c) SMALL EMPLOYER EXEMPTION.—

''(1) IN GENERAL.—This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of a small employer.

''(2) SMALL EMPLOYER.—For purposes of paragraph (1), the term 'small employer' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 25 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

''(3) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this subsection:

''(A) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—Rules similar to the rules under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 shall apply for purposes of treating persons as a single employer.

''(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

''(C) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

''(d) SEPARATE APPLICATION TO EACH OPTION OFFERED.—In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

''(e) DEFINITIONS.—For purposes of this section—

''(1) TREATMENT LIMITATION.—The term 'treatment limitation' means, with respect to benefits under a group health plan or health insurance coverage, any day or visit limits imposed on coverage of benefits under the plan or coverage during a period of time.

''(2) FINANCIAL REQUIREMENT.—The term 'financial requirement' means, with respect to benefits under a group health plan or health insurance coverage, any deductible, coinsurance, or cost-sharing or an annual or lifetime dollar limit imposed with respect to the benefits under the plan or coverage.

''(3) MEDICAL OR SURGICAL BENEFITS.—The term 'medical or surgical benefits' means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include substance abuse treatment benefits.

''(4) SUBSTANCE ABUSE TREATMENT BENEFITS.—The term 'substance abuse treatment benefits' means benefits with respect to substance abuse treatment services.

''(5) SUBSTANCE ABUSE TREATMENT SERVICES.—The term 'substance abuse services' means any of the following items and services provided for the treatment of substance abuse:

''(A) Inpatient treatment, including detoxification.

''(B) Non-hospital residential treatment.

''(C) Outpatient treatment, including screening and assessment, medication management, individual, group, and family counseling, and relapse prevention.

''(D) Prevention services, including health education and individual and group counseling to encourage the reduction of risk factors for substance abuse.

''(6) SUBSTANCE ABUSE.—The term 'substance abuse' includes chemical dependency.

''(f) NOTICE.—A group health plan under this part shall comply with the notice requirement under section 713(f) of the Employee Retirement Income Security Act of 1974 with respect to the requirements of this section as if such section applied to such plan.''.

(B) CONFORMING AMENDMENT.—Section 2723(c) of the Public Health Service Act (42 U.S.C. 300gg–23(c)) is amended by striking ''section 2704'' and inserting ''sections 2704 and 2707''.

(2) ERISA AMENDMENTS.—

(A) IN GENERAL.—Subpart B of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1185 et seq.) is amended by adding at the end the following:

''SEC. 714. PARITY IN THE APPLICATION OF TREATMENT LIMITATIONS AND FINANCIAL REQUIREMENTS TO SUBSTANCE ABUSE TREATMENT BENEFITS.

''(a) IN GENERAL.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and substance abuse treatment benefits, the plan or coverage shall not impose treatment limitations or financial requirements on the substance abuse treatment benefits unless similar limitations or requirements are imposed for medical and surgical benefits.

''(b) CONSTRUCTION.—Nothing in this section shall be construed—

''(1) as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any substance abuse treatment benefits; or

''(2) to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

''(c) SMALL EMPLOYER EXEMPTION.—

''(1) IN GENERAL.—This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of a small employer.

''(2) SMALL EMPLOYER.—For purposes of paragraph (1), the term 'small employer' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 25 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

''(3) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this subsection:

''(A) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—Rules similar to the rules under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 shall apply for purposes of treating persons as a single employer.

''(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

''(C) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

''(d) SEPARATE APPLICATION TO EACH OPTION OFFERED.—In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

''(e) DEFINITIONS.—For purposes of this section—

''(1) TREATMENT LIMITATION.—The term 'treatment limitation' means, with respect to benefits under a group health plan or health insurance coverage, any day or visit limits imposed on coverage of benefits under the plan or coverage during a period of time.

''(2) FINANCIAL REQUIREMENT.—The term 'financial requirement' means, with respect to benefits under a group health plan or health insurance coverage, any deductible, coinsurance, or cost-sharing or an annual or lifetime dollar limit imposed with respect to the benefits under the plan or coverage.

''(3) MEDICAL OR SURGICAL BENEFITS.—The term 'medical or surgical benefits' means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include substance abuse treatment benefits.

''(4) SUBSTANCE ABUSE TREATMENT BENEFITS.—The term 'substance abuse treatment benefits' means benefits with respect to substance abuse treatment services.

''(5) SUBSTANCE ABUSE TREATMENT SERVICES.—The term 'substance abuse services' means any of the following items and services provided for the treatment of substance abuse:

''(A) Inpatient treatment, including detoxification.

''(B) Non-hospital residential treatment.

''(C) Outpatient treatment, including screening and assessment, medication management, individual, group, and family counseling, and relapse prevention.

''(D) Prevention services, including health education and individual and group counseling to encourage the reduction of risk factors for substance abuse.

''(6) SUBSTANCE ABUSE.—The term 'substance abuse' includes chemical dependency.

''(f) NOTICE UNDER GROUP HEALTH PLAN.—The imposition of the requirements of this section shall be treated as a material modification in the terms of the plan described in section 102(a)(1), for purposes of assuring notice of such requirements under the plan; except that the summary description required to be provided under the last sentence of section 104(b)(1) with respect to such modification shall be provided by not later than 60 days after the first day of the first plan year in which such requirements apply.''.

(B) CONFORMING AMENDMENTS.—

(i) Section 731(c) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191(c)) is amended by striking ''section 711'' and inserting ''sections 711 and 714''.

(ii) Section 732(a) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1191a(a)) is amended by striking ''section 711'' and inserting ''sections 711 and 714''.

(iii) The table of contents in section 1 of the Employee Retirement Income Security Act of 1974 is amended by inserting after the item relating to section 713 the following new item:

''Sec. 714. Parity in the application of treatment limitations and financial requirements to substance abuse treatment benefits.''.

(3) INTERNAL REVENUE CODE AMENDMENTS.—

(A) IN GENERAL.—Subchapter B of chapter 100 of the Internal Revenue Code of 1986 is amended by inserting after section 9812, the following:

''SEC. 9813. PARITY IN THE APPLICATION OF TREATMENT LIMITATIONS AND FINANCIAL REQUIREMENTS TO SUBSTANCE ABUSE TREATMENT BENEFITS.

''(a) IN GENERAL.—In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and substance abuse treatment benefits, the plan or coverage shall not impose treatment limitations or financial requirements on the substance abuse treatment benefits unless similar limitations or requirements are imposed for medical and surgical benefits.

''(b) CONSTRUCTION.—Nothing in this section shall be construed—

''(1) as requiring a group health plan (or health insurance coverage offered in connection with such a plan) to provide any substance abuse treatment benefits; or

''(2) to prevent a group health plan or a health insurance issuer offering group health insurance coverage from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

''(c) SMALL EMPLOYER EXEMPTION.—

''(1) IN GENERAL.—This section shall not apply to any group health plan (and group health insurance coverage offered in connection with a group health plan) for any plan year of a small employer.

''(2) SMALL EMPLOYER.—For purposes of paragraph (1), the term 'small employer' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 25 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

''(3) APPLICATION OF CERTAIN RULES IN DETERMINATION OF EMPLOYER SIZE.—For purposes of this subsection:

''(A) APPLICATION OF AGGREGATION RULE FOR EMPLOYERS.—Rules similar to the rules under subsections (b), (c), (m), and (o) of section 414 of the Internal Revenue Code of 1986 shall apply for purposes of treating persons as a single employer.

''(B) EMPLOYERS NOT IN EXISTENCE IN PRECEDING YEAR.—In the case of an employer which was not in existence throughout the preceding calendar year, the determination of whether such employer is a small employer shall be based on the average number of employees that it is reasonably expected such employer will employ on business days in the current calendar year.

''(C) PREDECESSORS.—Any reference in this subsection to an employer shall include a reference to any predecessor of such employer.

''(d) SEPARATE APPLICATION TO EACH OPTION OFFERED.—In the case of a group health plan that offers a participant or beneficiary two or more benefit package options under the plan, the requirements of this section shall be applied separately with respect to each such option.

''(e) DEFINITIONS.—For purposes of this section—

''(1) TREATMENT LIMITATION.—The term 'treatment limitation' means, with respect to benefits under a group health plan or health insurance coverage, any day or visit limits imposed on coverage of benefits under the plan or coverage during a period of time.

''(2) FINANCIAL REQUIREMENT.—The term 'financial requirement' means, with respect to benefits under a group health plan or health insurance coverage, any deductible, coinsurance, or cost-sharing or an annual or lifetime dollar limit imposed with respect to the benefits under the plan or coverage.

''(3) MEDICAL OR SURGICAL BENEFITS.—The term 'medical or surgical benefits' means benefits with respect to medical or surgical services, as defined under the terms of the plan or coverage (as the case may be), but does not include substance abuse treatment benefits.

''(4) SUBSTANCE ABUSE TREATMENT BENEFITS.—The term 'substance abuse treatment benefits' means benefits with respect to substance abuse treatment services.

''(5) SUBSTANCE ABUSE TREATMENT SERVICES.—The term 'substance abuse services' means any of the following items and services provided for the treatment of substance abuse:

''(A) Inpatient treatment, including detoxification.

''(B) Non-hospital residential treatment.

''(C) Outpatient treatment, including screening and assessment, medication management, individual, group, and family counseling, and relapse prevention.

''(D) Prevention services, including health education and individual and group counseling to encourage the reduction of risk factors for substance abuse.

''(6) SUBSTANCE ABUSE.—The term 'substance abuse' includes chemical dependency.''.

(B) CONFORMING AMENDMENT.—The table of contents for chapter 100 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 9812 the following new item:

''Sec. 9813. Parity in the application of treatment limitations and financial requirements to substance abuse treatment benefits.''.

(b) INDIVIDUAL HEALTH INSURANCE.—

(1) IN GENERAL.—Part B of title XXVII of the Public Health Service Act (42 U.S.C. 300gg-41 et seq.) is amended by inserting after section 2752 the following:

''SEC. 2753. PARITY IN THE APPLICATION OF TREATMENT LIMITATIONS AND FINANCIAL REQUIREMENTS TO SUBSTANCE ABUSE BENEFITS.

''(a) IN GENERAL.—The provisions of section 2707 (other than subsection (e)) shall apply to health insurance coverage offered by a health insurance issuer in the individual market in the same manner as it applies to health insurance coverage offered by a health insurance issuer in connection with a group health plan in the small or large group market.

''(b) NOTICE.—A health insurance issuer under this part shall comply with the notice requirement under section 713(f) of the Employee Retirement Income Security Act of 1974 with respect to the requirements referred to in subsection (a) as if such section applied to such issuer and such issuer were a group health plan.''.

(2) CONFORMING AMENDMENT.—Section 2762(b)(2) of the Public Health Service Act (42 U.S.C. 300gg–62(b)(2)) is amended by striking ''section 2751'' and inserting ''sections 2751 and 2753''.

(c) EFFECTIVE DATES.—

(1) IN GENERAL.—Subject to paragraph (3), the amendments made by subsection (a) shall apply with respect to group health plans for plan years beginning on or after January 1, 2000.

(2) INDIVIDUAL MARKET.—The amendments made by subsection (b) shall apply with respect to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market on or after January 1, 2000.

(3) COLLECTIVE BARGAINING AGREEMENTS.—In the case of a group health plan maintained pursuant to 1 or more collective bargaining agreements between employee representatives and 1 or more employers ratified before the date of enactment of this Act, the amendments made subsection (a) shall not apply to plan years beginning before the later of—

(A) the date on which the last collective bargaining agreements relating to the plan terminates (determined without regard to any extension thereof agreed to after the date of enactment of this Act), or

(B) January 1, 2000.

For purposes of subparagraph (A), any plan amendment made pursuant to a collective bargaining agreement relating to the plan which amends the plan solely to conform to any requirement added by subsection (a) shall not be treated as a termination of such collective bargaining agreement.

(d) COORDINATED REGULATIONS.—Section 104(1) of Health Insurance Portability and

Accountability Act of 1996 is amended by striking ''this subtitle (and the amendments made by this subtitle and section 401)'' and inserting ''the provisions of part 7 of subtitle B of title I of the Employee Retirement Income Security Act of 1974, and the provisions of parts A and C of title XXVII of the Public Health Service Act, and chapter 1000 of the Internal Revenue Code of 1986''.

SEC. 3. PREEMPTION.

Nothing in the amendments made by this Act shall be construed to preempt any provision of State law that provides protections to enrollees that are greater than the protections provided under such amendments.●

By Mr. CONRAD (for himself, Mr. FRIST, Mr. ROBB, Mr. INOUYE, Mr. THOMPSON, Mr. MURKOWSKI, and Mr. DEWINE):

S. 1449. A bill to amend title XVIII of the Social Security Act to increase the payment amount for renal dialysis services furnished under the Medicare program; to the Committee on Finance.

MEDICARE RENAL DIALYSIS FAIR PAYMENT ACT OF 1999

● Mr. CONRAD. Mr. President, today I am pleased to join Senator FRIST to introduce the Medicare Renal Dialysis Fair Payment Act of 1999. This legislation takes important steps to help sustain and improve the quality of care for Medicare beneficiaries suffering from kidney-failure.

Nationwide, more than 280,000 Americans live with end-stage renal disease (ESRD). In my state of North Dakota, the number of patients living with ESRD is relatively small, just over 600 per year. However, for these patients, and others across the country, access to dialysis treatments means the difference between life and death.

In 1972, the Congress took important steps to ensure that elderly and disabled individuals with kidney-failure receive appropriate dialysis care. At that time, Medicare coverage was extended to include dialysis treatments for beneficiaries with ESRD.

Over the last three decades, dialysis facilities have provided services to increasing numbers of kidney-failure patients under increasingly strict quality standards. However, it has come to my attention that reimbursement to dialysis facilities does not reflect the more stringent quality requirements placed upon dialysis providers.

