difference between estimated spending under FAA's current plan for security improvements and spending for such improvements under the bill. Because S. 2440 would affect direct spending, pay-as-you-go procedures would apply, but CBO estimates the net impact on direct spending would be negligible.

S. 2440 contains an intergovernmental mandate as defined in the Unfunded Mandates Reform Act (UMRA) because it would require airport operators to improve airport security. CBO estimates that the new requirements would impose no significant costs on state, local, or tribal governments, including public airport authorities.

S. 2440 would impose private-sector mandates, as defined in UMRA, on air carriers and security screening companies. CBO expects that total costs of those mandates would not exceed the annual threshold established by UMRA for private-sector mandates ($109 million in 2000, adjusted for inflation).

ESTIMATED COST TO THE FEDERAL GOVERNMENT

The estimated budgetary impact of S. 2440 is shown in the following table. The costs of this legislation fall within budget function 400 (transportation).

SPENDING ON SECURITY IMPROVEMENTS TO AIR TRAFFIC CONTROL FACILITIES SUBJECT TO APPROPRIATION

[By fiscal year, in millions of dollars]

	2000	2001	2002	2003	2004	2005
Spending Under Current Plan:						
Estimated Authorization Level	12	19	20	23	25	25
Estimated Outlays	6	20	20	22	24	25
Proposed Changes:						
Estimated Authorization Level	0	61	70	67	−25	−25
Estimated Outlays	0	46	68	68	−2	−25
Spending Under S. 2440:						
Estimated Authorization Level	12	80	90	89	0	0
Estimated Outlays	6	66	88	90	22	0

BASIS OF ESTIMATE

For this estimate, CBO assumes that S. 2440 will be enacted near the beginning of fiscal year 2001 and that the necessary amounts will be appropriated for each fiscal year. Estimated outlays are based on historical spending patterns.

S. 2440 would require the FAA to expand and accelerate its current plans to improve security at air traffic control facilities. Based on information from the FAA, implementing this provision of the bill would cost about $155 million over the 2001–2005 period. This amount includes a spending increase of $182 million during the 2001–2003 period and a $27 million reduction in spending over the following two years, relative to current plans for security improvements.

Implementing S. 2440 would require airports and air carriers to increase the number of fingerprint checks on employees and potential hires that are conducted by the FBI with assistance from the Office of Personnel Management. Both of these agencies would receive payments from airport operators and air carriers (or their contractors), which would be recorded as offsetting receipts (a credit against direct spending). These payments could then be spent without further appropriation action to conduct fingerprint checks on employees. Since the additional direct spending and offsetting receipts would be approximately equal, we estimate that the net impact on direct spending of this provision would be negligible.

PAY-AS-YOU-GO CONSIDERATIONS

the Balanced Budget and Emergency Deficit Control Act sets up pay-as-you-go procedures for legislation affecting direct spending or receipts. implementing S. 2440 would affect direct spending, but CBO estimates that any such effects would be negligible.

ESTIAMTED IMPACT ON STATE, LOCAL, AND TRIBAL GOVERNMENTS

S. 2440 contains an intergovernmental mandate as defined in UMRA because it would require airport owners and operators to improve airport security. Based on information from the Airports Council International and the Air Transport Association, CBO estimates that the new requirements would impose no significant costs on state, local, or tribal governments, including airport authorities, because under existing contracts and agreements any additional costs would be borne by air carriers and other airport tenants.

ESTIMATED IMPACT ON THE PRIVATE SECTOR

S. 2440 would impose private-sector mandates, as defined by UMRA, on air carriers and security screening companies. Based on information from the FAA and industry representatives, CBO estimates that the costs of those mandates would not exceed the annual threshold established by UMRA for private-sector mandates ($109 million in 2000, adjusted for inflation).

First, the bill would mandate new hiring procedures and training standards for airport security workers. Section 2 would require air carriers to conduct an FBI electronic fingerprint check on all applicants for certain positions related to airport security positions with unescorted access to sensitive areas, positions with responsibility for screening passengers or property (screeners), and screener supervisor positions. Because the FBI electronic fingerprint checks would make the current price of employment investigations and subsequent audits of those investigations unnecessary, enacting this section could result in savings for air carriers. Section 3 would require additional hours of training for security screeners. In addition, the bill would require that computer training facilities be located near certain airports.

Second, the bill would accelerate the effective date of two sets of requirements that the FAA plans to implement in the next year. Section 3 would accelerate the FAA's current proposed rule on the Certification of Screening Companies. The rule is intended to improve aviation security by requiring companies and air carriers that provide security screening to be certified by the FAA. Section 4 would also accelerate a number of requirements on air carriers to improve security at access control points at airports. Most significantly, the section would require air carriers to develop and implement programs that foster and reward compliance with access control requirements. Because S. 2440 would accelerate implementation of those new mandates, air carriers and security screening companies would incur some compliance costs months earlier compared to current law.

Third, Section 6 would require the FAA to gradually increase the random selection factor in the Computer-Assisted Passenger Prescreening System (CAPPS) at airports where bulk explosive detection equipment is used. The selection factor controls the number of passengers randomly selected to have their baggage undergo enhanced security checks. If bulk explosive detection equipment is available, it is used for this enhanced security check. If it is not available, the passenger's baggage is placed on the airplane only after the air carrier has confirmed that the passenger is on board.

Because only about 5 percent of airports use the bulk explosive detection equipment, enacting Section 6 would, in theory, increase the number of bags that would be checked with the bulk explosive detection equipment in only a few airports. According to the FAA and industry representatives, however, a limitation in CAPPS would not allow an increase in the random factor in a subset of selected airports. All airports would be subject to the increased random factor. Thus, to comply with the mandate air carriers would have to either (1) reprogram their computer systems to selectively increase the random selection factor in airports that use bulk explosive detection equipment or (2) increase the number of bags undergoing enhanced security checks based on the factor whether or not an airport uses such equipment. In either case, air carriers would incur the incremental cost of checking the additional bags at airports that use bulk explosive detection equipment.

Estimate prepared by: Federal Costs: James O'Keeffe (226–2860). Impact on State, Local, and Tribal Governments: Victoria Heid Hall (225–3220). Impact on the Private Sector: Jean Wooster (226–2940).

Estimate approved by: Peter H. Fontaine, Deputy Assistant Director for Budget Analysis.

VICTIMS OF GUN VIOLENCE

Mr. REID. Mr. President, it has been more than a year since the Columbine tragedy, but still this Republican Congress refuses to act on sensible gun legislation.

Since Columbine, thousands of Americans have been killed by gunfire. Until we act, Democrats in the Senate will read the names of some of those who have lost their lives to gun violence in the past year, and we will continue to do so every day that the Senate is in session.

In the name of those who died, we will continue this fight. Following are the names of some of the people who were killed by gunfire one year ago today. September 6, 1999: Andres Aguliar, 33, Houston, TX; Sharon Barraso, 20, Philadelphia, PA; Tony Butler, 18, Philadelphia, PA; Edwin Cordova, 23, Houston, TX; Tijuan Dickey, 19, Baltimore, MD; Ellis Hair, 21, Chicago, IL; Anthony Jones, 32, Detroit, MI; Louis Merril, 17, Chicago, IL; Oscar Murray, 24, Detroit, MI; Isaac Noyola, 21, Houston, TX: Kevin Parker, 23, St. Louis, MO; Michael Sanchez, 28, Philadelphia, PA: Gregory Scott, 30, Houston, TX; Vincent Casey Stanley, 36, Memphis, TN; Cheryl Thornton, 20, New Orleans, LA; Unidentified Male, 58, Norfolk, VA; and Unidentified Male, 25, Norfolk, VA.

One of the gun violence victims I mentioned 23-year-old Edwin Cordova of Houston, was on his way home from a trip to Galveston with a group of friends. After passing a truck that had been attempting to block their way, one of the truck's passengers fired gunshots through the rear window of the vehicle. Cordova, who was riding in the front passenger's seat, died at the hospital of a gunshot wound to the neck.

We cannot sit back and allow such senseless gun violence to continue. The deaths of these people are a reminder to all of us that we need to enact sensible gun legislation now.

