

109TH CONGRESS } HOUSE OF REPRESENTATIVES { REPORT
1st Session } { 109-_____

DEFICIT REDUCTION ACT OF 2005

_____, 2005.—ORDERED TO BE PRINTED

Mr. Nussle, from the committee of conference,
submitted the following

CONFERENCE REPORT

[To accompany S. 1932]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the House to the bill (S. 1932), to provide for reconciliation pursuant to section 202(a) of the concurrent resolution on the budget for fiscal year 2006 (H. Con. Res. 95), having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the Senate recede from its disagreement to the amendment of the House and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the House amendment, insert the following:

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Deficit Reduction Act
3 of 2005”.

4 **SEC. 2. TABLE OF TITLES.**

5 The table of titles is as follows:

TITLE I—AGRICULTURE PROVISIONS

TITLE II—HOUSING AND DEPOSIT INSURANCE PROVISIONS

TITLE III—DIGITAL TELEVISION TRANSITION AND PUBLIC
SAFETY

TITLE IV—TRANSPORTATION PROVISIONS

TITLE V—MEDICARE

TITLE VI—MEDICAID AND SCHIP

TITLE VII—HUMAN RESOURCES AND OTHER PROVISIONS

TITLE VIII—EDUCATION AND PENSION BENEFIT PROVISIONS

TITLE IX—LIHEAP PROVISIONS

TITLE X—JUDICIARY RELATED PROVISIONS



1 **Subtitle A—Commodity Programs**

2 **SEC. 1101. NATIONAL DAIRY MARKET LOSS PAYMENTS.**

3 (a) **AMOUNT.**—Section 1502(c) of the Farm Security
4 and Rural Investment Act of 2002 (7 U.S.C. 7982(c)) is
5 amended by striking paragraph (3) and inserting the fol-
6 lowing new paragraph:

7 “(3)(A) during the period beginning on the first
8 day of the month the producers on a dairy farm
9 enter into a contract under this section and ending
10 on September 30, 2005, 45 percent;

11 “(B) during the period beginning on October 1,
12 2005, and ending on August 31, 2007, 34 percent;
13 and

14 “(C) during the period beginning on September
15 1, 2007, 0 percent.”

16 (b) **DURATION.**—Section 1502 of the Farm Security
17 and Rural Investment Act of 2002 (7 U.S.C. 7982) is
18 amended by striking “2005” each place it appears in sub-
19 sections (f) and (g)(1) and inserting “2007”.

20 (c) **CONFORMING AMENDMENTS.**—Section 1502 of
21 the Farm Security and Rural Investment Act of 2002 (7
22 U.S.C. 7982) is amended—

23 (1) in subsection (g)(1), by striking “and sub-
24 section (h)”;

25 (2) by striking subsection (h).



1 **SEC. 1102. ADVANCE DIRECT PAYMENTS.**

2 (a) COVERED COMMODITIES.—Section 1103(d)(2) of
3 the Farm Security and Rural Investment Act of 2002 (7
4 U.S.C. 7913(d)(2)) is amended in the first sentence by
5 striking “2007 crop years” and inserting “2005 crop
6 years, up to 40 percent of the direct payment for a covered
7 commodity for the 2006 crop year, and up to 22 percent
8 of the direct payment for a covered commodity for the
9 2007 crop year,”.

10 (b) PEANUTS.—Section 1303(e)(2) of the Farm Se-
11 curity and Rural Investment Act of 2002 (7 U.S.C.
12 7953(e)(2)) is amended in the first sentence by striking
13 “2007 crop years” and inserting “2005 crop years, up to
14 40 percent of the direct payment for the 2006 crop year,
15 and up to 22 percent of the direct payment for the 2007
16 crop year,”.

17 **SEC. 1103. COTTON COMPETITIVENESS PROVISIONS.**

18 (a) REPEAL OF AUTHORITY TO ISSUE COTTON USER
19 MARKETING CERTIFICATES.—Section 1207 of the Farm
20 Security and Rural Investment Act of 2002 (7 U.S.C.
21 7937) is amended—

22 (1) by striking subsection (a); and

23 (2) in subsection (b)(1)—

24 (A) in subparagraph (B), by striking “, ad-
25 justed for the value of any certificate issued
26 under subsection (a),”; and

1 (B) in subparagraph (C), by striking “, for
2 the value of any certificates issued under sub-
3 section (a)”.

4 (b) EFFECTIVE DATE.—The amendments made by
5 this section take effect on August 1, 2006.

6 **Subtitle B—Conservation**

7 **SEC. 1201. WATERSHED REHABILITATION PROGRAM.**

8 The authority to obligate funds previously made
9 available under section 14(h)(1) of the Watershed Protec-
10 tion and Flood Prevention Act (16 U.S.C. 1012(h)(1)) for
11 a fiscal year and unobligated as of October 1, 2006, is
12 hereby cancelled effective on that date.

13 **SEC. 1202. CONSERVATION SECURITY PROGRAM.**

14 (a) EXTENSION.—Section 1238A(a) of the Food Se-
15 curity Act of 1985 (16 U.S.C. 3838a(a)) is amended by
16 striking “2007” and inserting “2011”.

17 (b) FUNDING.—Section 1241(a)(3) of the Food Secu-
18 rity Act of 1985 (16 U.S.C. 3841(a)(3)) is amended by
19 striking “not more than \$6,037,000,000” and all that fol-
20 lows through “2014.” and inserting the following: “not
21 more than—

22 “(A) \$1,954,000,000 for the period of fis-
23 cal years 2006 through 2010; and

24 “(B) \$5,650,000,000 for the period of fis-
25 cal years 2006 through 2015.”.



1 **SEC. 1203. ENVIRONMENTAL QUALITY INCENTIVES PRO-**
2 **GRAM.**

3 (a) **EXTENSION.**—Section 1240B(a)(1) of the Food
4 Security Act of 1985 (16 U.S.C. 3839aa-2(a)(1)) is
5 amended by striking “2007” and inserting “2010”.

6 (b) **LIMITATION ON PAYMENTS.**—Section 1240G of
7 the Food Security Act of 1985 (16 U.S.C. 3839aa-7) is
8 amended by striking “the period of fiscal years 2002
9 through 2007” and inserting “any six-year period”.

10 (c) **FUNDING.**—Section 1241(a)(6) of the Food Secu-
11 rity Act of 1985 (16 U.S.C. 3841(a)(6)) is amended—

12 (1) by striking “and” at the end of subpara-
13 graph (D); and

14 (2) by striking subparagraph (E) and inserting
15 the following new subparagraphs:

16 “(E) \$1,270,000,000 in each of fiscal
17 years 2007 through 2009; and

18 “(F) \$1,300,000,000 in fiscal year 2010.”.

19 **Subtitle C—Energy**

20 **SEC. 1301. RENEWABLE ENERGY SYSTEMS AND ENERGY EF-**
21 **FICIENCY IMPROVEMENTS PROGRAM.**

22 Section 9006(f) of the Farm Security and Rural In-
23 vestment Act of 2002 (7 U.S.C. 8106(f)) is amended by
24 striking “2007” and inserting “2006 and \$3,000,000 for
25 fiscal year 2007”.



1 **Subtitle D—Rural Development**

2 **SEC. 1401. ENHANCED ACCESS TO BROADBAND TELE-**
3 **COMMUNICATIONS SERVICES IN RURAL**
4 **AREAS.**

5 The authority to obligate funds previously made
6 available under section 601(j)(1) of the Rural Electrifica-
7 tion Act of 1936 for a fiscal year and unobligated as of
8 October 1, 2006, is hereby cancelled effective on that date.

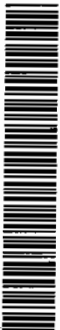
9 **SEC. 1402. VALUE-ADDED AGRICULTURAL PRODUCT MAR-**
10 **KET DEVELOPMENT GRANTS.**

11 The authority to obligate funds previously made
12 available under section 231(b)(4) of the Agricultural Risk
13 Protection Act of 2000 (Public Law 106-224; 7 U.S.C.
14 1621 note) for a fiscal year and unobligated as of October
15 1, 2006, is hereby cancelled effective on that date.

16 **SEC. 1403. RURAL BUSINESS INVESTMENT PROGRAM.**

17 (a) **TERMINATION OF FISCAL YEAR 2007 AND SUB-**
18 **SEQUENT FUNDING.**—Subsection (a)(1) of section 384S
19 of the Consolidated Farm and Rural Development Act (7
20 U.S.C. 2009cc-18) is amended by inserting after “nec-
21 essary” the following: “through fiscal year 2006”.

22 (b) **CANCELLATION OF UNOBLIGATED PRIOR-YEAR**
23 **FUNDS.**—The authority to obligate funds previously made
24 available under such section and unobligated as of October
25 1, 2006, is hereby cancelled effective on that date.



1 **SEC. 1404. RURAL BUSINESS STRATEGIC INVESTMENT**
2 **GRANTS.**

3 The authority to obligate funds previously made
4 available under section 385E of the Consolidated Farm
5 and Rural Development Act and unobligated as of October
6 1, 2006, is hereby cancelled effective on that date.

7 **SEC. 1405. RURAL FIREFIGHTERS AND EMERGENCY PER-**
8 **SONNEL GRANTS.**

9 (a) **TERMINATION OF FISCAL YEAR 2007 FUND-**
10 **ING.**—Subsection (c) of section 6405 of the Farm Security
11 and Rural Investment Act of 2002 (7 U.S.C. 2655) is
12 amended by striking “2007” and inserting “2006”.

13 (b) **CANCELLATION OF UNOBLIGATED PRIOR-YEAR**
14 **FUNDS.**—The authority to obligate funds previously made
15 available under such section for a fiscal year and unobli-
16 gated as of October 1, 2006, is hereby cancelled effective
17 on that date.

18 **Subtitle E—Research**

19 **SEC. 1501. INITIATIVE FOR FUTURE FOOD AND AGRI-**
20 **CULTURE SYSTEMS.**

21 (a) **TERMINATION OF FISCAL YEAR 2007, 2008, AND**
22 **2009 TRANSFERS.**—Subsection (b)(3)(D) of section 401
23 of the Agricultural Research, Extension, and Education
24 Reform Act of 1998 (7 U.S.C. 7621) is amended by strik-
25 ing “2006” and inserting “2009”.



1 (b) TERMINATION OF MULTI-YEAR AVAILABILITY OF
2 FISCAL YEAR 2006 FUNDS.—Paragraph (6) of subsection
3 (f) of such section is amended to read as follows:

4 “(6) AVAILABILITY OF FUNDS.—

5 “(A) TWO-YEAR AVAILABILITY.—Except as
6 provided in subparagraph (B), funds for grants
7 under this section shall be available to the Sec-
8 retary for obligation for a 2-year period begin-
9 ning on the date of the transfer of the funds
10 under subsection (b).

11 “(B) EXCEPTION FOR FISCAL YEAR 2006
12 TRANSFER.—In the case of the funds required
13 to be transferred by subsection (b)(3)(C), the
14 funds shall be available to the Secretary for ob-
15 ligation for the 1-year period beginning on Oc-
16 tober 1, 2005.”.



1 **TITLE II—HOUSING AND DE-**
2 **POSIT INSURANCE PROVI-**
3 **SIONS**

4 [REDACTED]
5 [REDACTED]
6 [REDACTED]
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100 [REDACTED]

6 **Subtitle A—FHA Asset Disposition**

7 ~~SECTION 2001. SHORT TITLE.~~

8 ~~This subtitle may be cited as the ‘FHA Asset Dis-~~
9 ~~position Act of 2005’.~~



1 **SEC. 2002. DEFINITIONS.**

2 For purposes of this subtitle, the following definitions
3 shall apply:

4 (1) The term "affordability requirements"
5 means any requirements or restrictions imposed by
6 the Secretary, at the time of sale, on a multifamily
7 real property or a multifamily loan, such as use re-
8 strictions, rent restrictions, and rehabilitation re-
9 quirements.

10 (2) The term "discount sale" means the sale of
11 a multifamily real property in a transaction, such as
12 a negotiated sale, in which the sale price is lower
13 than the property market value and is set outside of
14 a competitive bidding process that has no afford-
15 ability requirements.

16 (3) The term "discount loan sale" means the
17 sale of a multifamily loan in a transaction, such as
18 a negotiated sale, in which the sale price is lower
19 than the loan market value and is set outside of a
20 competitive bidding process that has no affordability
21 requirements.

22 (4) The term "loan market value" means the
23 value of a multifamily loan, without taking into ac-
24 count any affordability requirements.

25 (5) The term "multifamily real property"
26 means any rental or cooperative housing project of



1 5 or more units owned by the Secretary that prior
2 to acquisition by the Secretary was security for a
3 loan or loans insured under title II of the National
4 Housing Act.

5 (6) The term "multifamily loan" means a loan
6 held by the Secretary and secured by a multifamily
7 rental or cooperative housing project of 5 or more
8 units that was formerly insured under title II of the
9 National Housing Act.

10 (7) The term "property market value" means
11 the value of a multifamily real property for its cur-
12 rent use, without taking into account any afford-
13 ability requirements.

14 (8) The term "Secretary" means the Secretary
15 of Housing and Urban Development.

16 **SEC. 2003. APPROPRIATED FUNDS REQUIREMENT FOR**
17 **BELOW-MARKET SALES.**

18 (a) **DISCOUNT SALES.**—Notwithstanding any other
19 provision of law, except for affordability requirements for
20 the elderly and disabled required by statute, disposition
21 by the Secretary of a multifamily real property during fis-
22 cal years 2006 through 2010 through a discount sale
23 under sections 207(l) or 246 of the National Housing Act
24 (12 U.S.C. 1713(l), 1715z-11), section 203 of the Housing
25 and Community Development Amendments of 1978 (12



1 U.S.C. 1701z-11), or section 204 of the Departments of
2 Veterans Affairs and Housing and Urban Development,
3 and Independent Agencies Appropriations Act, 1997 (12
4 U.S.C. 1715z-11a), shall be subject to the availability of
5 appropriations to the extent that the property market
6 value exceeds the sale proceeds. If the multifamily real
7 property is sold, during such fiscal years, for an amount
8 equal to or greater than the property market value then
9 the transaction is not subject to the availability of appro-
10 priations.

11 (b) DISCOUNT LOAN SALES.—Notwithstanding any
12 other provision of law and in accordance with the Federal
13 Credit Reform Act of 1990 (2 U.S.C. 661 et seq.), a dis-
14 count loan sale during fiscal years 2006 through 2010
15 under section 207(k) of the National Housing Act (12
16 U.S.C. 1713(k)), section 203(k) of the Housing and Com-
17 munity Development Amendments of 1978 (12 U.S.C.
18 1701z-11(k)), or section 204(a) of the Departments of
19 Veterans Affairs and Housing and Urban Development,
20 and Independent Agencies Appropriations Act, 1997 (12
21 U.S.C. 1715z-11a(a)), shall be subject to the availability
22 of appropriations to the extent that the loan market value
23 exceeds the sale proceeds. If the multifamily loan is sold,
24 during such fiscal years, for an amount equal to or greater



1 than the loan market value then the transaction is not
2 subject to the availability of appropriations.

3 (c) APPLICABILITY.—This section shall not apply to
4 any transaction that formally commences within one year
5 prior to the enactment of this section.

6 **SEC. 2004. UP-FRONT GRANTS.**

7 (a) 1997 Act.—Section 204(a) of the Departments
8 of Veterans Affairs and Housing And Urban Development,
9 and Independent Agencies Appropriations Act, 1997 (12
10 U.S.C. 1715z-11a(a)) is amended by adding at the end
11 the following new sentence: “A grant provided under this
12 subsection during fiscal years 2006 through 2010 shall be
13 available only to the extent that appropriations are made
14 in advance for such purposes and shall not be derived from
15 the General Insurance Fund.”.

16 (b) 1978 Act.—Section 203(f)(4) of the Housing and
17 Community Development Amendments of 1978 (12 USC
18 1701z-11(f)(4)) is amended by adding at the end the fol-
19 lowing new sentence: “This paragraph shall be effective
20 during fiscal years 2006 through 2010 only to the extent
21 that such budget authority is made available for use under
22 this paragraph in advance in appropriation Acts.”.

23 (c) APPLICABILITY.—The amendments made by this
24 section shall not apply to any transaction that formally



1 commences within one year prior to the enactment of this
2 section.

3 [REDACTED]
4 [REDACTED]
5 [REDACTED]

6 **Subtitle B—Deposit Insurance**

7 **SEC. 2101. SHORT TITLE, TABLE OF CONTENTS.**

8 (a) ~~Section 2101.~~ This subtitle may be cited as the
9 “Federal Deposit Insurance Reform Act of 2005”.

10 (b) ~~TABLE OF CONTENTS.~~ [REDACTED]
11 [REDACTED]

- ~~Sec. 2102. [REDACTED]~~
- ~~Sec. 2103. [REDACTED]~~
- ~~Sec. 2104. [REDACTED]~~
- ~~Sec. 2105. [REDACTED]~~
- ~~Sec. 2106. [REDACTED]~~
- ~~Sec. 2107. [REDACTED]~~
- ~~Sec. 2108. [REDACTED]~~
- ~~Sec. 2109. [REDACTED]~~
- ~~Sec. 2110. [REDACTED]~~
- ~~Sec. 2111. [REDACTED]~~
- ~~Sec. 2112. [REDACTED]~~
- ~~Sec. 2113. [REDACTED]~~

12 **SEC. 2102. MERGING THE BIF AND SAIF.**

13 (a) **IN GENERAL.—**

14 (1) **MERGER.—**The Bank Insurance Fund and
15 the Savings Association Insurance Fund shall be
16 merged into the Deposit Insurance Fund.



1 (2) DISPOSITION OF ASSETS AND LIABIL-
 2 ITIES.—All assets and liabilities of the Bank Insur-
 3 ance Fund and the Savings Association Insurance
 4 Fund shall be transferred to the Deposit Insurance
 5 Fund.

6 (3) NO SEPARATE EXISTENCE.—The separate
 7 existence of the Bank Insurance Fund and the Sav-
 8 ings Association Insurance Fund shall cease on the
 9 effective date of the merger thereof under this sec-
 10 tion.

11 (b) REPEAL OF OUTDATED MERGER PROVISION.—
 12 Section 2704 of the Deposit Insurance Funds Act of 1996
 13 (12 U.S.C. 1821 note) is repealed.

14 (c) EFFECTIVE DATE.—This section shall take effect
 15 no later than the first day of the first calendar quarter
 16 that begins after the end of the 90-day period beginning
 17 on the date of the enactment of this Act.

18 **SEC. 2103. INCREASE IN DEPOSIT INSURANCE COVERAGE.**

19 (a) IN GENERAL.—Section 11(a)(1) of the Federal
 20 Deposit Insurance Act (12 U.S.C. 1821(a)(1)) is
 21 amended—

22 (1) by striking subparagraph (B) and inserting
 23 the following new subparagraph:

24 “(B) NET AMOUNT OF INSURED DE-
 25 POSIT.—The net amount due to any depositor



1 at an insured depository institution shall not
2 exceed the standard maximum deposit insur-
3 ance amount as determined in accordance with
4 subparagraphs (C), (D), (E) and (F) and para-
5 graph (3).”; and

6 (2) by adding at the end the following new sub-
7 paragraphs:

8 “(E) STANDARD MAXIMUM DEPOSIT IN-
9 SURANCE AMOUNT DEFINED.—For purposes of
10 this Act, the term ‘standard maximum deposit
11 insurance amount’ means \$100,000, adjusted
12 as provided under subparagraph (F) after
13 March 31, 2010.

14 “(F) INFLATION ADJUSTMENT.—

15 “(i) IN GENERAL.—By April 1 of
16 2010, and the 1st day of each subsequent
17 5-year period, the Board of Directors and
18 the National Credit Union Administration
19 Board shall jointly consider the factors set
20 forth under clause (v), and, upon deter-
21 mining that an inflation adjustment is ap-
22 propriate, shall jointly prescribe the
23 amount by which the standard maximum
24 deposit insurance amount and the standard
25 maximum share insurance amount (as de-



1 fined in section 207(k) of the Federal
2 Credit Union Act) applicable to any deposi-
3 tor at an insured depository institution
4 shall be increased by calculating the prod-
5 uct of—

6 “(I) \$100,000; and

7 “(II) the ratio of the published
8 annual value of the Personal Con-
9 sumption Expenditures Chain-Type
10 Price Index (or any successor index
11 thereto), published by the Department
12 of Commerce, for the calendar year
13 preceding the year in which the ad-
14 justment is calculated under this
15 clause, to the published annual value
16 of such index for the calendar year
17 preceding the date this subparagraph
18 takes effect under the Federal Deposit
19 Insurance Reform Act of 2005.

20 The values used in the calculation under
21 subclause (II) shall be, as of the date of
22 the calculation, the values most recently
23 published by the Department of Com-
24 merce.



1 “(ii) ROUNDING.—If the amount de-
2 termined under clause (ii) for any period is
3 not a multiple of \$10,000, the amount so
4 determined shall be rounded down to the
5 nearest \$10,000.

6 “(iii) PUBLICATION AND REPORT TO
7 THE CONGRESS.—Not later than April 5 of
8 any calendar year in which an adjustment
9 is required to be calculated under clause (i)
10 to the standard maximum deposit insur-
11 ance amount and the standard maximum
12 share insurance amount under such clause,
13 the Board of Directors and the National
14 Credit Union Administration Board
15 shall—

16 “(I) publish in the Federal Reg-
17 ister the standard maximum deposit
18 insurance amount, the standard max-
19 imum share insurance amount, and
20 the amount of coverage under para-
21 graph (3)(A) and section 207(k)(3) of
22 the Federal Credit Union Act, as so
23 calculated; and



1 “(II) jointly submit a report to
2 the Congress containing the amounts
3 described in subclause (I).

4 “(iv) 6-MONTH IMPLEMENTATION PE-
5 RIOD.—Unless an Act of Congress enacted
6 before July 1 of the calendar year in which
7 an adjustment is required to be calculated
8 under clause (i) provides otherwise, the in-
9 crease in the standard maximum deposit
10 insurance amount and the standard max-
11 imum share insurance amount shall take
12 effect on January 1 of the year imme-
13 diately succeeding such calendar year.

14 “(v) INFLATION ADJUSTMENT CON-
15 SIDERATION.—In making any determina-
16 tion under clause (i) to increase the stand-
17 ard maximum deposit insurance amount
18 and the standard maximum share insur-
19 ance amount, the Board of Directors and
20 the National Credit Union Administration
21 Board shall jointly consider—

22 “(I) the overall state of the De-
23 posit Insurance Fund and the eco-
24 nomic conditions affecting insured de-
25 pository institutions;



1 “(II) potential problems affecting
2 insured depository institutions; or

3 “(III) whether the increase will
4 cause the reserve ratio of the fund to
5 fall below 1.15 percent of estimated
6 insured deposits.”.

7 (b) COVERAGE FOR CERTAIN EMPLOYEE BENEFIT
8 PLAN DEPOSITS.—Section 11(a)(1)(D) of the Federal De-
9 posit Insurance Act (12 U.S.C. 1821(a)(1)(D)) is amend-
10 ed to read as follows:

11 “(D) COVERAGE FOR CERTAIN EMPLOYEE
12 BENEFIT PLAN DEPOSITS.—

13 “(i) PASS-THROUGH INSURANCE.—
14 The Corporation shall provide pass-
15 through deposit insurance for the deposits
16 of any employee benefit plan.

17 “(ii) PROHIBITION ON ACCEPTANCE
18 OF BENEFIT PLAN DEPOSITS.—An insured
19 depository institution that is not well cap-
20 italized or adequately capitalized may not
21 accept employee benefit plan deposits.

22 “(iii) DEFINITIONS.—For purposes of
23 this subparagraph, the following definitions
24 shall apply:



1 “(I) CAPITAL STANDARDS.—The
2 terms ‘well capitalized’ and ‘ade-
3 quately capitalized’ have the same
4 meanings as in section 38.

5 “(II) EMPLOYEE BENEFIT
6 PLAN.—The term ‘employee benefit
7 plan’ has the same meaning as in
8 paragraph (5)(B)(ii), and includes any
9 eligible deferred compensation plan
10 described in section 457 of the Inter-
11 nal Revenue Code of 1986.

12 “(III) PASS-THROUGH DEPOSIT
13 INSURANCE.—The term ‘pass-through
14 deposit insurance’ means, with respect
15 to an employee benefit plan, deposit
16 insurance coverage based on the inter-
17 est of each participant, in accordance
18 with regulations issued by the Cor-
19 poration.”.

20 (c) INCREASED AMOUNT OF DEPOSIT INSURANCE
21 FOR CERTAIN RETIREMENT ACCOUNTS.—Section
22 11(a)(3)(A) of the Federal Deposit Insurance Act (12
23 U.S.C. 1821(a)(3)(A)) is amended by striking “\$100,000”
24 and inserting “\$250,000 (which amount shall be subject
25 to inflation adjustments as provided in paragraph (1)(F),



1 except that \$250,000 shall be substituted for \$100,000
2 wherever such term appears in such paragraph)".

3 ~~(d) TECHNICAL AND CONFORMING AMENDMENTS~~
4 ~~RELATING TO GOVERNMENT DEPOSITS—Section~~
5 ~~11(a)(2) of the Federal Deposit Insurance Act (12 U.S.C.~~
6 ~~1821(a)(2)) is amended—~~

7 (1) ~~in subparagraph (A)~~

8 ~~(A) by moving the margins of clauses (i)~~
9 ~~through (v) 4 ems to the right;~~

10 ~~(B) by striking, in the matter following~~
11 ~~clause (v), "such depositor shall" and all that~~
12 ~~follows through the period, and~~

13 ~~(C) by striking the semicolon at the end of~~
14 ~~clause (v) and inserting a period,~~

15 ~~(2) by striking "(2)(A) Notwithstanding" and~~
16 ~~all that follows through "a depositor who is" and~~
17 ~~inserting the following:~~

18 ~~"(2) GOVERNMENT DEPOSITORS:~~

19 ~~"(A) IN GENERAL. Notwithstanding any~~
20 ~~limitation in this Act or in any other provision~~
21 ~~of law relating to the amount of deposit insur-~~
22 ~~ance available to any 1 depositor~~

23 ~~"(i) a government depositor shall, for~~
24 ~~the purpose of determining the amount of~~
25 ~~insured deposits under this subsection, be~~



1 ~~deemed to be a depositor separate and dis-~~
 2 ~~tinct from any other officer, employee, or~~
 3 ~~agent of the United States or any public~~
 4 ~~unit referred to in subparagraph (B); and~~

5 ~~“(ii) except as provided in subpara-~~
 6 ~~graph (C), the deposits of a government~~
 7 ~~depositor shall be insured in an amount~~
 8 ~~equal to the standard maximum deposit in-~~
 9 ~~surance amount (as determined under~~
 10 ~~paragraph (1)).~~

11 ~~“(B) GOVERNMENT DEPOSITOR.—In this~~
 12 ~~paragraph, the term ‘government depositor’~~
 13 ~~means a depositor that is—”;~~

14 (3) ~~by striking “(B) The” and inserting the fol-~~
 15 ~~lowing:~~

16 ~~“(C) AUTHORITY TO LIMIT DEPOSITS—~~
 17 ~~The”, and~~

18 (4) ~~by striking “depositor referred to in sub-~~
 19 ~~paragraph (A) of this paragraph” each place such~~
 20 ~~term appears and inserting “government depositor”.~~

21 (e) ~~TECHNICAL AND CONFORMING AMENDMENT RE-~~
 22 ~~LATING TO INSURANCE OF TRUST FUNDS.—Paragraphs~~
 23 (1) and (3) of section 7(i) of the Federal Deposit Insur-
 24 ance Act (12 U.S.C. 1817(i)) are each amended by strik-
 25 ing ~~“\$100,000” and inserting the standard maximum de-~~



1 ~~posit insurance amount (as determined under section~~
2 ~~11(a)(1))”.~~

3 (f) ~~OTHER TECHNICAL AND CONFORMING AMEND-~~
4 ~~MENTS.—~~

5 (1) ~~Section 11(m)(6) of the Federal Deposit In-~~
6 ~~surance Act (12 U.S.C. 1821(m)(6)) is amended by~~
7 ~~striking “\$100,000” and inserting “an amount equal~~
8 ~~to the standard maximum deposit insurance~~
9 ~~amount”.~~

10 (2) ~~Subsection (a) of section 18 of the Federal~~
11 ~~Deposit Insurance Act (12 U.S.C. 1828(a)) is~~
12 ~~amended to read as follows.~~

13 ~~“(a) INSURANCE LOGO.—~~

14 ~~“(1) INSURED DEPOSITORY INSTITUTIONS.—~~

15 ~~“(A) IN GENERAL.—Each insured deposi-~~
16 ~~tory institution shall display at each place of~~
17 ~~business maintained by that institution a sign,~~
18 ~~or signs relating to the insurance of the depos-~~
19 ~~its of the institution, in accordance with regula-~~
20 ~~tions to be prescribed by the Corporation.~~

21 ~~“(B) STATEMENT TO BE INCLUDED.—~~

22 ~~Each sign required under subparagraph (A)~~
23 ~~shall include a statement that insured deposits~~
24 ~~are backed by the full faith and credit of the~~
25 ~~United States Government.~~



1 ~~“(2) REGULATIONS. The Corporation shall~~
 2 ~~prescribe regulations to carry out this subsection, in-~~
 3 ~~cluding regulations governing the substance of signs~~
 4 ~~required by paragraph (1) and the manner of dis-~~
 5 ~~play or use of such signs.~~

6 ~~“(2) PENALTIES. For each day that an in-~~
 7 ~~sured depository institution continues to violate this~~
 8 ~~subsection or any regulation issued under this sub-~~
 9 ~~section it shall be subject to a penalty of not more~~
 10 ~~than \$100, which the Corporation may recover for~~
 11 ~~its use.”.~~

12 ~~(3) Section 43(d) of the Federal Deposit Insur-~~
 13 ~~ance Act (12 U.S.C. 1831d(u)) is amended by strik-~~
 14 ~~ing “\$100,000” and inserting “an amount equal to~~
 15 ~~the standard maximum deposit insurance amount”.~~

16 ~~(4) Section 6 of the International Banking Act~~
 17 ~~of 1978 (12 U.S.C. 3104) is amended—~~

18 ~~(A) by striking “\$100,000” each place~~
 19 ~~such term appears and inserting “an amount~~
 20 ~~equal to the standard maximum deposit insur-~~
 21 ~~ance amount”, and~~

22 ~~(B) by adding at the end the following new~~
 23 ~~subsection:~~

24 ~~“(c) STANDARD MAXIMUM DEPOSIT INSURANCE~~
 25 ~~AMOUNT DEFINED. For purposes of this section, the~~



1 ~~term 'standard maximum deposit insurance amount'~~
 2 ~~means the amount of the maximum amount of deposit in-~~
 3 ~~surance as determined under section 11(a)(1) of the Fed-~~
 4 ~~eral Deposit Insurance Act.~~

5 ~~(g) CONFIRMING CHANGE TO CREDIT UNION SHARE~~
 6 ~~INSURANCE FUND.—~~

7 ~~(1) IN GENERAL. Section 207(k) of the Fed-~~
 8 ~~eral Credit Union Act (12 U.S.C. 1787(k)) is~~
 9 ~~amended—~~

10 ~~(A) by striking "(k)(1)" and all that fol-~~
 11 ~~lows through the end of paragraph (1) and in-~~
 12 ~~serting the following:~~

13 ~~"(k) INSURED AMOUNTS PAYABLE.~~

14 ~~"(1) NET INSURED AMOUNT.—~~

15 ~~"(A) IN GENERAL.—Subject to the provi-~~
 16 ~~sions of paragraph (2), the net amount of share~~
 17 ~~insurance payable to any member at an insured~~
 18 ~~credit union shall not exceed the total amount~~
 19 ~~of the shares or deposits in the name of the~~
 20 ~~member (after deducting offsets), less any part~~
 21 ~~thereof which is in excess of the standard max-~~
 22 ~~imum share insurance amount, as determined~~
 23 ~~in accordance with this paragraph and para-~~
 24 ~~graphs (5) and (6), and consistently with ac-~~
 25 ~~tions taken by the Federal Deposit Insurance~~



1 ~~Corporation under section 11(a) of the Federal~~
2 ~~Deposit Insurance Act.~~

3 ~~“(B) ACCREGATION. Determination of~~
4 ~~the net amount of share insurance under sub-~~
5 ~~paragraph (A), shall be in accordance with such~~
6 ~~regulations as the Board may prescribe, and, in~~
7 ~~determining the amount payable to any mem-~~
8 ~~ber, there shall be added together all accounts~~
9 ~~in the credit union maintained by that member~~
10 ~~for that member’s own benefit, either in the~~
11 ~~member’s own name or in the names of others.~~

12 ~~“(C) AUTHORITY TO DEFINE THE EXTENT~~
13 ~~OF COVERAGE. The Board may define, with~~
14 ~~such classifications and exceptions as it may~~
15 ~~prescribe, the extent of the share insurance cov-~~
16 ~~erage provided for member accounts, including~~
17 ~~member accounts in the name of a union, in~~
18 ~~trust, or in joint tenancy.”;~~

19 ~~(B) in paragraph (2)~~

20 ~~(i) in subparagraph (A)—~~

21 ~~(1) in clauses (i) through (v), by~~
22 ~~moving the margins 4 ems to the~~
23 ~~right,~~

24 ~~(II) in the matter following~~
25 ~~clause (v), by striking “his account”~~

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and all that follows through the pe-
riod, and

(iii) by striking the semicolon at
the end of clause (v) and inserting a
period;

(ii) by striking "(2)(A) Notwith-
standing" and all that follows through "a
depositor or member who is" and insert-
ing the following:

"(2) ~~GOVERNMENT DEPOSITORS OR MEM-
BERS~~

~~"(A) ~~IN GENERAL~~ — Notwithstanding any
limitation in this Act or in any other provision
of law relating to the amount of insurance
available to any 1 depositor or member, depos-
its or shares of a government depositor or mem-
ber shall be insured in an amount equal to the
standard maximum share insurance amount (as
determined under paragraph (5)), subject to
subparagraph (C).~~

~~"(B) ~~GOVERNMENT DEPOSITOR~~. In this
paragraph, the term 'government depositor'
means a depositor that is";~~

(iii) by striking "(D) The" and insert-
ing the following:



1 ~~“(C) AUTHORITY TO LIMIT DEPOSITS.~~

2 ~~The”;~~ and ~~_____~~

3 (iv) by striking ~~“depositor or member~~
4 ~~referred to in subparagraph (A)”~~ and in-
5 ~~serting “government depositor or mem-~~
6 ~~ber”;~~ and ~~_____~~

7 (C) by adding at the end the following new
8 paragraphs:

9 ~~“(4) COVERAGE FOR CERTAIN EMPLOYEE BEN-~~
10 ~~EFIT PLAN DEPOSITS.~~

11 ~~“(A) PASS THROUGH INSURANCE. The~~
12 ~~Administration shall provide pass through share~~
13 ~~insurance for the deposits or shares of any em-~~
14 ~~ployee benefit plan.~~

15 ~~“(B) PROHIBITION ON ACCEPTANCE OF~~
16 ~~DEPOSITS.—All insured credit union that is not~~
17 ~~well capitalized or adequately capitalized may~~
18 ~~not accept employee benefit plan deposits.~~

19 ~~“(C) DEFINITIONS. For purposes of this~~
20 ~~paragraph, the following definitions shall apply.~~

21 ~~“(i) CAPITAL STANDARDS. The~~
22 ~~terms ‘well capitalized’ and ‘adequately~~
23 ~~capitalized’ have the same meanings as in~~
24 ~~section 210(c).~~



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~~“(ii) EMPLOYEE BENEFIT PLAN.~~

~~The term ‘employee benefit plan’~~

~~“(I) has the meaning given to such term in section 2(2) of the Employee Retirement Income Security Act of 1974,~~

~~“(II) includes any plan described in section 101(d) of the Internal Revenue Code of 1986 and~~

~~“(III) includes any eligible deferred compensation plan described in section 457 of the Internal Revenue Code of 1986.~~

~~“(iii) PASS THROUGH SHARE INSURANCE. The term ‘pass through share insurance’ means, with respect to an employee benefit plan, insurance coverage based on the interest of each participant, in accordance with regulations issued by the Administration.~~

~~“(D) RULE OF CONSTRUCTION. No provision of this paragraph shall be construed as authorizing an insured credit union to accept the deposits of an employee benefit plan in an amount greater than such credit union is au~~



1 ~~authorized to accept under any other provision of~~
2 ~~Federal or State law.~~

3 ~~“(5) STANDARD MAXIMUM SHARE INSURANCE~~
4 ~~AMOUNT DEFINED.—For purposes of this Act, the~~
5 ~~term “standard maximum share insurance amount”~~
6 ~~means \$100,000, adjusted as provided under section~~
7 ~~11(a)(1)(F) of the Federal Deposit Insurance Act.”~~

8 ~~“(2) INCREASE IN SHARE INSURANCE FOR CERTAIN~~
9 ~~RETIREMENT ACCOUNTS.—Section 207(l)(3)~~
10 ~~of the Federal Credit Union Act (12 U.S.C.~~
11 ~~1787(l)(3)) is amended by striking “\$100,000” and~~
12 ~~inserting “\$250,000 (which amount shall be subject~~
13 ~~to inflation adjustments as provided under section~~
14 ~~11(a)(1)(F) of the Federal Deposit Insurance Act,~~
15 ~~except that \$250,000 shall be substituted for~~
16 ~~\$100,000 wherever such term appears in such sec-~~
17 ~~tion).”~~

18 ~~“(9) OTHER TECHNICAL AND CONFORMING~~
19 ~~AMENDMENTS.—Section 205(a) of the Federal Cred-~~
20 ~~it Union Act (12 U.S.C. 1785(a)) is amended to~~
21 ~~read as follows:~~

22 ~~“(a) INSURANCE LOSS.—~~

23 ~~“(1) INSURED CREDIT UNIONS.—~~

24 ~~“(A) IN GENERAL.—Each insured credit~~
25 ~~union shall display at each place of business~~



1 ~~maintained by that credit union a sign or signs~~
2 ~~relating to the insurance of the share accounts~~
3 ~~of the institution, in accordance with regula-~~
4 ~~tions to be prescribed by the Board.~~

5 ~~“(D) STATEMENT TO BE INCLUDED.—~~
6 ~~Each sign required under subparagraph (A)~~
7 ~~shall include a statement that insured share ac-~~
8 ~~counts are backed by the full faith and credit~~
9 ~~of the United States Government.~~

10 ~~“(2) REGULATIONS.—The Board shall prescribe~~
11 ~~regulations to carry out this subsection, including~~
12 ~~regulations governing the substance of signs re-~~
13 ~~quired by paragraph (1) and the manner of display,~~
14 ~~or use of each sign.~~

15 ~~“(9) PENALTIES.—For each day that an in-~~
16 ~~sured credit union continues to violate this sub-~~
17 ~~section or any regulation issued under this sub-~~
18 ~~section, it shall be subject to a penalty of not more~~
19 ~~than \$100, which the Board may recover for its~~
20 ~~use.”.~~

21 (h) EFFECTIVE DATE.—This section and the amend-
22 ments made by this section shall take effect on the date
23 the final regulations required under section 9(a)(2) take
24 effect.



1 **SEC. 2104. SETTING ASSESSMENTS AND REPEAL OF SPE-**
2 **CIAL RULES RELATING TO MINIMUM ASSESS-**
3 **MENTS AND FREE DEPOSIT INSURANCE.**

4 (a) **SETTING ASSESSMENTS.**—Section 7(b)(2) of the
5 Federal Deposit Insurance Act (12 U.S.C. 1817(b)(2)) is
6 amended—

7 (1) by striking subparagraphs (A) and (B) and
8 inserting the following new subparagraphs:

9 “(A) **IN GENERAL.**—The Board of Direc-
10 tors shall set assessments for insured depository
11 institutions in such amounts as the Board of
12 Directors may determine to be necessary or ap-
13 propriate, subject to subparagraph (D).

14 “(B) **FACTORS TO BE CONSIDERED.**—In
15 setting assessments under subparagraph (A),
16 the Board of Directors shall consider the fol-
17 lowing factors:

18 “(i) The estimated operating expenses
19 of the Deposit Insurance Fund.

20 “(ii) The estimated case resolution ex-
21 penses and income of the Deposit Insur-
22 ance Fund.

23 “(iii) The projected effects of the pay-
24 ment of assessments on the capital and
25 earnings of insured depository institutions.



1 “(iv) The risk factors and other fac-
2 tors taken into account pursuant to para-
3 graph (1) under the risk-based assessment
4 system, including the requirement under
5 such paragraph to maintain a risk-based
6 system.

7 “(v) Any other factors the Board of
8 Directors may determine to be appro-
9 priate.”; and

10 (2) by inserting after subparagraph (C) the fol-
11 lowing new subparagraph:

12 “(D) NO DISCRIMINATION BASED ON
13 SIZE.—No insured depository institution shall
14 be barred from the lowest-risk category solely
15 because of size.”.

16 (b) ASSESSMENT RECORDKEEPING PERIOD SHORT-
17 ENED.—Paragraph (5) of section 7(b) of the Federal De-
18 posit Insurance Act (12 U.S.C. 1817(b)) is amended to
19 read as follows:

20 “(5) DEPOSITORY INSTITUTION REQUIRED TO
21 MAINTAIN ASSESSMENT-RELATED RECORDS.—Each
22 insured depository institution shall maintain all
23 records that the Corporation may require for veri-
24 fying the correctness of any assessment on the in-



1 sured depository institution under this subsection
2 until the later of—

3 “(A) the end of the 3-year period begin-
4 ning on the due date of the assessment; or

5 “(B) in the case of a dispute between the
6 insured depository institution and the Corpora-
7 tion with respect to such assessment, the date
8 of a final determination of any such dispute.”.

9 (c) INCREASE IN FEES FOR LATE ASSESSMENT PAY-
10 MENTS.—Subsection (h) of section 18 of the Federal De-
11 posit Insurance Act (12 U.S.C. 1828(h)) is amended to
12 read as follows:

13 “(h) PENALTY FOR FAILURE TO TIMELY PAY AS-
14 SESSMENTS.—

15 “(1) IN GENERAL.—Subject to paragraph (3),
16 any insured depository institution which fails or re-
17 fuses to pay any assessment shall be subject to a
18 penalty in an amount of not more than 1 percent of
19 the amount of the assessment due for each day that
20 such violation continues.

21 “(2) EXCEPTION IN CASE OF DISPUTE.—Para-
22 graph (1) shall not apply if—

23 “(A) the failure to pay an assessment is
24 due to a dispute between the insured depository



1 institution and the Corporation over the
2 amount of such assessment; and

3 “(B) the insured depository institution de-
4 posits security satisfactory to the Corporation
5 for payment upon final determination of the
6 issue.

7 “(3) SPECIAL RULE FOR SMALL ASSESSMENT
8 AMOUNTS.—If the amount of the assessment which
9 an insured depository institution fails or refuses to
10 pay is less than \$10,000 at the time of such failure
11 or refusal, the amount of any penalty to which such
12 institution is subject under paragraph (1) shall not
13 exceed \$100 for each day that such violation con-
14 tinues.

15 “(4) AUTHORITY TO MODIFY OR REMIT PEN-
16 ALTY.—The Corporation, in the sole discretion of
17 the Corporation, may compromise, modify or remit
18 any penalty which the Corporation may assess or
19 has already assessed under paragraph (1) upon a
20 finding that good cause prevented the timely pay-
21 ment of an assessment.”.

22 ~~(d) TECHNICAL AND CONFORMING AMENDMENTS.—~~

23 ~~(1) Paragraph (3) of section 7(a) of the Fed-~~
24 ~~eral Deposit Insurance Act (12 U.S.C. 1817(a)(3))~~
25 ~~is amended by striking the 3d sentence and inserting~~

1 ~~the following. "Such reports of condition shall be the~~
2 ~~basis for the certified statements to be filed pursu-~~
3 ~~ant to subsection (c)."~~

4 ~~(2) Subparagraphs (B)(ii) and (C) of section~~
5 ~~7(b)(1) of the Federal Deposit Insurance Act (12~~
6 ~~U.S.C. 1817(b)(1)) are each amended by striking~~
7 ~~"semiannual" where such term appears in each such~~
8 ~~subparagraph.~~

9 ~~(2) Section 7(b)(2) of the Federal Deposit In-~~
10 ~~surance Act (12 U.S.C. 1817(b)(2)) is amended~~

11 ~~(A) by striking subparagraphs (E), (F),~~
12 ~~and (G),~~

13 ~~(B) in subparagraph (C), by striking~~
14 ~~"semiannual", and~~

15 ~~(C) by redesignating subparagraph (ii) (as~~
16 ~~amended by subsection (e)(2) of this section) as~~
17 ~~subparagraph (E).~~

18 ~~(4) Section 7(b) of the Federal Deposit Insur-~~
19 ~~ance Act (12 U.S.C. 1817(b)) is amended by strik-~~
20 ~~ing paragraph (4) and redesignating paragraphs (5)~~
21 ~~(as amended by subsection (b) of this section), (6),~~
22 ~~and (7) as paragraphs (4), (5), and (6) respectively.~~

23 ~~(5) Section 7(e) of the Federal Deposit Insu-~~
24 ~~rance Act (12 U.S.C. 1817(e)) is amended~~



1 (A) in paragraph (1)(A), by striking
2 "semiannual",

3 (B) in paragraph (2)(A), by striking
4 "semiannual", and

5 (C) in paragraph (3), by striking "semi-
6 annual period" and inserting "initial assess-
7 ment period"

8 (6) Section 9(p) of the Federal Deposit Insur-
9 ance Act (12 U.S.C. 1818(p)) is amended by strik-
10 ing "semiannual".

11 (7) Section 9(q) of the Federal Deposit Insur-
12 ance Act (12 U.S.C. 1818(q)) is amended by strik-
13 ing "semiannual period" and inserting "assessment
14 period".

15 (8) Section 12(e)(4)(C)(ii)(II) of the Federal
16 Deposit Insurance Act (12 U.S.C.
17 1822(e)(4)(C)(ii)(II)) is amended by striking "semi-
18 annual period" and inserting "assessment period".

19 (9) Section 222(a) of the Federal Deposit In-
20 surance Corporation Improvement Act of 1991 (12
21 U.S.C. 1824(a)) is amended -

22 (A) in the matter preceding subparagraph
23 (A) of paragraph (2), by striking "the Board
24 and",



1 ~~(B) in subparagraph (J) of paragraph (2),~~
2 ~~by striking "the Board" and inserting "the~~
3 ~~Corporation";~~

4 ~~(C) by striking subparagraph (A) of para-~~
5 ~~graph (2) and inserting the following new sub-~~
6 ~~paragraph:~~

7 ~~"(A) CORPORATION. The term 'Corpora-~~
8 ~~tion' means the Federal Deposit Insurance Cor-~~
9 ~~poration."; and~~

10 ~~(D) in subparagraph (C) of paragraph (2)~~
11 ~~by striking "Board" and inserting "Corpora-~~
12 ~~tion".~~

13 (e) STATUTE OF LIMITATIONS FOR ASSESSMENT AC-
14 TIONS.—Subsection (g) of section 7 of the Federal Deposit
15 Insurance Act (12 U.S.C. 1817(g)) is amended to read
16 as follows:

17 "(g) ASSESSMENT ACTIONS.—

18 "(1) IN GENERAL.—The Corporation, in any
19 court of competent jurisdiction, shall be entitled to
20 recover from any insured depository institution the
21 amount of any unpaid assessment lawfully payable
22 by such insured depository institution.

23 "(2) STATUTE OF LIMITATIONS.—The following
24 provisions shall apply to actions relating to assess-



1 ments, notwithstanding any other provision in Fed-
2 eral law, or the law of any State:

3 “(A) Any action by an insured depository
4 institution to recover from the Corporation the
5 overpaid amount of any assessment shall be
6 brought within 3 years after the date the as-
7 sessment payment was due, subject to the ex-
8 ception in subparagraph (E).

9 “(B) Any action by the Corporation to re-
10 cover from an insured depository institution the
11 underpaid amount of any assessment shall be
12 brought within 3 years after the date the as-
13 sessment payment was due, subject to the ex-
14 ceptions in subparagraphs (C) and (E).

15 “(C) If an insured depository institution
16 has made a false or fraudulent statement with
17 intent to evade any or all of its assessment, the
18 Corporation shall have until 3 years after the
19 date of discovery of the false or fraudulent
20 statement in which to bring an action to recover
21 the underpaid amount.

22 “(D) Except as provided in subparagraph
23 (C), assessment deposit information contained
24 in records no longer required to be maintained



1 pursuant to subsection (b)(4) shall be consid-
2 ered conclusive and not subject to change.

3 “(E) Any action for the underpaid or over-
4 paid amount of any assessment that became
5 due before the amendment to this subsection
6 under the Federal Deposit Insurance Reform
7 Act of 2005 took effect shall be subject to the
8 statute of limitations for assessments in effect
9 at the time the assessment became due.”.

10 (f) EFFECTIVE DATE.—This section and the amend-
11 ments made by this section shall take effect on the date
12 that the final regulations required under section 9(a)(5)
13 take effect.

14 **SEC. 2105. REPLACEMENT OF FIXED DESIGNATED RESERVE**
15 **RATIO WITH RESERVE RANGE.**

16 (a) IN GENERAL.—Section 7(b)(3) of the Federal
17 Deposit Insurance Act (12 U.S.C. 1817(b)(3)) is amended
18 to read as follows:

19 “(3) DESIGNATED RESERVE RATIO.—

20 “(A) ESTABLISHMENT.—

21 “(i) IN GENERAL.—Before the begin-
22 ning of each calendar year, the Board of
23 Directors shall designate the reserve ratio
24 applicable with respect to the Deposit In-



1 insurance Fund and publish the reserve ratio
2 so designated.

3 “(ii) RULEMAKING REQUIREMENT.—
4 Any change to the designated reserve ratio
5 shall be made by the Board of Directors by
6 regulation after notice and opportunity for
7 comment.

8 “(B) RANGE.—The reserve ratio des-
9 igned by the Board of Directors for any
10 year—

11 “(i) may not exceed 1.5 percent of es-
12 timated insured deposits; and

13 “(ii) may not be less than 1.15 per-
14 cent of estimated insured deposits.

15 “(C) FACTORS.—In designating a reserve
16 ratio for any year, the Board of Directors
17 shall—

18 “(i) take into account the risk of
19 losses to the Deposit Insurance Fund in
20 such year and future years, including his-
21 toric experience and potential and esti-
22 mated losses from insured depository insti-
23 tutions;

24 “(ii) take into account economic con-
25 ditions generally affecting insured deposi-



1 tory institutions so as to allow the des-
2 ignated reserve ratio to increase during
3 more favorable economic conditions and to
4 decrease during less favorable economic
5 conditions, notwithstanding the increased
6 risks of loss that may exist during such
7 less favorable conditions, as determined to
8 be appropriate by the Board of Directors;

9 “(iii) seek to prevent sharp swings in
10 the assessment rates for insured depository
11 institutions; and

12 “(iv) take into account such other fac-
13 tors as the Board of Directors may deter-
14 mine to be appropriate, consistent with the
15 requirements of this subparagraph.

16 “(D) PUBLICATION OF PROPOSED CHANGE
17 IN RATIO.—In soliciting comment on any pro-
18 posed change in the designated reserve ratio in
19 accordance with subparagraph (A), the Board
20 of Directors shall include in the published pro-
21 posal a thorough analysis of the data and pro-
22 jections on which the proposal is based.”.

23 ~~(b) TECHNICAL AND CONFORMING AMENDMENT.—~~
24 ~~Section 3(y) of the Federal Deposit Insurance Act (12~~
25 ~~U.S.C. 1818(y)) is amended~~



1 (1) ~~by striking “(y) The term” and inserting~~
2 “~~(y) DEFINITIONS RELATING TO DEPOSIT INSUR-~~
3 ~~ANCE FUND.~~”

4 “~~(1) DEPOSIT INSURANCE FUND. The term~~”
5 and

6 (2) ~~by inserting after paragraph (1) (as so des-~~
7 ~~ignated by paragraph (1) of this subsection) the fol-~~
8 ~~lowing new paragraph.~~

9 “~~(2) DESIGNATED RESERVE RATIO. The term~~
10 ~~“designated reserve ratio” means the reserve ratio~~
11 ~~designated by the Board of Directors in accordance~~
12 ~~with section 7(b)(3).”~~

13 (c) EFFECTIVE DATE.—This section and the amend-
14 ments made by this section shall take effect on the date
15 that the final regulations required under section 9(a)(1)
16 take effect.

17 **SEC. 2106. REQUIREMENTS APPLICABLE TO THE RISK-**
18 **BASED ASSESSMENT SYSTEM.**

19 Section 7(b)(1) of the Federal Deposit Insurance Act
20 (12 U.S.C. 1817(b)(1)) is amended by adding at the end
21 the following new subparagraphs:

22 “(E) INFORMATION CONCERNING RISK OF
23 LOSS AND ECONOMIC CONDITIONS.—

24 “(i) SOURCES OF INFORMATION.—For
25 purposes of determining risk of losses at



1 insured depository institutions and eco-
2 nomic conditions generally affecting depos-
3 itory institutions, the Corporation shall col-
4 lect information, as appropriate, from all
5 sources the Board of Directors considers
6 appropriate, such as reports of condition,
7 inspection reports, and other information
8 from all Federal banking agencies, any in-
9 formation available from State bank super-
10 visors, State insurance and securities regu-
11 lators, the Securities and Exchange Com-
12 mission (including information described in
13 section 35), the Secretary of the Treasury,
14 the Commodity Futures Trading Commis-
15 sion, the Farm Credit Administration, the
16 Federal Trade Commission, any Federal
17 reserve bank or Federal home loan bank,
18 and other regulators of financial institu-
19 tions, and any information available from
20 credit rating entities, and other private
21 economic or business analysts.

22 “(ii) CONSULTATION WITH FEDERAL
23 BANKING AGENCIES.—

24 “(I) IN GENERAL.—Except as
25 provided in subclause (II), in assess-



1 ing the risk of loss to the Deposit In-
2 surance Fund with respect to any in-
3 sured depository institution, the Cor-
4 poration shall consult with the appro-
5 priate Federal banking agency of such
6 institution.

7 “(II) TREATMENT ON AGGRE-
8 GATE BASIS.—In the case of insured
9 depository institutions that are well
10 capitalized (as defined in section 38)
11 and, in the most recent examination,
12 were found to be well managed, the
13 consultation under subclause (I) con-
14 cerning the assessment of the risk of
15 loss posed by such institutions may be
16 made on an aggregate basis.

17 “(iii) RULE OF CONSTRUCTION.—No
18 provision of this paragraph shall be con-
19 strued as providing any new authority for
20 the Corporation to require submission of
21 information by insured depository institu-
22 tions to the Corporation.

23 “(F) MODIFICATIONS TO THE RISK-BASED
24 ASSESSMENT SYSTEM ALLOWED ONLY AFTER
25 NOTICE AND COMMENT.—In revising or modi-



1 fying the risk-based assessment system at any
 2 time after the date of the enactment of the
 3 Federal Deposit Insurance Reform Act of 2005,
 4 the Board of Directors may implement such re-
 5 visions or modification in final form only after
 6 notice and opportunity for comment.”.

7 **SEC. 2107. REFUNDS, DIVIDENDS, AND CREDITS FROM DE-**
 8 **POSIT INSURANCE FUND.**

9 (a) **IN GENERAL.**—Subsection (e) of section 7 of the
 10 Federal Deposit Insurance Act (12 U.S.C. 1817(e)) is
 11 amended to read as follows:

12 “(e) **REFUNDS, DIVIDENDS, AND CREDITS.**—

13 “(1) **REFUNDS OF OVERPAYMENTS.**—In the
 14 case of any payment of an assessment by an insured
 15 depository institution in excess of the amount due to
 16 the Corporation, the Corporation may—

17 “(A) refund the amount of the excess pay-
 18 ment to the insured depository institution; or

19 “(B) credit such excess amount toward the
 20 payment of subsequent assessments until such
 21 credit is exhausted.

22 “(2) **DIVIDENDS FROM EXCESS AMOUNTS IN**
 23 **DEPOSIT INSURANCE FUND.**—

24 “(A) **RESERVE RATIO IN EXCESS OF 1.5**
 25 **PERCENT OF ESTIMATED INSURED DEPOSITS.**—



1 If, at the end of a calendar year, the reserve
2 ratio of the Deposit Insurance Fund exceeds
3 1.5 percent of estimated insured deposits, the
4 Corporation shall declare the amount in the
5 Fund in excess of the amount required to main-
6 tain the reserve ratio at 1.5 percent of esti-
7 mated insured deposits, as dividends to be paid
8 to insured depository institutions.

9 “(B) RESERVE RATIO EQUAL TO OR IN EX-
10 CESS OF 1.35 PERCENT OF ESTIMATED INSURED
11 DEPOSITS AND NOT MORE THAN 1.5 PER-
12 CENT.—If, at the end of a calendar year, the
13 reserve ratio of the Deposit Insurance Fund
14 equals or exceeds 1.35 percent of estimated in-
15 sured deposits and is not more than 1.5 percent
16 of such deposits, the Corporation shall declare
17 the amount in the Fund that is equal to 50 per-
18 cent of the amount in excess of the amount re-
19 quired to maintain the reserve ratio at 1.35
20 percent of the estimated insured deposits as
21 dividends to be paid to insured depository insti-
22 tutions.

23 “(C) BASIS FOR DISTRIBUTION OF DIVI-
24 DENDS.—

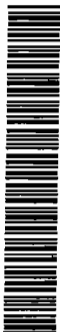


1 “(i) IN GENERAL.—Solely for the pur-
2 poses of dividend distribution under this
3 paragraph, the Corporation shall determine
4 each insured depository institution’s rel-
5 ative contribution to the Deposit Insurance
6 Fund (or any predecessor deposit insur-
7 ance fund) for calculating such institu-
8 tion’s share of any dividend declared under
9 this paragraph, taking into account the
10 factors described in clause (ii).

11 “(ii) FACTORS FOR DISTRIBUTION.—
12 In implementing this paragraph in accord-
13 ance with regulations, the Corporation
14 shall take into account the following fac-
15 tors:

16 “(I) The ratio of the assessment
17 base of an insured depository institu-
18 tion (including any predecessor) on
19 December 31, 1996, to the assessment
20 base of all eligible insured depository
21 institutions on that date.

22 “(II) The total amount of assess-
23 ments paid on or after January 1,
24 1997, by an insured depository insti-
25 tution (including any predecessor) to



1 the Deposit Insurance Fund (and any
2 predecessor deposit insurance fund).

3 “(III) That portion of assess-
4 ments paid by an insured depository
5 institution (including any predecessor)
6 that reflects higher levels of risk as-
7 sumed by such institution.

8 “(IV) Such other factors as the
9 Corporation may determine to be ap-
10 propriate.

11 “(D) NOTICE AND OPPORTUNITY FOR
12 COMMENT.—The Corporation shall prescribe by
13 regulation, after notice and opportunity for
14 comment, the method for the calculation, dec-
15 laration, and payment of dividends under this
16 paragraph.

17 “(E) LIMITATION.—The Board of Direc-
18 tors may suspend or limit dividends paid under
19 subparagraph (B), if the Board determines in
20 writing that—

21 “(i) a significant risk of losses to the
22 Deposit Insurance Fund exists over the
23 next 1-year period; and

24 “(ii) it is likely that such losses will be
25 sufficiently high as to justify a finding by



1 the Board that the reserve ratio should
2 temporarily be allowed—

3 “(I) to grow without requiring
4 dividends under subparagraph (B); or

5 “(II) to exceed the maximum
6 amount established under subsection
7 (b)(3)(B)(i).

8 “(F) CONSIDERATIONS.—In making a de-
9 termination under subparagraph (E), the Board
10 shall consider—

11 “(i) national and regional conditions
12 and their impact on insured depository in-
13 stitutions;

14 “(ii) potential problems affecting in-
15 sured depository institutions or a specific
16 group or type of depository institution;

17 “(iii) the degree to which the contin-
18 gent liability of the Corporation for antici-
19 pated failures of insured institutions ade-
20 quately addresses concerns over funding
21 levels in the Deposit Insurance Fund; and

22 “(iv) any other factors that the Board
23 determines are appropriate.

24



1 [REDACTED]
2 [REDACTED]
3 [REDACTED]
4 [REDACTED]
5 [REDACTED]
6 [REDACTED]
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9 [REDACTED]
10 [REDACTED]
11 [REDACTED]
12 [REDACTED]
13 [REDACTED]
14 [REDACTED]

15 “(H) REVIEW OF DETERMINATION.—

16 “(i) ANNUAL REVIEW.—A determina-
17 tion to suspend or limit dividends under
18 subparagraph (E) shall be reviewed by the
19 Board of Directors annually.

20 “(ii) ACTION BY BOARD.—Based on
21 each annual review under clause (i), the
22 Board of Directors shall either renew or
23 remove a determination to suspend or limit
24 dividends under subparagraph (E), or shall
25 make a new determination in accordance



1 with this paragraph. Unless justified under
2 the terms of the renewal or new determina-
3 tion, the Corporation shall be required to
4 provide cash dividends under subparagraph
5 (A) or (B), as appropriate.

6 “(3) ONE-TIME CREDIT BASED ON TOTAL AS-
7 SESSMENT BASE AT YEAR-END 1996.—

8 “(A) IN GENERAL.—Before the end of the
9 270-day period beginning on the date of the en-
10 actment of the Federal Deposit Insurance Re-
11 form Act of 2005, the Board of Directors shall,
12 by regulation after notice and opportunity for
13 comment, provide for a credit to each eligible
14 insured depository institution (or a successor
15 insured depository institution), based on the as-
16 sessment base of the institution on December
17 31, 1996, as compared to the combined aggre-
18 gate assessment base of all eligible insured de-
19 pository institutions, taking into account such
20 factors as the Board of Directors may deter-
21 mine to be appropriate.

22 “(B) CREDIT LIMIT.—The aggregate
23 amount of credits available under subparagraph
24 (A) to all eligible insured depository institutions
25 shall equal the amount that the Corporation



1 could collect if the Corporation imposed an as-
2 essment of 10.5 basis points on the combined
3 assessment base of the Bank Insurance Fund
4 and the Savings Association Insurance Fund as
5 of December 31, 2001.

6 “(C) ELIGIBLE INSURED DEPOSITORY IN-
7 STITUTION DEFINED.—For purposes of this
8 paragraph, the term ‘eligible insured depository
9 institution’ means any insured depository insti-
10 tution that—

11 “(i) was in existence on December 31,
12 1996, and paid a deposit insurance assess-
13 ment prior to that date; or

14 “(ii) is a successor to any insured de-
15 pository institution described in clause (i).

16 “(D) APPLICATION OF CREDITS.—

17 “(i) IN GENERAL.—Subject to clause
18 (ii), the amount of a credit to any eligible
19 insured depository institution under this
20 paragraph shall be applied by the Corpora-
21 tion, subject to subsection (b)(3)(E), to the
22 assessments imposed on such institution
23 under subsection (b) that become due for
24 assessment periods beginning after the ef-



1 fective date of regulations prescribed under
2 subparagraph (A).

3 “(ii) TEMPORARY RESTRICTION ON
4 USE OF CREDITS.—The amount of a credit
5 to any eligible insured depository institu-
6 tion under this paragraph may not be ap-
7 plied to more than 90 percent of the as-
8 sessments imposed on such institution
9 under subsection (b) that become due for
10 assessment periods beginning in fiscal
11 years 2008, 2009, and 2010.

12 “(iii) REGULATIONS.—The regulations
13 prescribed under subparagraph (A) shall
14 establish the qualifications and procedures
15 governing the application of assessment
16 credits pursuant to clause (i).

17 “(E) LIMITATION ON AMOUNT OF CREDIT
18 FOR CERTAIN DEPOSITORY INSTITUTIONS.—In
19 the case of an insured depository institution
20 that exhibits financial, operational, or compli-
21 ance weaknesses ranging from moderately se-
22 vere to unsatisfactory, or is not adequately cap-
23 italized (as defined in section 38) at the begin-
24 ning of an assessment period, the amount of
25 any credit allowed under this paragraph against



1 the assessment on that depository institution
2 for such period may not exceed the amount cal-
3 culated by applying to that depository institu-
4 tion the average assessment rate on all insured
5 depository institutions for such assessment pe-
6 riod.

7 “(F) SUCCESSOR DEFINED.—The Corpora-
8 tion shall define the term ‘successor’ for pur-
9 poses of this paragraph, by regulation, and may
10 consider any factors as the Board may deem
11 appropriate.

12 “(4) ADMINISTRATIVE REVIEW.—

13 “(A) IN GENERAL.—The regulations pre-
14 scribed under paragraphs (2)(D) and (3) shall
15 include provisions allowing an insured deposi-
16 tory institution a reasonable opportunity to
17 challenge administratively the amount of the
18 credit or dividend determined under paragraph
19 (2) or (3) for such institution.

20 “(B) ADMINISTRATIVE REVIEW.—Any re-
21 view under subparagraph (A) of any determina-
22 tion of the Corporation under paragraph (2) or
23 (3) shall be final and not subject to judicial re-
24 view.”.



1 (b) DEFINITION OF RESERVE RATIO.—Section 3(y)
2 of the Federal Deposit Insurance Act (12 U.S.C. 1813(y))
3 (as amended by section 2105(b) of this subtitle) is amend-
4 ed by adding at the end the following new paragraph:

5 “(3) RESERVE RATIO.—The term ‘reserve
6 ratio’, when used with regard to the Deposit Insur-
7 ance Fund other than in connection with a reference
8 to the designated reserve ratio, means the ratio of
9 the net worth of the Deposit Insurance Fund to the
10 value of the aggregate estimated insured deposits.”.

11 **SEC. 2108. DEPOSIT INSURANCE FUND RESTORATION**
12 **PLANS.**

13 Section 7(b)(3) of the Federal Deposit Insurance Act
14 (12 U.S.C. 1817(b)(3)) (as amended by section 2105(a)
15 of this subtitle) is amended by adding at the end the fol-
16 lowing new subparagraph:

17 “(E) DIF RESTORATION PLANS.—

18 “(i) IN GENERAL.—Whenever—

19 “(I) the Corporation projects
20 that the reserve ratio of the Deposit
21 Insurance Fund will, within 6 months
22 of such determination, fall below the
23 minimum amount specified in sub-
24 paragraph (B)(ii) for the designated
25 reserve ratio; or



1 “(II) the reserve ratio of the De-
2 posit Insurance Fund actually falls
3 below the minimum amount specified
4 in subparagraph (B)(ii) for the des-
5 ignated reserve ratio without any de-
6 termination under subclause (I) hav-
7 ing been made,
8 the Corporation shall establish and imple-
9 ment a Deposit Insurance Fund restora-
10 tion plan within 90 days that meets the re-
11 quirements of clause (ii) and such other
12 conditions as the Corporation determines
13 to be appropriate.

14 “(ii) REQUIREMENTS OF RESTORA-
15 TION PLAN.—A Deposit Insurance Fund
16 restoration plan meets the requirements of
17 this clause if the plan provides that the re-
18 serve ratio of the Fund will meet or exceed
19 the minimum amount specified in subpara-
20 graph (B)(ii) for the designated reserve
21 ratio before the end of the 5-year period
22 beginning upon the implementation of the
23 plan (or such longer period as the Corpora-
24 tion may determine to be necessary due to
25 extraordinary circumstances).



1 “(iii) RESTRICTION ON ASSESSMENT
2 CREDITS.—As part of any restoration plan
3 under this subparagraph, the Corporation
4 may elect to restrict the application of as-
5 sessment credits provided under subsection
6 (e)(3) for any period that the plan is in ef-
7 fect.

8 “(iv) LIMITATION ON RESTRICTION.—
9 Notwithstanding clause (iii), while any res-
10 toration plan under this subparagraph is in
11 effect, the Corporation shall apply credits
12 provided to an insured depository institu-
13 tion under subsection (e)(3) against any
14 assessment imposed on the institution for
15 any assessment period in an amount equal
16 to the lesser of—

17 “(I) the amount of the assess-
18 ment; or

19 “(II) the amount equal to 3 basis
20 points of the institution’s assessment
21 base.

22 “(v) TRANSPARENCY.—Not more than
23 30 days after the Corporation establishes
24 and implements a restoration plan under
25 clause (i), the Corporation shall publish in



1 the Federal Register a detailed analysis of
2 the factors considered and the basis for the
3 actions taken with regard to the plan.”.