Since 1983, reimbursement to dialysis facilities has actually declined. Today, according to the Medicare Payment Advisory Commission (MedPAC), dialysis facilities receive on average $122 per treatment, compared with $138 per treatment that they received in 1983. Adjusting for inflation, this means that dialysis providers are only receiving about $42 per treatment (in 1983 dollars) to provide nursing, social work and dietitian care, as well as the actual dialysis treatment.

I am concerned that a continued erosion in Medicare payments to dialysis facilities could jeopardize beneficiaries' access to dialysis services. According to MedPAC, ''without an increase in the payment (i.e. composite rate) the quality of dialysis services may decline. Therefore, an update to the composite rate is recommended.'' Further, MedPAC has concluded that the majority of dialysis facilities now lose money on Medicare reimbursement and the problem is especially acute for small, rural, and non-profit dialysis facilities. In my state, we simply cannot afford to lose rural providers—including providers of dialysis services.

This legislation will ensure dialysis facilities have the resources to continue offering critical dialysis services to individuals with kidney failure. I urge my colleagues to support this important legislation.●

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

S. 1450. A bill to authorize the Secretary of Transportation to convey a National Defense Reserve Fleet vessel to the Glacier Society, Inc., of Bridgeport, Connecticut; to the Committee on Commerce, Science, and Transportation.

CONVEYANCE OF THE SHIP GLACIER

● Mr. DODD. Mr. President, I rise today to introduce legislation that would save a historic vessel from the scrap heap. The Glacier, a 310 foot, 8,600 ton icebreaker was commissioned as a vessel of the U.S. Navy in 1955. It made 39 trips to the North and South poles; made the deepest penetration of the Antarctic by sea in 1961; rescued explorer Sir Vivan Fuchs; and was the largest icebreaker of its time. Currently, the Glacier is part of the reserve fleet awaiting disposition as scrap or transfer to the Glacier Society, a group dedicated to restoring the Glacier.

This bill would simply convey the Glacier from the reserve fleet to the Glacier Society. The Society is mainly composed of active and retired servicemen who served aboard the Glacier and is headed by Ben Koether, one of the ship's former navigators. The group envisions that the Glacier will operate as a museum and scientific laboratory. Both in port and underway, the Glacier Society hopes to provide hands-on training to children and adults while teaching the history of Polar exploration.

By passing the title of the Glacier to the Glacier Society, Congress will save taxpayers roughly $200,000 per year, enable the development of unique educational opportunities, contribute to the nation's maritime heritage and preserve a piece of history. I look forward to the day when the Glacier Society's vision for the Glacier is achieved. Passage of this bill would be the first step towards realization of that vision.●

By Mr. HARKIN (for himself, Mr. HOLLINGS, Mr. BIDEN, and Mr. GRAHAM):

S. 1451. A bill to amend titles XI and XVIII of the Social Security Act to improve efforts to combat Medicare fraud, waste, and abuse; to the Committee on Finance.

MEDICARE WASTE TAX REDUCTION ACT OF 1999

Mr. HARKIN. Mr. President, today I am introducing with Senator HOLLINGS, Senator BIDEN, and Senator GRAHAM an important piece of legislation that will help to protect and preserve Medicare. The bill is entitled the Medicare Waste Tax Reduction Act of 1999.

For over ten years now, I have worked to combat fraud, waste and abuse in the Medicare program. As Chairman and now Ranking Minority Member of the Senate Appropriations Subcommittee with oversight of the administration of Medicare, I've held hearing after hearing and released report after report documenting the extent of this problem. While virtually no one was paying attention to our effort for many years, we've succeeded in bringing greater attention and focus to this problem in recent years.

Part of our effort has been to try to quantify the scope of the problem. Several years ago, the General Accounting Office reported that up to 10 percent of Medicare funds could be lost to fraud, waste and abuse each year. Many questioned that estimate as too large. They said the problem existed, but it wasn't nearly as big as 10 percent. A few years ago, the Inspector General conducted the first-ever detailed audit of Medicare payments. That Chief Financial Officer Act audit found that fully 14 percent of Medicare payments in 1996, or over $23 billion, had been made improperly.

To combat these substantial losses, we have put into place the reforms embodied in the Health Insurance Portability Act and the Balanced Budget Act. HCFA, the Inspector General and the Justice Department also have continued to aggressively use new authority to crack down on Medicare fraud, waste, and abuse. As a result, we have seen a dramatic decrease in these improper payments. According to the most recent Inspector General's report, improper payments had been reduced from $23.2 billion in 1996, to $20.3 billion in 1997, to $12.6 billion in 1998.

While I am very pleased with the successful efforts so far in combating fraud, waste, and abuse, that still amounts to a nearly $13 billion annual ''waste tax'' on the American people. Now is not the time to rest on our laurels. We must now question, what is the best way to move forward and further cut this tax. I know there are no ''magic-wand'' solutions—this is a complex problem with many components. But basically, you need four things: well thought out laws, adequate resources, effective implementation and the help of seniors and health providers. We've made progress on each of these fronts over the last couple of years, but much more remains to be done.

Mr. President, we have many thousands of dedicated health providers who work very hard to improve the quality of life for all people. Through their efforts, Americans have the best quality health care in the world. But, unfortunately, there are a small minority of providers who take advantage of our health care system. This legislation is directly designed to deal with those situations. Further, it is clear that many mispayments to Medicare are the result of a simple lack of understanding of our often complex Medicare payment system. This legislation also addresses this problem by providing increased education and assistance for providers and by reducing the paperwork and administrative hassles that can often lead to innocent, but costly, billing errors.

The primary goal of this legislation is simply this—to ensure that Medicare pays for all that it should pay for—and only what it should pay for.

The Medicare Waste Tax Reduction Act I am introducing today will take a number of important steps to stop the continued ravaging of Medicare.

This Bill for example, would direct HCFA to double and better target audits and reviews to detect and discourage mispayments. Currently only a tiny fraction of Medicare claims are reviewed before being paid and less than 2 percent of providers receive a comprehensive audit annually. We must have the ability to separate needed care from bill padding and abuse.

Our bill would also give Medicare the authority to be a more prudent purchaser. As passed by the Senate, the Balanced Budget Act gave Medicare the authority to quickly reduce Part B payment rates (except those made for physician services) it finds to be grossly excessive when compared to rates paid by other government programs and the private sector. In conference, the provision was limited to reductions of no more than 15 percent. This bill would restore the original Senate language. In addition, to assure that Medicare gets the price it deserves given its status as by far the largest purchaser of medical supplies and equipment, Medicare would pay no more than any other government program for these items. Finally, overpayments for prescription drugs and biologicals would be eliminated by lowering Medicare's rate to the lowest of either the actual acquisition cost or 83% of the wholesale cost.

Our bill would also give the Secretary of Health and Human Services greater flexibility in contracting for claims processing and payment functions on behalf of Medicare beneficiaries and providers. It would update Medicare contracting procedures and bring it more in line with standard contracting procedures already used across the Federal Government and therefore allow Medicare the ability to get much better value for its contracting dollars.

The Medicare Waste Tax reduction Act of 1999 would also ensure that Medicare does not pay for claims owed by other plans. Too often, Medicare pays claims that are owed by private insurers because it has no way of knowing a beneficiary is working and has private insurance that should pay first. This provision would reduce Medicare losses by requiring insurers to report any Medicare beneficiaries they insure. Also, Medicare would be given the authority to recover double the amount owed by insurers who purposely let Medicare pay claims they should have paid.

Additionally, coordination between Medicare and private insurers would be strengthened. Often, those ripping off Medicare are also defrauding private health plans. Yet, too little information on fraud cases is shared between Medicare and private plans. In order to encourage better coordination, health plans and their employees could not be held liable for sharing information with Medicare regarding health care fraud as long as the information is not false, or the person providing the information had no reason to believe the information was false.

Our bill would also expand the Medicare Senior Waste Patrol Nationwide. Seniors are our front line of defense against Medicare fraud, waste and abuse. However, too often, seniors don't have the information they need to detect and report suspected mistakes and fraud. By moving the Waste Patrol nationwide, implementing important BBA provisions and assuring seniors have access to itemized bills we will strike an important blow to Medicare waste.

Another critical component of any successful comprehensive plan to cut the Medicare waste tax is to focus on prevention. Most of our efforts now look at finding and rectifying the problems after they occur. While this is important and we need to do even more of it, we all know that prevention is much more cost effective. The old adage ''A stitch in time saves nine'' was never more true. A major component of an enhanced prevention effort would be the provision of increased assistance and education for providers to comply with Medicare rules.

Further, a great deal of the mis-payments made by Medicare are the result not of fraud or abuse, but of simple misunderstanding of Medicare billing rules by providers. Therefore, this bill provides $10 million a year to fund a major expansion of assistance and education for providers on program integrity requirements. This bill would also ensure the reduction of paperwork and administrative hassle that could prove daunting to providers. Health professionals have to spend too much time completing paperwork and dealing with administrative hassles associated with Medicare and private health plans. In order to reduce this hassle and provide more time for patient care, the Institute of Medicine would be charged with developing a comprehensive plan by no later than June 1, 2000. Their recommendations are to include the streamlining of variations between Medicare and other payers.

Mr. President, while we have made changes to medicare in attempts to extend its solvency thru the next decade, we urgently need to take other steps to protect and preserve the program for the long-term. We should enact the reforms in this bill to weed out waste, fraud and abuse as a first priority in this effort. I urge all my colleagues to review this proposal and hope that they will join me in working to pass it yet this year.

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

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

S. 1451

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 ''Medicare Waste Tax Reduction Act of 1999''.

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

Sec. 1. Short title; table of contents.
Sec. 2. Increased medical reviews and anti-fraud activities.
Sec. 3. Oversight of home health agencies.
Sec. 4. No markup for drugs or biologicals.
Sec. 5. Ensuring that the medicare program does not reimburse claims owed by other payers.
Sec. 6. Extension of subpoena and injunction authority.
Sec. 7. Civil monetary penalties for services ordered or prescribed by an excluded individual or entity.
Sec. 8. Civil monetary penalties for false certification of eligibility to receive partial hospitalization and hospice services.
Sec. 9. Application of certain provisions of the bankruptcy code.
Sec. 10. Improving private sector coordination in combatting health care fraud.
Sec. 11. Fees for agreements with medicare providers and suppliers.
Sec. 12. Increased medicare compliance, education, and assistance for health care providers.
Sec. 13. Paperwork and administrative hassle reduction.
Sec. 14. Clarification of application of sanctions to Federal health care programs.
Sec. 15. Payments for durable medical equipment.
Sec. 16. Implementation of commercial claims auditing systems.
Sec. 17. Partial hospitalization payment reforms.
Sec. 18. Expansion of medicare senior waste patrol nationwide.
Sec. 19. Application of inherent reasonableness to all part B services other than physicians' services.
Sec. 20. Standards regarding payment for certain orthotics and prosthetics.
Sec. 21. Increased flexibility in contracting for medicare claims processing.
Sec. 22. Exemption of Inspectors General from Paperwork Reduction Act requirements.

SEC. 2. INCREASED MEDICAL REVIEWS AND ANTI-FRAUD ACTIVITIES.

(a) IN GENERAL.—Section 1893(d) of the Social Security Act (42 U.S.C. 1395ddd(d)) is

amended by inserting after paragraph (3) the following:

''(4) In the case of fiscal year 2000 and each subsequent fiscal year, procedures to ensure that—

''(A) the number of medical reviews, utilization reviews, and fraud reviews in a fiscal year of providers of services and other individuals and entities furnishing items and services for which payment may be made under this title is equal to at least twice the number of such reviews that were conducted in fiscal year 1999;

''(B) the number of provider cost reports audited in a fiscal year is equal to at least—

''(i) 15 percent of those submitted by a home health agency or a skilled nursing facility; and

''(ii) twice the number of such reports that were audited in fiscal year 1999 for those submitted by any other provider of services or any other individual or entity furnishing items and services for which payment may be made under this title; and

''(C) in determining which providers of services, individuals, entities, or cost reports to review or audit, priority is placed on providers, individuals, entities, and areas that the Secretary determines are subject to abuse and most likely to result in mispayment or overpayment recoveries.''.

(b) INCREASE IN APPROPRIATED AMOUNTS FOR MEDICARE AND MEDICAID ACTIVITIES.—

(1) IN GENERAL.—Section 1817(k)(3)(A)(i) of the Social Security Act (42 U.S.C. 1395i(k)(3)(A)(i)) is amended—

(A) in subclause (II)—

(i) by striking ''through 2003'' and inserting ''and 1999''; and

(ii) by striking ''and'' at the end;

(B) by redesignating subclause (III) as subclause (IV); and

(C) by inserting after subclause (II) the following:

''(III) for each of the fiscal years 2000 through 2003, the limit for the preceding fiscal year, increased by 25 percent; and''.

(2) ACTIVITIES.—Section 1817(k)(3)(A)(ii) of the Social Security Act (42 U.S.C. 1395i(k)(3)(A)(ii)) is amended—

(A) in subclause (IV), by striking ''not less than $110,000,000 and not more than $120,000,000'' and inserting ''$160,000,000'';

(B) in subclause (V), by striking ''not less than $120,000,000 and not more than $130,000,000'' and inserting ''$190,000,000'';

(C) in subclause (VI), by striking ''not less than $140,000,000 and not more than $150,000,000'' and inserting ''$230,000,000''; and

(D) in subclause (VII), by striking ''not less than $150,000,000 and not more than $160,000,000'' and inserting ''$260,000,000''.