A STRONG MEDICARE FOR OUR SENIORS' FUTURE

Mr. ABRAHAM. Mr. President, Medicare, that's what seniors and health care providers in Michigan talked

about with me over the August recess—Medicare. Whether it was prescription drug coverage for Medicare beneficiaries, Medicare reimbursement restoration so that health care providers can continue to provide quality health care for beneficiaries, or reining in the excesses in this Administration's crusade to ferret out Medicare fraud and abuse, even where it does not exist, I have heard the message of my constituents, and that is that Medicare needs to be modernized, reformed, and refocused on providing the best health care possible for seniors and the disabled.

Nowhere has the national debate on Medicare focused more clearly than on prescription drug costs. The increased reliance on prescription drugs in health care treatments in recent years means seniors are paying a much higher portion of their income on drugs. As new drugs come on the market that allow doctors to treat illnesses without surgery, or even allow them to treat illnesses for the first time, the result is that health care has shifted from inpatient hospital services for surgical treatment to outpatient care that utilizes more, better, and more specific drugs. The result is that while per unit costs of drugs are expected to increase by an average of 3.2 percent over the next five years, overall drug expenditures are expected to rise by almost 14.5 percent per year as the number of prescriptions per senior shoots up by more than 20 percent.

But Medicare, developed in the late 1960's, and little changed since then, is still geared primarily towards the antiquated focus on intensive, inpatient care, and continues to miss the fundamental shift towards modern care techniques, including prescription drugs. Comprehensive Medicare reform, such as that outlined in the recommendations of the Bipartisan National Commission on the Future of Medicare that embodies choice, competition, and modernization, would allow Medicare to continue its guarantee of health coverage, while providing the type of health coverage that a modern senior needs. Unfortunately, apparently due to the election cycle games of this Administration, the necessary super-majority could not be mustered to report these proposals to Congress. So, America's seniors continue to be denied without a modern Medicare system, including prescription drug coverage.

But these political realities do not lessen the immediacy of the problem, nor the need for this Congress to move now on providing a prescription drug benefit. I believe we must move on passing a prescription drug coverage plan for Medicare seniors, and pass it now. I hear the cry of my colleagues who say this will take the wind out of the sails for needed overall Medicare reform, but that assumes comprehensive reform is possible during this session of Congress. Given the politically charged nature of this election, and the fact that our colleagues on the other side of the aisle seem to find new excuses every week for why they can't vote for even the most non-controversial of the appropriations bills, I doubt that will happen. In the short term, Medicare will remain solvent and will be able to provide adequate medical care for seniors. However, Michigan seniors need prescription drug coverage as soon as possible, and I intend to see that happen.

Twice this summer, once on my own, and once with a bipartisan group of 12 other Senators, I have called upon the Senate Leadership to bring to the Senate floor a meaningful prescription drug plan that will not only cover these increasingly expensive drugs, but also ensure that such a plan does not impose additional costs on our seniors, additional costs that would wipe out any savings the coverage would provide. It makes little sense to me to establish a prescription drug plan that pays for 50 percent, or even 100 percent, of a senior's drug expenses, which average about $550 per year, but then saddle them with $600 in new premiums, and have them end up with greater out-of-pocket expenses than if they never had the coverage in the first place. That's not what I hear Michigan seniors say they want in a prescription drug plan. No, what I hear them say is that they want a prescription drug plan that will actually reduce their out-of-pocket expenses, allow them the most freedom and choice in determining their own coverage, and protect them from unexpectedly high drug expenses, expenses that can make their daily choice one between food and drugs.

That's why I am so excited about the prescription drug plan on which I have been working with Senators HAGEL and MCCAIN as well as the other cosponsors, the Medicare Rx Drug Discount and Security Act of 2000, S. 2836. Of all the plans we have seen presented before this and the other Chamber, I believe this bill most directly addresses the major issues of prescription drug coverage. First, unlike any other bill currently before Congress, it provides broad and deep discounts for prescription drugs, on average 30–39 percent discounts, through multiple, competing drug discount buying plans. Much has been made over the last few years about the relative price difference American seniors pay for their prescription drugs as compared to those paid by their Canadian counterparts, where prices are fixed by the Government. But those comparisons are of the retail price. When the prices paid by Canadian seniors are compared to the prices paid by American seniors that are in group buying plans, the American senior pays less.

And these plans are not uncommon. In fact, 71 percent of all prescription drugs paid for by third parties have been administered by these group buying plans, such as with the Michigan National Guard's drug insurance coverage plan. Furthermore, many group buying plans are offered outside of insurance programs, such as those innovative programs being offered by Macomb and Wayne Counties in Michigan, where price savings of as much as 70 percent on drugs are obtained. But as I've pointed out before, Medicare beneficiaries can't take advantage of these savings because the Medicare system still employs the antiquated priorities and structures of the days in which it was born.

For the average American senior with drug expenses of about $670 per year, in 2002, our plan would provide an immediate savings of $235 per year. And, depending upon the drugs they have prescribed, savings could be as high as 70–85 percent for the more common drugs where usage is higher and competing brands more plentiful. Furthermore, there would be even greater market pressure for lower prices under our plan because multiple, competing drug discount plans would be available from which seniors could choose. If the particular drugs a senior uses were cheaper under another plan, that senior could shift over to that plan, and enjoy those better discounts. By allowing the market to drive down prices we can provide robust market price discounts that no other plan before Congress can beat, and which are substantially better than those offered under almost every Democrat plan which I've seen. In fact, because almost every plan that has been offered by Democrats in both the Senate and the House allows for only a single entity to control the price discounting for Medicare seniors, there will be little competitive pressure to pass along savings to Senior consumers, and little incentive to even try to get prices down. The Congressional Budget Office recognized this during their analysis of the President's prescription drug proposal, and determined that drug discounts would only average 12.5 percent, or about a third of those that would be seen under the Hagel-Abraham plan.

But reducing the price of drugs is only half of the prescription drug equation. The other half is ensuring that Medicare provides the needed protections for Seniors against expensive drug treatments that may force them to decide between putting bread on the table or taking a life-saving drug. And the Hagel-Abraham bill does just that with the best catastrophic drug coverage of any bill before Congress. By tiering the coverage to income, we assure all seniors they will not be financially devastated by drug expenses for some of the new treatments that can approach $500 per month.

Here is how the prescription drug costs caps break down under the Hagel-Abraham plan. Seniors earning less than 200 percent of poverty, $16,700 for a single and $22,500 for a couple, would pay no more than $1,200 annually. All drug expenses after that would be covered by the Federal Government. For those seniors that earn more than that, but below 400 percent of poverty, $33,400 for singles and $45,000 for couples, costs

would be limited to $2,500 annually. And Seniors above 400 percent of the poverty level, up to $100,000 for singles and $200,000 for couples, would pay no more than $5,000 annually. Although some of my colleagues may believe that prescription drug insurance should be available to all Medicare beneficiaries, and that the government should subsidize the insurance of even the wealthiest Americans, I don't think it makes sense to subsidize the drug expenditures for those single seniors making more than $100,000, and those couples making more than $200,000, especially considering they have much easier access to private insurance coverage.

What makes this proposal particularly attractive, in my opinion, is that it does not require seniors to pay hundreds of dollars in new Medicare premiums, premiums that could be greater than their actual drug expenses. In fact, the Congressional Budget Office has determined that when the President's prescription drug proposal is fully implemented, seniors will have to pay more almost $600 per year in new Medicare premiums, on top of the $88 per month they will have to pay for their existing Part B Medicare coverage. I can't see how that can be a good deal for America's seniors. CBO also recently scored the drug proposal offered by Senator ROBB as an amendment to the Senate's Labor-HHS Appropriations Bill. That proposal would, according to CBO, increase Medicare's financing gap between revenues and outlays by 25 percent, while imposing new premiums of $80 per month, or $960 per year! Forcing America's seniors to pay almost $1,000 per year, just to have the privilege of participating in this big-government drug program, is wrong, flat-out wrong. And it will most likely wipe out any savings they would gain from the coverage in the first place. I believe by the time these plans were fully implemented, Michigan seniors would be wishing for the ''good ol' days'' where the government wasn't providing them such ''great'' coverage that forced them to spend more than they did before.