4 **SEC. 2109. REGULATIONS REQUIRED.**

5 (a) **IN GENERAL.**—Not later than 270 days after the
6 date of the enactment of this Act, the Board of Directors
7 of the Federal Deposit Insurance Corporation shall pre-
8 scribe final regulations, after notice and opportunity for
9 comment—

10 (1) designating the reserve ratio for the Deposit
11 Insurance Fund in accordance with section 7(b)(3)
12 of the Federal Deposit Insurance Act (as amended
13 by section 2105 of this subtitle);

14 (2) implementing increases in deposit insurance
15 coverage in accordance with the amendments made
16 by section 2103 of this subtitle;

17 (3) implementing the dividend requirement
18 under section 7(e)(2) of the Federal Deposit Insur-
19 ance Act (as amended by section 2107 of this sub-
20 title);

21 (4) implementing the 1-time assessment credit
22 to certain insured depository institutions in accord-
23 ance with section 7(e)(3) of the Federal Deposit In-
24 surance Act, as amended by section 2107 of this
25 subtitle, including the qualifications and procedures



1 under which the Corporation would apply assess-
2 ment credits; and

3 (5) providing for assessments under section
4 7(b) of the Federal Deposit Insurance Act, as
5 amended by this subtitle.

6 (b) TRANSITION PROVISIONS.—

7 (1) CONTINUATION OF EXISTING ASSESSMENT
8 REGULATIONS.—No provision of this subtitle or any
9 amendment made by this subtitle shall be construed
10 as affecting the authority of the Corporation to set
11 or collect deposit insurance assessments pursuant to
12 any regulations in effect before the effective date of
13 the final regulations prescribed under subsection (a).

14 (2) TREATMENT OF DIF MEMBERS UNDER EX-
15 ISTING REGULATIONS.—As of the date of the merger
16 of the Bank Insurance Fund and the Savings Asso-
17 ciation Insurance Fund pursuant to section 2102,
18 the assessment regulations in effect immediately be-
19 fore the date of the enactment of this Act shall con-
20 tinue to apply to all members of the Deposit Insur-
21 ance Fund, until such regulations are modified by
22 the Corporation, notwithstanding that such regula-
23 tions may refer to “Bank Insurance Fund members”
24 or “Savings Association Insurance Fund members”.



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19 p [REDACTED]
20 [REDACTED] with such
21 [REDACTED] administrative
22 [REDACTED] the agency may determine to be
23 [REDACTED] e.
24 [REDACTED]
25 [REDACTED]



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 4 [REDACTED]
 5 [REDACTED]
 6 [REDACTED]
 7 [REDACTED]

8 ~~Corporation shall submit a report to the Congress~~
 9 ~~before the end of the 1 year period beginning on the~~
 10 ~~date of the enactment of this Act containing the~~
 11 ~~findings and conclusions of the Corporation with re-~~
 12 ~~spect to the study required under paragraph (1) to-~~
 13 ~~gether with such recommendations for legislative or~~
 14 ~~administrative action as the Board of Directors of~~
 15 ~~the Corporation may determine to be appropriate.~~

16 ~~(1) STUDY OF RESERVE METHODOLOGY AND AC-~~
 17 ~~COUNTING FOR LOSS.~~

18 ~~(1) STUDY REQUIRED. The Federal Deposit~~
 19 ~~Insurance Corporation shall conduct a study of the~~
 20 ~~reserve methodology and loss accounting used by the~~
 21 ~~Corporation during the period beginning on January~~
 22 ~~1, 1992, and ending December 31, 2004, with re-~~
 23 ~~spect to insured depository institutions in a troubled~~
 24 ~~condition (as defined in the regulations prescribed~~
 25 ~~pursuant to section 22(f) of the Federal Deposit In-~~



1 ~~urance Act) The Corporation shall obtain com-~~
2 ~~ments on the design of the study from the Comp-~~
3 ~~troller General.~~

4 ~~(2) FACTORS TO BE INCLUDED. In conducting~~
5 ~~the study pursuant to paragraph (1), the Federal~~
6 ~~Deposit Insurance Corporation shall—~~

7 ~~(A) consider the overall effectiveness and~~
8 ~~accuracy of the methodology used by the Cor-~~
9 ~~poration for establishing and maintaining re-~~
10 ~~serves and estimating and accounting for losses~~
11 ~~at insured depository institutions, during the~~
12 ~~period described in such paragraph,~~

13 ~~(B) consider the appropriateness and reli-~~
14 ~~ability of information and criteria used by the~~
15 ~~Corporation in determining—~~

16 ~~(i) whether an insured depository in-~~
17 ~~stitution was in a troubled condition, and~~

18 ~~(ii) the amount of any loss anticipated~~
19 ~~at such institution;~~

20 ~~(C) analyze the actual historical loss expe-~~
21 ~~rience over the period described in paragraph~~
22 ~~(1) and the causes of the exceptionally high~~
23 ~~rate of losses experienced by the Corporation in~~
24 ~~the final 2 years of that period, and~~



1 ~~(D) rate the efforts of the Corporation to~~
2 ~~reduce losses in such 3 year period to minimally~~
3 ~~acceptable levels and to historical levels.~~

4 ~~(3) REPORT REQUIRED: The Board of Direc-~~
5 ~~tors of the Federal Deposit Insurance Corporation~~
6 ~~shall submit a report to the Congress before the end~~
7 ~~of the 1 year period beginning on the date of the en-~~
8 ~~actment of this Act, containing the findings and con-~~
9 ~~clusions of the Corporation with respect to the study~~
10 ~~required under paragraph (1) together with such~~
11 ~~recommendations for legislative or administrative ac-~~
12 ~~tion as the Board of Directors may determine to be~~
13 ~~appropriate. Before submitting the report to Con-~~
14 ~~gress, the Board of Directors shall provide a draft~~
15 ~~of the report to the Comptroller General for com-~~
16 ~~ment.~~

17 ~~(c) BASEL II STUDY.~~

18 ~~(1) IN GENERAL: Not later than 1 year after~~
19 ~~the date of enactment of this Act, the Comptroller~~
20 ~~General shall report to the Committee on Banking,~~
21 ~~Housing, and Urban Affairs of the Senate and the~~
22 ~~Committee on Financial Services of the House of~~
23 ~~Representatives on the potential impact on the fi-~~
24 ~~nanacial system of the United States of the imple-~~
25 ~~mentation of the new Basel Capital Accord (Basel~~



1 ~~It) and the proposed revisions to current reserve re-~~
2 ~~quirement regulations for non-Basel II banks.~~

3 ~~(2) FACTORS TO BE INCLUDED. The report~~
4 ~~required under paragraph (1) shall address the fol-~~
5 ~~lowing:~~

6 ~~(A) The potential impact of Basel II on~~
7 ~~capital requirements in the United States,~~
8 ~~including—~~

9 ~~(i) whether there would be a reduction~~
10 ~~in capital requirements;~~

11 ~~(ii) whether Basel II could hinder en-~~
12 ~~forcement of prompt corrective action laws~~
13 ~~and regulations; and~~

14 ~~(iii) the potential implications any~~
15 ~~changes in capital requirements may have~~
16 ~~on the safety and soundness of the finan-~~
17 ~~cial system in the United States.~~

18 ~~(B) By gathering available information,~~
19 ~~the ability of United States banks and bank~~
20 ~~regulators to implement and comply with the~~
21 ~~provisions of Basel II, including—~~

22 ~~(i) the costs of Basel II for financial~~
23 ~~institutions and regulators;~~

24 ~~(ii) the feasibility and appropriateness~~
25 ~~of Basel II's statistical models, and~~



1 ~~(iii) the ability of regulators to oversee~~
2 ~~capital requirement operations of financial~~
3 ~~institutions.~~

4 ~~(C) The ability of the United States finan-~~
5 ~~cial institution regulatory agencies—~~

6 ~~(i) to attract and retain sufficient ex-~~
7 ~~pertise, both among specialists and exam-~~
8 ~~iners, and~~

9 ~~(ii) to conduct the necessary oversight~~
10 ~~of capital and risk modeling by regulated~~
11 ~~financial institutions subject to Basel II.~~

12 ~~§ 193.101 ANNUAL REPORT ON~~
13 ~~REGULATORY OPERATIONS~~
14 ~~AND~~
15 ~~COMPLIANCE~~

16 ~~The Federal Deposit Insurance Act (12 U.S.C. 1811~~
17 ~~et seq.) is amended by adding at the end the following~~
18 ~~new section:~~

19 ~~“SEC. 19. BIENNIAL FDIC SURVEY AND REPORT ON EN-~~
20 ~~COURAGING USE OF DEPOSITARY INSTITU-~~
21 ~~TIONS BY THE UNBANKED.~~

22 ~~“(a) SURVEY REQUIRED.—~~

23 ~~“(1) IN GENERAL. The Corporation shall con-~~
24 ~~duct a biennial survey on efforts by insured deposi-~~
25 ~~tary institutions to bring those individuals and fami-~~



1 ~~lies who have rarely, if ever, held a checking ac-~~
2 ~~count, a savings account or other type of transaction~~
3 ~~or check cashing account at an insured depository~~
4 ~~institution" (hereafter in this section referred to as~~
5 ~~the 'unbanked') into the conventional finance sys-~~
6 ~~tem.~~

7 ~~"(2) FACTORS AND QUESTIONS TO CON-~~
8 ~~SIDER. In conducting the survey, the Corporation~~
9 ~~shall take the following factors and questions into~~
10 ~~account.~~

11 ~~"(A) To what extent do insured depository~~
12 ~~institutions promote financial education and fi-~~
13 ~~nancial literacy outreach?~~

14 ~~"(B) Which financial education efforts ap-~~
15 ~~pear to be the most effective in bringing~~
16 ~~'unbanked' individuals and families into the~~
17 ~~conventional finance system?~~

18 ~~"(C) What efforts are insured institutions~~
19 ~~making at converting 'unbanked' money order,~~
20 ~~wire transfer, and international remittance cus-~~
21 ~~tomers into conventional account holders?~~

22 ~~"(D) What cultural, language and identi-~~
23 ~~fication issues as well as transaction costs ap-~~
24 ~~pear to most prevent 'unbanked' individuals~~
25 ~~from establishing conventional accounts?~~



1 ~~“(B) What is a fair estimate of the size~~
2 ~~and worth of the unbanked market in the~~
3 ~~United States?”~~

4 ~~“(b) REPORTS.—The Chairperson of the Board of~~
5 ~~Directors shall submit a bi-annual report to the Com-~~
6 ~~mittee on Financial Services of the House of Representa-~~
7 ~~tives and the Committee on Banking, Housing, and Urban~~
8 ~~Affairs of the Senate containing the Corporation's findings~~
9 ~~and conclusions with respect to the survey conducted pur-~~
10 ~~suant to subsection (a), together with such recommenda-~~
11 ~~tions for legislative or administrative action as the Chair-~~
12 ~~person may determine to be appropriate.”~~

13 ~~SEC. 212. TECHNICAL AND CONFORMING AMENDMENTS~~
14 ~~TO THE FEDERAL DEPOSIT INSURANCE ACT~~
15 ~~RELATING TO THE MERGER OF THE FDIC AND~~
16 ~~SAIF~~

17 ~~(a) In GENERAL.—The Federal Deposit Insurance~~
18 ~~Act (12 U.S.C. 1811 et seq.) is amended~~

19 ~~(1) in section 3 (12 U.S.C. 1813)—~~

20 ~~(A) by striking subparagraph (B) of sub-~~
21 ~~section (a)(1) and inserting the following new~~
22 ~~subparagraph:~~

23 ~~“(B) includes any former savings associa-~~
24 ~~tion”, and~~



1 ~~(B) by striking paragraph (1) of sub-~~
2 ~~section (j) (as so designated by section 2105(b)~~
3 ~~of this subtitle) and inserting the following new~~
4 ~~paragraph:~~

5 ~~“(1) DEPOSIT INSURANCE FUND. The term~~
6 ~~‘Deposit Insurance Fund’ means the Deposit Insur-~~
7 ~~ance Fund established under section 11(a)(4). ;~~

8 ~~(2) in section 5(b)(5) (12 U.S.C. 1819(b)(5)),~~
9 ~~by striking “the Bank Insurance Fund or the Sav-~~
10 ~~ings Association Insurance Fund” and inserting~~
11 ~~“the Deposit Insurance Fund”.~~

12 ~~(3) in section 5(c)(4), by striking “deposit in-~~
13 ~~surance fund” and inserting “Deposit Insurance~~
14 ~~Fund”.~~

15 ~~(4) in section 5(d) (12 U.S.C. 1815(d)), by~~
16 ~~striking paragraphs (2) and (3) (and any funds re-~~
17 ~~sulting from the application of such paragraph (2)~~
18 ~~prior to its repeal shall be deposited into the general~~
19 ~~fund of the Deposit Insurance Fund),~~

20 ~~(5) in section 5(d)(1) (12 U.S.C. 1815(d)(1))~~

21 ~~(A) in subparagraph (A), by striking “re-~~
22 ~~serve ratios in the Bank Insurance Fund and~~
23 ~~the Savings Association Insurance Fund as re-~~
24 ~~quired by section 7” and inserting “the reserve~~
25 ~~ratio of the Deposit Insurance Fund”.~~

1 (B) by striking subparagraph (D) and in-
2 serting the following:

3 “(2) ~~FEE CREDITED TO THE DEPOSIT INSUR-~~
4 ~~ANCE FUND.~~ The fee paid by the depository insti-
5 tution under paragraph (1) shall be credited to the
6 ~~Deposit Insurance Fund.~~”;

7 (C) by striking “(1) ~~UNINSURED INSTI-~~
8 ~~TUTIONS.~~”, and

9 (D) by redesignating subparagraphs (A)
10 and (C) as paragraphs (1) and (3), respectively,
11 and moving the left margins 2 ems to the left;
12 (6) in section 5(c) (12 U.S.C. 1813(e))—

13 (A) in paragraph (5)(A) by striking
14 “~~Bank Insurance Fund of the Savings Associa-~~
15 ~~tion Insurance Fund~~” and inserting “~~Deposit~~
16 ~~Insurance Fund~~”.

17 (B) by striking paragraph (6); and

18 (C) by redesignating paragraphs (7), (8),
19 and (9) as paragraphs (6), (7), and (8), respec-
20 tively;

21 (7) in section 6(j) (12 U.S.C. 1816(j)), by
22 striking “~~Bank Insurance Fund of the Savings As-~~
23 ~~sociation Insurance Fund~~” and inserting “~~Deposit~~
24 ~~Insurance Fund~~”;

25 (8) in section 7(b) (12 U.S.C. 1817(b))—



- 1 (A) in paragraph (1)(C), by striking “~~de-~~
 - 2 ~~posit insurance fund~~” each place that term ap-
 - 3 ~~pears and inserting “Deposit Insurance Fund”;~~
- 4 (B) in paragraph (1)(D), by striking “~~each~~
 - 5 ~~deposit insurance fund~~” and inserting “the De-
 - 6 ~~posit Insurance Fund~~”; and
- 7 (C) in paragraph (5) (as so redesignated
 - 8 ~~by section 2101(d)(1) of this subtitle—~~
 - 9 (i) by striking “~~any such assessment~~”
 - 10 ~~and inserting “any such assessment is not~~
 - 11 ~~essential”;~~
 - 12 (ii) by striking subparagraph (B);
 - 13 (iii) in subparagraph (A)
 - 14 (I) by striking “(A) is nec-
 - 15 ~~essary—”;~~
 - 16 (II) by striking “~~Bank Insurance~~
 - 17 ~~Fund members~~” and inserting “in-
 - 18 ~~sured depository institutions”;~~ and
 - 19 (III) by redesignating clauses (i),
 - 20 (ii), and (iii) as subparagraphs (A),
 - 21 (B), and (C), respectively, and moving
 - 22 ~~the margins 2 ems to the left, and~~
 - 23 (iv) in subparagraph (C) (as so reded-
 - 24 ~~ignated)~~



1 (I) ~~by inserting "that" before~~
 2 ~~"the Corporation", and~~
 3 (II) ~~by striking ", and" and in-~~
 4 ~~serting a period,~~
 5 (9) ~~in section 7(j)(7)(F) (12 U.S.C.~~
 6 ~~1817(j)(7)(F)), by striking "Bank Insurance Fund~~
 7 ~~on the Savings Association Insurance Fund" and in-~~
 8 ~~serting "Deposit Insurance Fund ;~~
 9 (10) ~~in section 8(t)(2)(C) (12 U.S.C.~~
 10 ~~1818(t)(2)(C)), by striking "deposit insurance fund"~~
 11 ~~and inserting "Deposit Insurance Fund",~~
 12 (11) ~~in section 11 (12 U.S.C. 1821)~~
 13 (A) ~~by striking "deposit insurance fund"~~
 14 ~~each place that term appears and inserting~~
 15 ~~"Deposit Insurance Fund",~~
 16 (B) ~~by striking paragraph (4) of sub-~~
 17 ~~section (a) and inserting the following new~~
 18 ~~paragraph:~~
 19 ~~"(4) DEPOSIT INSURANCE FUND:~~
 20 ~~"(A) ESTABLISHMENT. There is estab-~~
 21 ~~lished the Deposit Insurance Fund, which the~~
 22 ~~Corporation shall~~
 23 ~~"(i) maintain and administer;~~



1 “(i) ~~use to carry out its insurance~~
2 ~~purposes, in the manner provided by this~~
3 ~~subsection, and~~

4 “(iii) ~~invest in accordance with section~~
5 ~~13(a).~~

6 “(B) ~~USES.~~ The Deposit Insurance Fund
7 ~~shall be available to the Corporation for use~~
8 ~~with respect to insured depository institutions~~
9 ~~the deposits of which are insured by the De-~~
10 ~~posit Insurance Fund.~~

11 “(C) ~~LIMITATION ON USE.~~ Notwith-
12 ~~standing any provision of law other than section~~
13 ~~13(e)(1)(C), the Deposit Insurance Fund shall~~
14 ~~not be used in any manner to benefit any share~~
15 ~~holder or affiliate (other than an insured depos-~~
16 ~~itory institution that receives assistance in ac-~~
17 ~~cordance with the provisions of this Act) of~~

18 “(j) ~~any insured depository institution~~
19 ~~for which the Corporation has been ap-~~
20 ~~pointed conservator or receiver, in connec-~~
21 ~~tion with any type of resolution by the~~
22 ~~Corporation,~~

23 “(i) ~~any other insured depository in-~~
24 ~~stitution in default or in danger of default,~~



1 in ~~connection with any type of resolution~~
2 ~~by the Corporation, or~~

3 “(iii) ~~any insured depository institu-~~
4 ~~tion, in connection with the provision of as-~~
5 ~~sistance under this section or section 13~~
6 ~~with respect to such institution, except~~
7 ~~that this clause shall not prohibit any as-~~
8 ~~sistance to any insured depository institu-~~
9 ~~tion that is not in default, or that is not~~
10 ~~in danger of default, that is acquiring (as~~
11 ~~defined in section 19(f)(3)(D)) another in-~~
12 ~~sured depository institution.~~

13 “(D) ~~Deposits. All amounts assessed~~
14 ~~against insured depository institutions by the~~
15 ~~Corporation shall be deposited into the Deposit~~
16 ~~Insurance Fund. ;~~

17 (C) ~~by striking paragraphs (5), (6), and~~
18 ~~(7) of subsection (a), and~~

19 (D) ~~by redesignating paragraph (9) of sub-~~
20 ~~section (a) as paragraph (5),~~

21 (19) ~~in section 11(f)(1) (12 U.S.C. 1821(f)(1)),~~
22 ~~by striking “, except that—” and all that follows~~
23 ~~through the end of the paragraph and inserting a~~
24 ~~period,~~



1 ~~(13) in section 11(i)(2) (12 U.S.C.~~

2 ~~1821(i)(2))~~

3 ~~(A) by striking subparagraph (B),~~

4 ~~(B) by redesignating subparagraph (C) as~~
5 ~~subparagraph (B), and~~

6 ~~(C) in subparagraph (D) (as so redesign-~~
7 ~~ated), by striking "subparagraphs (A) and~~
8 ~~(B)" and inserting "subparagraph (A)";~~

9 ~~(14) in section 11(p)(2)(B) (12 U.S.C.~~
10 ~~1821(p)(2)(B)), by striking "institution, any" and~~
11 ~~inserting "institution, the";~~

12 ~~(15) in section 11A(a) (12 U.S.C. 1821a(a))~~

13 ~~(A) in paragraph (2), by striking "LIABIL-~~
14 ~~ITIES" and all that follows through "Ex-~~
15 ~~cept" and inserting "LIABILITIES. Except";~~

16 ~~(D) by striking paragraph (2)(D), and~~

17 ~~(C) in paragraph (3), by striking the~~
18 ~~Bank Insurance Fund, the Savings Association~~
19 ~~Insurance Fund" and inserting "the Deposit~~
20 ~~Insurance Fund";~~

21 ~~(16) in section 11A(b) (12 U.S.C. 1821a(b)),~~
22 ~~by striking paragraph (1),~~

23 ~~(17) in section 11A(f) (12 U.S.C. 1821a(f)), by~~
24 ~~striking "Savings Association Insurance Fund" and~~
25 ~~inserting "Deposit Insurance Fund";~~



1 ~~(10) in section 1822(f)(4)(E)(iv) (18 U.S.C.~~
2 ~~1822(f)(4)(E)(iv)), by striking "Federal deposit in-~~
3 ~~surance funds" and inserting "the Deposit Insur-~~
4 ~~ance Fund (or any predecessor deposit insurance~~
5 ~~fund);~~

6 ~~(19) in section 18 (18 U.S.C. 1823)~~

7 ~~(A) by striking "deposit insurance fund"~~
8 ~~each place that term appears and inserting~~
9 ~~"Deposit Insurance Fund";~~

10 ~~(B) in subsection (a)(1), by striking "Bank~~
11 ~~Insurance Fund, the Savings Association Insur-~~
12 ~~ance Fund," and inserting "Deposit Insurance~~
13 ~~Fund";~~

14 ~~(C) in subsection (e)(4)(E) —~~

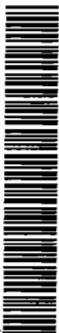
15 ~~(i) in the subparagraph heading, by~~
16 ~~striking "funds" and inserting "fund", and~~

17 ~~(ii) in clause (i), by striking "any in-~~
18 ~~surance fund" and inserting "the Deposit~~
19 ~~Insurance Fund";~~

20 ~~(D) in subsection (e)(4)(G)(ii) —~~

21 ~~(i) by striking "appropriate insurance~~
22 ~~fund" and inserting "Deposit Insurance~~
23 ~~Fund";~~

24 ~~(ii) by striking "the members of the~~
25 ~~insurance fund (or which such institution~~



1 ~~is a member)" and inserting "insured de-~~
2 ~~pository institutions";~~

3 ~~(iii) by striking "each member's" and~~
4 ~~inserting "each insured depository institu-~~
5 ~~tion's", and~~

6 ~~(iv) by striking "the member's" each~~
7 ~~place that term appears and inserting "the~~
8 ~~institution's";~~

9 ~~(E) in subsection (c), by striking para-~~
10 ~~graph (11);~~

11 ~~(F) in subsection (h) by striking "Bank~~
12 ~~Insurance Fund" and inserting "Deposit Insur-~~
13 ~~ance Fund";~~

14 ~~(G) in subsection (k)(1)(B)(i) by striking~~
15 ~~"Savings Association Insurance Fund member"~~
16 ~~and inserting "savings association" and~~

17 ~~(H) in subsection (k)(1)(A), by striking~~
18 ~~"Savings Association Insurance Fund mem-~~
19 ~~bers" and inserting "savings associations";~~

20 ~~(9) in section 14(a) (12 U.S.C. 1824(a)), in~~
21 ~~the 5th sentence—~~

22 ~~(A) by striking "Bank Insurance Fund or~~
23 ~~the Savings Association Insurance Fund" and~~
24 ~~inserting "Deposit Insurance Fund" and~~



1 ~~(B) by striking "each such fund" and in-~~
2 ~~serting "the Deposit Insurance Fund";~~

3 ~~(21) in section 14(b) (12 U.S.C. 1024(b)), by~~
4 ~~striking "Bank Insurance Fund or Savings Associa-~~
5 ~~tion Insurance Fund" and inserting "Deposit Insur-~~
6 ~~ance Fund";~~

7 ~~(22) in section 14(c) (12 U.S.C. 1024(c)), by~~
8 ~~striking paragraph (2);~~

9 ~~(23) in section 14(d) (12 U.S.C. 1024(d))~~

10 ~~(A) by striking "Bank Insurance Fund~~
11 ~~member" each place that term appears and in-~~
12 ~~serting "insured depository institution";~~

13 ~~(B) by striking "Bank Insurance Fund~~
14 ~~members" each place that term appears and in-~~
15 ~~serting "insured depository institutions";~~

16 ~~(C) by striking "Bank Insurance Fund"~~
17 ~~each place that term appears (other than in~~
18 ~~connection with a reference to a term amended~~
19 ~~by subparagraph (A) or (B) of this paragraph)~~
20 ~~and inserting "Deposit Insurance Fund";~~

21 ~~(D) by striking the subsection heading and~~
22 ~~inserting the following:~~

23 ~~“(d) Borrowings for the Deposit Insurance~~
24 ~~Fund from Insured Depository Institutions.”;~~



1 (F) in paragraph (3), in the paragraph
 2 heading, by striking "BIF" and inserting "THE
 3 DEPOSIT INSURANCE FUND"; and

4 (D) in paragraph (5), in the paragraph
 5 heading, by striking "BIF MEMBERS" and in-
 6 serting "INSURED DEPOSITORY INSTITUTIONS",
 7 (21) in section 14 (12 U.S.C. 1824), by adding
 8 at the end the following new subsection:

9 “(e) ~~BORROWING FOR THE DEPOSIT INSURANCE~~
 10 ~~FUND FROM FEDERAL HOME LOAN BANKS.~~”

11 “(1) ~~IN GENERAL.~~—The Corporation may bor-
 12 row from the Federal home loan banks, with the
 13 concurrence of the Federal Housing Finance Board,
 14 such funds as the Corporation considers necessary
 15 for the use of the Deposit Insurance Fund.

16 “(2) ~~TERMS AND CONDITIONS.~~ Any loan from
 17 any Federal home loan bank under paragraph (1) to
 18 the Deposit Insurance Fund shall—

19 “(A) bear a rate of interest of not less
 20 than the current marginal cost of funds to that
 21 bank, taking into account the maturities in-
 22 volved;

23 “(B) be adequately secured, as determined
 24 by the Federal Housing Finance Board;



1 ~~“(C) be a direct liability of the Deposit In-~~
2 ~~surance Fund, and~~

3 ~~“(D) be subject to the limitations of sec-~~
4 ~~tion 15(c).”~~

5 ~~(25) in section 15(e)(5) (12 U.S.C.~~
6 ~~1925(c)(5))—~~

7 (A) by striking ~~“the Bank Insurance Fund~~
8 ~~or Savings Association Insurance Fund, respec-~~
9 ~~tively” each place that term appears and insert-~~
10 ing ~~“the Deposit Insurance Fund”~~; and

11 ~~(B) in subparagraph (B), by striking “the~~
12 ~~Bank Insurance Fund or the Savings Associa-~~
13 ~~tion Insurance Fund, respectively” and insert-~~
14 ing ~~“the Deposit Insurance Fund”~~;

15 ~~(20) in section 17(a) (12 U.S.C. 1927(a))—~~

16 ~~(A) in the subsection heading, by striking~~
17 ~~“DIF, SAIF,” and inserting “THE DEPOSIT IN-~~
18 ~~SURANCE FUND”~~; and

19 (B) in paragraph (1)

20 (i) by striking ~~the Bank Insurance~~
21 ~~Fund, the Savings Association Insurance~~
22 ~~Fund” each place that term appears and~~
23 inserting ~~“the Deposit Insurance Fund”~~;
24 and



1 (ii) ~~in subparagraph (D), by striking~~
2 ~~“each insurance fund” and inserting “the~~
3 ~~Deposit Insurance Fund”;~~

4 (27) ~~in section 17(d) (12 U.S.C. 1827(d)) by~~
5 ~~striking “, the Bank Insurance Fund, the Savings~~
6 ~~Association Insurance Fund” each place that term~~
7 ~~appears and inserting “the Deposit Insurance~~
8 ~~Fund”;~~

9 (28) ~~in section 18(m)(2) (12 U.S.C.~~
10 ~~1828(m)(2))~~

11 (A) ~~by striking “Savings Association In-~~
12 ~~surance Fund” in the 1st sentence of subpara-~~
13 ~~graph (A) and inserting “Deposit Insurance~~
14 ~~Fund”;~~

15 (B) ~~by striking “Savings Association In-~~
16 ~~surance Fund member” in the last sentence of~~
17 ~~subparagraph (A) and inserting “savings asso-~~
18 ~~ciation”, and~~

19 (C) ~~by striking “Savings Association Insur-~~
20 ~~ance Fund or the Bank Insurance Fund” in~~
21 ~~subparagraph (C) and inserting “Deposit Insur-~~
22 ~~ance Fund”;~~

23 (29) ~~in section 18(s) (12 U.S.C. 1828(s)), by~~
24 ~~striking “deposit insurance funds” and “deposit in-~~



1 ~~sure~~ ~~each place these terms~~ ~~li~~
2 ~~set~~ ~~(f)(6)(B)~~ ~~by~~
3 (30) ~~with 20 (12 U.S.C. 1831b)~~ ~~by~~
4 ~~striking~~ ~~(f)(6)(B)~~ ~~and inserting~~
5 ~~“Deposit Insurance Fund”~~
6 (31) ~~with 94 (12 U.S.C. 1831b)~~
7 ~~(f)(6)(B)~~ ~~(1)(1)(A)~~
8 ~~striking~~ ~~(f)(6)(B)~~ ~~and~~
9 ~~each place that term appears and inserting~~
10 ~~“F~~
11 ~~(B)~~ ~~striking~~
12 ~~“risk”~~ ~~and~~
13 ~~riod and inserting~~ ~~“in the Deposit Insur~~
14 ~~and~~
15 ~~(C)~~ ~~(9)(D)(i)~~
16 (f)(6)(B) ~~by striking~~ ~~“the insurance fund of~~
17 ~~which each bank is insured”~~ ~~and~~
18 ~~term appears and inserting~~ ~~the Depos~~
19 ~~and~~ ~~”~~;
20 (32) ~~with 20 (12 U.S.C. 1831b)~~ ~~by strik-~~
21 ~~ing~~ ~~“affected deposit insurance fund”~~ ~~and~~
22 ~~that term~~ ~~and inserting~~ ~~“Deposit Ins~~
23 ~~F~~
24 (33) ~~with 21 (12 U.S.C. 1831b)~~



1 ~~(34) in section 96(i)(8) (12 U.S.C.~~
 2 ~~1891(i)(8)), by striking affected deposit insur-~~
 3 ~~ance fund" and inserting "Deposit Insurance~~
 4 ~~Fund";~~

5 ~~(35) in section 97(a)(1)(C) (12 U.S.C.~~
 6 ~~1891(a)(1)(C)), by striking "insurance fund" and~~
 7 ~~inserting "Deposit Insurance Fund";~~

8 ~~(36) in section 98 (12 U.S.C. 1891) by strik-~~
 9 ~~ing "the deposit insurance fund" each place that~~
 10 ~~term appears and inserting "the Deposit Insurance~~
 11 ~~Fund";~~

12 ~~(37) in section 99(a) (12 U.S.C. 1891(a)) in~~
 13 ~~the subsection heading, by striking "Fund" and in-~~
 14 ~~serting "Fund";~~

15 ~~(38) in section 99(a) (12 U.S.C. 1891(a))—~~
 16 ~~(A) in paragraph (1), by striking "the de-~~
 17 ~~posit insurance fund" and inserting "the De-~~
 18 ~~posit Insurance Fund";~~

19 ~~(B) in paragraph (2), by striking "the de-~~
 20 ~~posit insurance fund" and inserting "the De-~~
 21 ~~posit Insurance Fund";~~

22 ~~(C) in paragraphs (3)(A) and (3)(B) by~~
 23 ~~striking "the deposit insurance fund" and~~
 24 ~~each place that term appears and inserting "the~~
 25 ~~Deposit Insurance Fund";~~



1 (20) [REDACTED]

2 (A) [REDACTED]

3 all [REDACTED]

4 and [REDACTED] Subsections

5 (1) [REDACTED]

6 (B) [REDACTED]

7 (P) [REDACTED] (1) (2) and (3),

8 respectively, and moving the margin [REDACTED]

9 [REDACTED]

10 (C) [REDACTED] (1) [REDACTED],

11 by redesignating clauses (i) and (ii) [REDACTED]

12 group (A) and (B) respectively [REDACTED]

13 the margin 9 ems to the left [REDACTED]

14 (b) [REDACTED] and the amend-

15 ments made by this [REDACTED] shall take effect [REDACTED]

16 of the [REDACTED] and [REDACTED]

17 [REDACTED]

18 [REDACTED]

19 [REDACTED]

20 [REDACTED]

21 [REDACTED]

22 [REDACTED]

23 (a) Section 5126 [REDACTED] STATUTES.—

24 The paragraph designated the "Eleventh" of section 5126

25 of the Revised Statutes of the United States (19 U.S.C.

26 [REDACTED] is amended in the [REDACTED] by striking "e ff" [REDACTED]



1 d [REDACTED]

2 F [REDACTED]

3 (b) [REDACTED];

4 LIMITATIONS ON ACCESS [REDACTED] 33d

5 undesignated paragraph of section 9 of the Federal R

6 serve Act (12 U.S.C. 929) [REDACTED]

7 tence by striking "[REDACTED]" and

8 inserting "Deposit Insurance Fund".

9 (c) ADVANCEMENT OF [REDACTED]

10 DEPOSITORY INSTITUTIONS [REDACTED]

11 the Federal Reserve Act (12 U.S.C. 217(a)(9)(A)(i)) is

12 amended by striking "[REDACTED]"

13 inserting "(1) Deposit Insurance Fund".

14 (d) AMENDMENTS TO THE FEDERAL HOME LOAN

15 [REDACTED]

16 U.S.C. 1401 [REDACTED]

17 (1) in section 11(k) (12 U.S.C. 1101(k))

18 (A) [REDACTED]

19 "SAFER" [REDACTED] INSUR-

20 ANCE Fund" and

21 (B) by striking [REDACTED] In-

22 sume [REDACTED]

23 and [REDACTED]

24 (2) [REDACTED]



1 (A) in subsection (c)(9), by striking “
2 cent that” and all that follow through the
3 of the paragraph following a period, and
4 (B) in subsection (a), by striking para-
5 graph (1);

6 (3) in section 21A(b)(4)(D) (10, H.C.G.
7 1441 (4)(4)(D)) by striking “
8 ance fund” and inserting “
9 Fund”;

10 (4) in section 21A(d)(2)(D) (10, H.C.G.
11 1441 (4)(2)(D))

12 (A) in the paragraph following, by strik-
13 ing “
14 “CHAPTER CON
15 (D) by striking “
16 surance fund member” and inserting “
17 association”;

18 (5) in section 21A(b)(10)(A)(i) (10, H.C.G.
19 1441 (4)(10)(A)(i)(I)) by striking “
20 ciation Insurance Fund” and inserting “
21 surance Fund”;

22 (6) in section 21A(b)(4)(D) (10, H.C.G.
23 1441 (4)(4)(D)) by striking “
24 surance fund” and inserting “
25 a



1 (1) in section 21B(e) (12 U.S.C. 1441b(e))—

2 (A) in paragraph (3), by inserting “and

3 the date of funding” after “Starting on the date

4 Insurance Fund is established, the following

5 appears:—

6 (B) by striking paragraphs (7) and (9);

7 [REDACTED]

8 (8) in section 21B(1) (12 U.S.C. 1441b(1))—

9 (A) by inserting before the colon, the fo-

10 llowing definitions shall apply;

11 (B) by striking paragraph (6); and

12 (C) by redesignating paragraphs (6) and

13 (10) as paragraphs (9) and (8), respectively.

14 (e) AMENDMENT TO THE HOME OWNERS

15 Act—The Home Owners Loan Act (12 U.S.C. 1401 et

16 seq.) amended—

17 (1) in section 1 (12 U.S.C. 1401)

18 (A) in subsection (c)(3)(A), by striking

19 “41—” and inserting “Insurance

20 Fund”

21 (B) in subsection (e)(6) by striking “(1)

22 limited liability” and inserting “(1) non-

23 purposes of this subsection, the following defini-

24 tions shall apply:



1 (C) in subsection (b)(1), by striking "~~(1)~~"

2 ~~of the Bank Insurance Fund and member~~;

3 (D) in subsection (c)(1), by striking "~~a~~"

4 ~~Bank Insurance Fund member and each~~

5 ~~as it changes it to the Savings Association~~

6 ~~Insurance Fund member" and inserting "(~~

7 ~~1) of the Deposit Insurance Fund,~~

8 (E) in subsection (d)(5)(D)(iii)(I)

9 striking "~~affected deposit insurance fund~~" and

10 inserting "~~Deposit Insurance Fund~~";

11 (F) in subsection (d)(7)(C)(i)(I) by strik-

12 ing "~~affected deposit insurance fund~~" and in-

13 serting "~~Deposit Insurance Fund~~";

14 (G) in subsection (e)(4)(C), by striking

15 "~~the Savings Association Insurance Fund~~" and

16 inserting "~~the Deposit Insurance Fund~~"; and

17 (2) in section 10 (12 U.S.C. 1407a)

18 (A) in subsection (c)(C)(D) by striking

19 "~~this title~~" and inserting "~~this Act~~";

20 (B) in subsection (c)(1)(A), by striking

21 "~~Savings Association Insurance Fund and~~

22 ~~Insurance Fund~~" and inserting "~~Deposit I~~

23 ~~ance Fund~~;

24 (C) in subsection (c)(2), by striking

25 ing "~~Savings Association Insurance Fund or the Bank~~



1 ~~Inserting "Fund" and inserting "Deposit Insu-~~
2 ~~ance Fund";~~

3 (D) in subsection (a)(4)(D), by striking
4 "subsection (1)" and inserting "(1)";

5 (E) in subsection (a)(2)(A), by striking
6 "(5) of this section" and inserting "(5) of this
7 subsection";

8 (F) in subsection (i), by striking
9 paragraph (5) and paragraph (1);

10 (G) in subsection (a)(3), by striking sub-
11 paragraph (E) and by redesignating subpara-
12 graphs (F), (G), and (H) as subparagraphs

13 (F), (G), and (H);

14 (H) in subsection (a)(7)(A), by striking
15 "during the" and inserting "(during the re-
16 view)";

17 (I) in subsection (a)(8)(F), by striking
18 "section 5(a) and (1) of this Act" and inserting
19 "subsection (a) and (1) of this Act";

20 (f) ~~AGREEMENTS TO THE NATIONAL HOUSING~~

21 ~~ACT—The National Housing Act (12 U.S.C. 1701 et seq.)~~

22 ~~is amended—~~

23 (1) in section 1153(a)(1)(B), (12 U.S.C.

24 1723(a)(1)(B)), by striking "Fund" and

25 ~~inserting "Fund" and inserting "Deposit Insu-~~



1 ~~ance Fund for savings associations and inserting~~
2 ~~“Deposit Insurance Fund”, and~~

3 ~~(2) in section 530(b)(1)(D)(ii) (12 U.S.C.~~
4 ~~1751-14(b)(1)(B)(ii)), by striking “Bank Insurance~~
5 ~~Fund for banks and through the Savings Association~~
6 ~~Insurance Fund for savings associations and insert~~
7 ~~ing “Deposit Insurance Fund”.~~

8 ~~(g) AMENDMENTS TO THE FINANCIAL INSTITUTIONS~~
9 ~~REFORM, RECOVERY, AND ENFORCEMENT ACT OF~~
10 ~~1989. The Financial Institutions Reform, Recovery, and~~
11 ~~Enforcement Act of 1989 (12 U.S.C. 1811 note) is~~
12 ~~amended—~~

13 ~~(1) in section 951(b)(2)(P) (12 U.S.C.~~
14 ~~1833a(b)(2)(P)), by inserting “and after the merger~~
15 ~~of such funds, the Deposit Insurance Fund,” after~~
16 ~~“the Savings Association Insurance Fund,” and~~

17 ~~(2) in section 1112(c)(1)(D) (12 U.S.C.~~
18 ~~3841(c)(1)(D)), by striking “Bank Insurance Fund,~~
19 ~~the Savings Association Insurance Fund” and in-~~
20 ~~serting “Deposit Insurance Fund”.~~

21 ~~(h) AMENDMENT TO THE BANK HOLDING COMPANY~~
22 ~~ACT OF 1956. The Bank Holding Company Act of 1956~~
23 ~~(12 U.S.C. 1841 et seq.) is amended—~~



1 (1) in section 2(i)(2) (12 U.S.C. 1841(i)(2)) by
 2 striking "Savings Association Insur- F- 11" and
 3 inserting "(Deposit Insurance F- 11)",
 4 (2) in section 2(i)(2)(iii) (12 U.S.C.
 5 1841(i)(2)(iii)) by striking "(commercial deposit
 6 insurance fund" and inserting "(Deposit Insurance
 7 F- 11)".

8 (i) AMENDMENTS TO THE GRAMM LEACH B
 9 ACT Section 111 of the Gramm Leach Bl
 10 U.S.C. 1823a) is amended by striking "over F- 11" and
 11 inserting "and F- 11" (1)(B) paragraph
 12 (2)(B) and (4)(B) of section (1) and inserting
 13 (c)(1)(B) each place that term appears by striking "(1)
 14 Deposit I- 11".

15 (j) F- 11
 16 ments made by this section shall be as if made by
 17 of the members of the Board of F- 11
 18 ing Association Insurance F- 11
 19 9100



1 **TITLE III—DIGITAL TELEVISION**
2 **TRANSITION AND PUBLIC**
3 **SAFETY**

4 ~~SECTION 3000. TABLE OF CONTENTS.~~

- ~~Sec. 3000. Table of contents.~~
- ~~Sec. 3001. Short title, definition.~~
- ~~Sec. 3002. Analog spectrum transition from analog.~~
- ~~Sec. 3003. Analog spectrum transition from analog.~~
- ~~Sec. 3004. Transition of spectrum.~~
- ~~Sec. 3005. Digital transition.~~
- ~~Sec. 3006. Public safety interoperable communications.~~
- ~~Sec. 3007. NIMC 6/11 digital transition.~~
- ~~Sec. 3008. Low power television and translator. Digital to Analog.~~
- ~~Sec. 3009. Low power television and translator.~~
- ~~Sec. 3010. National alert and emergency program.~~
- ~~Sec. 3011. FM/AM/FM 91.1.~~
- ~~Sec. 3012. Transition program.~~
- ~~Sec. 3013. Call to action delivery system for digital television.~~
- ~~Sec. 3014. Supplemental provisions.~~

5 **SEC. 3001. SHORT TITLE; DEFINITION.**

6 (a) **SHORT TITLE.**—This title may be cited as the
7 “Digital Television Transition and Public Safety Act of
8 2005”.

9 (b) **DEFINITION.**—As used in this Act, the term “As-
10 sistant Secretary” means the Assistant Secretary for
11 Communications and Information of the Department of
12 Commerce.



1 SEC. 3002. ANALOG SPECTRUM RECOVERY: FIRM DEAD-
2 LINE.

3 (a) AMENDMENTS.—Section 309(j)(14) of the Com-
4 munications Act of 1934 (47 U.S.C. 309(j)(14)) is
5 amended—

6 (1) in subparagraph (A)—

7 (A) by inserting “full-power” before “tele-
8 vision broadcast license”; and

9 (B) by striking “December 31, 2006” and
10 inserting “February 17, 2009”;

11 (2) by striking subparagraph (B);

12 (3) in subparagraph (C)(i)(I), by striking “or
13 (B)”;

14 (4) in subparagraph (D), by striking “subpara-
15 graph (C)(i)” and inserting “subparagraph (B)(i)”;

16 and

17 (5) by redesignating subparagraphs (C) and
18 (D) as subparagraphs (B) and (C), respectively.

19 (b) TERMINATIONS OF ANALOG LICENSES AND
20 BROADCASTING.—The Federal Communications Commis-
21 sion shall take such actions as are necessary—

22 (1) to terminate all licenses for full-power tele-
23 vision stations in the analog television service, and
24 to require the cessation of broadcasting by full-
25 power stations in the analog television service, by
26 February 18, 2009; and



1 (2) to require by February 18, 2009, that all
2 broadcasting by Class A stations, whether in the
3 analog television service or digital television service,
4 and all broadcasting by full-power stations in the
5 digital television service, occur only on channels be-
6 tween channels 2 and 36, inclusive, or 38 and 51,
7 inclusive (between frequencies 54 and 698 mega-
8 hertz, inclusive).

9 (c) CONFORMING AMENDMENTS.—

10 (1) Section 337(e) of the Communications Act
11 of 1934 (47 U.S.C. 337(e)) is amended—

12 (A) in paragraph (1)—

13 (i) by striking “CHANNELS 60 TO 69”
14 and inserting “CHANNELS 52 TO 69”;

15 (ii) by striking “person who” and in-
16 serting “full-power television station li-
17 censee that”;

18 (iii) by striking “746 and 806 mega-
19 hertz” and inserting “698 and 806 mega-
20 hertz”; and

21 (iv) by striking “the date on which the
22 digital television service transition period
23 terminates, as determined by the Commis-
24 sion” and inserting “February 17, 2009”;



1 (B) in paragraph (2), by striking "746
2 megahertz" and inserting "698 megahertz";
3 and

4 ~~(C) by adding at the end the following new~~
5 ~~paragraph:~~

6 ~~"(2) CONTINUATION OF LOW-POWER BROAD-~~
7 ~~CASTING. Subject to section 336(f) of the Commu-~~
8 ~~nications Act of 1934 (47 U.S.C. 336(f)), a low-~~
9 ~~power television station, television translator station,~~
10 ~~or television booster station (as defined by Commis-~~
11 ~~sion regulations), but not a Class A television sta-~~
12 ~~tion, may operate above 600 megahertz on a sec-~~
13 ~~ondary basis in accordance with Commission rules,~~
14 ~~including rules governing completion of the digital~~
15 ~~television service transition for low-power broad-~~
16 ~~casters."~~

17 ~~(2) Section 226(f)(4) of such Act (47 U.S.C.~~
18 ~~226(f)(4)) is amended by inserting "or other low-~~
19 ~~power station" after "television translator station"~~
20 ~~in the first sentence.~~

21 **SEC. 3003. AUCTION OF RECOVERED SPECTRUM.**

22 (a) DEADLINE FOR AUCTION.—Section 309(j) of the
23 Communications Act of 1934 (47 U.S.C. 309(j)) is
24 amended—



1 (1) by redesignating the second paragraph (15)
 2 of such section (as added by section 203(b) of the
 3 Commercial Spectrum Enhancement Act (P.L. 108-
 4 494; 118 Stat. 3993)), as paragraph (16) of such
 5 section; and

6 (2) in the first paragraph (15) of such section
 7 (as added by section 3(a) of the Auction Reform Act
 8 of 2002 (P.L. 107-195; 116 Stat. 716)), by adding
 9 at the end of subparagraph (C) the following new
 10 clauses:

11 (v) ADDITIONAL DEADLINES FOR RE-
 12 COVERED ANALOG SPECTRUM.—Notwith-
 13 standing subparagraph (B), the Commis-
 14 sion shall conduct the auction of the li-
 15 censes for recovered analog spectrum by
 16 commencing the bidding not later than
 17 January 28, 2008, and shall deposit the
 18 proceeds of such auction in accordance
 19 with paragraph (8)(E)(ii) not later than
 20 June 30, 2008.

21 (vi) RECOVERED ANALOG SPEC-
 22 TRUM.—For purposes of clause (v), the
 23 term ‘recovered analog spectrum’ means
 24 the spectrum between channels 52 and 69,
 25 inclusive (between frequencies 698 and 806



1 megahertz, inclusive) reclaimed from ana-
2 log television service broadcasting under
3 paragraph (14), other than—

4 “(I) the spectrum required by
5 section 337 to be made available for
6 public safety services; and

7 “(II) the spectrum auctioned
8 prior to the date of enactment of the
9 Digital Television Transition and
10 Public Safety Act of 2005.”.

11 (b) **EXTENSION OF AUCTION AUTHORITY.**—Section
12 309(j)(11) of such Act (47 U.S.C. 309(j)(11)) is amended
13 by striking “2007” and inserting “2011”.

14 **SEC. 3004. RESERVATION OF AUCTION PROCEEDS.**

15 Section 309(j)(8) of the Communications Act of 1934
16 (47 U.S.C. 309(j)(8)) is amended—

17 (1) in subparagraph (A), by striking “subpara-
18 graph (B) or subparagraph (D)” and inserting “sub-
19 paragraphs (B), (D), and (E)”;

20 (2) in subparagraph (C)(i), by inserting before
21 the semicolon at the end the following: “, except as
22 otherwise provided in subparagraph (E)(ii)”;

23 (3) by adding at the end the following new sub-
24 paragraph:

25 “(E) **TRANSFER OF RECEIPTS.**—



1 “(i) ESTABLISHMENT OF FUND.—

2 There is established in the Treasury of the
3 United States a fund to be known as the
4 Digital Television Transition and Public
5 Safety Fund.

6 “(ii) PROCEEDS FOR FUNDS.—Not-
7 withstanding subparagraph (A), the pro-
8 ceeds (including deposits and upfront pay-
9 ments from successful bidders) from the
10 use of a competitive bidding system under
11 this subsection with respect to recovered
12 analog spectrum shall be deposited in the
13 Digital Television Transition and Public
14 Safety Fund.

15 “(iii) TRANSFER OF AMOUNT TO
16 TREASURY.—On September 30, 2009, the
17 Secretary shall transfer \$7,363,000,000
18 from the Digital Television Transition and
19 Public Safety Fund to the general fund of
20 the Treasury.

21 “(iv) RECOVERED ANALOG SPEC-
22 TRUM.—For purposes of clause (i), the
23 term ‘recovered analog spectrum’ has the
24 meaning provided in paragraph
25 (15)(C)(vi).”.



1 SEC. 3005. DIGITAL-TO-ANALOG CONVERTER BOX PRO-
2 GRAM.

3 (a) CREATION OF PROGRAM.—The Assistant Sec-
4 retary shall—

5 (1) implement and administer a program
6 through which households in the United States may
7 obtain coupons that can be applied toward the pur-
8 chase of digital-to-analog converter boxes; and

9 (2) make payments of not to exceed
10 \$990,000,000, in the aggregate, through fiscal year
11 2009 to carry out that program from the Digital
12 Television Transition and Public Safety Fund estab-
13 lished under section 309(j)(8)(E) of the Communica-
14 tions Act of 1934 (47 U.S.C. 309(j)(8)(E)).

15 (b) CREDIT.—The Assistant Secretary may borrow
16 from the Treasury ^{beginning on October 1, 2008} such sums as may be necessary, but
17 not to exceed \$1,500,000,000, to implement this section.
18 The Assistant Secretary shall reimburse the Treasury,
19 without interest, as funds are deposited into the Digital
20 Television Transition and Public Safety Fund.

21 (c) PROGRAM SPECIFICATIONS.—

22 (1) LIMITATIONS.—

23 (A) TWO-PER-HOUSEHOLD MAXIMUM.—A
24 household may obtain coupons by making a re-
25 quest as required by the regulations under this
26 section between January 1, 2008, and March

1 31, 2009, inclusive. The Assistant Secretary
2 shall ensure that each requesting household re-
3 ceives, via the United States Postal Service, no
4 more than two coupons.

5 (B) NO COMBINATIONS OF COUPONS.—
6 Two coupons may not be used in combination
7 toward the purchase of a single digital-to-ana-
8 log converter box.

9 (C) DURATION.—All coupons shall expire 3
10 months after issuance.

11 (2) DISTRIBUTION OF COUPONS.—The Assist-
12 ant Secretary shall expend not more than
13 \$100,000,000 on administrative expenses and shall
14 ensure that the sum of—

15 (A) all administrative expenses for the pro-
16 gram, including not more than \$5,000,000 for
17 consumer education concerning the digital tele-
18 vision transition and the availability of the dig-
19 ital-to-analog converter box program; and

20 (B) the total maximum value of all the
21 coupons redeemed, and issued but not expired,
22 does not exceed \$990,000,000.

23 (3) USE OF ADDITIONAL AMOUNT.—If the As-
24 sistant Secretary transmits to the Committee on En-
25 ergy and Commerce of the House of Representatives



1 and Committee on Commerce, Science, and Trans-
2 portation of the Senate a statement certifying that
3 the sum permitted to be expended under paragraph
4 (2) will be insufficient to fulfill the requests for cou-
5 pons from eligible households—

6 (A) paragraph (2) shall be applied—

7 (i) by substituting “\$160,000,000”
8 for “\$100,000,000”; and

9 (ii) by substituting “\$1,500,000,000”
10 for “\$990,000,000”;

11 (B) subsection (a)(2) shall be applied by
12 substituting “\$1,500,000,000” for
13 “\$990,000,000”; and

14 (C) the additional amount permitted to be
15 expended shall be available 60 days after the
16 Assistant Secretary sends such statement.

17 (4) COUPON VALUE.—The value of each coupon
18 shall be \$40.

19 ~~(1) IMPLEMENTATION.—The Secretary of Commerce~~
20 ~~shall promulgate, within 90 months after the date of enact-~~
21 ~~ment of the Digital Television Transition and Public Safe-~~
22 ~~ty Act of 2005, such regulations as are necessary to carry~~
23 ~~out this section.~~

24 (e) DEFINITION OF DIGITAL-TO-ANALOG CON-
25 VERTER BOX.—For purposes of this section, the term

1 “digital-to-analog converter box” means a stand-alone de-
2 vice that does not contain features or functions except
3 those necessary to enable a consumer to convert any chan-
4 nel broadcast in the digital television service into a format
5 that the consumer can display on television receivers de-
6 signed to receive and display signals only in the analog
7 television service, but may also include a remote control
8 device.

9 **SEC. 3006. PUBLIC SAFETY INTEROPERABLE COMMUNICA-**
10 **TIONS.**

11 (a) **CREATION OF PROGRAM.**—The Assistant Sec-
12 retary, in consultation with the Secretary of the Depart-
13 ment of Homeland Security—

14 (1) may take such administrative action as is
15 necessary to establish and implement a grant pro-
16 gram to assist public safety agencies in the acquisi-
17 tion of, deployment of, or training for the use of
18 interoperable communications systems that utilize,
19 or enable interoperability with communications sys-
20 tems that can utilize, reallocated public safety spec-
21 trum for radio communication; and

22 (2) shall make payments of not to exceed
23 \$1,000,000,000, in the aggregate, through fiscal
24 year 2010 to carry out that program from the Dig-
25 ital Television Transition and Public Safety Fund



1 established under section 309(j)(8)(E) of the Com-
2 munications Act of 1934 (47 U.S.C. 309(j)(8)(E).

3 (b) CREDIT.—The Assistant Secretary may borrow
4 from the Treasury ^{beginning on October 1, 2006} such sums as may be necessary, but
5 not to exceed \$1,000,000,000, to implement this section.

6 The Assistant Secretary shall reimburse the Treasury,
7 without interest, as funds are deposited into the Digital
8 Television Transition and Public Safety Fund.

9 (c) CONDITION OF GRANTS.—In order to obtain a
10 grant under the grant program, a public safety agency
11 shall agree to provide, from non-Federal sources, not less
12 than 20 percent of the costs of acquiring and deploying
13 the interoperable communications systems funded under
14 the grant program.

15 (d) DEFINITIONS.—For purposes of this section:

16 (1) PUBLIC SAFETY AGENCY.—The term “pub-
17 lic safety agency” means any State, local, or tribal
18 government entity, or nongovernmental organization
19 authorized by such entity, whose sole or principal
20 purpose is to protect the safety of life, health, or
21 property.

22 (2) INTEROPERABLE COMMUNICATIONS SYS-
23 TEMS.—The term “interoperable communications
24 systems” means communications systems which en-
25 able public safety agencies to share information



1 amongst local, State, Federal, and tribal public safe-
2 ty agencies in the same area via voice or data sig-
3 nals.

4 (3) REALLOCATED PUBLIC SAFETY SPEC-
5 TRUM.—The term “reallocated public safety spec-
6 trum” means the bands of spectrum located at 764
7 -776 megahertz and 794–806 megahertz, inclusive.

8 SEC. 3007. NYC 9/11 DIGITAL TRANSITION.

9 (a) FUNDS AVAILABLE.—From the Digital Television
10 Transition and Public Safety Fund established under sec-
11 tion 309(j)(8)(E) of the Communications Act of 1934 (47
12 U.S.C. 309(j)(8)(E)) the Assistant Secretary shall make
13 payments of not to exceed \$30,000,000, in the aggregate,
14 which shall be available to carry out this section for fiscal
15 years ⁷2006 through 2008. The Assistant Secretary may
16 borrow from the Treasury ^{beginning October 1, 2006} such sums as may be necessary
17 not to exceed \$30,000,000 to implement and administer
18 the program in accordance with this section. The Assistant
19 Secretary shall reimburse the Treasury, without interest,
20 as funds are deposited into the Digital Television Transi-
21 tion and Public Safety Fund.

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22 (b) USE OF FUNDS.—The sums available under sub-
23 section (a) shall be made available by the Assistant Sec-
24 retary by grant to be used to reimburse the Metropolitan
25 Television Alliance for costs incurred in the design and



1 deployment of a temporary digital television broadcast sys-
2 tem to ensure that, until a permanent facility atop the
3 Freedom Tower is constructed, the members of the Metro-
4 politan Television Alliance can provide the New York City
5 area with an adequate digital television signal as deter-
6 mined by the Federal Communications Commission.

7 ~~(c) RULE OF CONSTRUCTION. Nothing in this sec-~~
8 ~~tion shall be construed to alter or otherwise affect the Fed-~~
9 ~~eral Communications Commission's authority with respect~~
10 ~~to licensing and interference regulation.~~

11 (d) DEFINITIONS.—For purposes of this section:

12 (1) METROPOLITAN TELEVISION ALLIANCE.—

13 The term “Metropolitan Television Alliance” means
14 the organization formed by New York City television
15 broadcast station licensees to locate new shared fa-
16 cilities as a result of the attacks on September 11,
17 2001 and the loss of use of shared facilities that
18 housed broadcast equipment.

19 (2) NEW YORK CITY AREA.—The term “New
20 York City area” means the five counties comprising
21 New York City and counties of northern New Jersey
22 in immediate proximity to New York City (Bergen,
23 Essex, Union, and Hudson Counties) .

1 SEC. 3008. LOW-POWER TELEVISION AND TRANSLATOR DIG-
2 ITAL-TO-ANALOG CONVERSION.

3 (a) CREATION OF PROGRAM.—The Assistant Sec-
4 retary shall make payments of not to exceed \$10,000,000,
5 in the aggregate, during the fiscal year 2008 and 2009
6 period from the Digital Television Transition and Public
7 Safety Fund established under section 309(j)(8)(E) of the
8 Communications Act of 1934 (47 U.S.C. 309(j)(8)(E)) to
9 implement and administer a program through which each
10 eligible low-power television station may receive compensa-
11 tion toward the cost of the purchase of a digital-to-analog
12 conversion device that enables it to convert the incoming
13 digital signal of its corresponding full-power television sta-
14 tion to analog format for transmission on the low-power
15 television station's analog channel. An eligible low-power
16 television station may receive such compensation only if
17 it submits a request for such compensation on or before
18 February 17, 2009. Priority compensation shall be given
19 to eligible low-power television stations in which the license
20 is held by a non-profit corporation and eligible low-power
21 television stations that serve rural areas of fewer than
22 10,000 viewers.

23 (b) CREDIT.—The Assistant Secretary may borrow
24 from the Treasury ^{beginning October 1, 2006} such sums as may be necessary, but
25 not to exceed \$10,000,000, to implement this section. The
26 Assistant Secretary shall reimburse the Treasury, without



1 interest, as funds are deposited into the Digital Television
2 Transition and Public Safety Fund.

3 (c) ELIGIBLE STATIONS.—For purposes of this sec-
4 tion, the term “eligible low-power television station”
5 means a low-power television broadcast station, Class A
6 television station, television translator station, or tele-
7 vision booster station—

8 (1) that is itself broadcasting exclusively in ana-
9 log format; and

10 (2) that has not purchased a digital-to-analog
11 conversion device prior to the date of enactment of
12 the Digital Television Transition and Public Safety
13 Act of 2005.

14 **SEC. 3009. LOW-POWER TELEVISION AND TRANSLATOR UP-
15 GRADE PROGRAM.**

16 (a) ESTABLISHMENT.—The Assistant Secretary shall
17 make payments of not to exceed \$65,000,000, in the ag-
18 gregate, during the fiscal year ²⁰⁰⁹ ~~2011 and 2012~~ period from
19 the Digital Television Transition and Public Safety Fund
20 established under section 309(j)(8)(E) of the Communica-
21 tions Act of 1934 (47 U.S.C. 309(j)(8)(E)) to implement
22 and administer a program through which each licensee of
23 an eligible low-power television station may receive reim-
24 bursement for equipment to upgrade low-power television
25 stations from analog to digital in eligible rural commu-

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1 nities, as that term is defined in section 610(b)(2) of the
2 Rural Electrification Act of 1937 (7 U.S.C. 950bb(b)(2)).
3 Such reimbursements shall be issued to eligible stations
4 no earlier than October 1, 2010. Priority reimbursements
5 shall be given to eligible low-power television stations in
6 which the license is held by a non-profit corporation and
7 eligible low-power television stations that serve rural areas
8 of fewer than 10,000 viewers.

9 (b) ELIGIBLE STATIONS.—For purposes of this sec-
10 tion, the term “eligible low-power television station”
11 means a low-power television broadcast station, Class A
12 television station, television translator station, or tele-
13 vision booster station—

14 (1) that is itself broadcasting exclusively in ana-
15 log format; and

16 (2) that has not converted from analog to dig-
17 ital operations prior to the date of enactment of the
18 Digital Television Transition and Public Safety Act
19 of 2005.

20 **SEC. 3010. NATIONAL ALERT AND TSUNAMI WARNING PRO-**
21 **GRAM.**

22 The Assistant Secretary shall make payments of not
23 to exceed \$150,000,000, in the aggregate, during the fis-
24 cal year 2007 through 2012 period from the Digital Tele-
25 vision Transition and Public Safety Fund established



1 under section 309(j)(8)(E) of the Communications Act of
2 1934 (47 U.S.C. 309(j)(8)(E)) to implement a unified na-
3 tional alert system capable of alerting the public, on a na-
4 tional, regional, or local basis to emergency situations by
5 using a variety of communications technologies. The As-
6 sistant Secretary shall use \$50,000,000 of such amounts
7 to implement a tsunami warning and coastal vulnerability
8 program.

9 **SEC. 3011. ENHANCE 911.**

10 The Assistant Secretary shall make payments of not
11 to exceed \$43,500,000, in the aggregate, from the Digital
12 Television Transition and Public Safety Fund established
13 under section 309(j)(8)(E) of the Communications Act of
14 1934 (47 U.S.C. 309(j)(8)(E)) to implement the EN-
15 HANCE 911 Act of 2004.

16 **SEC. 3012. ESSENTIAL AIR SERVICE PROGRAM.**

17 (a) IN GENERAL.—If the amount appropriated to
18 carry out the essential air service program under sub-
19 chapter II of chapter 417 of title 49, United States Code,
20 equals or exceeds \$110,000,000 for fiscal year ~~2006~~,
21 ~~2007~~, or 2008, then the Secretary of Commerce shall
22 make \$15,000,000 available, from the Digital Television
23 Transition and Public Safety Fund established by section
24 309(j)(8)(E) of the Communications Act of 1934 (47
25 U.S.C. 309(j)(8)(E)), to the Secretary of Transportation



1 for use in carrying out the essential air service program
2 for that fiscal year.

3 (b) APPLICATION WITH OTHER FUNDS.—Amounts
4 made available under subsection (a) for any fiscal year
5 shall be in addition to any amounts—

6 (1) appropriated for that fiscal year; or

7 (2) derived from fees collected pursuant to sec-
8 tion 45301(a)(1) of title 49, United States Code,
9 that are made available for obligation and expendi-
10 ture to carry out the essential air service program
11 for that fiscal year.

12 (c) ADVANCES.—The Secretary of Transportation
13 may borrow from the Treasury such sums as may be nec-
14 essary, but not to exceed \$30,000,000 on a temporary and
15 reimbursable basis to implement subsection (a). The Sec-
16 retary of Transportation shall reimburse the Treasury,
17 without interest, as funds are deposited into the Digital
18 Television Transition and Public Safety Fund under sec-
19 tion 309(j)(8)(E) of the Communications Act of 1934 (47
20 U.S.C. 309(j)(8)(E)) and made available to the Secretary
21 under subsection (a).

22 ~~SEC. 3013. CABLE AND SATELLITE DELIVERY OF BROAD-~~
23 ~~CAST SIGNALS TO ANALOG TELEVISIONS.~~

24 ~~(c) Digital to Analog Conversion. Section~~
25 ~~614(b) of the Communications Act of 1934 (47 U.S.C.~~

1 ~~584(b)) is amended by adding at the end the following~~
2 ~~new paragraph:~~

3 ~~“(1) CHANNEL OF DIGITAL FORMATS.—~~

4 ~~“(A) PRIMARY VIDEO STREAM. With re-~~
5 ~~spect to any television station that is transmit-~~
6 ~~ting broadcast programming exclusively in the~~
7 ~~digital television service in a local market,~~
8 ~~cable operator of a cable system in that market~~
9 ~~shall carry the station’s primary video stream~~
10 ~~and program related material in the digital for-~~
11 ~~mat transmitted by that station, without mate-~~
12 ~~rial degradation, if the licensee for that~~
13 ~~station—~~

14 ~~“(i) relies on this section or section~~
15 ~~615 to obtain carriage of the primary video~~
16 ~~stream and program related material on~~
17 ~~that cable system in that market, and~~

18 ~~“(ii) permits the cable system to carry~~
19 ~~without compensation any other program~~
20 ~~being broadcast by that station that is car-~~
21 ~~ried on that system.~~

22 ~~“(B) MULTIPLE FORMATS PERMITTED. A~~
23 ~~cable operator of a cable system may offer the~~
24 ~~primary video stream and program related ma-~~
25 ~~terial of a local television station described in~~



1 subparagraph (A) in any analog or digital for-
2 mat or formats, whether or not doing so re-
3 quires conversion from the format transmitted
4 by the local television station, so long as

5 “(i) the cable operator offers the pri-
6 mary video stream and program-related
7 material in the converted analog or digital
8 format or formats without material deg-
9 radation, and

10 “(ii) also offers the primary video
11 stream and program-related material in
12 the manner or manners required by this
13 paragraph.

14 “(C) TRANSITIONAL CONVERSIONS. Not-
15 withstanding the requirement in subparagraph
16 (A) to carry the primary video stream and pro-
17 gram-related material in the digital format
18 transmitted by the local television station but
19 subject to the prohibition on material degrada-
20 tion until January 1, 2014.