(c) INCREASE IN APPROPRIATED AMOUNTS FOR MEDICARE INTEGRITY PROGRAM.—Section 1817(k)(4) of the Social Security Act (42 U.S.C. 1395i(k)(4)(B)) is amended—

(1) in subparagraph (A), by striking ''such amounts as are necessary to carry out the Medicare Integrity Program under section 1893, subject to subparagraph (B) and to'' and inserting ''the amount appropriated under subparagraph (B), and such amount shall''; and

(2) in subparagraph (B)—

(A) in clause (iv), by striking ''such amount shall be not less than $620,000,000 and not more than $630,000,000'' and inserting ''$780,000,000'';

(B) in clause (v), by striking ''such amount shall be not less than $670,000,000 and not more than $680,000,000'' and inserting ''$830,000,000'';

(C) in clause (vi), by striking ''such amount shall be not less than $690,000,000 and not more than $700,000,000'' and inserting ''$850,000,000''; and

(D) in clause (vii), by striking ''such amount shall be not less than $710,000,000 and not more than $720,000,000'' and inserting ''$870,000,000''.

SEC. 3. OVERSIGHT OF HOME HEALTH AGENCIES.

(a) VALIDATION SURVEYS OF HOME HEALTH AGENCIES.—Section 1891(c) of the Social Security Act (42 U.S.C. 1395bbb(c)) is amended by adding at the end the following:

''(3)(A)(i) The Secretary shall conduct onsite surveys of a representative sample of home health agencies in each State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under this subsection.

''(ii) A survey described in clause (i) shall be conducted by the Secretary within 2 months of the date of the survey conducted by the State and may be conducted concurrently with the State survey.

''(iii) In conducting a survey described in clause (i), the Secretary shall use the same survey protocols as the State is required to use under this subsection.

''(iv) If, through a State survey, the State has determined that a home health agency is in compliance with the requirements specified in or pursuant to section 1861(o), this section, or this title, but the Secretary determines (after conducting the survey described in clause (i)) that the facility does not meet such requirements, the Secretary's determination as to the facility's noncompliance with such requirements is binding and supersedes that of the State survey.

''(B) With respect to each State, the Secretary shall conduct surveys under subparagraph (A) each year with respect to at least 5 percent of the number of home health agencies surveyed by the State in the year, but in no case less than 5 home health agencies in the State.

''(C) If the Secretary finds, on the basis of such surveys, that a State has failed to perform surveys as required under this subsection or that a State's survey and certification performance otherwise is not adequate, the Secretary shall provide for an appropriate remedy, which may include the training of survey teams in the State.

''(D) If the Secretary has reason to question the compliance of a home health agency with any of the requirements specified in or pursuant to section 1861(o), this section, or this title, the Secretary may conduct a survey of the agency and, on the basis of that survey, make independent and binding determinations concerning the extent to which the home health agency meets such requirements.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act.

SEC. 4. NO MARKUP FOR DRUGS OR BIOLOGICALS.

(a) IN GENERAL.—Section 1842(o) (42 U.S.C. 1395u(o)) is amended to read as follows:

''(o)(1) If a physician's, supplier's, or any other person's bill or request for payment for services includes a charge for a drug or biological for which payment may be made under this part and the drug or biological is not paid on a cost or prospective payment basis as otherwise provided in this part, the payment amount established in this subsection for the drug or biological shall be the lowest of the following:

''(A) The actual acquisition cost, as defined in paragraph (2), to the person submitting the claim for payment for the drug or biological.

''(B) 83 percent of the average wholesale price of such drug or biological, as determined by the Secretary.

''(C) For payments for any drug or biological furnished on or after January 1, 2001, the median actual acquisition cost of all claims for payment for such drug or biological for the 12-month period beginning July 1, 1999 (and adjusted, as the Secretary determines appropriate, to reflect changes in the cost of such drug or biological due to inflation, and such other factors as the Secretary determines appropriate).

''(D) The amount otherwise determined under this part.

''(2) For purposes of paragraph (1)(A), the term 'actual acquisition cost' means, with respect to such drug or biological, the cost of the drug or biological based on the most economical case size in inventory on the date of dispensing or, if less, the most economical case size purchased within 6 months of the date of dispensing whether or not that specific drug or biological was furnished to an individual whether or not enrolled under this part. Such term includes appropriate adjustments, as determined by the Secretary, for all discounts, rebates, or any other benefit in cash or in kind (including travel, equipment, or free products). The Secretary shall include an additional payment for administrative, storage, and handling costs.

''(3)(A) No payment shall be made under this part for any drug or biological to a person whose bill or request for payment for such drug or biological does not include a statement of the person's actual acquisition cost.

''(B) A person may not bill an individual enrolled under this part—

''(i) any amount other than the payment amount specified in paragraph (1) or (4) (plus any applicable deductible and coinsurance amounts), or

''(ii) any amount for such drug or biological for which payment may not be made pursuant to subparagraph (A).

''(C) If a person knowingly and willfully in repeated cases bills 1 or more individuals in violation of subparagraph (B), the Secretary may apply sanctions against that person in accordance with subsection (j)(2).

''(4) The Secretary may pay a reasonable dispensing fee (less the applicable deductible and coinsurance amounts) for any drug or biological to a licensed pharmacy approved to dispense drugs or biologicals under this part, if payment for such drug or biological is made to the pharmacy.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to drugs or biologicals furnished on or after January 1, 2000.

(c) ELIMINATION OF REPORT ON AVERAGE WHOLESALE PRICE.—Section 4556 of the Balanced Budget Act of 1997 is amended by striking subsection (c).

SEC. 5. ENSURING THAT THE MEDICARE PROGRAM DOES NOT REIMBURSE CLAIMS OWED BY OTHER PAYERS.

(a) INFORMATION FROM GROUP HEALTH PLANS.—Section 1862(b) of the Social Security Act (42 U.S.C. 1395y(b)) is amended by adding at the end the following:

''(7) INFORMATION FROM GROUP HEALTH PLANS.—

''(A) PROVISION OF INFORMATION BY GROUP HEALTH PLANS.—The administrator of a group health plan that is subject to the requirements of paragraph (1) shall provide the Secretary with the information described in subparagraph (C) for each individual covered under the plan who is entitled to any benefits under this title. Such information shall be provided in such manner and at such times as the Secretary may specify (but in no case more frequently than 4 times per year).

''(B) PROVISION OF INFORMATION BY EMPLOYERS AND EMPLOYEE ORGANIZATIONS.—An employer (or employee organization) that maintains or participates in a group health plan that is subject to the requirements of paragraph (1) shall provide to the administrator of the plan the information described in subparagraph (C) for each individual covered

under the plan who is entitled to any benefits under this title. Such information shall be provided in such manner and at such times as the Secretary may specify (but in no case more frequently than 4 times per year).

''(C) INFORMATION.—The information described in this subparagraph is as follows:

''(i) ELEMENTS CONCERNING THE INDIVIDUAL.—

''(I) The individual's name.

''(II) The individual's date of birth.

''(III) The individual's sex.

''(IV) The individual's social security insurance number.

''(V) The number assigned by the Secretary to the individual for claims under this title.

''(VI) The family relationship of the individual to the person who has current or prior employment status with the employer.

''(ii) ELEMENTS CONCERNING THE FAMILY MEMBER WITH CURRENT OR PRIOR EMPLOYMENT STATUS.—

''(I) The name of the person in the individual's family who has current or prior employment status with the employer.

''(II) That person's social security insurance number.

''(III) The number or other identifier assigned by the plan to that person.

''(IV) The periods of coverage for that person under the plan.

''(V) The employment status of that person (current or former employee) during those periods of coverage.

''(VI) The classes (of that person's family members) covered under the plan.

''(iii) PLAN ELEMENTS.—

''(I) The items and services covered under the plan.

''(II) The name and address to which claims under the plan are to be sent.

''(III) The name, address, and tax identification number of the plan sponsor.

''(iv) ELEMENTS CONCERNING THE EMPLOYER.—

''(I) The employer's name.

''(II) The employer's address.

''(III) The employer identification number of the employer.

''(IV) The tax identification number of the employer if different than the number in clause (iii)(III).

''(D) USE OF IDENTIFIERS.—The administrator of a group health plan shall utilize a unique identifier for the plan in providing information under subparagraph (A) and in other transactions, as may be specified by the Secretary, related to the provisions of this subsection. The Secretary may provide to the administrator the unique identifier described in the preceding sentence.

''(E) PENALTY FOR NONCOMPLIANCE.—Any individual or entity that knowingly and willfully fails to comply with a requirement imposed by this paragraph shall be subject to a civil money penalty not to exceed $1,000 for each incident of such failure. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as those provisions apply to a penalty or proceeding under section 1128A(a).

''(F) GROUP HEALTH PLAN DEFINED.—In this paragraph, the term 'group health plan' has the meaning given such term in paragraph (1)(A)(v).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2000.

SEC. 6. EXTENSION OF SUBPOENA AND INJUNCTION AUTHORITY.

(a) SUBPOENA AUTHORITY.—Section 1128A(j)(1) of the Social Security Act (42 U.S.C. 1320a–7a(j)(1)) is amended by inserting ''and section 1128'' after ''with respect to this section''.

(b) INJUNCTION AUTHORITY.—Section 1128A(k) of the Social Security Act (42 U.S.C. 1320a–7a(k)) is amended by inserting ''or an exclusion under section 1128,'' after ''subject to a civil monetary penalty under this section,''.

(c) CLARIFYING AMENDMENTS.—

(1) IN GENERAL.—Section 1128A(j)(1) of the Social Security Act (42 U.S.C. 1320a–7a(j)(1)) is amended—

(A) by inserting '', except that, in so applying such sections, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively'' after ''with respect to title II''; and

(B) by striking the second sentence.

(2) AUTHORITY.—Section 1128A(j)(2) of the Social Security Act (42 U.S.C. 1320a–7a(j)(2)) is amended to read as follows:

''(2) The Secretary may delegate to the Inspector General of the Department of Health and Human Services any or all authority granted under this section or under section 1128.''.

(d) CONFORMING AMENDMENT.—Section 1128 of the Social Security Act (42 U.S.C. 1320a–7) is amended by adding at the end the following:

''(k) For provisions of law concerning the Secretary's subpoena and injunction authority with respect to activities under this section, see subsections (j) and (k) of section 1128A.''.

SEC. 7. CIVIL MONETARY PENALTIES FOR SERVICES ORDERED OR PRESCRIBED BY AN EXCLUDED INDIVIDUAL OR ENTITY.

(a) IN GENERAL.—Section 1128A(a)(1) of the Social Security Act (42 U.S.C. 1320a–7a(a)(1)) is amended—

(1) in subparagraph (D)—

(A) by inserting '', ordered, or prescribed by such person'' after ''other item or service furnished'';

(B) by inserting ''(pursuant to this title or title XVIII)'' after ''period in which the person was excluded'';

(C) by striking ''pursuant to a determination by the Secretary'' and all that follows through ''the provisions of section 1842(j)(2)''; and

(D) by striking ''or'' at the end;

(2) by redesignating subparagraph (E) as subparagraph (F); and

(3) by adding after subparagraph (D) the following:

''(E) is for a medical or other item or service ordered or prescribed by a person excluded (pursuant to this title or title XVIII) from the program under which the claim was made, and the person furnishing such item or service knows or should know of such exclusion, or''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to claims presented on or after the date of enactment of this Act.

SEC. 8. CIVIL MONETARY PENALTIES FOR FALSE CERTIFICATION OF ELIGIBILITY TO RECEIVE PARTIAL HOSPITALIZATION AND HOSPICE SERVICES.

(a) IN GENERAL.—Section 1128A(b)(3) of the Social Security Act (42 U.S.C. 1320a–7a(b)(3)) is amended—

(1) in subparagraph (A)(ii), by inserting '', hospice care, or partial hospitalization services'' after ''home health services''; and

(2) in subparagraph (B), by inserting '', section 1814(a)(7) in the case of hospice care, or section 1835(a)(2)(F) in the case of partial hospitalization services'' after ''home health services''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to documents executed on or after the date of enactment of this Act.

SEC. 9. APPLICATION OF CERTAIN PROVISIONS OF THE BANKRUPTCY CODE.

(a) RESTRICTED APPLICABILITY OF BANKRUPTCY STAY, DISCHARGE, AND PREFERENTIAL TRANSFER PROVISIONS TO MEDICARE AND MEDICAID DEBTS.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1143 the following:

''APPLICATION OF CERTAIN PROVISIONS OF THE BANKRUPTCY CODE

''SEC. 1144. (a) MEDICARE- AND MEDICAID-RELATED ACTIONS NOT STAYED BY BANKRUPTCY PROCEEDINGS.—The commencement or continuation of any action against a debtor under this title, title XVIII, or title XIX (other than an action with respect to health care services provided to the debtor under title XVIII), including any action or proceeding to exclude or suspend the debtor from program participation, assess civil money penalties, recoup or set off overpayments, or deny or suspend payment of claims shall not be subject to the provisions of section 362(a) of title 11, United States Code.

''(b) MEDICARE- AND MEDICAID-RELATED DEBT NOT DISCHARGEABLE IN BANKRUPTCY.—A debt owed to the United States or to a State for an overpayment under title XVIII or title XIX (other than an overpayment for health care services provided to the debtor under title XVIII), or for a penalty, fine, or assessment under this title, title XVIII, or title XIX, shall not be dischargeable under any provision of title 11, United States Code.

''(c) REPAYMENT OF CERTAIN DEBTS CONSIDERED FINAL.—Payments made to repay a debt to the United States or to a State with respect to items or services provided, or claims for payment made, under title XVIII or XIX (including repayment of an overpayment (other than an overpayment for health care services provided to the debtor under title XVIII)), or to pay a penalty, fine, or assessment under this title, title XVIII, or title XIX, shall be considered final and not preferential transfers under section 547 of title 11, United States Code.''.