I am not merely railing against these plans because they represent a big-government view of legislating. No, it's that I am deeply concerned with the record of the Health Care Financing Administration and its existing prescription drug programs. The fact of the matter is that HCFA's centralized, top-down, bureaucratic method of providing it's current inpatient drug benefit has led to drug rationing, cutbacks in coverage, and price fixing. Just recently this Administration announced that it intends to cut back coverage of cancer-fighting drugs administered in doctors' offices and set the price for those drugs by Executive fiat, even while it says that it's proposed additional drug coverage will not result in these same things. There is no escaping the fact that when the government controls all aspects of prescription drug insurance the quality of care and access are placed in jeopardy. It has been happening in Canada and we cannot allow that to happen to whatever new prescription drug coverage we provide.

But we are taking action to stop the Administration's attempts to cut back cancer drug coverage for sick seniors. I am cosponsoring with Senator ASHCROFT the Cancer Care Preservation Act, which will guarantee that HCFA cannot implement any reductions in Medicare reimbursements for outpatient cancer treatment unless those changes are developed in conjunction with the Medicare Payment Advisory Commission and representatives of the cancer care community, provides for appropriate payment rates for outpatient cancer therapy services, and is specifically authorized by an act of Congress. Furthermore, I am sending a letter to the President of the United States today, calling upon him to rescind HCFA's plan until such time as such changes can be fully examined by the cancer care community and Congress. To think that the Medicare system could stop covering the most effective cancer treatments simply by it's own edict should be a clear warning to all of my colleagues on the dangers in having a single agency control the access to our senior's prescription drugs.

And that leads me to the second problem I've been hearing about in Michigan the issue of how HCFA and this Administration manage Medicare, especially with regard to reimbursement rates. When I first came to the Senate, Medicare was going broke quickly, and was bound for bankruptcy by 2001. The Balanced Budget Act of 1997 implemented necessary changes to contain the growth in Medicare spending to extend the system's solvency until 2015, giving us time to implement necessary structural and market-based reforms in Medicare, reforms that can make the program viable for generations to come. But those modest reductions in the rate of growth for Medicare have become full-blown cuts in the face of this Administration's refusal to spend the money Congress has authorized them to spend.

In fact, this Administration has short-changed Medicare by $37 billion in the last two years. The Congressional Budget Office's July 2000 Budget Projection update indicates that Medicare spending this year will be $14 billion below what Congress budgeted, following last year's spending by the Administration of only $209 billion for Medicare versus the $232 billion Congress provided. The fact of the matter, is that most reimbursement rates are set by the Administration and HCFA, and this Administration has repeatedly refused to spend the money on Medicare that Congress has given them. In fact, while the original Balanced Budget Act of 1997 was expected to reduce Medicare growth by $103 billion between 1998 and 2002, this Administration's relentless ratcheting down of reimbursements over and above that authorized by Congress has pushed those cuts to almost $250 billion. And between 2001 and 2005, the cuts are expected to be even more dramatic, climbing from $163 billion to $457 billion, 280 percent greater than Congress originally intended.

The consequences for Michigan's health care industry are devastating. According to the March 2000 Michigan Health and Hospital Association report, ''The Declining State of Michigan Hospitals'' HCFA's implementation of BBA 97 has cost Michigan hospitals an average of $8.5 million each. As a result, 68 percent of the hospitals have been forced to eliminate at least one service, ranging from urgent care and rural health clinics, to rehabilitation and pain management centers, to screening and preventative health services. Forty-five percent of all the hospitals have eliminated at least two of the services, and more than half of those who haven't yet eliminated services yet are considering it for 2000. Previous reports have put the statewide total lost hospital revenue at $2.5 billion, or just over $13.5 million per hospital.

But hospitals are not the only health care provider hit by the effects of BBA 97 and the voracious appetite of HCFA bureaucrats. Home Heath Care agencies have been particularly hard hit by HCFA policies seemingly intent on driving them all out of business. Home health care spending was expected to grow by $2 billion even after BBA 97 cost containment measures, but have dropped by $9 billion, a 54 percent drop in just two years. In fact, the number of home health care claims have dropped by 50 percent in just two years, and the average payment per patient lowered by 38.5 percent, far lower than originally projected with BBA 97. CBO stated this unexpected drop in reimbursements as the primary reason that total Medicare spending dropped last year. Over the four years covered by BBA 97, CBO now expects home health care spending to be reduced by $69 billion, over four times the original $16 billion that they originally estimated. Like hospitals, home health care has been decimated. Over 2,500 home health agencies have closed or stopped serving Medicare patients. Moreover, HCFA estimates that nearly 900,000 fewer home health patients received services in 1999 than in 1997.

Finally, I think we need to look at the effects of this Administration's policies on reimbursements to skilled nursing facilities. Under BBA 97, the rate of growth for skilled nursing facility reimbursements was to be slowed by $19.8 billion between 1998 and 2004. However, since that original projection, reimbursements are now expected to fall by an additional $15.8 billion. This even takes into account the $2 billion in reimbursement restorations provided by the Balanced Budget Refinement Act of 1999. For Michigan, the numbers are equally disconcerting.

Michigan has lost $643 million in nursing facility reimbursements, over and above those projected with BBA 97, over 75 percent more than originally projected. Is it any wonder then, that 25 percent of all skilled nursing facilities serving Medicare patients are operating in bankruptcy and that why the number one problem for hospital discharge coordinators is that they can't find nursing facilities for their patients needing them?

We have provided some important reimbursement relief in the Balanced Budget Refinement Act of 1999. But it was only a first step and by no means a complete response to the Administration's policies. While Medicare reimbursements over the next five years are projected to be cut by $295 billion more than originally projected, BBRA 99 only restored about $16 billion of that, or less than 5 percent of the additional cuts. Containing the growth of Medicare was necessary to ensure Medicare did not go bankrupt, but this continuous, unsustainable ratcheting down of reimbursements is simply wrong, and we must reverse it now. That is why this body must bring to the floor real, substantive, Medicare reimbursement restoration legislation. And we must do it very soon. We cannot wait until next Congress, or even until next month. We must do it now. Ensuring Medicare's fiscal solvency on the backs of Medicare providers is not only wrong, but counterproductive, and will ultimately lead to the insolvency of Medicare's health care guarantees as we know it.

I have been working very hard to provide specific reimbursement relief for Michigan's health care providers. First, Senator HUTCHISON of Texas and I have been fighting for two years now to improve the inpatient reimbursements for hospitals. Our American Hospital Preservation Acts of 1999 and 2000 would do just that. This year's version will restore the entirety of the Market Basket Indicator inflation adjustment for inpatient hospital reimbursement rates, returning over $6.9 billion to hospitals over the next five years, and $13.5 billion over the next 10. That will in turn mean more than $536 million in increased reimbursements for Michigan hospitals over the next ten years, or more than $3.4 million per hospital.

Likewise, I have joined 53 of my colleagues in cosponsoring S. 2365, the Home Health Payment Fairness Act to eliminate the automatic 15 percent reduction to home health payments currently scheduled to go into effect on October 1, 2001. The home health care industry cannot survive with the current reimbursement reductions, let alone another 15 percent across-the-board cut. Finally, I am working closely with a number of my colleagues to craft a bill that will provide for adequate nursing home reimbursements through a refinement of the inflation adjustment factors. We believe appropriate legislation will be available this week or next, and if any of my colleagues are interested in joining this effort, I encourage them to contact me immediately.

The third concern I hear from Michiganians about Medicare, is that even with the steps we have taken to improve its financial standing and the quality of care, it is still headed towards bankruptcy in the very near future. Seniors in Michigan are scared, scared that they will lose their Medicare benefits because we cannot modernize Medicare so that it will stay solvent for generations to come. But it looks like things are getting better with Medicare and that at least in the short term, we have the fiscal breathing room to make the necessary changes to avoid a train wreck down the way.

This summer the Board of Trustees of the Federal Hospital Insurance Trust Fund issued a correction to their 2000 Annual Report. In it, the Trustees reported that the financial projections were more favorable than those made in 1999, that the Trust Fund income exceeded expenditures for the second year in a row, and that the Fund now met the Trustees' test of short-range financial adequacy. In fact, income is now projected to continue to exceed expenditures for the next 17 years, a substantial increase over previous estimates.