21 “(i) a cable operator

22 “(I) shall offer the primary video
23 stream and program-related material
24 in the format or formats necessary for
25 such stream and material to be



1 ~~viewable on analog and digital tele-~~
2 ~~visions, and~~

3 ~~“(II) may convert the primary~~
4 ~~video stream and program related ma-~~
5 ~~terial to standard definition digital~~
6 ~~format in lieu of offering it in the dig-~~
7 ~~ital format transmitted by the local~~
8 ~~television station,~~

9 ~~“(iii) notwithstanding clause (I), a~~
10 ~~cable operator of a cable system with an~~
11 ~~activated capacity of 550 megahertz or~~
12 ~~less—~~

13 ~~“(I) shall offer the primary video~~
14 ~~stream and program related material~~
15 ~~of the local television station described~~
16 ~~in subparagraph (A), converted to an~~
17 ~~analog format, and~~

18 ~~“(II) may, but shall not be re-~~
19 ~~quired to, offer the primary video~~
20 ~~stream and program related material~~
21 ~~in any digital format or formats.~~

22 ~~“(D) LOCATION AND METHOD OF CONVER-~~
23 ~~SION.~~

24 ~~“(i) A cable operator of a cable sys-~~
25 ~~tem may perform any conversions permitted~~



1 ~~or required by this paragraph at any loca-~~
2 ~~tion, from the cable head end to the cus-~~
3 ~~tomers premises, inclusive.~~

4 ~~“(i) Notwithstanding any other provi-~~
5 ~~sion of this Act other than the prohibition~~
6 ~~on material degradation, a cable operator~~
7 ~~may use switched digital video technology~~
8 ~~to accomplish any conversion or trans-~~
9 ~~mission permitted or required by this para-~~
10 ~~graph.~~

11 ~~“(E) CONVERSIONS NOT TREATED AS DEG-~~
12 ~~RADATION. Any conversion permitted or re-~~
13 ~~quired by this paragraph shall not, by itself, be~~
14 ~~treated as a material degradation.~~

15 ~~“(F) CARRIAGE OF PROGRAM RELATED~~
16 ~~MATERIAL. The obligation to carry program~~
17 ~~related material under this paragraph is effec-~~
18 ~~tive only to the extent technically feasible.~~

19 ~~“(G) DEFINITION OF STANDARD DEFINI-~~
20 ~~TION FORMAT. For purposes of this para-~~
21 ~~graph, a stream shall be in standard definition~~
22 ~~digital format if such stream meets the criteria~~
23 ~~for such format as specified in the standard~~
24 ~~recognized by the Commission in section 73.682.~~



1 ~~of its rules (47 CFR 78.682) or a successor~~
2 ~~regulation.~~

3 ~~(b) The rule. Clause (iii) of section 629(b)(7)(A) of~~
4 ~~such Act (17 U.S.C. 549(b)(7)(A)(iii)) is amended to read~~
5 ~~as follows:~~

6 ~~“(iii) Both of the following signals:~~

7 ~~“(I) the primary video stream~~
8 ~~and program related material of any~~
9 ~~television broadcast station that is~~
10 ~~provided by the cable operator to any~~
11 ~~subscriber in an analog format, and~~

12 ~~“(II) the primary video stream~~
13 ~~and program related material~~

14 ~~“(aa) of any television~~
15 ~~broadcast station that is trans-~~
16 ~~mitting exclusively in digital for-~~
17 ~~mat, and~~

18 ~~“(bb) that is provided by the~~
19 ~~cable operator to any subscriber~~
20 ~~in a digital format, but excluding~~
21 ~~a signal that is secondarily trans-~~
22 ~~mitted by a satellite carrier be-~~
23 ~~yond the local service area of~~
24 ~~such station.”~~



1 ~~(c) COMPARABLE TREATMENT OF SATELLITE CARRIERS~~

2 ~~REPEALS Section 338 of the Communications Act of 1934~~

3 ~~(47 U.S.C. 338) is amended—~~

4 ~~(1) by adding at the end the following new sub-~~
5 ~~section:~~

6 ~~“(1) SPECIFIC CARRIAGE OBLIGATIONS AFTER DIG-~~
7 ~~ITAL TRANSITION.—~~

8 ~~“(1) CARRIAGE OF DIGITAL FORMATS.—With~~
9 ~~respect to any television broadcast station that is eli-~~
10 ~~gible for carriage under subsection (a)(1) of this sec-~~
11 ~~tion and that is transmitting broadcast program-~~
12 ~~ming exclusively in the digital television service in a~~
13 ~~local market in the contiguous United States (here-~~
14 ~~after in this paragraph referred to as an eligible re-~~
15 ~~questing station), a satellite carrier carrying the dig-~~
16 ~~ital signal of any other local television broadcast sta-~~
17 ~~tion in that local market shall carry the eligible re-~~
18 ~~questing station’s primary video stream and pro-~~
19 ~~gram related material without material degradation,~~
20 ~~if the licensee for that eligible requesting station~~

21 ~~“(A) relies on this section to obtain car-~~
22 ~~riage of the primary video stream and program~~
23 ~~related material by that satellite carrier in that~~
24 ~~market; and~~



1 ~~“(B) permits the satellite carrier to carry~~
2 ~~without compensation any other programming~~
3 ~~broadcast by that local station that is carried~~
4 ~~on that system.~~

5 ~~“(9) FORMATTING OF PRIMARY VIDEO~~
6 ~~STREAM. A satellite carrier must offer the primary~~
7 ~~video stream and program related material of an eli-~~
8 ~~gible requesting station in the digital format trans-~~
9 ~~mitted by the station if the satellite carrier carries~~
10 ~~the primary video stream of any other local tele-~~
11 ~~vision broadcast station in that local market in the~~
12 ~~same digital format.~~

13 ~~“(8) MULTIPLE FORMATS PERMITTED. A sat-~~
14 ~~ellite carrier may offer the primary video stream and~~
15 ~~program related material of an eligible requesting~~
16 ~~station in any analog or digital format or formats,~~
17 ~~whether or not doing so requires conversion from the~~
18 ~~format transmitted by that eligible requesting sta-~~
19 ~~tion, so long as~~

20 ~~“(A) the satellite carrier offers the primary~~
21 ~~video stream and program-related material in~~
22 ~~the converted analog or digital format or for-~~
23 ~~mate without material degradation, and~~



1 ~~“(B) also offers the primary video stream~~
2 ~~and program related material in the manner or~~
3 ~~manners required by this subsection.~~

4 ~~“(4) TRANSITIONAL CONVERSIONS. Notwith-~~
5 ~~standing any requirement in paragraphs (1) and (2)~~
6 ~~to carry the primary video stream and program-re-~~
7 ~~lated material in the digital format transmitted by~~
8 ~~the local television broadcast station, but subject to~~
9 ~~the prohibition on material degradation, until Janu-~~
10 ~~ary 1, 2014, a satellite carrier~~

11 ~~“(A) shall offer the primary video stream~~
12 ~~and program related material of any local tele-~~
13 ~~vision broadcast station required to be carried~~
14 ~~under paragraph (1) in the format necessary~~
15 ~~for such stream to be viewable on analog and~~
16 ~~digital televisions, and~~

17 ~~“(B) may convert the primary video~~
18 ~~stream and program related material to stand-~~
19 ~~ard definition format in lieu of carrying it in the~~
20 ~~digital format transmitted by the local television~~
21 ~~broadcast station.~~

22 ~~“(5) LOCATION AND METHOD OF CONVER-~~
23 ~~SION. A satellite carrier may perform any conver-~~
24 ~~sion permitted or required by this subsection at any~~



1 ~~location, from the local receive facility to the cus-~~
2 ~~tomer premises, inclusive.~~

3 ~~“(6) CONVERSIONS NOT TREATED AS DEGRADA-~~
4 ~~TION.—Any conversion permitted or required by this~~
5 ~~subsection shall not, by itself, be treated as a mate-~~
6 ~~rial degradation.~~

7 ~~“(7) CARRIAGE OF PROGRAM-RELATED MATE-~~
8 ~~RIAL.—The obligation to carry program-related ma-~~
9 ~~terial under this subsection is effective only to the~~
10 ~~extent technically feasible.~~

11 ~~“(8) DEFINITION OF STANDARD DEFINITION~~
12 ~~FORMAT.—For purposes of this subsection, a stream~~
13 ~~shall be in standard definition digital format if such~~
14 ~~stream meets the criteria for such format as speci-~~
15 ~~fied in the standard recognized by the Commission~~
16 ~~in section 73.682 of its rules (47 CFR 73.682) or~~
17 ~~a successor regulation.”~~

18 (2) ~~in subsection (b)(1), by striking “subsection~~
19 ~~(a)” and inserting “subsection (a) or (b)”;~~

20 (2) ~~in subsection (c)(1), by striking “subsection~~
21 ~~(c)(1)” and inserting “subsections (a)(1) and (b)”;~~

22 ~~and~~

23 (4) ~~in subsection (e)(2), by striking “subsecti-~~
24 ~~(a)” and inserting “subsections (a) and (b)”;~~



1 ~~(d) DEADLINE. The Federal Communications Com-~~
2 ~~mission shall revise its regulations to implement the~~
3 ~~amendments made by this section within one year after~~
4 ~~the date of enactment of this Act.~~

5 **SEC. 3014. SUPPLEMENTAL LICENSE FEES.**

6 In addition to any fees assessed under the Commu-
7 nications Act of 1934 (47 U.S.C. 151 et seq.), the Federal
8 Communications Commission shall assess extraordinary
9 fees for licenses in the aggregate amount of \$10,000,000,
10 which shall be deposited in the Treasury during fiscal year
11 2006 as offsetting receipts.



FINAL

Elizabeth R. Neff
H.L.C.
Jana Sutherland

1 **TITLE IV—TRANSPORTATION**
2 **PROVISIONS**

3 **SEC. 4001. EXTENSION OF VESSEL TONNAGE DUTIES.**

4 (a) **EXTENSION OF DUTIES.**—Section 36 of the Act
5 entitled “An Act to provide revenue, equalize duties, and
6 encourage the industries of the United States, and for
7 other purposes”, approved August 5, 1909 (36 Stat. 111;
8 46 U.S.C. App. 121), is amended—

9 (1) by striking “9 cents per ton” and all that
10 follows through “2002,” the first place it appears
11 and inserting “4.5 cents per ton, not to exceed in
12 the aggregate 22.5 cents per ton in any one year, for
13 fiscal years 2006 through 2010,”; and

14 (2) by striking “27 cents per ton” and all that
15 follows through “2002,” and inserting “13.5 cents
16 per ton, not to exceed 67.5 cents per ton per annum,
17 for fiscal years 2006 through 2010,”.

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18 (b) **CONFORMING AMENDMENT.**—The Act entitled
19 “An Act concerning tonnage duties on vessels entering
20 otherwise than by sea”, approved March 8, 1910 (36 Stat.
21 234; 46 U.S.C. App. 132), is amended by striking “9 cents
22 per ton” and all that follows through “and 2 cents” and
23 inserting “4.5 cents per ton, not to exceed in the aggre-



- 1 gate 22.5 cents per ton in any one year, for fiscal years
- 2 2006 through 2010, and 2 cents”.



1 **TITLE V—MEDICARE**
 2 **Subtitle A—Provisions Relating to**
 3 **Part A**

4 **SEC. 5001. HOSPITAL QUALITY IMPROVEMENT.**

5 (a) SUBMISSION OF HOSPITAL DATA.—Section
 6 1886(b)(3)(B) of the Social Security Act (42 U.S.C.
 7 1395ww(b)(3)(B)) is amended—

8 (1) in clause (i)—

9 (A) in subclause (XIX), by striking
 10 “2007” and inserting “2006”; and

11 (B) in subclause (XX), by striking “for fis-
 12 cal year 2008 and each subsequent fiscal year,”
 13 and inserting “for each subsequent fiscal year,
 14 subject to clause (viii),”;

15 (2) in clause (vii)—

16 (A) in subclause (I), by striking “for each
 17 of fiscal years 2005 through 2007” and insert-
 18 ing “for fiscal years 2005 and 2006”; and

19 (B) in subclause (II), by striking “Each”
 20 and inserting “For fiscal years 2005 and 2006,
 21 each”; and

22 (3) by adding at the end the following new
 23 clauses:

24 “(viii)(I) For purposes of clause (i)
 25 for fiscal year 2007 and each subsequent



1 fiscal year, in the case of a subsection (d)
2 hospital that does not submit, to the Sec-
3 retary in accordance with this clause, data
4 required to be submitted on measures se-
5 lected under this clause with respect to
6 such a fiscal year, the applicable percent-
7 age increase under clause (i) for such fiscal
8 year shall be reduced by 2.0 percentage
9 points. Such reduction shall apply only
10 with respect to the fiscal year involved and
11 the Secretary shall not take into account
12 such reduction in computing the applicable
13 percentage increase under clause (i) for a
14 subsequent fiscal year, and the Secretary
15 and the Medicare Payment Advisory Com-
16 mission shall carry out the requirements
17 under section 5001(b) of the Deficit Re-
18 duction Act of 2005.

19 “(II) Each subsection (d) hospital
20 shall submit data on measures selected
21 under this clause to the Secretary in a
22 form and manner, and at a time, specified
23 by the Secretary for purposes of this
24 clause.



1 “(III) The Secretary shall expand, be-
2 yond the measures specified under clause
3 (vii)(II) and consistent with the succeeding
4 subclauses, the set of measures that the
5 Secretary determines to be appropriate for
6 the measurement of the quality of care fur-
7 nished by hospitals in inpatient settings.

8 “(IV) Effective for payments begin-
9 ning with fiscal year 2007, in expanding
10 the number of measures under subclause
11 (III), the Secretary shall begin to adopt
12 the baseline set of performance measures
13 as set forth in the November 2005 report
14 by the Institute of Medicine of the Na-
15 tional Academy of Sciences under section
16 238(b) of the Medicare Prescription Drug,
17 Improvement, and Modernization Act of
18 2003.

19 “(V) Effective for payments beginning
20 with fiscal year 2008, the Secretary shall
21 add other measures that reflect consensus
22 among affected parties and, to the extent
23 feasible and practicable, shall include
24 measures set forth by one or more national
25 consensus building entities.



1 “(VI) For purposes of this clause and
2 clause (vii), the Secretary may replace any
3 measures or indicators in appropriate
4 cases, such as where all hospitals are effec-
5 tively in compliance or the measures or in-
6 dicators have been subsequently shown not
7 to represent the best clinical practice.

8 “(VII) The Secretary shall establish
9 procedures for making data submitted
10 under this clause available to the public.
11 Such procedures shall ensure that a hos-
12 pital has the opportunity to review the
13 data that are to be made public with re-
14 spect to the hospital prior to such data
15 being made public. The Secretary shall re-
16 port quality measures of process, structure,
17 outcome, patients’ perspectives on care, ef-
18 ficiency, and costs of care that relate to
19 services furnished in inpatient settings in
20 hospitals on the Internet website of the
21 Centers for Medicare & Medicaid Serv-
22 ices.”.

23 (b) PLAN FOR HOSPITAL VALUE BASED PUR-
24 CHASING PROGRAM.—



1 (1) IN GENERAL.—The Secretary of Health and
 2 Human Services shall develop a plan to implement
 3 a value based purchasing program for payments
 4 under the Medicare program for subsection (d) hos-
 5 pitals beginning with fiscal year 2009.

6 (2) DETAILS.—Such a plan shall include con-
 7 sideration of the following issues:

8 (A) The on-going development, selection,
 9 and modification process for measures of qual-
 10 ity and efficiency in hospital inpatient settings.

11 (B) The reporting, collection, and valida-
 12 tion of quality data.

13 (C) The structure of value based payment
 14 adjustments, including the determination of
 15 thresholds or improvements in quality that
 16 would substantiate a payment adjustment, the
 17 size of such payments, and the sources of fund-
 18 ing for the value based payments.

19 (D) The disclosure of information on hos-
 20 pital performance.

21 In developing such a plan, the Secretary shall con-
 22 sult with relevant affected parties and shall consider
 23 experience with such demonstrations that are rel-
 24 evant to the value based purchasing program under
 25 this subsection.



1 (3) CONGRESSIONAL REPORT.—By not later
2 than August 1, 2007, the Secretary of Health and
3 Human Services shall submit a report to Congress
4 on the plan for the value based purchasing program
5 developed under this subsection.

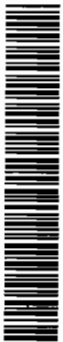
6 (4) MEDPAC REPORT ON HOSPITAL VALUE
7 BASED PURCHASING PROGRAM.—

8 (A) IN GENERAL.—By not later than June
9 1, 2007, the Medicare Payment Advisory Com-
10 mission shall submit to Congress a report that
11 includes detailed recommendations on a struc-
12 ture of value based payment adjustments for
13 hospital services under the Medicare program
14 under title XVIII of the Social Security Act.

15 (B) CONTENTS.—Such report shall include
16 the following:

17 (i) Determinations of the thresholds,
18 the size of payments, the sources of funds,
19 and the relationship of payments to im-
20 provement and attainment of quality.

21 (ii) An analysis of hospital efficiency
22 measures such as costs per discharge, re-
23 lated services within an episode of care in-
24 cluding payments for physicians' services



1 associated with the discharge or episode of
2 care.

3 (iii) An identification of other changes
4 that are needed within the payment struc-
5 ture under section 1886(d) of the Social
6 Security Act (42 U.S.C. 1395ww(d)) to as-
7 sure consistency between such structure
8 and the value based payment program.

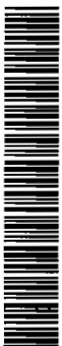
9 (c) QUALITY ADJUSTMENT IN DRG PAYMENTS FOR
10 CERTAIN HOSPITAL ACQUIRED INFECTIONS.—

11 (1) IN GENERAL.—Section 1886(d)(4) of the
12 Social Security Act (42 U.S.C. 1395ww(d)(4)) is
13 amended by adding at the end the following new
14 subparagraph:

15 “(D)(i) For discharges occurring on or after October
16 1, 2008, the diagnosis-related group to be assigned under
17 this paragraph for a discharge described in clause (ii) shall
18 be a diagnosis-related group that does not result in higher
19 payment based on the presence of a secondary diagnosis
20 code described in clause (iv).

21 “(ii) A discharge described in this clause is a dis-
22 charge which meets the following requirements:

23 “(I) The discharge includes a condition identi-
24 fied by a diagnosis code selected under clause (iv) as
25 a secondary diagnosis.



1 “(II) But for clause (i), the discharge would
2 have been classified to a diagnosis-related group that
3 results in a higher payment based on the presence
4 of a secondary diagnosis code selected under clause
5 (iv).

6 “(III) At the time of admission, no code se-
7 lected under clause (iv) was present.

8 “(iii) As part of the information required to be re-
9 ported by a hospital with respect to a discharge of an indi-
10 vidual in order for payment to be made under this sub-
11 section, for discharges occurring on or after October 1,
12 2007, the information shall include the secondary diag-
13 nosis of the individual at admission.

14 “(iv) By not later than October 1, 2007, the Sec-
15 retary shall select diagnosis codes associated with at least
16 two conditions, each of which codes meets all of the fol-
17 lowing requirements (as determined by the Secretary):

18 “(I) Cases described by such code have a high
19 cost or high volume, or both, under this title.

20 “(II) The code results in the assignment of a
21 case to a diagnosis-related group that has a higher
22 payment when the code is present as a secondary di-
23 agnosis.

1 “(III) The code describes such conditions that
2 could reasonably have been prevented through the
3 application of evidence-based guidelines.

4 The Secretary may from time to time revise (through addi-
5 tion or deletion of codes) the diagnosis codes selected
6 under this clause so long as there are diagnosis codes asso-
7 ciated with at least two conditions selected for discharges
8 occurring during any fiscal year.

9 “(v) In selecting and revising diagnosis codes under
10 clause (iv), the Secretary shall consult with the Centers
11 for Disease Control and Prevention and other appropriate
12 entities.

13 “(vi) Any change resulting from the application of
14 this subparagraph shall not be taken into account in ad-
15 justing the weighting factors under subparagraph (C)(i)
16 or in applying budget neutrality under subparagraph
17 (C)(iii).”.

18 (2) NO JUDICIAL REVIEW.—Section
19 1886(d)(7)(B) of such Act (42 U.S.C.
20 1395ww(d)(7)(B)) is amended by inserting before
21 the period the following: “, including the selection
22 and revision of codes under paragraph (4)(D)”.



1 **SEC. 5002. CLARIFICATION OF DETERMINATION OF MED-**
2 **ICAID PATIENT DAYS FOR DSH COMPUTA-**
3 **TION.**

4 (a) **IN GENERAL.**—Section 1886(d)(5)(F)(vi) of the
5 Social Security Act (42 U.S.C. 1395ww(d)(5)(F)(vi)) is
6 amended by adding after and below subclause (II) the fol-
7 lowing:

8 “In determining under subclause (II) the number of the
9 hospital’s patient days for such period which consist of
10 patients who (for such days) were eligible for medical as-
11 sistance under a State plan approved under title XIX, the
12 Secretary may, to the extent and for the period the Sec-
13 retary determines appropriate, include patient days of pa-
14 tients not so eligible but who are regarded as such because
15 they receive benefits under a demonstration project ap-
16 proved under title XI.”

17 (b) **RATIFICATION AND PROSPECTIVE APPLICATION**
18 **OF PREVIOUS REGULATIONS.**—

19 (1) **IN GENERAL.**—Subject to paragraph (2),
20 regulations described in paragraph (3), insofar as
21 such regulations provide for the treatment of indi-
22 viduals eligible for medical assistance under a dem-
23 onstration project approved under title XI of the So-
24 cial Security Act under section 1886(d)(5)(F)(vi) of
25 such Act, are hereby ratified, effective as of the date
26 of their respective promulgations.

1 (2) NO APPLICATION TO CLOSED COST RE-
2 PORTS.—Paragraph (1) shall not be applied in a
3 manner that requires the reopening of any cost re-
4 ports which are closed as of the date of the enact-
5 ment of this Act.

6 (3) REGULATIONS DESCRIBED.—For purposes
7 of paragraph (1), the regulations described in this
8 paragraph are as follows:

9 (A) 2000 REGULATION.—Regulations pro-
10 mulgated on January 20, 2000, at 65 Federal
11 Register 3136 et seq, including the policy in
12 such regulations regarding discharges occurring
13 prior to January 20, 2000.

14 (B) 2003 REGULATION.—Regulations pro-
15 mulgated on August 1, 2003, at 68 Federal
16 Register 45345 et seq.

17 **SEC. 5003. IMPROVEMENTS TO THE MEDICARE-DEPENDENT**
18 **HOSPITAL (MDH) PROGRAM.**

19 (a) 5-YEAR EXTENSION.—

20 (1) EXTENSION OF PAYMENT METHOD-
21 OLOGY.—Section 1886(d)(5)(G) of the Social Secu-
22 rity Act (42 U.S.C. 1395ww(d)(5)(G)) is amended—

23 (A) in clause (i), by striking “October 1,
24 2006” and inserting “October 1, 2011”; and

25 (B) in clause (ii)(II)—



1 (i) by striking “October 1, 2006” and
2 inserting “October 1, 2011”; and

3 (ii) by inserting “or for discharges in
4 the fiscal year” after “for the cost report-
5 ing period”.

6 (2) CONFORMING AMENDMENTS.—

7 (A) EXTENSION OF TARGET AMOUNT.—
8 Section 1886(b)(3)(D) of such Act (42 U.S.C.
9 1395ww(b)(3)(D)) is amended—

10 (i) in the matter preceding clause
11 (i)—

12 (I) by striking “beginning” and
13 inserting “occurring”; and

14 (II) by striking “October 1,
15 2006” and inserting “October 1,
16 2011”; and

17 (ii) in clause (iv), by striking
18 “through fiscal year 2005” and inserting
19 “through fiscal year 2011”.

20 (B) PERMITTING HOSPITALS TO DECLINE
21 RECLASSIFICATION.—Section 13501(e)(2) of
22 the Omnibus Budget Reconciliation Act of 1993
23 (42 U.S.C. 1395ww note) is amended by strik-
24 ing “through fiscal year 2005” and inserting
25 “through fiscal year 2011”.



1 (b) OPTION TO USE 2002 AS BASE YEAR.—Section
2 1886(b)(3) of such Act (42 U.S.C. 1395ww(b)(3)) is
3 amended—

4 (1) in subparagraph (D), by inserting “subject
5 to subparagraph (K),” after “(d)(5)(G),”; and

6 (2) by adding at the end the following new sub-
7 paragraph:

8 “(K)(i) With respect to discharges occurring on or
9 after October 1, 2006, in the case of a medicare-depend-
10 ent, small rural hospital, for purposes of applying sub-
11 paragraph (D)—

12 “(I) there shall be substituted for the base cost
13 reporting period described in subparagraph (D)(i)
14 the 12-month cost reporting period beginning during
15 fiscal year 2002; and

16 “(II) any reference in such subparagraph to the
17 ‘first cost reporting period’ described in such sub-
18 paragraph is deemed a reference to the first cost re-
19 porting period beginning on or after October 1,
20 2006.

21 “(ii) This subparagraph shall only apply to a hospital
22 if the substitution described in clause (i)(I) results in an
23 increase in the target amount under subparagraph (D) for
24 the hospital.”.



1 (c) ENHANCED PAYMENT FOR AMOUNT BY WHICH
2 THE TARGET EXCEEDS THE PPS RATE.—Section
3 1886(d)(5)(G)(ii)(II) of such Act (42 U.S.C.
4 1395ww(d)(5)(G)(iv)(II)) is amended by inserting “(or 75
5 percent in the case of discharges occurring on or after Oc-
6 tober 1, 2006)” after “50 percent”.

7 (d) ENHANCED DISPROPORTIONATE SHARE HOS-
8 PITAL (DSH) TREATMENT FOR MEDICARE DEPENDENT
9 HOSPITALS.—Section 1886(d)(5)(F)(xiv)(II) of such Act
10 (42 U.S.C. 1395ww(d)(5)(F)(xiv)(II)) is amended by in-
11 serting “or, in the case of discharges occurring on or after
12 October 1, 2006, as a medicare-dependent, small rural
13 hospital under subparagraph (G)(iv)” before the period at
14 the end.

15 **SEC. 5004. REDUCTION IN PAYMENTS TO SKILLED NURSING**
16 **FACILITIES FOR BAD DEBT.**

17 (a) IN GENERAL.—Section 1861(v)(1) of the Social
18 Security Act (42 U.S.C. 1395x(v)(1)) is amended by add-
19 ing at the end the following new subparagraph:

20 “(V) In determining such reasonable costs for skilled
21 nursing facilities with respect to cost reporting periods be-
22 ginning on or after October 1, 2005, the amount of bad
23 debts otherwise treated as allowed costs which are attrib-
24 utable to the coinsurance amounts under this title for indi-
25 viduals who are entitled to benefits under part A and—



1 “(i) are not described in section
2 1935(c)(6)(A)(ii) shall be reduced by 30 percent of
3 such amount otherwise allowable; and

4 “(ii) are described in such section shall not be
5 reduced.”.

6 (b) **TECHNICAL AMENDMENT.**—Section
7 1861(v)(1)(T) of such Act (42 U.S.C. 1395x(v)(1)(T)) is
8 amended by striking “section 1833(t)(5)(B)” and insert-
9 ing “section 1833(t)(8)(B)”.

10 **SEC. 5005. EXTENDED PHASE-IN OF THE INPATIENT REHA-**
11 **BILITATION FACILITY CLASSIFICATION CRI-**
12 **TERIA.**

13 (a) **IN GENERAL.**—Notwithstanding section
14 412.23(b)(2) of title 42, Code of Federal Regulations, the
15 Secretary of Health and Human Services shall apply the
16 applicable percent specified in subsection (b) in the classi-
17 fication criterion used under the IRF regulation (as de-
18 fined in subsection (c)) to determine whether a hospital
19 or unit of a hospital is an inpatient rehabilitation facility
20 under the Medicare program under title XVIII of the So-
21 cial Security Act.

22 (b) **APPLICABLE PERCENT.**—For purposes of sub-
23 section (a), the applicable percent specified in this sub-
24 section for cost reporting periods—



1 (1) beginning during the 12-month period be-
2 ginning on July 1, 2006, is 60 percent;

3 (2) beginning during the 12-month period be-
4 ginning on July 1, 2007, is 65 percent; and

5 (3) beginning on or after July 1, 2008, is 75
6 percent.

7 (c) IRF REGULATION.—For purposes of subsection
8 (a), the term “IRF regulation” means the rule published
9 in the Federal Register on May 7, 2004, entitled “Medi-
10 care Program; Final Rule; Changes to the Criteria for
11 Being Classified as an Inpatient Rehabilitation Facility”
12 (69 Fed. Reg. 25752).

13 **SEC. 5006. DEVELOPMENT OF A STRATEGIC PLAN REGARD-**
14 **ING PHYSICIAN INVESTMENT IN SPECIALTY**
15 **HOSPITALS.**

16 (a) DEVELOPMENT.—

17 (1) IN GENERAL.—The Secretary of Health and
18 Human Services (in this section referred to as the
19 “Secretary”) shall develop a strategic and imple-
20 menting plan to address issues described in para-
21 graph (2) regarding physician investment in spe-
22 cialty hospitals (as defined in section 1877(h)(7)(A)
23 of the Social Security Act (42 U.S.C.
24 1395nn(h)(7)(A)).



1 (2) ISSUES DESCRIBED.—The issues described
2 in this paragraph are the following:

3 (A) Proportionality of investment return.

4 (B) Bona fide investment.

5 (C) Annual disclosure of investment infor-
6 mation.

7 (D) The provision by specialty hospitals
8 of—

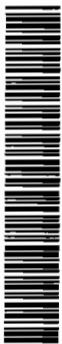
9 (i) care to patients who are eligible for
10 medical assistance under a State plan ap-
11 proved under title XIX of the Social Secu-
12 rity Act, including patients not so eligible
13 but who are regarded as such because they
14 receive benefits under a demonstration
15 project approved under title XI of such
16 Act; and

17 (ii) charity care.

18 (E) Appropriate enforcement.

19 (b) REPORTS.—

20 (1) INTERIM REPORT.—Not later than 3
21 months after the date of the enactment of this Act,
22 the Secretary shall submit an interim report to the
23 appropriate committees of jurisdiction of Congress
24 on the status of the development of the plan under
25 subsection (a).



1 (2) FINAL REPORT.—Not later six months after
2 the date of the enactment of this Act, the Secretary
3 shall submit a final report to the appropriate com-
4 mittees of jurisdiction of Congress on the plan devel-
5 oped under subsection (a) together with rec-
6 ommendations for such legislation and administra-
7 tive actions as the Secretary considers appropriate.

8 (c) CONTINUATION OF SUSPENSION ON ENROLL-
9 MENT.—

10 (1) IN GENERAL.—Subject to paragraph (2),
11 the Secretary shall continue the suspension on en-
12 rollment of new specialty hospitals (as so defined)
13 under title XVIII of the Social Security Act until the
14 earlier of—

15 (A) the date that the Secretary submits
16 the final report under subsection (b)(2); or

17 (B) the date that is six months after the
18 date of the enactment of this Act.

19 (2) EXTENSION OF SUSPENSION.—If the Sec-
20 retary fails to submit the final report described in
21 subsection (b)(2) by the date required under such
22 subsection, the Secretary shall—

23 (A) extend the suspension on enrollment
24 under paragraph (1) for an additional two
25 months; and



1 (B) provide a certification to the appro-
2 priate committees of jurisdiction of Congress of
3 such failure.

4 (d) WAIVER.—In developing the plan and report re-
5 quired under this section, the Secretary may waive such
6 requirements of section 553 of title 5, United States Code,
7 as the Secretary determines necessary.

8 (e) FUNDING.—Out of any funds in the Treasury not
9 otherwise appropriated, there are appropriated to the Sec-
10 retary for fiscal year 2006, \$2,000,000 to carry out this
11 section.

12 **SEC. 5007. MEDICARE DEMONSTRATION PROJECTS TO PER-**
13 **MIT GAINSHARING ARRANGEMENTS.**

14 (a) ESTABLISHMENT.—The Secretary shall establish
15 under this section a qualified gainsharing demonstration
16 program under which the Secretary shall approve dem-
17 onstration projects by not later than November 1, 2006,
18 to test and evaluate methodologies and arrangements be-
19 tween hospitals and physicians designed to govern the uti-
20 lization of inpatient hospital resources and physician work
21 to improve the quality and efficiency of care provided to
22 Medicare beneficiaries and to develop improved oper-
23 ational and financial hospital performance with sharing of
24 remuneration as specified in the project. Such projects
25 shall be operational by not later than January 1, 2007.



1 (b) REQUIREMENTS DESCRIBED.—A demonstration
2 project under this section shall meet the following require-
3 ments for purposes of maintaining or improving quality
4 while achieving cost savings:

5 (1) ARRANGEMENT FOR REMUNERATION AS
6 SHARE OF SAVINGS.—The demonstration project
7 shall involve an arrangement between a hospital and
8 a physician under which the hospital provides remun-
9 eration to the physician that represents solely a
10 share of the savings incurred directly as a result of
11 collaborative efforts between the hospital and the
12 physician.

13 (2) WRITTEN PLAN AGREEMENT.—The dem-
14 onstration project shall be conducted pursuant to a
15 written agreement that—

16 (A) is submitted to the Secretary prior to
17 implementation of the project; and

18 (B) includes a plan outlining how the
19 project will achieve improvements in quality and
20 efficiency.

21 (3) PATIENT NOTIFICATION.—The demonstra-
22 tion project shall include a notification process to in-
23 form patients who are treated in a hospital partici-
24 pating in the project of the participation of the hos-
25 pital in such project.



1 (4) MONITORING QUALITY AND EFFICIENCY OF
2 CARE.—The demonstration project shall provide
3 measures to ensure that the quality and efficiency of
4 care provided to patients who are treated in a hos-
5 pital participating in the demonstration project is
6 continuously monitored to ensure that such quality
7 and efficiency is maintained or improved.

8 (5) INDEPENDENT REVIEW.—The demonstra-
9 tion project shall certify, prior to implementation,
10 that the elements of the demonstration project are
11 reviewed by an organization that is not affiliated
12 with the hospital or the physician participating in
13 the project.

14 (6) REFERRAL LIMITATIONS.—The demonstra-
15 tion project shall not be structured in such a manner
16 as to reward any physician participating in the
17 project on the basis of the volume or value of refer-
18 rals to the hospital by the physician.

19 (c) WAIVER OF CERTAIN RESTRICTIONS.—

20 (1) IN GENERAL.—An incentive payment made
21 by a hospital to a physician under and in accordance
22 with a demonstration project shall not constitute—

23 (A) remuneration for purposes of section
24 1128B of the Social Security Act (42 U.S.C.
25 1320a-7b);



1 (B) a payment intended to induce a physi-
2 cian to reduce or limit services to a patient en-
3 titled to benefits under Medicare or a State
4 plan approved under title XIX of such Act in
5 violation of section 1128A of such Act (42
6 U.S.C. 1320a-7a); or

7 (C) a financial relationship for purposes of
8 section 1877 of such Act (42 U.S.C. 1395nn).

9 (2) PROTECTION FOR EXISTING ARRANGE-
10 MENTS.—In no case shall the failure to comply with
11 the requirements described in paragraph (1) affect a
12 finding made by the Inspector General of the De-
13 partment of Health and Human Services prior to
14 the date of the enactment of this Act that an ar-
15 rangement between a hospital and a physician does
16 not violate paragraph (1) or (2) of section 1128A(a)
17 of the Social Security Act (42 U.S.C. 1320a-7(a)).
18 (d) PROGRAM ADMINISTRATION.—

19 (1) SOLICITATION OF APPLICATIONS.—By not
20 later than 90 days after the date of the enactment
21 of this Act, the Secretary shall solicit applications
22 for approval of a demonstration project, in such
23 form and manner, and at such time specified by the
24 Secretary.



1 (2) NUMBER OF PROJECTS APPROVED.—The
2 Secretary shall approve not more than 6 demonstra-
3 tion projects, at least 2 of which shall be located in
4 a rural area.

5 (3) DURATION.—The qualified gainsharing
6 demonstration program under this section shall be
7 conducted for the period beginning on January 1,
8 2007, and ending on December 31, 2009.

9 (e) REPORTS.—

10 (1) INITIAL REPORT.—By not later than De-
11 cember 1, 2006, the Secretary shall submit to Con-
12 gress a report on the number of demonstration
13 projects that will be conducted under this section.

14 (2) PROJECT UPDATE.—By not later than De-
15 cember 1, 2007, the Secretary shall submit to Con-
16 gress a report on the details of such projects (includ-
17 ing the project improvements towards quality and ef-
18 ficiency described in subsection (b)(2)(B)).

19 (3) QUALITY IMPROVEMENT AND SAVINGS.—By
20 not later than December 1, 2008, the Secretary shall
21 submit to Congress a report on quality improvement
22 and savings achieved as a result of the qualified
23 gainsharing demonstration program established
24 under subsection (a).



1 (4) FINAL REPORT.—By not later than May 1,
2 2010, the Secretary shall submit to Congress a final
3 report on the information described in paragraph
4 (3).

5 (f) FUNDING.—

6 (1) IN GENERAL.—Out of any funds in the
7 Treasury not otherwise appropriated, there are ap-
8 propriated to the Secretary for fiscal year 2006
9 \$6,000,000, to carry out this section.

10 (2) AVAILABILITY.—Funds appropriated under
11 paragraph (1) shall remain available for expenditure
12 through fiscal year 2010.

13 (g) DEFINITIONS.—For purposes of this section:

14 (1) DEMONSTRATION PROJECT.—The term
15 “demonstration project” means a project imple-
16 mented under the qualified gainsharing demonstra-
17 tion program established under subsection(a).

18 (2) HOSPITAL.—The term “hospital” means a
19 hospital that receives payment under section
20 1886(d) of the Social Security Act (42 U.S.C.
21 1395ww(d)), and does not include a critical access
22 hospital (as defined in section 1861(mm) of such
23 Act (42 U.S.C. 1395x(mm))).



1 (3) MEDICARE.—The term “Medicare” means
2 the programs under title XVIII of the Social Secu-
3 rity Act.

4 (4) PHYSICIAN.—The term “physician” means,
5 with respect to a demonstration project, a physician
6 described in paragraph (1) or (3) of section 1861(r)
7 of the Social Security Act (42 U.S.C. 1395x(r)) who
8 is licensed as such a physician in the area in which
9 the project is located and meets requirements to pro-
10 vide services for which benefits are provided under
11 Medicare. Such term shall be deemed to include a
12 practitioner described in section 1842(e)(18)(C) of
13 such Act (42 U.S.C. 1395u(e)(18)(C)).

14 (5) SECRETARY.—The term “Secretary” means
15 the Secretary of Health and Human Services.

16 **SEC. 5008. POST-ACUTE CARE PAYMENT REFORM DEM-**
17 **ONSTRATION PROGRAM.**

18 (a) ESTABLISHMENT.—

19 (1) IN GENERAL.—By not later than January
20 1, 2008, the Secretary of Health and Human Serv-
21 ices (in this section referred to as the “Secretary”)
22 shall establish a demonstration program for pur-
23 poses of understanding costs and outcomes across
24 different post-acute care sites. Under such program,
25 with respect to diagnoses specified by the Secretary,



1 an individual who receives treatment from a provider
2 for such a diagnosis shall receive a single com-
3 prehensive assessment on the date of discharge from
4 a subsection (d) hospital (as defined in section
5 1886(d)(1)(B) of the Social Security Act (42 U.S.C.
6 1395ww(d)(1)(B))) of the needs of the patient and
7 the clinical characteristics of the diagnosis to deter-
8 mine the appropriate placement of such patient in a
9 post-acute care site. The Secretary shall use a stand-
10 ardized patient assessment instrument across all
11 post-acute care sites to measure functional status
12 and other factors during the treatment and at dis-
13 charge from each provider. Participants in the pro-
14 gram shall provide information on the fixed and
15 variable costs for each individual. An additional com-
16 prehensive assessment shall be provided at the end
17 of the episode of care.

18 (2) NUMBER OF SITES.—The Secretary shall
19 conduct the demonstration program under this sec-
20 tion with sufficient numbers to determine statis-
21 tically reliable results.

22 (3) DURATION.—The Secretary shall conduct
23 the demonstration program under this section for a
24 3-year period.



1 (b) WAIVER AUTHORITY.—The Secretary may waive
 2 such requirements of titles XI and XVIII of the Social
 3 Security Act (42 U.S.C. 1301 et seq.; 42 U.S.C. 1395 et
 4 seq.) as may be necessary for the purpose of carrying out
 5 the demonstration program under this section.

6 (c) REPORT.—Not later than 6 months after the com-
 7 pletion of the demonstration program under this section,
 8 the Secretary shall submit to Congress a report on such
 9 program, that includes the results of the program and rec-
 10 ommendations for such legislation and administrative ac-
 11 tion as the Secretary determines to be appropriate.

12 (d) FUNDING.—The Secretary shall provide for the
 13 transfer from the Federal Hospital Insurance Trust Fund
 14 established under section 1817 of the Social Security Act
 15 (42 U.S.C. 1395i), \$6,000,000 for the costs of carrying
 16 out the demonstration program under this section.

17 **Subtitle B—Provisions Relating to**
 18 **Part B**

19 **CHAPTER 1—PAYMENT PROVISIONS**

20 **SEC. 5101. BENEFICIARY OWNERSHIP OF CERTAIN DURA-**
 21 **BLE MEDICAL EQUIPMENT (DME).**

22 (a) DME.—

23 (1) IN GENERAL.—Section 1834(a)(7)(A) of the
 24 Social Security Act (42 U.S.C. 1395m(a)(7)(A)) is
 25 amended to read as follows:



1 “(A) PAYMENT.—In the case of an item of
 2 durable medical equipment not described in
 3 paragraphs (2) through (6), the following rules
 4 shall apply:

5 “(i) RENTAL.—

6 “(I) IN GENERAL.—Except as
 7 provided in clause (iii), payment for
 8 the item shall be made on a monthly
 9 basis for the rental of the item during
 10 the period of medical need (but pay-
 11 ments under this clause may not ex-
 12 tend over a period of continuous use
 13 (as determined by the Secretary) of
 14 longer than 13 months).

15 “(II) PAYMENT AMOUNT.—Sub-
 16 ject to subparagraph (B), the amount
 17 recognized for the item, for each of
 18 the first 3 months of such period, is
 19 10 percent of the purchase price rec-
 20 ognized under paragraph (8) with re-
 21 spect to the item, and, for each of the
 22 remaining months of such period, is
 23 7.5 percent of such purchase price.

24 “(ii) OWNERSHIP AFTER RENTAL.—

25 On the first day that begins after the 13th



1 continuous month during which payment is
2 made for the rental of an item under
3 clause (i), the supplier of the item shall
4 transfer title to the item to the individual.

5 “(iii) PURCHASE AGREEMENT OPTION
6 FOR POWER-DRIVEN WHEELCHAIRS.—In
7 the case of a power-driven wheelchair, at
8 the time the supplier furnishes the item,
9 the supplier shall offer the individual the
10 option to purchase the item, and payment
11 for such item shall be made on a lump-sum
12 basis if the individual exercises such op-
13 tion.

14 “(iv) MAINTENANCE AND SERV-
15 ICING.—After the supplier transfers title to
16 the item under clause (ii) or in the case of
17 a power-driven wheelchair for which a pur-
18 chase agreement has been entered into
19 under clause (iii), maintenance and serv-
20 icing payments shall, if the Secretary de-
21 termines such payments are reasonable
22 and necessary, be made (for parts and
23 labor not covered by the supplier’s or man-
24 ufacturer’s warranty, as determined by the
25 Secretary to be appropriate for the par-



1 ticular type of durable medical equipment),
 2 and such payments shall be in an amount
 3 determined to be appropriate by the Sec-
 4 retary.”.

5 (2) EFFECTIVE DATE.—The amendment made
 6 by paragraph (1) shall apply to items furnished for
 7 which the first rental month occurs on or after Jan-
 8 uary 1, 2006.

9 (b) OXYGEN EQUIPMENT.—

10 (1) IN GENERAL.—Section 1834(a)(5) of such
 11 Act (42 U.S.C. 1395m(a)(5)) is amended—

12 (A) in subparagraph (A), by striking “and
 13 (E)” and inserting “(E), and (F)”; and

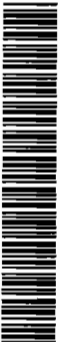
14 (B) by adding at the end the following new
 15 subparagraph:

16 “(F) OWNERSHIP OF EQUIPMENT.—

17 “(i) IN GENERAL.—Payment for oxy-
 18 gen equipment (including portable oxygen
 19 equipment) under this paragraph may not
 20 extend over a period of continuous use (as
 21 determined by the Secretary) of longer
 22 than ~~12~~ months. (36)

23 “(ii) OWNERSHIP.—

24 “(I) TRANSFER OF TITLE.—On
 25 the first day that begins after the



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th continuous month during which
payment is made for the equipment
under this paragraph, the supplier of
the equipment shall transfer title to
the equipment to the individual.

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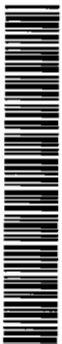
“(II) PAYMENTS FOR OXYGEN
AND MAINTENANCE AND SERV-
ICING.—After the supplier transfers
title to the equipment under subclause
(I)—

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“(aa) payments for oxygen
shall continue to be made in the
amount recognized for oxygen
under paragraph (9) for the pe-
riod of medical need; and

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“(bb) maintenance and serv-
icing payments shall, if the Sec-
retary determines such payments
are reasonable and necessary, be
made (for parts and labor not
covered by the supplier’s or man-
ufacturer’s warranty, as deter-
mined by the Secretary to be ap-
propriate for the equipment), and
such payments shall be in an



1 amount determined to be appro-
2 priate by the Secretary.”.

3 (2) EFFECTIVE DATE.—

4 (A) IN GENERAL.—The amendments made
5 by paragraph (1) shall take effect on January
6 1, 2006.

7 (B) APPLICATION TO CERTAIN INDIVID-
8 UALS.—In the case of an individual receiving
9 oxygen equipment on December 31, 2005, for
10 which payment is made under section 1834(a)
11 of the Social Security Act (42 U.S.C.
12 1395m(a)), the ~~x~~-month period described in **(36)**
13 paragraph (5)(F)(i) of such section, as added
14 by paragraph (1), shall begin on January 1,
15 2006.

16 **SEC. 5102. ADJUSTMENTS IN PAYMENT FOR IMAGING SERV-**
17 **ICES.**

18 (a) MULTIPLE PROCEDURE PAYMENT REDUCTION
19 FOR IMAGING EXEMPTED FROM BUDGET NEUTRALITY.—
20 Section 1848(c)(2)(B) of the Social Security Act (42
21 U.S.C. 1395w-4(c)(2)(B)) is amended—

22 (1) in clause (ii)(II), by striking “clause (iv)”
23 and inserting “clauses (iv) and (v)”;



1 (2) in clause (iv) in the heading, by inserting
2 “OF CERTAIN ADDITIONAL EXPENDITURES” after
3 “EXEMPTION”; and

4 (3) by adding at the end the following new
5 clause:

6 “(v) EXEMPTION OF CERTAIN RE-
7 DUCED EXPENDITURES FROM BUDGET-
8 NEUTRALITY CALCULATION.—The fol-
9 lowing reduced expenditures, as estimated
10 by the Secretary, shall not be taken into
11 account in applying clause (ii)(II):

12 “(I) REDUCED PAYMENT FOR
13 MULTIPLE IMAGING PROCEDURES.—
14 Effective for fee schedules established
15 beginning with 2007, reduced expendi-
16 tures attributable to the multiple pro-
17 cedure payment reduction for imaging
18 under the final rule published by the
19 Secretary in the Federal Register on
20 November 21, 2005 (42 CFR 405, et
21 al.) insofar as it relates to the physi-
22 cian fee schedules for 2006 and
23 2007.”.



1 (b) REDUCTION IN PHYSICIAN FEE SCHEDULE TO
 2 OPD PAYMENT AMOUNT FOR IMAGING SERVICES.—Sec-
 3 tion 1848 of such Act (42 U.S.C. 1395w-4) is amended—

4 (1) in subsection (b), by adding at the end the
 5 following new paragraph:

6 “(4) SPECIAL RULE FOR IMAGING SERVICES.—

7 “(A) IN GENERAL.—In the case of imaging
 8 services described in subparagraph (B) fur-
 9 nished on or after January 1, 2007, if—

10 “(i) the technical component (includ-
 11 ing the technical component portion of a
 12 global fee) of the service established for a
 13 year under the fee schedule described in
 14 paragraph (1) without application of the
 15 geographic adjustment factor described in
 16 paragraph (1)(C), exceeds

17 “(ii) the medicare OPD fee schedule
 18 amount established under the prospective
 19 payment system for hospital outpatient de-
 20 partment services under paragraph (3)(D)
 21 of section 1833(t) for such service for such
 22 year, determined without regard to geo-
 23 graphic adjustment under paragraph
 24 (2)(D) of such section,



1 the Secretary shall substitute the amount de-
2 scribed in clause (ii), adjusted by the geo-
3 graphic adjustment factor described in para-
4 graph (1)(C), for the fee schedule amount for
5 such technical component for such year.

6 “(B) IMAGING SERVICES DESCRIBED.—For
7 purposes of subparagraph (A), imaging services
8 described in this subparagraph are imaging and
9 computer-assisted imaging services, including
10 X-ray, ultrasound (including echocardiography),
11 nuclear medicine (including positron emission
12 tomography), magnetic resonance imaging,
13 computed tomography, and fluoroscopy, but ex-
14 cluding diagnostic and screening mammog-
15 raphy.”; and

16 (2) in subsection (c)(2)(B)(v), as added by sub-
17 section (a)(3), by adding at the end the following
18 new subclause:

19 “(II) OPD PAYMENT CAP FOR
20 IMAGING SERVICES.—Effective for fee
21 schedules established beginning with
22 2007, reduced expenditures attrib-
23 utable to subsection (b)(4).”.



1 **SEC. 5103. LIMITATION ON PAYMENTS FOR PROCEDURES**
2 **IN AMBULATORY SURGICAL CENTERS.**

3 Section 1833(i)(2) of the Social Security Act (42
4 U.S.C. 1395l(i)(2)) is amended—

5 (1) in subparagraph (A), by inserting “subject
6 to subparagraph (E),” after “subparagraph (D),”;

7 (2) in subparagraph (D)(ii), by inserting before
8 the period at the end the following: “and taking into
9 account reduced expenditures that would apply if
10 subparagraph (E) were to continue to apply, as esti-
11 mated by the Secretary”; and

12 (3) by adding at the end the following new sub-
13 paragraph:

14 “(E) With respect to surgical procedures furnished
15 on or after January 1, 2007, and before the effective date
16 of the implementation of a revised payment system under
17 subparagraph (D), if—

18 “(i) the standard overhead amount under sub-
19 paragraph (A) for a facility service for such proce-
20 dure, without the application of any geographic ad-
21 justment, exceeds

22 “(ii) the medicare OPD fee schedule amount es-
23 tablished under the prospective payment system for
24 hospital outpatient department services under para-
25 graph (3)(D) of section 1833(t) for such service for

1 such year, determined without regard to geographic
2 adjustment under paragraph (2)(D) of such section,
3 the Secretary shall substitute under subparagraph (A) the
4 amount described in clause (ii) for the standard overhead
5 amount for such service referred to in clause (i).”.

6 **SEC. 5104. UPDATE FOR PHYSICIANS' SERVICES FOR 2006.**

7 (a) **UPDATE FOR 2006.**—Section 1848(d) of the So-
8 cial Security Act (42 U.S.C. 1395w-4(d)) is amended—

9 (1) in paragraph (4)(B), in the matter pre-
10 ceeding clause (i), by striking “paragraph (5)” and
11 inserting “paragraphs (5) and (6)”; and

12 (2) by adding at the end the following new
13 paragraph:

14 “(6) **UPDATE FOR 2006.**—The update to the
15 single conversion factor established in paragraph
16 (1)(C) for 2006 shall be 0 percent.”.

17 (b) **NOT TREATED AS CHANGE IN LAW AND REGULA-**
18 **TION IN SUSTAINABLE GROWTH RATE DETERMINA-**
19 **TION.**—The amendments made by subsection (a) shall not
20 be treated as a change in law for purposes of applying
21 section 1848(f)(2)(D) of the Social Security Act (42
22 U.S.C. 1395w-4(f)(2)(D)).

23 (c) **MEDPAC REPORT.**—

24 (1) **IN GENERAL.**—By not later than March 1,
25 2007, the Medicare Payment Advisory Commission



1 shall submit a report to Congress on mechanisms
2 that could be used to replace the sustainable growth
3 rate system under section 1848(f) of the Social Se-
4 curity Act (42 U.S.C. 1395w-4(f)).

5 (2) REQUIREMENTS.—The report required
6 under paragraph (1) shall—

7 (A) identify and examine alternative meth-
8 ods for assessing volume growth;

9 (B) review options to control the volume of
10 physicians' services under the Medicare pro-
11 gram while maintaining access to such services
12 by Medicare beneficiaries;

13 (C) examine the application of volume con-
14 trols under the Medicare physician fee schedule
15 under section 1848 of the Social Security Act
16 (42 U.S.C. 1395w-4);

17 (D) identify levels of application of volume
18 controls, such as group practice, hospital med-
19 ical staff, type of service, geographic area, and
20 outliers;

21 (E) examine the administrative feasibility
22 of implementing the options reviewed under
23 subparagraph (B), including the availability of
24 data and time lags;

1 (F) examine the extent to which the alter-
2 native methods identified and examined under
3 subparagraph (A) should be specified in such
4 section 1848; and

5 (G) identify the appropriate level of discre-
6 tion for the Secretary of Health and Human
7 Services to change payment rates under the
8 Medicare physician fee schedule or otherwise
9 take steps that affect physician behavior.

10 Such report shall include such recommendations on
11 alternative mechanisms to replace the sustainable
12 growth rate system as the Medicare Payment Advi-
13 sory Commission determines appropriate.

14 (3) FUNDING.—Out of any funds in the Treas-
15 ury not otherwise appropriated, there are appro-
16 priated to the Medicare Payment Advisory Commis-
17 sion \$550,000, to carry out this subsection.

18 **SEC. 5105. THREE-YEAR TRANSITION OF HOLD HARMLESS**
19 **PAYMENTS FOR SMALL RURAL HOSPITALS**
20 **UNDER THE PROSPECTIVE PAYMENT SYSTEM**
21 **FOR HOSPITAL OUTPATIENT DEPARTMENT**
22 **SERVICES.**

23 Section 1833(t)(7)(D)(i) of the Social Security Act
24 (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

25 (1) by inserting “(I)” before “In the case”; and



1 (2) by adding at the end the following new sub-
2 clause:

3 “(II) In the case of a hospital located
4 in a rural area and that has not more than
5 100 beds and that is not a sole community
6 hospital (as defined in section
7 1886(d)(5)(D)(iii)), for covered OPD serv-
8 ices furnished on or after January 1, 2006,
9 and before January 1, 2009, for which the
10 PPS amount is less than the pre-BBA
11 amount, the amount of payment under this
12 subsection shall be increased by the appli-
13 cable percentage of the amount of such dif-
14 ference. For purposes of the previous sen-
15 tence, with respect to covered OPD serv-
16 ices furnished during 2006, 2007, or 2008,
17 the applicable percentage shall be 95 per-
18 cent, 90 percent, and 85 percent, respec-
19 tively.”.

20 **SEC. 5106. UPDATE TO THE COMPOSITE RATE COMPONENT**
21 **OF THE BASIC CASE-MIX ADJUSTED PRO-**
22 **SPECTIVE PAYMENT SYSTEM FOR DIALYSIS**
23 **SERVICES.**

24 Section 1881(b)(12) of the Social Security Act (42
25 U.S.C. 1395rr(b)(12)) is amended—



1 (1) in subparagraph (F), in the flush matter at
2 the end, by striking “Nothing” and inserting “Ex-
3 cept as provided in subparagraph (G), nothing”;

4 (2) by redesignating subparagraph (G) as sub-
5 paragraph (H); and

6 (3) by inserting after subparagraph (F) the fol-
7 lowing new subparagraph:

8 “(G) The Secretary shall increase the amount of the
9 composite rate component of the basic case-mix adjusted
10 system under subparagraph (B) for dialysis services fur-
11 nished on or after January 1, 2006, by 1.6 percent above
12 the amount of such composite rate component for such
13 services furnished on December 31, 2005.”.

14 **SEC. 5107. REVISIONS TO PAYMENTS FOR THERAPY SERV-**
15 **ICES.**

16 (a) **EXCEPTION TO CAPS FOR 2006.—**

17 (1) **IN GENERAL.—**Section 1833(g) of the So-
18 cial Security Act (42 U.S.C. 1395l(g)) is amended—

19 (A) in each of paragraphs (1) and (3), by
20 striking “paragraph (4)” and inserting “para-
21 graphs (4) and (5)”;

22 (B) by adding at the end the following new
23 paragraph:

24 “(5) With respect to expenses incurred during 2006
25 for services, the Secretary shall implement a process under

1 which an individual enrolled under this part may, upon
2 request of the individual or a person on behalf of the indi-
3 vidual, obtain an exception from the uniform dollar limita-
4 tion specified in paragraph (2), for services described in
5 paragraphs (1) and (3) if the provision of such services
6 is determined to be medically necessary. Under such proc-
7 ess, if the Secretary does not make a decision on such
8 a request for an exception within 10 business days of the
9 date of the Secretary's receipt of the request, the Sec-
10 retary shall be deemed to have found the services to be
11 medically necessary."

12 (2) TIMELY IMPLEMENTATION.—The Secretary
13 of Health and Human Services shall waive such pro-
14 visions of law and regulation (including those de-
15 scribed in section 110(c) of Public Law 108-173) as
16 are necessary to implement the amendments made
17 by paragraph (1) on a timely basis and, notwith-
18 standing any other provision of law, may implement
19 such amendments by program instruction or other-
20 wise. There shall be no administrative or judicial re-
21 view under section 1869 or section 1878 of the So-
22 cial Security Act (42 U.S.C. 1395ff and 1395oo), or
23 otherwise of the process (including the establishment
24 of the process) under section 1833(g)(5) of such
25 Act, as added by paragraph (1).



1 (b) IMPLEMENTATION OF CLINICALLY APPROPRIATE
2 CODE EDITS IN ORDER TO IDENTIFY AND ELIMINATE
3 IMPROPER PAYMENTS FOR THERAPY SERVICES.—By not
4 later than July 1, 2006, the Secretary of Health and
5 Human Services shall implement clinically appropriate
6 code edits with respect to payments under part B of title
7 XVIII of the Social Security Act for physical therapy serv-
8 ices, occupational therapy services, and speech-language
9 pathology services in order to identify and eliminate im-
10 proper payments for such services, including edits of clini-
11 cally illogical combinations of procedure codes and other
12 edits to control inappropriate billings.

13 **CHAPTER 2—MISCELLANEOUS**

14 **SEC. 5111. ACCELERATED IMPLEMENTATION OF INCOME-**
15 **RELATED REDUCTION IN PART B PREMIUM**
16 **SUBSIDY.**

17 Section 1839(i)(3)(B) of the Social Security Act (42
18 U.S.C. 1395r(i)(3)(B)) is amended—

19 (1) in the heading, by striking “5-YEAR” and
20 inserting “3-YEAR”;

21 (2) in the matter preceding clause (i), by strik-
22 ing “2011” and inserting “2009”;

23 (3) in clause (i), by striking “20 percent” and
24 inserting “33 percent”;



1 (4) in clause (ii), by striking “40 percent” and
2 inserting “67 percent”; and
3 (5) by striking clauses (iii) and (iv).

4 **SEC. 5112. MEDICARE COVERAGE OF ULTRASOUND**
5 **SCREENING FOR ABDOMINAL AORTIC ANEU-**
6 **RYSMS.**

7 (a) IN GENERAL.—Section 1861 of the Social Secu-
8 rity Act (42 U.S.C. 1395x) is amended—

9 (1) in subsection (s)(2)—

10 (A) by striking “and” at the end of sub-
11 paragraph (Y);

12 (B) by adding “and” at the end of sub-
13 paragraph (Z) and moving such subparagraph
14 2 ems to the left; and

15 (C) by adding at the end the following new
16 subparagraph:

17 “(AA) ultrasound screening for abdominal aor-
18 tic aneurysm (as defined in subsection (bbb)) for an
19 individual—

20 “(i) who receives a referral for such an
21 ultrasound screening as a result of an initial
22 preventive physical examination (as defined in
23 section 1861(w)(1));



1 “(ii) who has not been previously furnished
 2 such an ultrasound screening under this title;
 3 and

4 “(iii) who—

5 “(I) has a family history of abdominal
 6 aortic aneurysm; or

7 “(II) manifests risk factors included
 8 in a beneficiary category recommended for
 9 screening by the United States Preventive
 10 Services Task Force regarding abdominal
 11 aortic aneurysms;” and

12 (2) by adding at the end the following new sub-
 13 section:

14 “Ultrasound Screening for Abdominal Aortic Aneurysm

15 “(bbb) The term ‘ultrasound screening for abdominal
 16 aortic aneurysm’ means—

17 “(1) a procedure using sound waves (or such
 18 other procedures using alternative technologies, of
 19 commensurate accuracy and cost, that the Secretary
 20 may specify) provided for the early detection of ab-
 21 dominal aortic aneurysm; and

22 “(2) includes a physician’s interpretation of the
 23 results of the procedure.”.

24 (b) INCLUSION OF ULTRASOUND SCREENING FOR
 25 ABDOMINAL AORTIC ANEURYSM IN INITIAL PREVENTIVE



1 PHYSICAL EXAMINATION.—Section 1861(ww)(2) of such
2 Act (42 U.S.C. 1395x(ww)(2)) is amended by adding at
3 the end the following new subparagraph:

4 “(L) Ultrasound screening for abdominal aortic
5 aneurysm as defined in section 1861(bbb).”

6 (c) PAYMENT FOR ULTRASOUND SCREENING FOR
7 ABDOMINAL AORTIC ANEURYSM.—Section 1848(j)(3) of
8 such Act (42 U.S.C. 1395w-4(j)(3)) is amended by insert-
9 ing “(2)(AA),” after “(2)(W),”

10 (d) FREQUENCY.—Section 1862(a)(1) of such Act
11 (42 U.S.C. 1395y(a)(1)) is amended—

12 (1) by striking “and” at the end of subpara-
13 graph (L);

14 (2) by striking the semicolon at the end of sub-
15 paragraph (M) and inserting “, and”; and

16 (3) by adding at the end the following new sub-
17 paragraph:

18 “(N) in the case of ultrasound screening for ab-
19 dominal aortic aneurysm which is performed more
20 frequently than is provided for under section
21 1861(s)(2)(AA);”

22 (e) NON-APPLICATION OF PART B DEDUCTIBLE.—
23 Section 1833(b) of such Act (42 U.S.C. 1395l(b)) is
24 amended in the first sentence—

25 (1) by striking “and” before “(6)”; and



1 (2) by inserting “, and (7) such deductible shall
2 not apply with respect to ultrasound screening for
3 abdominal aortic aneurysm (as defined in section
4 1861(bbb))” before the period at the end.

5 (f) EFFECTIVE DATE.—The amendments made by
6 this section shall apply to services furnished on or after
7 January 1, 2007.

8 **SEC. 5113. IMPROVING PATIENT ACCESS TO, AND UTILIZA-**
9 **TION OF, COLORECTAL CANCER SCREENING.**

10 (a) NON-APPLICATION OF DEDUCTIBLE FOR
11 COLORECTAL CANCER SCREENING TESTS.—Section
12 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)),
13 as amended by section 5112(e), is amended in the first
14 sentence—

15 (1) by striking “and” before “(7)”; and

16 (2) by inserting “, and (8) such deductible shall
17 not apply with respect to colorectal cancer screening
18 tests (as described in section 1861(pp)(1))” before
19 the period at the end.

20 (b) CONFORMING AMENDMENTS.—Paragraphs
21 (2)(C)(ii) and (3)(C)(ii) of section 1834(d) of such Act
22 (42 U.S.C. 1395m(d)) are each amended—

23 (1) by striking “DEDUCTIBLE AND” in the
24 heading; and

1 (2) in subclause (I), by striking “deductible or”
2 each place it appears.

3 (c) EFFECTIVE DATE.—The amendments made by
4 this section shall apply to services furnished on or after
5 January 1, 2007.

6 **SEC. 5114. DELIVERY OF SERVICES AT FEDERALLY QUALI-**
7 **FIED HEALTH CENTERS.**

8 (a) COVERAGE.—

9 (1) IN GENERAL.—Section 1861(aa)(3) of the
10 Social Security Act (42 U.S.C. 1395x(aa)(3)) is
11 amended—

12 (A) in subparagraph (A), by striking “,
13 and” and inserting “and services described in
14 subsections (qq) and (vv); and”;

15 (B) in subparagraph (B), by striking “sec-
16 tions 329, 330, and 340” and inserting “section
17 330”; and

18 (C) in the flush matter at the end, by in-
19 serting “by the center or by a health care pro-
20 fessional under contract with the center” after
21 “outpatient of a Federally qualified health cen-
22 ter”.

23 (2) CONSOLIDATED BILLING.—The first sen-
24 tence of section 1842(b)(6)(F) of such Act (42
25 U.S.C. 1395u(b)(6)(F)) is amended—



1 (A) by striking “and (G)” and inserting
2 “(G)”; and

3 (B) by inserting before the period at the
4 end the following: “, and (H) in the case of
5 services described in section 1861(aa)(3) that
6 are furnished by a health care professional
7 under contract with a Federally qualified health
8 center, payment shall be made to the center”.

9 (b) TECHNICAL CORRECTIONS.—Clauses (i) and
10 (ii)(II) of section 1861(aa)(4)(A) of such Act (42 U.S.C.
11 1395x(aa)(4)(A)) are each amended by striking “(other
12 than subsection (h))”.

13 (c) EFFECTIVE DATES.—The amendments made by
14 this section shall apply to services furnished on or after
15 January 1, 2006.

16 **SEC. 5115. WAIVER OF PART B LATE ENROLLMENT PEN-**
17 **ALTY FOR CERTAIN INTERNATIONAL VOLUN-**
18 **TEERS.**

19 (a) IN GENERAL.—

20 (1) WAIVER OF PENALTY.—Section 1839(b) of
21 the Social Security Act (42 U.S.C. 1395r(b)) is
22 amended in the second sentence by inserting the fol-
23 lowing before the period at the end: “or months for
24 which the individual can demonstrate that the indi-



1 vidual was an individual described in section
2 1837(k)(3)”.

3 (2) SPECIAL ENROLLMENT PERIOD.—

4 (A) IN GENERAL.—Section 1837 of such
5 Act (42 U.S.C. 1395p) is amended by adding at
6 the end the following new subsection:

7 “(k)(1) In the case of an individual who—

8 “(A) at the time the individual first satisfies
9 paragraph (1) or (2) of section 1836, is described in
10 paragraph (3), and has elected not to enroll (or to
11 be deemed enrolled) under this section during the in-
12 dividual’s initial enrollment period; or

13 “(B) has terminated enrollment under this sec-
14 tion during a month in which the individual is de-
15 scribed in paragraph (3),

16 there shall be a special enrollment period described in
17 paragraph (2).

18 “(2) The special enrollment period described in this
19 paragraph is the 6-month period beginning on the first
20 day of the month which includes the date that the indi-
21 vidual is no longer described in paragraph (3).

22 “(3) For purposes of paragraph (1), an individual de-
23 scribed in this paragraph is an individual who—

24 “(A) is serving as a volunteer outside of the
25 United States through a program—

1 “(i) that covers at least a 12-month period;
2 and

3 “(ii) that is sponsored by an organization
4 described in section 501(c)(3) of the Internal
5 Revenue Code of 1986 and exempt from tax-
6 ation under section 501(a) of such Code; and

7 “(B) demonstrates health insurance coverage
8 while serving in the program.”.

9 (B) COVERAGE PERIOD.—Section 1838 of
10 such Act (42 U.S.C. 1395q) is amended by add-
11 ing at the end the following new subsection:

12 “(f) Notwithstanding subsection (a), in the case of
13 an individual who enrolls during a special enrollment pe-
14 riod pursuant to section 1837(k), the coverage period shall
15 begin on the first day of the month following the month
16 in which the individual so enrolls.”.

17 (b) EFFECTIVE DATE.—The amendment made by
18 subsection (a)(1) shall apply to months beginning with
19 January 2007 and the amendments made by subsection
20 (a)(2) shall take effect on January 1, 2007.



1 **Subtitle C—Provisions Relating to**
2 **Parts A and B**

3 **SEC. 5201. HOME HEALTH PAYMENTS.**

4 (a) 2006 UPDATE.—Section 1895(b)(3)(B)(ii) of the
5 Social Security Act (42 U.S.C. 1395fff(b)(3)(B)(ii)) is
6 amended—

7 (1) in subclause (III), by striking “each of
8 2005 and 2006” and inserting “all of 2005”;

9 (2) by striking “or” at the end of subclause
10 (III);

11 (3) in subclause (IV), by striking “2007 and”
12 and by redesignating such subclause as subclause
13 (V); and

14 (4) by inserting after subclause (III) the fol-
15 lowing new subclause:

16 “(IV) 2006, 0 percent; and”.

17 (b) APPLYING RURAL ADD-ON POLICY FOR 2006.—
18 Section 421(a) of Medicare Prescription Drug, Improve-
19 ment, and Modernization Act of 2003 (Public Law 108-
20 173; 117 Stat. 2283) is amended by inserting “and epi-
21 sodes and visits beginning on or after January 1, 2006,
22 and before January 1, 2007,” after “April 1, 2005.”

23 (c) HOME HEALTH CARE QUALITY IMPROVEMENT.—

24 Section 1895(b)(3)(B) of the Social Security Act (42
25 U.S.C.fff(b)(3)(B)) is amended—

1 (1) in clause (ii)(V), as redesignated by sub-
 2 section (a)(3), by inserting “subject to clause (v),”
 3 after “subsequent year,”; and

4 (2) by adding at the end the following new
 5 clause:

6 “(v) ADJUSTMENT IF QUALITY DATA
 7 NOT SUBMITTED.—

8 “(I) ADJUSTMENT.—For pur-
 9 poses of clause (ii)(V), for 2007 and
 10 each subsequent year, in the case of a
 11 home health agency that does not sub-
 12 mit data to the Secretary in accord-
 13 ance with subclause (II) with respect
 14 to such a year, the home health mar-
 15 ket basket percentage increase appli-
 16 cable under such clause for such year
 17 shall be reduced by 2 percentage
 18 points. Such reduction shall apply
 19 only with respect to the year involved,
 20 and the Secretary shall not take into
 21 account such reduction in computing
 22 the prospective payment amount
 23 under this section for a subsequent
 24 year, and the Medicare Payment Advi-
 25 sory Commission shall carry out the



1 requirements under section 5201(d) of
2 the Deficit Reduction Act of 2005.