(b) MEDICARE RULES APPLICABLE TO BANKRUPTCY PROCEEDINGS.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following:

''APPLICATION OF PROVISIONS OF THE BANKRUPTCY CODE

''SEC. 1897. (a) USE OF MEDICARE STANDARDS AND PROCEDURES.—Notwithstanding any provision of title 11, United States Code, or any other provision of law, in the case of claims by a debtor in bankruptcy for payment under this title, the determination of whether the claim is allowable, and of the amount payable, shall be made in accordance with the provisions of this title and title XI.

''(b) NOTICE TO CREDITOR OF BANKRUPTCY PETITIONER.—In the case of a debt owed to the United States with respect to items or services provided, or claims for payment made, under this title (including a debt arising from an overpayment or a penalty, fine, or assessment under title XI or this title), the notices to the creditor of bankruptcy petitions, proceedings, and relief required under title 11, United States Code (including under section 342 of that title and section 2002(j) of the Federal Rules of Bankruptcy Procedure), shall be given to the Secretary. Provision of such notice to a fiscal agent of the Secretary shall not be considered to satisfy this requirement.

''(c) TURNOVER OF PROPERTY TO THE BANKRUPTCY ESTATE.—For purposes of section 542(b) of title 11, United States Code, a claim for payment under this title shall not be considered to be a matured debt payable to the estate of a debtor until such claim has been allowed by the Secretary in accordance with procedures under this title.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to petitions

filed on or after the date of enactment of this Act.

SEC. 10. IMPROVING PRIVATE SECTOR COORDINATION IN COMBATTING HEALTH CARE FRAUD.

(a) IN GENERAL.—Title XI of the Social Security Act (42 U.S.C. 1301 et seq.) is amended by inserting after section 1157 the following:

''IMPROVING PRIVATE SECTOR COORDINATION IN COMBATTING HEALTH CARE FRAUD

''SEC. 1157A. (a) IN GENERAL.—Notwithstanding any other provision of law, no health plan (as defined in section 1128C(c)), issuer of a health plan, or employee of a health plan shall be held liable in any civil action with respect to the provision of information regarding suspected health care fraud, including Federal health care offenses (as defined in section 24(a) of title 18, United States Code) to an applicable individual unless such information is false and the person providing it knew, or had reason to believe, that such information was false.

''(b) APPLICABLE INDIVIDUAL.—In subsection (a), the term 'applicable individual' means—

''(1) a Federal, State, or local law enforcement official responsible for the investigation or prosecution of suspected health care fraud offenses; or

''(2) an employee of a health plan or issuer of a health plan.

''(c) ATTORNEY'S FEES.—Any health plan, issuer of a health plan, or employee of a health plan against whom a civil action is brought, and who is found to be entitled to immunity from liability by reason of this section, shall be entitled to recover reasonable attorney's fees and costs from the person who brought the civil action.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act.

SEC. 11. FEES FOR AGREEMENTS WITH MEDICARE PROVIDERS AND SUPPLIERS.

(a) FEES RELATED TO MEDICARE PROVIDER AND SUPPLIER ENROLLMENT AND REENROLLMENT.—Section 1866 of the Social Security Act (42 U.S.C. 1395cc) is amended by adding at the end the following:

''(j) ENROLLMENT PROCEDURES AND FEES.—

''(1) ENROLLMENT OF INDIVIDUALS AND ENTITIES THAT ARE NOT PROVIDERS OF SERVICES.—The Secretary may establish a procedure for enrollment (and periodic reenrollment) of individuals or entities that are not providers of services subject to the provisions of subsection (a) but that furnish health care items or services under this title.

''(2) FEES.—

''(A) IN GENERAL.—The Secretary may impose fees for initiation and renewal of provider agreements under subsection (a) and for enrollment and periodic reenrollment of other individuals and entities furnishing health care items or services under this title under paragraph (1), in amounts up to the full amount which the Secretary reasonably estimates to be sufficient to cover the Secretary's costs related to the process for initiating and reviewing such agreements and enrollments.

''(B) FEES CREDITED TO SPECIAL FUND IN TREASURY.—Fees collected pursuant to this paragraph shall be credited to a special fund of the United States Treasury, and shall remain available until expended, to the extent and in such amounts as provided in advance in appropriations Acts, for necessary expenses for these purposes, including costs of establishing and maintaining procedures and records systems, processing applications, and conducting background investigations.''.

(b) CLERICAL AMENDMENT.—The heading of section 1866 of the Social Security Act (42 U.S.C. 1395cc) is amended to read as follows:

''AGREEMENTS WITH PROVIDERS OF SERVICES AND ENROLLMENT OF OTHER PERSONS FURNISHING SERVICES''.

SEC. 12. INCREASED MEDICARE COMPLIANCE, EDUCATION, AND ASSISTANCE FOR HEALTH CARE PROVIDERS.

(a) DEVELOPMENT OF PLAN.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall, in consultation with health care provider representatives, develop and implement a comprehensive plan of activities to—

(1) maximize health care provider knowledge of medicare program integrity requirements, including anti-fraud and abuse laws and administrative actions;

(2) assist health care providers with medicare program integrity compliance, including educating such providers regarding compliance activities and procedures of the Health Care Financing Administration and the Inspector General of the Department of Health and Human Services;

(3) develop improved computer technology for health care providers to both reduce their administrative hassles and facilitate their compliance with medicare program requirements, including physician evaluation and management guidelines; and

(4) otherwise improve compliance among health care providers with rules and regulations under the medicare program.

(b) FUNDING.—Notwithstanding any other provision of law, of the amounts appropriated under section 1817(k)(4) of the Social Security Act (42 U.S.C. 1395i(k)(4)) for a fiscal year, there shall be made available $10,000,000 in fiscal year 2000 and such sums as are necessary in fiscal years 2001 through 2004 to carry out the purposes of this section.

SEC. 13. PAPERWORK AND ADMINISTRATIVE HASSLE REDUCTION.

(a) STUDY BY COMMITTEE.—

(1) ESTABLISHMENT.—Not later than 90 days after the date of enactment of this Act, the Secretary of Health and Human Services shall contract with the Institute of Medicine of the National Academy of Sciences to establish a committee to study medicare program administrative requirements that are applicable to health care providers under such program.

(2) COMMITTEE.—The committee described in paragraph (1) shall be composed of—

(A) at least 9 health care providers who participate in, and have significant experience working with, the medicare program;

(B) experts in paperwork reduction; and

(C) beneficiaries under the medicare program or their representatives.

(b) RECOMMENDATIONS.—The committee described in subsection (a) shall develop recommendations regarding how paperwork and administrative requirements under the medicare program can be minimized in a manner that—

(1) increases the time health care providers that are subject to such requirements have to spend in direct patient care; and

(2) maintains medicare program integrity and compliance with anti-fraud and abuse requirements.

In developing such recommendations, the committee shall seek to streamline variations in administrative and paperwork requirements between the medicare program and other government health programs and private health plans.

(c) REPORT.—

(1) IN GENERAL.—Not later than June 1, 2000, the committee described in subsection (a) shall submit a report to the Secretary of Health and Human Services, the Committees on Finance and Appropriations of the Senate and the Committees on Ways and Means, Commerce, and Appropriations of the House of Representatives.

(2) CONTENTS.—The report required under paragraph (1) shall contain a detailed description of the matters studied pursuant to subsection (a) and the recommendations developed pursuant to subsection (b), including such legislation and administrative actions as the committee considers appropriate.

(d) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated $1,000,000 for fiscal year 2000 to carry out the purposes of this section.

(2) AVAILABILITY.—Any sums appropriated under the authorization contained in this subsection shall remain available, without fiscal year limitation, until expended.

SEC. 14. CLARIFICATION OF APPLICATION OF SANCTIONS TO FEDERAL HEALTH CARE PROGRAMS.

(a) COVERAGE OF EMPLOYMENT.—Section 1128 of the Social Security Act (42 U.S.C. 1320a–7) is amended—

(1) in subsection (a), in the matter preceding paragraph (1), by inserting ''(including employment under)'' after ''participation in''; and

(2) in subsection (b), in the matter preceding paragraph (1), by inserting ''(including employment under)'' after ''participation in''.

(b) APPLICATION UNDER CIVIL MONEY PENALTY AUTHORITY.—Section 1128A of the Social Security Act (42 U.S.C. 1320a–7a) is amended—

(1) in subsection (a)(4), by striking ''program under title XVIII or a State health care program'' and inserting ''Federal health care program'' each place it appears;

(2) in subsection (a)(5)—

(A) by striking ''title XVIII of this Act, or under a State health care program (as defined in section 1128(h))'' and inserting ''a Federal health care program''; and

(B) by striking ''title XVIII, or a State health care program (as so defined)'' and inserting ''such program'';

(3) in the last sentence of subsection (a), by striking ''and to direct the appropriate State agency to exclude the person from participation in any State health care program''; and

(4) in subsection (h), by striking ''State agency or agencies administering or supervising the administration of State health care programs (as defined in section 1128(h))'' and inserting ''Federal or State agency or agencies administering or supervising the administration of any Federal health care program''.

(c) APPLICATION OF WAIVER PROVISIONS TO FEDERAL HEALTH CARE PROGRAMS.—Section 1128 of the Social Security Act (42 U.S.C. 1320a–7) is amended—

(1) in subsection (c)(3)(B), by striking ''upon the request of a State'' and inserting ''upon the request of the director of a Federal health care program'';

(2) in subsection (d)(3)(B)(i)—

(A) by striking ''State health care program'' and inserting ''Federal health care program''; and

(B) by striking ''State agency'' and inserting ''Federal or State agency''; and

(3) in subsection (d)(3)(B)(ii), by striking ''State health care program'' and inserting ''Federal health care program (other than under title XVIII)''.

(d) NOTICE PROVISION REGARDING FEDERAL HEALTH CARE PROGRAMS.—Section 1128 of the Social Security Act (42 U.S.C. 1320a–7) is amended—

(1) in the heading of subsection (d), by striking ''TO STATE AGENCIES AND EXCLUSION UNDER STATE HEALTH CARE PROGRAMS'' and inserting ''AND EXCLUSION UNDER FEDERAL HEALTH CARE PROGRAMS'';

(2) in subsection (d)(1), by striking ''State'' and inserting ''Federal'';

(3) in subsection (d)(2)—

(A) by striking ''State agency'' and inserting ''Federal or State agency'' each place it appears; and

(B) by striking ''State health care program'' and inserting ''Federal health care program'' each place it appears;

(4) in subsection (d)(3)(A), by striking ''State'' and inserting ''Federal''; and

(5) in subsection (g)(3)—

(A) by striking ''State agency'' and inserting ''Federal or State agency''; and

(B) by striking ''State health care program'' and inserting ''Federal health care program''.

(e) USE OF DEFINITION OF FEDERAL HEALTH CARE PROGRAM AND TREATMENT OF FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM AS A FEDERAL HEALTH CARE PROGRAM.—Section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f)) is amended—

(1) in the matter preceding paragraph (1), by inserting ''and sections 1128 and 1128A'' after ''this section''; and

(2) in paragraph (1), by striking ''(other than the health insurance program under chapter 89 of title 5, United States Code)''.

(f) AUTHORITY TO EXCLUDE FROM FEDERAL HEALTH CARE PROGRAMS BASED ON PRO RECOMMENDATIONS.—Section 1156(b)(1) of the Social Security Act (42 U.S.C. 1320c–5(b)(1)) is amended—

(1) in the second sentence, by striking ''eligibility to provide services under this Act on a reimbursable basis'' and inserting ''participation in any Federal health care program (as defined in section 1128B(f))''; and

(2) in the third sentence, by striking ''eligibility to provide services on a reimbursable basis'' and inserting ''participation in such programs''.

(g) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (2), the amendments made by this section shall take effect on the date of enactment of this Act.

(2) CONVICTIONS UNDER FEHBP.—The amendment made by subsection (e)(2) shall apply, with respect to convictions under the health insurance program under chapter 89 of title 5, United States Code, to convictions that occur on or after the date of enactment of this Act.

SEC. 15. PAYMENTS FOR DURABLE MEDICAL EQUIPMENT.

(a) IN GENERAL.—Section 1834(a)(1) of the Social Security Act (42 U.S.C. 1395m(a)(1)) is amended—

(1) in subparagraph (B)—

(A) in clause (i), by striking '', or'' at the end and inserting a semicolon; and

(B) by inserting after clause (ii) the following:

''(iii) the least expensive amount that the supplier of the item is paid by a Medicare+Choice organization for such item; or

''(iv) the least expensive amount that the supplier of the item is paid by any Federal health care program (as defined in section 1128B(f)) for such item;''; and

(2) by adding at the end the following:

''(E) ADMINISTRATIVE COSTS.—

''(i) IN GENERAL.—Except as provided in clause (ii), if—

''(I) the payment amount for an item is covered under clauses (iii) or (iv) of subparagraph (B); and

''(II) the Secretary determines that the administrative costs associated with billing and receiving reimbursement from the Secretary for the item exceeds the administrative costs associated with providing such item to a Medicare+Choice organization or another Federal health care program (as so defined);

then the Secretary shall adjust the payment rate for such item to reflect such excess.

''(ii) LIMITATION.—In no case may the payment rate for an item that is adjusted under clause (i) exceed the payment rate for such item determined in clauses (i) and (ii) of subparagraph (B).

''(iii) COLLECTION OF INFORMATION.—The Secretary shall collect from durable medical equipment suppliers that receive reimbursement under Federal health care programs (as so defined) such information as the Secretary determines is necessary in order to make the determination described in clause (i)(II).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to items provided on or after January 1, 2000.

SEC. 16. IMPLEMENTATION OF COMMERCIAL CLAIMS AUDITING SYSTEMS.

(a) COMMERCIAL CLAIMS AUDITING SYSTEMS.—

(1) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary shall require medicare carriers to use commercial claims auditing systems in the processing of claims under part B of the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) for the purpose of identifying billing errors and abuses.