Now 2017 is still too soon for us to rest in our efforts to ensure the permanent solvency of Medicare through market-based modernization and reform, as well as provide seniors' access to the full spectrum of health care options. First, we need to shift Medicare from a centrally-controlled government system to a market-based system, one that maximizes choice and can best respond to changing medical care needs, such as recommended by the National Bipartisan Commission on the Future of Medicare.

Second, to ensure that we don't raid the Medicare Trust Funds to pay for non-Medicare spending, as repeatedly proposed by this Administration, we need to wall off the Medicare Trust Fund surpluses so that they can only be used for Medicare. I have been proud to vote for a Medicare lockbox proposal. But recent analysis by conservative groups such as the Heritage Foundation, and liberal groups such as the Center on Budget and Policy Priorities have raised serious questions about the efficacy of each of these proposals, and so I will be working with my colleagues on both sides of the aisle, especially my fellow Budget Committee Members, to draft a Medicare lockbox that not only protects the Medicare surpluses, but also enhances our ability to provide for the long-term solvency of the system. Even after providing for a new prescription drug benefit, and after providing for healthier reimbursements for health care providers, we will still have about $110 billion in Medicare surpluses available to fund this reform. Given that the Bipartisan Medicare Commission's reform proposal would actually end up costing less than the current Medicare system through competition and choice, I believe this is more than adequate to fix our problems with Medicare. Regardless, the Medicare lockbox will ensure those surpluses are still there when the need comes for any funds to finance reform.

Third, I believe we need to allow Americans to prepare for their retirement health care needs outside of Medicare through Medical Savings Accounts, or MSAs, long-term care insurance, and existing health care benefit flexibility. Today's able-bodied workers will be tomorrow's seniors, and to the extent that we can set in motion now provisions that will allow them more choices, more options, and more access to quality health care, the healthier our entire retirement health care system will be, including Medicare. As we all know, MSAs are a market-based alternative for quality health care. They offer maximum flexibility for the self-employed, employees, and employers while reducing the out-of-pocket cost of insurance. MSAs are an alternative health insurance plan with real cost-control benefits for the millions of Americans who have been forced into managed care and feel they have lost control of their health care decisions. By establishing these MSAs now, tomorrow's seniors will have sizable balances available in their retirement years to supplement whatever coverage is available under Medicare. To that end, I believe we should make MSAs permanent and affordable by removing eligibility restrictions, including allowing Federal employees to have MSAs, lowering the minimum deductible, permitting both employer and employee MSA contributions, and allowing MSAs in cafeteria plans. Furthermore, I believe we should also waive the 15 percent penalty tax on non-medical distributions if the remaining balance at least equals the plan deductible.

As for long-term care insurance, I support legislation phasing-in 100 percent deductibility of long-term care insurance premiums, when they are not substantially subsidized by an employer. Under my plan, individuals age 60 and older would not be subject to such a phase-in period, and would qualify for 100 percent deductibility immediately. I believe we should also allow long-term care insurance to be offered as a cafeteria plan benefit. By providing for more accessible long-term care options, retirees can build insurance against the catastrophic expenses of long-term home and nursing facility care that is becoming increasingly difficult to obtain under Medicare.

Finally, we should allow for greater health insurance plan flexibility, especially with regards to the multipurpose Flexible Spending Accounts. Flexible Spending Accounts and cafeteria plans have become a popular means of providing health benefits to employees, but under current law, unused benefits are forfeited. This ''use it or lose it''

rule has limited the appeal of these plans as well as forfeiting substantial amounts of money that could be available for retirement health care needs. I support legislation which will allow transferring up to $500 in unused Flexible Spending Account balances from one year to the next, or to roll-over that amount into an IRA, 401(k) retirement plan, or a Medical Savings Account.

All of these proposals will help retirees better plan for and provide for their health care needs. But regardless of these supplemental programs, Medicare will still be at the base of any retirees health care program. That's why it's even more heartening to see in the corrected Medicare Trustees' report that some of the more drastic measures we once thought would be required are no longer necessary to keep Medicare sound. For example, in 1997, when Medicare was on the verge of bankruptcy by 2001, many of us, on a bipartisan basis, voted in favor of a limited move to raise the retirement age for Medicare eligibility from 65 to 67 years of age starting in 2003 and phased-in over the following twenty-four years. We did that on a near emergency basis, because the Medicare system was threatened. But I noted at the time, if the situation improved, such a change would not be necessary. In my opinion, that is now the case, and that kind of approach no longer needs to be considered in light of the improved financial condition of Medicare and the emergence of significant Medicare trust fund surpluses.

In fact, at the time I cast my vote on this question, I entered into the RECORD on July 14, 1997, a number of prerequisites which I indicated would have to be met in order for me to support the actual implementation of the proposal. In that none of these prerequisites—the development of a viable system for low- and middle-income seniors to obtain and maintain affordable health care until eligible for Medicare, as well as concurrence by the National Bipartisan Medicare Commission on the Future of Medicare on raising the eligibility age—have been addressed in the two to three year time-frame that I set forth in my statement, I have withdrawn my support for raising the eligibility age. I no longer believe this change is necessary in light of the improved financial status of Medicare, or prudent in light of the failure of its sponsors to adequately address the concerns I raised.

Finally, the fourth Medicare issue on which I have been inundated with complaints is how hard it is to navigate the regulatory complexity of the Medicare system. I have heard from doctors and hospital administrators, home health care agencies and skilled nursing facilities, about how even a simple mistake, or even a difference of opinion, can embroil them in legal controversies that take years to resolve, and many times more in legal bills than the amount of the originally contested bill. HCFA has now produced over 111,000 pages of Medicare regulations, three times the size of the incredibly complex Internal Revenue Code. These regulations make it nearly impossible to operate efficiently, and make simple administrative errors appear to be criminal fraud. In fact, on August 10th, 1998, Dr. Robert Walker, president emeritus of the Mayo Foundation, told the National Bipartisan Commission on the Future of Medicare, ''The public has been led to believe that the, Medicare, program is riddled with fraud, when in reality, complexity is the root of the problem. This has contributed to the continuing erosion in public confidence in our health care system. We must all have zero tolerance for real fraud, but differences in interpretation and honest mistakes are not fraud.''

Recently, the Association of American Physicians and Surgeons conducted a survey of its members as to the impact of HCFA regulations on their ability to treat patients. They found that it costs on average 27 percent more to process a Medicare claim as it does a private health insurer claim, and that doctors and their staffs spend more than a fifth of their time on Medicare compliance issues. Furthermore, more than half of all doctors say they will retire from active patient care at a younger age because of ''increased hassles with Medicare.'' This is bad news for Medicare seniors, as further pointed out by the survey. Almost a quarter of all doctors are no longer accepting new Medicare patients, and of those that do, 34 percent are restricting services to those patients, such as difficult surgical procedures or comprehensive medical work-ups. Last, these are not changes simply to stop previously fraudulent activity. Thirty-eight percent of all doctors surveyed stated they submitted Medicare claims that they knew were for less than for which they were entitled, or ''downcoding'' in the Medicare regulatory parlance, but did not want to subject themselves to the potential of erroneous HCFA reviews and claim denials. Similar ''downcoding'' results have been found with hospitals who deny patients the most appropriate regimen of care in complex cases because they do not believe they will be fully reimbursed by Medicare if they submit such a complex care claim.

That is why on July 27, I introduced S. 2999, the Health Care Providers Bill of Rights, a bill aimed at addressing the numerous regulatory and law enforcement abuses in the Medicare system that have brought to my attention by Michigan health care providers. This bill addresses many of the specific regulatory ''hassles'' experienced by doctors and providers everyday as they try to provide the best possible care for our Seniors.

The bill is divided into six titles: Title I—Reform of HCFA Regulatory Process; Title II—Reform of Appeals Process; Title III—Reform of Overpayment Procedure; Title IV—Reform of Voluntary Disclosure Procedure; Title V—Criminal Law Enforcement Reforms; and Title VI—Provider Compliance Education.