3 “(II) SUBMISSION OF QUALITY
4 DATA.—For 2007 and each subse-
5 quent year, each home health agency
6 shall submit to the Secretary such
7 data that the Secretary determines
8 are appropriate for the measurement
9 of health care quality. Such data shall
10 be submitted in a form and manner,
11 and at a time, specified by the Sec-
12 retary for purposes of this clause.

13 “(III) PUBLIC AVAILABILITY OF
14 DATA SUBMITTED.—The Secretary
15 shall establish procedures for making
16 data submitted under subclause (II)
17 available to the public. Such proce-
18 dures shall ensure that a home health
19 agency has the opportunity to review
20 the data that is to be made public
21 with respect to the agency prior to
22 such data being made public.”.

23 (d) MEDPAC REPORT ON VALUE BASED PUR-
24 CHASING.—



1 (1) IN GENERAL.—Not later than June 1,
2 2007, the Medicare Payment Advisory Commission
3 shall submit to Congress a report that includes rec-
4 ommendations on a detailed structure of value based
5 payment adjustments for home health services under
6 the Medicare program under title XVIII of the So-
7 cial Security Act. Such report shall include rec-
8 ommendations concerning the determination of
9 thresholds, the size of such payments, sources of
10 funds, and the relationship of payments for improve-
11 ment and attainment of quality.

12 (2) FUNDING.—Out of any funds in the Treas-
13 ury not otherwise appropriated, there are appro-
14 priated to the Medicare Payment Advisory Commis-
15 sion \$550,000, to carry out this subsection.

16 **SEC. 5202. REVISION OF PERIOD FOR PROVIDING PAYMENT**
17 **FOR CLAIMS THAT ARE NOT SUBMITTED**
18 **ELECTRONICALLY.**

19 (a) REVISION.—

20 (1) PART A.—Section 1816(e)(3)(B)(ii) of the
21 Social Security Act (42 U.S.C. 1395h(e)(3)(B)(ii)) is
22 amended by striking “26 days” and inserting “28
23 days”.



1 (2) PART B.—Section 1842(c)(3)(B)(ii) of such
2 Act (42 U.S.C. 1395u(c)(3)(B)(ii)) is amended by
3 striking “26 days” and inserting “28 days”.

4 (b) EFFECTIVE DATE.—The amendments made by
5 this section shall apply to claims submitted on or after
6 January 1, 2006.

7 **SEC. 5203. TIMEFRAME FOR PART A AND B PAYMENTS.**

8 Notwithstanding sections 1816(c) and 1842(e)(2) of
9 the Social Security Act or any other provision of law—

10 (1) any payment from the Federal Hospital In-
11 surance Trust Fund under section 1817 of the So-
12 cial Security Act (42 U.S.C. 1395i) or from the Fed-
13 eral Supplementary Medical Insurance Trust Fund
14 under section 1841 of such Act (42 U.S.C. 1395t)
15 for claims submitted under part A or B of title
16 XVIII of such Act for items and services furnished
17 under such part A or B, respectively, that would
18 otherwise be payable during the period beginning on
19 September 22, 2006, and ending on September 30,
20 2006, shall be paid on the first business day of Oc-
21 tober 2006; and

22 (2) no interest or late penalty shall be paid to
23 an entity or individual for any delay in a payment
24 by reason of the application of paragraph (1).



1 **SEC. 5204. MEDICARE INTEGRITY PROGRAM FUNDING.**

2 Section 1817(k)(4) of the Social Security Act (42
3 U.S.C. 1395i(k)(4)) is amended—

4 (1) in subparagraph (B), by striking “The
5 amount” and inserting “Subject to subparagraph
6 (C), the amount”; and

7 (2) by adding at the end the following new sub-
8 paragraph:

9 “(C) ADJUSTMENTS.—The amount appro-
10 priated under subparagraph (A) for a fiscal
11 year is increased as follows:

12 “(i) For fiscal year 2006,
13 \$100,000,000.”

14 **Subtitle D—Provisions Relating to**
15 **Part C**

16 **SEC. 5301. PHASE-OUT OF RISK ADJUSTMENT BUDGET NEU-**
17 **TRALITY IN DETERMINING THE AMOUNT OF**
18 **PAYMENTS TO MEDICARE ADVANTAGE ORGA-**
19 **NIZATIONS.**

20 (a) IN GENERAL.—Section 1853 of the Social Secu-
21 rity Act (42 U.S.C. 1395w-23) is amended—

22 (1) in subsection (j)(1)—

23 (A) in subparagraph (A)—

24 (i) by inserting “(or, beginning with
25 2007, $\frac{1}{12}$ of the applicable amount deter-



1 mined under subsection (k)(1))” after
2 “1853(c)(1)”; and

3 (ii) by inserting “(for years before
4 2007)” after “adjusted as appropriate”;

5 (B) in subparagraph (B), by inserting
6 “(for years before 2007)” after “adjusted as
7 appropriate”; and

8 (2) by adding at the end the following new sub-
9 section:

10 “(k) DETERMINATION OF APPLICABLE AMOUNT FOR
11 PURPOSES OF CALCULATING THE BENCHMARK
12 AMOUNTS.—

13 “(1) APPLICABLE AMOUNT DEFINED.—For
14 purposes of subsection (j), subject to paragraph (2),
15 the term ‘applicable amount’ means for an area—

16 “(A) for 2007—

17 “(i) if such year is not specified under
18 subsection (c)(1)(D)(ii), an amount equal
19 to the amount specified in subsection
20 (c)(1)(C) for the area for 2006—

21 “(I) first adjusted by the re-
22 scaling factor for 2006 for the area
23 (as made available by the Secretary in
24 the announcement of the rates on
25 April 4, 2005, under subsection



1 (b)(1), but excluding any national ad-
2 justment factors for coding intensity
3 and risk adjustment budget neutrality
4 that were included in such factor);
5 and

6 “(II) then increased by the na-
7 tional per capita MA growth percent-
8 age, described in subsection (c)(6) for
9 2007, but not taking into account any
10 adjustment under subparagraph (C)
11 of such subsection for a year before
12 2004;

13 “(ii) if such year is specified under
14 subsection (c)(1)(D)(ii), an amount equal
15 to the greater of—

16 “(I) the amount determined
17 under clause (i) for the area for the
18 year; or

19 “(II) the amount specified in
20 subsection (c)(1)(D) for the area for
21 the year; and

22 “(B) for a subsequent year—

23 “(i) if such year is not specified under
24 subsection (c)(1)(D)(ii), an amount equal
25 to the amount determined under this para-



1 graph for the area for the previous year
 2 (determined without regard to paragraph
 3 (2)), increased by the national per capita
 4 MA growth percentage, described in sub-
 5 section (c)(6) for that succeeding year, but
 6 not taking into account any adjustment
 7 under subparagraph (C) of such subsection
 8 for a year before 2004; and

9 “(ii) if such year is specified under
 10 subsection (c)(1)(D)(ii), an amount equal
 11 to the greater of—

12 “(I) the amount determined
 13 under clause (i) for the area for the
 14 year; or

15 “(II) the amount specified in
 16 subsection (c)(1)(D) for the area for
 17 the year.

18 “(2) PHASE-OUT OF BUDGET NEUTRALITY FAC-
 19 TOR.—

20 “(A) IN GENERAL.—Except as provided in
 21 subparagraph (D), in the case of 2007 through
 22 2010, the applicable amount determined under
 23 paragraph (1) shall be multiplied by a factor
 24 equal to 1 plus the product of—



1 “(i) the percent determined under
2 subparagraph (B) for the year; and

3 “(ii) the applicable phase-out factor
4 for the year under subparagraph (C).

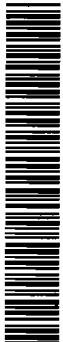
5 “(B) PERCENT DETERMINED.—

6 “(i) IN GENERAL.—For purposes of
7 subparagraph (A)(i), subject to clause (iv),
8 the percent determined under this subpara-
9 graph for a year is a percent equal to a
10 fraction the numerator of which is de-
11 scribed in clause (ii) and the denominator
12 of which is described in clause (iii).

13 “(ii) NUMERATOR BASED ON DIF-
14 ERENCE BETWEEN DEMOGRAPHIC RATE
15 AND RISK RATE.—

16 “(I) IN GENERAL.—The numer-
17 ator described in this clause is an
18 amount equal to the amount by which
19 the demographic rate described in
20 subclause (II) exceeds the risk rate
21 described in subclause (III).

22 “(II) DEMOGRAPHIC RATE.—The
23 demographic rate described in this
24 subclause is the Secretary’s estimate
25 of the total payments that would have



1 been made under this part in the year
2 if all the monthly payment amounts
3 for all MA plans were equal to $\frac{1}{12}$ of
4 the annual MA capitation rate under
5 subsection (c)(1) for the area and
6 year, adjusted pursuant to subsection
7 (a)(1)(C).

8 “(III) RISK RATE.—The risk rate
9 described in this subclause is the Sec-
10 retary’s estimate of the total pay-
11 ments that would have been made
12 under this part in the year if all the
13 monthly payment amounts for all MA
14 plans were equal to the amount de-
15 scribed in subsection (j)(1)(A) (deter-
16 mined as if this paragraph had not
17 applied) under subsection (j) for the
18 area and year, adjusted pursuant to
19 subsection (a)(1)(C).

20 “(iii) DENOMINATOR BASED ON RISK
21 RATE.—The denominator described in this
22 clause is equal to the total amount esti-
23 mated for the year under clause (ii)(III).



1 “(iv) REQUIREMENTS.—In estimating
2 the amounts under the previous clauses,
3 the Secretary shall—

4 “(I) use a complete set of the
5 most recent and representative Medi-
6 care Advantage risk scores under sub-
7 section (a)(3) that are available from
8 the risk adjustment model announced
9 for the year;

10 “(II) adjust the risk scores to re-
11 flect changes in treatment and coding
12 practices in the fee-for-service sector;

13 “(III) adjust the risk scores for
14 differences in coding patterns between
15 Medicare Advantage plans and pro-
16 viders under the original medicare fee-
17 for-service program under parts A and
18 B to the extent that the Secretary has
19 identified such differences, as required
20 in subsection (a)(1)(C);

21 “(IV) as necessary, adjust the
22 risk scores for late data submitted by
23 Medicare Advantage organizations;

24 “(V) as necessary, adjust the risk
25 scores for lagged cohorts; and



1 “(VI) as necessary, adjust the
2 risk scores for changes in enrollment
3 in Medicare Advantage plans during
4 the year.

5 “(v) AUTHORITY.—In computing such
6 amounts the Secretary may take into ac-
7 count the estimated health risk of enrollees
8 in preferred provider organization plans
9 (including MA regional plans) for the year.

10 “(C) APPLICABLE PHASE-OUT FACTOR.—
11 For purposes of subparagraph (A)(ii), the term
12 ‘applicable phase-out factor’ means—

13 “(i) for 2007, 0.55;

14 “(ii) for 2008, 0.40;

15 “(iii) for 2009, 0.25; and

16 “(iv) for 2010, 0.05.

17 “(D) TERMINATION OF APPLICATION.—
18 Subparagraph (A) shall not apply in a year if
19 the amount estimated under subparagraph
20 (B)(ii)(III) for the year is equal to or greater
21 than the amount estimated under subparagraph
22 (B)(ii)(II) for the year.

23 “(3) NO REVISION IN PERCENT.—



1 “(A) IN GENERAL.—The Secretary may
2 not make any adjustment to the percent deter-
3 mined under paragraph (2)(B) for any year.

4 “(B) RULE OF CONSTRUCTION.—Nothing
5 in this subsection shall be construed to limit the
6 authority of the Secretary to make adjustments
7 to the applicable amounts determined under
8 paragraph (1) as appropriate for purposes of
9 updating data or for purposes of adopting an
10 improved risk adjustment methodology.”.

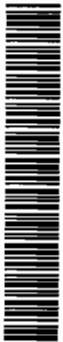
11 (b) REFINEMENTS TO HEALTH STATUS ADJUST-
12 MENT.—Section 1853(a)(1)(C) of such Act (42 U.S.C.
13 1395w-23) is amended—

14 (1) by designating the matter after the heading
15 as a clause (i) with the following heading: “IN GEN-
16 ERAL.—” and indenting appropriately; and

17 (2) by adding at the end the following:

18 “(ii) APPLICATION DURING PHASE-
19 OUT OF BUDGET NEUTRALITY FACTOR.—
20 For 2006 through 2010:

21 “(I) In applying the adjustment
22 under clause (i) for health status to
23 payment amounts, the Secretary shall
24 ensure that such adjustment reflects
25 changes in treatment and coding prac-



1 tices in the fee-for-service sector and
2 reflects differences in coding patterns
3 between Medicare Advantage plans
4 and providers under part A and B to
5 the extent that the Secretary has
6 identified such differences.

7 “(II) In order to ensure payment
8 accuracy, the Secretary shall conduct
9 an analysis of the differences de-
10 scribed in subclause (I). The Sec-
11 retary shall complete such analysis by
12 a date necessary to ensure that the
13 results of such analysis are incor-
14 porated into the risk scores only for
15 2008, 2009, and 2010. In conducting
16 such analysis, the Secretary shall use
17 data submitted with respect to 2004
18 and subsequent years, as available.”

19 **SEC. 5302. RURAL PACE PROVIDER GRANT PROGRAM.**

20 (a) **DEFINITIONS.**—In this section:

21 (1) **CMS.**—The term “CMS” means the Cen-
22 ters for Medicare & Medicaid Services.

23 (2) **PACE PROGRAM.**—The term “PACE pro-
24 gram” has the meaning given that term in sections



1 1894(a)(2) and 1934(a)(2) of the Social Security
2 Act (42 U.S.C. 1395eee(a)(2); 1396u-4(a)(2)).

3 (3) PACE PROVIDER.—The term “PACE pro-
4 vider” has the meaning given that term in section
5 1894(a)(3) or 1934(a)(3) of the Social Security Act
6 (42 U.S.C. 1395eee(a)(3); 1396u-4(a)(3)).

7 (4) RURAL AREA.—The term “rural area” has
8 the meaning given that term in section
9 1886(d)(2)(D) of the Social Security Act (42 U.S.C.
10 1395ww(d)(2)(D)).

11 (5) RURAL PACE PILOT SITE.—The term “rural
12 PACE pilot site” means a PACE provider that has
13 been approved to provide services in a geographic
14 service area that is, in whole or in part, a rural area,
15 and that has received a site development grant
16 under this section.

17 (6) SECRETARY.—The term “Secretary” means
18 the Secretary of Health and Human Services.

19 (b) SITE DEVELOPMENT GRANTS AND TECHNICAL
20 ASSISTANCE PROGRAM.—

21 (1) SITE DEVELOPMENT GRANTS.—

22 (A) IN GENERAL.—The Secretary shall es-
23 tablish a process and criteria to award site de-
24 velopment grants to qualified PACE providers
25 that have been approved to serve a rural area.



1 (B) AMOUNT PER AWARD.—A site develop-
2 ment grant awarded under subparagraph (A) to
3 any individual rural PACE pilot site shall not
4 exceed \$750,000.

5 (C) NUMBER OF AWARDS.—Not more than
6 15 rural PACE pilot sites shall be awarded a
7 site development grant under subparagraph
8 (A).

9 (D) USE OF FUNDS.—Funds made avail-
10 able under a site development grant awarded
11 under subparagraph (A) may be used for the
12 following expenses only to the extent such ex-
13 penses are incurred in relation to establishing
14 or delivering PACE program services in a rural
15 area:

16 (i) Feasibility analysis and planning.

17 (ii) Interdisciplinary team develop-
18 ment.

19 (iii) Development of a provider net-
20 work, including contract development.

21 (iv) Development or adaptation of
22 claims processing systems.

23 (v) Preparation of special education
24 and outreach efforts required for the
25 PACE program.



1 (vi) Development of expense reporting
2 required for calculation of outlier payments
3 or reconciliation processes.

4 (vii) Development of any special qual-
5 ity of care or patient satisfaction data col-
6 lection efforts.

7 (viii) Establishment of a working cap-
8 ital fund to sustain fixed administrative,
9 facility, or other fixed costs until the pro-
10 vider reaches sufficient enrollment size.

11 (ix) Startup and development costs in-
12 curred prior to the approval of the rural
13 PACE pilot site's PACE provider applica-
14 tion by CMS.

15 (x) Any other efforts determined by
16 the rural PACE pilot site to be critical to
17 its successful startup, as approved by the
18 Secretary.

19 (E) APPROPRIATION.—

20 (i) IN GENERAL.—Out of funds in the
21 Treasury not otherwise appropriated, there
22 are appropriated to the Secretary to carry
23 out this subsection for fiscal year 2006,
24 \$7,500,000.



1 (ii) AVAILABILITY.—Funds appro-
2 priated under clause (i) shall remain avail-
3 able for expenditure through fiscal year
4 2008.

5 (2) TECHNICAL ASSISTANCE PROGRAM.—The
6 Secretary shall establish a technical assistance pro-
7 gram to provide—

8 (A) outreach and education to State agen-
9 cies and provider organizations interested in es-
10 tablishing PACE programs in rural areas; and

11 (B) technical assistance necessary to sup-
12 port rural PACE pilot sites.

13 (c) COST OUTLIER PROTECTION FOR RURAL PACE
14 PILOT SITES.—

15 (1) ESTABLISHMENT OF FUND FOR REIM-
16 BURSEMENT OF OUTLIER COSTS.—Notwithstanding
17 any other provision of law, the Secretary shall estab-
18 lish an outlier fund to reimburse rural PACE pilot
19 sites for recognized outlier costs (as defined in para-
20 graph (3)) incurred for eligible outlier participants
21 (as defined in paragraph (2)) in an amount, subject
22 to paragraph (4), equal to 80 percent of the amount
23 by which the recognized outlier costs exceeds
24 \$50,000.



1 (2) ELIGIBLE OUTLIER PARTICIPANT.—For
2 purposes of this subsection, the term “eligible outlier
3 participant” means a PACE program eligible indi-
4 vidual (as defined in sections 1894(a)(5) and
5 1934(a)(5) of the Social Security Act (42 U.S.C.
6 1395eee(a)(5); 1396u–4(a)(5) who resides in a rural
7 area and with respect to whom the rural PACE pilot
8 site incurs more than \$50,000 in recognized costs in
9 a 12-month period.

10 (3) RECOGNIZED OUTLIER COSTS DEFINED.—

11 (A) IN GENERAL.—For purposes of this
12 subsection, the term “recognized outlier costs”
13 means, with respect to services furnished to an
14 eligible outlier participant by a rural PACE
15 pilot site, the least of the following (as docu-
16 mented by the site to the satisfaction of the
17 Secretary) for the provision of inpatient and re-
18 lated physician and ancillary services for the eli-
19 gible outlier participant in a given 12-month pe-
20 riod:

21 (i) If the services are provided under
22 a contract between the pilot site and the
23 provider, the payment rate specified under
24 the contract.



1 (ii) The payment rate established
2 under the original medicare fee-for-service
3 program for such service.

4 (iii) The amount actually paid for the
5 services by the pilot site.

6 (B) INCLUSION IN ONLY ONE PERIOD.—
7 Recognized outlier costs may not be included in
8 more than one 12-month period.

9 (3) OUTLIER EXPENSE PAYMENT.—

10 (A) PAYMENT FOR OUTLIER COSTS.—Sub-
11 ject to subparagraph (B), in the case of a rural
12 PACE pilot site that has incurred outlier costs
13 for an eligible outlier participant, the rural
14 PACE pilot site shall receive an outlier expense
15 payment equal to 80 percent of such costs that
16 exceed \$50,000.

17 (4) LIMITATIONS.—

18 (A) COSTS INCURRED PER ELIGIBLE
19 OUTLIER PARTICIPANT.—The total amount of
20 outlier expense payments made under this sub-
21 section to a rural PACE pilot site with respect
22 to an eligible outlier participant for any 12-
23 month period shall not exceed \$100,000 for the
24 12-month period used to calculate the payment.



1 (B) COSTS INCURRED PER PROVIDER.—No
2 rural PACE pilot site may receive more than
3 \$500,000 in total outlier expense payments in
4 a 12-month period.

5 (C) LIMITATION OF OUTLIER COST REIM-
6 BURSEMENT PERIOD.—A rural PACE pilot site
7 shall only receive outlier expense payments
8 under this subsection with respect to costs in-
9 curred during the first 3 years of the site's op-
10 eration.

11 (5) REQUIREMENT TO ACCESS RISK RESERVES
12 PRIOR TO PAYMENT.—A rural PACE pilot site shall
13 access and exhaust any risk reserves held or ar-
14 ranged for the provider (other than revenue or re-
15 serves maintained to satisfy the requirements of sec-
16 tion 460.80(c) of title 42, Code of Federal Regula-
17 tions) and any working capital established through
18 a site development grant awarded under subsection
19 (b)(1), prior to receiving any payment from the
20 outlier fund.

21 (6) APPLICATION.—In order to receive an
22 outlier expense payment under this subsection with
23 respect to an eligible outlier participant, a rural
24 PACE pilot site shall submit an application
25 containing—

1 (A) documentation of the costs incurred
2 with respect to the participant;

3 (B) a certification that the site has com-
4 plied with the requirements under paragraph
5 (4); and

6 (C) such additional information as the Sec-
7 retary may require.

8 (7) APPROPRIATION.—

9 (A) IN GENERAL.—Out of funds in the
10 Treasury not otherwise appropriated, there are
11 appropriated to the Secretary to carry out this
12 subsection for fiscal year 2006, \$10,000,000.

13 (B) AVAILABILITY.—Funds appropriated
14 under subparagraph (A) shall remain available
15 for expenditure through fiscal year 2010.

16 (d) EVALUATION OF PACE PROVIDERS SERVING
17 RURAL SERVICE AREAS.—Not later than 60 months after
18 the date of enactment of this Act, the Secretary shall sub-
19 mit a report to Congress containing an evaluation of the
20 experience of rural PACE pilot sites.

21 (e) AMOUNTS IN ADDITION TO PAYMENTS UNDER
22 SOCIAL SECURITY ACT.—Any amounts paid under the au-
23 thority of this section to a PACE provider shall be in addi-
24 tion to payments made to the provider under section 1894



- 1 or 1934 of the Social Security Act (42 U.S.C. 1395eee;
- 2 1396u-4).



1 **TITLE VI—MEDICAID AND SCHIP**
 2 **Subtitle A—Medicaid**
 3 **CHAPTER 1—PAYMENT FOR**
 4 **PRESCRIPTION DRUGS**

5 **SEC. 6001. FEDERAL UPPER PAYMENT LIMIT FOR MUL-**
 6 **TIPLE SOURCE DRUGS AND OTHER DRUG**
 7 **PAYMENT PROVISIONS.**

8 (a) MODIFICATION OF FEDERAL UPPER PAYMENT
 9 LIMIT FOR MULTIPLE SOURCE DRUGS; DEFINITION OF
 10 MULTIPLE SOURCE DRUGS.—Section 1927 of the Social
 11 Security Act (42 U.S.C. 1396r-8) is amended—

12 (1) in subsection (e)(4)—

13 (A) by striking “The Secretary” and in-
 14 serting “Subject to paragraph (5), the Sec-
 15 retary”; and

16 (B) by inserting “(or, effective January 1,
 17 2007, two or more)” after “three or more”;

18 (2) by adding at the end of subsection (e) the
 19 following new paragraph:

20 “(5) USE OF AMP IN UPPER PAYMENT LIM-
 21 ITS.—Effective January 1, 2007, in applying the
 22 Federal upper reimbursement limit under paragraph
 23 (4) and section 447.332(b) of title 42 of the Code
 24 of Federal Regulations, the Secretary shall sub-
 25 stitute 250 percent of the average manufacturer



1 price (as computed without regard to customary
2 prompt pay discounts extended to wholesalers) for
3 150 percent of the published price.”;

4 (3) in subsection (k)(7)(A)(i), in the matter
5 preceding subclause (I), by striking “are 2 or more
6 drug products” and inserting “at least 1 other drug
7 product”; and

8 (4) in subclauses (I), (II), and (III) of sub-
9 section (k)(7)(A)(i), by striking “are” and inserting
10 “is” each place it appears.

11 (b) DISCLOSURE OF PRICE INFORMATION TO
12 STATES AND THE PUBLIC.—Subsection (b)(3) of such sec-
13 tion is amended—

14 (1) in subparagraph (A)—

15 (A) in clause (i), by inserting “month of a”
16 after “last day of each”; and

17 (B) by adding at the end the following:
18 “Beginning July 1, 2006, the Secretary shall
19 provide on a monthly basis to States under sub-
20 paragraph (D)(iv) the most recently reported
21 average manufacturer prices for single source
22 drugs and for multiple source drugs and shall,
23 on at least a quarterly basis, update the infor-
24 mation posted on the website under subpara-
25 graph (D)(v).”; and



- 1 (2) in subparagraph (D)—
- 2 (A) by striking “and” at the end of clause
- 3 (ii);
- 4 (B) by striking the period at the end of
- 5 clause (iii) and inserting a comma; and
- 6 (C) by inserting after clause (iii) the fol-
- 7 lowing new clauses:
- 8 “(iv) to States to carry out this title,
- 9 and
- 10 “(v) to the Secretary to disclose
- 11 (through a website accessible to the public)
- 12 average manufacturer prices.”.

13 (c) DEFINITION OF AVERAGE MANUFACTURER
 14 PRICE.—

15 (1) EXCLUSION OF CUSTOMARY PROMPT PAY
 16 DISCOUNTS EXTENDED TO WHOLESALERS.—Sub-
 17 section (k)(1) of such section is amended—

18 (A) by striking “The term” and inserting
 19 the following:

20 “(A) IN GENERAL.—Subject to subpara-
 21 graph (B), the term”;

22 (B) by striking “, after deducting cus-
 23 tomary prompt pay discounts”; and

24 (C) by adding at the end the following:



1 “(B) EXCLUSION OF CUSTOMARY PROMPT
2 PAY DISCOUNTS EXTENDED TO WHOLE-
3 SALERS.—The average manufacturer price for a
4 covered outpatient drug shall be determined
5 without regard to customary prompt pay dis-
6 counts extended to wholesalers.”.

7 (2) MANUFACTURER REPORTING OF PROMPT
8 PAY DISCOUNTS.—Subsection (b)(3)(A)(i) of such
9 section is amended by inserting “, customary prompt
10 pay discounts extended to wholesalers,” after
11 “(k)(1)”.

12 (3) REQUIREMENT TO PROMULGATE REGULA-
13 TION.—

14 (A) INSPECTOR GENERAL RECOMMENDA-
15 TIONS.—Not later than June 1, 2006, the In-
16 spector General of the Department of Health
17 and Human Services shall—

18 (i) review the requirements for, and
19 manner in which, average manufacturer
20 prices are determined under section 1927
21 of the Social Security Act, as amended by
22 this section; and

23 (ii) shall submit to the Secretary of
24 Health and Human Services and Congress
25 such recommendations for changes in such



1 requirements or manner as the Inspector
2 General determines to be appropriate.

3 (B) DEADLINE FOR PROMULGATION.—Not
4 later than July 1, 2007, the Secretary of
5 Health and Human Services shall promulgate a
6 regulation that clarifies the requirements for,
7 and manner in which, average manufacturer
8 prices are determined under section 1927 of the
9 Social Security Act, taking into consideration
10 the recommendations submitted to the Sec-
11 retary in accordance with subparagraph (A)(ii).

12 (d) EXCLUSION OF SALES AT A NOMINAL PRICE
13 FROM DETERMINATION OF BEST PRICE.—

14 (1) MANUFACTURER REPORTING OF SALES.—
15 Subsection (b)(3)(A)(iii) of such section is amended
16 by inserting before the period at the end the fol-
17 lowing: “, and, for calendar quarters beginning on or
18 after January 1, 2007 and only with respect to the
19 information described in subclause (III), for covered
20 outpatient drugs”.

21 (2) LIMITATION ON SALES AT A NOMINAL
22 PRICE.—Subsection (c)(1) of such section is amend-
23 ed by adding at the end the following new subpara-
24 graph:



1 “(D) LIMITATION ON SALES AT A NOMINAL
2 PRICE.—

3 “(i) IN GENERAL.—For purposes of
4 subparagraph (C)(ii)(III) and subsection
5 (b)(3)(A)(iii)(III), only sales by a manufac-
6 turer of covered outpatient drugs at nomi-
7 nal prices to the following shall be consid-
8 ered to be sales at a nominal price or
9 merely nominal in amount:

10 “(I) A covered entity described in
11 section 340B(a)(4) of the Public
12 Health Service Act.

13 “(II) An intermediate care facil-
14 ity for the mentally retarded.

15 “(III) A State-owned or operated
16 nursing facility.

17 “(IV) Any other facility or entity
18 that the Secretary determines is a
19 safety net provider to which sales of
20 such drugs at a nominal price would
21 be appropriate based on the factors
22 described in clause (ii).

23 “(ii) FACTORS.—The factors de-
24 scribed in this clause with respect to a fa-
25 cility or entity are the following:



1 “(I) The type of facility or entity.

2 “(II) The services provided by
3 the facility or entity.

4 “(III) The patient population
5 served by the facility or entity.

6 “(IV) The number of other facili-
7 ties or entities eligible to purchase at
8 nominal prices in the same service
9 area.

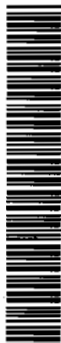
10 “(iii) NONAPPLICATION.—Clause (i)
11 shall not apply with respect to sales by a
12 manufacturer at a nominal price of covered
13 outpatient drugs pursuant to a master
14 agreement under section 8126 of title 38,
15 United States Code.”.

16 (e) RETAIL SURVEY PRICES; STATE PAYMENT AND
17 UTILIZATION RATES; AND PERFORMANCE RANKINGS.—
18 Such section is further amended by inserting after sub-
19 section (e) the following new subsection:

20 “(f) SURVEY OF RETAIL PRICES; STATE PAYMENT
21 AND UTILIZATION RATES; AND PERFORMANCE
22 RANKINGS.—

23 “(1) SURVEY OF RETAIL PRICES.—

24 “(A) USE OF VENDOR.—The Secretary
25 may contract services for—



1 “(i) the determination on a monthly
2 basis of retail survey prices for covered
3 outpatient drugs that represent a nation-
4 wide average of consumer purchase prices
5 for such drugs, net of all discounts and re-
6 bates (to the extent any information with
7 respect to such discounts and rebates is
8 available); and

9 “(ii) the notification of the Secretary
10 when a drug product that is therapeuti-
11 cally and pharmaceutically equivalent and
12 bioequivalent becomes generally available.

13 “(B) SECRETARY RESPONSE TO NOTIFICA-
14 TION OF AVAILABILITY OF MULTIPLE SOURCE
15 PRODUCTS.—If contractor notifies the Secretary
16 under subparagraph (A)(ii) that a drug product
17 described in such subparagraph has become
18 generally available, the Secretary shall make a
19 determination, within 7 days after receiving
20 such notification, as to whether the product is
21 now described in subsection (e)(4).

22 “(C) USE OF COMPETITIVE BIDDING.—In
23 contracting for such services, the Secretary
24 shall competitively bid for an outside vendor
25 that has a demonstrated history in—



1 “(i) surveying and determining, on a
2 representative nationwide basis, retail
3 prices for ingredient costs of prescription
4 drugs;

5 “(ii) working with retail pharmacies,
6 commercial payers, and States in obtaining
7 and disseminating such price information;
8 and

9 “(iii) collecting and reporting such
10 price information on at least a monthly
11 basis.

12 In contracting for such services, the Secretary
13 may waive such provisions of the Federal Ac-
14 quisition Regulation as are necessary for the ef-
15 ficient implementation of this subsection, other
16 than provisions relating to confidentiality of in-
17 formation and such other provisions as the Sec-
18 retary determines appropriate.

19 “(D) ADDITIONAL PROVISIONS.—A con-
20 tract with a vendor under this paragraph shall
21 include such terms and conditions as the Sec-
22 retary shall specify, including the following:

23 “(i) The vendor must monitor the
24 marketplace and report to the Secretary



1 each time there is a new covered outpatient
2 drug generally available.

3 “(ii) The vendor must update the Sec-
4 retary no less often than monthly on the
5 retail survey prices for covered outpatient
6 drugs.

7 “(iii) The contract shall be effective
8 for a term of 2 years.

9 “(E) AVAILABILITY OF INFORMATION TO
10 STATES.—Information on retail survey prices
11 obtained under this paragraph, including appli-
12 cable information on single source drugs, shall
13 be provided to States on at least a monthly
14 basis. The Secretary shall devise and implement
15 a means for providing access to each State
16 agency designated under section 1902(a)(5)
17 with responsibility for the administration or su-
18 pervision of the administration of the State
19 plan under this title of the retail survey price
20 determined under this paragraph.

21 “(2) ANNUAL STATE REPORT.—Each State
22 shall annually report to the Secretary information
23 on—



1 “(A) the payment rates under the State
2 plan under this title for covered outpatient
3 drugs;

4 “(B) the dispensing fees paid under such
5 plan for such drugs; and

6 “(C) utilization rates for noninnovator
7 multiple source drugs under such plan.

8 “(3) ANNUAL STATE PERFORMANCE
9 RANKINGS.—

10 “(A) COMPARATIVE ANALYSIS.—The Sec-
11 retary annually shall compare, for the 50 most
12 widely prescribed drugs identified by the Sec-
13 retary, the national retail sales price data (col-
14 lected under paragraph (1)) for such drugs with
15 data on prices under this title for each such
16 drug for each State.

17 “(B) AVAILABILITY OF INFORMATION.—
18 The Secretary shall submit to Congress and the
19 States full information regarding the annual
20 rankings made under subparagraph (A).

21 “(4) APPROPRIATION.—Out of any funds in the
22 Treasury not otherwise appropriated, there is appro-
23 priated to the Secretary of Health and Human Serv-
24 ices \$5,000,000 for each of fiscal years 2006
25 through 2010 to carry out this subsection.”.



1 (f) MISCELLANEOUS AMENDMENTS.—

2 (1) IN GENERAL.—Sections
3 1927(g)(1)(B)(i)(II) and 1861(t)(2)(B)(ii)(I) of
4 such Act are each amended by inserting “(or its suc-
5 cessor publications)” after “United States Pharma-
6 copoeia-Drug Information”.

7 (2) PAPERWORK REDUCTION.—The last sen-
8 tence of section 1927(g)(2)(A)(ii) of such Act (42
9 U.S.C. 1396r-8(g)(2)(A)(ii)) is amended by insert-
10 ing before the period at the end the following: “, or
11 to require verification of the offer to provide con-
12 sultation or a refusal of such offer”.

13 (3) EFFECTIVE DATE.—The amendments made
14 by this subsection shall take effect on the date of the
15 enactment of this Act.

16 (g) EFFECTIVE DATE.—Except as otherwise pro-
17 vided, the amendments made by this section shall take ef-
18 fect on January 1, 2007, without regard to whether or
19 not final regulations to carry out such amendments have
20 been promulgated by such date.



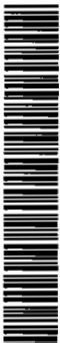
1 **SEC. 6002. COLLECTION AND SUBMISSION OF UTILIZATION**
2 **DATA FOR CERTAIN PHYSICIAN ADMINIS-**
3 **TERED DRUGS.**

4 (a) **IN GENERAL.**—Section 1927(a) of the Social Se-
5 curity Act (42 U.S.C. 1396r-8(a)) is amended by adding
6 at the end the following new paragraph:

7 “(7) **REQUIREMENT FOR SUBMISSION OF UTILI-**
8 **ZATION DATA FOR CERTAIN PHYSICIAN ADMINIS-**
9 **TERED DRUGS.**—

10 “(A) **SINGLE SOURCE DRUGS.**—In order
11 for payment to be available under section
12 1903(a) for a covered outpatient drug that is a
13 single source drug that is physician adminis-
14 tered under this title (as determined by the Sec-
15 retary), and that is administered on or after
16 January 1, 2006, the State shall provide for the
17 collection and submission of such utilization
18 data and coding (such as J-codes and National
19 Drug Code numbers) for each such drug as the
20 Secretary may specify as necessary to identify
21 the manufacturer of the drug in order to secure
22 rebates under this section for drugs adminis-
23 tered for which payment is made under this
24 title.

25 “(B) **MULTIPLE SOURCE DRUGS.**—



1 “(i) IDENTIFICATION OF MOST FRE-
2 QUENTLY PHYSICIAN ADMINISTERED MUL-
3 TIPLE SOURCE DRUGS.—Not later than
4 January 1, 2007, the Secretary shall pub-
5 lish a list of the 20 physician administered
6 multiple source drugs that the Secretary
7 determines have the highest dollar volume
8 of physician administered drugs dispensed
9 under this title. The Secretary may modify
10 such list from year to year to reflect
11 changes in such volume.

12 “(ii) REQUIREMENT.—In order for
13 payment to be available under section
14 1903(a) for a covered outpatient drug that
15 is a multiple source drug that is physician
16 administered (as determined by the Sec-
17 retary), that is on the list published under
18 clause (i), and that is administered on or
19 after January 1, 2008, the State shall pro-
20 vide for the submission of such utilization
21 data and coding (such as J-codes and Na-
22 tional Drug Code numbers) for each such
23 drug as the Secretary may specify as nec-
24 essary to identify the manufacturer of the



1 drug in order to secure rebates under this
2 section.

3 “(C) USE OF NDC CODES.—Not later
4 than January 1, 2007, the information shall be
5 submitted under subparagraphs (A) and (B)(ii)
6 using National Drug Code codes unless the Sec-
7 retary specifies that an alternative coding sys-
8 tem should be used.

9 “(D) HARDSHIP WAIVER.—The Secretary may
10 delay the application of subparagraph (A) or (B)(ii),
11 or both, in the case of a State to prevent hardship
12 to States which require additional time to implement
13 the reporting system required under the respective
14 subparagraph.”.

15 (b) LIMITATION ON PAYMENT.—Section 1903(i)(10)
16 of such Act (42 U.S.C. 1396b(i)(10)), is amended—

17 (1) by striking “and” at the end of subpara-
18 graph (A);

19 (2) by striking “or” at the end of subparagraph
20 (B) and inserting “and”; and

21 (3) by adding at the end the following new sub-
22 paragraph:

23 “(C) with respect to covered outpatient drugs
24 described in section 1927(a)(7), unless information
25 respecting utilization data and coding on such drugs



1 that is required to be submitted under such section
2 is submitted in accordance with such section; or”.

3 **SEC. 6003. IMPROVED REGULATION OF DRUGS SOLD**
4 **UNDER A NEW DRUG APPLICATION AP-**
5 **PROVED UNDER SECTION 505(c) OF THE FED-**
6 **ERAL FOOD, DRUG, AND COSMETIC ACT.**

7 (a) INCLUSION WITH OTHER REPORTED AVERAGE
8 MANUFACTURER AND BEST PRICES.—Section
9 1927(b)(3)(A) of the Social Security Act (42 U.S.C.
10 1396r-8(b)(3)(A)) is amended—

11 (1) by striking clause (i) and inserting the fol-
12 lowing:

13 “(i) not later than 30 days after the
14 last day of each rebate period under the
15 agreement—

16 “(I) on the average manufacturer
17 price (as defined in subsection (k)(1))
18 for covered outpatient drugs for the
19 rebate period under the agreement
20 (including for all such drugs that are
21 sold under a new drug application ap-
22 proved under section 505(c) of the
23 Federal Food, Drug, and Cosmetic
24 Act); and



1 “(II) for single source drugs and
2 innovator multiple source drugs (in-
3 cluding all such drugs that are sold
4 under a new drug application ap-
5 proved under section 505(c) of the
6 Federal Food, Drug, and Cosmetic
7 Act), on the manufacturer’s best price
8 (as defined in subsection (c)(1)(C))
9 for such drugs for the rebate period
10 under the agreement;” and

11 (2) in clause (ii), by inserting “(including for
12 such drugs that are sold under a new drug applica-
13 tion approved under section 505(c) of the Federal
14 Food, Drug, and Cosmetic Act)” after “drugs”.

15 (b) CONFORMING AMENDMENTS.—Section 1927 of
16 such Act (42 U.S.C. 1396r–8) is amended—

17 (1) in subsection (c)(1)(C)—

18 (A) in clause (i), in the matter preceding
19 subclause (I), by inserting after “or innovator
20 multiple source drug of a manufacturer” the
21 following: “(including the lowest price available
22 to any entity for any such drug of a manufac-
23 turer that is sold under a new drug application
24 approved under section 505(c) of the Federal
25 Food, Drug, and Cosmetic Act)”; and



1 (B) in clause (ii)—

2 (i) in subclause (II), by striking
3 “and” at the end;

4 (ii) in subclause (III), by striking the
5 period at the end and inserting “; and”;
6 and

7 (iii) by adding at the end the fol-
8 lowing:

9 “(IV) in the case of a manufac-
10 turer that approves, allows, or other-
11 wise permits any other drug of the
12 manufacturer to be sold under a new
13 drug application approved under sec-
14 tion 505(c) of the Federal Food,
15 Drug, and Cosmetic Act, shall be in-
16 clusive of the lowest price for such au-
17 thorized drug available from the man-
18 ufacturer during the rebate period to
19 any manufacturer, wholesaler, retailer,
20 provider, health maintenance organi-
21 zation, nonprofit entity, or govern-
22 mental entity within the United
23 States, excluding those prices de-
24 scribed in subclauses (I) through (IV)
25 of clause (i).”; and



1 (2) in subsection (k), as amended by section
2 6001(c)(1), by adding at the end the following:

3 “(C) INCLUSION OF SECTION 505(c)
4 DRUGS.—In the case of a manufacturer that
5 approves, allows, or otherwise permits any drug
6 of the manufacturer to be sold under a new
7 drug application approved under section 505(c)
8 of the Federal Food, Drug, and Cosmetic Act,
9 such term shall be inclusive of the average price
10 paid for such drug by wholesalers for drugs dis-
11 tributed to the retail pharmacy class of trade.”.

12 (c) EFFECTIVE DATE.—The amendments made by
13 this section take effect on January 1, 2007.

14 **SEC. 6004. CHILDREN’S HOSPITAL PARTICIPATION IN SEC-**
15 **TION 340B DRUG DISCOUNT PROGRAM.**

16 (a) IN GENERAL.—Section 1927(a)(5)(B) of the So-
17 cial Security Act (42 U.S.C. 1396r–8(a)(5)(B)) is amend-
18 ed by inserting before the period at the end the following:
19 “and a children’s hospital described in section
20 1886(d)(1)(B)(iii) which meets the requirements of
21 clauses (i) and (iii) of section 340B(b)(4)(L) of the Public
22 Health Service Act and which would meet the require-
23 ments of clause (ii) of such section if that clause were ap-
24 plied by taking into account the percentage of care pro-



1 vided by the hospital to patients eligible for medical assist-
2 ance under a State plan under this title”.

3 (b) EFFECTIVE DATE.—The amendment made by
4 subsection (a) shall apply to drugs purchased on or after
5 the date of the enactment of this Act.

6 **CHAPTER 2—LONG-TERM CARE UNDER**
7 **MEDICAID**

8 **Subchapter A—Reform of Asset Transfer**
9 **Rules**

10 **SEC. 6011. LENGTHENING LOOK-BACK PERIOD; CHANGE IN**
11 **BEGINNING DATE FOR PERIOD OF INELIGI-**
12 **BILITY.**

13 (a) LENGTHENING LOOK-BACK PERIOD FOR ALL
14 DISPOSALS TO 5 YEARS.—Section 1917(c)(1)(B)(i) of the
15 Social Security Act (42 U.S.C. 1396p(c)(1)(B)(i)) is
16 amended by inserting “or in the case of any other disposal
17 of assets made on or after the date of the enactment of
18 the Deficit Reduction Act of 2005” before “, 60 months”.

19 (b) CHANGE IN BEGINNING DATE FOR PERIOD OF
20 INELIGIBILITY.—Section 1917(c)(1)(D) of such Act (42
21 U.S.C. 1396p(c)(1)(D)) is amended—

22 (1) by striking “(D) The date” and inserting
23 “(D)(i) In the case of a transfer of asset made be-
24 fore the date of the enactment of the Deficit Reduc-
25 tion Act of 2005, the date”; and



1 (2) by adding at the end the following new
2 clause:

3 “(ii) In the case of a transfer of asset made on or
4 after the date of the enactment of the Deficit Reduction
5 Act of 2005, the date specified in this subparagraph is
6 the first day of a month during or after which assets have
7 been transferred for less than fair market value, or the
8 date on which the individual is eligible for medical assist-
9 ance under the State plan and would otherwise be receiv-
10 ing institutional level care described in subparagraph (C)
11 based on an approved application for such care but for
12 the application of the penalty period, whichever is later,
13 and which does not occur during any other period of ineli-
14 gibility under this subsection.”.

15 (c) EFFECTIVE DATE.—The amendments made by
16 this section shall apply to transfers made on or after the
17 date of the enactment of this Act.

18 (d) AVAILABILITY OF HARDSHIP WAIVERS.—Each
19 State shall provide for a hardship waiver process in ac-
20 cordance with section 1917(c)(2)(D) of the Social Security
21 Act (42 U.S.C. 1396p(c)(2)(D))—

22 (1) under which an undue hardship exists when
23 application of the transfer of assets provision would
24 deprive the individual—



1 (A) of medical care such that the individ-
2 ual's health or life would be endangered; or

3 (B) of food, clothing, shelter, or other ne-
4 cessities of life; and

5 (2) which provides for—

6 (A) notice to recipients that an undue
7 hardship exception exists;

8 (B) a timely process for determining
9 whether an undue hardship waiver will be
10 granted; and

11 (C) a process under which an adverse de-
12 termination can be appealed.

13 (e) ADDITIONAL PROVISIONS ON HARDSHIP WAIV-
14 ERS.—

15 (1) APPLICATION BY FACILITY.—Section
16 1917(c)(2) of the Social Security Act (42 U.S.C.
17 1396p(c)(2)) is amended—

18 (A) by striking the semicolon at the end of
19 subparagraph (D) and inserting a period; and

20 (B) by adding after and below such sub-
21 paragraph the following:

22 “The procedures established under subparagraph
23 (D) shall permit the facility in which the institu-
24 tionalized individual is residing to file an undue
25 hardship waiver application on behalf of the indi-



1 vidual with the consent of the individual or the per-
2 sonal representative of the individual.”.

3 (2) **AUTHORITY TO MAKE BED HOLD PAYMENTS**
4 **FOR HARDSHIP APPLICANTS.**—Such section is fur-
5 ther amended by adding at the end the following:
6 “While an application for an undue hardship waiver
7 is pending under subparagraph (D) in the case of an
8 individual who is a resident of a nursing facility, if
9 the application meets such criteria as the Secretary
10 specifies, the State may provide for payments for
11 nursing facility services in order to hold the bed for
12 the individual at the facility, but not in excess of
13 payments for 30 days.”.

14 **SEC. 6012. DISCLOSURE AND TREATMENT OF ANNUITIES.**

15 (a) **IN GENERAL.**—Section 1917 of the Social Secu-
16 rity Act (42 U.S.C. 1396p) is amended by redesignating
17 subsection (e) as subsection (f) and by inserting after sub-
18 section (d) the following new subsection:

19 “(e)(1) In order to meet the requirements of this sec-
20 tion for purposes of section 1902(a)(18), a State shall re-
21 quire, as a condition for the provision of medical assist-
22 ance for services described in subsection (c)(1)(C)(i) (re-
23 lating to long-term care services) for an individual, the ap-
24 plication of the individual for such assistance (including
25 any recertification of eligibility for such assistance) shall



1 disclose a description of any interest the individual or com-
2 munity spouse has in an annuity (or similar financial in-
3 strument, as may be specified by the Secretary), regard-
4 less of whether the annuity is irrevocable or is treated as
5 an asset. Such application or recertification form shall in-
6 clude a statement that under paragraph (2) the State be-
7 comes a remainder beneficiary under such an annuity or
8 similar financial instrument by virtue of the provision of
9 such medical assistance.

10 “(2)(A) In the case of disclosure concerning an annu-
11 ity under subsection (c)(1)(F), the State shall notify the
12 issuer of the annuity of the right of the State under such
13 subsection as a preferred remainder beneficiary in the an-
14 nuity for medical assistance furnished to the individual.
15 Nothing in this paragraph shall be construed as pre-
16 venting such an issuer from notifying persons with any
17 other remainder interest of the State’s remainder interest
18 under such subsection.

19 “(B) In the case of such an issuer receiving notice
20 under subparagraph (A), the State may require the issuer
21 to notify the State when there is a change in the amount
22 of income or principal being withdrawn from the amount
23 that was being withdrawn at the time of the most recent
24 disclosure described in paragraph (1). A State shall take
25 such information into account in determining the amount



1 of the State's obligations for medical assistance or in the
2 individual's eligibility for such assistance.

3 “(3) The Secretary may provide guidance to States
4 on categories of transactions that may be treated as a
5 transfer of asset for less than fair market value.

6 “(4) Nothing in this subsection shall be construed as
7 preventing a State from denying eligibility for medical as-
8 sistance for an individual based on the income or resources
9 derived from an annuity described in paragraph (1).”.

10 (b) REQUIREMENT FOR STATE TO BE NAMED AS A
11 REMAINDER BENEFICIARY.—Section 1917(c)(1) of such
12 Act (42 U.S.C. 1396p(c)(1)), is amended by adding at the
13 end the following:

14 “(F) For purposes of this paragraph, the purchase
15 of an annuity shall be treated as the disposal of an asset
16 for less than fair market value unless—

17 “(i) the State is named as the remainder bene-
18 ficiary in the first position for at least the total
19 amount of medical assistance paid on behalf of the
20 annuitant under this title; or

21 “(ii) the State is named as such a beneficiary
22 in the second position after the community spouse or
23 minor or disabled child and is named in the first po-
24 sition if such spouse or a representative of such



1 child disposes of any such remainder for less than
2 fair market value.”.

3 (c) INCLUSION OF TRANSFERS TO PURCHASE BAL-
4 LOON ANNUITIES.—Section 1917(c)(1) of such Act (42
5 U.S.C. 1396p(c)(1)), as amended by subsection (b), is
6 amended by adding at the end the following:

7 “(G) For purposes of this paragraph with respect to
8 a transfer of assets, the term ‘assets’ includes an annuity
9 purchased by or on behalf of an annuitant who has applied
10 for medical assistance with respect to nursing facility serv-
11 ices or other long-term care services under this title
12 unless—

13 “(i) the annuity is—

14 “(I) an annuity described in subsection (b)
15 or (q) of section 408 of the Internal Revenue
16 Code of 1986; or

17 “(II) purchased with proceeds from—

18 “(aa) an account or trust described in
19 subsection (a), (e), (p) of section 408 of
20 such Code;

21 “(bb) a simplified employee pension
22 (within the meaning of section 408(k) of
23 such Code); or

24 “(cc) a Roth IRA described in section
25 408A of such Code; or

1 “(ii) the annuity—
2 “(I) is irrevocable and nonassignable;
3 “(II) is actuarially sound (as determined in
4 accordance with actuarial publications of the
5 Office of the Chief Actuary of the Social Secu-
6 rity Administration); and
7 “(III) provides for payments in equal
8 amounts during the term of the annuity, with
9 no deferral and no balloon payments made.”.

10 (d) **EFFECTIVE DATE.**—The amendments made by
11 this section shall apply to transactions (including the pur-
12 chase of an annuity) occurring on or after the date of the
13 enactment of this Act.

14 **SEC. 6013. APPLICATION OF “INCOME-FIRST” RULE IN AP-**
15 **PLYING COMMUNITY SPOUSE’S INCOME BE-**
16 **FORE ASSETS IN PROVIDING SUPPORT OF**
17 **COMMUNITY SPOUSE.**

18 (a) **IN GENERAL.**—Section 1924(d) of the Social Se-
19 curity Act (42 U.S.C. 1396r-5(d)) is amended by adding
20 at the end the following new subparagraph:

21 “(6) **APPLICATION OF ‘INCOME FIRST’ RULE TO**
22 **REVISION OF COMMUNITY SPOUSE RESOURCE AL-**
23 **LOWANCE.**—For purposes of this subsection and
24 subsections (c) and (e), a State must consider that
25 all income of the institutionalized spouse that could

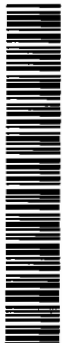
1 be made available to a community spouse, in accord-
2 ance with the calculation of the community spouse
3 monthly income allowance under this subsection, has
4 been made available before the State allocates to the
5 community spouse an amount of resources adequate
6 to provide the difference between the minimum
7 monthly maintenance needs allowance and all income
8 available to the community spouse.”.

9 (b) **EFFECTIVE DATE.**—The amendment made by
10 subsection (a) shall apply to transfers and allocations
11 made on or after the date of the enactment of this Act
12 by individuals who become institutionalized spouses on or
13 after such date.

14 **SEC. 6014. DISQUALIFICATION FOR LONG-TERM CARE AS-**
15 **SISTANCE FOR INDIVIDUALS WITH SUBSTAN-**
16 **TIAL HOME EQUITY.**

17 (a) **IN GENERAL.**—Section 1917 of the Social Secu-
18 rity Act, as amended by section 6012(a), is further amend-
19 ed by redesignating subsection (f) as subsection (g) and
20 by inserting after subsection (e) the following new sub-
21 section:

22 “(f)(1)(A) Notwithstanding any other provision of
23 this title, subject to subparagraphs (B) and (C) of this
24 paragraph and paragraph (2), in determining eligibility of
25 an individual for medical assistance with respect to nurs-



1 ing facility services or other long-term care services, the
2 individual shall not be eligible for such assistance if the
3 individual's equity interest in the individual's home ex-
4 ceeds \$500,000.

5 “(B) A State may elect, without regard to the re-
6 quirements of section 1902(a)(1) (relating to
7 statewideness) and section 1902(a)(10)(B) (relating to
8 comparability), to apply subparagraph (A) by substituting
9 for ‘\$500,000’, an amount that exceeds such amount, but
10 does not exceed \$750,000.

11 “(C) The dollar amounts specified in this paragraph
12 shall be increased, beginning with 2011, from year to year
13 based on the percentage increase in the consumer price
14 index for all urban consumers (all items; United States
15 city average), rounded to the nearest \$1,000.

16 “(2) Paragraph (1) shall not apply with respect to
17 an individual if—

18 “(A) the spouse of such individual, or

19 “(B) such individual's child who is under age
20 21, or (with respect to States eligible to participate
21 in the State program established under title XVI) is
22 blind or permanently and totally disabled, or (with
23 respect to States which are not eligible to participate
24 in such program) is blind or disabled as defined in
25 section 1614,



1 is lawfully residing in the individual's home.

2 “(3) Nothing in this subsection shall be construed as
3 preventing an individual from using a reverse mortgage
4 or home equity loan to reduce the individual's total equity
5 interest in the home.

6 “(4) The Secretary shall establish a process whereby
7 paragraph (1) is waived in the case of a demonstrated
8 hardship.”.

9 (b) **EFFECTIVE DATE.**—The amendment made by
10 subsection (a) shall apply to individuals who are deter-
11 mined eligible for medical assistance with respect to nurs-
12 ing facility services or other long-term care services based
13 on an application filed on or after January 1, 2006.

14 **SEC. 6015. ENFORCEABILITY OF CONTINUING CARE RE-**
15 **TIREMENT COMMUNITIES (CCRC) AND LIFE**
16 **CARE COMMUNITY ADMISSION CONTRACTS.**

17 (a) **ADMISSION POLICIES OF NURSING FACILITIES.**—
18 Section 1919(c)(5) of the Social Security Act (42 U.S.C.
19 1396r(c)(5)) is amended—

20 (1) in subparagraph (A)(i)(II), by inserting
21 “subject to clause (v),” after “(II)”; and

22 (2) by adding at the end of subparagraph (B)
23 the following new clause:

24 “(v) **TREATMENT OF CONTINUING**
25 **CARE RETIREMENT COMMUNITIES ADMIS-**

1 SION CONTRACTS.—Notwithstanding sub-
2 clause (II) of subparagraph (A)(i), subject
3 to subsections (c) and (d) of section 1924,
4 contracts for admission to a State licensed,
5 registered, certified, or equivalent con-
6 tinuing care retirement community or life
7 care community, including services in a
8 nursing facility that is part of such com-
9 munity, may require residents to spend on
10 their care resources declared for the pur-
11 poses of admission before applying for
12 medical assistance.”.

13 (b) TREATMENT OF ENTRANCE FEES.—Section
14 1917 of such Act (42 U.S.C. 1396p), as amended by sec-
15 tions 6012(a) and 6014(a), is amended by redesignating
16 subsection (g) as subsection (h) and by inserting after
17 subsection (f) the following new subsection:

18 “(g) TREATMENT OF ENTRANCE FEES OF INDIVID-
19 UALS RESIDING IN CONTINUING CARE RETIREMENT
20 COMMUNITIES.—

21 “(1) IN GENERAL.—For purposes of deter-
22 mining an individual’s eligibility for, or amount of,
23 benefits under a State plan under this title, the rules
24 specified in paragraph (2) shall apply to individuals
25 residing in continuing care retirement communities



1 or life care communities that collect an entrance fee
2 on admission from such individuals.

3 “(2) TREATMENT OF ENTRANCE FEE.—For
4 purposes of this subsection, an individual’s entrance
5 fee in a continuing care retirement community or
6 life care community shall be considered a resource
7 available to the individual to the extent that—

8 “(A) the individual has the ability to use
9 the entrance fee, or the contract provides that
10 the entrance fee may be used, to pay for care
11 should other resources or income of the indi-
12 vidual be insufficient to pay for such care;

13 “(B) the individual is eligible for a refund
14 of any remaining entrance fee when the indi-
15 vidual dies or terminates the continuing care re-
16 tirement community or life care community
17 contract and leaves the community; and

18 “(C) the entrance fee does not confer an
19 ownership interest in the continuing care retire-
20 ment community or life care community.”.

21 **SEC. 6016. ADDITIONAL REFORMS OF MEDICAID ASSET**
22 **TRANSFER RULES.**

23 (a) REQUIREMENT TO IMPOSE PARTIAL MONTHS OF
24 INELIGIBILITY.—Section 1917(c)(1)(E) of the Social Se-



1 curity Act (42 U.S.C. 1396p(c)(1)(E)) is amended by add-
2 ing at the end the following:

3 “(iv) A State shall not round down, or otherwise dis-
4 regard any fractional period of ineligibility determined
5 under clause (i) or (ii) with respect to the disposal of as-
6 sets.”.

7 (b) AUTHORITY FOR STATES TO ACCUMULATE MUL-
8 TIPLE TRANSFERS INTO ONE PENALTY PERIOD.—Sec-
9 tion 1917(c)(1) of such Act (42 U.S.C. 1396p(c)(1)), as
10 amended by subsections (b) and (c) of section 6012, is
11 amended by adding at the end the following:

12 “(H) Notwithstanding the preceding provisions of
13 this paragraph, in the case of an individual (or individual’s
14 spouse) who makes multiple fractional transfers of assets
15 in more than 1 month for less than fair market value on
16 or after the applicable look-back date specified in subpara-
17 graph (B), a State may determine the period of ineligi-
18 bility applicable to such individual under this paragraph
19 by—

20 “(i) treating the total, cumulative uncompen-
21 sated value of all assets transferred by the individual
22 (or individual’s spouse) during all months on or
23 after the look-back date specified in subparagraph
24 (B) as 1 transfer for purposes of clause (i) or (ii)
25 (as the case may be) of subparagraph (E); and

1 “(ii) beginning such period on the earliest date
2 which would apply under subparagraph (D) to any
3 of such transfers.”.

4 (c) INCLUSION OF TRANSFER OF CERTAIN NOTES
5 AND LOANS ASSETS.—Section 1917(c)(1) of such Act (42
6 U.S.C. 1396 p(c)(1)), as amended by subsection (b), is
7 amended by adding at the end the following:

8 “(I) For purposes of this paragraph with respect to
9 a transfer of assets, the term ‘assets’ includes funds used
10 to purchase a promissory note, loan, or mortgage unless
11 such note, loan, or mortgage—

12 “(i) has a repayment term that is actuarially
13 sound (as determined in accordance with actuarial
14 publications of the Office of the Chief Actuary of the
15 Social Security Administration);

16 “(ii) provides for payments to be made in equal
17 amounts during the term of the loan, with no defer-
18 ral and no balloon payments made; and

19 “(iii) prohibits the cancellation of the balance
20 upon the death of the lender.

21 In the case of a promissory note, loan, or mortgage that
22 does not satisfy the requirements of clauses (i) through
23 (iii), the value of such note, loan, or mortgage shall be
24 the outstanding balance due as of the date of the individ-



1 ual's application for medical assistance for services de-
2 scribed in subparagraph (C).”.

3 (d) INCLUSION OF TRANSFERS TO PURCHASE LIFE
4 ESTATES.—Section 1917(c)(1) of such Act (42 U.S.C.
5 1396p(c)(1)), as amended by subsection (c), is amended
6 by adding at the end the following:

7 “(J) For purposes of this paragraph with respect to
8 a transfer of assets, the term ‘assets’ includes the pur-
9 chase of a life estate interest in another individual’s home
10 unless the purchaser resides in the home for a period of
11 at least 1 year after the date of the purchase.”.

12 (e) EFFECTIVE DATES.—

13 (1) IN GENERAL.—Except as provided in para-
14 graphs (2) and (3), the amendments made by this
15 section shall apply to payments under title XIX of
16 the Social Security Act (42 U.S.C. 1396 et seq.) for
17 calendar quarters beginning on or after the date of
18 enactment of this Act, without regard to whether or
19 not final regulations to carry out such amendments
20 have been promulgated by such date.

21 (2) EXCEPTIONS.—The amendments made by
22 this section shall not apply—

23 (A) to medical assistance provided for serv-
24 ices furnished before the date of enactment;



1 (B) with respect to assets disposed of on
2 or before the date of enactment of this Act; or

3 (C) with respect to trusts established on or
4 before the date of enactment of this Act.

5 (3) EXTENSION OF EFFECTIVE DATE FOR
6 STATE LAW AMENDMENT.—In the case of a State
7 plan under title XIX of the Social Security Act (42
8 U.S.C. 1396 et seq.) which the Secretary of Health
9 and Human Services determines requires State legis-
10 lation in order for the plan to meet the additional
11 requirements imposed by the amendments made by
12 a provision of this section, the State plan shall not
13 be regarded as failing to comply with the require-
14 ments of such title solely on the basis of its failure
15 to meet these additional requirements before the
16 first day of the first calendar quarter beginning
17 after the close of the first regular session of the
18 State legislature that begins after the date of the en-
19 actment of this Act. For purposes of the previous
20 sentence, in the case of a State that has a 2-year
21 legislative session, each year of the session is consid-
22 ered to be a separate regular session of the State
23 legislature.



1 **Subchapter B—Expanded Access to Certain**
2 **Benefits**

3 **SEC. 6021. EXPANSION OF STATE LONG-TERM CARE PART-**
4 **NERSHIP PROGRAM.**

5 (a) **EXPANSION AUTHORITY.—**

6 (1) **IN GENERAL.—**Section 1917(b) of the So-
7 cial Security Act (42 U.S.C. 1396p(b)) is
8 amended—

9 (A) in paragraph (1)(C)—

10 (i) in clause (ii), by inserting “and
11 which satisfies clause (iv), or which has a
12 State plan amendment that provides for a
13 qualified State long-term care insurance
14 partnership (as defined in clause (iii))”
15 after “1993,”; and

16 (ii) by adding at the end the following
17 new clauses:

18 “(iii) For purposes of this paragraph, the term
19 ‘qualified State long-term care insurance partner-
20 ship’ means an approved State plan amendment
21 under this title that provides for the disregard of
22 any assets or resources in an amount equal to the
23 insurance benefit payments that are made to or on
24 behalf of an individual who is a beneficiary under a



1 long-term care insurance policy if the following re-
2 quirements are met:

3 “(I) The policy covers an insured who was
4 a resident of such State when coverage first be-
5 came effective under the policy.

6 “(II) The policy is a qualified long-term
7 care insurance policy (as defined in section
8 7702B(b) of the Internal Revenue Code of
9 1986) issued not earlier than the effective date
10 of the State plan amendment.

11 “(III) The policy meets the model regula-
12 tions and the requirements of the model Act
13 specified in paragraph (5).

14 “(IV) If the policy is sold to an individual
15 who—

16 “(aa) has not attained age 61 as of
17 the date of purchase, the policy provides
18 compound annual inflation protection;

19 “(bb) has attained age 61 but has not
20 attained age 76 as of such date, the policy
21 provides some level of inflation protection;
22 and

23 “(cc) has attained age 76 as of such
24 date, the policy may (but is not required



1 to) provide some level of inflation protec-
2 tion.

3 “(V) The State Medicaid agency under sec-
4 tion 1902(a)(5) provides information and tech-
5 nical assistance to the State insurance depart-
6 ment on the insurance department’s role of as-
7 suring that any individual who sells a long-term
8 care insurance policy under the partnership re-
9 ceives training and demonstrates evidence of an
10 understanding of such policies and how they re-
11 late to other public and private coverage of
12 long-term care.

13 “(VI) The issuer of the policy provides reg-
14 ular reports to the Secretary, in accordance
15 with regulations of the Secretary, that include
16 notification regarding when benefits provided
17 under the policy have been paid and the amount
18 of such benefits paid, notification regarding
19 when the policy otherwise terminates, and such
20 other information as the Secretary determines
21 may be appropriate to the administration of
22 such partnerships.

23 “(VII) The State does not impose any re-
24 quirement affecting the terms or benefits of
25 such a policy unless the State imposes such re-



1 quirement on long-term care insurance policies
2 without regard to whether the policy is covered
3 under the partnership or is offered in connec-
4 tion with such a partnership.

5 In the case of a long-term care insurance policy
6 which is exchanged for another such policy, sub-
7 clause (I) shall be applied based on the coverage of
8 the first such policy that was exchanged. For pur-
9 poses of this clause and paragraph (5), the term
10 ‘long-term care insurance policy’ includes a certifi-
11 cate issued under a group insurance contract

12 “(iv) With respect to a State which had a State
13 plan amendment approved as of May 14, 1993, such
14 a State satisfies this clause for purposes of clause
15 (ii) if the Secretary determines that the State plan
16 amendment provides for consumer protection stand-
17 ards which are no less stringent than the consumer
18 protection standards which applied under such State
19 plan amendment as of December 31, 2005.

20 “(v) The regulations of the Secretary required
21 under clause (iii)(VI) shall be promulgated after
22 consultation with the National Association of Insur-
23 ance Commissioners, issuers of long-term care insur-
24 ance policies, States with experience with long-term
25 care insurance partnership plans, other States, and



1 representatives of consumers of long-term care in-
2 surance policies, and shall specify the type and for-
3 mat of the data and information to be reported and
4 the frequency with which such reports are to be
5 made. The Secretary, as appropriate, shall provide
6 copies of the reports provided in accordance with
7 that clause to the State involved.

8 “(vi) The Secretary, in consultation with other
9 appropriate Federal agencies, issuers of long-term
10 care insurance, the National Association of Insur-
11 ance Commissioners, State insurance commissioners,
12 States with experience with long-term care insurance
13 partnership plans, other States, and representatives
14 of consumers of long-term care insurance policies,
15 shall develop recommendations for Congress to au-
16 thorize and fund a uniform minimum data set to be
17 reported electronically by all issuers of long-term
18 care insurance policies under qualified State long-
19 term care insurance partnerships to a secure, cen-
20 tralized electronic query and report-generating
21 mechanism that the State, the Secretary, and other
22 Federal agencies can access.”; and

23 (B) by adding at the end the following:



1 “(5)(A) For purposes of clause (iii)(III), the model
2 regulations and the requirements of the model Act speci-
3 fied in this paragraph are:

4 “(i) In the case of the model regulation, the fol-
5 lowing requirements:

6 “(I) Section 6A (relating to guaranteed re-
7 newal or noncancellability), other than para-
8 graph (5) thereof, and the requirements of sec-
9 tion 6B of the model Act relating to such sec-
10 tion 6A.

11 “(II) Section 6B (relating to prohibitions
12 on limitations and exclusions) other than para-
13 graph (7) thereof.

14 “(III) Section 6C (relating to extension of
15 benefits).