(2) SUPPLEMENT TO OTHER TECHNOLOGY.—Commercial claims auditing systems required under paragraph (1) shall be used as a supplement to any other information technology used by medicare carriers in processing claims under the medicare program.

(3) UNIFORMITY.—In order to ensure uniformity in processing claims under the medicare program, the Secretary may require that medicare carriers utilize 1 or more common commercial claims auditing systems, provided that the selection of such system or systems by the Secretary shall be—

(A) after due consideration of competing alternative systems; but

(B) without regard to any provision of law that requires the use of competitive procedures (as defined in section 4 of the Office of Federal Procurement Policy Act (41 U.S.C. 403)) or the publication of notice of proposed procurements.

(4) IMPLEMENTATION.—Commercial claims auditing systems required under paragraph (1) shall be implemented by all medicare carriers by not later than 180 days after the date of enactment of this Act.

(b) MINIMUM SOFTWARE REQUIREMENTS.—Any commercial claims auditing system required to be implemented pursuant to subsection (a) shall, at a minimum—

(1) be a commercial item;

(2) surpass the capability of systems currently used in the processing of claims under part B of the medicare program; and

(3) be modifiable to—

(A) satisfy pertinent statutory requirements of the medicare program; and

(B) conform to policies of the Secretary regarding claims processing under such program.

(c) DISCLOSURE.—

(1) IN GENERAL.—Except as provided in paragraph (2), notwithstanding any other provision of law, any information technology (or data related thereto) utilized by medicare carriers in establishing a commercial claims auditing system pursuant to subsection (a) shall not be subject to public disclosure.

(2) AUTHORIZED DISCLOSURE.—The Secretary may authorize the public disclosure of the information described in paragraph (1) if the Secretary determines that—

(A) release of such information is in the public interest; and

(B) the information to be released is not protected from disclosure under section 552(b) of title 5, United States Code.

(d) DEFINITIONS.—In this section—

(1) COMMERCIAL CLAIMS AUDITING SYSTEM.—The term ''commercial claims auditing system'' means a commercial specialized auditing system that includes edits which identify inappropriately coded health care claims.

(2) COMMERCIAL ITEM.—The term ''commercial item'' has the meaning given such term in section 4 of the Office of Federal Procurement Policy Act (41 U.S.C. 403).

(3) INFORMATION TECHNOLOGY.—The term ''information technology'' has the meaning given such term in subparagraphs (A) and (B) of section 5002(3) of the Information Technology Management Reform Act of 1996 (40 U.S.C. 1401(3)), were such information technology to be acquired by an executive agency.

(4) MEDICARE CARRIER.—The term ''medicare carrier'' means an entity that has a contract with the Secretary pursuant to section 1842(a) of the Social Security Act (42 U.S.C. 1395u(a)).

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

SEC. 17. PARTIAL HOSPITALIZATION PAYMENT REFORMS.

(a) LIMITATION ON LOCATION OF PROVISION OF SERVICES.—

(1) IN GENERAL.—Section 1861(ff)(2) of the Social Security Act (42 U.S.C. 1395x(ff)(2)) is amended in the matter following subparagraph (I)—

(A) by striking ''and furnished'' and inserting ''furnished''; and

(B) by inserting '', and furnished other than in a skilled nursing facility or in an individual's personal residence'' before the period.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to partial hospitalization services furnished on or after the first day of the third month beginning after the date of enactment of this Act.

(b) QUALIFICATIONS FOR COMMUNITY MENTAL HEALTH CENTERS.—Section 1861(ff)(3)(B) of the Social Security Act (42 U.S.C. 1395x(ff)(3)(B)) is amended by striking ''entity'' and all that follows and inserting the following: ''entity that—

''(i) provides the mental health services described in paragraph (1) of section 1913(c) of the Public Health Service Act;

''(ii) meets applicable licensing or certification requirements for community mental health centers in the State in which it is located; and

''(iii) meets such additional standards or requirements as the Secretary may specify to ensure—

''(I) the health and safety of individuals being furnished such services;

''(II) the effective or efficient furnishing of such services (including protecting against fraud, waste, and abuse); and

''(III) the compliance of such entity with the criteria described in such section.''.

(c) REENROLLMENT OF PROVIDERS OF CMHC PARTIAL HOSPITALIZATION SERVICES.—

(1) IN GENERAL.—With respect to each community mental health center that furnishes partial hospitalization services for which payment is made under title XVIII of the Social Security Act, the Secretary of Health and Human Services shall provide for periodic recertification to ensure that the provision of such services complies with section 1913(c) of the Public Health Service Act.

(2) DEADLINE FOR FIRST RECERTIFICATION.—The first recertification under paragraph (1) shall be completed not later than 1 year after the date of enactment of this Act.

(d) PROSPECTIVE PAYMENT SYSTEM FOR PARTIAL HOSPITALIZATION SERVICES.—

(1) ESTABLISHMENT OF SYSTEM.—Section 1833 of the Social Security Act (42 U.S.C. 1395l) is amended by inserting after subsection (o) the following:

''(p)(1) The Secretary may establish by regulation a prospective payment system for partial hospitalization services provided by a community mental health center or by a hospital to its outpatients. The system shall provide for appropriate payment levels for efficient centers and hospitals and take into account payment levels for similar services furnished by other efficient entities.

''(2) A prospective payment system established pursuant to paragraph (1) shall provide for payment amounts for—

''(A) the first year in which such system applies, at a level so that, as estimated by the Secretary, the total aggregate payments under this part (including payments attributable to deductibles and coinsurance) for such year are not greater than the total aggregate payments that would have otherwise been made under this part if such system had not been implemented (assuming full implementation of the provisions contained in subsections (a) through (c) of section 17 of the Medicare Waste Tax Reduction Act of 1999); and

''(B) each subsequent year, in an amount equal to the payment amount provided for under this paragraph for the preceding year updated by the percentage increase in the Consumer Price Index for all urban consumers (all items; United States city average) for the 12-month period ending with September of that preceding year.''.

(2) COINSURANCE.—Section 1866(a)(2)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(A)) is amended by adding at the end the following: ''In the case of services described in section 1832(a)(2)(J), clause (ii) of the first sentence of this subparagraph shall be applied by substituting the payment basis established under section 1833(p) for the reasonable charges.''.

(3) CONFORMING AMENDMENTS.—

(A) Section 1832(a)(2) of the Social Security Act (42 U.S.C. 1395k(a)(2)) is amended—

(i) in subparagraph (B), by striking ''or subparagraph (I)'' and inserting '', (I), or (J)''; and

(ii) in subparagraph (J), by striking ''provided by a community mental health center (as described in section 1861(ff)(2)(B))''.

(B) Section 1833(a) of the Social Security Act (42 U.S.C. 1395l(a)) is amended—

(i) in paragraph (2) in the matter preceding subparagraph (A), by striking ''(H), and (I)'' and inserting ''(H), (I), and (J)'';

(ii) in paragraph (8), by striking ''and'' at the end;

(iii) in paragraph (9), by striking the period at the end and inserting ''; and''; and

(iv) by adding at the end the following:

''(10) in the case of partial hospitalization services, 80 percent of the payment basis under the prospective payment system established under section 1833(p).''.

(4) EFFECTIVE DATE.—The amendments made by paragraphs (2) and (3) apply to services furnished on or after January 1 of the first year that begins at least 6 months after the date on which regulations are issued under section 1833(p) of the Social Security Act (42 U.S.C. 1395l(p)) (as inserted by paragraph (1)).

SEC. 18. EXPANSION OF MEDICARE SENIOR WASTE PATROL NATIONWIDE.

There are authorized to be appropriated $25,000,000 in fiscal year 2000, and such sums as are necessary for fiscal years 2001 through 2003, for the purpose of carrying out, and expanding nationwide, the Health Care Anti-Fraud, Waste and Abuse Community Volunteer Demonstration Projects conducted by the Administration on Aging pursuant to the Omnibus Consolidated Appropriations Act, 1997 (Public Law 104–208).

SEC. 19. APPLICATION OF INHERENT REASONABLENESS TO ALL PART B SERVICES OTHER THAN PHYSICIANS' SERVICES.

(a) REPEAL OF CERTAIN PROVISIONS OF THE BALANCED BUDGET ACT OF 1997.—

(1) REPEAL.—Section 4316 of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 390), and the amendments made by such section, are repealed effective August 5, 1997.

(2) APPLICABILITY.—Effective August 5, 1997, the Social Security Act shall be applied and administered as if section 4316 of the Balanced Budget Act of 1997 (Public Law 105–33; 111 Stat. 390), and the amendments made by such section, had not been enacted.

(b) APPLICATION OF INHERENT REASONABLENESS TO ALL PART B SERVICES OTHER THAN PHYSICIANS' SERVICES.—

(1) IN GENERAL.—Section 1842(b)(8) of the Social Security Act (42 U.S.C. 1395u(b)(8)) is amended to read as follows:

''(8) The Secretary shall describe by regulation the factors to be used in determining the cases (of particular items or services) in which the application of this part (other than to physicians' services paid under section 1848) results in the determination of an amount that, because of its being grossly excessive or grossly deficient, is not inherently reasonable, and provide in those cases for the factors to be considered in establishing an amount that is realistic and equitable.''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall take effect August 5, 1997.

SEC. 20. STANDARDS REGARDING PAYMENT FOR CERTAIN ORTHOTICS AND PROSTHETICS.

(a) STANDARDS.—

(1) IN GENERAL.—Section 1834(h)(1) of the Social Security Act (42 U.S.C. 1395m(h)(1)) is amended by adding at the end the following:

''(F) ESTABLISHMENT OF STANDARDS FOR CERTAIN ITEMS.—

''(i) IN GENERAL.—No payment shall be made for an applicable item unless such item is provided by a qualified practitioner or a qualified supplier under the system established by the Secretary under clause (iii). For purposes of the preceding sentence, if a qualified practitioner or a qualified supplier contracts with an entity to provide an applicable item, then no payment shall be made for such item unless the entity is also a qualified supplier.

''(ii) DEFINITIONS.—In this subparagraph—

''(I) APPLICABLE ITEM.—The term 'applicable item' means orthotics and prosthetics that require education, training, and experience to custom fabricate such item. Such term does not include shoes and shoe inserts.

''(II) QUALIFIED PRACTITIONER.—The term 'qualified practitioner' means a physician or health professional who—

''(aa) is specifically trained and educated to provide or manage the provision of custom-designed, fabricated, modified, and fitted orthotics and prosthetics, and is either certified by the American Board for Certification in Orthotics and Prosthetics, Inc., or is credentialed and approved by a program that the Secretary determines, in consultation with appropriate experts in orthotics and prosthetics, has training and education standards that are necessary to provide applicable items;

''(bb) is licensed in orthotics or prosthetics by the State in which the applicable item is supplied; or

''(cc) has completed at least 10 years practice in the provision of applicable items.

''(III) QUALIFIED SUPPLIER.—The term 'qualified supplier' means any entity that is—

''(aa) accredited by the American Board for Certification in Orthotics and Prosthetics, Inc.; or

''(bb) accredited and approved by a program that the Secretary determines has accreditation and approval standards that are essentially equivalent to those of such Board.

''(iii) SYSTEM.—The Secretary, in consultation with appropriate experts in orthotics and prosthetics, shall establish a system under which the Secretary shall—

''(I) determine which items are applicable items and formulate a list of such items;

''(II) review the applicable items billed under the coding system established under this title; and

''(III) limit payment for applicable items pursuant to clause (i).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items provided on or after January 1, 2000.

(b) REVISION OF DEFINITION OF ORTHOTICS.—

(1) IN GENERAL.—Section 1861(s)(9) of the Social Security Act (42 U.S.C. 1395x(s)(9)) is amended by inserting ''(including such braces that are used in conjunction with, or as components of, other medical or non-medical equipment when provided by a qualified practitioner (as defined in subclause (II) of section 1834(h)(1)(F))) or a qualified supplier (as defined in subclause (III) of such section)'' after ''braces''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items provided on or after January 1, 2000.

SEC. 21. INCREASED FLEXIBILITY IN CONTRACTING FOR MEDICARE CLAIMS PROCESSING.

(a) CARRIERS TO INCLUDE ENTITIES THAT ARE NOT INSURANCE COMPANIES.—Section 1842 of the Social Security Act (42 U.S.C. 1395u) is amended—

(1) in subsection (a), in the matter preceding paragraph (1), by striking ''with carriers'' and inserting ''with agencies and organizations (in this section referred to as 'carriers')''; and

(2) by striking subsection (f).

(b) SECRETARIAL FLEXIBILITY IN CONTRACTING FOR AND IN ASSIGNING FISCAL INTERMEDIARY AND CARRIER FUNCTIONS.—

(1) IN GENERAL.—

(A) Section 1816(a) of the Social Security Act (42 U.S.C. 1395h(a)) is amended to read as follows:

''(a)(1) The Secretary may enter into contracts with agencies or organizations to perform any or all of the following functions, or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other organizations) to—

''(A) determine (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this part to be made to providers of services;

''(B) make payments described in subparagraph (A);

''(C) provide consultative services to institutions or agencies to enable them to establish and maintain fiscal records necessary for purposes of this part and otherwise to qualify as providers of services;

''(D) serve as a center for, and communicate to individuals entitled to benefits under this part and to providers of services, any information or instructions furnished to the agency or organization by the Secretary, and serve as a channel of communication from individuals entitled to benefits under this part and from providers of services to the Secretary;

''(E) make such audits of the records of providers of services as may be necessary to ensure that proper payments are made under this part;

''(F) perform the functions described by subsection (d); and

''(G) perform such other functions as are necessary to carry out the purposes of this part.

''(2) As used in this title and title XI, the term 'fiscal intermediary' means an agency or organization with a contract under this section.''.