Provisions that should be of particular interest to my colleagues are those that rescind HCFA's ability to withhold future reimbursements in order to offset alleged prior underpayments, a strict 180 day time line for completion of the Medicare administrative appeals cases, placing program participation terminations and suspensions in abeyance while appeals are pending, prohibiting the use of sample audit results to reduce future reimbursement rates, stopping overpayment collections while appeals are pending, and establishing voluntary disclosure procedures that also bring the Department of Justice and U.S. Attorneys into the process, as well as providing safe harbor from prosecution for those that enter into and abide by the voluntary disclosure requirements.

Some further provisions that were specifically recommended by providers include requiring HCFA, fiscal intermediaries, and carriers to all spend a portion of their Medicare funds on provider education, requiring them to provide legally binding advisory opinions on Medicare coverage, billing, documentation, coding, and cost reporting requirements, as well as extending the current anti-kickback, civil monetary penalty, and physician self-referral advisory opinion requirements that are set to expire August 21st of this year.

A number of organizations have expressed their strong support for this legislation, including the Michigan Health & Hospital Association, the Federation of American Hospitals, the National Association for Home Care, the American Federation of Home Care Providers, the Healthcare Leadership Council, and the American Health Care Association. I ask unanimous consent these letters of support be printed in the RECORD.

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

MICHIGAN HEALTH &
HOSPITAL ASSOCIATION,
Lansing, MI, August 9, 2000.

Hon. SPENCER ABRAHAM,
U.S. Senate, Dirksen Senate Building, Washington, DC.

DEAR SENATOR ABRAHAM: The Michigan Health and Hospital Association (MHA) appreciates the opportunity to comment on the Health Care Provider Bill of Rights and Access Assurance Act. The legislation includes many provisions aimed at ensuring that health care providers are treated in a fair, equitable and civil manner.

Michigan's hospitals and health systems must contend with an array of complex Medicare laws and regulations. Too often, Medicare billing errors, due to confusing and conflicting regulations and instructions, are presumed to be purposeful and intentional acts. Title I of the bill positively addresses this regulatory maze, mandating that the Health Care Financing Administration follow clear and specific procedures when issuing regulations.

Another provision that will be particularly beneficial is the inclusion of criminal law enforcement reform. Establishing specific

search warrant rules as well as revising current law enforcement powers of the Health and Human Services Office of Inspector General will greatly assist in minimizing any disruption of patient care or threats to the confidentiality of patient records.

We commend you for addressing these areas of concern. The MHA also would like to express its gratitude for your leadership on hospital issues as we work to maintain the highest quality of care for Medicare beneficiaries.

Sincerely,

BRIAN PETERS,
Vice President, Advocacy.

FEDERATION OF AMERICAN HOSPITALS,
Washington, DC, July 27, 2000.

Hon. SPENCER ABRAHAM,
Dirksen Senate Office Building, Washington, DC.

DEAR SENATOR ABRAHAM: The Federation of American Hospitals commends you for your work to clarify and improve the regulatory burdens and administration of the Medicare program. The regulatory burden health care providers face is massive, growing every day, and diverts us from our primary mission of delivering high quality health care to the patients in our communities. Hospitals and other health care providers take their responsibility to comply with Medicare laws and regulations very seriously and have devoted significant amounts of energy and resources to these obligations. While HHS has been diligent in its efforts to implement an unprecedented number of regulatory changes in the program, more work is needed to address problem areas in the current administration of the Medicare Program and to develop a more active partnership with health care providers to promote the integrity of the Program.

The ''Health Care Provider Bill of Rights and Access Assurance Act'' proposes some important changes to the status quo to address some key problem areas. One of the most important checks and balances on the validity of the regulations HCFA promulgates is the ability of health care providers to challenge those regulations in a court of law when they believe that the regulations are excessive, unconstitutional, beyond the scope of statutory authority or have been promulgated in violation of the Administrative Procedures Act. This legislation solidifies timely judicial review of these challenges. Another important provision in the legislation promotes greater health care provider participation in program integrity efforts by improving the voluntary disclosure and overpayment repayment processes.

The bill also contributes to health care provider education and compliance efforts by providing for the reauthorization of the existing advisory opinion provisions subject to expire in August and setting some new advisory opinion requirements. The existing advisory opinion statutes provide guidance on the application of the antikickback and physician self-referral laws. The bill also adds a new requirement that HCFA, acting through its contractors, provide written answers to health care providers on nuts and bolts billing, coding and cost report questions. In a program this complex, errors are likely and providers need greater assistance to navigate the myriad of law, regulation and policy. Hospitals want to be active partners in the effort to promote program integrity and hope to work closely with HCFA and its program integrity partners on education and prevention efforts.

We appreciate your interest in these matters and look forward to working with you on this important legislation.

Sincerely,

THOMAS A. SCULLY,
President and CEO.

NATIONAL ASSOCIATION FOR HOME CARE,
Washington, DC, July 27, 2000.

Hon. SPENCER ABRAHAM,
U.S. Senate, Dirksen Senate Office Building, Washington, DC.

DEAR SENATOR ABRAHAM: On behalf of the National Association for Home Care (NAHC), the nation's largest organization representing home care providers and the patients they serve, I want to extend my sincerest appreciation and support for your legislation, ''The Health Care Provider Bill of Rights and Access Assurance Act.'' This legislation to reform the regulatory processes used by the Health Care Financing Administration (HCFA) to administer the Medicare program is greatly needed.

Home health agencies are currently instituting an overwhelming number of administrative changes. Many of these changes are costly and significantly increase the workloads of already strained agency staffs, affecting the ability of agencies to retain staff and continue to provide high-quality, appropriate care. HCFA frequently ignores public notice and comment requirements in implementing programmatic changes, and often underestimates or downplays the impact of new requirements on struggling agencies. As a result, providers are subject to onerous and burdensome requirements without an opportunity for input, and are given insufficient time to make operational changes in order to comply with regulations.

This legislation would ensure public input in HCFA's regulatory process and prevent arbitrary actions and erroneous decisions by HCFA from having a devastating impact on home care providers and their patients before corrective action is taken. Too often today home care agencies are bankrupted and their patients lose care before faulty policies are corrected. This bill would provide an opportunity to correct errors before irreparable harm is done. It would also prevent sanctions for conduct which providers did not know was against the rules. Providers have every intention of following the rules, but they must have advance notice of what the rules are.

The Medicare home health benefit is at great risk due to severe financial reductions and onerous and unnecessary administrative burdens. Direct intervention by the Congress is necessary to ensure the integrity and future of this important and popular benefit. We deeply appreciate your concern for home health patients and those who care for them. Enactment of the provisions in this bill would make a major contribution to expanding access to home health care and strengthening the home care infrastructure. Our hats are off to you for this groundbreaking legislation.

With best regards,

Sincerely,

VAL HALAMANDARIS,
President.

HEALTHCARE LEADERSHIP COUNCIL,
Washington, DC, July 26, 2000.

Hon. SPENCER ABRAHAM,
U.S. Senate, Dirksen Senate Office Building, Washington, DC.

DEAR SENATOR ABRAHAM: On behalf of the Healthcare Leadership Council (HLC), I would like to express our deep appreciation for your proposal to help health care providers comply with Medicare's increasingly burdensome regulatory maze.

The HLC is a chief executive coalition of over 50 of the largest health care organizations in the country, including hospital systems, insurers, pharmaceutical companies, and medical device companies. The HLC has zero tolerance for true fraud and abuse. True fraud and abuse in our health care system undermines quality, threatens patients' trust and should not be tolerated.

However, the public's confidence in the nation's health care system has been eroded by headlines of health care fraud investigations that are most often not the result of true, intentional fraud—but rather errors or misunderstandings due to countless, complex regulations. We believe strongly that Medicare's complexity actually undermines compliance and, ultimately, the quality of patient care.

The Provider Bill of Rights and Access Assurance Act contains several provisions that will improve communication and relations among Medicare's providers, regulators, and enforcers. Provisions that we particularly support are those that would expand providers' appeals rights, coordinate voluntary disclosure procedures among enforcement agencies, and educate providers regarding the application of certain regulations through advisory opinions and other means.