16 “(IV) Section 6D (relating to continuation
17 or conversion of coverage).

18 “(V) Section 6E (relating to discontinu-
19 ance and replacement of policies).

20 “(VI) Section 7 (relating to unintentional
21 lapse).

22 “(VII) Section 8 (relating to disclosure),
23 other than sections 8F, 8G, 8H, and 8I thereof.

24 “(VIII) Section 9 (relating to required dis-
25 closure of rating practices to consumer).



1 “(IX) Section 11 (relating to prohibitions
2 against post-claims underwriting).

3 “(X) Section 12 (relating to minimum
4 standards).

5 “(XI) Section 14 (relating to application
6 forms and replacement coverage).

7 “(XII) Section 15 (relating to reporting re-
8 quirements).

9 “(XIII) Section 22 (relating to filing re-
10 quirements for marketing).

11 “(XIV) Section 23 (relating to standards
12 for marketing), including inaccurate completion
13 of medical histories, other than paragraphs (1),
14 (6), and (9) of section 23C.

15 “(XV) Section 24 (relating to suitability).

16 “(XVI) Section 25 (relating to prohibition
17 against preexisting conditions and probationary
18 periods in replacement policies or certificates).

19 “(XVII) The provisions of section 26 relat-
20 ing to contingent nonforfeiture benefits, if the
21 policyholder declines the offer of a nonforfeiture
22 provision described in paragraph (4).

23 “(XVIII) Section 29 (relating to standard
24 format outline of coverage).



1 “(XIX) Section 30 (relating to require-
2 ment to deliver shopper’s guide).

3 “(ii) In the case of the model Act, the following:

4 “(I) Section 6C (relating to preexisting
5 conditions).

6 “(II) Section 6D (relating to prior hos-
7 pitalization).

8 “(III) The provisions of section 8 relating
9 to contingent nonforfeiture benefits.

10 “(IV) Section 6F (relating to right to re-
11 turn).

12 “(V) Section 6G (relating to outline of cov-
13 erage).

14 “(VI) Section 6H (relating to requirements
15 for certificates under group plans).

16 “(VII) Section 6J (relating to policy sum-
17 mary).

18 “(VIII) Section 6K (relating to monthly
19 reports on accelerated death benefits).

20 “(IX) Section 7 (relating to incontest-
21 ability period).

22 “(B) For purposes of this paragraph and paragraph
23 (1)(C)—

24 “(i) the terms ‘model regulation’ and ‘model
25 Act’ mean the long-term care insurance model regu-



1 lation, and the long-term care insurance model Act,
2 respectively, promulgated by the National Associa-
3 tion of Insurance Commissioners (as adopted as of
4 October 2000);

5 “(ii) any provision of the model regulation or
6 model Act listed under subparagraph (A) shall be
7 treated as including any other provision of such reg-
8 ulation or Act necessary to implement the provision;
9 and

10 “(iii) with respect to a long-term care insurance
11 policy issued in a State, the policy shall be deemed
12 to meet applicable requirements of the model regula-
13 tion or the model Act if the State plan amendment
14 under paragraph (1)(C)(iii) provides that the State
15 insurance commissioner for the State certifies (in a
16 manner satisfactory to the Secretary) that the policy
17 meets such requirements.

18 “(C) Not later than 12 months after the National As-
19 sociation of Insurance Commissioners issues a revision,
20 update, or other modification of a model regulation or
21 model Act provision specified in subparagraph (A), or of
22 any provision of such regulation or Act that is sub-
23 stantively related to a provision specified in such subpara-
24 graph, the Secretary shall review the changes made to the
25 provision, determine whether incorporating such changes



1 into the corresponding provision specified in such subpara-
2 graph would improve qualified State long-term care insur-
3 ance partnerships, and if so, shall incorporate the changes
4 into such provision.”.

5 (2) STATE REPORTING REQUIREMENTS.—Noth-
6 ing in clauses (iii)(VI) and (v) of section
7 1917(b)(1)(C) of the Social Security Act (as added
8 by paragraph (1)) shall be construed as prohibiting
9 a State from requiring an issuer of a long-term care
10 insurance policy sold in the State (regardless of
11 whether the policy is issued under a qualified State
12 long-term care insurance partnership under section
13 1917(b)(1)(C)(iii) of such Act) to require the issuer
14 to report information or data to the State that is in
15 addition to the information or data required under
16 such clauses.

17 (3) EFFECTIVE DATE.—A State plan amend-
18 ment that provides for a qualified State long-term
19 care insurance partnership under the amendments
20 made by paragraph (1) may provide that such
21 amendment is effective for long-term care insurance
22 policies issued on or after a date, specified in the
23 amendment, that is not earlier than the first day of
24 the first calendar quarter in which the plan amend-



1 ment was submitted to the Secretary of Health and
2 Human Services.

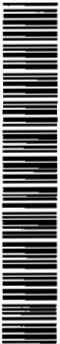
3 (b) STANDARDS FOR RECIPROCAL RECOGNITION
4 AMONG PARTNERSHIP STATES.—In order to permit port-
5 ability in long-term care insurance policies purchased
6 under State long-term care insurance partnerships, the
7 Secretary of Health and Human Services shall develop,
8 not later than January 1, 2007, and in consultation with
9 the National Association of Insurance Commissioners,
10 issuers of long-term care insurance policies, States with
11 experience with long-term care insurance partnership
12 plans, other States, and representatives of consumers of
13 long-term care insurance policies, standards for uniform
14 reciprocal recognition of such policies among States with
15 qualified State long-term care insurance partnerships
16 under which—

17 (1) benefits paid under such policies will be
18 treated the same by all such States; and

19 (2) States with such partnerships shall be sub-
20 ject to such standards unless the State notifies the
21 Secretary in writing of the State's election to be ex-
22 empt from such standards.

23 (c) ANNUAL REPORTS TO CONGRESS.—

24 (1) IN GENERAL.—The Secretary of Health and
25 Human Services shall annually report to Congress



1 on the long-term care insurance partnerships estab-
2 lished in accordance with section 1917(b)(1)(C)(ii)
3 of the Social Security Act (42 U.S.C.
4 1396p(b)(1)(C)(ii)) (as amended by subsection
5 (a)(1)). Such reports shall include analyses of the
6 extent to which such partnerships expand or limit
7 access of individuals to long-term care and the im-
8 pact of such partnerships on Federal and State ex-
9 penditures under the Medicare and Medicaid pro-
10 grams. Nothing in this section shall be construed as
11 requiring the Secretary to conduct an independent
12 review of each long-term care insurance policy of-
13 fered under or in connection with such a partner-
14 ship.

15 (2) APPROPRIATION.—Out of any funds in the
16 Treasury not otherwise appropriated, there is appro-
17 priated to the Secretary of Health and Human Serv-
18 ices, \$1,000,000 for the period of fiscal years 2006
19 through 2010 to carry out paragraph (1).

20 (d) NATIONAL CLEARINGHOUSE FOR LONG-TERM
21 CARE INFORMATION.—

22 (1) ESTABLISHMENT.—The Secretary of Health
23 and Human Services shall establish a National
24 Clearinghouse for Long-Term Care Information. The



1 Clearinghouse may be established through a contract
2 or interagency agreement.

3 (2) DUTIES.—

4 (A) IN GENERAL.—The National Clearing-
5 house for Long-Term Care Information shall—

6 (i) educate consumers with respect to
7 the availability and limitations of coverage
8 for long-term care under the Medicaid pro-
9 gram and provide contact information for
10 obtaining State-specific information on
11 long-term care coverage, including eligi-
12 bility and estate recovery requirements
13 under State Medicaid programs;

14 (ii) provide objective information to
15 assist consumers with the decisionmaking
16 process for determining whether to pur-
17 chase long-term care insurance or to pur-
18 sue other private market alternatives for
19 purchasing long-term care and provide con-
20 tact information for additional objective re-
21 sources on planning for long-term care
22 needs; and

23 (iii) maintain a list of States with
24 State long-term care insurance partner-
25 ships under the Medicaid program that



1 provide reciprocal recognition of long-term
2 care insurance policies issued under such
3 partnerships.

4 (B) REQUIREMENT.—In providing infor-
5 mation to consumers on long-term care in ac-
6 cordance with this subsection, the National
7 Clearinghouse for Long-Term Care Information
8 shall not advocate in favor of a specific long-
9 term care insurance provider or a specific long-
10 term care insurance policy.

11 (3) APPROPRIATION.—Out of any funds in the
12 Treasury not otherwise appropriated, there is appro-
13 priated to carry out this subsection, \$3,000,000 for
14 each of fiscal years 2006 through 2010.

15 **CHAPTER 3—ELIMINATING FRAUD,**
16 **WASTE, AND ABUSE IN MEDICAID**

17 ~~SECTION 100-01-01~~

18 ~~SECTION 100-01-02~~

19 (a) ~~SECTION 100-01-03~~

20 ~~SECTION 100-01-04~~

21 ~~SECTION 100-01-05~~

22 (1) ~~SECTION 100-01-06~~

23 ~~SECTION 100-01-07~~

24 (2) ~~SECTION 100-01-08~~

25 ~~SECTION 100-01-09~~



1 ~~(b) [redacted] (21) [redacted]~~

2 ~~[redacted]~~

3 ~~“(22) [redacted] in~~

4 ~~[redacted] (the [redacted]~~

5 ~~[redacted] 1009() [redacted]~~

6 ~~[redacted] 1009() (5) [redacted]~~

7 ~~[redacted]~~

8 ~~[redacted]~~

9 ~~[redacted] the contractor if the terms of~~

10 ~~[redacted]~~

11 ~~[redacted]~~

12 ~~[redacted]~~

13 ~~600(2) of the Deficit Reduction Act of 2005.”~~

14 ~~(3) [redacted]~~

15 ~~Not later than 6 months [redacted]~~

16 ~~of this Act, the Secretary of Health and H~~

17 ~~[redacted]~~

18 ~~[redacted] and other [redacted]~~

19 ~~[redacted] (including [redacted]) [redacted]~~

20 ~~[redacted]~~

21 ~~[redacted]~~

22 ~~integrity with respect to Federal funds. The Secretary of~~

23 ~~Health and [redacted] shall review and revise, as~~

24 ~~[redacted] to promptly address any com-~~



1 [REDACTED]

2 [REDACTED]

3 [REDACTED]

4 [REDACTED]

5 [REDACTED]

6 [REDACTED]

7 [REDACTED]

8 [REDACTED]

9 [REDACTED]

10 [REDACTED]

11 **SEC. 6032. ENCOURAGING THE ENACTMENT OF STATE**

12 **FALSE CLAIMS ACTS.**

13 (a) IN GENERAL.—Title XIX of the Social Security

14 Act (42 U.S.C. 1396 et seq.) is amended by inserting after

15 section 1908A the following:

16 “STATE FALSE CLAIMS ACT REQUIREMENTS FOR

17 INCREASED STATE SHARE OF RECOVERIES

18 “SEC. 1909. (a) IN GENERAL.—Notwithstanding sec-

19 tion 1905(b), if a State has in effect a law relating to

20 false or fraudulent claims that meets the requirements of

21 subsection (b), the Federal medical assistance percentage

22 with respect to any amounts recovered under a State ac-

23 tion brought under such law, shall be decreased by 10 per-

24 centage points.

25 “(b) REQUIREMENTS.—For purposes of subsection

26 (a), the requirements of this subsection are that the In-



1 spector General of the Department of Health and Human
2 Services, in consultation with the Attorney General, deter-
3 mines that the State has in effect a law that meets the
4 following requirements:

5 “(1) The law establishes liability to the State
6 for false or fraudulent claims described in section
7 3729 of title 31, United States Code, with respect
8 to any expenditure described in section 1903(a).

9 “(2) The law contains provisions that are at
10 least as effective in rewarding and facilitating qui
11 tam actions for false or fraudulent claims as those
12 described in sections 3730 through 3732 of title 31,
13 United States Code.

14 “(3) The law contains a requirement for filing
15 an action under seal for 60 days with review by the
16 State Attorney General.

17 “(4) The law contains a civil penalty that is not
18 less than the amount of the civil penalty authorized
19 under section 3729 of title 31, United States Code.

20 “(c) DEEMED COMPLIANCE.—A State that, as of
21 January 1, 2007, has a law in effect that meets the re-
22 quirements of subsection (b) shall be deemed to be in com-
23 pliance with such requirements for so long as the law con-
24 tinues to meet such requirements.



1 “(d) NO PRECLUSION OF BROADER LAWS.—Nothing
2 in this section shall be construed as prohibiting a State
3 that has in effect a law that establishes liability to the
4 State for false or fraudulent claims described in section
5 3729 of title 31, United States Code, with respect to pro-
6 grams in addition to the State program under this title,
7 or with respect to expenditures in addition to expenditures
8 described in section 1903(a), from being considered to be
9 in compliance with the requirements of subsection (a) so
10 long as the law meets such requirements.”.

11 (b) EFFECTIVE DATE.—Except as provided in sec-
12 tion 6035(e), the amendments made by this section take
13 effect on January 1, 2007.

14 **SEC. 6033. EMPLOYEE EDUCATION ABOUT FALSE CLAIMS**
15 **RECOVERY.**

16 (a) IN GENERAL.—Section 1902(a) of the Social Se-
17 curity Act (42 U.S.C. 1396a(a)) is amended—

18 (1) in paragraph (66), by striking “and” at the
19 end;

20 (2) in paragraph (67) by striking the period at
21 the end and inserting “; and”; and

22 (3) by inserting after paragraph (67) the fol-
23 lowing:

24 “(68) provide that any entity that receives or
25 makes annual payments under the State plan of at



1 least \$5,000,000, as a condition of receiving such
2 payments, shall—

3 “(A) establish written policies for all em-
4 ployees of the entity (including management),
5 and of any contractor or agent of the entity,
6 that provide detailed information about the
7 False Claims Act established under sections
8 3729 through 3733 of title 31, United States
9 Code, administrative remedies for false claims
10 and statements established under chapter 38 of
11 title 31, United States Code, any State laws
12 pertaining to civil or criminal penalties for false
13 claims and statements, and whistleblower pro-
14 tections under such laws, with respect to the
15 role of such laws in preventing and detecting
16 fraud, waste, and abuse in Federal health care
17 programs (as defined in section 1128B(f));

18 “(B) include as part of such written poli-
19 cies, detailed provisions regarding the entity’s
20 policies and procedures for detecting and pre-
21 venting fraud, waste, and abuse; and

22 “(C) include in any employee handbook for
23 the entity, a specific discussion of the laws de-
24 scribed in subparagraph (A), the rights of em-
25 ployees to be protected as whistleblowers, and



1 the entity's policies and procedures for detect-
2 ing and preventing fraud, waste, and abuse.”.

3 (b) EFFECTIVE DATE.—Except as provided in sec-
4 tion 6035(e), the amendments made by subsection (a) take
5 effect on January 1, 2007.

6 **SEC. 6034. PROHIBITION ON RESTOCKING AND DOUBLE**
7 **BILLING OF PRESCRIPTION DRUGS.**

8 (a) IN GENERAL.—Section 1903(i)(10) of the Social
9 Security Act (42 U.S.C. 1396b(i)), as amended by section
10 6002(b), is amended—

11 (1) in subparagraph (B), by striking “and” at
12 the end;

13 (2) in subparagraph (C), by striking “; or” at
14 the end and inserting “, and”; and

15 (3) by adding at the end the following:

16 “(D) with respect to any amount expended for
17 reimbursement to a pharmacy under this title for
18 the ingredient cost of a covered outpatient drug for
19 which the pharmacy has already received payment
20 under this title (other than with respect to a reason-
21 able restocking fee for such drug); or”.

22 (b) EFFECTIVE DATE.—The amendments made by
23 subsection (a) take effect on the first day of the first fiscal
24 year quarter that begins after the date of enactment of
25 this Act.



1 **SEC. 6035. MEDICAID INTEGRITY PROGRAM.**

2 (a) ESTABLISHMENT OF MEDICAID INTEGRITY PRO-
3 GRAM.—Title XIX of the Social Security Act (42 U.S.C.
4 1396 et seq.) is amended—

5 (1) by redesignating section 1936 as section
6 1937; and

7 (2) by inserting after section 1935 the fol-
8 lowing:

9 “MEDICAID INTEGRITY PROGRAM

10 “SEC. 1936. (a) IN GENERAL.—There is hereby es-
11 tablished the Medicaid Integrity Program (in this section
12 referred to as the ‘Program’) under which the Secretary
13 shall promote the integrity of the program under this title
14 by entering into contracts in accordance with this section
15 with eligible entities to carry out the activities described
16 in subsection (b).

17 “(b) ACTIVITIES DESCRIBED—Activities described in
18 this subsection are as follows:

19 “(1) Review of the actions of individuals or en-
20 tities furnishing items or services (whether on a fee-
21 for-service, risk, or other basis) for which payment
22 may be made under a State plan approved under
23 this title (or under any waiver of such plan approved
24 under section 1115) to determine whether fraud,
25 waste, or abuse has occurred, is likely to occur, or
26 whether such actions have any potential for resulting



1 in an expenditure of funds under this title in a man-
2 ner which is not intended under the provisions of
3 this title.

4 “(2) Audit of claims for payment for items or
5 services furnished, or administrative services ren-
6 dered, under a State plan under this title,
7 including—

8 “(A) cost reports;

9 “(B) consulting contracts; and

10 “(C) risk contracts under section 1903(m).

11 “(3) Identification of overpayments to individ-
12 uals or entities receiving Federal funds under this
13 title.

14 “(4) Education of providers of services, man-
15 aged care entities, beneficiaries, and other individ-
16 uals with respect to payment integrity and quality of
17 care.

18 “(c) ELIGIBLE ENTITY AND CONTRACTING REQUIRE-
19 MENTS.—

20 “(1) IN GENERAL.—An entity is eligible to
21 enter into a contract under the Program to carry
22 out any of the activities described in subsection (b)
23 if the entity satisfies the requirements of paragraphs
24 (2) and (3).



1 “(2) ELIGIBILITY REQUIREMENTS.—The re-
2 quirements of this paragraph are the following:

3 “(A) The entity has demonstrated capa-
4 bility to carry out the activities described in
5 subsection (b).

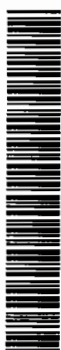
6 “(B) In carrying out such activities, the
7 entity agrees to cooperate with the Inspector
8 General of the Department of Health and
9 Human Services, the Attorney General, and
10 other law enforcement agencies, as appropriate,
11 in the investigation and deterrence of fraud and
12 abuse in relation to this title and in other cases
13 arising out of such activities.

14 “(C) The entity complies with such conflict
15 of interest standards as are generally applicable
16 to Federal acquisition and procurement.

17 “(D) The entity meets such other require-
18 ments as the Secretary may impose.

19 “(3) CONTRACTING REQUIREMENTS.—The enti-
20 ty has contracted with the Secretary in accordance
21 with such procedures as the Secretary shall by regu-
22 lation establish, except that such procedures shall in-
23 clude the following:

24 “(A) Procedures for identifying, evalu-
25 ating, and resolving organizational conflicts of



1 interest that are generally applicable to Federal
2 acquisition and procurement.

3 “(B) Competitive procedures to be used—

4 “(i) when entering into new contracts
5 under this section;

6 “(ii) when entering into contracts that
7 may result in the elimination of respon-
8 sibilities under section 202(b) of the
9 Health Insurance Portability and Account-
10 ability Act of 1996; and

11 “(iii) at any other time considered ap-
12 propriate by the Secretary.

13 “(C) Procedures under which a contract
14 under this section may be renewed without re-
15 gard to any provision of law requiring competi-
16 tion if the contractor has met or exceeded the
17 performance requirements established in the
18 current contract.

19 The Secretary may enter into such contracts without
20 regard to final rules having been promulgated.

21 “(4) LIMITATION ON CONTRACTOR LIABIL-
22 ITY.—The Secretary shall by regulation provide for
23 the limitation of a contractor’s liability for actions
24 taken to carry out a contract under the Program,
25 and such regulation shall, to the extent the Sec-



1 retary finds appropriate, employ the same or com-
2 parable standards and other substantive and proce-
3 dural provisions as are contained in section 1157.

4 “(d) COMPREHENSIVE PLAN FOR PROGRAM INTEG-
5 RITY.—

6 “(1) 5-YEAR PLAN.—With respect to the 5 fis-
7 cal year period beginning with fiscal year 2006, and
8 each such 5-fiscal year period that begins thereafter,
9 the Secretary shall establish a comprehensive plan
10 for ensuring the integrity of the program established
11 under this title by combatting fraud, waste, and
12 abuse.

13 “(2) CONSULTATION.—Each 5-fiscal year plan
14 established under paragraph (1) shall be developed
15 by the Secretary in consultation with the Attorney
16 General, the Director of the Federal Bureau of In-
17 vestigation, the Comptroller General of the United
18 States, the Inspector General of the Department of
19 Health and Human Services, and State officials with
20 responsibility for controlling provider fraud and
21 abuse under State plans under this title.

22 “(e) APPROPRIATION.—

23 “(1) IN GENERAL.—Out of any money in the
24 Treasury of the United States not otherwise appro-
25 priated, there are appropriated to carry out the



1 Medicaid Integrity Program under this section, with-
2 out further appropriation—

3 “(A) for fiscal year 2006, \$5,000,000;

4 “(B) for each of fiscal years 2007 and
5 2008, \$50,000,000; and

6 “(C) for each fiscal year thereafter,
7 \$75,000,000.

8 “(2) AVAILABILITY.—Amounts appropriated
9 pursuant to paragraph (1) shall remain available
10 until expended.

11 “(3) INCREASE IN CMS STAFFING DEVOTED TO
12 PROTECTING MEDICAID PROGRAM INTEGRITY.—
13 From the amounts appropriated under paragraph
14 (1), the Secretary shall increase by 100 the number
15 of full-time equivalent employees whose duties con-
16 sist solely of protecting the integrity of the Medicaid
17 program established under this section by providing
18 effective support and assistance to States to combat
19 provider fraud and abuse.

20 “(4) ANNUAL REPORT.—Not later than 180
21 days after the end of each fiscal year (beginning
22 with fiscal year 2006), the Secretary shall submit a
23 report to Congress which identifies—

24 “(A) the use of funds appropriated pursu-
25 ant to paragraph (1); and



1 “(B) the effectiveness of the use of such
2 funds.”.

3 (b) STATE REQUIREMENT TO COOPERATE WITH IN-
4 INTEGRITY PROGRAM EFFORTS.—Section 1902(a) of such
5 Act (42 U.S.C. 1396a(a)), as amended by section 6033(a),
6 is amended—

7 (1) in paragraph (67), by striking “and” at the
8 end;

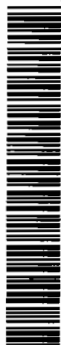
9 (2) in paragraph (68), by striking the period at
10 the end and inserting “; and”; and

11 (3) by inserting after paragraph (68), the fol-
12 lowing:

13 “(69) provide that the State must comply with
14 any requirements determined by the Secretary to be
15 necessary for carrying out the Medicaid Integrity
16 Program established under section 1936.”.

17 (c) INCREASED FUNDING FOR MEDICAID FRAUD AND
18 ABUSE CONTROL ACTIVITIES.—

19 (1) IN GENERAL.—Out of any money in the
20 Treasury of the United States not otherwise appro-
21 priated, there are appropriated to the Office of the
22 Inspector General of the Department of Health and
23 Human Services, without further appropriation,
24 \$25,000,000 for each of fiscal years 2006 through
25 2010, for activities of such Office with respect to the



1 Medicaid program under title XIX of the Social Se-
2 curity Act (42 U.S.C. 1396 et seq.).

3 (2) AVAILABILITY; AMOUNTS IN ADDITION TO
4 OTHER AMOUNTS APPROPRIATED FOR SUCH ACTIVI-
5 TIES.—Amounts appropriated pursuant to para-
6 graph (1) shall—

7 (A) remain available until expended; and

8 (B) be in addition to any other amounts
9 appropriated or made available to the Office of
10 the Inspector General of the Department of
11 Health and Human Services for activities of
12 such Office with respect to the Medicaid pro-
13 gram.

14 (3) ANNUAL REPORT.—Not later than 180 days
15 after the end of each fiscal year (beginning with fis-
16 cal year 2006), the Inspector General of the Depart-
17 ment of Health and Human Services shall submit a
18 report to Congress which identifies—

19 (A) the use of funds appropriated pursuant
20 to paragraph (1); and

21 (B) the effectiveness of the use of such
22 funds.

23 (d) NATIONAL EXPANSION OF THE MEDICARE-MED-
24 ICAID (MEDI-MEDI) DATA MATCH PILOT PROGRAM.—



1 (1) REQUIREMENT OF THE MEDICARE INTEG-
2 RITY PROGRAM.—Section 1893 of the Social Secu-
3 rity Act (42 U.S.C. 1395ddd) is amended—

4 (A) in subsection (b), by adding at the end
5 the following:

6 “(6) The Medicare-Medicaid Data Match Pro-
7 gram in accordance with subsection (g).”; and

8 (B) by adding at the end the following:

9 “(g) MEDICARE-MEDICAID DATA MATCH PRO-
10 GRAM.—

11 “(1) EXPANSION OF PROGRAM.—

12 “(A) IN GENERAL.—The Secretary shall
13 enter into contracts with eligible entities for the
14 purpose of ensuring that, beginning with 2006,
15 the Medicare-Medicaid Data Match Program
16 (commonly referred to as the ‘Medi-Medi Pro-
17 gram’) is conducted with respect to the pro-
18 gram established under this title and State
19 Medicaid programs under title XIX for the pur-
20 pose of—

21 “(i) identifying program
22 vulnerabilities in the program established
23 under this title and the Medicaid program
24 established under title XIX through the
25 use of computer algorithms to look for



1 payment anomalies (including billing or
2 billing patterns identified with respect to
3 service, time, or patient that appear to be
4 suspect or otherwise implausible);

5 “(ii) working with States, the Attor-
6 ney General, and the Inspector General of
7 the Department of Health and Human
8 Services to coordinate appropriate actions
9 to protect the Federal and State share of
10 expenditures under the Medicaid program
11 under title XIX, as well as the program es-
12 tablished under this title; and

13 “(iii) increasing the effectiveness and
14 efficiency of both such programs through
15 cost avoidance, savings, and recoupments
16 of fraudulent, wasteful, or abusive expendi-
17 tures.

18 “(B) REPORTING REQUIREMENTS.—The
19 Secretary shall make available in a timely man-
20 ner any data and statistical information col-
21 lected by the Medi-Medi Program to the Attor-
22 ney General, the Director of the Federal Bu-
23 reau of Investigation, the Inspector General of
24 the Department of Health and Human Services,
25 and the States (including a medicaid fraud and



1 abuse control unit described in section
2 1903(q)). Such information shall be dissemi-
3 nated no less frequently than quarterly.

4 “(2) LIMITED WAIVER AUTHORITY.—The Sec-
5 retary shall waive only such requirements of this sec-
6 tion and of titles XI and XIX as are necessary to
7 carry out paragraph (1).”.

8 (2) FUNDING.—Section 1817(k)(4) of such Act
9 (42 U.S.C. 1395i(k)(4)), as amended by section
10 5204 of this Act, is amended—

11 (A) in subparagraph (A), by striking “sub-
12 paragraph (B)” and inserting “subparagraphs
13 (B), (C), and (D)”; and

14 (B) by adding at the end the following:

15 “(D) EXPANSION OF THE MEDICARE-MED-
16 ICAID DATA MATCH PROGRAM.—The amount
17 appropriated under subparagraph (A) for a fis-
18 cal year is further increased as follows for pur-
19 poses of carrying out section 1893(b)(6) for the
20 respective fiscal year:

21 “(i) \$12,000,000 for fiscal year 2006.

22 “(ii) \$24,000,000 for fiscal year 2007.

23 “(iii) \$36,000,000 for fiscal year
24 2008.



1 “(iv) \$48,000,000 for fiscal year
2 2009.

3 “(v) \$60,000,000 for fiscal year 2010
4 and each fiscal year thereafter.”.

5 (e) DELAYED EFFECTIVE DATE FOR CHAPTER.—Ex-
6 cept as otherwise provided in this chapter, in the case of
7 a State plan under title XIX of the Social Security Act
8 which the Secretary determines requires State legislation
9 in order for the plan to meet the additional requirements
10 imposed by the amendments made by a provision of this
11 chapter, the State plan shall not be regarded as failing
12 to comply with the requirements of such Act solely on the
13 basis of its failure to meet these additional requirements
14 before the first day of the first calendar quarter beginning
15 after the close of the first regular session of the State leg-
16 islature that begins after the date of enactment of this
17 Act. For purposes of the previous sentence, in the case
18 of a State that has a 2-year legislative session, each year
19 of the session shall be considered to be a separate regular
20 session of the State legislature.

21 **SEC. 6036. ENHANCING THIRD PARTY IDENTIFICATION AND**
22 **PAYMENT.**

23 (a) CLARIFICATION OF THIRD PARTIES LEGALLY
24 RESPONSIBLE FOR PAYMENT OF A CLAIM FOR A HEALTH



1 CARE ITEM OR SERVICE.—Section 1902(a)(25) of the So-
2 cial Security Act (42 U.S.C. 1396a(a)(25)) is amended—

3 (1) in subparagraph (A), in the matter pre-
4 ceding clause (i)—

5 (A) by inserting “, self-insured plans”
6 after “health insurers”; and

7 (B) by striking “and health maintenance
8 organizations” and inserting “managed care or-
9 ganizations, pharmacy benefit managers, or
10 other parties that are, by statute, contract, or
11 agreement, legally responsible for payment of a
12 claim for a health care item or service”; and

13 (2) in subparagraph (G)—

14 (A) by inserting “a self-insured plan,”
15 after “1974,”; and

16 (B) by striking “and a health maintenance
17 organization” and inserting “a managed care
18 organization, a pharmacy benefit manager, or
19 other party that is, by statute, contract, or
20 agreement, legally responsible for payment of a
21 claim for a health care item or service”.

22 (b) REQUIREMENT FOR THIRD PARTIES TO PROVIDE
23 THE STATE WITH COVERAGE ELIGIBILITY AND CLAIMS
24 DATA.—Section 1902(a)(25) of such Act (42 U.S.C.
25 1396a(a)(25)) is amended—



1 (1) in subparagraph (G), by striking “and” at
2 the end;

3 (2) in subparagraph (H), by adding “and” after
4 the semicolon at the end; and

5 (3) by inserting after subparagraph (H), the
6 following:

7 “(I) that the State shall provide assur-
8 ances satisfactory to the Secretary that the
9 State has in effect laws requiring health insur-
10 ers, including self-insured plans, group health
11 plans (as defined in section 607(1) of the Em-
12 ployee Retirement Income Security Act of
13 1974), service benefit plans, managed care or-
14 ganizations, pharmacy benefit managers, or
15 other parties that are, by statute, contract, or
16 agreement, legally responsible for payment of a
17 claim for a health care item or service, as a
18 condition of doing business in the State, to—

19 “(i) provide, with respect to individ-
20 uals who are eligible for, or are provided,
21 medical assistance under the State plan,
22 upon the request of the State, information
23 to determine during what period the indi-
24 vidual or their spouses or their dependents
25 may be (or may have been) covered by a



1 health insurer and the nature of the cov-
2 erage that is or was provided by the health
3 insurer (including the name, address, and
4 identifying number of the plan) in a man-
5 ner prescribed by the Secretary;

6 “(ii) accept the State’s right of recov-
7 ery and the assignment to the State of any
8 right of an individual or other entity to
9 payment from the party for an item or
10 service for which payment has been made
11 under the State plan;

12 “(iii) respond to any inquiry by the
13 State regarding a claim for payment for
14 any health care item or service that is sub-
15 mitted not later than 3 years after the
16 date of the provision of such health care
17 item or service; and

18 “(iv) agree not to deny a claim sub-
19 mitted by the State solely on the basis of
20 the date of submission of the claim, the
21 type or format of the claim form, or a fail-
22 ure to present proper documentation at the
23 point-of-sale that is the basis of the claim,
24 if—



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1 “(I) the claim is submitted by
 2 the State within the 3-year period be-
 3 ginning on the date on which the item
 4 or service was furnished; and

5 “(II) any action by the State to
 6 enforce its rights with respect to such
 7 claim is commenced within 6 years of
 8 the State’s submission of such
 9 claim;”.

10 (c) EFFECTIVE DATE.—Except as provided in section
 11 6035(e), the amendments made by this section take effect
 12 on January 1, 2006.

13 **SEC. 6037. IMPROVED ENFORCEMENT OF DOCUMENTATION**
 14 **REQUIREMENTS.**

15 (a) IN GENERAL.—Section 1903 of the Social Secu-
 16 rity Act (42 U.S.C. 1396b) is amended—

17 (1) in subsection (i), as amended by section 104
 18 of Public Law 109-91 and ~~section 6031(a) of this~~
 19 ~~Act—~~

20 (A) by striking “or” at the end of para-
 21 graph ~~(21)~~; ⁽²⁰⁾

22 (B) by striking the period at the end of
 23 paragraph ~~(22)~~ and inserting “; or”; and ⁽²¹⁾

24 (C) by inserting after paragraph ~~(22)~~ the ⁽²¹⁾
 25 following new paragraph:

22

1 “(23) with respect to amounts expended for
 2 medical assistance for an individual who declares
 3 under section 1137(d)(1)(A) to be a citizen or na-
 4 tional of the United States for purposes of estab-
 5 lishing eligibility for benefits under this title, unless
 6 the requirement of subsection (x) is met.”; and

7 (2) by adding at the end the following new sub-
 8 section:

9 “(x)(1) For purposes of subsection (i)(23), the re-
 10 quirement of this subsection is, with respect to an indi-
 11 vidual declaring to be a citizen or national of the United
 12 States, that, subject to paragraph (2), there is presented
 13 satisfactory documentary evidence of citizenship or nation-
 14 ality (as defined in paragraph (3)) of the individual.

15 “(2) The requirement of paragraph (1) shall not
 16 apply to an alien who is eligible for medical assistance
 17 under this title—

18 “(A) and is entitled to or enrolled for benefits
 19 under any part of title XVIII;

20 “(B) on the basis of receiving supplemental se-
 21 curity income benefits under title XVI; or

22 “(C) on such other basis as the Secretary may
 23 specify under which satisfactory documentary evi-
 24 dence of citizenship or nationality had been pre-
 25 viously presented.

1 “(3)(A) For purposes of this subsection, the term
2 ‘satisfactory documentary evidence of citizenship or na-
3 tionality’ means—

4 “(i) any document described in subparagraph
5 (B); or

6 “(ii) a document described in subparagraph (C)
7 and a document described in subparagraph (D).

8 “(B) The following are documents described in this
9 subparagraph:

10 “(i) A United States passport.

11 “(ii) Form N-550 or N-570 (Certificate of
12 Naturalization).

13 “(iii) Form N-560 or N-561 (Certificate of
14 United States Citizenship).

15 “(iv) A valid State-issued driver’s license or
16 other identity document described in section
17 274A(b)(1)(D) of the Immigration and Nationality
18 Act, but only if the State issuing the license or such
19 document requires proof of United States citizenship
20 before issuance of such license or document or ob-
21 tains a social security number from the applicant
22 and verifies before certification that such number is
23 valid and assigned to the applicant who is a citizen.

24 “(v) Such other document as the Secretary may
25 specify, by regulation, that provides proof of United



1 States citizenship or nationality and that provides a
2 reliable means of documentation of personal identity.

3 “(C) The following are documents described in this
4 subparagraph:

5 “(i) A certificate of birth in the United States.

6 “(ii) Form FS-545 or Form DS-1350 (Certifi-
7 cation of Birth Abroad).

8 “(iii) Form I-97 (United States Citizen Identi-
9 fication Card).

10 “(iv) Form FS-240 (Report of Birth Abroad of
11 a Citizen of the United States).

12 “(v) Such other document (not described in
13 subparagraph (B)(iv)) as the Secretary may specify
14 that provides proof of United States citizenship or
15 nationality.

16 “(D) The following are documents described in this
17 subparagraph:

18 “(i) Any identity document described in section
19 274A(b)(1)(D) of the Immigration and Nationality
20 Act.

21 “(ii) Any other documentation of personal iden-
22 tity of such other type as the Secretary finds, by
23 regulation, provides a reliable means of identifica-
24 tion.



1 “(E) A reference in this paragraph to a form includes
2 a reference to any successor form.”.

3 (b) EFFECTIVE DATE.—The amendments made by
4 subsection (a) shall apply to determinations of initial eligi-
5 bility for medical assistance made on or after July 1,
6 2006, and to redeterminations of eligibility made on or
7 after such date in the case of individuals for whom the
8 requirement of section 1903(z) of the Social Security Act,
9 as added by such amendments, was not previously met.

10 (c) IMPLEMENTATION REQUIREMENT.—As soon as
11 practicable after the date of enactment of this Act, the
12 Secretary of Health and Human Services shall establish
13 an outreach program that is designed to educate individ-
14 uals who are likely to be affected by the requirements of
15 subsections (i)(23) and (x) of section 1903 of the Social
16 Security Act (as added by subsection (a)) about such re-
17 quirements and how they may be satisfied.

18 **CHAPTER 4—FLEXIBILITY IN COST**

19 **SHARING AND BENEFITS**

20 **SEC. 6041. STATE OPTION FOR ALTERNATIVE MEDICAID**

21 **PREMIUMS AND COST SHARING.**

22 (a) IN GENERAL.—Title XIX of the Social Security
23 Act is amended by inserting after section 1916 the fol-
24 lowing new section:

1 "STATE OPTION FOR ALTERNATIVE PREMIUMS AND COST
2 SHARING

3 "SEC. 1916A. (a) STATE FLEXIBILITY.—

4 "(1) IN GENERAL.—Notwithstanding sections
5 1916 and 1902(a)(10)(B), a State, at its option and
6 through a State plan amendment, may impose pre-
7 miums and cost sharing for any group of individuals
8 (as specified by the State) and for any type of serv-
9 ices (other than drugs for which cost sharing may be
10 imposed under subsection (c)), and may vary such
11 premiums and cost sharing among such groups or
12 types, consistent with the limitations established
13 under this section. Nothing in this section shall be
14 construed as superseding (or preventing the applica-
15 tion of) section 1916(g).

16 "(2) DEFINITIONS.—In this section:

17 "(A) PREMIUM.—The term 'premium' in-
18 cludes any enrollment fee or similar charge.

19 "(B) COST SHARING.—The term 'cost
20 sharing' includes any deduction, copayment, or
21 similar charge.

22 "(b) LIMITATIONS ON EXERCISE OF AUTHORITY.—

23 "(1) INDIVIDUALS WITH FAMILY INCOME BE-
24 TWEEN 100 AND 150 PERCENT OF THE POVERTY
25 LINE.—In the case of an individual whose family in-



1 come exceeds 100 percent, but does not exceed 150
2 percent, of the poverty line applicable to a family of
3 the size involved, subject to subsections (c)(2) and
4 (e)(2)(A)—

5 “(A) no premium may be imposed under
6 the plan; and

7 “(B) with respect to cost sharing—

8 “(i) the cost sharing imposed under
9 subsection (a) with respect to any item or
10 service may not exceed 10 percent of the
11 cost of such item or service; and

12 “(ii) the total aggregate amount of
13 cost sharing imposed under this section
14 (including any cost sharing imposed under
15 subsection (c) or (e)) for all individuals in
16 the family may not exceed 5 percent of the
17 family income of the family involved, as
18 applied on a quarterly or monthly basis (as
19 specified by the State).

20 “(2) INDIVIDUALS WITH FAMILY INCOME
21 ABOVE 150 PERCENT OF THE POVERTY LINE.—In
22 the case of an individual whose family income ex-
23 ceeds 150 percent of the poverty line applicable to
24 a family of the size involved, subject to subsections
25 (c)(2) and (e)(2)(A)—



1 “(A) the total aggregate amount of pre-
2 miums and cost sharing imposed under this sec-
3 tion (including any cost sharing imposed under
4 subsection (c) or (e)) for all individuals in the
5 family may not exceed 5 percent of the family
6 income of the family involved, as applied on a
7 quarterly or monthly basis (as specified by the
8 State); and

9 “(B) with respect to cost sharing, the cost
10 sharing imposed with respect to any item or
11 service under subsection (a) may not exceed 20
12 percent of the cost of such item or service.

13 “(3) ADDITIONAL LIMITATIONS.—

14 “(A) PREMIUMS.—No premiums shall be
15 imposed under this section with respect to the
16 following:

17 “(i) Individuals under 18 years of age
18 that are required to be provided medical
19 assistance under section 1902(a)(10)(A)(i),
20 and including individuals with respect to
21 whom aid or assistance is made available
22 under part B of title IV to children in fos-
23 ter care and individuals with respect to
24 whom adoption or foster care assistance is



1 made available under part E of such title,
2 without regard to age.

3 “(ii) Pregnant women.

4 “(iii) Any terminally ill individual who
5 is receiving hospice care (as defined in sec-
6 tion 1905(o)).

7 “(iv) Any individual who is an inpa-
8 tient in a hospital, nursing facility, inter-
9 mediate care facility for the mentally re-
10 tardated, or other medical institution, if such
11 individual is required, as a condition of re-
12 ceiving services in such institution under
13 the State plan, to spend for costs of med-
14 ical care all but a minimal amount of the
15 individual’s income required for personal
16 needs.

17 “(v) Women who are receiving medical
18 assistance by virtue of the application of
19 sections 1902(a)(10)(A)(ii)(XVIII) and
20 1902(aa).

21 “(B) COST SHARING.—Subject to the suc-
22 ceeding provisions of this section, no cost shar-
23 ing shall be imposed under subsection (a) with
24 respect to the following:



1 “(i) Services furnished to individuals
2 under 18 years of age that are required to
3 be provided medical assistance under sec-
4 tion 1902(a)(10)(A)(i), and including serv-
5 ices furnished to individuals with respect
6 to whom aid or assistance is made avail-
7 able under part B of title IV to children in
8 foster care and individuals with respect to
9 whom adoption or foster care assistance is
10 made available under part E of such title,
11 without regard to age.

12 “(ii) Preventive services (such as well
13 baby and well child care and immuniza-
14 tions) provided to children under 18 years
15 of age regardless of family income.

16 “(iii) Services furnished to pregnant
17 women, if such services relate to the preg-
18 nancy or to any other medical condition
19 which may complicate the pregnancy.

20 “(iv) Services furnished to a termi-
21 nally ill individual who is receiving hospice
22 care (as defined in section 1905(o)).

23 “(v) Services furnished to any indi-
24 vidual who is an inpatient in a hospital,
25 nursing facility, intermediate care facility



1 for the mentally retarded, or other medical
2 institution, if such individual is required,
3 as a condition of receiving services in such
4 institution under the State plan, to spend
5 for costs of medical care all but a minimal
6 amount of the individual's income required
7 for personal needs.

8 “(vi) Emergency services (as defined
9 by the Secretary for purposes of section
10 1916(a)(2)(D)).

11 “(vii) Family planning services and
12 supplies described in section
13 1905(a)(4)(C).

14 “(viii) Services furnished to women
15 who are receiving medical assistance by
16 virtue of the application of sections
17 1902(a)(10)(A)(ii)(XVIII) and 1902(aa).

18 “(C) CONSTRUCTION.—Nothing in this
19 paragraph shall be construed as preventing a
20 State from exempting additional classes of indi-
21 viduals from premiums under this section or
22 from exempting additional individuals or serv-
23 ices from cost sharing under subsection (a).

24 “(4) DETERMINATIONS OF FAMILY INCOME.—
25 In applying this subsection, family income shall be



1 determined in a manner specified by the State for
2 purposes of this subsection, including the use of
3 such disregards as the State may provide. Family in-
4 come shall be determined for such period and at
5 such periodicity as the State may provide under this
6 title.

7 “(5) POVERTY LINE DEFINED.—For purposes
8 of this section, the term ‘poverty line’ has the mean-
9 ing given such term in section 673(2) of the Com-
10 munity Services Block Grant Act (42 U.S.C.
11 9902(2)), including any revision required by such
12 section.

13 “(6) CONSTRUCTION.—Nothing in this section
14 shall be construed—

15 “(A) as preventing a State from further
16 limiting the premiums and cost sharing imposed
17 under this section beyond the limitations pro-
18 vided under this section;

19 “(B) as affecting the authority of the Sec-
20 retary through waiver to modify limitations on
21 premiums and cost sharing under this section;
22 or

23 “(C) as affecting any such waiver of re-
24 quirements in effect under this title before the
25 date of the enactment of this section with re-



1 gard to the imposition of premiums and cost
2 sharing.

3 “(d) ENFORCEABILITY OF PREMIUMS AND OTHER
4 COST SHARING.—

5 “(1) PREMIUMS.—Notwithstanding section
6 1916(c)(3) and section 1902(a)(10)(B), a State
7 may, at its option, condition the provision of medical
8 assistance for an individual upon prepayment of a
9 premium authorized to be imposed under this sec-
10 tion, or may terminate eligibility for such medical
11 assistance on the basis of failure to pay such a pre-
12 mium but shall not terminate eligibility of an indi-
13 vidual for medical assistance under this title on the
14 basis of failure to pay any such premium until such
15 failure continues for a period of not less than 60
16 days. A State may apply the previous sentence for
17 some or all groups of beneficiaries as specified by
18 the State and may waive payment of any such pre-
19 mium in any case where the State determines that
20 requiring such payment would create an undue hard-
21 ship.

22 “(2) COST SHARING.—Notwithstanding section
23 1916(e) or any other provision of law, a State may
24 permit a provider participating under the State plan
25 to require, as a condition for the provision of care,



1 items, or services to an individual entitled to medical
2 assistance under this title for such care, items, or
3 services, the payment of any cost sharing authorized
4 to be imposed under this section with respect to
5 such care, items, or services. Nothing in this para-
6 graph shall be construed as preventing a provider
7 from reducing or waiving the application of such
8 cost sharing on a case-by-case basis.”.

9 (b) INDEXING NOMINAL COST SHARING AND CON-
10 FORMING AMENDMENT.—Section 1916 of such Act (42
11 U.S.C. 1396o) is amended—

12 (1) in subsection (f), by inserting “and section
13 1916A” after “(b)(3)”; and

14 (2) by adding at the end the following new sub-
15 section:

16 “(h) In applying this section and subsections (c) and
17 (e) of section 1916A, with respect to cost sharing that is
18 ‘nominal’ in amount, the Secretary shall increase such
19 ‘nominal’ amounts for each year (beginning with 2006)
20 by the annual percentage increase in the medical care
21 component of the consumer price index for all urban con-
22 sumers (U.S. city average) as rounded up in an appro-
23 priate manner.”.



1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to cost sharing imposed for items
3 and services furnished on or after March 31, 2006.

4 **SEC. 6042. SPECIAL RULES FOR COST SHARING FOR PRE-**
5 **SCRIPTION DRUGS.**

6 (a) IN GENERAL.—Section 1916A of the Social Secu-
7 rity Act, as inserted by section 6041(a), is amended by
8 inserting after subsection (b) the following new subsection:

9 “(c) SPECIAL RULES FOR COST SHARING FOR PRE-
10 SCRIPTON DRUGS.—

11 “(1) IN GENERAL.—In order to encourage
12 beneficiaries to use drugs (in this subsection referred
13 to as ‘preferred drugs’) identified by the State as the
14 least (or less) costly effective prescription drugs
15 within a class of drugs (as defined by the State),
16 with respect to one or more groups of beneficiaries
17 specified by the State, subject to paragraph (2), the
18 State may—

19 “(A) provide cost sharing (instead of the
20 level of cost sharing otherwise permitted under
21 section 1916, but subject to paragraphs (2) and
22 (3)) with respect to drugs that are not pre-
23 ferred drugs within a class; and

24 “(B) waive or reduce the cost sharing oth-
25 erwise applicable for preferred drugs within



1 such class and shall not apply any such cost
2 sharing for such preferred drugs for individuals
3 for whom cost sharing may not otherwise be im-
4 posed under subsection (b)(3)(B).

5 “(2) LIMITATIONS.—

6 “(A) BY INCOME GROUP.—In no case may
7 the cost sharing under paragraph (1)(A) with
8 respect to a non-preferred drug exceed—

9 “(i) in the case of an individual whose
10 family income does not exceed 150 percent
11 of the poverty line applicable to a family of
12 the size involved, the amount of nominal
13 cost sharing (as otherwise determined
14 under section 1916); or

15 “(ii) in the case of an individual
16 whose family income exceeds 150 percent
17 of the poverty line applicable to a family of
18 the size involved, 20 percent of the cost of
19 the drug.

20 “(B) LIMITATION TO NOMINAL FOR EX-
21 EMPT POPULATIONS.—In the case of an indi-
22 vidual who is otherwise not subject to cost shar-
23 ing due to the application of subsection
24 (b)(3)(B), any cost sharing under paragraph
25 (1)(A) with respect to a non-preferred drug



1 may not exceed a nominal amount (as otherwise
2 determined under section 1916).

3 “(C) CONTINUED APPLICATION OF AGGREGATE CAP.—In addition to the limitations imposed under subparagraphs (A) and (B), any
4 cost sharing under paragraph (1)(A) continues
5 to be subject to the aggregate cap on cost sharing applied under paragraph (1) or (2) of subsection (b), as the case may be.
6
7
8
9

10 “(3) WAIVER.—In carrying out paragraph (1),
11 a State shall provide for the application of cost sharing levels applicable to a preferred drug in the case
12 of a drug that is not a preferred drug if the prescribing physician determines that the preferred
13 drug for treatment of the same condition either
14 would not be as effective for the individual or would
15 have adverse effects for the individual or both.
16
17

18 “(4) EXCLUSION AUTHORITY.—Nothing in this
19 subsection shall be construed as preventing a State
20 from excluding specified drugs or classes of drugs
21 from the application of paragraph (1).”.

22 (b) EFFECTIVE DATE.—The amendment made by
23 subsection (a) shall apply to cost sharing imposed for
24 items and services furnished on or after March 31, 2006.



1 SEC. 6043. EMERGENCY ROOM COPAYMENTS FOR NON-
2 EMERGENCY CARE.

3 (a) IN GENERAL.—Section 1916A of the Social Secu-
4 rity Act, as inserted by section 6041 and as amended by
5 section 6042, is further amended by adding at the end
6 the following new subsection:

7 “(e) STATE OPTION FOR PERMITTING HOSPITALS
8 TO IMPOSE COST SHARING FOR NON-EMERGENCY CARE
9 FURNISHED IN AN EMERGENCY DEPARTMENT.—

10 “(1) IN GENERAL.—Notwithstanding section
11 1916 and section 1902(a)(1) or the previous provi-
12 sions of this section, but subject to the limitations
13 of paragraph (2), a State may, by amendment to its
14 State plan under this title, permit a hospital to im-
15 pose cost sharing for non-emergency services fur-
16 nished to an individual (within one or more groups
17 of individuals specified by the State) in the hospital
18 emergency department under this subsection if the
19 following conditions are met:

20 “(A) ACCESS TO NON-EMERGENCY ROOM
21 PROVIDER.—The individual has actually avail-
22 able and accessible (as such terms are applied
23 by the Secretary under section 1916(b)(3)) an
24 alternate non-emergency services provider with
25 respect to such services.



1 “(B) NOTICE.—The hospital must inform
2 the beneficiary after receiving an appropriate
3 medical screening examination under section
4 1867 and after a determination has been made
5 that the individual does not have an emergency
6 medical condition, but before providing the non-
7 emergency services, of the following:

8 “(i) The hospital may require the pay-
9 ment of the State specified cost sharing
10 before the service can be provided.

11 “(ii) The name and location of an al-
12 ternate non-emergency services provider
13 (described in subparagraph (A)) that is ac-
14 tually available and accessible (as described
15 in such subparagraph).

16 “(iii) The fact that such alternate
17 provider can provide the services without
18 the imposition of cost sharing described in
19 clause (i).

20 “(iv) The hospital provides a referral
21 to coordinate scheduling of this treatment.

22 Nothing in this subsection shall be construed as
23 preventing a State from applying (or waiving)
24 cost sharing otherwise permissible under this
25 section to services described in clause (iii).



1 “(2) LIMITATIONS.—

2 “(A) FOR POOREST BENEFICIARIES.—In
3 the case of an individual described in subsection
4 (b)(1), the cost sharing imposed under this sub-
5 section may not exceed twice the amount deter-
6 mined to be nominal under section 1916, sub-
7 ject to the percent of income limitation other-
8 wise applicable under subsection (b)(1).

9 “(B) APPLICATION TO EXEMPT POPU-
10 LATIONS.—In the case of an individual who is
11 otherwise not subject to cost sharing under sub-
12 section (b)(3), a State may impose cost sharing
13 under paragraph (1) for care in an amount that
14 does not exceed a nominal amount (as otherwise
15 determined under section 1916) so long as no
16 cost sharing is imposed to receive such care
17 through an outpatient department or other al-
18 ternative health care provider in the geographic
19 area of the hospital emergency department in-
20 volved.

21 “(C) CONTINUED APPLICATION OF AGGRE-
22 GATE CAP; RELATION TO OTHER COST SHAR-
23 ING.—In addition to the limitations imposed
24 under subparagraphs (A) and (B), any cost
25 sharing under paragraph (1) is subject to the



1 aggregate cap on cost sharing applied under
2 paragraph (1) or (2) of subsection (b), as the
3 case may be. Cost sharing imposed for services
4 under this subsection shall be instead of any
5 cost sharing that may be imposed for such serv-
6 ices under subsection (a).

7 “(3) CONSTRUCTION.—Nothing in this section
8 shall be construed—

9 “(A) to limit a hospital’s obligations with
10 respect to screening and stabilizing treatment
11 of an emergency medical condition under sec-
12 tion 1867; or

13 “(B) to modify any obligations under ei-
14 ther State or Federal standards relating to the
15 application of a prudent-layperson standard
16 with respect to payment or coverage of emer-
17 gency services by any managed care organiza-
18 tion.

19 “(4) STANDARD REGARDING IMPOSITION OF
20 COST SHARING.—No hospital or physician shall be
21 liable in any civil action or proceeding for the impo-
22 sition of cost-sharing under this section, absent a
23 finding by clear and convincing evidence of gross
24 negligence by the hospital or physician. The previous
25 sentence shall not affect any liability under section



1 1867 or otherwise applicable under State law based
2 upon the provision of (or failure to provide) care.

3 “(5) DEFINITIONS.—For purposes of this sub-
4 section:

5 “(A) NON-EMERGENCY SERVICES.—The
6 term ‘non-emergency services’ means any care
7 or services furnished in a emergency depart-
8 ment of a hospital that the physician deter-
9 mines do not constitute an appropriate medical
10 screening examination or stabilizing examina-
11 tion and treatment required to be provided by
12 the hospital under section 1867.

13 “(B) ALTERNATE NON-EMERGENCY SERV-
14 ICES PROVIDER.—The term ‘alternative non-
15 emergency services provider’ means, with re-
16 spect to non-emergency services for the diag-
17 nosis or treatment of a condition, a health care
18 provider, such as a physician’s office, health
19 care clinic, community health center, hospital
20 outpatient department, or similar health care
21 provider, that can provide clinically appropriate
22 services for the diagnosis or treatment of a con-
23 dition contemporaneously with the provision of
24 the non-emergency services that would be pro-
25 vided in a emergency department of a hospital



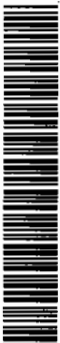
1 for the diagnosis or treatment of a condition,
2 and that is participating in the program under
3 this title.”.

4 (b) GRANT FUNDS FOR ESTABLISHMENT OF ALTER-
5 NATE NON-EMERGENCY SERVICES PROVIDERS.—Section
6 1903 of the Social Security Act (42 U.S.C. 1396b), as
7 amended by section 6037(a)(2), is amended by adding at
8 the end the following new subsection:

9 “(y) PAYMENTS FOR ESTABLISHMENT OF ALTER-
10 NATE NON-EMERGENCY SERVICES PROVIDERS.—

11 “(1) PAYMENTS.—In addition to the payments
12 otherwise provided under subsection (a), subject to
13 paragraph (2), the Secretary shall provide for pay-
14 ments to States under such subsection for the estab-
15 lishment of alternate non-emergency service pro-
16 viders (as defined in section 1916A(e)(5)(B)), or
17 networks of such providers.

18 “(2) LIMITATION.—The total amount of pay-
19 ments under this subsection shall not exceed
20 \$50,000,000 during the 4-year period beginning
21 with 2006. This subsection constitutes budget au-
22 thority in advance of appropriations Acts and rep-
23 represents the obligation of the Secretary to provide for
24 the payment of amounts provided under this sub-
25 section.



1 “(3) PREFERENCE.—In providing for payments
 2 to States under this subsection, the Secretary shall
 3 provide preference to States that establish, or pro-
 4 vide for, alternate non-emergency services providers
 5 or networks of such providers that—

6 “(A) serve rural or underserved areas
 7 where beneficiaries under this title may not
 8 have regular access to providers of primary care
 9 services; or

10 “(B) are in partnership with local commu-
 11 nity hospitals.

12 “(4) FORM AND MANNER OF PAYMENT.—Pay-
 13 ment to a State under this subsection shall be made
 14 only upon the filing of such application in such form
 15 and in such manner as the Secretary shall specify.
 16 Payment to a State under this subsection shall be
 17 made in the same manner as other payments under
 18 section 1903(a).”.

19 (c) EFFECTIVE DATE.—The amendments made by
 20 this section shall apply to non-emergency services fur-
 21 nished on or after January 1, 2007.

22 **SEC. 6044. USE OF BENCHMARK BENEFIT PACKAGES.**

23 (a) IN GENERAL.—Title XIX of the Social Security
 24 Act, as amended by section 6035, is amended by redesignig-



1 nating section 1937 as section 1938 and by inserting after
2 section 1936 the following new section:

3 "STATE FLEXIBILITY IN BENEFIT PACKAGES

4 "SEC. 1937. (a) STATE OPTION OF PROVIDING
5 BENCHMARK BENEFITS.—

6 "(1) AUTHORITY.—

7 "(A) IN GENERAL.—Notwithstanding any
8 other provision of this title, a State, at its op-
9 tion as a State plan amendment, may provide
10 for medical assistance under this title to indi-
11 viduals within one or more groups of individuals
12 specified by the State through enrollment in
13 coverage that provides—

14 "(i) benchmark coverage described in
15 subsection (b)(1) or benchmark equivalent
16 coverage described in subsection (b)(2);
17 and

18 "(ii) for any child under 19 years of
19 age who is covered under the State plan
20 under section 1902(a)(10)(A), wrap-
21 around benefits to the benchmark coverage
22 or benchmark equivalent coverage con-
23 sisting of early and periodic screening, di-
24 agnostic, and treatment services defined in
25 section 1905(r).



1 “(B) LIMITATION.—The State may only
2 exercise the option under subparagraph (A) for
3 an individual eligible under an eligibility cat-
4 egory that had been established under the State
5 plan on or before the date of the enactment of
6 this section.

7 “(C) OPTION OF WRAP-AROUND BENE-
8 FITS.—In the case of coverage described in sub-
9 paragraph (A), a State, at its option, may pro-
10 vide such wrap-around or additional benefits as
11 the State may specify.

12 “(D) TREATMENT AS MEDICAL ASSIST-
13 ANCE.—Payment of premiums for such cov-
14 erage under this subsection shall be treated as
15 payment of other insurance premiums described
16 in the third sentence of section 1905(a).

17 “(2) APPLICATION.—

18 “(A) IN GENERAL.—Except as provided in
19 subparagraph (B), a State may require that a
20 full-benefit eligible individual (as defined in
21 subparagraph (C)) within a group obtain bene-
22 fits under this title through enrollment in cov-
23 erage described in paragraph (1)(A). A State
24 may apply the previous sentence to individuals
25 within 1 or more groups of such individuals.



1 “(B) LIMITATION ON APPLICATION.—A
2 State may not require under subparagraph (A)
3 an individual to obtain benefits through enroll-
4 ment described in paragraph (1)(A) if the indi-
5 vidual is within one of the following categories
6 of individuals:

7 “(i) MANDATORY PREGNANT
8 WOMEN.—The individual is a pregnant
9 woman who is required to be covered under
10 the State plan under section
11 1902(a)(10)(A)(i).

12 “(ii) BLIND OR DISABLED INDIVID-
13 UALS.—The individual qualifies for medical
14 assistance under the State plan on the
15 basis of being blind or disabled (or being
16 treated as being blind or disabled) without
17 regard to whether the individual is eligible
18 for supplemental security income benefits
19 under title XVI on the basis of being blind
20 or disabled and including an individual
21 who is eligible for medical assistance on
22 the basis of section 1902(e)(3).

23 “(iii) DUAL ELIGIBLES.—The indi-
24 vidual is entitled to benefits under any
25 part of title XVIII.



1 “(iv) TERMINALLY ILL HOSPICE PA-
2 TIENTS.—The individual is terminally ill
3 and is receiving benefits for hospice care
4 under this title.

5 “(v) ELIGIBLE ON BASIS OF INSTITU-
6 TIONALIZATION.—The individual is an in-
7 patient in a hospital, nursing facility, in-
8 termediate care facility for the mentally re-
9 tarded, or other medical institution, and is
10 required, as a condition of receiving serv-
11 ices in such institution under the State
12 plan, to spend for costs of medical care all
13 but a minimal amount of the individual’s
14 income required for personal needs.

15 “(vi) MEDICALLY FRAIL AND SPECIAL
16 MEDICAL NEEDS INDIVIDUALS.—The indi-
17 vidual is medically frail or otherwise an in-
18 dividual with special medical needs (as
19 identified in accordance with regulations of
20 the Secretary).

21 “(vii) BENEFICIARIES QUALIFYING
22 FOR LONG-TERM CARE SERVICES.—The in-
23 dividual qualifies based on medical condi-
24 tion for medical assistance for long-term



1 care services described in section
2 1917(e)(1)(C).

3 “(viii) CHILDREN IN FOSTER CARE
4 RECEIVING CHILD WELFARE SERVICES AND
5 CHILDREN RECEIVING FOSTER CARE OR
6 ADOPTION ASSISTANCE.—The individual is
7 an individual with respect to whom aid or
8 assistance is made available under part B
9 of title IV to children in foster care and in-
10 dividuals with respect to whom adoption or
11 foster care assistance is made available
12 under part E of such such title, without re-
13 gard to age.

14 “(ix) TANF AND SECTION 1931 PAR-
15 ENTS.—The individual qualifies for med-
16 ical assistance on the basis of eligibility to
17 receive assistance under a State plan fund-
18 ed under part A of title IV (as in effect on
19 or after the welfare reform effective date
20 defined in section 1931(i)).

21 “(x) WOMEN IN THE BREAST OR CER-
22 VICAL CANCER PROGRAM.—The individual
23 is a woman who is receiving medical assist-
24 ance by virtue of the application of sec-



1 tions 1902(a)(10)(A)(ii)(XVIII) and
2 1902(aa).

3 “(xii) LIMITED SERVICES BENE-
4 FICIARIES.—The individual—

5 “(I) qualifies for medical assist-
6 ance on the basis of section
7 1902(a)(10)(A)(ii)(XII); or

8 “(II) is not a qualified alien (as
9 defined in section 431 of the Personal
10 Responsibility and Work Opportunity
11 Reconciliation Act of 1996) and re-
12 ceives care and services necessary for
13 the treatment of an emergency med-
14 ical condition in accordance with sec-
15 tion 1903(v).

16 “(C) FULL-BENEFIT ELIGIBLE INDIVID-
17 UALS.—

18 “(i) IN GENERAL.—For purposes of
19 this paragraph, subject to clause (ii), the
20 term ‘full-benefit eligible individual’ means
21 for a State for a month an individual who
22 is determined eligible by the State for med-
23 ical assistance for all services defined in
24 section 1905(a) which are covered under
25 the State plan under this title for such



1 month under section 1902(a)(10)(A) or
2 under any other category of eligibility for
3 medical assistance for all such services
4 under this title, as determined by the Sec-
5 retary.

6 “(ii) EXCLUSION OF MEDICALLY
7 NEEDY AND SPEND-DOWN POPULATIONS.—
8 Such term shall not include an individual
9 determined to be eligible by the State for
10 medical assistance under section
11 1902(a)(10)(C) or by reason of section
12 1902(f) or otherwise eligible based on a re-
13 duction of income based on costs incurred
14 for medical or other remedial care.

15 “(b) BENCHMARK BENEFIT PACKAGES.—

16 “(1) IN GENERAL.—For purposes of subsection
17 (a)(1), each of the following coverage shall be con-
18 sidered to be benchmark coverage:

19 “(A) FEHBP-EQUIVALENT HEALTH IN-
20 SURANCE COVERAGE.—The standard Blue
21 Cross/Blue Shield preferred provider option
22 service benefit plan, described in and offered
23 under section 8903(1) of title 5, United States
24 Code.



1 “(B) STATE EMPLOYEE COVERAGE.—A
2 health benefits coverage plan that is offered and
3 generally available to State employees in the
4 State involved.

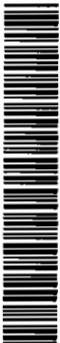
5 “(C) COVERAGE OFFERED THROUGH
6 HMO.—The health insurance coverage plan
7 that—

8 “(i) is offered by a health mainte-
9 nance organization (as defined in section
10 2791(b)(3) of the Public Health Service
11 Act), and

12 “(ii) has the largest insured commer-
13 cial, non-medicaid enrollment of covered
14 lives of such coverage plans offered by
15 such a health maintenance organization in
16 the State involved.

17 “(D) SECRETARY-APPROVED COVERAGE.—
18 Any other health benefits coverage that the Sec-
19 retary determines, upon application by a State,
20 provides appropriate coverage for the popu-
21 lation proposed to be provided such coverage.

22 “(2) BENCHMARK-EQUIVALENT COVERAGE.—
23 For purposes of subsection (a)(1), coverage that
24 meets the following requirement shall be considered
25 to be benchmark-equivalent coverage:



1 “(A) INCLUSION OF BASIC SERVICES.—

2 The coverage includes benefits for items and
3 services within each of the following categories
4 of basic services:

5 “(i) Inpatient and outpatient hospital
6 services.

7 “(ii) Physicians’ surgical and medical
8 services.

9 “(iii) Laboratory and x-ray services.

10 “(iv) Well-baby and well-child care,
11 including age-appropriate immunizations.

12 “(v) Other appropriate preventive
13 services, as designated by the Secretary.

14 “(B) AGGREGATE ACTUARIAL VALUE
15 EQUIVALENT TO BENCHMARK PACKAGE.—The
16 coverage has an aggregate actuarial value that
17 is at least actuarially equivalent to one of the
18 benchmark benefit packages described in para-
19 graph (1).

20 “(C) SUBSTANTIAL ACTUARIAL VALUE FOR
21 ADDITIONAL SERVICES INCLUDED IN BENCH-
22 MARK PACKAGE.—With respect to each of the
23 following categories of additional services for
24 which coverage is provided under the bench-
25 mark benefit package used under subparagraph



1 (B), the coverage has an actuarial value that is
2 equal to at least 75 percent of the actuarial
3 value of the coverage of that category of serv-
4 ices in such package:

5 “(i) Coverage of prescription drugs.

6 “(ii) Mental health services.

7 “(iii) Vision services.

8 “(iv) Hearing services.

9 “(3) DETERMINATION OF ACTUARIAL VALUE.—

10 The actuarial value of coverage of benchmark benefit
11 packages shall be set forth in an actuarial opinion
12 in an actuarial report that has been prepared—

13 “(A) by an individual who is a member of
14 the American Academy of Actuaries;

15 “(B) using generally accepted actuarial
16 principles and methodologies;

17 “(C) using a standardized set of utilization
18 and price factors;

19 “(D) using a standardized population that
20 is representative of the population involved;

21 “(E) applying the same principles and fac-
22 tors in comparing the value of different cov-
23 erage (or categories of services);

24 “(F) without taking into account any dif-
25 ferences in coverage based on the method of de-



1 livery or means of cost control or utilization
2 used; and

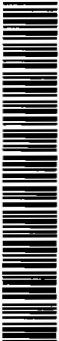
3 “(G) taking into account the ability of a
4 State to reduce benefits by taking into account
5 the increase in actuarial value of benefits cov-
6 erage offered under this title that results from
7 the limitations on cost sharing under such cov-
8 erage.

9 The actuary preparing the opinion shall select and
10 specify in the memorandum the standardized set and
11 population to be used under subparagraphs (C) and
12 (D).

13 “(4) COVERAGE OF RURAL HEALTH CLINIC AND
14 FQHC SERVICES.—Notwithstanding the previous pro-
15 visions of this section, a State may not provide for
16 medical assistance through enrollment of an indi-
17 vidual with benchmark coverage or benchmark equiv-
18 alent coverage under this section unless—

19 “(A) the individual has access, through
20 such coverage or otherwise, to services de-
21 scribed in subparagraphs (B) and (C) of section
22 1905(a)(2); and

23 “(B) payment for such services is made in
24 accordance with the requirements of section
25 1902(bb).”.