(B) Section 1816(b)(1)(A) of the Social Security Act (42 U.S.C. 1395h(b)(1)(A)) is amended by striking ''after applying the standards, criteria, and procedures'' and inserting ''after evaluating the ability of the agency or organization to fulfill the contract performance requirements''.

(C) Section 1816(d) of the Social Security Act (42 U.S.C. 1395h(d)) is amended to read as follows:

''(d) Each provider of services shall have a fiscal intermediary that—

''(1) acts as a single point of contact for the provider of services under this part;

''(2) makes its services sufficiently available to meet the needs of the provider of services; and

''(3) is responsible and accountable for arranging the resolution of issues raised under this part by the provider of services.''.

(D) Section 1816(e) of the Social Security Act (42 U.S.C. 1395h(d)) is amended to read as follows:

''(e) The Secretary, in evaluating the performance of a fiscal intermediary, may solicit comments from providers of services.''.

(E) Section 1816(f)(1) of the Social Security Act (42 U.S.C. 1395h(f)(1)) is amended to read as follows:

''(f)(1) With respect to performance requirements under subsection (a), the Secretary may consult with—

''(A) Medicare+Choice organizations under part C of this title;

''(B) providers of services and other persons who furnish items or services for which payment may be made under this title; and

''(C) organizations and agencies performing functions necessary to carry out the purposes of this part.''.

(F) Section 1842(b)(2) of the Social Security Act (42 U.S.C. 1395u(b)(2)) is amended—

(i) in subparagraph (A)—

(I) by inserting ''(i)'' before ''No such contract'';

(II) by striking the second sentence and inserting the following:

''(ii) With respect to performance requirements for contracts under subsection (a), the Secretary may consult with—

''(I) Medicare+Choice organizations under part C of this title;

''(II) providers of services and other persons who furnish items or services for which payment may be made under this title; and

''(III) organizations and agencies performing functions necessary to carry out the purposes of this part.'';

(III) by striking the third sentence; and

(IV) by striking the fourth sentence and inserting the following:

''(iii) The Secretary may not require, as a condition of entering into a contract under this section or under section 1871, that a carrier match data obtained other than in its activities under this part with data used in the administration of this part for purposes of identifying situations in which section 1862(b) may apply.'';

(ii) in subparagraph (B), in the matter preceding clause (i), by striking ''establish standards'' and inserting ''develop contract performance requirements''; and

(iii) in subparagraph (D), by striking ''standards and criteria'' each place it appears and inserting ''contract performance requirements''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1816(b) of the Social Security Act (42 U.S.C. 1395h(b)) is amended—

(i) in the matter preceding paragraph (1), by striking ''an agreement'' and inserting ''a contract'';

(ii) in paragraph (1)(B), by striking ''agreement'' and inserting ''contract''; and

(iii) in paragraph (2)(A), by striking ''agreement'' and inserting ''contract''.

(B) Section 1816(c) of the Social Security Act (42 U.S.C. 1395h(c)) is amended—

(i) in paragraph (1)—

(I) in the first sentence, by striking ''An agreement'' and inserting ''A contract''; and

(II) in the last sentence, by striking ''an agreement'' and inserting ''a contract'';

(ii) in paragraph (2)(A), in the matter preceding clause (i)—

(I) by striking ''agreement'' and inserting ''contract''; and

(II) by inserting ''that provides for making payments under this part'' after ''this section'';

(iii) in paragraph (2)(C), by striking ''hospital, rural primary care hospital, skilled nursing facility, home health agency, hospice program, comprehensive outpatient rehabilitation facility, or rehabilitation agency'' and inserting ''provider of services (as defined in section 1861(u))''; and

(iv) in paragraph (3)(A)—

(I) by striking ''agreement'' and inserting ''contract''; and

(II) by inserting ''that provides for making payments under this part'' after ''this section''.

(C) Section 1816(h) of the Social Security Act (42 U.S.C. 1395h(h)) is amended—

(i) by striking ''An agreement'' and inserting ''A contract''; and

(ii) by striking ''the agreement'' each place it appears and inserting ''the contract''.

(D) Section 1816(i)(1) of the Social Security Act (42 U.S.C. 1395h(i)(1)) is amended by striking ''an agreement'' and inserting ''a contract''.

(E) Section 1816(j) of the Social Security Act (42 U.S.C. 1395h(j)) is amended in the matter preceding paragraph (1)—

(i) by striking ''An agreement'' and inserting ''A contract''; and

(ii) by striking ''for home health services, extended care services, or post-hospital extended care services''.

(F) Section 1816(k) of the Social Security Act (42 U.S.C. 1395h(k)) is amended—

(i) by striking ''An agreement'' and inserting ''A contract''; and

(ii) by inserting ''(as appropriate)'' after ''submit''.

(G) Section 1816(l) of the Social Security Act (42 U.S.C. 1395h(l)) is amended by striking ''an agreement'' and inserting ''a contract''.

(H) Section 1842(a) of the Social Security Act (42 U.S.C. 1395u(a)) is amended—

(i) in the matter preceding paragraph (1) (as amended by subsection (a)(1))—

(I) by striking ''carriers with which agreements'' and inserting ''single contracts under section 1816 and this section together, or separate contracts with eligible agencies and organizations with which contracts''; and

(II) by striking ''some or all of the following functions'' and inserting ''any or all of the following functions, or parts of those functions''; and

(ii) in paragraph (3), by inserting ''(to and from individuals enrolled under this part and to and from physicians and other entities that furnish items and services)'' after ''communication''.

(I) Section 1842(b) of the Social Security Act (42 U.S.C. 1395u(b)(2)(C)) is amended—

(i) in paragraph (2)(C), in the first sentence, by inserting ''(as appropriate)'' after ''carriers'';

(ii) in paragraph (3), in the matter preceding subparagraph (A), by inserting ''(as appropriate)'' after ''contract'';

(iii) in paragraph (7)(A), in the matter preceding clause (i), by striking ''the carrier'' and inserting ''a carrier''; and

(iv) in paragraph (11)(A), in the matter preceding clause (i), by inserting ''(as appropriate)'' after ''each carrier''.

(J) Section 1842(h) of the Social Security Act (42 U.S.C. 1395u(h)) is amended—

(i) in paragraph (2), in the first sentence—

(I) by striking ''an agreement'' and inserting ''a contract''; and

(II) by inserting ''(as appropriate)'' after ''shall'';

(ii) in paragraph (3)(A), by striking ''an agreement'' and inserting ''a contract'';

(iii) in paragraph (3)(B), in the third sentence, by striking ''agreements'' and inserting ''contracts'';

(iv) in paragraph (5)(A), by inserting ''(as appropriate)'' after ''carriers''; and

(v) in paragraph (8)—

(I) by striking ''an agreement'' and inserting ''a contract''; and

(II) by striking ''such agreement'' and inserting ''such contract''.

(c) ELIMINATION OF SPECIAL PROVISIONS FOR TERMINATIONS OF CONTRACTS.—

(1) Section 1816 of the Social Security Act (42 U.S.C. 1395h) is amended—

(A) in subsection (b), in the matter preceding paragraph (1), by striking ''or renew'';

(B) in subsection (c)(1), in the last sentence, by striking ''or renewing''; and

(C) by striking subsection (g).

(2) Section 1842(b) of the Social Security Act (42 U.S.C. 1395u(b)(2)) is amended by striking paragraph (5).

(d) REPEAL OF FISCAL INTERMEDIARY REQUIREMENTS THAT ARE NOT COST-EFFECTIVE.—Section 1816(f)(2) of the Social Security Act (42 U.S.C. 1395h(f)(2)) is amended to read as follows:

''(2) The contract performance requirements described in paragraph (1) shall include—

''(A) with respect to claims for services furnished under this part by any provider of services (as defined in section 1861(u)) other than a hospital, whether such agency or organization is able to process 75 percent of reconsiderations within 60 days and 90 percent of reconsiderations within 90 days; and''.

(e) REPEAL OF COST REIMBURSEMENT REQUIREMENTS.—

(1) Section 1816(c)(1) of the Social Security Act (42 U.S.C. 1395h(c)(1)) is amended—

(A) in the first sentence—

(i) by striking the comma after ''appropriate'' and inserting ''and''; and

(ii) by striking '', and shall provide for payment'' and all that follows before the period; and

(B) by striking the second and third sentences.

(2) Section 1842(c)(1) of the Social Security Act (42 U.S.C. 1395h(c)(1)) is amended—

(A) in the first sentence—

(i) by striking ''section shall provide'' and inserting ''section may provide''; and

(ii) by striking '', and shall provide'' and all that follows before the period; and

(B) by striking the second and third sentences.

(3) Section 2326 of the Deficit Reduction Act of 1984 (42 U.S.C. 1395h note) is amended by striking subsection (a).

(f) SECRETARIAL FLEXIBILITY WITH RESPECT TO RENEWING CONTRACTS AND TRANSFER OF FUNCTIONS.—

(1) Section 1816(c) of the Social Security Act (42 U.S.C. 1395h(c)) is amended by adding at the end the following:

''(4)(A) Except as provided in laws with general applicability to Federal acquisition and procurement or in subparagraph (B), the

Secretary shall use competitive procedures when entering into contracts under this section.

''(B)(i) The Secretary may renew a contract with a fiscal intermediary under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the fiscal intermediary has met or exceeded the performance requirements established in the current contract.

''(ii) Functions may be transferred among fiscal intermediaries without regard to any provision of law requiring competition. However, the Secretary shall ensure that performance quality is considered in such transfers.''.

(2) Section 1842(b)(1) of the Social Security Act (42 U.S.C. 1395u(b)(1)) is amended to read as follows:

''(b)(1)(A) Except as provided in laws with general applicability to Federal acquisition and procurement or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts under this section.

''(B)(i) The Secretary may renew a contract with a carrier under subsection (a) from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the carrier has met or exceeded the performance requirements established in the current contract.

''(ii) Functions may be transferred among carriers without regard to any provision of law requiring competition. However, the Secretary shall ensure that performance quality is considered in such transfers.''.

(g) YEAR 2000 COMPLIANCE.—

(1) Section 1816(f)(2) of the Social Security Act (42 U.S.C. 1395h(f)(2)) (as amended by subsection (d)) is amended by adding at the end the following:

''(B) a requirement that, by such time as the Secretary considers reasonable, the information technology that is used or acquired by the agency or organization to carry out its responsibilities under this title (to the extent that the Secretary finds such information technology is under the control of such agency or organization)—

''(i) meets the definition of 'Year 2000 compliant' under the Federal Acquisition Regulation (concerning accurate processing of date and time data (including calculating, comparing, and sequencing) from, into, and between the 20th and 21st centuries, and the years 1999 and 2000 and leap year calculations) but without regard to whether the information technology is being acquired; and

''(ii) meets such other criteria for Year 2000 compliance as the Secretary considers appropriate.''.

(2) Section 1842(b)(2)(A)(i) of the Social Security Act (42 U.S.C. 1395u(b)(2)(A)(i)) (as amended by subsection (b)(1)(F)) is amended by striking the period and inserting '', including a requirement that, by such time as the Secretary considers reasonable, the information technology that is used or acquired by such carrier to carry out its responsibilities under this title (to the extent that the Secretary finds such information technology is under the control of such carrier) meets—

''(I) the definition of 'Year 2000 compliant' under the Federal Acquisition Regulation (concerning accurate processing of date and time data (including calculating, comparing, and sequencing) from, into, and between the 20th and 21st centuries, and the years 1999 and 2000 and leap year calculations) but without regard to whether the information technology is being acquired; and

''(II) such other criteria for Year 2000 compliance as the Secretary considers appropriate.''.

(h) WAIVER OF COMPETITIVE REQUIREMENTS FOR INITIAL CONTRACTS.—Contracts that have periods that begin before or during the 1-year period that begins on the first day of the fourth calendar month that begins after the date of enactment of this Act may be entered into under section 1816(a) or 1842(a) of the Social Security Act (42 U.S.C. 1395h(a) and 1395u(a)) without regard to any provision of law requiring use of competitive procedures.

(i) EFFECTIVE DATES.—

(1) The amendments made by subsection (c) apply to contracts that have periods ending on or after the end of the third calendar month that begins after the date of enactment of this Act.

(2) The amendments made by subsections (a), (b), (d), and (e) apply to contracts that have periods beginning after the third calendar month that begins after the date of enactment of this Act.

(3) The amendments made by subsection (f) apply to contracts that have periods that begin after the end of the 1-year period specified in paragraph (1) of this subsection.

(4) The amendment made by subsection (g) shall take effect on the date of enactment of this Act.

SEC. 22. EXEMPTION OF INSPECTORS GENERAL FROM PAPERWORK REDUCTION ACT REQUIREMENTS.

(a) IN GENERAL.—Chapter 35 of title 44, United States Code, is amended by inserting after section 3502 the following:

''§ 3502a. Exemption of any Office of Inspector General

''This chapter shall not apply with respect to any Office of Inspector General established within an agency under the Inspector General Act of 1978.''.

(b) TABLE OF CONTENTS AMENDMENT.—The table of contents of chapter 35 of title 44, United States Code, is amended by adding after the item relating to section 3502 the following new item:

''3502a. Exemption of any Office of Inspector General.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act.

By Mr. SHELBY (for himself, Mr. BAYH, Mr. BRYAN, Mr. ROCKEFELLER, and Mr. BINGAMAN):

S. 1452. A bill to modernize the requirements under the National Manufactured Housing Construction and Safety Standards Act of 1974 and to establish a balanced consensus process for the development, revision, and interpretation of Federal construction and safety standards for manufactured homes; to the Committee on Banking, Housing, and Urban Affairs.

MANUFACTURING HOUSING IMPROVEMENT ACT.