The Healthcare Leadership Council commends you for your leadership on this very important issue and we stand ready to help you further refine this legislation so that it will serve to greatly improve the Medicare program for providers and patients alike.

Sincerely,

MARY R. GREALY,
President.

AMERICAN FEDERATION OF HOMECARE PROVIDERS, INC.,
Silver Spring, MD, July 25, 2000.

Sen. SPENCER ABRAHAM,
U.S. Senate, Washington, DC.

DEAR SENATOR ABRAHAM: The American Federation of HomeCare Providers is pleased to endorse your legislation, the ''Medicare Provider Bill of Rights.''

Our members are small business health care providers who say that they would much rather deal with the Internal Revenue Service than with the Health Care Financing Administration (HCFA) and its contractors. Home care businesses have no rights that the Fiscal Intermediaries, carriers, and state surveyors appear to feel obligated to respect. There is no penalty for incorrect contractor decisions and no viable system to resolve disputes. Even instances of blatant abuse of providers and beneficiaries go without remedy because there is nothing to hold HCFA and its agents accountable when they are wrong and when their behavior goes beyond the bounds of ethical and legal behavior. Contractors routinely refuse to consider documentation, deny that they received records sent by providers, deny the obvious wording of the law and regulation, and sometimes even refuse to abide by court decisions.

Health care providers also believe that speaking out for the right of patients to receive an appropriate level of care and standing up for their own rights become grounds to target them for harassment. They believe that they are held to 100 percent standards of excellence and accuracy, which they are proud to meet, and those who serve as HCFA's contractors are held to no standards of excellence and accuracy in their dealings with the provider community. It is now time to ensure due process rights so that conscientious health care companies, who render critical and appropriate services in their communities and abide by the tenets of the Medicare law and regulation, are not subject to arbitrary and abusive behavior that has the potential to put them out of business, literally on the spot. Favorable decisions by Administrative Law Judges are of little comfort to a home health agency that has unjustifiably been shut down, on specious surveyor claims that it does not meet the Medicare Conditions of Participation, or

by massive statistical sampling overpayment assessments, later overturned on appeal.

Medicare providers must be accorded the same type of protections that Congress saw fit to enact for the American pubic in the Taxpayer Bill of Rights. We believe that your legislation would do just that.

Sincerely yours,

ANN B. HOWARD,
Vice President for Policy.

AMERICAN HEALTH CARE ASSOCIATION,
Washington, DC, July 28, 2000.

Hon. SPENCER ABRAHAM,
U.S. Senate, Dirksen Senate Office Building, Washington, DC.

DEAR SENATOR ABRAHAM: On behalf of the American Health Care Association (AHCA), a federation of state affiliates representing more than 12,000 non-profit and for-profit nursing facility, assisted living, residential care, intermediate care for the mentally retarded, and subacute care providers I am writing to thank you and express our support for your legislation, The Health Care Provider Bill of Rights and Access Assurance Act.

This legislation is extremely important to long term care providers for a number of reasons. Recently, in, Shalala v. Illinois Council on Long Term Care, Inc., the U.S. Supreme Court ruled that virtually all challenges to the legality of Medicare regulations or policy must be brought through the same Department of Health and Human Services (''HHS'') administrative review process used to address individual provider reimbursement and certification issues before proceeding to federal court. The Court's decision means that a provider or beneficiary cannot challenge the legality of any Medicare regulation or policy without accepting an adverse agency action and proceeding through a time-consuming and costly administrative process. It is particularly problematic for nursing homes because many components of HHS's survey and enforcement regulations and policies conflict with federal law and are fundamentally flawed. Your legislation would give Medicare providers the right to challenge directly the constitutionality and statutory authority of HCFA's regulations and policies.

Additionally, the bill will suspend the termination and sanction process while appeals on deficiencies are pending, as well as prohibit the public dissemination of deficiency determinations while an appeal is pending, absent clear and convincing evidence of criminal activity. In the current survey system, skilled nursing facilities are cited and then may be terminated for highly questionable deficiencies which do not present a risk to resident health and safety. Additionally, these citations may be posted on a public website and this plus the risk of closure of a facility can confuse and scare the residents and their families. Your bill would prevent facilities from closing while they appeal a citation. Also, the bill establishes precedence for administrative appeals so that providers will have an affirmative defense in appeals where other providers have gone through similar appeals. This would add must needed certainly to the complex rules and regulations under the Medicare program. We appreciate your commitment to this important provision.

Among many other provisions in the legislation, the bill will make needed changes to the False Claims Act. It will require that claims brought under the Act for damages alleged to have been sustained by the government must be of a material amount, which will limit False Claims Act claims to those that have a significant impact on the Medicare program.

Senator Abraham, we commend your efforts and praise your leadership. As the nation's largest association of long term care providers, AHCA is available to assist you in any way that we can to advance this legislation.

Sincerely,

CHARLES H. ROADMAN II, M.D.,
President and CEO.

Mr. ABRAHAM. I am continuing to reach out to additional organizations to garner their support, as well as to my colleagues in the Senate to join Senators COCHRAN of Mississippi and Senator GRAMS of Minnesota as cosponsors. Furthermore, Members of the other body will soon introduce companion legislation to S. 2999 in the hope that we can incorporate these necessary reforms in a Medicare reimbursement restoration bill or other reform legislation that may pass this Congress. Finally, I am joining Senator CRAIG in calling on the Senate Finance Committee to hold immediate hearings on this legislation, and the broader issue of HCFA regulatory complexity. With this legislation, I believe we can break down one of the primary obstacles to assuring access to quality health care in this country, the seemingly unfettered abuses of Medicare bureaucrats against doctors and providers alike. I urge my colleagues to join me on this important measure.

I believe I have laid out a comprehensive and sensible policy for ensuring the continued viability of Medicare. Medicare has provided millions of seniors access to quality health care where otherwise they would go without. But more must be done, and must be done soon: we must modernize Medicare so that it provides for coverage of prescription drug expenses; we must improve reimbursements to providers so that reform and cost containment does not come at the expense of the very access to health care Medicare is trying to provide; we must implement comprehensive Medicare reform that improves beneficiaries choices in their health care decisions, mirrors the health care needs of the modern senior, and is fiscally sound for generations to come; and we must rein in the abusive and incredibly complex bureaucratic behemoth that has crippled health care providers' ability to operate efficiently in the Medicare system. We can do all of this, but time is running very short. Our seniors need these changes, and the time to act is now.

I ask unanimous consent a section-by-section analysis of the measure be printed in the RECORD.

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

THE ABRAHAM HEALTH CARE PROVIDERS' BILL OF RIGHTS (S. 2999)

SECTION-BY-SECTION SUMMARY

Title I—Regulatory Reform

Section 101. Prohibiting the Retroactive Application of Regulations

Providers have complained that HCFA, its Financial Intermediaries (FI's; the private firms that administer the Part A payments), and its carriers (the private firms that administer the Part B payments), issue retroactive rules and policies that are not subject to the Administrative Procedures Act. In fact, they show where HCFA has often issued these rules and policies rather than regulations specifically to avoid the requirements of the Administrative Procedures Act (public hearings, public discussion periods, publication in the Federal Register, etc.), and that they do so retroactively. This section will prohibit HCFA from issuing anything regarding the legal standards governing the scope of benefits, the payments rates, or eligibility rules except by regulation, and then only prospectively, so that no retroactive regulations are issued.

Section 102. Requiring HCFA to Follow Normal Regulation Issuance Procedures

Providers also complain about how HCFA circumvents the Administrative Procedures Act regulatory process by issuing interim final rules, which are implemented without the public discussion period and hearings, under emergency powers called the ''Good Cause'' clause, but fails to provide any justification other than simply that they have good cause. In order to prevent these tautologies from continuing, this section prohibits HCFA from issuing interim final regulations that haven't gone through the normal regulation public vetting process.

Section 103. GAO Report on HCFA Compliance with Regulatory Procedure Laws

Given the extensive reports of HCFA abusing its regulatory issuance authority, this section directs GAO to conduct an audit of, and report to Congress within 18 months on, HCFA's compliance with the Administrative Procedures Act and the Regulatory Flexibility Act.