1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) takes effect on March 31, 2006.

3 **CHAPTER 5—STATE FINANCING UNDER**
4 **MEDICAID**

5 **SEC. 6051. MANAGED CARE ORGANIZATION PROVIDER TAX**
6 **REFORM.**

7 (a) IN GENERAL.—Section 1903(w)(7)(A)(viii) of the
8 Social Security Act (42 U.S.C. 1396b(w)(7)(A)(viii)) is
9 amended to read as follows:

10 “(viii) Services of managed care organiza-
11 tions (including health maintenance organiza-
12 tions, preferred provider organizations, and
13 such other similar organizations as the Sec-
14 retary may specify by regulation).”

15 (b) EFFECTIVE DATE.—

16 (1) IN GENERAL.—Subject to paragraph (2),
17 the amendment made by subsection (a) shall be ef-
18 fective as of the date of the enactment of this Act.

19 (2) DELAY IN EFFECTIVE DATE.—

20 (A) IN GENERAL.—Subject to subpara-
21 graph (B), in the case of a State specified in
22 subparagraph (B), the amendment made by
23 subsection (a) shall be effective as of October 1,
24 2009.



1 (B) SPECIFIED STATES.—For purposes of
2 subparagraph (A), the States specified in this
3 subparagraph are States that have enacted a
4 law providing for a tax on the services of a
5 medicaid managed care organization with a con-
6 tract under section 1903(m) of the Social Secu-
7 rity Act as of December 8, 2005.

8 (c) CLARIFICATION REGARDING NON-REGULATION
9 OF TRANSFERS.—

10 (1) IN GENERAL.—Nothing in section 1903(w)
11 of the Social Security Act (42 U.S.C. 1396b(w))
12 shall be construed by the Secretary of Health and
13 Human Services as prohibiting a State's use of
14 funds as the non-Federal share of expenditures
15 under title XIX of such Act where such funds are
16 transferred from or certified by a publicly-owned re-
17 gional medical center located in another State and
18 described in paragraph (2), so long as the Secretary
19 determines that such use of funds is proper and in
20 the interest of the program under title XIX.

21 (2) CENTER DESCRIBED.—A center described
22 in this paragraph is a publicly-owned regional med-
23 ical center that—

24 (A) provides level 1 trauma and burn care
25 services;



1 (B) provides level 3 neonatal care services;

2 (C) is obligated to serve all patients, re-
3 gardless of State of origin;

4 (D) is located within a Standard Metro-
5 politan Statistical Area (SMSA) that includes
6 at least 3 States, including the States described
7 in paragraph (1);

8 (E) serves as a tertiary care provider for
9 patients residing within a 125 mile radius; and

10 (F) meets the criteria for a dispropor-
11 tionate share hospital under section 1923 of
12 such Act in at least one State other than the
13 one in which the center is located.

14 (3) EFFECTIVE PERIOD.—This subsection shall
15 apply through December 31, 2006.

16 **SEC. 6052. REFORMS OF CASE MANAGEMENT AND TAR-**
17 **GETED CASE MANAGEMENT.**

18 (a) IN GENERAL.—Section 1915(g) of the Social Se-
19 curity Act (42 U.S.C. 1396n(g)(2)) is amended by striking
20 paragraph (2) and inserting the following:

21 “(2) For purposes of this subsection:

22 “(A)(i) The term ‘case management services’
23 means services which will assist individuals eligible
24 under the plan in gaining access to needed medical,
25 social, educational, and other services.



1 “(ii) Such term includes the following:

2 “(I) Assessment of an eligible individual to
3 determine service needs, including activities
4 that focus on needs identification, to determine
5 the need for any medical, educational, social, or
6 other services. Such assessment activities in-
7 clude the following:

8 “(aa) Taking client history.

9 “(bb) Identifying the needs of the in-
10 dividual, and completing related docu-
11 mentation.

12 “(cc) Gathering information from
13 other sources such as family members,
14 medical providers, social workers, and edu-
15 cators, if necessary, to form a complete as-
16 sessment of the eligible individual.

17 “(II) Development of a specific care plan
18 based on the information collected through an
19 assessment, that specifies the goals and actions
20 to address the medical, social, educational, and
21 other services needed by the eligible individual,
22 including activities such as ensuring the active
23 participation of the eligible individual and work-
24 ing with the individual (or the individual’s au-
25 thorized health care decision maker) and others



1 to develop such goals and identify a course of
2 action to respond to the assessed needs of the
3 eligible individual.

4 “(III) Referral and related activities to
5 help an individual obtain needed services, in-
6 cluding activities that help link eligible individ-
7 uals with medical, social, educational providers
8 or other programs and services that are capable
9 of providing needed services, such as making re-
10 ferrals to providers for needed services and
11 scheduling appointments for the individual.

12 “(IV) Monitoring and followup activities,
13 including activities and contacts that are nec-
14 essary to ensure the care plan is effectively im-
15 plemented and adequately addressing the needs
16 of the eligible individual, and which may be
17 with the individual, family members, providers,
18 or other entities and conducted as frequently as
19 necessary to help determine such matters as—

20 “(aa) whether services are being fur-
21 nished in accordance with an individual’s
22 care plan;

23 “(bb) whether the services in the care
24 plan are adequate; and



1 “(cc) whether there are changes in the
2 needs or status of the eligible individual,
3 and if so, making necessary adjustments in
4 the care plan and service arrangements
5 with providers.

6 “(iii) Such term does not include the direct de-
7 livery of an underlying medical, educational, social,
8 or other service to which an eligible individual has
9 been referred, including, with respect to the direct
10 delivery of foster care services, services such as (but
11 not limited to) the following:

12 “(I) Research gathering and completion of
13 documentation required by the foster care pro-
14 gram.

15 “(II) Assessing adoption placements.

16 “(III) Recruiting or interviewing potential
17 foster care parents.

18 “(IV) Serving legal papers.

19 “(V) Home investigations.

20 “(VI) Providing transportation.

21 “(VII) Administering foster care subsidies.

22 “(VIII) Making placement arrangements.

23 “(B) The term ‘targeted case management serv-
24 ices’ are case management services that are fur-
25 nished without regard to the requirements of section



1 1902(a)(1) and section 1902(a)(10)(B) to specific
2 classes of individuals or to individuals who reside in
3 specified areas.

4 “(3) With respect to contacts with individuals who
5 are not eligible for medical assistance under the State plan
6 or, in the case of targeted case management services, indi-
7 viduals who are eligible for such assistance but are not
8 part of the target population specified in the State plan,
9 such contacts—

10 “(A) are considered an allowable case manage-
11 ment activity, when the purpose of the contact is di-
12 rectly related to the management of the eligible indi-
13 vidual’s care; and

14 “(B) are not considered an allowable case man-
15 agement activity if such contacts relate directly to
16 the identification and management of the noneligible
17 or nontargeted individual’s needs and care.

18 “(4)(A) In accordance with section 1902(a)(25), Fed-
19 eral financial participation only is available under this title
20 for case management services or targeted case manage-
21 ment services if there are no other third parties liable to
22 pay for such services, including as reimbursement under
23 a medical, social, educational, or other program.

24 “(B) A State shall allocate the costs of any part of
25 such services which are reimbursable under another feder-

1 ally funded program in accordance with OMB Circular A-
2 87 (or any related or successor guidance or regulations
3 regarding allocation of costs among federally funded pro-
4 grams) under an approved cost allocation program.

5 “(5) Nothing in this subsection shall be construed as
6 affecting the application of rules with respect to third
7 party liability under programs, or activities carried out
8 under title XXVI of the Public Health Service Act or by
9 the Indian Health Service.”

10 (b) REGULATIONS.—The Secretary shall promulgate
11 regulations to carry out the amendment made by sub-
12 section (a) which may be effective and final immediately
13 on an interim basis as of the date of publication of the
14 interim final regulation. If the Secretary provides for an
15 interim final regulation, the Secretary shall provide for a
16 period of public comments on such regulation after the
17 date of publication. The Secretary may change or revise
18 such regulation after completion of the period of public
19 comment.

20 (c) EFFECTIVE DATE.—The amendment made by
21 subsection (a) shall take effect on January 1, 2006.

22 **SEC. 6053. ADDITIONAL FMAP ADJUSTMENTS.**

23 (a) HOLD HARMLESS FOR CERTAIN DECREASE.—
24 Notwithstanding the first sentence of section 1905(b) of
25 the Social Security Act (42 U.S.C. 1396d(b)), if, for pur-



1 poses of titles XIX and XXI of the Social Security Act
2 (42 U.S.C. 1396 et seq., 1397aa et seq.), the Federal med-
3 ical assistance percentage determined for the State speci-
4 fied in section 4725(a) of Public Law 105-33 for fiscal
5 year 2006 or fiscal year 2007 is less than the Federal
6 medical assistance percentage determined for such State
7 for fiscal year 2005, the Federal medical assistance per-
8 centage determined for such State for fiscal year 2005
9 shall be substituted for the Federal medical assistance
10 percentage otherwise determined for such State for fiscal
11 year 2006 or fiscal year 2007, as the case may be.

12 (b) HOLD HARMLESS FOR KATRINA IMPACT.—Not-
13 withstanding any other provision of law, for purposes of
14 titles XIX and XXI of the Social Security Act, the Sec-
15 retary of Health and Human Services, in computing the
16 Federal medical assistance percentage under section
17 1905(b) of such Act (42 U.S.C. 1396d(b)) for any year
18 after 2006 for a State that the Secretary determines has
19 a significant number of evacuees who were evacuated to,
20 and live in, the State as a result of Hurricane Katrina
21 as of October 1, 2005, shall disregard such evacuees (and
22 income attributable to such evacuees) from such computa-
23 tion.



1 **SEC. 6054. DSH ALLOTMENT FOR THE DISTRICT OF COLUM-**
2 **BIA.**

3 (a) **IN GENERAL.**—For purposes of determining the
4 DSH allotment for the District of Columbia under section
5 1923 of the Social Security Act (42 U.S.C. 1396r-4) for
6 fiscal year 2006 and each subsequent fiscal year, the table
7 in subsection (f)(2) of such section is amended under each
8 of the columns for FY 00, FY 01, and FY 02, in the entry
9 for the District of Columbia by striking “32” and insert-
10 ing “49”.

11 (b) **EFFECTIVE DATE.**—The amendments made by
12 subsection (a) shall take effect as if enacted on October
13 1, 2005, and shall only apply to disproportionate share
14 hospital adjustment expenditures applicable to fiscal year
15 2006 and subsequent fiscal years made on or after that
16 date.

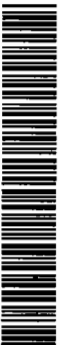
17 **SEC. 6055. INCREASE IN MEDICAID PAYMENTS TO INSULAR**
18 **AREAS.**

19 Section 1108(g) of the Social Security Act (42 U.S.C.
20 1308(g)) is amended—

21 (1) in paragraph (2), by inserting “and subject
22 to paragraph (3)” after “subsection (f)”; and

23 (2) by adding at the end the following new
24 paragraph:

25 “(3) **FISCAL YEARS 2006 AND 2007 FOR CERTAIN**
26 **INSULAR AREAS.**—The amounts otherwise deter-



1 mined under this subsection for Puerto Rico, the
2 Virgin Islands, Guam, the Northern Mariana Is-
3 lands, and American Samoa for fiscal year 2006 and
4 fiscal year 2007 shall be increased by the following
5 amounts:

6 “(A) For Puerto Rico, \$12,000,000 for fis-
7 cal year 2006 and \$12,000,000 for fiscal year
8 2007.

9 “(B) For the Virgin Islands, \$2,500,000
10 for fiscal year 2006 and \$5,000,000 for fiscal
11 year 2007.

12 “(C) For Guam, \$2,500,000 for fiscal year
13 2006 and \$5,000,000 for fiscal year 2007.

14 “(D) For the Northern Mariana Islands,
15 \$1,000,000 for fiscal year 2006 and \$2,000,000
16 for fiscal year 2007.

17 “(E) For American Samoa, \$2,000,000 for
18 fiscal year 2006 and \$4,000,000 for fiscal year
19 2007.

20 Such amounts shall not be taken into account in ap-
21 plying paragraph (2) for fiscal year 2007 but shall
22 be taken into account in applying such paragraph
23 for fiscal year 2008 and subsequent fiscal years.”.



1 **CHAPTER 6—OTHER PROVISIONS**

2 **Subchapter A—Family Opportunity Act**

3 **SEC. 6061. SHORT TITLE OF SUBCHAPTER.**

4 This subchapter may be cited as the “Family Oppor-
5 tunity Act of 2005” or the “Dylan Lee James Act”.

6 **SEC. 6062. OPPORTUNITY FOR FAMILIES OF DISABLED**
7 **CHILDREN TO PURCHASE MEDICAID COV-**
8 **ERAGE FOR SUCH CHILDREN.**

9 (a) STATE OPTION TO ALLOW FAMILIES OF DIS-
10 ABLED CHILDREN TO PURCHASE MEDICAID COVERAGE
11 FOR SUCH CHILDREN.—

12 (1) IN GENERAL.—Section 1902 of the Social
13 Security Act (42 U.S.C. 1396a) is amended—

14 (A) in subsection (a)(10)(A)(ii)—

15 (i) by striking “or” at the end of sub-
16 clause (XVII);

17 (ii) by adding “or” at the end of sub-
18 clause (XVIII); and

19 (iii) by adding at the end the fol-
20 lowing new subclause:

21 “(XIX) who are disabled children
22 described in subsection (cc)(1);”; and

23 (B) by adding at the end the following new
24 subsection:



1 “(cc)(1) Individuals described in this paragraph are
2 individuals—

3 “(A) who are children who have not attained 19
4 years of age and are born—

5 “(i) on or after January 1, 2001 (or, at
6 the option of a State, on or after an earlier
7 date), in the case of the second, third, and
8 fourth quarters of fiscal year 2007;

9 “(ii) on or after October 1, 1995 (or, at
10 the option of a State, on or after an earlier
11 date), in the case of each quarter of fiscal year
12 2008; and

13 “(iii) after October 1, 1989, in the case of
14 each quarter of fiscal year 2009 and each quar-
15 ter of any fiscal year thereafter;

16 “(B) who would be considered disabled under
17 section 1614(a)(3)(C) (as determined under title
18 XVI for children but without regard to any income
19 or asset eligibility requirements that apply under
20 such title with respect to children); and

21 “(C) whose family income does not exceed such
22 income level as the State establishes and does not
23 exceed—



1 “(i) 300 percent of the poverty line (as de-
2 fined in section 2110(c)(5)) applicable to a fam-
3 ily of the size involved; or

4 “(ii) such higher percent of such poverty
5 line as a State may establish, except that—

6 “(I) any medical assistance provided
7 to an individual whose family income ex-
8 ceeds 300 percent of such poverty line may
9 only be provided with State funds; and

10 “(II) no Federal financial participa-
11 tion shall be provided under section
12 1903(a) for any medical assistance pro-
13 vided to such an individual.”.

14 (2) INTERACTION WITH EMPLOYER-SPONSORED
15 FAMILY COVERAGE.—Section 1902(cc) of such Act
16 (42 U.S.C. 1396a(cc)), as added by paragraph
17 (1)(B), is amended by adding at the end the fol-
18 lowing new paragraph:

19 “(2)(A) If an employer of a parent of an individual
20 described in paragraph (1) offers family coverage under
21 a group health plan (as defined in section 2791(a) of the
22 Public Health Service Act), the State shall—

23 “(i) notwithstanding section 1906, require such
24 parent to apply for, enroll in, and pay premiums for
25 such coverage as a condition of such parent’s child



1 being or remaining eligible for medical assistance
2 under subsection (a)(10)(A)(ii)(XIX) if the parent is
3 determined eligible for such coverage and the em-
4 ployer contributes at least 50 percent of the total
5 cost of annual premiums for such coverage; and

6 “(ii) if such coverage is obtained—

7 “(I) subject to paragraph (2) of section
8 1916(h), reduce the premium imposed by the
9 State under that section in an amount that rea-
10 sonably reflects the premium contribution made
11 by the parent for private coverage on behalf of
12 a child with a disability; and

13 “(II) treat such coverage as a third party
14 liability under subsection (a)(25).

15 “(B) In the case of a parent to which subparagraph
16 (A) applies, a State, notwithstanding section 1906 but
17 subject to paragraph (1)(C)(ii), may provide for payment
18 of any portion of the annual premium for such family cov-
19 erage that the parent is required to pay. Any payments
20 made by the State under this subparagraph shall be con-
21 sidered, for purposes of section 1903(a), to be payments
22 for medical assistance.”.

23 (b) STATE OPTION TO IMPOSE INCOME-RELATED
24 PREMIUMS.—Section 1916 of such Act (42 U.S.C. 1396o)
25 is amended—



1 (1) in subsection (a), by striking “subsection
2 (g)” and inserting “subsections (g) and (i)”; and

3 (2) by adding at the end, as amended by section
4 6041(b)(2), the following new subsection:

5 “(i)(1) With respect to disabled children provided
6 medical assistance under section 1902(a)(10)(A)(ii)(XIX),
7 subject to paragraph (2), a State may (in a uniform man-
8 ner for such children) require the families of such children
9 to pay monthly premiums set on a sliding scale based on
10 family income.

11 “(2) A premium requirement imposed under para-
12 graph (1) may only apply to the extent that—

13 “(A) in the case of a disabled child described in
14 that paragraph whose family income—

15 “(i) does not exceed 200 percent of the
16 poverty line, the aggregate amount of such pre-
17 mium and any premium that the parent is re-
18 quired to pay for family coverage under section
19 1902(cc)(2)(A)(i) and other cost-sharing
20 charges do not exceed 5 percent of the family’s
21 income; and

22 “(ii) exceeds 200, but does not exceed 300,
23 percent of the poverty line, the aggregate
24 amount of such premium and any premium that
25 the parent is required to pay for family cov-



1 erage under section 1902(cc)(2)(A)(i) and other
2 cost-sharing charges do not exceed 7.5 percent
3 of the family's income; and

4 “(B) the requirement is imposed consistent with
5 section 1902(cc)(2)(A)(ii)(I).

6 “(3) A State shall not require prepayment of a pre-
7 mium imposed pursuant to paragraph (1) and shall not
8 terminate eligibility of a child under section
9 1902(a)(10)(A)(ii)(XIX) for medical assistance under this
10 title on the basis of failure to pay any such premium until
11 such failure continues for a period of at least 60 days from
12 the date on which the premium became past due. The
13 State may waive payment of any such premium in any
14 case where the State determines that requiring such pay-
15 ment would create an undue hardship.”.

16 (c) CONFORMING AMENDMENTS.—(1) Section
17 1903(f)(4) of such Act (42 U.S.C. 1396b(f)(4)) is amend-
18 ed in the matter preceding subparagraph (A), by inserting
19 “1902(a)(10)(A)(ii)(XIX),” after
20 “1902(a)(10)(A)(ii)(XVIII),”.

21 (2) Section 1905(u)(2)(B) of such Act (42 U.S.C.
22 1396d(u)(2)(B)) is amended by adding at the end the fol-
23 lowing sentence: “Such term excludes any child eligible for
24 medical assistance only by reason of section
25 1902(a)(10)(A)(ii)(XIX).”.

1 (d) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to medical assistance for items and
3 services furnished on or after January 1, 2007.

4 **SEC. 6063. DEMONSTRATION PROJECTS REGARDING HOME**
5 **AND COMMUNITY-BASED ALTERNATIVES TO**
6 **PSYCHIATRIC RESIDENTIAL TREATMENT FA-**
7 **CILITIES FOR CHILDREN.**

8 (a) IN GENERAL.—The Secretary is authorized to
9 conduct, during each of fiscal years 2007 through 2011,
10 demonstration projects (each in the section referred to as
11 a “demonstration project”) in accordance with this section
12 under which up to 10 States (as defined for purposes of
13 title XIX of the Social Security Act) are awarded grants,
14 on a competitive basis, to test the effectiveness in improv-
15 ing or maintaining a child’s functional level and cost-effec-
16 tiveness of providing coverage of home and community-
17 based alternatives to psychiatric residential treatment for
18 children enrolled in the Medicaid program under title XIX
19 of such Act.

20 (b) APPLICATION OF TERMS AND CONDITIONS.—

21 (1) IN GENERAL.—Subject to the provisions of
22 this section, for the purposes of the demonstration
23 projects, and only with respect to children enrolled
24 under such demonstration projects, a psychiatric res-
25 idential treatment facility (as defined in section



1 483.352 of title 42 of the Code of Federal Regula-
2 tions) shall be deemed to be a facility specified in
3 section 1915(c) of the Social Security Act (42
4 U.S.C. 1396n(c)), and to be included in each ref-
5 erence in such section 1915(c) to hospitals, nursing
6 facilities, and intermediate care facilities for the
7 mentally retarded.

8 (2) STATE OPTION TO ASSURE CONTINUITY OF
9 MEDICAID COVERAGE.—Upon the termination of a
10 demonstration project under this section, the State
11 that conducted the project may elect, only with re-
12 spect to a child who is enrolled in such project on
13 the termination date, to continue to provide medical
14 assistance for coverage of home and community-
15 based alternatives to psychiatric residential treat-
16 ment for the child in accordance with section
17 1915(c) of the Social Security Act (42 U.S.C.
18 1396n(c)), as modified through the application of
19 paragraph (1). Expenditures incurred for providing
20 such medical assistance shall be treated as a home
21 and community-based waiver program under section
22 1915(c) of the Social Security Act (42 U.S.C.
23 1396n(c)) for purposes of payment under section
24 1903 of such Act (42 U.S.C. 1396b).

25 (c) TERMS OF DEMONSTRATION PROJECTS.—



1 (1) IN GENERAL.—Except as otherwise pro-
2 vided in this section, a demonstration project shall
3 be subject to the same terms and conditions as apply
4 to a waiver under section 1915(c) of the Social Se-
5 curity Act (42 U.S.C. 1396n(c)), including the waiv-
6 er of certain requirements under the first sentence
7 of paragraph (3) of such section but not applying
8 the second sentence of such paragraph.

9 (2) BUDGET NEUTRALITY.—In conducting the
10 demonstration projects under this section, the Sec-
11 retary shall ensure that the aggregate payments
12 made by the Secretary under title XIX of the Social
13 Security Act (42 U.S.C. 1396 et seq.) do not exceed
14 the amount which the Secretary estimates would
15 have been paid under that title if the demonstration
16 projects under this section had not been imple-
17 mented.

18 (3) EVALUATION.—The application for a dem-
19 onstration project shall include an assurance to pro-
20 vide for such interim and final evaluations of the
21 demonstration project by independent third parties,
22 and for such interim and final reports to the Sec-
23 retary, as the Secretary may require.

24 (d) PAYMENTS TO STATES; LIMITATIONS TO SCOPE
25 AND FUNDING.—



1 (1) IN GENERAL.—Subject to paragraph (2), a
2 demonstration project approved by the Secretary
3 under this section shall be treated as a home and
4 community-based waiver program under section
5 1915(c) of the Social Security Act (42 U.S.C.
6 1396n(c)) for purposes of payment under section
7 1903 of such Act (42 U.S.C. 1396b).

8 (2) LIMITATION.—In no case may the amount
9 of payments made by the Secretary under this sec-
10 tion for State demonstration projects for a fiscal
11 year exceed the amount available under subsection
12 (f)(2)(A) for such fiscal year.

13 (e) SECRETARY'S EVALUATION AND REPORT.—The
14 Secretary shall conduct an interim and final evaluation of
15 State demonstration projects under this section and shall
16 report to the President and Congress the conclusions of
17 such evaluations within 12 months of completing such
18 evaluations.

19 (f) FUNDING.—

20 (1) IN GENERAL.—For the purpose of carrying
21 out this section, there are appropriated, from
22 amounts in the Treasury not otherwise appropriated,
23 for fiscal years 2007 through 2011, a total of
24 \$218,000,000, of which—



1 (A) the amount specified in paragraph (2)
 2 shall be available for each of fiscal years 2007
 3 through 2011; and

4 (B) a total of \$1,000,000 shall be available
 5 to the Secretary for the evaluations and report
 6 under subsection (e).

7 (2) FISCAL YEAR LIMIT.—

8 (A) IN GENERAL.—For purposes of para-
 9 graph (1), the amount specified in this para-
 10 graph for a fiscal year is the amount specified
 11 in subparagraph (B) for the fiscal year plus the
 12 difference, if any, between the total amount
 13 available under this paragraph for prior fiscal
 14 years and the total amount previously expended
 15 under paragraph (1)(A) for such prior fiscal
 16 years.

17 (B) FISCAL YEAR AMOUNTS.—The amount
 18 specified in this subparagraph for—

- 19 (i) fiscal year 2007 is \$21,000,000;
- 20 (ii) fiscal year 2008 is \$37,000,000;
- 21 (iii) fiscal year 2009 is \$49,000,000;
- 22 (iv) fiscal year 2010 is \$53,000,000;
- 23 and
- 24 (v) fiscal year 2011 is \$57,000,000.



1 **SEC. 6064. DEVELOPMENT AND SUPPORT OF FAMILY-TO-**
2 **FAMILY HEALTH INFORMATION CENTERS.**

3 Section 501 of the Social Security Act (42 U.S.C.
4 701) is amended by adding at the end the following new
5 subsection:

6 “(c)(1)(A) For the purpose of enabling the Secretary
7 (through grants, contracts, or otherwise) to provide for
8 special projects of regional and national significance for
9 the development and support of family-to-family health in-
10 formation centers described in paragraph (2), there is ap-
11 propriated to the Secretary, out of any money in the
12 Treasury not otherwise appropriated—

13 “(i) \$3,000,000 for fiscal year 2007;

14 “(ii) \$4,000,000 for fiscal year 2008; and

15 “(iii) \$5,000,000 for fiscal year 2009.

16 “(B) Funds appropriated or authorized to be appro-
17 priated under subparagraph (A) shall—

18 “(i) be in addition to amounts appropriated
19 under subsection (a) and retained under section
20 502(a)(1) for the purpose of carrying out activities
21 described in subsection (a)(2); and

22 “(ii) remain available until expended.

23 “(2) The family-to-family health information centers
24 described in this paragraph are centers that—

25 “(A) assist families of children with disabilities
26 or special health care needs to make informed

1 choices about health care in order to promote good
2 treatment decisions, cost-effectiveness, and improved
3 health outcomes for such children;

4 “(B) provide information regarding the health
5 care needs of, and resources available for, such chil-
6 dren;

7 “(C) identify successful health delivery models
8 for such children;

9 “(D) develop with representatives of health care
10 providers, managed care organizations, health care
11 purchasers, and appropriate State agencies, a model
12 for collaboration between families of such children
13 and health professionals;

14 “(E) provide training and guidance regarding
15 caring for such children;

16 “(F) conduct outreach activities to the families
17 of such children, health professionals, schools, and
18 other appropriate entities and individuals; and

19 “(G) are staffed—

20 “(i) by such families who have expertise in
21 Federal and State public and private health
22 care systems; and

23 “(ii) by health professionals.



1 “(3) The Secretary shall develop family-to-family
2 health information centers described in paragraph (2) in
3 accordance with the following:

4 “(A) With respect to fiscal year 2007, such cen-
5 ters shall be developed in not less than 25 States.

6 “(B) With respect to fiscal year 2008, such
7 centers shall be developed in not less than 40 States.

8 “(C) With respect to fiscal year 2009 and each
9 fiscal year thereafter, such centers shall be developed
10 in all States.

11 “(4) The provisions of this title that are applicable
12 to the funds made available to the Secretary under section
13 502(a)(1) apply in the same manner to funds made avail-
14 able to the Secretary under paragraph (1)(A).

15 “(5) For purposes of this subsection, the term ‘State’
16 means each of the 50 States and the District of Colum-
17 bia.”.

18 **SEC. 6065. RESTORATION OF MEDICAID ELIGIBILITY FOR**
19 **CERTAIN SSI BENEFICIARIES.**

20 (a) IN GENERAL.—Section 1902(a)(10)(A)(i)(II) of
21 the Social Security Act (42 U.S.C.
22 1396a(a)(10)(A)(i)(II)) is amended—

23 (1) by inserting “(aa)” after “(II)”;

24 (2) by striking “) and” and inserting “and”;

1 (3) by striking “section or who are” and insert-
2 ing “section), (bb) who are”; and

3 (4) by inserting before the comma at the end
4 the following: “, or (cc) who are under 21 years of
5 age and with respect to whom supplemental security
6 income benefits would be paid under title XVI if
7 subparagraphs (A) and (B) of section 1611(c)(7)
8 were applied without regard to the phrase ‘the first
9 day of the month following’”.

10 (b) EFFECTIVE DATE.—The amendments made by
11 subsection (a) shall apply to medical assistance for items
12 and services furnished on or after the date that is 1 year
13 after the date of enactment of this Act.

14 **Subchapter B—Money Follows the Person**
15 **Rebalancing Demonstration**

16 **SEC. 6071. MONEY FOLLOWS THE PERSON REBALANCING**
17 **DEMONSTRATION.**

18 (a) PROGRAM PURPOSE AND AUTHORITY.—The Sec-
19 retary is authorized to award, on a competitive basis,
20 grants to States in accordance with this section for dem-
21 onstration projects (each in this section referred to as an
22 “MFP demonstration project”) designed to achieve the
23 following objectives with respect to institutional and home
24 and community-based long-term care services under State
25 Medicaid programs:



1 (1) REBALANCING.—Increase the use of home
2 and community-based, rather than institutional,
3 long-term care services.

4 (2) MONEY FOLLOWS THE PERSON.—Eliminate
5 barriers or mechanisms, whether in the State law,
6 the State Medicaid plan, the State budget, or other-
7 wise, that prevent or restrict the flexible use of Med-
8 icaid funds to enable Medicaid-eligible individuals to
9 receive support for appropriate and necessary long-
10 term services in the settings of their choice.

11 (3) CONTINUITY OF SERVICE.—Increase the
12 ability of the State Medicaid program to assure con-
13 tinued provision of home and community-based long-
14 term care services to eligible individuals who choose
15 to transition from an institutional to a community
16 setting.

17 (4) QUALITY ASSURANCE AND QUALITY IM-
18 PROVEMENT.—Ensure that procedures are in place
19 (at least comparable to those required under the
20 qualified HCB program) to provide quality assur-
21 ance for eligible individuals receiving Medicaid home
22 and community-based long-term care services and to
23 provide for continuous quality improvement in such
24 services.

25 (b) DEFINITIONS.—For purposes of this section:



1 (1) HOME AND COMMUNITY-BASED LONG-TERM
2 CARE SERVICES.—The term “home and community-
3 based long-term care services” means, with respect
4 to a State Medicaid program, home and community-
5 based services (including home health and personal
6 care services) that are provided under the State’s
7 qualified HCB program or that could be provided
8 under such a program but are otherwise provided
9 under the Medicaid program.

10 (2) ELIGIBLE INDIVIDUAL.—The term “eligible
11 individual” means, with respect to an MFP dem-
12 onstration project of a State, an individual in the
13 State—

14 (A) who, immediately before beginning
15 participation in the MFP demonstration
16 project—

17 (i) resides (and has resided, for a pe-
18 riod of not less than 6 months or for such
19 longer minimum period, not to exceed 2
20 years, as may be specified by the State) in
21 an inpatient facility;

22 (ii) is receiving Medicaid benefits for
23 inpatient services furnished by such inpa-
24 tient facility; and



1 (iii) with respect to whom a deter-
2 mination has been made that, but for the
3 provision of home and community-based
4 long-term care services, the individual
5 would continue to require the level of care
6 provided in an inpatient facility and, in
7 any case in which the State applies a more
8 stringent level of care standard as a result
9 of implementing the State plan option per-
10 mitted under section 1915(i) of the Social
11 Security Act, the individual must continue
12 to require at least the level of care which
13 had resulted in admission to the institu-
14 tion; and

15 (B) who resides in a qualified residence be-
16 ginning on the initial date of participation in
17 the demonstration project.

18 (3) INPATIENT FACILITY.—The term “inpatient
19 facility” means a hospital, nursing facility, or inter-
20 mediate care facility for the mentally retarded. Such
21 term includes an institution for mental diseases, but
22 only, with respect to a State, to the extent medical
23 assistance is available under the State Medicaid plan
24 for services provided by such institution.



1 (4) MEDICAID.—The term “Medicaid” means,
2 with respect to a State, the State program under
3 title XIX of the Social Security Act (including any
4 waiver or demonstration under such title or under
5 section 1115 of such Act relating to such title).

6 (5) QUALIFIED HCB PROGRAM.—The term
7 “qualified HCB program” means a program pro-
8 viding home and community-based long-term care
9 services operating under Medicaid, whether or not
10 operating under waiver authority.

11 (6) QUALIFIED RESIDENCE.—The term “quali-
12 fied residence” means, with respect to an eligible
13 individual—

14 (A) a home owned or leased by the indi-
15 vidual or the individual’s family member;

16 (B) an apartment with an individual lease,
17 with lockable access and egress, and which in-
18 cludes living, sleeping, bathing, and cooking
19 areas over which the individual or the individ-
20 ual’s family has domain and control; and

21 (C) a residence, in a community-based res-
22 idential setting, in which no more than 4 unre-
23 lated individuals reside.

24 (7) QUALIFIED EXPENDITURES.—The term
25 “qualified expenditures” means expenditures by the



1 State under its MFP demonstration project for
 2 home and community-based long-term care services
 3 for an eligible individual participating in the MFP
 4 demonstration project, but only with respect to serv-
 5 ices furnished during the 12-month period beginning
 6 on the date the individual is discharged from an in-
 7 patient facility referred to in paragraph (2)(A)(i).

8 (8) SELF-DIRECTED SERVICES.—The term
 9 “self-directed” means, with respect to home and
 10 community-based long-term care services for an eli-
 11 gible individual, such services for the individual
 12 which are planned and purchased under the direc-
 13 tion and control of such individual or the individ-
 14 ual’s authorized representative (as defined by the
 15 Secretary), including the amount, duration, scope,
 16 provider, and location of such services, under the
 17 State Medicaid program consistent with the fol-
 18 lowing requirements:

19 (A) ASSESSMENT.—There is an assess-
 20 ment of the needs, capabilities, and preferences
 21 of the individual with respect to such services.

22 (B) SERVICE PLAN.—Based on such as-
 23 sessment, there is developed jointly with such
 24 individual or the individual’s authorized rep-
 25 resentative a plan for such services for such in-



1 dividual that is approved by the State and
2 that—

3 (i) specifies those services, if any,
4 which the individual or the individual's au-
5 thorized representative would be respon-
6 sible for directing;

7 (ii) identifies the methods by which
8 the individual or the individual's author-
9 ized representative or an agency designated
10 by an individual or representative will se-
11 lect, manage, and dismiss providers of such
12 services;

13 (iii) specifies the role of family mem-
14 bers and others whose participation is
15 sought by the individual or the individual's
16 authorized representative with respect to
17 such services;

18 (iv) is developed through a person-
19 centered process that—

20 (I) is directed by the individual
21 or the individual's authorized rep-
22 resentative;

23 (II) builds upon the individual's
24 capacity to engage in activities that
25 promote community life and that re-



1 spect the individual's preferences,
2 choices, and abilities; and

3 (III) involves families, friends,
4 and professionals as desired or re-
5 quired by the individual or the indi-
6 vidual's authorized representative;

7 (v) includes appropriate risk manage-
8 ment techniques that recognize the roles
9 and sharing of responsibilities in obtaining
10 services in a self-directed manner and as-
11 sure the appropriateness of such plan
12 based upon the resources and capabilities
13 of the individual or the individual's author-
14 ized representative; and

15 (vi) may include an individualized
16 budget which identifies the dollar value of
17 the services and supports under the control
18 and direction of the individual or the indi-
19 vidual's authorized representative.

20 (C) BUDGET PROCESS.—With respect to
21 individualized budgets described in subpara-
22 graph (B)(vi), the State application under sub-
23 section (c)—

24 (i) describes the method for calcu-
25 lating the dollar values in such budgets



1 based on reliable costs and service utiliza-
2 tion;

3 (ii) defines a process for making ad-
4 justments in such dollar values to reflect
5 changes in individual assessments and
6 service plans; and

7 (iii) provides a procedure to evaluate
8 expenditures under such budgets.

9 (9) STATE.—The term “State” has the mean-
10 ing given such term for purposes of title XIX of the
11 Social Security Act.

12 (c) STATE APPLICATION.—A State seeking approval
13 of an MFP demonstration project shall submit to the Sec-
14 retary, at such time and in such format as the Secretary
15 requires, an application meeting the following require-
16 ments and containing such additional information, provi-
17 sions, and assurances, as the Secretary may require:

18 (1) ASSURANCE OF A PUBLIC DEVELOPMENT
19 PROCESS.—The application contains an assurance
20 that the State has engaged, and will continue to en-
21 gage, in a public process for the design, develop-
22 ment, and evaluation of the MFP demonstration
23 project that allows for input from eligible individ-
24 uals, the families of such individuals, authorized rep-



1 representatives of such individuals, providers, and other
2 interested parties.

3 (2) OPERATION IN CONNECTION WITH QUALI-
4 FIED HCB PROGRAM TO ASSURE CONTINUITY OF
5 SERVICES.—The State will conduct the MFP dem-
6 onstration project for eligible individuals in conjunc-
7 tion with the operation of a qualified HCB program
8 that is in operation (or approved) in the State for
9 such individuals in a manner that assures continuity
10 of Medicaid coverage for such individuals so long as
11 such individuals continue to be eligible for medical
12 assistance.

13 (3) DEMONSTRATION PROJECT PERIOD.—The
14 application shall specify the period of the MFP dem-
15 onstration project, which shall include at least 2 con-
16 secutive fiscal years in the 5-fiscal-year period begin-
17 ning with fiscal year 2007.

18 (4) SERVICE AREA.—The application shall
19 specify the service area or areas of the MFP dem-
20 onstration project, which may be a statewide area or
21 1 or more geographic areas of the State.

22 (5) TARGETED GROUPS AND NUMBERS OF INDI-
23 VIDUALS SERVED.—The application shall specify—

24 (A) the target groups of eligible individuals
25 to be assisted to transition from an inpatient



1 facility to a qualified residence during each fis-
2 cal year of the MFP demonstration project;

3 (B) the projected numbers of eligible indi-
4 viduals in each targeted group of eligible indi-
5 viduals to be so assisted during each such year;
6 and

7 (C) the estimated total annual qualified ex-
8 penditures for each fiscal year of the MFP
9 demonstration project.

10 (6) INDIVIDUAL CHOICE, CONTINUITY OF
11 CARE.—The application shall contain assurances
12 that—

13 (A) each eligible individual or the individ-
14 ual’s authorized representative will be provided
15 the opportunity to make an informed choice re-
16 garding whether to participate in the MFP
17 demonstration project;

18 (B) each eligible individual or the individ-
19 ual’s authorized representative will choose the
20 qualified residence in which the individual will
21 reside and the setting in which the individual
22 will receive home and community-based long-
23 term care services;

24 (C) the State will continue to make avail-
25 able, so long as the State operates its qualified



1 HCB program consistent with applicable re-
2 quirements, home and community-based long-
3 term care services to each individual who com-
4 pletes participation in the MFP demonstration
5 project for as long as the individual remains eli-
6 gible for medical assistance for such services
7 under such qualified HCB program (including
8 meeting a requirement relating to requiring a
9 level of care provided in an inpatient facility
10 and continuing to require such services, and, if
11 the State applies a more stringent level of care
12 standard as a result of implementing the State
13 plan option permitted under section 1915(i) of
14 the Social Security Act, meeting the require-
15 ment for at least the level of care which had re-
16 sulted in the individual's admission to the insti-
17 tution).

18 (7) REBALANCING.—The application shall—

19 (A) provide such information as the Sec-
20 retary may require concerning the dollar
21 amounts of State Medicaid expenditures for the
22 fiscal year, immediately preceding the first fis-
23 cal year of the State's MFP demonstration
24 project, for long-term care services and the per-
25 centage of such expenditures that were for in-



1 stitutional long-term care services or were for
2 home and community-based long-term care
3 services;

4 (B)(i) specify the methods to be used by
5 the State to increase, for each fiscal year dur-
6 ing the MFP demonstration project, the dollar
7 amount of such total expenditures for home and
8 community-based long-term care services and
9 the percentage of such total expenditures for
10 long-term care services that are for home and
11 community-based long-term care services; and

12 (ii) describe the extent to which the MFP
13 demonstration project will contribute to accom-
14 plishment of objectives described in subsection
15 (a).

16 (8) MONEY FOLLOWS THE PERSON.—The appli-
17 cation shall describe the methods to be used by the
18 State to eliminate any legal, budgetary, or other bar-
19 riers to flexibility in the availability of Medicaid
20 funds to pay for long-term care services for eligible
21 individuals participating in the project in the appro-
22 priate settings of their choice, including costs to
23 transition from an institutional setting to a qualified
24 residence.



1 (9) MAINTENANCE OF EFFORT AND COST-EF-
2 FECTIVENESS.—The application shall contain or be
3 accompanied by such information and assurances as
4 may be required to satisfy the Secretary that—

5 (A) total expenditures under the State
6 Medicaid program for home and community-
7 based long-term care services will not be less
8 for any fiscal year during the MFP demonstra-
9 tion project than for the greater of such ex-
10 penditures for—

11 (i) fiscal year 2005; or

12 (ii) any succeeding fiscal year before
13 the first year of the MFP demonstration
14 project; and

15 (B) in the case of a qualified HCB pro-
16 gram operating under a waiver under sub-
17 section (e) or (d) of section 1915 of the Social
18 Security Act (42 U.S.C. 1396n), but for the
19 amount awarded under a grant under this sec-
20 tion, the State program would continue to meet
21 the cost-effectiveness requirements of subsection
22 (c)(2)(D) of such section or comparable require-
23 ments under subsection (d)(5) of such section,
24 respectively.



1 (10) WAIVER REQUESTS.—The application shall
2 contain or be accompanied by requests for any modi-
3 fication or adjustment of waivers of Medicaid re-
4 quirements described in subsection (d)(3), including
5 adjustments to the maximum numbers of individuals
6 included and package of benefits, including one-time
7 transitional services, provided.

8 (11) QUALITY ASSURANCE AND QUALITY IM-
9 PROVEMENT.—The application shall include—

10 (A) a plan satisfactory to the Secretary for
11 quality assurance and quality improvement for
12 home and community-based long-term care
13 services under the State Medicaid program, in-
14 cluding a plan to assure the health and welfare
15 of individuals participating in the MFP dem-
16 onstration project; and

17 (B) an assurance that the State will co-
18 operate in carrying out activities under sub-
19 section (f) to develop and implement continuous
20 quality assurance and quality improvement sys-
21 tems for home and community-based long-term
22 care services.

23 (12) OPTIONAL PROGRAM FOR SELF-DIRECTED
24 SERVICES.—If the State elects to provide for any
25 home and community-based long-term care services



1 as self-directed services (as defined in subsection
2 (b)(8)) under the MFP demonstration project, the
3 application shall provide the following:

4 (A) MEETING REQUIREMENTS.—A descrip-
5 tion of how the project will meet the applicable
6 requirements of such subsection for the provi-
7 sion of self-directed services.

8 (B) VOLUNTARY ELECTION.—A description
9 of how eligible individuals will be provided with
10 the opportunity to make an informed election to
11 receive self-directed services under the project
12 and after the end of the project.

13 (C) STATE SUPPORT IN SERVICE PLAN DE-
14 VELOPMENT.—Satisfactory assurances that the
15 State will provide support to eligible individuals
16 who self-direct in developing and implementing
17 their service plans.

18 (D) OVERSIGHT OF RECEIPT OF SERV-
19 ICES.—Satisfactory assurances that the State
20 will provide oversight of eligible individual's re-
21 ceipt of such self-directed services, including
22 steps to assure the quality of services provided
23 and that the provision of such services are con-
24 sistent with the service plan under such sub-
25 section.



1 Nothing in this section shall be construed as requir-
2 ing a State to make an election under the project to
3 provide for home and community-based long-term
4 care services as self-directed services, or as requiring
5 an individual to elect to receive self-directed services
6 under the project.

7 (13) REPORTS AND EVALUATION.—The applica-
8 tion shall provide that—

9 (A) the State will furnish to the Secretary
10 such reports concerning the MFP demonstra-
11 tion project, on such timetable, in such uniform
12 format, and containing such information as the
13 Secretary may require, as will allow for reliable
14 comparisons of MFP demonstration projects
15 across States; and

16 (B) the State will participate in and co-
17 operate with the evaluation of the MFP dem-
18 onstration project.

19 (d) SECRETARY'S AWARD OF COMPETITIVE
20 GRANTS.—

21 (1) IN GENERAL.—The Secretary shall award
22 grants under this section on a competitive basis to
23 States selected from among those with applications
24 meeting the requirements of subsection (c), in ac-
25 cordance with the provisions of this subsection.



1 (2) SELECTION AND MODIFICATION OF STATE
2 APPLICATIONS.—In selecting State applications for
3 the awarding of such a grant, the Secretary—

4 (A) shall take into consideration the man-
5 ner in which, and extent to which, the State
6 proposes to achieve the objectives specified in
7 subsection (a);

8 (B) shall seek to achieve an appropriate
9 national balance in the numbers of eligible indi-
10 viduals, within different target groups of eligi-
11 ble individuals, who are assisted to transition to
12 qualified residences under MFP demonstration
13 projects, and in the geographic distribution of
14 States operating MFP demonstration projects;

15 (C) shall give preference to State applica-
16 tions proposing—

17 (i) to provide transition assistance to
18 eligible individuals within multiple target
19 groups; and

20 (ii) to provide eligible individuals with
21 the opportunity to receive home and com-
22 munity-based long-term care services as
23 self-directed services, as defined in sub-
24 section (b)(8); and



1 (D) shall take such objectives into consid-
2 eration in setting the annual amounts of State
3 grant awards under this section.

4 (3) WAIVER AUTHORITY.—The Secretary is au-
5 thorized to waive the following provisions of title
6 XIX of the Social Security Act, to the extent nec-
7 essary to enable a State initiative to meet the re-
8 quirements and accomplish the purposes of this sec-
9 tion:

10 (A) STATEWIDENESS.—Section
11 1902(a)(1), in order to permit implementation
12 of a State initiative in a selected area or areas
13 of the State.

14 (B) COMPARABILITY.—Section
15 1902(a)(10)(B), in order to permit a State ini-
16 tiative to assist a selected category or categories
17 of individuals described in subsection (b)(2)(A).

18 (C) INCOME AND RESOURCES ELIGI-
19 BILITY.—Section 1902(a)(10)(C)(i)(III), in
20 order to permit a State to apply institutional
21 eligibility rules to individuals transitioning to
22 community-based care.

23 (D) PROVIDER AGREEMENTS.—Section
24 1902(a)(27), in order to permit a State to im-



1 plement self-directed services in a cost-effective
2 manner.

3 (4) CONDITIONAL APPROVAL OF OUTYEAR
4 GRANT.—In awarding grants under this section, the
5 Secretary shall condition the grant for the second
6 and any subsequent fiscal years of the grant period
7 on the following:

8 (A) NUMERICAL BENCHMARKS.—The
9 State must demonstrate to the satisfaction of
10 the Secretary that it is meeting numerical
11 benchmarks specified in the grant agreement
12 for—

13 (i) increasing State Medicaid support
14 for home and community-based long-term
15 care services under subsection (c)(5); and

16 (ii) numbers of eligible individuals as-
17 sisted to transition to qualified residences.

18 (B) QUALITY OF CARE.—The State must
19 demonstrate to the satisfaction of the Secretary
20 that it is meeting the requirements under sub-
21 section (c)(11) to assure the health and welfare
22 of MFP demonstration project participants.

23 (e) PAYMENTS TO STATES; CARRYOVER OF UNUSED
24 GRANT AMOUNTS.—



1 (1) PAYMENTS.—For each calendar quarter in
2 a fiscal year during the period a State is awarded
3 a grant under subsection (d), the Secretary shall pay
4 to the State from its grant award for such fiscal
5 year an amount equal to the lesser of—

6 (A) the MFP-enhanced FMAP (as defined
7 in paragraph (5)) of the amount of qualified ex-
8 penditures made during such quarter; or

9 (B) the total amount remaining in such
10 grant award for such fiscal year (taking into
11 account the application of paragraph (2)).

12 (2) CARRYOVER OF UNUSED AMOUNTS.—Any
13 portion of a State grant award for a fiscal year
14 under this section remaining at the end of such fis-
15 cal year shall remain available to the State for the
16 next 4 fiscal years, subject to paragraph (3).

17 (3) REAWARDING OF CERTAIN UNUSED
18 AMOUNTS.—In the case of a State that the Sec-
19 retary determines pursuant to subsection (d)(4) has
20 failed to meet the conditions for continuation of a
21 MFP demonstration project under this section in a
22 succeeding year or years, the Secretary shall rescind
23 the grant awards for such succeeding year or years,
24 together with any unspent portion of an award for
25 prior years, and shall add such amounts to the ap-



1 propriation for the immediately succeeding fiscal
2 year for grants under this section.

3 (4) PREVENTING DUPLICATION OF PAYMENT.—

4 The payment under a MFP demonstration project
5 with respect to qualified expenditures shall be in lieu
6 of any payment with respect to such expenditures
7 that could otherwise be paid under Medicaid, includ-
8 ing under section 1903(a) of the Social Security Act.
9 Nothing in the previous sentence shall be construed
10 as preventing the payment under Medicaid for such
11 expenditures in a grant year after amounts available
12 to pay for such expenditures under the MFP dem-
13 onstration project have been exhausted.

14 (5) MFP-ENHANCED FMAP.—For purposes of
15 paragraph (1)(A), the “MFP-enhanced FMAP”, for
16 a State for a fiscal year, is equal to the Federal
17 medical assistance percentage (as defined in the first
18 sentence of section 1905(b)) for the State increased
19 by a number of percentage points equal to 50 per-
20 cent of the number of percentage points by which
21 (A) such Federal medical assistance percentage for
22 the State, is less than (B) 100 percent; but in no
23 case shall the MFP-enhanced FMAP for a State ex-
24 ceed 90 percent.



1 (f) QUALITY ASSURANCE AND IMPROVEMENT; TECH-
2 NICAL ASSISTANCE; OVERSIGHT.—

3 (1) IN GENERAL.—The Secretary, either di-
4 rectly or by grant or contract, shall provide for tech-
5 nical assistance to, and oversight of, States for pur-
6 poses of upgrading quality assurance and quality im-
7 provement systems under Medicaid home and com-
8 munity-based waivers, including—

9 (A) dissemination of information on prom-
10 ising practices;

11 (B) guidance on system design elements
12 addressing the unique needs of participating
13 beneficiaries;

14 (C) ongoing consultation on quality, in-
15 cluding assistance in developing necessary tools,
16 resources, and monitoring systems; and

17 (D) guidance on remedying programmatic
18 and systemic problems.

19 (2) FUNDING.—From the amounts appro-
20 priated under subsection (h)(1) for the portion of
21 fiscal year 2007 that begins on January 1, 2007,
22 and ends on September 30, 2007, and for fiscal year
23 2008, not more than \$2,400,000 shall be available
24 to the Secretary to carry out this subsection during



1 the period that begins on January 1, 2007, and ends
2 on September 30, 2011.

3 (g) RESEARCH AND EVALUATION.—

4 (1) IN GENERAL.—The Secretary, directly or
5 through grant or contract, shall provide for research
6 on, and a national evaluation of, the program under
7 this section, including assistance to the Secretary in
8 preparing the final report required under paragraph
9 (2). The evaluation shall include an analysis of pro-
10 jected and actual savings related to the transition of
11 individuals to qualified residences in each State con-
12 ducting an MFP demonstration project.

13 (2) FINAL REPORT.—The Secretary shall make
14 a final report to the President and Congress, not
15 later than September 30, 2011, reflecting the eval-
16 uation described in paragraph (1) and providing
17 findings and conclusions on the conduct and effec-
18 tiveness of MFP demonstration projects.

19 (3) FUNDING.—From the amounts appro-
20 priated under subsection (h)(1) for each of fiscal
21 years 2008 through 2011, not more than \$1,100,000
22 per year shall be available to the Secretary to carry
23 out this subsection.

24 (h) APPROPRIATIONS.—



1 (1) IN GENERAL.—There are appropriated,
2 from any funds in the Treasury not otherwise appro-
3 priated, for grants to carry out this section—

4 (A) \$250,000,000 for the portion of fiscal
5 year 2007 beginning on January 1, 2007, and
6 ending on September 30, 2007;

7 (B) \$300,000,000 for fiscal year 2008;

8 (C) \$350,000,000 for fiscal year 2009;

9 (D) \$400,000,000 for fiscal year 2010;

10 and

11 (E) \$450,000,000 for fiscal year 2011.

12 (2) AVAILABILITY.—Amounts made available
13 under paragraph (1) for a fiscal year shall remain
14 available for the awarding of grants to States by not
15 later than September 30, 2011.

16 **Subchapter C—Miscellaneous**

17 **SEC. 6081. MEDICAID TRANSFORMATION GRANTS.**

18 (a) IN GENERAL.—Section 1903 of the Social Secu-
19 rity Act (42 U.S.C. 1396b), as amended by sections
20 6037(a)(2) and 6043(b), is amended by adding at the end
21 the following new subsection:

22 “(z) MEDICAID TRANSFORMATION PAYMENTS.—

23 “(1) IN GENERAL.—In addition to the pay-
24 ments provided under subsection (a), subject to
25 paragraph (4), the Secretary shall provide for pay-



1 ments to States for the adoption of innovative meth-
2 ods to improve the effectiveness and efficiency in
3 providing medical assistance under this title.

4 “(2) PERMISSIBLE USES OF FUNDS.—The fol-
5 lowing are examples of innovative methods for which
6 funds provided under this subsection may be used:

7 “(A) Methods for reducing patient error
8 rates through the implementation and use of
9 electronic health records, electronic clinical deci-
10 sion support tools, or e-prescribing programs.

11 “(B) Methods for improving rates of collec-
12 tion from estates of amounts owed under this
13 title.

14 “(C) Methods for reducing waste, fraud,
15 and abuse under the program under this title,
16 such as reducing improper payment rates as
17 measured by annual payment error rate meas-
18 urement (PERM) project rates.

19 “(D) Implementation of a medication risk
20 management program as part of a drug use re-
21 view program under section 1927(g).

22 “(E) Methods in reducing, in clinically ap-
23 propriate ways, expenditures under this title for
24 covered outpatient drugs, particularly in the
25 categories of greatest drug utilization, by in-



1 creasing the utilization of generic drugs
2 through the use of education programs and
3 other incentives to promote greater use of ge-
4 neric drugs.

5 “(F) Methods for improving access to pri-
6 mary and specialty physician care for the unin-
7 sured using integrated university-based hospital
8 and clinic systems.

9 “(3) APPLICATION; TERMS AND CONDITIONS.—

10 “(A) IN GENERAL.—No payments shall be
11 made to a State under this subsection unless
12 the State applies to the Secretary for such pay-
13 ments in a form, manner, and time specified by
14 the Secretary.

15 “(B) TERMS AND CONDITIONS.—Such pay-
16 ments are made under such terms and condi-
17 tions consistent with this subsection as the Sec-
18 retary prescribes.

19 “(C) ANNUAL REPORT.—Payment to a
20 State under this subsection is conditioned on
21 the State submitting to the Secretary an annual
22 report on the programs supported by such pay-
23 ment. Such report shall include information
24 on—

25 “(i) the specific uses of such payment;



1 “(ii) an assessment of quality im-
2 provements and clinical outcomes under
3 such programs; and

4 “(iii) estimates of cost savings result-
5 ing from such programs.

6 “(4) FUNDING.—

7 “(A) LIMITATION ON FUNDS.—The total
8 amount of payments under this subsection shall
9 be equal to, and shall not exceed—

10 “(i) \$75,000,000 for fiscal year 2007;

11 and

12 “(ii) \$75,000,000 for fiscal year 2008.

13 This subsection constitutes budget authority in
14 advance of appropriations Acts and represents
15 the obligation of the Secretary to provide for
16 the payment of amounts provided under this
17 subsection.

18 “(B) ALLOCATION OF FUNDS.—The Sec-
19 retary shall specify a method for allocating the
20 funds made available under this subsection
21 among States. Such method shall provide pref-
22 erence for States that design programs that
23 target health providers that treat significant
24 numbers of Medicaid beneficiaries. Such method
25 shall provide that not less than 25 percent of



1 such funds shall be allocated among States the
2 population of which (as determined according to
3 data collected by the United States Census Bu-
4 reau) as of July 1, 2004, was more than 105
5 percent of the population of the respective State
6 (as so determined) as of April 1, 2000.

7 “(C) FORM AND MANNER OF PAYMENT.—
8 Payment to a State under this subsection shall
9 be made in the same manner as other payments
10 under section 1903(a). There is no requirement
11 for State matching funds to receive payments
12 under this subsection.

13 “(5) MEDICATION RISK MANAGEMENT PRO-
14 GRAM.—

15 “(A) IN GENERAL.—For purposes of this
16 subsection, the term ‘medication risk manage-
17 ment program’ means a program for targeted
18 beneficiaries that ensures that covered out-
19 patient drugs are appropriately used to opti-
20 mize therapeutic outcomes through improved
21 medication use and to reduce the risk of ad-
22 verse events.

23 “(B) ELEMENTS.—Such program may in-
24 clude the following elements:



1 “(i) The use of established principles
2 and standards for drug utilization review
3 and best practices to analyze prescription
4 drug claims of targeted beneficiaries and
5 identify outlier physicians.

6 “(ii) On an ongoing basis provide
7 outlier physicians—

8 “(I) a comprehensive pharmacy
9 claims history for each targeted bene-
10 ficiary under their care;

11 “(II) information regarding the
12 frequency and cost of relapses and
13 hospitalizations of targeted bene-
14 ficiaries under the physician’s care;
15 and

16 “(III) applicable best practice
17 guidelines and empirical references.

18 “(iii) Monitor outlier physician’s pre-
19 scribing, such as failure to refill, dosage
20 strengths, and provide incentives and in-
21 formation to encourage the adoption of
22 best clinical practices.

23 “(C) TARGETED BENEFICIARIES.—For
24 purposes of this paragraph, the term ‘targeted
25 beneficiaries’ means Medicaid eligible bene-



1 ficiaries who are identified as having high pre-
2 scription drug costs and medical costs, such as
3 individuals with behavioral disorders or multiple
4 chronic diseases who are taking multiple medi-
5 cations.”.

6 **SEC. 6082. HEALTH OPPORTUNITY ACCOUNTS.**

7 Title XIX of the Social Security Act, as amended by
8 sections 6035 and 6044, is amended—

9 (1) by redesignating section 1938 as section
10 1939; and

11 (2) by inserting after section 1937 the following
12 new section:

13 “HEALTH OPPORTUNITY ACCOUNTS

14 “SEC. 1938. (a) AUTHORITY.—

15 “(1) IN GENERAL.—Notwithstanding any other
16 provision of this title, the Secretary shall establish a
17 demonstration program under which States may pro-
18 vide under their State plans under this title (includ-
19 ing such a plan operating under a statewide waiver
20 under section 1115) in accordance with this section
21 for the provision of alternative benefits consistent
22 with subsection (c) for eligible population groups in
23 one or more geographic areas of the State specified
24 by the State. An amendment under the previous sen-
25 tence is referred to in this section as a ‘State dem-
26 onstration program’.

1 “(2) INITIAL DEMONSTRATION.—

2 “(A) IN GENERAL.—The demonstration
3 program under this section shall begin on Janu-
4 ary 1, 2007. During the first 5 years of such
5 program, the Secretary shall not approve more
6 than 10 States to conduct demonstration pro-
7 grams under this section, with each State dem-
8 onstration program covering 1 or more geo-
9 graphic areas specified by the State. After such
10 5-year period—

11 “(i) unless the Secretary finds, taking
12 into account cost-effectiveness, quality of
13 care, and other criteria that the Secretary
14 specifies, that a State demonstration pro-
15 gram previously implemented has been un-
16 successful, such a demonstration program
17 may be extended or made permanent in
18 the State; and

19 “(ii) unless the Secretary finds, taking
20 into account cost-effectiveness, quality of
21 care, and other criteria that the Secretary
22 specifies, that all State demonstration pro-
23 grams previously implemented were unsuc-
24 cessful, other States may implement State
25 demonstration programs.



1 “(B) GAO REPORT.—

2 “(i) IN GENERAL.—Not later than 3
3 months after the end of the 5-year period
4 described in subparagraph (A), the Comp-
5 troller General of the United States shall
6 submit a report to Congress evaluating the
7 demonstration programs conducted under
8 this section during such period.

9 “(ii) APPROPRIATION.—Out of any
10 funds in the Treasury not otherwise appro-
11 priated, there is appropriated to the Comp-
12 troller General of the United States,
13 \$550,000 for the period of fiscal years
14 2007 through 2010 to carry out clause (i).

15 “(3) APPROVAL.—The Secretary shall not ap-
16 prove a State demonstration program under para-
17 graph (1) unless the program includes the following:

18 “(A) Creating patient awareness of the
19 high cost of medical care.

20 “(B) Providing incentives to patients to
21 seek preventive care services.

22 “(C) Reducing inappropriate use of health
23 care services.

24 “(D) Enabling patients to take responsi-
25 bility for health outcomes.



1 “(E) Providing enrollment counselors and
2 ongoing education activities.

3 “(F) Providing transactions involving
4 health opportunity accounts to be conducted
5 electronically and without cash.

6 “(G) Providing access to negotiated pro-
7 vider payment rates consistent with this section.

8 Nothing in this section shall be construed as pre-
9 venting a State demonstration program from pro-
10 viding incentives for patients obtaining appropriate
11 preventive care (as defined for purposes of section
12 223(c)(2)(C) of the Internal Revenue Code of 1986),
13 such as additional account contributions for an indi-
14 vidual demonstrating healthy prevention practices.

15 “(4) NO REQUIREMENT FOR
16 STATEWIDENESS.—Nothing in this section or any
17 other provision of law shall be construed to require
18 that a State must provide for the implementation of
19 a State demonstration program on a Statewide
20 basis.

21 “(b) ELIGIBLE POPULATION GROUPS.—

22 “(1) IN GENERAL.—A State demonstration pro-
23 gram under this section shall specify the eligible
24 population groups consistent with paragraphs (2)
25 and (3).



1 “(2) ELIGIBILITY LIMITATIONS DURING INITIAL
2 DEMONSTRATION PERIOD.—During the initial 5
3 years of the demonstration program under this sec-
4 tion, a State demonstration program shall not apply
5 to any of the following individuals:

6 “(A) Individuals who are 65 years of age
7 or older.

8 “(B) Individuals who are disabled, regard-
9 less of whether or not their eligibility for med-
10 ical assistance under this title is based on such
11 disability.

12 “(C) Individuals who are eligible for med-
13 ical assistance under this title only because they
14 are (or were within the previous 60 days) preg-
15 nant.

16 “(D) Individuals who have been eligible for
17 medical assistance for a continuous period of
18 less than 3 months.

19 “(3) ADDITIONAL LIMITATIONS.—A State dem-
20 onstration program shall not apply to any individual
21 within a category of individuals described in section
22 1937(a)(2)(B).

23 “(4) LIMITATIONS.—



1 “(A) STATE OPTION.—This subsection
2 shall not be construed as preventing a State
3 from further limiting eligibility.

4 “(B) ON ENROLLEES IN MEDICAID MAN-
5 AGED CARE ORGANIZATIONS.—Insofar as the
6 State provides for eligibility of individuals who
7 are enrolled in medicaid managed care organi-
8 zations, such individuals may participate in the
9 State demonstration program only if the State
10 provides assurances satisfactory to the Sec-
11 retary that the following conditions are met
12 with respect to any such organization:

13 “(i) In no case may the number of
14 such individuals enrolled in the organiza-
15 tion who participate in the program exceed
16 5 percent of the total number of individ-
17 uals enrolled in such organization.

18 “(ii) The proportion of enrollees in
19 the organization who so participate is not
20 significantly disproportionate to the pro-
21 portion of such enrollees in other such or-
22 ganizations who participate.

23 “(iii) The State has provided for an
24 appropriate adjustment in the per capita
25 payments to the organization to account



1 for such participation, taking into account
2 differences in the likely use of health serv-
3 ices between enrollees who so participate
4 and enrollees who do not so participate.

5 “(5) VOLUNTARY PARTICIPATION.—An eligible
6 individual shall be enrolled in a State demonstration
7 program only if the individual voluntarily enrolls.
8 Except in such hardship cases as the Secretary shall
9 specify, such an enrollment shall be effective for a
10 period of 12 months, but may be extended for addi-
11 tional periods of 12 months each with the consent of
12 the individual.

13 “(6) 1-YEAR MORATORIUM FOR REENROLL-
14 MENT.—An eligible individual who, for any reason,
15 is disenrolled from a State demonstration program
16 conducted under this section shall not be permitted
17 to reenroll in such program before the end of the 1-
18 year period that begins on the effective date of such
19 disenrollment.

20 “(c) ALTERNATIVE BENEFITS.—

21 “(1) IN GENERAL.—The alternative benefits
22 provided under this section shall consist, consistent
23 with this subsection, of at least—

24 “(A) coverage for medical expenses in a
25 year for items and services for which benefits



1 are otherwise provided under this title after an
2 annual deductible described in paragraph (2)
3 has been met; and

4 “(B) contribution into a health opportunity
5 account.

6 Nothing in subparagraph (A) shall be construed as
7 preventing a State from providing for coverage of
8 preventive care (referred to in subsection (a)(3))
9 within the alternative benefits without regard to the
10 annual deductible.

11 “(2) ANNUAL DEDUCTIBLE.—The amount of
12 the annual deductible described in paragraph (1)(A)
13 shall be at least 100 percent, but no more than 110
14 percent, of the annualized amount of contributions
15 to the health opportunity account under subsection
16 (d)(2)(A)(i), determined without regard to any limi-
17 tation described in subsection (d)(2)(C)(i)(II).

18 “(3) ACCESS TO NEGOTIATED PROVIDER PAY-
19 MENT RATES.—

20 “(A) FEE-FOR-SERVICE ENROLLEES.—In
21 the case of an individual who is participating in
22 a State demonstration program and who is not
23 enrolled with a medicaid managed care organi-
24 zation, the State shall provide that the indi-



1 vidual may obtain demonstration program med-
2 icaid services from—

3 “(i) any participating provider under
4 this title at the same payment rates that
5 would be applicable to such services if the
6 deductible described in paragraph (1)(A)
7 was not applicable; or

8 “(ii) any other provider at payment
9 rates that do not exceed 125 percent of the
10 payment rate that would be applicable to
11 such services furnished by a participating
12 provider under this title if the deductible
13 described in paragraph (1)(A) was not ap-
14 plicable.

15 “(B) TREATMENT UNDER MEDICAID MAN-
16 AGED CARE PLANS.—In the case of an indi-
17 vidual who is participating in a State dem-
18 onstration program and is enrolled with a med-
19 icaid managed care organization, the State shall
20 enter into an arrangement with the organiza-
21 tion under which the individual may obtain
22 demonstration program medicaid services from
23 any provider described in clause (ii) of subpara-
24 graph (A) at payment rates that do not exceed



1 the payment rates that may be imposed under
2 that clause.

3 “(C) COMPUTATION.—The payment rates
4 described in subparagraphs (A) and (B) shall
5 be computed without regard to any cost sharing
6 that would be otherwise applicable under sec-
7 tions 1916 and 1916A.

8 “(D) DEFINITIONS.—For purposes of this
9 paragraph:

10 “(i) The term ‘demonstration program
11 medicaid services’ means, with respect to
12 an individual participating in a State dem-
13 onstration program, services for which the
14 individual would be provided medical as-
15 sistance under this title but for the appli-
16 cation of the deductible described in para-
17 graph (1)(A).

18 “(ii) The term ‘participating provider’
19 means—

20 “(I) with respect to an individual
21 described in subparagraph (A), a
22 health care provider that has entered
23 into a participation agreement with
24 the State for the provision of services



1 to individuals entitled to benefits
2 under the State plan; or

3 “(II) with respect to an indi-
4 vidual described in subparagraph (B)
5 who is enrolled in a medicaid man-
6 aged care organization, a health care
7 provider that has entered into an ar-
8 rangement for the provision of serv-
9 ices to enrollees of the organization
10 under this title.

11 “(4) NO EFFECT ON SUBSEQUENT BENEFITS.—
12 Except as provided under paragraphs (1) and (2),
13 alternative benefits for an eligible individual shall
14 consist of the benefits otherwise provided to the indi-
15 vidual, including cost sharing relating to such bene-
16 fits.