● Mr. SHELBY. Mr. President, today I rise to introduce a bipartisan bill with my colleagues, Senators BAYH, BRYAN, ROCKEFELLER and BINGAMAN. Entitled the ''Manufactured Housing Improvement Act,'' (MHIA) this bill is designed to modernize the requirements under the National Manufactured Housing Construction and Safety Standards Act of 1974 and to establish a balanced consensus process for the development, revision, and interpretation of Federal construction and safety standards for manufactured homes.

Many do not realize that the majority of new manufactured homes of today are completely different from those of twenty or even ten years ago, and that this is the fastest growing segment of the housing industry. Today nearly one out of four new single family homes is a manufactured home, and the industry recently set a twenty-year sales record. There are good consumer-oriented reasons for this tremendous growth—manufactured homes offer quality and aesthetically pleasing housing at an average cost of $41,100, excluding the land. Today, manufactured housing has lowered the threshold to the American Dream of home ownership for millions of Americans, including first-time home buyers, senior citizens, young families, and single parents.

With 5.3 million American households in need of affordable housing, I believe it is imperative to update the laws that regulate the private sector solution to affordable housing. In order for the manufactured housing industry to remain competitive, Congress must modernize the National Manufactured Housing Construction and Safety Standards Act of 1974.

My bill would do just that. MHIA would establish a consensus committee that would submit recommendations to the Secretary of Housing and Urban Development (HUD) for developing, amending, and revising the Federal Manufactured Home Construction and Safety Standards. In addition, the committee would be authorized to interpret the standards and recommend appropriate regulations. Consumers will still be protected by HUD because the Secretary will have absolute authority to reject any recommendations, for any reason, submitted by the consensus committee.

The Manufactured Housing Improvement Act would authorize the Secretary of HUD to use industry label fees for the administration of the consensus committee and the hiring of additional HUD staff in order to assure adequate consumer protection. The Secretary of HUD would also be authorized to use industry label fees to facilitate the availability and affordability of manufactured homes.

This legislation is a very significant step forward in that both consumer and industry groups such as the Seniors Coalition, 60 Plus, and the Council for Affordable and Rural Housing, the National Association of Affordable Housing Lenders, the North American Steel Framing Alliance, and the Community Associations Institute, along with the Manufactured Housing Institute and the Manufactured Housing Association for Regulatory Reform, have endorsed this legislation.

The industry participants have modernized the quality and technology of manufactured housing. It's time for Congress to modernize the laws that regulate an industry that provides affordable housing and contributes more than $33 billion annually to our nation's economy.

Similar legislation passed the House at the end of last Congress on a bipartisan basis under suspension of the

rules and has been introduced again this year. I hope this year the Senate will take the lead and send the MHIA to the House as soon as possible.●

● Mr. BAYH. Mr. President, I am pleased to join with my colleague from Alabama, Senator SHELBY, to introduce the Manufactured Housing Improvement Act. This important legislation is designed to ensure that the manufactured housing industry continues to provide safe, affordable housing by modernizing the requirements under the National Manufactured Housing Construction and Safety Standards Act of 1974. The bill also provides the Department of Housing and Urban Development (HUD) with the resources necessary to meet its obligations to manufactured homeowners.

Manufactured housing has evolved significantly in the last twenty-five years; it's no longer the stereotypical mobile home. In fact, the vast majority of manufactured homes installed today are never moved once they have been sited. At an average cost of $40,000 for a new manufactured home, excluding land, manufactured housing is the fastest growing sector of the housing industry. One in every four new single family homes sold in the United States is a manufactured home. Manufactured housing provides many American families with the opportunity to not only own their own homes, but to live in safe, comfortable, and affordable housing. In addition, improvements in construction have led to the development of aesthetically pleasing homes. Most manufactured homes built today are manufactured to resemble traditional site built homes and are enjoyed by an array of Americans, including first time home buyers, senior citizens, and single parent families. Manufactured housing is an industry that not only provides affordable housing but also creates jobs. In my home state of Indiana, the manufactured housing industry employees more than 20,000 Hoosiers and has a total economic impact in my state of nearly $3 billion per year.

The Manufactured Housing Program at HUD, which oversees the industry, has faced many administrative challenges in the last decade. Lack of resources has prevented the program from keeping up with the changing needs of manufactured housing. While the industry has voluntary implemented numerous code changes in recent years, many requests to review standards or regulations currently await action by HUD or have taken numerous years to process, because of inadequate resources at the Department. Ten years ago, the number of HUD employees assigned to this program was 34. Today, only 8 HUD employees are responsible for this program. With the rapid growth in housing technology, it is imperative that HUD not only address these standards but do so in a timely fashion, allowing the industry to remain competitive while providing homeowners with the most advanced housing technology.

Our legislation will remedy this situation by modernizing the program by implementing procedures in which all proposed construction and safety standards are addressed and considered in a reasonable time frame. The Manufactured Housing Improvement Act requires that action on any proposed standard or regulation be taken within one year after it has been proposed to the Secretary. This is an important provision. It requires the Secretary to act, but protects consumers by authorizing the Secretary to reject any proposal which is deemed to be adverse to consumers.

Finally, through the use of industry labeling fees, this legislation provides economic resources to the Secretary for the hiring of additional HUD program staff. The costs of operating this program and the re-staffing of the manufactured housing program will continue to be borne by the manufactured housing industry, not the taxpayer. I note that the industry is willing to bear this expense in order to improve the efficiency of the regulatory system.

As we strive to ensure that all Americans have access to safe, affordable, and quality housing, we need to ensure that best practices are applied to the housing industry and that we support the modernization of housing technology. Manufactured housing is a valuable housing resource and provides access to home ownership for many Americans. I look forward to working with my colleagues to enact this legislation.●

● Mr. ROCKEFELLER. Mr. President, Once again, I am joining Senator SHELBY and other colleagues to introduce legislation intended to strengthen the manufactured housing industry. Manufactured housing provides a major source of affordable housing for American families, including seniors. This industry represents almost thirty percent of new single-family homes sold in the United States. In my state of West Virginia, manufactured housing represents over 60 percent of new homes.

Manufactured housing should play a strong role to increase the availability of affordable housing. This issue will be especially important to seniors who, according to a national survey, forty-five percent of households living in manufactured homes are headed by a person over 50 years old.

Manufactured housing is affordable housing, and it is the fastest growing type of housing nationally. The average cost of a new manufactured home without land in 1997 was $38,400, and even with land and installation fees this cost is well below the typical costs of a newly constructed site-built home.

But this industry faces challenges. Unlike other housing, manufactured housing is regulated by the 1974 National Manufactured Housing Construction and Safety Standards Act by the Department of Housing and Urban Development, (HUD). Because of reform in HUD management, the federal officials overseeing manufactured housing have declined from 34 staff members at its peak to less than a dozen professional staff now. This decline in staff has occurred at the same time that the industry has grown. Unfortunately, due to a lack of staff, HUD cannot keep pace with the need to update the code on a consistent basis and timely manner. In fact, between 1989 and 1996, a consensus committee made 140 suggestions to HUD about changes for the federal codes on manufactured housing, and 80 of these provisions are still pending in the Department. For example, the 1999 National Electrical Code has new, state-of-the-art standards but given staffing shortage, how long will it take to update the electrical standards? Shouldn't we address the staffing shortage, and get action on the lingering recommendations?

In 1990, Congress established a National Commission on Manufactured Housing, and pushed the commission to forge consensus on key issues for this important industry, unfortunately that effort collapsed in 1994.

This legislation is a new effort to address the challenges facing the industry. Introduction of the bill is just a first step. We all understand that the legislative process is designed to seek consensus and improve legislation. I believe that we must work hard to forge consensus among the industry and the consumers. This will be a challenge, but the potential rewards can be great for both sides. The industry can win and prosper with a more effective, streamlined regulatory process that keeps pace with improvements and standards. Consumers will win if safety standards and regulations are adopted more efficiently. Also, if the industry uses new standards to provide better housing, manufactured housing could be designed to meet a wider variety of needs including modules for assisted living.

The current system of regulations and oversight is not working for the industry, nor is it working as well as it should for consumers, according to a survey by seniors. But when there are problems and concerns, all groups need to work together on a strategy for change.

This legislation is intended to promote reform that will help both the industry and the consumers of manufactured housing. My hope is that all sides will work together to forge consensus about reform.

We should use this as an opportunity to come together and develop a new, improved strategy for manufactured housing. Affordable housing is a major issue for families and communities. Manufactured housing is playing a key role in affordable housing, but more could and should be done. To achieve success, we need to develop a bipartisan, consensus approach. We need to help the industry and assure consumers that safety and standards will be retained and improved, not weakened. This is worth our combined effort to provide more affordable housing.●

● Mr. BINGAMAN. Mr. President, I am pleased to rise today as a cosponsor of the Manufactured Housing Improvement Act. This Act has come about as a result of much negotiation between buyers of manufactured housing, the Housing and Urban Development Agency and manufacturers and dealers of manufactured housing. I commend the industry for coming to Congress with its plan to modify the Federal Manufactured Home Construction and Safety Standards Act of 1974. Over twenty years has elapsed since we comprehensively addressed the topic of safety and manufactured housing. Manufactured housing has changed significantly in the past twenty years. With the rise in the number of buyers of manufactured housing, it is time we ensure that safety standards are up-to-date and adequate to address consumers' concerns.

The Senate bill has eleven sections that cover everything from the establishment of a Consensus Committee to a section encouraging secondary market securitization programs for FHA manufactured home loans and other loan programs. The new Consensus Committee will consist of 25 voting members and one non-voting member representing the Secretary of HUD. The Committee will represent a wide spectrum of interested parties, including but not limited to, home producers, retailers, lenders, insurers, consumers, consumer organizations, local public officials, and fire marshals. The Committee will be responsible for recommending amendments to the current safety standards and enforcement regulations to HUD.

Most notably, there is no funding being authorized in this bill. The Secretary of HUD is authorized to use the industry label fees to carry out the responsibilities under the Act and to administer the Consensus Committee.

Not only does manufactured housing provide an affordable housing option for New Mexicans, the overall economic impact of the manufactured housing industry on New Mexico is significant. In 1998, the total economic impact on the state was over $264 million. Although most New Mexicans are familiar with the 157 retailers in the state, many are not aware that we also have two manufacturers located in the state. Last year, these manufacturers produced over 1,000 homes and the entire industry was responsible for employing more than 2,000 people. Anyone driving the highways of New Mexico is familiar with the site of a manufactured home moving across Interstate 40 or Interstate 25. However, many New Mexicans may not know that almost 7,000 homes were shipped into the state in 1998 alone.

Manufactured housing serves an important role in New Mexico. With the rising cost of homes in the metropolitan areas, and even in the smaller northern communities, manufactured housing that have an average cost of only $42,900 enable many more individuals and families to become homeowners. Currently, 41.8% of the housing in New Mexico is manufactured housing.

I think this bill is important not only to New Mexico but to all owners of manufactured housing. With a focus on construction safety standards, consumers will be safer and more secure in their new homes. Both the manufactured Housing Industry and the Congress need to take the concerns raised in the survey conducted by the American Association of Retired Persons seriously. The Consensus Committee created by this bill will play an important role in raising the standards for construction and safety. I hope the Committee thoroughly evaluates the construction concerns and safety issues raised by those responding to AARP's survey. It is critical to the success of this program that the owners, the builders and the regulators work together to achieve a higher level of safety and consumer satisfaction.

I thank Senator SHELBY for introducing this bill and I encourage the Senate to take up this bill and pass this worthwhile legislation.●

By Mr. FRIST (for himself, Mr. FEINGOLD, Mr. BROWNBACK, and Mr. LIEBERMAN):

S. 1453. A bill to facilitate relief efforts and a comprehensive solution to the war in Sudan; to the Committee on Foreign Relations.

SUDAN PEACE ACT

● Mr. FRIST. Mr. President, the United States has a tradition of defining our national interests overseas to reflect our values: freedom from persecution, freedom from religious intolerance, and the inalienable rights of self-determination and economic opportunity. In the twentieth century alone, we have sacrificed so much to defend those interests worldwide, based on the belief that freedom is truly an inalienable right, not simply for Americans, but for all peoples. Even now, in Kosovo and in Bosnia, we have been the world leaders in defending against tyranny and oppression, believing that, although far away, injustice must be met with resolve.

Our response to the tragedy and injustice in Sudan has not been quite so aggressive. The radical Islamic regime in power in Sudan has coordinated a systematic campaign of terror against southern Sudan which includes calculated starvation, slavery, and the killing of innocent women and children. The war of low-level ethnic cleansing in Sudan has ground on for 16 years, claiming the lives of nearly 2 million and displacing over 4 million. That staggering number represents more dead than the wars in Bosnia, Kosovo, Somalia, Afghanistan, and Chechnya combined. In terms of loss of life, it has been the costliest war this century since the Second World War. After 10 years of feeding the starving, with the war no closer to resolution than it was in 1983 when it began, we must change our approach. While we have been very generous as a Nation in terms of humanitarian relief, we have done little to address the causes of the war.

Along with my colleagues, Senator FEINGOLD, Senator BROWNBACK, and Senator LIEBERMAN, I am introducing the ''Sudan Peace Act,'' which aims to strengthen American policy and resolve to end the status quo.

The timing of this initiative is critical. The Government of Sudan has publicly announced that they will use incoming oil revenues to increase the tempo and lethality of the war. An increase in the lethality and tempo of the war would translate into more death and destruction, more shattered lives and more slaves. Thus, time is of the essence in supporting efforts to reach a comprehensive conclusion to the hostilities. Even under such grim circumstances, a glimmer of opportunity to push for a comprehensive solution to the conflict may be at hand. We must take full advantage of that chance, for without the leadership of the United States, the war will certainly drag on for many more years.

International relief operations have been in existence for 10 years with little change. The current arrangement allows Khartoum to manipulate our food donations as a weapon of mass destruction by vetoing United Nations' relief flight plans in areas of rebel activity. Also, at a cost of over $1 million per day, the effort is wrought with the potential for extreme donor fatigue.