Section 104. Providing for Summary Judicial Challenges of HCFA Regulations on Constitutional or Other Broad Grounds

Before the Supreme Court Decision of Shalala v. Illinois Council this spring, providers had a right to prospective judicial challenges to HCFA regulations they thought were either unconstitutional or were beyond HCFA's statutory authority to issue. After this decision, however, the only recourse providers have to challenge these regulations is to wait until they are found in violation, then appeal the HCFA decision. This section reestablishes a prospective regulatory and judicial challenge process of those HCFA regulations to challenge the constitutionality or statutory authority of a regulation, or to preemptively challenge an interim final rule issued under the Good Cause clause.

Section 105. Delineating Procedures for National Coverage Determination Changes

There is a regulatory process that is exempt from even the currently liberal HCFA regulatory issuance rules, called National Coverage Determinations. These determine what will, and will not, be covered by the Medicare program, and can change rules on what medical procedures that will be covered rules overnight. This section establishes a National Coverage Determination review process that requires a 30-day prior notice of initiating such a process, and allows for adequate public comment before implementing the new coverage determination.

Title II—Appeals Process Reform

Section 201. Expanding Providers' Overpayment Appeal Rights

Current appeal regulations only allow providers three options when HCFA tells them

they have been overpaid: admit the overpayment and pay it; submit evidence in mitigation to reduce the amount of alleged overpayment but waive all appeal rights; or appeal the decision, but be subjected to a Statistically Valid Random Sample Audit (SVRS), a process which essentially shuts the provider down. This section will allow providers to exercise the second option (submitting evidence in mitigation) without waiving their appeal rights.

Section 202. Deadlines for Appeal Adjudication

This section requires the Medicare appeals process to be completed within 180 days, 90 days for the Administrative Law Judge first level appeal and 90 days for the Departmental Appeals Board second level appeal. Where the appeals process does not meet these deadlines, this section provides for the appeals process to be automatically advanced to the next stage.

Section 203. Provider Appeals on the Part of Deceased Beneficiaries

This section allows providers to pursue appeals on behalf of deceased beneficiaries where no substitute party is available.

Section 204. Suspending Terminations and Sanctions During Appeals

Currently, if HCFA makes a determination that a provider is abiding by HCFA standards, it can terminate that provider's participation in Medicare, publicly disseminate that deficiency information, and impose sanctions short of termination, even if the provider appeals the determination. This section suspends the termination and sanction process while appeals on deficiencies are pending, as well as prohibits the public dissemination of deficiency determinations while the appeal is pending, absent clear and convincing evidence of criminal activity.

Section 205. Establishing Precedence for Administrative Appeals

Ninety-eight percent of all appeals that are adjudicated at the first level of the appeals process (the Administrative Law Judge level), are determined in favor of the provider. This appears to be due in large part because HCFA apparently tries to squeeze providers into not fighting overpayment determinations in the hope that some providers simply will pay rather than fight. This section will give Departmental Appeals Board decisions national precedence in the Medicare appeals process so that providers will not have to fight the same appeal over and over.

Section 206. Safe Harbor for Substantial Compliance With HCFA Procedures

Providers can try their very best to comply with HCFA regulations but then be told by HCFA that they have violated some policy or rule, and be subject to fines and overpayment determinations. This section gives providers protection from HCFA action where a claim was submitted by a provider in reliance on erroneous information or written statements supplied by a Federal agency.

Section 207. GAO Audit of HCFA's Statistical Sampling Procedures

HCFA bases much of its compliance determinations on statistical sample audits, either through random audits as part of the Medicare Integrity Program, or through overpayment audits. However, there is substantial evidence that HCFA's statistical sampling procedures do not follow generally accepted procedures, and don't interpret the data in a statistically valid manner. This section direct GAO to conduct an audit of HCFA's (and its Financial Intermediaries' and Carriers') statistical sampling and utilization procedures.

Title III—Overpayment Procedure Reform

Section 301. Prohibit Retroactive Overpayment Determinations through New Policies

HCFA currently has the authority to change policy interpretations and implement them so as to make retroactive overpayments determinations, even though the previous policy may have allowed the charges. This section bars HCFA from making overpayment determinations based upon the retroactive application of a new policy interpretation.

Section 302. Prohibit Reductions of Future Payments Based on Sample Audits of Past Claims

HCFA currently reduces future payments by whatever error rate they derive from their statistical sample audits, even where there is no evidence that the pending or future payments are similarly in error, they simply assume that they are so, even if under appeal. Furthermore, the provider has no way to stop that withholding until the appeal is decided in their favor. This section bars HCFA from making such blanket withholdings from future payments, without clear and convincing evidence of fraud.

Section 303. Prohibit Withholding of Underpayments or Future Payments for Past Overpayments

In addition to withholding future payments by whatever error rate a HCFA sample audits produce, HCFA also regularly withholds underpayments owed the provider, as well as the full amount of future payments, and applies them to past overpayments, regardless of whether the provider is appealing the overpayment determination, or has entered into a repayment agreement. This can effectively strangle a provider's entire revenue flow, and has forced many providers into bankruptcy, even when such overpayments are being appealed. This section prohibits HCFA from withholding underpayments or future payments to pay for past overpayments, unless clear and convincing evidence of fraud exists.

Section 304. Suspend Overpayment Collections While Appeals are Pending

Even if a provider decides to be subjected to the lengthy and expensive appeals process, they are still required to immediately repay HCFA for alleged overpayments. This section suspends overpayment recoupment while appeals are pending. Given that appeals will be expedited under this bill to 180 days, the Medicare system will still have timely access to any overpayment funds.

Title IV—Voluntary Disclosure Procedure Reform

Section 401. Effective Voluntary Disclosure Procedures

Many times the first person to discover that a provider has been overpaid or has not been in compliance with Medicare regulations is the provider himself. However, the Department of Health and Human Services voluntary disclosure procedures still allow the Attorney General and U.S. Attorneys to use the exact same information provided by the provider to the Department Office of Inspector General under the current voluntary disclosure process against the provider for prosecution. This section directs the Secretary of Health and Human Services (HCFA's parent department) and the Attorney General to make joint voluntary disclosure procedures which provide a safe harbor from prosecution for providers who report the violation so long as these agencies haven't already approached them about the possible violation or overpayment, and there isn't previously and independently obtained clear and convincing evidence of fraud.

Title V—Criminal Law Enforcement Reform

Section 501. Rescind Law Enforcement Powers of HHS OIG Investigators

Currently, the Department of Health and Human Services' Office of Inspector General investigators are the enforcement arm of the Medicare program for HCFA, and are deputized by the U.S. Marshal Service to execute those duties. This has turned into their being granted near carte blanche authority for enforcing Medicare laws and regulations. With that, it is increasingly evident that OIG investigators may abuse that power, such as raiding hospitals and physicians offices with the same tactics that SWAT teams use on crack houses. This section rescinds OIG's deputation, and bars those investigators from carrying weapons in the execution of their duties.

Section 502. Codify More Stringent Search Warrant Rules for Health Care Facilities

Many health care providers who find themselves on the wrong side of an HHS OIG investigation are subjected to unnecessarily intrusive search warrant executions, with doctors and nurses accosted by gun-wielding investigators, and patients removed from medical care. This section codifies search warrant rules that so as to protect the confidentiality of medical records, the provider-patient relationship, and the uninterrupted continuation of medical care. Specifically, it requires the law enforcement agency requesting the search warrant to take the least intrusive approach to executing the warrant, consistent with vigorous and effective law enforcement. It also directs the law enforcement agency seeking the warrant to work closely with the Department of Justice and the relevant U.S. Attorney's office to ensure the warrant is indeed necessary and that the search minimizes disruption to patient care or threats to the confidentiality of patient records.

Title VI—Provider Compliance Education

Section 601. Provider Education Funding

This section requires Financial Intermediaries and Carriers to spend 3 percent of their Medicare funds on provider billing and compliance education, and HCFA to dedicate 10% of their Medicare Integrity Program funds to such education, so as to try to decrease the rate of provider non-compliance, as well as over- and under-billing.

Section 602. Advisory Opinions for Health Care Providers

This section requires HCFA to provide written answers to questions about coverage, billing, documentation, coding, cost reporting and procedures under the Medicare program, answers which can be used as an affirmative defense against an overpayment determination or an allegation of violating Medicare regulations.