17 “(5) OVERRIDING COST SHARING AND COM-
18 PARABILITY REQUIREMENTS FOR ALTERNATIVE
19 BENEFITS.—The provisions of this title relating to
20 cost sharing for benefits (including sections 1916
21 and 1916A) shall not apply with respect to benefits
22 to which the annual deductible under paragraph
23 (1)(A) applies. The provisions of section
24 1902(a)(10)(B) (relating to comparability) shall not



1 apply with respect to the provision of alternative
2 benefits (as described in this subsection).

3 “(6) TREATMENT AS MEDICAL ASSISTANCE.—
4 Subject to subparagraphs (D) and (E) of subsection
5 (d)(2), payments for alternative benefits under this
6 section (including contributions into a health oppor-
7 tunity account) shall be treated as medical assist-
8 ance for purposes of section 1903(a).

9 “(7) USE OF TIERED DEDUCTIBLE AND COST
10 SHARING.—

11 “(A) IN GENERAL.—A State—

12 “(i) may vary the amount of the an-
13 nual deductible applied under paragraph
14 (1)(A) based on the income of the family
15 involved so long as it does not favor fami-
16 lies with higher income over those with
17 lower income; and

18 “(ii) may vary the amount of the max-
19 imum out-of-pocket cost sharing (as de-
20 fined in subparagraph (B)) based on the
21 income of the family involved so long as it
22 does not favor families with higher income
23 over those with lower income.

24 “(B) MAXIMUM OUT-OF-POCKET COST
25 SHARING.—For purposes of subparagraph



1 (A)(ii), the term ‘maximum out-of-pocket cost
 2 sharing’ means, for an individual or family, the
 3 amount by which the annual deductible level ap-
 4 plied under paragraph (1)(A) to the individual
 5 or family exceeds the balance in the health op-
 6 portunity account for the individual or family.

7 “(8) CONTRIBUTIONS BY EMPLOYERS.—Noth-
 8 ing in this section shall be construed as preventing
 9 an employer from providing health benefits coverage
 10 consisting of the coverage described in paragraph
 11 (1)(A) to individuals who are provided alternative
 12 benefits under this section.

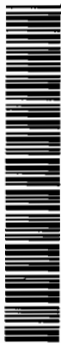
13 “(d) HEALTH OPPORTUNITY ACCOUNT.—

14 “(1) IN GENERAL.—For purposes of this sec-
 15 tion, the term ‘health opportunity account’ means an
 16 account that meets the requirements of this sub-
 17 section.

18 “(2) CONTRIBUTIONS.—

19 “(A) IN GENERAL.—No contribution may
 20 be made into a health opportunity account
 21 except—

22 “(i) contributions by the State under
 23 this title; and



1 “(ii) contributions by other persons
2 and entities, such as charitable organiza-
3 tions, as permitted under section 1903(w).

4 “(B) STATE CONTRIBUTION.—A State
5 shall specify the contribution amount that shall
6 be deposited under subparagraph (A)(i) into a
7 health opportunity account.

8 “(C) LIMITATION ON ANNUAL STATE CON-
9 TRIBUTION PROVIDED AND PERMITTING IMPO-
10 SITION OF MAXIMUM ACCOUNT BALANCE.—

11 “(i) IN GENERAL.—A State—

12 “(I) may impose limitations on
13 the maximum contributions that may
14 be deposited under subparagraph
15 (A)(i) into a health opportunity ac-
16 count in a year;

17 “(II) may limit contributions into
18 such an account once the balance in
19 the account reaches a level specified
20 by the State; and

21 “(III) subject to clauses (ii) and
22 (iii) and subparagraph (D)(i), may
23 not provide contributions described in
24 subparagraph (A)(i) to a health op-
25 portunity account on behalf of an in-



1 dividual or family to the extent the
2 amount of such contributions (includ-
3 ing both State and Federal shares)
4 exceeds, on an annual basis, \$2,500
5 for each individual (or family mem-
6 ber) who is an adult and \$1,000 for
7 each individual (or family member)
8 who is a child.

9 “(ii) INDEXING OF DOLLAR LIMITA-
10 TIONS.—For each year after 2006, the dol-
11 lar amounts specified in clause (i)(III)
12 shall be annually increased by the Sec-
13 retary by a percentage that reflects the an-
14 nual percentage increase in the medical
15 care component of the consumer price
16 index for all urban consumers.

17 “(iii) BUDGET NEUTRAL ADJUST-
18 MENT.—A State may provide for dollar
19 limitations in excess of those specified in
20 clause (i)(III) (as increased under clause
21 (ii)) for specified individuals if the State
22 provides assurances satisfactory to the Sec-
23 retary that contributions otherwise made
24 to other individuals will be reduced in a
25 manner so as to provide for aggregate con-



1 tributions that do not exceed the aggregate
2 contributions that would otherwise be per-
3 mitted under this subparagraph.

4 “(D) LIMITATIONS ON FEDERAL MATCH-
5 ING.—

6 “(i) STATE CONTRIBUTION.—A State
7 may contribute under subparagraph (A)(i)
8 amounts to a health opportunity account in
9 excess of the limitations provided under
10 subparagraph (C)(i)(III), but no Federal
11 financial participation shall be provided
12 under section 1903(a) with respect to con-
13 tributions in excess of such limitations.

14 “(ii) NO FFP FOR PRIVATE CONTRIBU-
15 TIONS.—No Federal financial participation
16 shall be provided under section 1903(a)
17 with respect to any contributions described
18 in subparagraph (A)(ii) to a health oppor-
19 tunity account.

20 “(E) APPLICATION OF DIFFERENT MATCH-
21 ING RATES.—The Secretary shall provide a
22 method under which, for expenditures made
23 from a health opportunity account for medical
24 care for which the Federal matching rate under
25 section 1903(a) exceeds the Federal medical as-



1 sistance percentage, a State may obtain pay-
2 ment under such section at such higher match-
3 ing rate for such expenditures.

4 “(3) USE.—

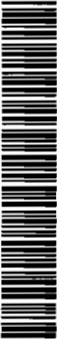
5 “(A) GENERAL USES.—

6 “(i) IN GENERAL.—Subject to the
7 succeeding provisions of this paragraph,
8 amounts in a health opportunity account
9 may be used for payment of such health
10 care expenditures as the State specifies.

11 “(ii) GENERAL LIMITATION.—Subject
12 to subparagraph (B)(ii), in no case shall
13 such account be used for payment for
14 health care expenditures that are not pay-
15 ment of medical care (as defined by section
16 213(d) of the Internal Revenue Code of
17 1986).

18 “(iii) STATE RESTRICTIONS.—In ap-
19 plying clause (i), a State may restrict pay-
20 ment for—

21 “(I) providers of items and serv-
22 ices to providers that are licensed or
23 otherwise authorized under State law
24 to provide the item or service and may
25 deny payment for such a provider on



1 the basis that the provider has been
2 found, whether with respect to this
3 title or any other health benefit pro-
4 gram, to have failed to meet quality
5 standards or to have committed 1 or
6 more acts of fraud or abuse; and

7 “(II) items and services insofar
8 as the State finds they are not medi-
9 cally appropriate or necessary.

10 “(iv) ELECTRONIC WITHDRAWALS.—
11 The State demonstration program shall
12 provide for a method whereby withdrawals
13 may be made from the account for such
14 purposes using an electronic system and
15 shall not permit withdrawals from the ac-
16 count in cash.

17 “(B) MAINTENANCE OF HEALTH OPPOR-
18 TUNITY ACCOUNT AFTER BECOMING INELI-
19 GIBLE FOR PUBLIC BENEFIT.—

20 “(i) IN GENERAL.—Notwithstanding
21 any other provision of law, if an account
22 holder of a health opportunity account be-
23 comes ineligible for benefits under this title
24 because of an increase in income or
25 assets—



1 “(I) no additional contribution
2 shall be made into the account under
3 paragraph (2)(A)(i);

4 “(II) subject to clause (iii), the
5 balance in the account shall be re-
6 duced by 25 percent; and

7 “(III) subject to the succeeding
8 provisions of this subparagraph, the
9 account shall remain available to the
10 account holder for 3 years after the
11 date on which the individual becomes
12 ineligible for such benefits for with-
13 drawals under the same terms and
14 conditions as if the account holder re-
15 mained eligible for such benefits, and
16 such withdrawals shall be treated as
17 medical assistance in accordance with
18 subsection (c)(6).

19 “(ii) SPECIAL RULES.—Withdrawals
20 under this subparagraph from an
21 account—

22 “(I) shall be available for the
23 purchase of health insurance coverage;
24 and



1 “(II) may, subject to clause (iv),
2 be made available (at the option of
3 the State) for such additional expendi-
4 tures (such as job training and tuition
5 expenses) specified by the State (and
6 approved by the Secretary) as the
7 State may specify.

8 “(iii) EXCEPTION FROM 25 PERCENT
9 SAVINGS TO GOVERNMENT FOR PRIVATE
10 CONTRIBUTIONS.—Clause (i)(II) shall not
11 apply to the portion of the account that is
12 attributable to contributions described in
13 paragraph (2)(A)(ii). For purposes of ac-
14 counting for such contributions, with-
15 drawals from a health opportunity account
16 shall first be attributed to contributions
17 described in paragraph (2)(A)(i).

18 “(iv) CONDITION FOR NON-HEALTH
19 WITHDRAWALS.—No withdrawal may be
20 made from an account under clause (ii)(II)
21 unless the accountholder has participated
22 in the program under this section for at
23 least 1 year.

24 “(v) NO REQUIREMENT FOR CONTINU-
25 ATION OF COVERAGE.—An account holder



1 of a health opportunity account, after be-
2 coming ineligible for medical assistance
3 under this title, is not required to purchase
4 high-deductible or other insurance as a
5 condition of maintaining or using the ac-
6 count.

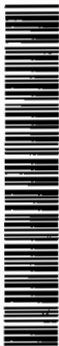
7 “(4) ADMINISTRATION.—A State may coordi-
8 nate administration of health opportunity accounts
9 through the use of a third party administrator and
10 reasonable expenditures for the use of such adminis-
11 trator shall be reimbursable to the State in the same
12 manner as other administrative expenditures under
13 section 1903(a)(7).

14 “(5) TREATMENT.—Amounts in, or contributed
15 to, a health opportunity account shall not be counted
16 as income or assets for purposes of determining eli-
17 gibility for benefits under this title.

18 “(6) UNAUTHORIZED WITHDRAWALS.—A State
19 may establish procedures—

20 “(A) to penalize or remove an individual
21 from the health opportunity account based on
22 nonqualified withdrawals by the individual from
23 such an account; and

24 “(B) to recoup costs that derive from such
25 nonqualified withdrawals.”



1 **SEC. 6083. STATE OPTION TO ESTABLISH NON-EMERGENCY**
2 **MEDICAL TRANSPORTATION PROGRAM.**

3 (a) IN GENERAL.—Section 1902(a) of the Social Se-
4 curity Act (42 U.S.C. 1396a(a)), as amended by sections
5 6033(a) and 6035(b), is amended—

6 (1) in paragraph (68), by striking “and” at the
7 end;

8 (2) in paragraph (69) by striking the period at
9 the end and inserting “; and”; and

10 (3) by inserting after paragraph (69) the fol-
11 lowing:

12 “(70) at the option of the State and notwith-
13 standing paragraphs (1), (10)(B), and (23), provide
14 for the establishment of a non-emergency medical
15 transportation brokerage program in order to more
16 cost-effectively provide transportation for individuals
17 eligible for medical assistance under the State plan
18 who need access to medical care or services and have
19 no other means of transportation which—

20 “(A) may include a wheelchair van, taxi,
21 stretcher car, bus passes and tickets, secured
22 transportation, and such other transportation
23 as the Secretary determines appropriate; and

24 “(B) may be conducted under contract
25 with a broker who—



1 “(i) is selected through a competitive
2 bidding process based on the State’s eval-
3 uation of the broker’s experience, perform-
4 ance, references, resources, qualifications,
5 and costs;

6 “(ii) has oversight procedures to mon-
7 itor beneficiary access and complaints and
8 ensure that transport personnel are li-
9 censed, qualified, competent, and cour-
10 teous;

11 “(iii) is subject to regular auditing
12 and oversight by the State in order to en-
13 sure the quality of the transportation serv-
14 ices provided and the adequacy of bene-
15 ficiary access to medical care and services;
16 and

17 “(iv) complies with such requirements
18 related to prohibitions on referrals and
19 conflict of interest as the Secretary shall
20 establish (based on the prohibitions on
21 physician referrals under section 1877 and
22 such other prohibitions and requirements
23 as the Secretary determines to be appro-
24 priate).”



1 (b) **EFFECTIVE DATE.**—The amendments made by
2 subsection (a) take effect on the date of the enactment
3 of this Act.

4 **SEC. 6084. EXTENSION OF TRANSITIONAL MEDICAL ASSIST-**
5 **ANCE (TMA) AND ABSTINENCE EDUCATION**
6 **PROGRAM.**

7 Effective as if enacted on December 31, 2005, activi-
8 ties authorized by sections 510 and 1925 of the Social Se-
9 curity Act shall continue through December 31, 2006, in
10 the manner authorized for fiscal year 2005, notwith-
11 standing section 1902(e)(1)(A) of such Act, and out of
12 any money in the Treasury of the United States not other-
13 wise appropriated, there are hereby appropriated such
14 sums as may be necessary for such purpose. Grants and
15 payments may be made pursuant to this authority through
16 the first quarter of fiscal year 2007 at the level provided
17 for such activities through the first quarter of fiscal year
18 2006.

19 **SEC. 6085. EMERGENCY SERVICES FURNISHED BY NON-**
20 **CONTRACT PROVIDERS FOR MEDICAID MAN-**
21 **AGED CARE ENROLLEES.**

22 (a) **IN GENERAL.**—Section 1932(b)(2) of the Social
23 Security Act (42 U.S.C. 1396u-2(b)(2)) is amended by
24 adding at the end the following new subparagraph:



1 “(D) EMERGENCY SERVICES FURNISHED
2 BY NON-CONTRACT PROVIDERS.—Any provider
3 of emergency services that does not have in ef-
4 fect a contract with a medicaid managed care
5 entity that establishes payment amounts for
6 services furnished to a beneficiary enrolled in
7 the entity’s Medicaid managed care plan must
8 accept as payment in full no more than the
9 amounts (less any payments for indirect costs
10 of medical education and direct costs of grad-
11 uate medical education) that it could collect if
12 the beneficiary received medical assistance
13 under this title other than through enrollment
14 in such an entity. In a State where rates paid
15 to hospitals under the State plan are negotiated
16 by contract and not publicly released, the pay-
17 ment amount applicable under this subpara-
18 graph shall be the average contract rate that
19 would apply under the State plan for general
20 acute care hospitals or the average contract
21 rate that would apply under such plan for ter-
22 tiary hospitals.”.

23 (b) EFFECTIVE DATE.—The amendment made by
24 subsection (a) shall take effect on January 1, 2007.



1 **SEC. 6086. EXPANDED ACCESS TO HOME AND COMMUNITY-**
2 **BASED SERVICES FOR THE ELDERLY AND**
3 **DISABLED.**

4 (a) HOME AND COMMUNITY-BASED SERVICES AS AN
5 OPTIONAL BENEFIT FOR ELDERLY AND DISABLED INDI-
6 VIDUALS.—Section 1915 of the Social Security Act (42
7 U.S.C. 1396n) is amended by adding at the end the fol-
8 lowing new subsection:

9 “(i) STATE PLAN AMENDMENT OPTION TO PROVIDE
10 HOME AND COMMUNITY-BASED SERVICES FOR ELDERLY
11 AND DISABLED INDIVIDUALS.—

12 “(1) IN GENERAL.—Subject to the succeeding
13 provisions of this subsection, a State may provide
14 through a State plan amendment for the provision
15 of medical assistance for home and community-based
16 services (within the scope of services described in
17 paragraph (4)(B) of subsection (c) for which the
18 Secretary has the authority to approve a waiver and
19 not including room and board or such other services
20 requested by the State as the Secretary may ap-
21 prove) for individuals eligible for medical assistance
22 under the State plan whose income does not exceed
23 150 percent of the poverty line (as defined in section
24 2110(c)(5)), without determining that but for the
25 provision of such services the individuals would re-
26 quire the level of care provided in a hospital or a



1 nursing facility or intermediate care facility for the
2 mentally retarded, but only if the State meets the
3 following requirements:

4 “(A) NEEDS-BASED CRITERIA FOR ELIGI-
5 BILITY FOR, AND RECEIPT OF, HOME AND COM-
6 MUNITY-BASED SERVICES.—The State estab-
7 lishes needs-based criteria for determining an
8 individual’s eligibility under the State plan for
9 medical assistance for such home and commu-
10 nity-based services, and if the individual is eligi-
11 ble for such services, the specific home and
12 community-based services that the individual
13 will receive.

14 “(B) ESTABLISHMENT OF MORE STRIN-
15 GENT NEEDS-BASED ELIGIBILITY CRITERIA FOR
16 INSTITUTIONALIZED CARE.—The State estab-
17 lishes needs-based criteria for determining
18 whether an individual requires the level of care
19 provided in a hospital, a nursing facility, or an
20 intermediate care facility for the mentally re-
21 tardated under the State plan or under any waiv-
22 er of such plan that are more stringent than
23 the needs-based criteria established under sub-
24 paragraph (A) for determining eligibility for
25 home and community-based services.



1 “(C) PROJECTION OF NUMBER OF INDI-
 2 VIDUALS TO BE PROVIDED HOME AND COMMU-
 3 NITY-BASED SERVICES.—

4 “(i) IN GENERAL.—The State submits
 5 to the Secretary, in such form and man-
 6 ner, and upon such frequency as the Sec-
 7 retary shall specify, the projected number
 8 of individuals to be provided home and
 9 community-based services.

10 “(ii) AUTHORITY TO LIMIT NUMBER
 11 OF ELIGIBLE INDIVIDUALS.—A State may
 12 limit the number of individuals who are eli-
 13 gible for such services and may establish
 14 waiting lists for the receipt of such serv-
 15 ices.

16 “(D) CRITERIA BASED ON INDIVIDUAL AS-
 17 SESSMENT.—

18 “(i) IN GENERAL.—The criteria estab-
 19 lished by the State for purposes of sub-
 20 paragraphs (A) and (B) requires an as-
 21 sessment of an individual’s support needs
 22 and capabilities, and may take into ac-
 23 count the inability of the individual to per-
 24 form 2 or more activities of daily living (as
 25 defined in section 7702B(c)(2)(B) of the



1 Internal Revenue Code of 1986) or the
2 need for significant assistance to perform
3 such activities, and such other risk factors
4 as the State determines to be appropriate.

5 “(ii) ADJUSTMENT AUTHORITY.—The
6 State plan amendment provides the State
7 with the option to modify the criteria es-
8 tablished under subparagraph (A) (without
9 having to obtain prior approval from the
10 Secretary) in the event that the enrollment
11 of individuals eligible for home and com-
12 munity-based services exceeds the pro-
13 jected enrollment submitted for purposes
14 of subparagraph (C), but only if—

15 “(I) the State provides at least
16 60 days notice to the Secretary and
17 the public of the proposed modifica-
18 tion;

19 “(II) the State deems an indi-
20 vidual receiving home and community-
21 based services on the basis of the
22 most recent version of the criteria in
23 effect prior to the effective date of the
24 modification to be eligible for such
25 services for a period of at least 12



1 months beginning on the date the in-
2 dividual first received medical assist-
3 ance for such services; and

4 “(III) after the effective date of
5 such modification, the State, at a
6 minimum, applies the criteria for de-
7 termining whether an individual re-
8 quires the level of care provided in a
9 hospital, a nursing facility, or an in-
10 termediate care facility for the men-
11 tally retarded under the State plan or
12 under any waiver of such plan which
13 applied prior to the application of the
14 more stringent criteria developed
15 under subparagraph (B).

16 “(E) INDEPENDENT EVALUATION AND AS-
17 SESSMENT.—

18 “(i) ELIGIBILITY DETERMINATION.—
19 The State uses an independent evaluation
20 for making the determinations described in
21 subparagraphs (A) and (B).

22 “(ii) ASSESSMENT.—In the case of an
23 individual who is determined to be eligible
24 for home and community-based services,



1 the State uses an independent assessment,
2 based on the needs of the individual to—

3 “(I) determine a necessary level
4 of services and supports to be pro-
5 vided, consistent with an individual’s
6 physical and mental capacity;

7 “(II) prevent the provision of un-
8 necessary or inappropriate care; and

9 “(III) establish an individualized
10 care plan for the individual in accord-
11 ance with subparagraph (G).

12 “(F) ASSESSMENT.—The independent as-
13 sessment required under subparagraph (E)(ii)
14 shall include the following:

15 “(i) An objective evaluation of an in-
16 dividual’s inability to perform 2 or more
17 activities of daily living (as defined in sec-
18 tion 7702B(c)(2)(B) of the Internal Rev-
19 enue Code of 1986) or the need for signifi-
20 cant assistance to perform such activities.

21 “(ii) A face-to-face evaluation of the
22 individual by an individual trained in the
23 assessment and evaluation of individuals
24 whose physical or mental conditions trigger



1 a potential need for home and community-
2 based services.

3 “(iii) Where appropriate, consultation
4 with the individual’s family, spouse, guard-
5 ian, or other responsible individual.

6 “(iv) Consultation with appropriate
7 treating and consulting health and support
8 professionals caring for the individual.

9 “(v) An examination of the individ-
10 ual’s relevant history, medical records, and
11 care and support needs, guided by best
12 practices and research on effective strate-
13 gies that result in improved health and
14 quality of life outcomes.

15 “(vi) If the State offers individuals
16 the option to self-direct the purchase of, or
17 control the receipt of, home and commu-
18 nity-based service, an evaluation of the
19 ability of the individual or the individual’s
20 representative to self-direct the purchase
21 of, or control the receipt of, such services
22 if the individual so elects.

23 “(G) INDIVIDUALIZED CARE PLAN.—

24 “(i) IN GENERAL.—In the case of an
25 individual who is determined to be eligible



1 for home and community-based services,
2 the State uses the independent assessment
3 required under subparagraph (E)(ii) to es-
4 tablish a written individualized care plan
5 for the individual.

6 “(ii) PLAN REQUIREMENTS.—The
7 State ensures that the individualized care
8 plan for an individual—

9 “(I) is developed—

10 “(aa) in consultation with
11 the individual, the individual’s
12 treating physician, health care or
13 support professional, or other ap-
14 propriate individuals, as defined
15 by the State, and, where appro-
16 priate the individual’s family,
17 caregiver, or representative; and

18 “(bb) taking into account
19 the extent of, and need for, any
20 family or other supports for the
21 individual;

22 “(II) identifies the necessary
23 home and community-based services
24 to be furnished to the individual (or,
25 if the individual elects to self-direct



1 the purchase of, or control the receipt
2 of, such services, funded for the indi-
3 vidual); and

4 “(III) is reviewed at least annu-
5 ally and as needed when there is a
6 significant change in the individual’s
7 circumstances.

8 “(iii) STATE OPTION TO OFFER ELEC-
9 TION FOR SELF-DIRECTED SERVICES.—

10 “(I) INDIVIDUAL CHOICE.—At
11 the option of the State, the State may
12 allow an individual or the individual’s
13 representative to elect to receive self-
14 directed home and community-based
15 services in a manner which gives them
16 the most control over such services
17 consistent with the individual’s abili-
18 ties and the requirements of sub-
19 clauses (II) and (III).

20 “(II) SELF-DIRECTED SERV-
21 ICES.—The term ‘self-directed’ means,
22 with respect to the home and commu-
23 nity-based services offered under the
24 State plan amendment, such services
25 for the individual which are planned



1 and purchased under the direction
2 and control of such individual or the
3 individual's authorized representative,
4 including the amount, duration, scope,
5 provider, and location of such services,
6 under the State plan consistent with
7 the following requirements:

8 “(aa) ASSESSMENT.—There
9 is an assessment of the needs, ca-
10 pabilities, and preferences of the
11 individual with respect to such
12 services.

13 “(bb) SERVICE PLAN.—
14 Based on such assessment, there
15 is developed jointly with such in-
16 dividual or the individual's au-
17 thorized representative a plan for
18 such services for such individual
19 that is approved by the State and
20 that satisfies the requirements of
21 subclause (III).

22 “(III) PLAN REQUIREMENTS.—
23 For purposes of subclause (II)(bb),
24 the requirements of this subclause are
25 that the plan—



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“(aa) specifies those services which the individual or the individual’s authorized representative would be responsible for directing;

“(bb) identifies the methods by which the individual or the individual’s authorized representative will select, manage, and dismiss providers of such services;

“(cc) specifies the role of family members and others whose participation is sought by the individual or the individual’s authorized representative with respect to such services;

“(dd) is developed through a person-centered process that is directed by the individual or the individual’s authorized representative, builds upon the individual’s capacity to engage in activities that promote community life and that respects the individual’s preferences, choices, and abilities,



1 and involves families, friends,
2 and professionals as desired or
3 required by the individual or the
4 individual's authorized represent-
5 ative;

6 “(ee) includes appropriate
7 risk management techniques that
8 recognize the roles and sharing of
9 responsibilities in obtaining serv-
10 ices in a self-directed manner and
11 assure the appropriateness of
12 such plan based upon the re-
13 sources and capabilities of the in-
14 dividual or the individual's au-
15 thorized representative; and

16 “(ff) may include an individ-
17 ualized budget which identifies
18 the dollar value of the services
19 and supports under the control
20 and direction of the individual or
21 the individual's authorized rep-
22 resentative.

23 “(IV) BUDGET PROCESS.—With
24 respect to individualized budgets de-



1 scribed in subclause (III)(ff), the
2 State plan amendment—

3 “(aa) describes the method
4 for calculating the dollar values
5 in such budgets based on reliable
6 costs and service utilization;

7 “(bb) defines a process for
8 making adjustments in such dol-
9 lar values to reflect changes in
10 individual assessments and serv-
11 ice plans; and

12 “(cc) provides a procedure
13 to evaluate expenditures under
14 such budgets.

15 “(H) QUALITY ASSURANCE; CONFLICT OF
16 INTEREST STANDARDS.—

17 “(i) QUALITY ASSURANCE.—The
18 State ensures that the provision of home
19 and community-based services meets Fed-
20 eral and State guidelines for quality assur-
21 ance.

22 “(ii) CONFLICT OF INTEREST STAND-
23 ARDS.—The State establishes standards
24 for the conduct of the independent evalua-



1 tion and the independent assessment to
2 safeguard against conflicts of interest.

3 “(I) REDETERMINATIONS AND APPEALS.—

4 The State allows for at least annual redeter-
5 minations of eligibility, and appeals in accord-
6 ance with the frequency of, and manner in
7 which, redeterminations and appeals of eligi-
8 bility are made under the State plan.

9 “(J) PRESUMPTIVE ELIGIBILITY FOR AS-
10 SESSMENT.—The State, at its option, elects to
11 provide for a period of presumptive eligibility
12 (not to exceed a period of 60 days) only for
13 those individuals that the State has reason to
14 believe may be eligible for home and commu-
15 nity-based services. Such presumptive eligibility
16 shall be limited to medical assistance for car-
17 rying out the independent evaluation and as-
18 sessment under subparagraph (E) to determine
19 an individual’s eligibility for such services and
20 if the individual is so eligible, the specific home
21 and community-based services that the indi-
22 vidual will receive.

23 “(2) DEFINITION OF INDIVIDUAL’S REP-
24 RESENTATIVE.—In this section, the term ‘individ-
25 ual’s representative’ means, with respect to an indi-



1 vidual, a parent, a family member, or a guardian of
2 the individual, an advocate for the individual, or any
3 other individual who is authorized to represent the
4 individual.

5 “(3) NONAPPLICATION.—A State may elect in
6 the State plan amendment approved under this sec-
7 tion to not comply with the requirements of section
8 1902(a)(1) (relating to statewideness) and section
9 1902(a)(10)(C)(i)(III) (relating to income and re-
10 source rules applicable in the community), but only
11 for purposes of provided home and community-based
12 services in accordance with such amendment. Any
13 such election shall not be construed to apply to the
14 provision of services to an individual receiving med-
15 ical assistance in an institutionalized setting as a re-
16 sult of a determination that the individual requires
17 the level of care provided in a hospital or a nursing
18 facility or intermediate care facility for the mentally
19 retarded.

20 “(4) NO EFFECT ON OTHER WAIVER AUTHOR-
21 ITY.—Nothing in this subsection shall be construed
22 as affecting the option of a State to offer home and
23 community-based services under a waiver under sub-
24 sections (c) or (d) of this section or under section
25 1115.



1 “(5) CONTINUATION OF FEDERAL FINANCIAL
2 PARTICIPATION FOR MEDICAL ASSISTANCE PRO-
3 VIDED TO INDIVIDUALS AS OF EFFECTIVE DATE OF
4 STATE PLAN AMENDMENT.—Notwithstanding para-
5 graph (1)(B), Federal financial participation shall
6 continue to be available for an individual who is re-
7 ceiving medical assistance in an institutionalized set-
8 ting, or home and community-based services pro-
9 vided under a waiver under this section or section
10 1115 that is in effect as of the effective date of the
11 State plan amendment submitted under this sub-
12 section, as a result of a determination that the indi-
13 vidual requires the level of care provided in a hos-
14 pital or a nursing facility or intermediate care facil-
15 ity for the mentally retarded, without regard to
16 whether such individuals satisfy the more stringent
17 eligibility criteria established under that paragraph,
18 until such time as the individual is discharged from
19 the institution or waiver program or no longer re-
20 quires such level of care.”.

21 (b) QUALITY OF CARE MEASURES.—

22 (1) IN GENERAL.—The Secretary, acting
23 through the Director of the Agency for Healthcare
24 Research and Quality, shall consult with consumers,
25 health and social service providers and other profes-



1 sionals knowledgeable about long-term care services
2 and supports to develop program performance indi-
3 cators, client function indicators, and measures of
4 client satisfaction with respect to home and commu-
5 nity-based services offered under State Medicaid
6 programs.

7 (2) BEST PRACTICES.—The Secretary shall—

8 (A) use the indicators and measures devel-
9 oped under paragraph (1) to assess such home
10 and community-based services, the outcomes as-
11 sociated with the receipt of such services (par-
12 ticularly with respect to the health and welfare
13 of the recipient of the services), and the overall
14 system for providing home and community-
15 based services under the Medicaid program
16 under title XIX of the Social Security Act; and

17 (B) make publicly available the best prac-
18 tices identified through such assessment and a
19 comparative analyses of the system features of
20 each State.

21 (3) APPROPRIATION.—Out of any funds in the
22 Treasury not otherwise appropriated, there is appro-
23 priated to the Secretary of Health and Human Serv-
24 ices, \$1,000,000 for the period of fiscal years 2006
25 through 2010 to carry out this subsection.



1 (c) EFFECTIVE DATE.—The amendments made by
2 subsections (a) and (b) take effect on January 1, 2007,
3 and apply to expenditures for medical assistance for home
4 and community-based services provided in accordance with
5 section 1915(i) of the Social Security Act (as added by
6 subsections (a) and (b)) on or after that date.

7 **SEC. 6087. OPTIONAL CHOICE OF SELF-DIRECTED PER-**
8 **SONAL ASSISTANCE SERVICES (CASH AND**
9 **COUNSELING).**

10 (a) EXEMPTION FROM CERTAIN REQUIREMENTS.—
11 Section 1915 of the Social Security Act (42 U.S.C.
12 1396n), as amended by section 6086(a), is amended by
13 adding at the end the following new subsection:

14 “(j)(1) A State may provide, as ‘medical assistance’,
15 payment for part or all of the cost of self-directed personal
16 assistance services (other than room and board) under the
17 plan which are provided pursuant to a written plan of care
18 to individuals with respect to whom there has been a de-
19 termination that, but for the provision of such services,
20 the individuals would require and receive personal care
21 services under the plan, or home and community-based
22 services provided pursuant to a waiver under subsection
23 (c). Self-directed personal assistance services may not be
24 provided under this subsection to individuals who reside
25 in a home or property that is owned, operated, or con-



1 trolled by a provider of services, not related by blood or
2 marriage.

3 “(2) The Secretary shall not grant approval for a
4 State self-directed personal assistance services program
5 under this section unless the State provides assurances
6 satisfactory to the Secretary of the following:

7 “(A) Necessary safeguards have been taken to
8 protect the health and welfare of individuals pro-
9 vided services under the program, and to assure fi-
10 nancial accountability for funds expended with re-
11 spect to such services.

12 “(B) The State will provide, with respect to in-
13 dividuals who—

14 “(i) are entitled to medical assistance for
15 personal care services under the plan, or receive
16 home and community-based services under a
17 waiver granted under subsection (c);

18 “(ii) may require self-directed personal as-
19 sistance services; and

20 “(iii) may be eligible for self-directed per-
21 sonal assistance services,

22 an evaluation of the need for personal care under
23 the plan, or personal services under a waiver granted
24 under subsection (c).



1 “(C) Such individuals who are determined to be
2 likely to require personal care under the plan, or
3 home and community-based services under a waiver
4 granted under subsection (c) are informed of the
5 feasible alternatives, if available under the State’s
6 self-directed personal assistance services program, at
7 the choice of such individuals, to the provision of
8 personal care services under the plan, or personal
9 assistance services under a waiver granted under
10 subsection (c).

11 “(D) The State will provide for a support sys-
12 tem that ensures participants in the self-directed
13 personal assistance services program are appro-
14 priately assessed and counseled prior to enrollment
15 and are able to manage their budgets. Additional
16 counseling and management support may be pro-
17 vided at the request of the participant.

18 “(E) The State will provide to the Secretary an
19 annual report on the number of individuals served
20 and total expenditures on their behalf in the aggre-
21 gate. The State shall also provide an evaluation of
22 overall impact on the health and welfare of partici-
23 pating individuals compared to non-participants
24 every three years.



1 “(3) A State may provide self-directed personal as-
2 sistance services under the State plan without regard to
3 the requirements of section 1902(a)(1) and may limit the
4 population eligible to receive these services and limit the
5 number of persons served without regard to section
6 1902(a)(10)(B).

7 “(4)(A) For purposes of this subsection, the term
8 ‘self-directed personal assistance services’ means personal
9 care and related services, or home and community-based
10 services otherwise available under the plan under this title
11 or subsection (c), that are provided to an eligible partici-
12 pant under a self-directed personal assistance services pro-
13 gram under this section, under which individuals, within
14 an approved self-directed services plan and budget, pur-
15 chase personal assistance and related services, and per-
16 mits participants to hire, fire, supervise, and manage the
17 individuals providing such services.

18 “(B) At the election of the State—

19 “(i) a participant may choose to use any indi-
20 vidual capable of providing the assigned tasks in-
21 cluding legally liable relatives as paid providers of
22 the services; and

23 “(ii) the individual may use the individual’s
24 budget to acquire items that increase independence
25 or substitute (such as a microwave oven or an acces-



1 sibility ramp) for human assistance, to the extent
2 that expenditures would otherwise be made for the
3 human assistance.

4 “(5) For purpose of this section, the term ‘approved
5 self-directed services plan and budget’ means, with respect
6 to a participant, the establishment of a plan and budget
7 for the provision of self-directed personal assistance serv-
8 ices, consistent with the following requirements:

9 “(A) SELF-DIRECTION.—The participant (or in
10 the case of a participant who is a minor child, the
11 participant’s parent or guardian, or in the case of an
12 incapacitated adult, another individual recognized by
13 State law to act on behalf of the participant) exer-
14 cises choice and control over the budget, planning,
15 and purchase of self-directed personal assistance
16 services, including the amount, duration, scope, pro-
17 vider, and location of service provision.

18 “(B) ASSESSMENT OF NEEDS.—There is an as-
19 sessment of the needs, strengths, and preferences of
20 the participants for such services.

21 “(C) SERVICE PLAN.—A plan for such services
22 (and supports for such services) for the participant
23 has been developed and approved by the State based
24 on such assessment through a person-centered proc-
25 ess that—



1 “(i) builds upon the participant’s capacity
2 to engage in activities that promote community
3 life and that respects the participant’s pref-
4 erences, choices, and abilities; and

5 “(ii) involves families, friends, and profes-
6 sionals in the planning or delivery of services or
7 supports as desired or required by the partici-
8 pant.

9 “(D) SERVICE BUDGET.—A budget for such
10 services and supports for the participant has been
11 developed and approved by the State based on such
12 assessment and plan and on a methodology that uses
13 valid, reliable cost data, is open to public inspection,
14 and includes a calculation of the expected cost of
15 such services if those services were not self-directed.
16 The budget may not restrict access to other medi-
17 cally necessary care and services furnished under the
18 plan and approved by the State but not included in
19 the budget.

20 “(E) APPLICATION OF QUALITY ASSURANCE
21 AND RISK MANAGEMENT.—There are appropriate
22 quality assurance and risk management techniques
23 used in establishing and implementing such plan and
24 budget that recognize the roles and responsibilities
25 in obtaining services in a self-directed manner and



1 assure the appropriateness of such plan and budget
2 based upon the participant's resources and capabili-
3 ties.

4 “(6) A State may employ a financial management en-
5 tity to make payments to providers, track costs, and make
6 reports under the program. Payment for the activities of
7 the financial management entity shall be at the adminis-
8 trative rate established in section 1903(a).”.

9 (b) EFFECTIVE DATE.—The amendment made by
10 subsection (a) shall apply to services furnished on or after
11 January 1, 2007.

12 Subtitle B—SCHIP

13 SEC. 6101. ADDITIONAL ALLOTMENTS TO ELIMINATE FIS- 14 CAL YEAR 2006 FUNDING SHORTFALLS.

15 (a) IN GENERAL.—Section 2104 of the Social Secu-
16 rity Act (42 U.S.C. 1397dd) is amended by inserting after
17 subsection (c) the following:

18 “(d) ADDITIONAL ALLOTMENTS TO ELIMINATE
19 FUNDING SHORTFALLS.—

20 “(1) APPROPRIATION; ALLOTMENT AUTHOR-
21 ITY.—For the purpose of providing additional allot-
22 ments to shortfall States described in paragraph (2),
23 there is appropriated, out of any money in the
24 Treasury not otherwise appropriated, \$283,000,000
25 for fiscal year 2006.



1 “(2) SHORTFALL STATES DESCRIBED.—For
2 purposes of paragraph (1), a shortfall State de-
3 scribed in this paragraph is a State with a State
4 child health plan approved under this title for which
5 the Secretary estimates, on the basis of the most re-
6 cent data available to the Secretary as of December
7 16, 2005, that the projected expenditures under
8 such plan for such State for fiscal year 2006 will ex-
9 ceed the sum of—

10 “(A) the amount of the State’s allotments
11 for each of fiscal years 2004 and 2005 that will
12 not be expended by the end of fiscal year 2005;

13 “(B) the amount, if any, that is to redis-
14 tributed to the State during fiscal year 2006 in
15 accordance with subsection (f); and

16 “(C) the amount of the State’s allotment
17 for fiscal year 2006.

18 “(3) ALLOTMENTS.—In addition to the allot-
19 ments provided under subsections (b) and (c), sub-
20 ject to paragraph (4), of the amount available for
21 the additional allotments under paragraph (1) for
22 fiscal year 2006, the Secretary shall allot—

23 “(A) to each shortfall State described in
24 paragraph (2) such amount as the Secretary



1 determines will eliminate the estimated shortfall
2 described in such paragraph for the State; and

3 “(B) to each commonwealth or territory
4 described in subsection (c)(3), the same propor-
5 tion as the proportion of the commonwealth’s or
6 territory’s allotment under subsection (c) (de-
7 termined without regard to subsection (f)) to
8 1.05 percent of the amount appropriated under
9 paragraph (1).

10 “(4) USE OF ADDITIONAL ALLOTMENT.—Addi-
11 tional allotments provided under this subsection are
12 only available for amounts expended under a State
13 plan approved under this title for child health assist-
14 ance for targeted low-income children.

15 “(5) 1-YEAR AVAILABILITY; NO REDISTRIBU-
16 TION OF UNEXPENDED ADDITIONAL ALLOTMENTS.—
17 Notwithstanding subsections (e) and (f), amounts al-
18 lotted to a State pursuant to this subsection for fis-
19 cal year 2006 shall only remain available for expend-
20 iture by the State through September 30, 2006. Any
21 amounts of such allotments that remain unexpended
22 as of such date shall not be subject to redistribution
23 under subsection (f) and shall revert to the Treasury
24 on October 1, 2006.”



1 (b) CONFORMING AMENDMENTS.—Section 2104 of
2 the Social Security Act (42 U.S.C. 1397dd) is amended—

3 (1) in subsection (a), by inserting “subject to
4 subsection (d),” after “under this section,”;

5 (2) in subsection (b)(1), by inserting “and sub-
6 section (d)” after “Subject to paragraph (4)”; and

7 (3) in subsection (c)(1), by inserting “subject to
8 subsection (d),” after “for a fiscal year,”.

9 (c) EFFECTIVE DATE.—The amendments made by
10 this section apply to items and services furnished on or
11 after October 1, 2005, without regard to whether or not
12 regulations implementing such amendments have been
13 issued.

14 **SEC. 6102. PROHIBITION AGAINST COVERING NONPREG-**
15 **NANT CHILDLESS ADULTS WITH SCHIP**
16 **FUNDS.**

17 (a) PROHIBITION ON USE OF SCHIP FUNDS.—Sec-
18 tion 2107 of the Social Security Act (42 U.S.C. 1397gg)
19 is amended by adding at the end the following:

20 “(f) LIMITATION OF WAIVER AUTHORITY.—Notwith-
21 standing subsection (e)(2)(A) and section 1115(a), the
22 Secretary may not approve a waiver, experimental, pilot,
23 or demonstration project that would allow funds made
24 available under this title to be used to provide child health
25 assistance or other health benefits coverage to a nonpreg-



1 nant childless adult. For purposes of the preceding sen-
2 tence, a caretaker relative (as such term is defined for pur-
3 poses of carrying out section 1931) shall not be considered
4 a childless adult.”.

5 (b) CONFORMING AMENDMENTS.—Section
6 2105(c)(1) of such Act (42 U.S.C. 1397ee(c)(1)) is
7 amended—

8 (1) by inserting “and may not include coverage
9 of a nonpregnant childless adult” after “section
10 2101”); and

11 (2) by adding at the end the following: “For
12 purposes of the preceding sentence, a caretaker rel-
13 ative (as such term is defined for purposes of car-
14 rying out section 1931) shall not be considered a
15 childless adult.”.

16 (c) RULE OF CONSTRUCTION.—Nothing in this sec-
17 tion or the amendments made by this section shall be con-
18 strued to—

19 (1) authorize the waiver of any provision of title
20 XIX or XXI of the Social Security Act (42 U.S.C.
21 1396 et seq., 1397aa et seq.) that is not otherwise
22 authorized to be waived under such titles or under
23 title XI of such Act (42 U.S.C. 1301 et seq.) as of
24 the date of enactment of this Act;



1 (2) imply congressional approval of any waiver,
2 experimental, pilot, or demonstration project affect-
3 ing funds made available under the State children's
4 health insurance program under title XXI of the So-
5 cial Security Act (42 U.S.C. 1397aa et. seq.) or any
6 amendment to such a waiver or project that has
7 been approved as of such date of enactment; or

8 (3) apply to any waiver, experimental, pilot, or
9 demonstration project that would allow funds made
10 available under title XXI of the Social Security Act
11 (42 U.S.C. 1397aa et seq.) to be used to provide
12 child health assistance or other health benefits cov-
13 erage to a nonpregnant childless adult that is ap-
14 proved before the date of enactment of this Act or
15 to any extension, renewal, or amendment of such a
16 waiver or project that is approved on or after such
17 date of enactment.

18 (d) EFFECTIVE DATE.—This section and the amend-
19 ments made by this section shall take effect as if enacted
20 on October 1, 2005, and shall apply to any waiver, experi-
21 mental, pilot, or demonstration project that is approved
22 on or after that date.



1 **SEC. 6103. CONTINUED AUTHORITY FOR QUALIFYING**
2 **STATES TO USE CERTAIN FUNDS FOR MED-**
3 **ICAID EXPENDITURES.**

4 (a) **IN GENERAL.**—Section 2105(g)(1)(A) of the So-
5 cial Security Act (42 U.S.C. 1397ee(g)(1)(A)) is amended
6 by striking “or 2001” and inserting “2001, 2004, or
7 2005”.

8 (b) **EFFECTIVE DATE.**—The amendment made by
9 subsection (a) shall apply to expenditures made under title
10 XIX of the Social Security Act (42 U.S.C. 1396 et seq.)
11 on or after October 1, 2005.

12 **Subtitle C—Katrina Relief**

13 **SEC. 6201. ADDITIONAL FEDERAL PAYMENTS UNDER HUR-**
14 **RICANE-RELATED MULTI-STATE SECTION**
15 **1115 DEMONSTRATIONS.**

16 (a) **IN GENERAL.**—The Secretary of Health and
17 Human Services shall pay to each eligible State, from
18 amounts appropriated pursuant to subsection (e),
19 amounts for the following purposes:

20 (1) Under the authority of an approved Multi-
21 State Section 1115 Demonstration Project (in this
22 section referred to as an “section 1115 project”)—

23 (A) with respect to evacuees receiving
24 health care under such project, for the non-
25 Federal share of expenditures:



1 (i) for medical assistance furnished
2 under title XIX of the Social Security Act,
3 and

4 (ii) for child health assistance fur-
5 nished under title XXI of such Act;

6 (B) with respect to evacuees who do not
7 have other coverage for such assistance through
8 insurance, including (but not limited to) private
9 insurance, under title XIX or title XXI of the
10 Social Security Act, or under State-funded
11 health insurance programs, for the total uncom-
12 pensated care costs incurred for medically nec-
13 essary services and supplies or premium assist-
14 ance for such persons, and for those evacuees
15 receiving medical assistance under the project
16 for the total uncompensated care costs incurred
17 for medically necessary services and supplies be-
18 yond those included as medical assistance or
19 child health assistance under the State's ap-
20 proved plan under title XIX or title XXI of the
21 Social Security Act;

22 (C) with respect to affected individuals re-
23 ceiving health care under such project for the
24 non-Federal share of the following expenditures:



1 (i) for medical assistance furnished
2 under title XIX of the Social Security Act,
3 and

4 (ii) for child health assistance fur-
5 nished under title XXI of such Act; and

6 (D) with respect to affected individuals
7 who do not have other coverage for such assist-
8 ance through insurance, including (but not lim-
9 ited to) private insurance, under title XIX or
10 title XXI of the Social Security Act, or under
11 State-funded health insurance programs, for the
12 total uncompensated care costs incurred for
13 medically necessary services and supplies or
14 premium assistance for such persons; and for
15 those affected individuals receiving medical as-
16 sistance under the project for the total uncom-
17 pensated care costs incurred for medically nec-
18 essary services and supplies beyond those in-
19 cluded as medical assistance or child health as-
20 sistance under the State's approved plan under
21 title XIX or title XXI of the Social Security
22 Act.

23 (2) For reimbursement of the reasonable ad-
24 ministrative costs related to subparagraphs (A)



1 through (D) of paragraph (1) as determined by the
2 Secretary.

3 (3) Only with respect to affected counties or
4 parishes, for reimbursement with respect to individ-
5 uals receiving medical assistance under existing
6 State plans approved by the Secretary of Health and
7 Human Services for the following non-Federal share
8 of expenditures:

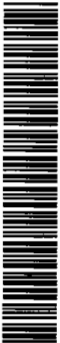
9 (A) For medical assistance furnished under
10 title XIX of the Social Security Act.

11 (B) For child health assistance furnished
12 under title XXI of such Act.

13 (4) For other purposes, if approved by the Sec-
14 retary under the Secretary's authority, to restore ac-
15 cess to health care in impacted communities.

16 (b) DEFINITIONS.—For purposes of this section:

17 (1) The term "affected individual" means an
18 individual who resided in an individual assistance
19 designation county or parish pursuant to section 408
20 of the Robert T. Stafford Disaster Relief and Emer-
21 gency Assistance Act, as declared by the President
22 as a result of Hurricane Katrina and continues to
23 reside in the same State that such county or parish
24 is located in.



1 (2) The term “affected counties or parishes”
2 means a county or parish described in paragraph
3 (1).

4 (3) The term “evacuee” means an affected indi-
5 vidual who has been displaced to another State.

6 (4) The term “eligible State” means a State
7 that has provided care to affected individuals or
8 evacuees under a section 1115 project.

9 (c) APPLICATION TO MATCHING REQUIREMENTS.—
10 The non-Federal share paid under this section shall not
11 be regarded as Federal funds for purposes of Medicaid
12 matching requirements, the effect of which is to provide
13 fiscal relief to the State in which the Medicaid eligible indi-
14 vidual originally resided.

15 (d) TIME LIMITS ON PAYMENTS.—

16 (1) No payments shall be made by the Sec-
17 retary under subsection (a)(1)(A) or (a)(1)(C), for
18 costs of health care provided to an eligible evacuee
19 or affected individual for services for such individual
20 incurred after June 30, 2006.

21 (2) No payments shall be made by the Sec-
22 retary under subsection (a)(1)(B) or (a)(1)(D) for
23 costs of health care incurred after January 31,
24 2006.



1 (b) TREATMENT.—The amount appropriated
2 under—

3 (1) paragraph (1) shall be treated as if it had
4 been appropriated under subsection (c)(2) of such
5 section; and

6 (2) paragraph (2) shall be treated as if it had
7 been appropriated under subsection (c)(1) of such
8 section.

9 (c) REFERENCES.—Effective upon the enactment of
10 the State High Risk Pool Funding Extension Act of
11 2005—

12 (1) subsection (a)(1) shall be applied by sub-
13 stituting “subsections (b)(2) and (c)(3)” for “sub-
14 section “(b)(1)”;

15 (2) subsection (b)(1) shall be applied by sub-
16 stituting “(d)(1)(B)” for “(c)(2)”;

17 (3) subsection (b)(2) shall be applied by sub-
18 stituting “(d)(1)(A)” for “(c)(1)”.

19 **SEC. 6203. IMPLEMENTATION FUNDING.**

20 For purposes of implementing the provisions of, and
21 amendments made by, title V of this Act and this title—

22 (1) the Secretary of Health and Human Serv-
23 ices shall provide for the transfer, in appropriate
24 part from the Federal Hospital Insurance Trust
25 Fund established under section 1817 of the Social



1 Security Act (42 U.S.C. 1395i) and the Federal
2 Supplementary Medical Insurance Trust Fund es-
3 tablished under section 1841 of such Act (42 U.S.C.
4 1395t), of \$30,000,000 to the Centers for Medicare
5 & Medicaid Services Program Management Account
6 for fiscal year 2006; and
7 (2) out of any funds in the Treasury not other-
8 wise appropriated, there are appropriated to such
9 Secretary for the Centers for Medicare & Medicaid
10 Services Program Management Account,
11 \$30,000,000 for fiscal year 2006.



1 TITLE VII—HUMAN RESOURCES 2 AND OTHER PROVISIONS

3 ~~SEC. 7001. TABLE OF CONTENTS.~~

4 ~~The table of contents of this title is as follows:~~

~~Sec. 7001. Table of contents.~~

~~Sec. 7002. References.~~

~~Subtitle B—TANF~~

~~Sec. 7101. Temporary assistance for needy families and related programs funding through September 30, 2010.~~

~~Sec. 7102. Improved calculation of work participation rates and program integrity.~~

~~Sec. 7103. Grants for needy marriage promotion and responsible fatherhood.~~

~~Subtitle C—Child care~~

~~Sec. 7201. Child care funding.~~

~~Subtitle D—Child support~~

~~Sec. 7301. Child support enforcement funding.~~

~~Sec. 7302. Mandatory review and adjustment of child support orders for parents receiving TANF.~~

~~Sec. 7303. Decrease in amount of child support arrears resulting from payment denial.~~

~~Sec. 7304. Maintenance enforcement assistance funding.~~

~~Sec. 7305. Maintenance of Federal Parent Locator Service funding.~~

~~Sec. 7306. Information comparison with child support data.~~

~~Sec. 7307. Requirement that State child support enforcement agencies and child support for children from other parent.~~

~~Sec. 7308. Reduction of Federal matching funds to pay costs incurred in determining paternity.~~

~~Sec. 7309. Ending Federal matching of State spending of Federal child support payments.~~

~~Sec. 7310. Mandatory enforcement of child support collection for family that has not received TANF.~~

~~Sec. 7311. Exemption to general effective date for State plans requiring State law amendments.~~

~~Subtitle E—Child welfare~~

~~Sec. 7401. Strengthening courts.~~

~~Sec. 7402. Funding of safe and stable families program.~~

~~Sec. 7403. Clarification regarding Federal matching of certain administrative costs under the foster care maintenance program.~~

~~Sec. 7404. Clarification of eligibility for foster care maintenance and adoption assistance.~~



~~Subtitle E—Supplemental security income~~

~~Sec. 7501. Recipients of disability benefits and disability determinations.~~
~~Sec. 7502. Payment of certain lump-sum benefits in installments under the supplemental security income program.~~

~~Subtitle F—Repeal of continued dumping and subsidy~~

~~Sec. 7601. Repeal of continued dumping and subsidy~~

~~Subtitle G—Effective date~~

~~Sec. 7701. Effective date~~

1 **SEC. 7002. REFERENCES.**

2 Except as otherwise expressly provided, wherever in
3 this title an amendment or repeal is expressed in terms
4 of an amendment to, or repeal of, a section or other provi-
5 sion, the amendment or repeal shall be considered to be
6 made to a section or other provision of the Social Security
7 Act.

8 **Subtitle A—TANF**

9 **SEC. 7101. TEMPORARY ASSISTANCE FOR NEEDY FAMILIES**
10 **AND RELATED PROGRAMS FUNDING**
11 **THROUGH SEPTEMBER 30, 2010.**

12 (a) **IN GENERAL.**—Activities authorized by part A of
13 title IV and section 1108(b) of the Social Security Act
14 (adjusted, as applicable, by or under this subtitle, the
15 amendments made by this subtitle, and the TANF Emer-
16 gency Response and Recovery Act of 2005) shall continue
17 through September 30, 2010, in the manner authorized
18 for fiscal year 2004, and out of any money in the Treasury
19 of the United States not otherwise appropriated, there are
20 hereby appropriated such sums as may be necessary for



1 such purpose. Grants and payments may be made pursu-
2 ant to this authority on a quarterly basis through fiscal
3 year 2010 at the level provided for such activities for the
4 corresponding quarter of fiscal year 2004 (or, as applica-
5 ble, at such greater level as may result from the applica-
6 tion of this subtitle, the amendments made by this sub-
7 title, and the TANF Emergency Response and Recovery
8 Act of 2005), except that in the case of section 403(a)(3)
9 of the Social Security Act, grants and payments may be
10 made pursuant to this authority only through fiscal year
11 2008 and in the case of section 403(a)(4) of the Social
12 Security Act, no grants shall be made for any fiscal year
13 occurring after fiscal year 2005.

14 (b) CONFORMING AMENDMENTS.—Part A of title IV
15 (42 U.S.C. 601 et seq.) is amended—

16 (1) in section 403(a)(3)(H)(ii), by striking “De-
17 cember, 31, 2005” and inserting “fiscal year 2008”;

18 (2) in section 403(b)(3)(C)(ii), by striking
19 “2006” and inserting “2010”; and

20 (3) in section 409(a)(7)—

21 (A) in subparagraph (A), by striking “or
22 2007” and inserting “2007, 2008, 2009, 2010,
23 or 2011”; and

24 (B) in subparagraph (B)(ii), by striking
25 “2006” and inserting “2010”.



1 (c) EXTENSION OF THE NATIONAL RANDOM SAMPLE
2 STUDY OF CHILD WELFARE THROUGH SEPTEMBER 30,
3 2010.—Activities authorized by section 429A of the Social
4 Security Act shall continue through September 30, 2010,
5 in the manner authorized for fiscal year 2004, and out
6 of any money in the Treasury of the United States not
7 otherwise appropriated, there are hereby appropriated
8 such sums as may be necessary for such purpose. Grants
9 and payments may be made pursuant to this authority on
10 a quarterly basis through fiscal year 2010 at the level pro-
11 vided for such activities for the corresponding quarter of
12 fiscal year 2004.

13 **SEC. 7102. IMPROVED CALCULATION OF WORK PARTICIPA-**
14 **TION RATES AND PROGRAM INTEGRITY.**

15 (a) RECALIBRATION OF CASELOAD REDUCTION
16 CREDIT.—

17 (1) IN GENERAL.—Section 407(b)(3)(A) (42
18 U.S.C. 607(b)(3)(A)) is amended—

19 (A) in clause (i), by inserting “or any
20 other State program funded with qualified
21 State expenditures (as defined in section
22 409(a)(7)(B)(i))” after “this part” ; and

23 (B) by striking clause (ii) and inserting the
24 following:



1 “(ii) the average monthly number of
2 families that received assistance under any
3 State program referred to in clause (i)
4 during fiscal year 2005.”.

5 (2) CONFORMING AMENDMENT.—Section
6 407(b)(3)(B) (42 U.S.C. 607(b)(3)(B)) is amended
7 by striking “and eligibility criteria” and all that fol-
8 lows through the close parenthesis and inserting
9 “and the eligibility criteria in effect during fiscal
10 year 2005”.

11 (b) INCLUSION OF FAMILIES RECEIVING ASSISTANCE
12 UNDER SEPARATE STATE PROGRAMS IN CALCULATION
13 OF PARTICIPATION RATES.—

14 (1) Section 407 (42 U.S.C. 607) is amended in
15 each of subsections (a)(1), (a)(2), (b)(1)(B)(i),
16 (c)(2)(A)(i), (e)(1), and (e)(2), by inserting “or any
17 other State program funded with qualified State ex-
18 penditures (as defined in section 409(a)(7)(B)(i))”
19 after “this part”.

20 (2) Section 411(a)(1) (42 U.S.C. 611(a)(1)) is
21 amended—

22 (A) in subparagraph (A), by inserting “or
23 any other State program funded with qualified
24 State expenditures (as defined in section
25 409(a)(7)(B)(i))” before the colon; and



1 (B) in subparagraph (B)(ii), by inserting
2 “and any other State programs funded with
3 qualified State expenditures (as defined in sec-
4 tion 409(a)(7)(B)(i))” after “this part”.

5 (c) IMPROVED VERIFICATION AND OVERSIGHT OF
6 WORK PARTICIPATION.—

7 (1) IN GENERAL.—Section 407(i) (42 U.S.C.
8 607(i)) is amended to read as follows:

9 “(i) VERIFICATION OF WORK AND WORK-ELIGIBLE
10 INDIVIDUALS IN ORDER TO IMPLEMENT REFORMS.—

11 “(1) SECRETARIAL DIRECTION AND OVER-
12 SIGHT.—

13 “(A) REGULATIONS FOR DETERMINING
14 WHETHER ACTIVITIES MAY BE COUNTED AS
15 ‘WORK ACTIVITIES’, HOW TO COUNT AND VER-
16 IFY REPORTED HOURS OF WORK, AND DETER-
17 MINING WHO IS A WORK-ELIGIBLE INDI-
18 VIDUAL.—

19 “(i) IN GENERAL.—Not later than
20 June 30, 2006, the Secretary shall promul-
21 gate regulations to ensure consistent meas-
22 urement of work participation rates under
23 State programs funded under this part and
24 State programs funded with qualified State
25 expenditures (as defined in section

1 409(a)(7)(B)(i)), which shall include infor-
2 mation with respect to—

3 “(I) determining whether an ac-
4 tivity of a recipient of assistance may
5 be treated as a work activity under
6 subsection (d);

7 “(II) uniform methods for report-
8 ing hours of work by a recipient of as-
9 sistance;

10 “(III) the type of documentation
11 needed to verify reported hours of
12 work by a recipient of assistance; and

13 “(IV) the circumstances under
14 which a parent who resides with a
15 child who is a recipient of assistance
16 should be included in the work partici-
17 pation rates.

18 “(ii) ISSUANCE OF REGULATIONS ON
19 AN INTERIM FINAL BASIS.—The regula-
20 tions referred to in clause (i) may be effec-
21 tive and final immediately on an interim
22 basis as of the date of publication of the
23 regulations. If the Secretary provides for
24 an interim final regulation, the Secretary
25 shall provide for a period of public com-



1 ment on the regulation after the date of
2 publication. The Secretary may change or
3 revise the regulation after the public com-
4 ment period.

5 “(B) OVERSIGHT OF STATE PROCE-
6 DURES.—The Secretary shall review the State
7 procedures established in accordance with para-
8 graph (2) to ensure that such procedures are
9 consistent with the regulations promulgated
10 under subparagraph (A) and are adequate to
11 ensure an accurate measurement of work par-
12 ticipation under the State programs funded
13 under this part and any other State programs
14 funded with qualified State expenditures (as so
15 defined).

16 “(2) REQUIREMENT FOR STATES TO ESTABLISH
17 AND MAINTAIN WORK PARTICIPATION VERIFICATION
18 PROCEDURES.—Not later than September 30, 2006,
19 a State to which a grant is made under section 403
20 shall establish procedures for determining, with re-
21 spect to recipients of assistance under the State pro-
22 gram funded under this part or under any State
23 programs funded with qualified State expenditures
24 (as so defined), whether activities may be counted as
25 work activities, how to count and verify reported



1 hours of work, and who is a work-eligible individual,
2 in accordance with the regulations promulgated pur-
3 suant to paragraph (1)(A)(i) and shall establish in-
4 ternal controls to ensure compliance with the proce-
5 dures.”.

6 (2) STATE PENALTY FOR FAILURE TO ESTAB-
7 LISH OR COMPLY WITH WORK PARTICIPATION VER-
8 IFICATION PROCEDURES.—Section 409(a) (42
9 U.S.C. 609(a)) is amended by adding at the end the
10 following:

11 “(15) PENALTY FOR FAILURE TO ESTABLISH
12 OR COMPLY WITH WORK PARTICIPATION VERIFICA-
13 TION PROCEDURES.—

14 “(A) IN GENERAL.—If the Secretary deter-
15 mines that a State to which a grant is made
16 under section 403 in a fiscal year has violated
17 section 407(i)(2) during the fiscal year, the
18 Secretary shall reduce the grant payable to the
19 State under section 403(a)(1) for the imme-
20 diately succeeding fiscal year by an amount
21 equal to not less than 1 percent and not more
22 than 5 percent of the State family assistance
23 grant.

24 “(B) PENALTY BASED ON SEVERITY OF
25 FAILURE.—The Secretary shall impose reduc-



1 tions under subparagraph (A) with respect to a
2 fiscal year based on the degree of noncompli-
3 ance.”.

4 (d) **EFFECTIVE DATE.**—The amendments made by
5 subsections (a) and (b) shall take effect on October 1,
6 2006.

7 **SEC. 7103. GRANTS FOR HEALTHY MARRIAGE PROMOTION**
8 **AND RESPONSIBLE FATHERHOOD.**

9 (a) **HEALTHY MARRIAGE AND FAMILY FUNDS.**—Sec-
10 tion 403(a)(2) (42 U.S.C. 603(a)(2)) is amended to read
11 as follows:

12 “(2) **HEALTHY MARRIAGE PROMOTION AND RE-**
13 **SPONSIBLE FATHERHOOD GRANTS.**—

14 “(A) **IN GENERAL.**—

15 “(i) **USE OF FUNDS.**—Subject to sub-
16 paragraphs (B) and (C), the Secretary
17 may use the funds made available under
18 subparagraph (D) for the purpose of con-
19 ducting and supporting research and dem-
20 onstration projects by public or private en-
21 tities, and providing technical assistance to
22 States, Indian tribes and tribal organiza-
23 tions, and such other entities as the Sec-
24 retary may specify that are receiving a
25 grant under another provision of this part.



1 “(ii) LIMITATIONS.—The Secretary
2 may not award funds made available under
3 this paragraph on a noncompetitive basis,
4 and may not provide any such funds to an
5 entity for the purpose of carrying out
6 healthy marriage promotion activities or
7 for the purpose of carrying out activities
8 promoting responsible fatherhood unless
9 the entity has submitted to the Secretary
10 an application which—

11 “(I) describes—

12 “(aa) how the programs or
13 activities proposed in the applica-
14 tion will address, as appropriate,
15 issues of domestic violence; and

16 “(bb) what the applicant will
17 do, to the extent relevant, to en-
18 sure that participation in the
19 programs or activities is vol-
20 untary, and to inform potential
21 participants that their participa-
22 tion is voluntary; and

23 “(II) contains a commitment by
24 the entity—



1 “(aa) to not use the funds
2 for any other purpose; and

3 “(bb) to consult with experts
4 in domestic violence or relevant
5 community domestic violence coa-
6 litions in developing the pro-
7 grams and activities.

8 “(iii) **HEALTHY MARRIAGE PRO-**
9 **MOTION ACTIVITIES.**—In clause (ii), the
10 term ‘healthy marriage promotion activi-
11 ties’ means the following:

12 “(I) Public advertising cam-
13 paigns on the value of marriage and
14 the skills needed to increase marital
15 stability and health.

16 “(II) Education in high schools
17 on the value of marriage, relationship
18 skills, and budgeting.

19 “(III) Marriage education, mar-
20 riage skills, and relationship skills
21 programs, that may include parenting
22 skills, financial management, conflict
23 resolution, and job and career ad-
24 vancement, for non-married pregnant



1 women and non-married expectant fa-
2 thers.

3 “(IV) Pre-marital education and
4 marriage skills training for engaged
5 couples and for couples or individuals
6 interested in marriage.

7 “(V) Marriage enhancement and
8 marriage skills training programs for
9 married couples.

10 “(VI) Divorce reduction pro-
11 grams that teach relationship skills.

12 “(VII) Marriage mentoring pro-
13 grams which use married couples as
14 role models and mentors in at-risk
15 communities.

16 “(VIII) Programs to reduce the
17 disincentives to marriage in means-
18 tested aid programs, if offered in con-
19 junction with any activity described in
20 this subparagraph.

21 “(B) LIMITATION ON USE OF FUNDS FOR
22 DEMONSTRATION PROJECTS FOR COORDINATION
23 OF PROVISION OF CHILD WELFARE AND TANF
24 SERVICES TO TRIBAL FAMILIES AT RISK OF
25 CHILD ABUSE OR NEGLECT.—



1 “(i) IN GENERAL.—Of the amounts
2 made available under subparagraph (D)
3 for a fiscal year, the Secretary may not
4 award more than \$2,000,000 on a competi-
5 tive basis to fund demonstration projects
6 designed to test the effectiveness of tribal
7 governments or tribal consortia in coordi-
8 nating the provision to tribal families at
9 risk of child abuse or neglect of child wel-
10 fare services and services under tribal pro-
11 grams funded under this part.

12 “(ii) LIMITATION ON USE OF
13 FUNDS.—A grant made pursuant to clause
14 (i) to such a project shall not be used for
15 any purpose other than—

16 “(I) to improve case management
17 for families eligible for assistance
18 from such a tribal program;

19 “(II) for supportive services and
20 assistance to tribal children in out-of-
21 home placements and the tribal fami-
22 lies caring for such children, including
23 families who adopt such children; and



1 “(III) for prevention services and
2 assistance to tribal families at risk of
3 child abuse and neglect.

4 “(iii) REPORTS.—The Secretary may
5 require a recipient of funds awarded under
6 this subparagraph to provide the Secretary
7 with such information as the Secretary
8 deems relevant to enable the Secretary to
9 facilitate and oversee the administration of
10 any project for which funds are provided
11 under this subparagraph.

12 “(C) LIMITATION ON USE OF FUNDS FOR
13 ACTIVITIES PROMOTING RESPONSIBLE FATHER-
14 HOOD.—

15 “(i) IN GENERAL.—Of the amounts
16 made available under subparagraph (D)
17 for a fiscal year, the Secretary may not
18 award more than \$50,000,000 on a com-
19 petitive basis to States, territories, Indian
20 tribes and tribal organizations, and public
21 and nonprofit community entities, includ-
22 ing religious organizations, for activities
23 promoting responsible fatherhood.

24 “(ii) ACTIVITIES PROMOTING RESPON-
25 SIBLE FATHERHOOD.—In this paragraph,



1 the term 'activities promoting responsible
2 fatherhood' means the following:

3 “(I) Activities to promote mar-
4 riage or sustain marriage through ac-
5 tivities such as counseling, mentoring,
6 disseminating information about the
7 benefits of marriage and 2-parent in-
8 volvement for children, enhancing re-
9 lationship skills, education regarding
10 how to control aggressive behavior,
11 disseminating information on the
12 causes of domestic violence and child
13 abuse, marriage preparation pro-
14 grams, premarital counseling, marital
15 inventories, skills-based marriage edu-
16 cation, financial planning seminars,
17 including improving a family's ability
18 to effectively manage family business
19 affairs by means such as education,
20 counseling, or mentoring on matters
21 related to family finances, including
22 household management, budgeting,
23 banking, and handling of financial
24 transactions and home maintenance,
25 and divorce education and reduction



1 programs, including mediation and
2 counseling.