We need a new policy using all points of pressure and directing all efforts toward a comprehensive negotiated solution. Reinvigorating and pursuing a peace process based on the Declaration of Principles, signed by the combatants in 1994, is the best means we have to push for a comprehensive solution at this time. So far, the Government of Sudan has refused to negotiate in good faith, choosing instead to continue the brutal war and create political diversions to any credible, binding process.

With a set of new or strengthened political and humanitarian tools, this legislation aims to push all players toward a comprehensive negotiated solution.

The Government of Sudan has long abetted the practice of slavery. Additionally, it has helped organize and coordinate militia, Popular Defense Forces, and paramilitary holy warriors (''muraheleen'') to terrorize and sometimes enslave traditional agricultural and pastoralist tribes in the south and in the Nuba Mountains.

The legislation condemns the gross violations of human rights in Sudan—including slavery, the use of the denial of access to food as a weapon of mass destruction, and targeting of civilians—and increases pressure for action in the United Nations Security Council and for UN human rights monitors to be deployed in contested areas.

The effort to stop the conflict in Sudan has the best chance of success if

it is a multinational effort. The shameful lack of resolve among the international community to pressure the combatants has been a factor in the perpetuation of the conflict.

The legislation does more than simply highlight the shameful lack of resolve internationally, it seeks to change our own policy to address the causes of the famine and the war.

The legislation gives the Secretary of State clear authority to commit all necessary diplomatic efforts toward reinvigorating the Inter-governmental Authority on Development (IGAD) peace process, including any necessary support for implementation of a settlement. It calls upon the leadership of the members of IGAD and the IGAD Partners Forum (IPF—a grouping of donors and multilateral organizations) to give all necessary support.

The combination of a Declaration of Principles on which a peace process should be based and the engagement of the IGAD Partners' Forum bodes well for a reinvigoration of what has been a foundering process. The fact that IGAD is a credible regional organization adds to its potential success. The Declaration of Principles provides a first critical, measurable step to which the combatants can be held accountable.

The legislation supports the President's sanctions against Sudan, codifying them into law and protecting them from piecemeal erosion until Sudan makes substantial and verifiable progress toward peace. The existing sanctions must be used as a pressure point for peace.

The United States must maintain or strengthen every possible point on which to pressure Sudan to engage in a meaningful peace process. Any relaxation of any portion of the sanctions would essentially be a reward to Khartoum.

The legislation also requires the President to report to Congress on the status and means of financing the new oil fields in Sudan and that financing's relationship to the sanctions, the number and circumstances of bombings of civilian targets by the Government of Sudan, the extent to which humanitarian operations are being compromised, and whether progress is being made toward peace by all parties.

The issue of financing oil fields is especially important. The revenues from the new sources of oil will add a new source of hard currency to finance the war. A key player in making that influx of hard currency into Khartoum is a Canadian company that is listed on the New York Stock Exchange. Considering the wording of the sanctions in the President's Executive order of 1997, such a financial instrument would seem to be something the United States would not be able to legally facilitate. It is certainly not something the United States should want to facilitate.

The United Nations-coordinated relief effort in Sudan, known as Operation Lifeline Sudan (OLS), was founded in 1989 in response to the starvation deaths of 250,000 people in southern Sudan. In March and April 1998 the Government of Sudan denied OLS access to much of Bahr el Ghazal in an effort to starve out rebels. The ban caused severe famine.

The ability of the Government of Sudan to veto OLS relief flight plans has allowed Khartoum to use food as a weapon of mass destruction. It indiscriminately targets combatants and noncombatants alike. Only with the cooperation and pressure from the members of the Security Council and those countries which continue normal trade relations with Sudan can we ever hope to achieve success on this point. Having a viable alternative to OLS would not only allow for the distribution of relief should a flight ban be imposed, it will immediately discourage Khartoum's use of flight bans as an instrument of war.

This legislation continues to press for reform of all humanitarian assistance in Sudan. The bill includes measures to press for reform of OLS, for the continued use of relief organizations outside OLS to deliver the United States' relief assistance, and directs the Administration to develop a possible alternative organization to deliver relief, should Khartoum again place bans on relief flights.

The use of non-OLS groups to distribute relief has two primary benefits. First, it fills in holes where OLS is prohibited from operating either by Khartoum or by its own security concerns. It can also strengthen the hand of OLS with respect to flight bans because Khartoum is reluctant to exercise its veto power when it clearly strengthens organizations outside its control.

The legislation provides new and expanded authority for the Sudan Transition Assistance for Rehabilitation (STAR) program, which seeks to build the basic civil and economic institutions in areas devastated by the war.

The move away from providing only disaster assistance toward providing development assistance is critical. STAR seeks to build the basic administrative and social institutions in areas outside of government control essential for a self sustaining Sudan: civil administration, civil society, agricultural extension services, courts, etc. One of the greatest advantages Khartoum enjoys is a destroyed society in the south. Again, a stronger society and economy in the south serves to disabuse Khartoum of the notion that it can win outright on the battlefield and is thus a pressure point to push for commitment to a viable peace process. The reconciliation efforts between the Dinka and Nuer peoples is arguably the most significant development in recent years in terms of strengthening the areas outside of the government's control and putting pressure on Khartoum to come to the table. Support for those efforts are critical. Finally, this position makes no assumption nor policy statement with regard to the eventual political status of the south.

The legislation also provides for an independent assessment of the humanitarian needs of certain regions in Sudan, which are heavily contested and thus excluded from most multilateral humanitarian operations. The Nuba Mountains and its unique and fast-disappearing people and culture is especially vulnerable.

In an effort to reduce the diversion of food assistance to combatants, to strengthen the targeted population's ability to defend themselves, and to provide for separation of combatants from ongoing humanitarian operations and the personnel who run them, the bill gives the President authority to provide direct food assistance to those forces protecting noncombatants from attacks by government or government-sponsored forces. However, such a program may only be conducted completely separate from current or future humanitarian operations and without compromising them.

Currently, the majority of relief agencies, both within and outside OLS, provide assistance only to noncombatants. As a consequence, hungry rebel forces routinely divert food aid away from delivery areas, either by taxation, or by taking the food outright. The result is that normal food distribution is disrupted and any reasonable separation between combatants and noncombatants is breached. Providing a separate mechanism to feed combatants—who will be receiving food aid in one form or another, regardless of the distribution scheme—hOLSs the possibility of reducing diversions, maintaining a clear separation between combatant and noncombatants, and thus helping to minimize risk to relief agency personnel. Additionally, the necessity of pursuing food has seriously undermined the effectiveness of those forces to defend the population in areas outside of government control, as they must often demobilize for long periods of time to exact food from relief supplies or tend to farming or herding responsibilities. The Administration should make a determination on the potential for such a program to meet the goals outlined in the section. This legislation gives the President the authority to do so, with strong provisions to protect current humanitarian operations. Like other capacity building measures in this legislation, enhancing the ability of those in areas outside of government control to defend themselves from government aggression will ultimately help to dissuade the government from continued prosecution of the war and will thus strengthen the push to engage in a comprehensive peace process.

These are all critical measures and opportunities which the United States must seize. Our policy has not done enough to change the status quo. Our generous response, which began in 1989, has grown and continued to feed more of the starving, yet as a response to the war, it has grown tepid. Unless we do all we can to end the conflict in Sudan,

we are part of the problem. For sixteen years we have witnessed the destruction of a nation and the loss of millions of lives, ground into dust as the world misses opportunity after opportunity to stop it.●

By Mr. ROBB (for himself, Mr. LAUTENBERG, Mr. CONRAD, Mr. HARKIN, Mr. KENNEDY, Mr. DASCHLE, Mr. REID, Mrs. MURRAY, Mr. LEVIN, Mr. CLELAND, Mr. DODD, Mr. TORRICELLI, Mr. SCHUMER, Mrs. LINCOLN, Mr. JOHNSON, Mr. WELLSTONE, Mr. KERRY, Mr. KERREY, and Mr. AKAKA):

S. 1454. A bill to amend the Internal Revenue Code of 1986 to expand the incentives for the construction and renovation of public schools and to provide tax incentives for corporations to participate in cooperative agreements with public schools in distressed areas; to the Committee on Finance.

PUBLIC SCHOOL MODERNIZATION AND OVERCROWDING RELIEF ACT OF 1999

Mr. ROBB. Mr. President, I have come before this chamber on numerous occasions to urge our colleagues to find a way to give states and localities the additional resources they so urgently need to build and renovate our nation's schools. In January, Senator LAUTENBERG and I, with several other colleagues, introduced the Public School Modernization Act of 1999. In March, Senators LAUTENBERG, HARKIN, and I were successful in offering an amendment to this year's budget resolution which called for $24.8 billion in zero-interest bonds as well as direct grants for school construction and repair. That amendment passed the Senate unanimously. Regrettably the Senate Finance Committee tax bill includes only minimal school infrastructure assistance, despite the opportunity we had in Committee to include much more substantial infrastructure relief.

Proposals regarding school construction have been offered from both sides of the aisle. Unfortunately, however, the debate about education infrastructure needs and the federal role to address those needs has too often been partisan and has been characterized by an inability or an unwillingness to recognize that there is no one-size-fits-all solution to the school construction dilemma facing many of our nation's school districts.

So today, I am pleased to be joined by Senators LAUTENBERG, CONRAD, HARKIN, KENNEDY, DASCHLE, REID, MURRAY, LEVIN, CLELAND, DODD, TORRICELLI, SCHUMER, LINCOLN, JOHNSON, WELLSTONE, KERRY, KERREY, and AKAKA in introducing legislation designed to combine various bipartisan school construction proposals to create a menu of school construction financing options. The Public School Modernization and Overcrowding Relief Act of 1999 will help school districts build new schools to accommodate the record enrollments of elementary and secondary students we know are coming. It will also help modernize schools to ensure that our children have the benefit of modern technology. And it will help repair old schools which have become outdated and unsafe.

Mr. President, 14 million children attend schools in need of extensive repair or replacement. Twelve million attend schools with leaky roofs, and 7 million attend schools with safety code violations. The President of the Maine Education Association testified before the Health, Education, Labor and Pensions Committee recently and stated that there are schools in Maine that actually turn the lights out when it rains because the electrical wiring is exposed under their leaky roofs.

Compounding the safety problem is the significant overcrowding in the nation's schools. Across the country, there are thousands and thousands of trailers used for instruction—over 3,000 are in use in Virginia alone. So instead of attending science class equipped with the latest technology to conduct biology experiments, our children are going to class in poorly-ventilated portable trailers that can actually be harmful to their health.

Mr. President, Loudon County, Virginia will need to build 22 new schools over the next six years to accommodate its enormous population growth. Despite the help that our own Virginia General Assembly has approved, the state will only provide two to three percent of Virginia's total school infrastructure needs. This isn't just a Virginia phenomenon; it's a national crisis. The National Center for Education Statistics estimates that by 2003, the nation will need to build 2,400 new schools to accommodate record enrollments in our elementary and secondary schools.

In short, school boards should not be forced to choose between hiring an additional teacher or fixing a leaky roof. School superintendents should be installing computer labs, not basic air conditioning. And students should attend schools of the future, not relics of the past.

The legislation we offer today will allow school districts to issue tax-exempt bonds for school construction. Localities will be able to save significant amounts of money on capital improvement projects, as the federal government would give bondholders a tax credit in the amount of the interest that the locality would otherwise be required to pay. The legislation also knocks down a statutory hurdle which currently hinders more private sector involvement in public education by allowing private entities to pool resources with states and localities to build and renovate school buildings. Furthermore, if a state or locality has previously issued bonds at a time when interest rates were high, this legislation would allow them to essentially refinance that debt to take advantage of today's lower interest rates. The legislation will also make it easier for small communities to issue a greater number of bonds without being subject to onerous arbitrage requirements. All of these provisions provide states and localities with choices. Under this legislation, our states and localities will be able to avail themselves of those provisions that best suit their financial needs. The bill creates a menu of options through which states and localities can assemble their own financing packages.

Mr. President, as a former governor, I acknowledge that education is primarily a state and local responsibility. The federal government, however, can be a helpful partner in education by helping to defray the cost of capital improvements without interfering with the substantive decisions that states and localities are struggling to make regarding their academic reform efforts. Providing a variety of financing options to fund capital improvements, therefore, is an imminently constructive role for the federal government to play. For our public education system to be the best in the world, all three levels of government—local, state, and federal—will have to work together.

I thank my colleagues who have cosponsored this legislation, and I look forward to working with them to pass it. It's flexible. It's sensible. And it provides the most financing options of any school construction proposal to date. I hope this legislation brings us one step closer to the compromise I know we can reach.

Mr. President, in the 1930's and again in the 1950's, our grandparents and parents summoned the political will to build the vast majority of our nation's existing school buildings. It is my hope that we can summon that will again. Our nation's students and families deserve no less.●

By Mr. ABRAHAM (for himself and Mr. FEINGOLD):

S. 1455. A bill to enhance protections against fraud in the offering of financial assistance for college education, and for other purposes; to the Committee on the Judiciary.

THE COLLEGE SCHOLARSHIP FRAUD PREVENTION ACT OF 1999

Mr. ABRAHAM. Mr. President, I rise today with my colleague from Wisconsin, Senator FEINGOLD, to introduce the College Scholarship Fraud Prevention Act of 1999. This legislation will prevent unscrupulous businesses from defrauding students seeking to finance a college education.

Students in Michigan and across the nation are targeted by corrupt companies preying on their hopes and dreams of a college education. A college diploma is the key that opens the door to many of today's career opportunities, but the reality is that this diploma is becoming more and more expensive to obtain. A number of organizations have sprung up to address this problem, and many of them perform an invaluable