Section 603. Extension of Existing Advisory Opinion Provisions of Law

The Health Insurance Portability and Accountability Act (HIPAA) included a provision requiring the Secretary to issue written advisory opinions on certain specified topics under the anti-kickback statute and civil monetary penalty provisions. However, that provision sunsets on August 21st, 2000. The Balanced Budget Act of 1997 (BBA 97) provides a similar provision regarding the legality of referrals under the physician self-referral laws, which also sunsets August 21st, 2000. This section extends these advisory opinion provisions permanently.

Supporting Organizations

Michigan Health & Hospital Association.
Federation of American Hospitals.
National Association for Home Care.
American Federation of Home Care Providers.

Healthcare Leadership Council.
American Health Care Association.

SUPPORTING THE PRESIDENTIAL VETO OF THE ESTATE TAX REPEAL LEGISLATION

Mr. JOHNSON. Mr. President, I will vote to uphold the President's veto of the wildly irresponsible estate tax repeal bill sent to his desk, and I will also continue to support changes in the law that will provide additional relief for the two percent of American families that are subject to this law.

Under current law, family farms and small business pay no Federal estate tax unless their property is worth more than $1.3 million. Others are eligible for an estate tax exemption of $675,000. I recently voted to raise the small business and family farm exemption to $4 million by 2001 and with a phased in exemption of $8 million by 2010. The general exemption would increase to $2 million by 2001 and $4 million by 2010.

The cost to the Treasury for this additional exemption for America's wealthiest families comes to about $61 billion over ten years. The cost of the total-repeal bill being vetoed by the President, however, comes to $105 billion over the first ten years, and a whopping $750 billion when fully phased in during the next ten years.

Very few South Dakota farms or small businesses have any Federal estate tax liability whatever under current law, but I do want to make sure that exemptions are ample. What I don't want to see, however, is an estate tax repeal bill that is so terribly expensive that it makes it almost impossible for Congress to pass tax relief for middle class taxpayers, to shore up Medicare, to pay down more of the accumulated national debt or improve education.

Keep in mind that most of the budget surplus that is being talked about will not materialize for another five years or so, and prudence would suggest to us that it may never materialize at all. Thank heavens for some adult supervision from the White House at a time when Congress has been behaving like spoiled children under the Christmas tree. Supporters of this irresponsible legislation believe there is room in our budget to give multimillionaires an $8 million tax break, but the legislation sent to the President would have broken the bank and denied relief and assistance to the other 98 percent of American families.

Once Congress concludes its partisan political finger-pointing games, it is my hope that estate tax and marriage penalty relief can be passed in a proper and careful manner that will allow for debt reduction, Medicare improvements, and a commitment to education.

PURPLE HEART AWARDED TO SPECIALIST RAYMOND S. TESTON

Mr. BURNS. Mr. President, I would like to take a moment to recognize Raymond S. Teston. Ray is a great man, and an American hero.

Specialist Raymond S. Teston had served close to one full year of field duty and was to leave Vietnam to return home to Georgia. The night before his departure, August 12, 1969, and the following morning, ''C'' troop, First Squadron, 1st Calvary of the American Division was overrun while at Base Camp, Hawk Hill, Hill 29. The first wave of the attack was from rocket propelled grenades and 122 mm rockets killing several soldiers and injuring many more. Ray was critically wounded during the ensuing battle and out of the 86 men assigned, was one of only eleven who survived.

On November 5, 1999, the President of the United States of America, the Army Adjutant General and the Secretary of the Army awarded the Purple Heart to Specialist Raymond S. Teston, United States Army, for wounds received in action in the Republic of Vietnam on August 12, 1969. This is Ray's second award of the Purple Heart; his first came on April 2, 1968, just outside of the Tam Key, Vietnam.

I commend Ray Teston's courage and bravery. I thank him, and all veterans, for their service and sacrifices to our great country and for defending our freedoms. Each time I salute the flag, I like to think of heroes such as Raymond S. Teston, who symbolize all the things that are good about this country—duty—honor—faith in our democracy. Thank you Raymond S. Teston.

SENATOR MOYNIHAN: A PROFILE IN RARE COURAGE

Mr. SCHUMER. Mr. President, I ask unanimous consent that ''Moynihan—a Profile in Rare Courage'' from yesterday's Newsday in praise of the courage and commitment of Senator DANIEL PATRICK MOYNIHAN be incorporated into the CONGRESSIONAL RECORD.

Mr. President, while certainly the race for the seat which Senator MOYNIHAN has left open has excited New Yorkers and the Nation, it is my desire today to simply remind the Nation what a treasure the State of New York bestowed on all of us through Senator MOYNIHAN. I am confident that I speak for all of my colleagues in the Senate when I say that his intellect and leadership will be greatly missed.

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

MOYNIHAN—A PROFILE IN RARE COURAGE

(By Gray Maxwell)

As the final summer of Sen. Daniel Patrick Moynihan's public career comes to an end, I think back to one languid Friday afternoon three summers ago.

Not much was happening. The Senate was in recess. So Moynihan—my boss at the time—and I went to see an exhibit of Tyndale Bibles at the Library of Congress. William Tyndale wrote the first English Bible from extant Greek and Hebrew manuscripts. Moynihan was eager to learn more about a man whose impact on the English language, largely unacknowledged, is equal to Shakespeare's.

One might wonder what Tyndale has to do with the United States Senate. Not much, I suppose. But like Tennyson's Ulysses, Moynihan is a ''gray spirit yearning in desire to follow knowledge like a sinking star.'' He has unbounded curiosity. I'm not one who thinks his intellectualism is some sort of indictment. Those who do are jealous of his capabilities, or just vapid. In a diminished era when far too many senators know far too little, I have been fortunate to work for one who knows so much and yet strives to learn so much more.

There is little I can add to what others have written or will write about his career. But I would make a few observations. On a parochial note, no other senator shares his remarkable facility for understanding and manipulating formulas—that arcane bit of legislating that drives the allocation of billions of dollars. He has ''delivered'' for New York, but it's not frequently noted because so few understand it.

More important, every time he speaks or writes, it's worth paying attention. I think back to the summer of 1990, when Sen. Phil Gramm (R–Texas) offered an amendment to a housing bill. Gramm wanted to rob Community Development Block Grant funds from a few ''Rust Belt'' states and spread them across the rest of the country. The amendment looked like a winner: More than 30 states would benefit. Moynihan spoke in opposition. He delivered an extemporaneous speech on the nature of our federal system worthy of inclusion in the seminal work of Hamilton, Madison, and Jay as The Federalist No. 86.

(His speech was effective. The amendment was defeated. New York's share of CDBG funding was preserved.) What I most want to comment on is Moynihan's courage. Too many of today's tepid, timid legislators are afraid to offer amendments they know will fail.

They are afraid of offending this constituency or that special interest. They have no heart, no courage. Moynihan always stands on principle, never on expediency. He's not afraid to cast a tough vote, to be in the minority—even a minority of one. His positions on issues from bankruptcy ''reform'' to government secrecy, from welfare repeal to habeas corpus, from the ''line item'' veto to Constitutional amendments du jour, haven't been popular. But I'm confident they are right. It just takes the rest of us a while to catch up with him.

While Moynihan has been successful as a legislator, I think of him as the patron senator of lost causes (i.e., right but unpopular). Every senator is an advocate for the middle class. That's where the votes are. What I admire and cherish about Moynihan is his long, hard, eloquent fight on behalf of the underclass—the disenfranchised, the demoralized, the destitute, the despised.

T.S. Eliot wrote to a friend, ''We fight for lost causes because we know that our defeat and dismay may be the preface to our successors' victory, though that victory itself will be temporary; we fight rather to keep something alive than in the expectation that anything will triumph.'' Eliot's wistful statement, to me, captures the essence of Moynihan. He has an unflinching sense of responsibility.

For the past quarter century, Moynihan has been the Senate's reigning intellectual. But he has been more than that. He has defended precious government institutions under attack by those who have contempt for government.

And he has been the Senate's—and the nation's—conscience. His fealty as a public servant, ultimately, has been to the truth as