3 “(II) Activities to promote re-
4 sponsible parenting through activities
5 such as counseling, mentoring, and
6 mediation, disseminating information
7 about good parenting practices, skills-
8 based parenting education, encour-
9 aging child support payments, and
10 other methods.

11 “(III) Activities to foster eco-
12 nomic stability by helping fathers im-
13 prove their economic status by pro-
14 viding activities such as work first
15 services, job search, job training, sub-
16 sidized employment, job retention, job
17 enhancement, and encouraging edu-
18 cation, including career-advancing
19 education, dissemination of employ-
20 ment materials, coordination with ex-
21 isting employment services such as
22 welfare-to-work programs, referrals to
23 local employment training initiatives,
24 and other methods.



1 “(IV) Activities to promote re-
2 sponsible fatherhood that are con-
3 ducted through a contract with a na-
4 tionally recognized, nonprofit father-
5 hood promotion organization, such as
6 the development, promotion, and dis-
7 tribution of a media campaign to en-
8 courage the appropriate involvement
9 of parents in the life of any child and
10 specifically the issue of responsible fa-
11 therhood, and the development of a
12 national clearinghouse to assist States
13 and communities in efforts to promote
14 and support marriage and responsible
15 fatherhood.

16 “(D) APPROPRIATION.—Out of any money
17 in the Treasury of the United States not other-
18 wise appropriated, there are appropriated
19 \$150,000,000 for each of fiscal years 2006
20 through 2010, for expenditure in accordance
21 with this paragraph.”.

22 (b) COUNTING OF SPENDING ON CERTAIN PRO-FAM-
23 ILY ACTIVITIES.—Section 409(a)(7)(B)(i) (42 U.S.C.
24 609(a)(7)(B)(i)) is amended by adding at the end the fol-
25 lowing:



1 “(V) COUNTING OF SPENDING
2 ON CERTAIN PRO-FAMILY ACTIVI-
3 TIES.—The term ‘qualified State ex-
4 penditures’ includes the total expendi-
5 tures by the State during the fiscal
6 year under all State programs for a
7 purpose described in paragraph (3) or
8 (4) of section 401(a).”.

9 **Subtitle B—Child Care**

10 **SEC. 7201. ENTITLEMENT FUNDING.**

11 Section 418(a)(3) (42 U.S.C. 618(a)(3)) is
12 amended—

13 (1) by striking “and” at the end of subpara-
14 graph (E);

15 (2) by striking the period at the end of sub-
16 paragraph (F) and inserting a semicolon; and

17 (3) by adding at the end the following:

18 “(G) \$2,917,000,000 for each of fiscal
19 years 2006 through 2010.”.

20 **Subtitle C—Child Support**

21 **SEC. 7301. ASSIGNMENT AND DISTRIBUTION OF CHILD SUP-
22 PORT.**

23 (a) MODIFICATION OF RULE REQUIRING ASSIGN-
24 MENT OF SUPPORT RIGHTS AS A CONDITION OF RECEIV-



1 ING TANF.—Section 408(a)(3) (42 U.S.C. 608(a)(3)) is
2 amended to read as follows:

3 “(3) NO ASSISTANCE FOR FAMILIES NOT AS-
4 SIGNING CERTAIN SUPPORT RIGHTS TO THE
5 STATE.—A State to which a grant is made under
6 section 403 shall require, as a condition of paying
7 assistance to a family under the State program
8 funded under this part, that a member of the family
9 assign to the State any right the family member
10 may have (on behalf of the family member or of any
11 other person for whom the family member has ap-
12 plied for or is receiving such assistance) to support
13 from any other person, not exceeding the total
14 amount of assistance so paid to the family, which ac-
15 crued during the period that the family receives as-
16 sistance under the program.”.

17 (b) INCREASING CHILD SUPPORT PAYMENTS TO
18 FAMILIES AND SIMPLIFYING CHILD SUPPORT DISTRIBU-
19 TION RULES.—

20 (1) DISTRIBUTION RULES.—

21 (A) IN GENERAL.—Section 457(a) (42
22 U.S.C. 657(a)) is amended to read as follows:

23 “(a) IN GENERAL.—Subject to subsections (d) and
24 (e), the amounts collected on behalf of a family as support



1 by a State pursuant to a plan approved under this part
2 shall be distributed as follows:

3 “(1) FAMILIES RECEIVING ASSISTANCE.—In the
4 case of a family receiving assistance from the State,
5 the State shall—

6 “(A) pay to the Federal Government the
7 Federal share of the amount collected, subject
8 to paragraph (3)(A);

9 “(B) retain, or pay to the family, the State
10 share of the amount collected, subject to para-
11 graph (3)(B); and

12 “(C) pay to the family any remaining
13 amount.

14 “(2) FAMILIES THAT FORMERLY RECEIVED AS-
15 SISTANCE.—In the case of a family that formerly re-
16 ceived assistance from the State:

17 “(A) CURRENT SUPPORT.—To the extent
18 that the amount collected does not exceed the
19 current support amount, the State shall pay the
20 amount to the family.

21 “(B) ARREARAGES.—Except as otherwise
22 provided in an election made under section
23 454(34), to the extent that the amount col-
24 lected exceeds the current support amount, the
25 State—



1 “(i) shall first pay to the family the
2 excess amount, to the extent necessary to
3 satisfy support arrearages not assigned
4 pursuant to section 408(a)(3);

5 “(ii) if the amount collected exceeds
6 the amount required to be paid to the fam-
7 ily under clause (i), shall—

8 “(I) pay to the Federal Govern-
9 ment the Federal share of the excess
10 amount described in this clause, sub-
11 ject to paragraph (3)(A); and

12 “(II) retain, or pay to the family,
13 the State share of the excess amount
14 described in this clause, subject to
15 paragraph (3)(B); and

16 “(iii) shall pay to the family any re-
17 maining amount.

18 “(3) LIMITATIONS.—

19 “(A) FEDERAL REIMBURSEMENTS.—The
20 total of the amounts paid by the State to the
21 Federal Government under paragraphs (1) and
22 (2) of this subsection with respect to a family
23 shall not exceed the Federal share of the
24 amount assigned with respect to the family pur-
25 suant to section 408(a)(3).



1 “(B) STATE REIMBURSEMENTS.—The
2 total of the amounts retained by the State
3 under paragraphs (1) and (2) of this subsection
4 with respect to a family shall not exceed the
5 State share of the amount assigned with respect
6 to the family pursuant to section 408(a)(3).

7 “(4) FAMILIES THAT NEVER RECEIVED ASSIST-
8 ANCE.—In the case of any other family, the State
9 shall distribute to the family the portion of the
10 amount so collected that remains after withholding
11 any fee pursuant to section 454(6)(B)(ii).

12 “(5) FAMILIES UNDER CERTAIN AGREE-
13 MENTS.—Notwithstanding paragraphs (1) through
14 (3), in the case of an amount collected for a family
15 in accordance with a cooperative agreement under
16 section 454(33), the State shall distribute the
17 amount collected pursuant to the terms of the agree-
18 ment.”.

19 (B) STATE OPTION TO PASS THROUGH AD-
20 DITIONAL SUPPORT WITH FEDERAL FINANCIAL
21 PARTICIPATION BEGINNING WITH FISCAL YEAR
22 2009.—

23 (i) IN GENERAL.—Section 457(a) (42
24 U.S.C. 657(a)) is amended by adding at
25 the end the following:



1 “(7) STATE OPTION TO PASS THROUGH ADDI-
 2 TIONAL SUPPORT WITH FEDERAL FINANCIAL PAR-
 3 TICIPATION.—

4 “(A) FAMILIES THAT FORMERLY RE-
 5 CEIVED ASSISTANCE.—Notwithstanding para-
 6 graph (2), a State shall not be required to pay
 7 to the Federal Government the Federal share of
 8 an amount collected on behalf of a family that
 9 formerly received assistance from the State to
 10 the extent that the State pays the amount to
 11 the family.

12 “(B) FAMILIES THAT CURRENTLY RE-
 13 CEIVE ASSISTANCE.—

14 “(i) IN GENERAL.—Notwithstanding
 15 paragraph (1), in the case of a family that
 16 receives assistance from the State, a State
 17 shall not be required to pay to the Federal
 18 Government the Federal share of the ex-
 19 cepted portion (as defined in clause (ii)) of
 20 any amount collected on behalf of such
 21 family during a month to the extent that—

22 “(I) the State pays the excepted
 23 portion to the family; and

24 “(II) the excepted portion is dis-
 25 regarded in determining the amount



1 and type of assistance provided to the
2 family under such program.

3 “(ii) EXCEPTED PORTION DEFINED.—

4 For purposes of this subparagraph, the
5 term “excepted portion” means that por-
6 tion of the amount collected on behalf of a
7 family during a month that does not ex-
8 ceed \$100 per month, or in the case of a
9 family that includes 2 or more children,
10 that does not exceed an amount established
11 by the State that is not more than \$200
12 per month.”.

13 (ii) EFFECTIVE DATE.—The amend-
14 ment made by clause (i) shall take effect
15 on October 1, 2008.

16 (iii) REDESIGNATION.—Effective Oc-
17 tober 1, 2009, paragraph (7) of section
18 457(a) of the Social Security Act (as
19 added by clause (i)) is redesignated as
20 paragraph (6).

21 (C) STATE PLAN TO INCLUDE ELECTION
22 AS TO WHICH RULES TO APPLY IN DISTRIB-
23 UTING CHILD SUPPORT ARREARAGES COL-
24 LECTED ON BEHALF OF FAMILIES FORMERLY



1 RECEIVING ASSISTANCE.—Section 454 (42
2 U.S.C. 654) is amended—

3 (i) by striking “and” at the end of
4 paragraph (32);

5 (ii) by striking the period at the end
6 of paragraph (33) and inserting “; and”;
7 and

8 (iii) by inserting after paragraph (33)
9 the following:

10 “(34) include an election by the State to apply
11 section 457(a)(2)(B) of this Act or former section
12 457(a)(2)(B) of this Act (as in effect for the State
13 immediately before the date this paragraph first ap-
14 plies to the State) to the distribution of the amounts
15 which are the subject of such sections and, for so
16 long as the State elects to so apply such former sec-
17 tion, the amendments made by subsection (b)(1) of
18 section 7301 of the Deficit Reduction Act of 2005
19 shall not apply with respect to the State, notwith-
20 standing subsection (e) of such section 7301.”

21 (2) CURRENT SUPPORT AMOUNT DEFINED.—
22 Section 457(c) (42 U.S.C. 657(c)) is amended by
23 adding at the end the following:

24 “(5) CURRENT SUPPORT AMOUNT.—The term
25 ‘current support amount’ means, with respect to



1 amounts collected as support on behalf of a family,
2 the amount designated as the monthly support obli-
3 gation of the noncustodial parent in the order re-
4 quiring the support or calculated by the State based
5 on the order.”.

6 (c) STATE OPTION TO DISCONTINUE OLDER SUP-
7 PORT ASSIGNMENTS.—Section 457(b) (42 U.S.C. 657(b))
8 is amended to read as follows:

9 “(b) CONTINUATION OF ASSIGNMENTS.—

10 “(1) STATE OPTION TO DISCONTINUE PRE-1997
11 SUPPORT ASSIGNMENTS.—

12 “(A) IN GENERAL.—Any rights to support
13 obligations assigned to a State as a condition of
14 receiving assistance from the State under part
15 A and in effect on September 30, 1997 (or such
16 earlier date on or after August 22, 1996, as the
17 State may choose), may remain assigned after
18 such date.

19 “(B) DISTRIBUTION OF AMOUNTS AFTER
20 ASSIGNMENT DISCONTINUATION.—If a State
21 chooses to discontinue the assignment of a sup-
22 port obligation described in subparagraph (A),
23 the State may treat amounts collected pursuant
24 to the assignment as if the amounts had never
25 been assigned and may distribute the amounts



1 to the family in accordance with subsection
2 (a)(4).

3 “(2) STATE OPTION TO DISCONTINUE POST-1997
4 ASSIGNMENTS.—

5 “(A) IN GENERAL.—Any rights to support
6 obligations accruing before the date on which a
7 family first receives assistance under part A
8 that are assigned to a State under that part
9 and in effect before the implementation date of
10 this section may remain assigned after such
11 date.

12 “(B) DISTRIBUTION OF AMOUNTS AFTER
13 ASSIGNMENT DISCONTINUATION.—If a State
14 chooses to discontinue the assignment of a sup-
15 port obligation described in subparagraph (A),
16 the State may treat amounts collected pursuant
17 to the assignment as if the amounts had never
18 been assigned and may distribute the amounts
19 to the family in accordance with subsection
20 (a)(4).”

21 (d) CONFORMING AMENDMENTS.—Section 6402(c)
22 of the Internal Revenue Code of 1986 (relating to offset
23 of past-due support against overpayments) is amended—

24 (1) in the first sentence, by striking “the Social
25 Security Act.” and inserting “of such Act.”; and



1 (2) by striking the third sentence and inserting
2 the following: “The Secretary shall apply a reduction
3 under this subsection first to an amount certified by
4 the State as past due support under section 464 of
5 the Social Security Act before any other reductions
6 allowed by law.”.

7 (e) EFFECTIVE DATE.—

8 (1) IN GENERAL.—Except as otherwise pro-
9 vided in this section, the amendments made by the
10 preceding provisions of this section shall take effect
11 on October 1, 2009, and shall apply to payments
12 under parts A and D of title IV of the Social Secu-
13 rity Act for calendar quarters beginning on or after
14 such date, and without regard to whether regula-
15 tions to implement the amendments (in the case of
16 State programs operated under such part D) are
17 promulgated by such date.

18 (2) STATE OPTION TO ACCELERATE EFFECTIVE
19 DATE.—Notwithstanding paragraph (1), a State
20 may elect to have the amendments made by the pre-
21 ceding provisions of this section apply to the State
22 and to amounts collected by the State (and the pay-
23 ments under parts A and D), on and after such date
24 as the State may select that is not earlier than Octo-
25 ber 1, 2008, and not later than September 30, 2009.



1 (f) USE OF TAX REFUND INTERCEPT PROGRAM TO
2 COLLECT PAST-DUE CHILD SUPPORT ON BEHALF OF
3 CHILDREN WHO ARE NOT MINORS.—

4 (1) IN GENERAL.—Section 464 (42 U.S.C. 664)
5 is amended—

6 (A) in subsection (a)(2)(A), by striking
7 “(as that term is defined for purposes of this
8 paragraph under subsection (c))”; and

9 (B) in subsection (c)—

10 (i) in paragraph (1)—

11 (I) by striking “(1) Except as
12 provided in paragraph (2), as used
13 in” and inserting “In”; and

14 (II) by inserting “(whether or not
15 a minor)” after “a child” each place
16 it appears; and

17 (ii) by striking paragraphs (2) and
18 (3).

19 (2) EFFECTIVE DATE.—The amendments made
20 by paragraph (1) shall take effect on October 1,
21 2007.

22 (g) STATE OPTION TO USE STATEWIDE AUTOMATED
23 DATA PROCESSING AND INFORMATION RETRIEVAL SYS-
24 TEM FOR INTERSTATE CASES.—Section
25 466(a)(14)(A)(iii) (42 U.S.C. 666(a)(14)(A)(iii)) is



1 amended by inserting before the semicolon the following:
2 “(but the assisting State may establish a corresponding
3 case based on such other State’s request for assistance)”.

4 **SEC. 7302. MANDATORY REVIEW AND ADJUSTMENT OF**
5 **CHILD SUPPORT ORDERS FOR FAMILIES RE-**
6 **CEIVING TANF.**

7 (a) **IN GENERAL.**—Section 466(a)(10)(A)(i) (42
8 U.S.C. 666(a)(10)(A)(i)) is amended—

9 (1) by striking “parent, or,” and inserting
10 “parent or”; and

11 (2) by striking “upon the request of the State
12 agency under the State plan or of either parent,”.

13 (b) **EFFECTIVE DATE.**—The amendments made by
14 subsection (a) shall take effect on October 1, 2007.

15 **SEC. 7303. DECREASE IN AMOUNT OF CHILD SUPPORT AR-**
16 **REARAGE TRIGGERING PASSPORT DENIAL.**

17 (a) **IN GENERAL.**—Section 452(k)(1) (42 U.S.C.
18 652(k)(1)) is amended by striking “\$5,000” and inserting
19 “\$2,500”.

20 (b) **CONFORMING AMENDMENT.**—Section 454(31)
21 (42 U.S.C. 654(31)) is amended by striking “\$5,000” and
22 inserting “\$2,500”.

23 (c) **EFFECTIVE DATE.**—The amendments made by
24 this section shall take effect on October 1, 2006.



1 **SEC. 7304. MAINTENANCE OF TECHNICAL ASSISTANCE**
2 **FUNDING.**

3 Section 452(j) (42 U.S.C. 652(j)) is amended by in-
4 serting “or the amount appropriated under this paragraph
5 for fiscal year 2002, whichever is greater” before “, which
6 shall be available”.

7 **SEC. 7305. MAINTENANCE OF FEDERAL PARENT LOCATOR**
8 **SERVICE FUNDING.**

9 Section 453(o) (42 U.S.C. 653(o)) is amended—

10 (1) in the first sentence, by inserting “or the
11 amount appropriated under this paragraph for fiscal
12 year 2002, whichever is greater” before “, which
13 shall be available”; and

14 (2) in the second sentence, by striking “for
15 each of fiscal years 1997 through 2001”.

16 **SEC. 7306. INFORMATION COMPARISONS WITH INSURANCE**
17 **DATA.**

18 (a) **DUTIES OF THE SECRETARY.**—Section 452 (42
19 U.S.C. 652) is amended by adding at the end the fol-
20 lowing:

21 “(1) **COMPARISONS WITH INSURANCE INFORMA-**
22 **TION.**—

23 “(1) **IN GENERAL.**—The Secretary, through the
24 Federal Parent Locator Service, may—

25 “(A) compare information concerning indi-
26 viduals owing past-due support with informa-



1 tion maintained by insurers (or their agents)
2 concerning insurance claims, settlements,
3 awards, and payments; and

4 “(B) furnish information resulting from
5 the data matches to the State agencies respon-
6 sible for collecting child support from the indi-
7 viduals.

8 “(2) LIABILITY.—An insurer (including any
9 agent of an insurer) shall not be liable under any
10 Federal or State law to any person for any dislo-
11 sure provided for under this subsection, or for any
12 other action taken in good faith in accordance with
13 this subsection.”.

14 (b) STATE REIMBURSEMENT OF FEDERAL COSTS.—
15 Section 453(k)(3) (42 U.S.C. 653(k)(3)) is amended by
16 inserting “or section 452(l)” after “pursuant to this sec-
17 tion”.

18 **SEC. 7307. REQUIREMENT THAT STATE CHILD SUPPORT EN-**
19 **FORCEMENT AGENCIES SEEK MEDICAL SUP-**
20 **PORT FOR CHILDREN FROM EITHER PARENT.**

21 (a) STATE AGENCIES REQUIRED TO SEEK MEDICAL
22 SUPPORT FROM EITHER PARENT.—

23 (1) IN GENERAL.—Section 466(a)(19)(A) (42
24 U.S.C. 666(a)(19)(A)) is amended by striking
25 “which include a provision for the health care cov-



1 erage of the child are enforced” and inserting “shall
2 include a provision for medical support for the child
3 to be provided by either or both parents, and shall
4 be enforced”.

5 (2) CONFORMING AMENDMENTS.—

6 (A) TITLE IV-D.—

7 (i) Section 452(f) (42 U.S.C. 652(f))
8 is amended by striking “include medical
9 support as part of any child support order
10 and enforce medical support” and inserting
11 “enforce medical support included as part
12 of a child support order”.

13 (ii) Section 466(a)(19) (42 U.S.C.
14 666(a)(19)), as amended by paragraph (1)
15 of this subsection, is amended—

16 (I) in subparagraph (A)—

17 (aa) by striking “section
18 401(e)(3)(C)” and inserting “sec-
19 tion 401(e)”; and

20 (bb) by striking “section
21 401(f)(5)(C)” and inserting “sec-
22 tion 401(f)”;

23 (II) in subparagraph (B)—

24 (aa) by striking “noncusto-
25 dial” each place it appears; and



1 (bb) in clause (iii), by strik-
2 ing “section 466(b)” and insert-
3 ing “subsection (b)”; and
4 (III) in subparagraph (C), by
5 striking “noncustodial” each place it
6 appears and inserting “obligated”.

7 (B) STATE OR LOCAL GOVERNMENTAL
8 GROUP HEALTH PLANS.—Section 401(e)(2) of
9 the Child Support Performance and Incentive
10 Act of 1998 (29 U.S.C. 1169 note) is amended,
11 in the matter preceding subparagraph (A), by
12 striking “who is a noncustodial parent of the
13 child”.

14 (C) CHURCH PLANS.—Section 401(f)(5)(C)
15 of the Child Support Performance and Incentive
16 Act of 1998 (29 U.S.C. 1169 note) is amended
17 by striking “noncustodial” each place it ap-
18 pears.

19 (b) ENFORCEMENT OF MEDICAL SUPPORT REQUIRE-
20 MENTS.—Section 452(f) (42 U.S.C. 652(f)), as amended
21 by subsection (a)(2)(A)(i), is amended by inserting after
22 the first sentence the following: “A State agency admin-
23 istering the program under this part may enforce medical
24 support against a custodial parent if health care coverage



1 is available to the custodial parent at a reasonable cost,
2 notwithstanding any other provision of this part.”.

3 (c) **DEFINITION OF MEDICAL SUPPORT.**—Section
4 452(f) (42 U.S.C. 652(f)), as amended by subsections
5 (a)(2)(A)(i) and (b) of this section, is amended by adding
6 at the end the following: “For purposes of this part, the
7 term ‘medical support’ may include health care coverage,
8 such as coverage under a health insurance plan (including
9 payment of costs of premiums, co-payments, and
10 deductibles) and payment for medical expenses incurred
11 on behalf of a child.”.

12 **SEC. 7308. REDUCTION OF FEDERAL MATCHING RATE FOR**
13 **LABORATORY COSTS INCURRED IN DETER-**
14 **MINING PATERNITY.**

15 (a) **IN GENERAL.**—Section 455(a)(1)(C) (42 U.S.C.
16 655(a)(1)(C)) is amended by striking “90 percent (rather
17 than the percentage specified in subparagraph (A))” and
18 inserting “66 percent”.

19 (b) **EFFECTIVE DATE.**—The amendment made by
20 subsection (a) shall take effect on October 1, 2006, and
21 shall apply to costs incurred on or after that date.

22 **SEC. 7309. ENDING FEDERAL MATCHING OF STATE SPEND-**
23 **ING OF FEDERAL INCENTIVE PAYMENTS.**

24 (a) **IN GENERAL.**—Section 455(a)(1) (42 U.S.C.
25 655(a)(1)) is amended by inserting “from amounts paid



1 to the State under section 458 or” before “to carry out
2 an agreement”.

3 (b) **EFFECTIVE DATE.**—The amendment made by
4 subsection (a) shall take effect on October 1, 2007.

5 **SEC. 7310. MANDATORY FEE FOR SUCCESSFUL CHILD SUP-**
6 **PORT COLLECTION FOR FAMILY THAT HAS**
7 **NEVER RECEIVED TANF.**

8 (a) **IN GENERAL.**—Section 454(6)(B) (42 U.S.C.
9 654(6)(B)) is amended—

10 (1) by inserting “(i)” after “(B)”;

11 (2) by redesignating clauses (i) and (ii) as sub-
12 clauses (I) and (II), respectively;

13 (3) by adding “and” after the semicolon; and

14 (4) by adding after and below the end the fol-
15 lowing new clause:

16 “(ii) in the case of an individual who has
17 never received assistance under a State pro-
18 gram funded under part A and for whom the
19 State has collected at least \$500 of support, the
20 State shall impose an annual fee of \$25 for
21 each case in which services are furnished, which
22 shall be retained by the State from support col-
23 lected on behalf of the individual (but not from
24 the 1st \$500 so collected), paid by the indi-
25 vidual applying for the services, recovered from



1 the absent parent, or paid by the State out of
2 its own funds (the payment of which from State
3 funds shall not be considered as an administra-
4 tive cost of the State for the operation of the
5 plan, and the fees shall be considered income to
6 the program);”.

7 (b) CONFORMING AMENDMENTS.—Section 457(a)(3)
8 (42 U.S.C. 657(a)(3)) is amended to read as follows:

9 “(3) FAMILIES THAT NEVER RECEIVED ASSIST-
10 ANCE.—In the case of any other family, the State
11 shall distribute to the family the portion of the
12 amount so collected that remains after withholding
13 any fee pursuant to section 454(6)(B)(ii).”.

14 (c) EFFECTIVE DATE.—The amendments made by
15 this section shall take effect on October 1, 2006.

16 **SEC. 7311. EXCEPTION TO GENERAL EFFECTIVE DATE FOR**
17 **STATE PLANS REQUIRING STATE LAW**
18 **AMENDMENTS.**

19 In the case of a State plan under part D of title IV
20 of the Social Security Act which the Secretary determines
21 requires State legislation in order for the plan to meet the
22 additional requirements imposed by the amendments made
23 by this subtitle, the effective date of the amendments im-
24 posing the additional requirements shall be 3 months after
25 the first day of the first calendar quarter beginning after



1 the close of the first regular session of the State legisla-
2 ture that begins after the date of the enactment of this
3 Act. For purposes of the preceding sentence, in the case
4 of a State that has a 2-year legislative session, each year
5 of the session shall be considered to be a separate regular
6 session of the State legislature.

7 **Subtitle D—Child Welfare**

8 **SEC. 7401. STRENGTHENING COURTS.**

9 (a) COURT IMPROVEMENT GRANTS.—

10 (1) IN GENERAL.—Section 438(a) (42 U.S.C.
11 629h(a)) is amended—

12 (A) by striking “and” at the end of para-
13 graph (1);

14 (B) by striking the period at the end of
15 paragraph (2) and inserting a semicolon; and

16 (C) by adding at the end the following:

17 “(3) to ensure that the safety, permanence, and
18 well-being needs of children are met in a timely and
19 complete manner; and

20 “(4) to provide for the training of judges, attor-
21 neys and other legal personnel in child welfare
22 cases.”.

23 (2) APPLICATIONS.—Section 438(b) (42 U.S.C.
24 629h(b)) is amended to read as follows:

25 “(b) APPLICATIONS.—



1 “(1) IN GENERAL.—In order to be eligible to
2 receive a grant under this section, a highest State
3 court shall submit to the Secretary an application at
4 such time, in such form, and including such infor-
5 mation and assurances as the Secretary may require,
6 including—

7 “(A) in the case of a grant for the purpose
8 described in subsection (a)(3), a description of
9 how courts and child welfare agencies on the
10 local and State levels will collaborate and jointly
11 plan for the collection and sharing of all rel-
12 evant data and information to demonstrate how
13 improved case tracking and analysis of child
14 abuse and neglect cases will produce safe and
15 timely permanency decisions;

16 “(B) in the case of a grant for the purpose
17 described in subsection (a)(4), a demonstration
18 that a portion of the grant will be used for
19 cross-training initiatives that are jointly
20 planned and executed with the State agency or
21 any other agency under contract with the State
22 to administer the State program under the
23 State plan under subpart 1, the State plan ap-
24 proved under section 434, or the State plan ap-
25 proved under part E; and



1 “(C) in the case of a grant for any purpose
2 described in subsection (a), a demonstration of
3 meaningful and ongoing collaboration among
4 the courts in the State, the State agency or any
5 other agency under contract with the State who
6 is responsible for administering the State pro-
7 gram under part B or E, and, where applicable,
8 Indian tribes..

9 “(2) SEPARATE APPLICATIONS.— A highest
10 State court desiring grants under this section for 2
11 or more purposes shall submit separate applications
12 for the following grants:

13 “(A) A grant for the purposes described in
14 paragraphs (1) and (2) of subsection (a).

15 “(B) A grant for the purpose described in
16 subsection (a)(3).

17 “(C) A grant for the purpose described in
18 subsection (a)(4).”.

19 “(3) ALLOTMENTS.—Section 438(c) (42 U.S.C.
20 429h(c)) is amended—

21 (A) in paragraph (1)—

22 (i) by inserting “of this section for a
23 grant described in subsection (b)(2)(A) of
24 this section” after “subsection (b)”; and



1 (ii) by striking “paragraph (2) of this
2 subsection” and inserting “subparagraph
3 (B) of this paragraph”;
4 (B) in paragraph (2)—

5 (i) by striking “this paragraph” and
6 inserting “this subparagraph”;

7 (ii) by striking “paragraph (1) of this
8 subsection” and inserting “subparagraph
9 (A) of this paragraph”; and

10 (iii) by inserting “for such a grant”
11 after “subsection (b)”;

12 (C) by redesignating and indenting para-
13 graphs (1) and (2) as subparagraphs (A) and
14 (B), respectively;

15 (D) by inserting before and above such
16 subparagraph (A) the following:

17 “(1) GRANTS TO ASSESS AND IMPROVE HAN-
18 DLING OF COURT PROCEEDINGS RELATING TO FOS-
19 TER CARE AND ADOPTION.—”; and

20 (E) by adding at the end the following:

21 “(2) GRANTS FOR IMPROVED DATA COLLEC-
22 TION AND TRAINING.—

23 “(A) IN GENERAL.—Each highest State
24 court which has an application approved under
25 subsection (b) of this section for a grant re-



1 ferred to in subparagraph (B) or (C) of sub-
2 section (b)(2) shall be entitled to payment, for
3 each of fiscal years 2006 through 2010, from
4 the amount made available under whichever of
5 paragraph (1) or (2) of subsection (e) applies
6 with respect to the grant, of an amount equal
7 to the sum of \$85,000 plus the amount de-
8 scribed in subparagraph (B) of this paragraph
9 for the fiscal year with respect to the grant.

10 “(B) FORMULA.—The amount described in
11 this subparagraph for any fiscal year with re-
12 spect to a grant referred to in subparagraph
13 (B) or (C) of subsection (b)(2) is the amount
14 that bears the same ratio to the amount made
15 available under subsection (e) for such a grant
16 (reduced by the dollar amount specified in sub-
17 paragraph (A) of this paragraph) as the num-
18 ber of individuals in the State who have not at-
19 tained 21 years of age bears to the total num-
20 ber of such individuals in all States the highest
21 State courts of which have approved applica-
22 tions under subsection (b) for such a grant.”.

23 (4) FUNDING.—Section 438 (42 U.S.C. 629h)
24 is amended by adding at the end the following:



1 “(e) FUNDING FOR GRANTS FOR IMPROVED DATA
2 COLLECTION AND TRAINING.—Out of any money in the
3 Treasury of the United States not otherwise appropriated,
4 there are appropriated to the Secretary, for each of fiscal
5 years 2006 through 2010—

6 “(1) \$10,000,000 for grants referred to in sub-
7 section (b)(2)(B); and

8 “(2) \$10,000,000 for grants referred to in sub-
9 section (b)(2)(C).”.

10 (b) REQUIREMENT TO DEMONSTRATE MEANINGFUL
11 COLLABORATION BETWEEN COURTS AND AGENCIES IN
12 CHILD WELFARE SERVICES PROGRAMS.—Section 422(b)
13 (42 U.S.C. 622(b)) is amended—

14 (1) by striking “and” at the end of paragraph
15 (13);

16 (2) by striking the period at the end of para-
17 graph (14) and inserting “; and”; and

18 (3) by adding at the end the following:

19 “(15) demonstrate substantial, ongoing, and
20 meaningful collaboration with State courts in the de-
21 velopment and implementation of the State plan
22 under subpart 1, the State plan approved under sub-
23 part 2, and the State plan approved under part E,
24 and in the development and implementation of any



1 program improvement plan required under section
2 1123A.”.

3 (c) USE OF CHILD WELFARE RECORDS IN STATE
4 COURT PROCEEDINGS.—Section 471 (42 U.S.C. 671) is
5 amended—

6 (1) in subsection (a)(8), by inserting “subject
7 to subsection (c),” after “(8)”; and

8 (2) by adding at the end the following:

9 “(c) USE OF CHILD WELFARE RECORDS IN STATE
10 COURT PROCEEDINGS.—Subsection (a)(8) shall not be
11 construed to limit the flexibility of a State in determining
12 State policies relating to public access to court proceedings
13 to determine child abuse and neglect or other court hear-
14 ings held pursuant to part B or this part, except that such
15 policies shall, at a minimum, ensure the safety and well-
16 being of the child, parents, and family.”.

17 **SEC. 7402. FUNDING OF SAFE AND STABLE FAMILIES PRO-**
18 **GRAMS.**

19 Section 436(a) (42 U.S.C. 629f(a)) is amended to
20 read as follows:

21 “(a) AUTHORIZATION.—In addition to any amount
22 otherwise made available to carry out this subpart, there
23 are authorized to be appropriated to carry out this subpart
24 \$345,000,000 for fiscal year 2006. Notwithstanding the
25 preceding sentence, the total amount authorized to be so



1 appropriated for fiscal year 2006 under this subsection
2 and under this subsection (as in effect before the date of
3 the enactment of the Deficit Reduction Act of 2005) is
4 \$345,000,000.”

5 **SEC. 7403. CLARIFICATION REGARDING FEDERAL MATCH-**
6 **ING OF CERTAIN ADMINISTRATIVE COSTS**
7 **UNDER THE FOSTER CARE MAINTENANCE**
8 **PAYMENTS PROGRAM.**

9 (a) ADMINISTRATIVE COSTS RELATING TO UNLI-
10 CENSED CARE.—Section 472 (42 U.S.C. 672) is amended
11 by inserting after subsection (h) the following:

12 “(i) ADMINISTRATIVE COSTS ASSOCIATED WITH
13 OTHERWISE ELIGIBLE CHILDREN NOT IN LICENSED FOS-
14 TER CARE SETTINGS.—Expenditures by a State that
15 would be considered administrative expenditures for pur-
16 poses of section 474(a)(3) if made with respect to a child
17 who was residing in a foster family home or child-care in-
18 stitution shall be so considered with respect to a child not
19 residing in such a home or institution—

20 “(1) in the case of a child who has been re-
21 moved in accordance with subsection (a) of this sec-
22 tion from the home of a relative specified in section
23 406(a) (as in effect on July 16, 1996), only for
24 expenditures—



1 “(A) with respect to a period of not more
2 than the lesser of 12 months or the average
3 length of time it takes for the State to license
4 or approve a home as a foster home, in which
5 the child is in the home of a relative and an ap-
6 plication is pending for licensing or approval of
7 the home as a foster family home; or

8 “(B) with respect to a period of not more
9 than 1 calendar month when a child moves
10 from a facility not eligible for payments under
11 this part into a foster family home or child care
12 institution licensed or approved by the State;
13 and

14 “(2) in the case of any other child who is poten-
15 tially eligible for benefits under a State plan ap-
16 proved under this part and at imminent risk of re-
17 moval from the home, only if—

18 “(A) reasonable efforts are being made in
19 accordance with section 471(a)(15) to prevent
20 the need for, or if necessary to pursue, removal
21 of the child from the home; and

22 “(B) the State agency has made, not less
23 often than every 6 months, a determination (or
24 redetermination) as to whether the child re-



1 mains at imminent risk of removal from the
2 home.”.

3 (b) CONFORMING AMENDMENT.—Section 474(a)(3)
4 (42 U.S.C. 674(a)(3)) is amended by inserting “subject
5 to section 472(i)” before “an amount equal to”.

6 **SEC. 7404. CLARIFICATION OF ELIGIBILITY FOR FOSTER**
7 **CARE MAINTENANCE PAYMENTS AND ADOP-**
8 **TION ASSISTANCE.**

9 (a) FOSTER CARE MAINTENANCE PAYMENTS.—Sec-
10 tion 472(a) (42 U.S.C. 672(a)) is amended to read as fol-
11 lows:

12 “(a) IN GENERAL.—

13 “(1) ELIGIBILITY.—Each State with a plan ap-
14 proved under this part shall make foster care main-
15 tenance payments on behalf of each child who has
16 been removed from the home of a relative specified
17 in section 406(a) (as in effect on July 16, 1996)
18 into foster care if—

19 “(A) the removal and foster care place-
20 ment met, and the placement continues to meet,
21 the requirements of paragraph (2); and

22 “(B) the child, while in the home, would
23 have met the AFDC eligibility requirement of
24 paragraph (3).

1 “(2) REMOVAL AND FOSTER CARE PLACEMENT
2 REQUIREMENTS.—The removal and foster care
3 placement of a child meet the requirements of this
4 paragraph if—

5 “(A) the removal and foster care place-
6 ment are in accordance with—

7 “(i) a voluntary placement agreement
8 entered into by a parent or legal guardian
9 of the child who is the relative referred to
10 in paragraph (1); or

11 “(ii) a judicial determination to the
12 effect that continuation in the home from
13 which removed would be contrary to the
14 welfare of the child and that reasonable ef-
15 forts of the type described in section
16 471(a)(15) for a child have been made;

17 “(B) the child’s placement and care are
18 the responsibility of—

19 “(i) the State agency administering
20 the State plan approved under section 471;
21 or

22 “(ii) any other public agency with
23 which the State agency administering or
24 supervising the administration of the State



1 plan has made an agreement which is in
2 effect; and

3 “(C) the child has been placed in a foster
4 family home or child-care institution.

5 “(3) AFDC ELIGIBILITY REQUIREMENT.—

6 “(A) IN GENERAL.—A child in the home
7 referred to in paragraph (1) would have met
8 the AFDC eligibility requirement of this para-
9 graph if the child—

10 “(i) would have received aid under the
11 State plan approved under section 402 (as
12 in effect on July 16, 1996) in the home, in
13 or for the month in which the agreement
14 was entered into or court proceedings lead-
15 ing to the determination referred to in
16 paragraph (2)(A)(ii) of this subsection
17 were initiated; or

18 “(ii)(I) would have received the aid in
19 the home, in or for the month referred to
20 in clause (i), if application had been made
21 therefor; or

22 “(II) had been living in the home
23 within 6 months before the month in which
24 the agreement was entered into or the pro-
25 ceedings were initiated, and would have re-



1 ceived the aid in or for such month, if, in
2 such month, the child had been living in
3 the home with the relative referred to in
4 paragraph (1) and application for the aid
5 had been made.

6 “(B) RESOURCES DETERMINATION.—For
7 purposes of subparagraph (A), in determining
8 whether a child would have received aid under
9 a State plan approved under section 402 (as in
10 effect on July 16, 1996), a child whose re-
11 sources (determined pursuant to section
12 402(a)(7)(B), as so in effect) have a combined
13 value of not more than \$10,000 shall be consid-
14 ered a child whose resources have a combined
15 value of not more than \$1,000 (or such lower
16 amount as the State may determine for pur-
17 poses of section 402(a)(7)(B)).

18 “(4) ELIGIBILITY OF CERTAIN ALIEN CHIL-
19 DREN.—Subject to title IV of the Personal Responsi-
20 bility and Work Opportunity Reconciliation Act of
21 1996, if the child is an alien disqualified under sec-
22 tion 245A(h) or 210(f) of the Immigration and Na-
23 tionality Act from receiving aid under the State plan
24 approved under section 402 in or for the month in
25 which the agreement described in paragraph



1 (2)(A)(i) was entered into or court proceedings lead-
2 ing to the determination described in paragraph
3 (2)(A)(ii) were initiated, the child shall be consid-
4 ered to satisfy the requirements of paragraph (3),
5 with respect to the month, if the child would have
6 satisfied the requirements but for the disqualifica-
7 tion.”.

8 (b) ADOPTION ASSISTANCE.—Section 473(a)(2) (42
9 U.S.C. 673(a)(2)) is amended to read as follows:

10 “(2)(A) For purposes of paragraph (1)(B)(ii), a child
11 meets the requirements of this paragraph if the child—

12 “(i)(I)(aa) was removed from the home of a rel-
13 ative specified in section 406(a) (as in effect on July
14 16, 1996) and placed in foster care in accordance
15 with a voluntary placement agreement with respect
16 to which Federal payments are provided under sec-
17 tion 474 (or section 403, as such section was in ef-
18 fect on July 16, 1996), or in accordance with a judi-
19 cial determination to the effect that continuation in
20 the home would be contrary to the welfare of the
21 child; and

22 “(bb) met the requirements of section 472(a)(3)
23 with respect to the home referred to in item (aa) of
24 this subclause;

1 “(II) meets all of the requirements of title XVI
2 with respect to eligibility for supplemental security
3 income benefits; or

4 “(III) is a child whose costs in a foster family
5 home or child-care institution are covered by the fos-
6 ter care maintenance payments being made with re-
7 spect to the minor parent of the child as provided
8 in section 475(4)(B); and

9 “(ii) has been determined by the State, pursu-
10 ant to subsection (c) of this section, to be a child
11 with special needs.

12 “(B) Section 472(a)(4) shall apply for purposes of
13 subparagraph (A) of this paragraph, in any case in which
14 the child is an alien described in such section.

15 “(C) A child shall be treated as meeting the require-
16 ments of this paragraph for the purpose of paragraph
17 (1)(B)(ii) if the child—

18 “(i) meets the requirements of subparagraph
19 (A)(ii);

20 “(ii) was determined eligible for adoption assist-
21 ance payments under this part with respect to a
22 prior adoption;

23 “(iii) is available for adoption because—



1 “(I) the prior adoption has been dissolved,
2 and the parental rights of the adoptive parents
3 have been terminated; or

4 “(II) the child’s adoptive parents have
5 died; and

6 “(iv) fails to meet the requirements of subpara-
7 graph (A) but would meet such requirements if—

8 “(I) the child were treated as if the child
9 were in the same financial and other cir-
10 cumstances the child was in the last time the
11 child was determined eligible for adoption as-
12 sistance payments under this part; and

13 “(II) the prior adoption were treated as
14 never having occurred.”.

15 **Subtitle E—Supplemental Security** 16 **Income**

17 **SEC. 7501. REVIEW OF STATE AGENCY BLINDNESS AND DIS-** 18 **ABILITY DETERMINATIONS.**

19 Section 1633 (42 U.S.C. 1383b) is amended by add-
20 ing at the end the following:

21 “(e)(1) The Commissioner of Social Security shall re-
22 view determinations, made by State agencies pursuant to
23 subsection (a) in connection with applications for benefits
24 under this title on the basis of blindness or disability, that
25 individuals who have attained 18 years of age are blind



1 or disabled as of a specified onset date. The Commissioner
2 of Social Security shall review such a determination before
3 any action is taken to implement the determination.

4 “(2)(A) In carrying out paragraph (1), the Commis-
5 sioner of Social Security shall review—

6 “(i) at least 20 percent of all determinations re-
7 ferred to in paragraph (1) that are made in fiscal
8 year 2006;

9 “(ii) at least 40 percent of all such determina-
10 tions that are made in fiscal year 2007; and

11 “(iii) at least 50 percent of all such determina-
12 tions that are made in fiscal year 2008 or thereafter.

13 “(B) In carrying out subparagraph (A), the Commis-
14 sioner of Social Security shall, to the extent feasible, select
15 for review the determinations which the Commissioner of
16 Social Security identifies as being the most likely to be
17 incorrect.”.

18 **SEC. 7502. PAYMENT OF CERTAIN LUMP SUM BENEFITS IN**
19 **INSTALLMENTS UNDER THE SUPPLEMENTAL**
20 **SECURITY INCOME PROGRAM.**

21 (a) IN GENERAL.—Section 1631(a)(10)(A)(i) (42
22 U.S.C. 1383(a)(10)(A)(i)) is amended by striking “12”
23 and inserting “3”.



1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall take effect 3 months after the date
3 of the enactment of this Act.

4 **Subtitle F—Repeal of Continued**
5 **Dumping and Subsidy Offset**

6 **SEC. 7601. REPEAL OF CONTINUED DUMPING AND SUBSIDY**
7 **OFFSET.**

8 ~~Section 754 of the Tariff Act of 1930 (19 U.S.C. 1675c) is repealed.~~

(a) REPEAL.—Effective upon the date of enactment of this Act, section 754 of the Tariff Act of 1930 (19 U.S.C. 1675c), and the item relating to section 754 in the table of contents for title VII of that Act, are repealed.

(b) DISTRIBUTIONS ON CERTAIN ENTRIES.—All duties on entries of goods made and filed before October 1, 2007, that would, but for subsection (a) of this section, be distributed under section 754 of the Tariff Act of 1930, shall be distributed as if section 754 of the Tariff Act of 1930 had not been repealed by subsection (a).

16 ~~of this title, shall be deposited in the general fund~~

17 ~~of the Treasury.~~

18 **Subtitle G—Effective Date**

19 **SEC. 7701. EFFECTIVE DATE.**

20 Except as otherwise provided in this title, this title
21 and the amendments made by this title shall take effect
22 as if enacted on October 1, 2005.



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H.L.C.
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1 **TITLE VIII—EDUCATION AND**
2 **PENSION BENEFIT PROVISIONS**
3 ~~SECTION 8000. TABLE OF CONTENTS.~~

~~Sec. 8000. Table of Contents.~~

~~Subtitle H—Higher Education Provisions~~

- ~~Sec. 8001. Short title, reference, effective date.~~
- ~~Sec. 8002. M. Allocation of DO/DO fund.~~
- ~~Sec. 8003. Academic Competitiveness grants.~~
- ~~Sec. 8004. Renegotiation of Federal Family Education Loan Program.~~
- ~~Sec. 8005. Loan limits.~~
- ~~Sec. 8006. PLUS loan interest rates and annual payment.~~
- ~~Sec. 8007. Disbursement of student loans.~~
- ~~Sec. 8008. Additional student loan limits.~~
- ~~Sec. 8009. College loan changes.~~
- ~~Sec. 8010. Requirements for encumbrances of student loans.~~
- ~~Sec. 8011. Payment of credit bureaus and credit reporting agencies.~~
- ~~Sec. 8012. Grant as lender.~~
- ~~Sec. 8013. Repayment by the Secretary of Education of loans that are discharged as due to death of borrower, treatment of borrower attending schools that fail to provide needed services, and loans discharged as fully repaid.~~
- ~~Sec. 8014. Prohibition of financial aid from Temporary Teacher Protection Act of 2004.~~
- ~~Sec. 8015. Additional administrative provisions.~~
- ~~Sec. 8016. Federal administrative expenses.~~
- ~~Sec. 8017. Cost of attendance.~~
- ~~Sec. 8018. Family contribution.~~
- ~~Sec. 8019. Financial need test and automatic non-impoverishment.~~
- ~~Sec. 8020. Additional need analysis.~~
- ~~Sec. 8021. General provisions.~~
- ~~Sec. 8022. Student eligibility.~~
- ~~Sec. 8023. Institutional refunds.~~
- ~~Sec. 8024. College access.~~
- ~~Sec. 8025. Program participation.~~
- ~~Sec. 8026. Work-based learning.~~
- ~~Sec. 8027. Administrative capacity standard.~~



1 **Subtitle A—Higher Education**
2 **Provisions**

3 **SEC. 8001. SHORT TITLE; REFERENCE; EFFECTIVE DATE.**

4 (a) **SHORT TITLE.**—This subtitle may be cited as the
5 “Higher Education Reconciliation Act of 2005”.

6 (b) **REFERENCES.**—Except as otherwise expressly
7 provided, whenever in this subtitle an amendment or re-
8 peal is expressed in terms of an amendment to, or repeal
9 of, a section or other provision, the reference shall be con-
10 sidered to be made to a section or other provision of the
11 Higher Education Act of 1965 (20 U.S.C. 1001 et seq.).

12 (c) **EFFECTIVE DATE.**—Except as otherwise provided
13 in this subtitle or the amendments made by this subtitle,
14 the amendments made by this subtitle shall be effective
15 July 1, 2006.

16 **SEC. 8002. MODIFICATION OF 50/50 RULE.**

17 Section 102(a)(3) (20 U.S.C. 1002(a)(3)) is
18 amended—

19 (1) in subparagraph (A), by inserting “(exclud-
20 ing courses offered by telecommunications as defined
21 in section 484(l)(4))” after “courses by correspond-
22 ence”; and

23 (2) in subparagraph (B), by inserting “(exclud-
24 ing courses offered by telecommunications as defined



1 in section 484(l)(4))” after “correspondence
2 courses”.

3 **SEC. 8003. ACADEMIC COMPETITIVENESS GRANTS.**

4 Subpart 1 of part A of title IV (20 U.S.C. 1070a)
5 is amended by adding after section 401 the following new
6 section:

7 **“SEC. 401A. ACADEMIC COMPETITIVENESS GRANTS.**

8 ~~“(a) PURPOSE. The purpose of this section is to in-~~
9 ~~crease the number of postsecondary students from low in-~~
10 ~~come backgrounds who are enrolled in studies leading to~~
11 ~~baccalaureate degrees in physical, life, and computer~~
12 ~~sciences, mathematics, technology, engineering, and for-~~
13 ~~eign languages critical to national security.~~

14 **“(b) ACADEMIC COMPETITIVENESS GRANT PRO-**
15 **GRAM.—**

16 **“(1) ACADEMIC COMPETITIVENESS GRANTS AU-**
17 **THORIZED.—**The Secretary shall award grants, in
18 the amounts specified in subsection (e)(1), to eligible
19 students to assist the eligible students in paying
20 their college education expenses.

21 **“(2) ACADEMIC COMPETITIVENESS COUNCIL.—**

22 **“(A) ESTABLISHMENT.—**There is estab-
23 lished an Academic Competitiveness Council
24 (referred to in this paragraph as the ‘Council’).
25 From the funds made available under sub-



1 section (f) for fiscal year 2006, \$50,000 shall
2 be available to the Council to carry out the du-
3 ties described in subparagraph (B). The Council
4 shall be chaired by the Secretary of Education,
5 and the membership of the Council shall consist
6 of officials from Federal agencies with respon-
7 sibilities for managing existing Federal pro-
8 grams that promote mathematics and science
9 (or designees of such officials with significant
10 decision-making authority).

11 “(B) DUTIES.—The Council shall—

12 “(i) identify all Federal programs
13 with a mathematics or science focus;

14 “(ii) identify the target populations
15 being served by such programs;

16 “(iii) determine the effectiveness of
17 such programs;

18 “(iv) identify areas of overlap or du-
19 plication in such programs; and

20 “(v) recommend ways to efficiently in-
21 tegrate and coordinate such programs.

22 “(C) REPORT.—Not later than one year
23 after the date of enactment of the Higher Edu-
24 cation Reconciliation Act of 2005, the Council
25 shall transmit a report to each committee of



1 Congress with jurisdiction over a Federal pro-
2 gram identified under subparagraph (B)(i), de-
3 tailing the findings and recommendations under
4 subparagraph (B), including recommendations
5 for legislative or administrative action.

6 “(c) DESIGNATION.—A grant under this section—

7 “(1) for the first or second academic year of a
8 program of undergraduate education shall be known
9 as an ‘Academic Competitiveness Grant’; and

10 “(2) for the third or fourth academic year of a
11 program of undergraduate education shall be known
12 as a ‘National Science and Mathematics Access to
13 Retain Talent Grant’ or a ‘National SMART Grant’.

14 “(d) DEFINITION OF ELIGIBLE STUDENT.—In this
15 section the term ‘eligible student’ means a full-time stu-
16 dent who, for the academic year for which the determina-
17 tion of eligibility is made—

18 “(1) is a citizen of the United States;

19 “(2) is eligible for a Federal Pell Grant; and

20 “(3) in the case of a student enrolled or accept-
21 ed for enrollment in—

22 “(A) the first academic year of a program
23 of undergraduate education at a two- or four-
24 year degree-granting institution of higher
25 education—



1 “(i) has successfully completed, after
2 January 1, 2006, a rigorous secondary
3 school program of study established by a
4 State or local educational agency and rec-
5 ognized as such by the Secretary; and

6 “(ii) has not been previously enrolled
7 in a program of undergraduate education;

8 “(B) the second academic year of a pro-
9 gram of undergraduate education at a two- or
10 four-year degree-granting institution of higher
11 education—

12 “(i) has successfully completed, after
13 January 1, 2005, a rigorous secondary
14 school program of study established by a
15 State or local educational agency and rec-
16 ognized as such by the Secretary; and

17 “(ii) has obtained a cumulative
18 grade point average of at least 3.0 (or the
19 equivalent as determined under regulations
20 prescribed by the Secretary) at the end of
21 the first academic year of such program of
22 undergraduate education; or

23 “(C) the third or fourth academic year of
24 a program of undergraduate education at a



1 four-year degree-granting institution of higher
2 education—

3 “(i) is pursuing a major in—

4 “(I) the physical, life, or com-
5 puter sciences, mathematics, tech-
6 nology, or engineering (as determined
7 by the Secretary pursuant to regula-
8 tions); or

9 “(II) a foreign language that the
10 Secretary, in consultation with the Di-
11 rector of National Intelligence, deter-
12 mines is critical to the national secu-
13 rity of the United States; and

14 “(ii) has obtained a cumulative
15 grade point average of at least 3.0 (or the
16 equivalent as determined under regulations
17 prescribed by the Secretary) in the
18 coursework required for the major de-
19 scribed in clause (i).

20 “(e) GRANT AWARD.—

21 “(1) AMOUNTS.—

22 “(A) The Secretary shall award a grant
23 under this section in the amount of—

24 “(i) \$750 for an eligible student
25 under subsection (d)(3)(A);



1 “(ii) \$1,300 for an eligible student
2 under subsection (d)(3)(B); or

3 “(iii) \$4,000 for an eligible student
4 under subsection (d)(3)(C).

5 “(B) Notwithstanding subparagraph (A)—

6 “(i) the amount of such grant, in
7 combination with the Federal Pell Grant
8 assistance and other student financial as-
9 sistance available to such student, shall not
10 exceed the student’s cost of attendance;

11 “(ii) if the amount made available
12 under subsection (f) for any fiscal year is
13 less than the amount required to be pro-
14 vide grants to all eligible students in the
15 amounts determined under subparagraph
16 (A) and clause (i) of this subparagraph,
17 then the amount of the grant to each eligi-
18 ble student shall be ratably reduced; and

19 “(iii) if additional amounts are appro-
20 priated for any such fiscal year, such re-
21 duced amounts shall be increased on the
22 same basis as they were reduced.

23 “(2) LIMITATIONS.—The Secretary shall not
24 award a grant under this section—



1 “(A) to any student for an academic year
2 of a program of undergraduate education de-
3 scribed in subparagraph (A), (B), or (C) of sub-
4 section (d)(3) for which the student received
5 credit before the date of enactment of the High-
6 er Education Reconciliation Act of 2005; or

7 “(B) to any student for more than—

8 “(i) one academic year under sub-
9 section (d)(3)(A);

10 “(ii) one academic year under sub-
11 section (d)(3)(B); or

12 “(iii) two academic years under sub-
13 section (d)(3)(C).

14 “(f) FUNDING.—

15 “(1) AUTHORIZATION AND APPROPRIATION OF
16 FUNDS.—There are authorized to be appropriated,
17 and there are appropriated, out of any money in the
18 Treasury not otherwise appropriated, for the De-
19 partment of Education to carry out this section—

20 “(A) \$790,000,000 for fiscal year 2006;

21 “(B) \$850,000,000 for fiscal year 2007;

22 “(C) \$920,000,000 for fiscal year 2008;

23 “(D) \$960,000,000 for fiscal year 2009;

24 and

25 “(E) \$1,010,000,000 for fiscal year 2010.



1 “(2) USE OF EXCESS FUNDS.—If, at the end of
2 a fiscal year, the funds available for awarding grants
3 under this section exceed the amount necessary to
4 make such grants in the amounts authorized by sub-
5 section (e), then all of the excess funds shall remain
6 available for awarding grants under this section dur-
7 ing the subsequent fiscal year.

8 “(g) RECOGNITION OF PROGRAMS OF STUDY.—The
9 Secretary shall recognize at least one rigorous secondary
10 school program of study in each State under subsection
11 (d)(3)(A) and (B) for the purpose of determining student
12 eligibility under such subsection.

13 “(h) SUNSET PROVISION.—The authority to make
14 grants under this section shall expire at the end of aca-
15 demic year 2010–2011.”.

16 **SEC. 8004. REAUTHORIZATION OF FEDERAL FAMILY EDU-**
17 **CATION LOAN PROGRAM.**

18 (a) AUTHORIZATION OF APPROPRIATIONS.—Section
19 421(b)(5) (20 U.S.C. 1071(b)(5)) is amended by striking
20 “an administrative cost allowance” and inserting “a loan
21 processing and issuance fee”.

22 (b) EXTENSION OF AUTHORITY.—

23 (1) FEDERAL INSURANCE LIMITATIONS.—Sec-
24 tion 424(a) (20 U.S.C. 1074(a)) is amended—



1 (A) by striking "2004" and inserting
2 "2012"; and

3 (B) by striking "2008" and inserting
4 "2016".

5 (2) GUARANTEED LOANS.—Section 428(a)(5)
6 (20 U.S.C. 1078(a)(5)) is amended—

7 (A) by striking "2004" and inserting
8 "2012"; and

9 (B) by striking "2008" and inserting
10 "2016".

11 (3) CONSOLIDATION LOANS.—Section 428C(e)
12 (20 U.S.C. 1078-3(e)) is amended by striking
13 "2004" and inserting "2012".

14 **SEC. 8005. LOAN LIMITS.**

15 (a) FEDERAL INSURANCE LIMITS.—Section
16 425(a)(1)(A) (20 U.S.C. 1075(a)(1)(A)) is amended—

17 (1) in clause (i)(I), by striking "\$2,625" and
18 inserting "\$3,500"; and

19 (2) in clause (ii)(I), by striking "\$3,500" and
20 inserting "\$4,500".

21 (b) GUARANTEE LIMITS.—Section 428(b)(1)(A) (20
22 U.S.C. 1078(b)(1)(A)) is amended—

23 (1) in clause (i)(I), by striking "\$2,625" and
24 inserting "\$3,500"; and

1 (2) in clause (ii)(I), by striking “\$3,500” and
2 inserting “\$4,500”.

3 (c) FEDERAL PLUS LOANS.—Section 428B (20
4 U.S.C. 1078–2) is amended—

5 (1) in subsection (a)(1)—

6 (A) in the matter preceding subparagraph
7 (A), by striking “Parents” and inserting “A
8 graduate or professional student or the par-
9 ents”;

10 (B) in subparagraph (A), by striking “the
11 parents” and inserting “the graduate or profes-
12 sional student or the parents”; and

13 (C) in subparagraph (B), by striking “the
14 parents” and inserting “the graduate or profes-
15 sional student or the parents”;

16 (2) in subsection (b), by striking “any parent”
17 and inserting “any graduate or professional student
18 or any parent”;

19 (3) in subsection (c)(2), by striking “parent”
20 and inserting “graduate or professional student or
21 parent”; and

22 (4) in subsection (d)(1), by striking “the par-
23 ent” and inserting “the graduate or professional stu-
24 dent or the parent”.

1 (d) UNSUBSIDIZED STAFFORD LOANS FOR GRAD-
2 UATE OR PROFESSIONAL STUDENTS.—Section
3 428H(d)(2) (20 U.S.C. 1078–8(d)(2)) is amended—

4 (1) in subparagraph (C), by striking “\$10,000”
5 and inserting “\$12,000”; and

6 (2) in subparagraph (D)—

7 (A) in clause (i), by striking “\$5,000” and
8 inserting “\$7,000”; and

9 (B) in clause (ii), by striking “\$5,000”
10 and inserting “\$7,000”.

11 (e) EFFECTIVE DATE OF INCREASES.—The amend-
12 ments made by subsections subsections (a), (b), and (d)
13 shall be effective July 1, 2007.

14 **SEC. 8006. PLUS LOAN INTEREST RATES AND ZERO SPE-**
15 **CIAL ALLOWANCE PAYMENT.**

16 (a) PLUS LOANS.—Section 427A(l)(2) (20 U.S.C.
17 1077a(l)(2)) is amended by striking “7.9 percent” and in-
18 serting “8.5 percent”.

19 (b) CONFORMING AMENDMENTS FOR SPECIAL AL-
20 LOWANCES.—

21 (1) AMENDMENTS.—Subparagraph (I) of sec-
22 tion 438(b)(2) (20 U.S.C. 1087–1(b)(2)) is
23 amended—

24 (A) in clause (iii), by striking “, subject to
25 clause (v) of this subparagraph”;

1 (B) in clause (iv), by striking “, subject to
2 clause (vi) of this subparagraph”; and

3 (C) by striking clauses (v), (vi), and (vii)
4 and inserting the following:

5 “(v) RECAPTURE OF EXCESS INTER-
6 EST.—

7 “(I) EXCESS CREDITED.—With
8 respect to a loan on which the applica-
9 ble interest rate is determined under
10 subsection (k) or (l) of section 427A
11 and for which the first disbursement
12 of principal is made on or after April
13 1, 2006, if the applicable interest rate
14 for any 3-month period exceeds the
15 special allowance support level appli-
16 cable to such loan under this subpara-
17 graph for such period, then an adjust-
18 ment shall be made by calculating the
19 excess interest in the amount com-
20 puted under subclause (II) of this
21 clause, and by crediting the excess in-
22 terest to the Government not less
23 often than annually.

24 “(II) CALCULATION OF EX-
25 CESS.—The amount of any adjust-



1 ment of interest on a loan to be made
2 under this subsection for any quarter
3 shall be equal to—

4 “(aa) the applicable interest
5 rate minus the special allowance
6 support level determined under
7 this subparagraph; multiplied by

8 “(bb) the average daily prin-
9 cipal balance of the loan (not in-
10 cluding unearned interest added
11 to principal) during such cal-
12 endar quarter; divided by

13 “(cc) four.

14 “(III) SPECIAL ALLOWANCE SUP-
15 PORT LEVEL.—For purposes of this
16 clause, the term ‘special allowance
17 support level’ means, for any loan, a
18 number expressed as a percentage
19 equal to the sum of the rates deter-
20 mined under subclauses (I) and (III)
21 of clause (i), and applying any substi-
22 tution rules applicable to such loan
23 under clauses (ii), (iii), and (iv) in de-
24 termining such sum.”.



1 (2) EFFECTIVE DATE.—The amendments made
2 by this subsection shall not apply with respect to
3 any special allowance payment made under section
4 438 of the Higher Education Act of 1965 (20 U.S.C.
5 1087–1) before April 1, 2006.

6 **SEC. 8007. DEFERMENT OF STUDENT LOANS FOR MILITARY**
7 **SERVICE.**

8 (a) FEDERAL FAMILY EDUCATION LOANS.—Section
9 428(b)(1)(M) (20 U.S.C. 1078(b)(1)(M)) is amended—

10 (1) by striking “or” at the end of clause (ii);

11 (2) by redesignating clause (iii) as clause (iv);

12 and

13 (3) by inserting after clause (ii) the following
14 new clause:

15 “(iii) not in excess of 3 years during
16 which the borrower—

17 “(I) is serving on active duty
18 during a war or other military oper-
19 ation or national emergency; or

20 “(II) is performing qualifying
21 National Guard duty during a war or
22 other military operation or national
23 emergency; or”.

24 (b) DIRECT LOANS.—Section 455(f)(2) (20 U.S.C.
25 1087e(f)(2)) is amended—

1 (1) by redesignating subparagraph (C) as sub-
2 paragraph (D); and

3 (2) by inserting after subparagraph (B) the fol-
4 lowing new subparagraph:

5 “(C) not in excess of 3 years during which
6 the borrower—

7 “(i) is serving on active duty during a
8 war or other military operation or national
9 emergency; or

10 “(ii) is performing qualifying National
11 Guard duty during a war or other military
12 operation or national emergency; or”.

13 (c) PERKINS LOANS.—Section 464(c)(2)(A) (20
14 U.S.C. 1087dd(c)(2)(A)) is amended—

15 (1) by redesignating clauses (iii) and (iv) as
16 clauses (iv) and (v), respectively; and

17 (2) by inserting after clause (ii) the following
18 new clause:

19 “(iii) not in excess of 3 years during
20 which the borrower—

21 “(I) is serving on active duty
22 during a war or other military oper-
23 ation or national emergency; or

24 “(II) is performing qualifying
25 National Guard duty during a war or



1 other military operation or national
2 emergency;”.

3 (d) DEFINITIONS.—Section 481 (20 U.S.C. 1088) is
4 amended by adding at the end the following new sub-
5 section:

6 “(d) DEFINITIONS FOR MILITARY DEFERMENTS.—
7 For purposes of parts B, D, and E of this title:

8 “(1) ACTIVE DUTY.—The term ‘active duty’ has
9 the meaning given such term in section 101(d)(1) of
10 title 10, United States Code, except that such term
11 does not include active duty for training or attend-
12 ance at a service school.

13 “(2) MILITARY OPERATION.—The term ‘mili-
14 tary operation’ means a contingency operation as
15 such term is defined in section 101(a)(13) of title
16 10, United States Code.

17 “(3) NATIONAL EMERGENCY.—The term ‘na-
18 tional emergency’ means the national emergency by
19 reason of certain terrorist attacks declared by the
20 President on September 14, 2001, or subsequent na-
21 tional emergencies declared by the President by rea-
22 son of terrorist attacks.

23 “(4) SERVING ON ACTIVE DUTY.—The term
24 ‘serving on active duty during a war or other mili-



1 tary operation or national emergency' means service
2 by an individual who is—

3 "(A) a Reserve of an Armed Force ordered
4 to active duty under section 12301(a),
5 12301(g), 12302, 12304, or 12306 of title 10,
6 United States Code, or any retired member of
7 an Armed Force ordered to active duty under
8 section 688 of such title, for service in connec-
9 tion with a war or other military operation or
10 national emergency, regardless of the location
11 at which such active duty service is performed;
12 and

13 "(B) any other member of an Armed Force
14 on active duty in connection with such emer-
15 gency or subsequent actions or conditions who
16 has been assigned to a duty station at a loca-
17 tion other than the location at which such mem-
18 ber is normally assigned.

19 "(5) QUALIFYING NATIONAL GUARD DUTY.—
20 The term 'qualifying National Guard duty during a
21 war or other military operation or national emer-
22 gency' means service as a member of the National
23 Guard on full-time National Guard duty (as defined
24 in section 101(d)(5) of title 10, United States Code)
25 under a call to active service authorized by the



1 President or the Secretary of Defense for a period
2 of more than 30 consecutive days under section
3 502(f) of title 32, United States Code, in connection
4 with a war, other military operation, or a national
5 emergency declared by the President and supported
6 by Federal funds.”.

7 (e) **RULE OF CONSTRUCTION.**—Nothing in the
8 amendments made by this section shall be construed to
9 authorize any refunding of any repayment of a loan.

10 (f) **EFFECTIVE DATE.**—The amendments made by
11 this section shall apply with respect to loans for which the
12 first disbursement is made on or after July 1, 2001.

13 **SEC. 8008. ADDITIONAL LOAN TERMS AND CONDITIONS.**

14 (a) **DISBURSEMENT.**—Section 428(b)(1)(N) (20
15 U.S.C. 1078(b)(1)(N)) is amended—

16 (1) by striking “or” at the end of clause (i);
17 and

18 (2) by striking clause (ii) and inserting the fol-
19 lowing:

20 “(ii) in the case of a student who is
21 studying outside the United States in a
22 program of study abroad that is approved
23 for credit by the home institution at which
24 such student is enrolled, and only after
25 verification of the student’s enrollment by



1 the lender or guaranty agency, are, at the
2 request of the student, disbursed directly
3 to the student by the means described in
4 clause (i), unless such student requests
5 that the check be endorsed, or the funds
6 transfer be authorized, pursuant to an au-
7 thorized power-of-attorney; or

8 “(iii) in the case of a student who is
9 studying outside the United States in a
10 program of study at an eligible foreign in-
11 stitution, are, at the request of the foreign
12 institution, disbursed directly to the stu-
13 dent, only after verification of the stu-
14 dent’s enrollment by the lender or guar-
15 anty agency by the means described in
16 clause (i).”.

17 (b) REPAYMENT PLANS: DIRECT LOANS.—Section
18 455(d)(1) (20 U.S.C. 1087e(d)(1)) is amended by striking
19 subparagraphs (A), (B), and (C) and inserting the fol-
20 lowing:

21 “(A) a standard repayment plan, con-
22 sistent with subsection (a)(1) of this section
23 and with section 428(b)(9)(A)(i);

24 “(B) a graduated repayment plan, con-
25 sistent with section 428(b)(9)(A)(ii);

1 “(C) an extended repayment plan, con-
2 sistent with section 428(b)(9)(A)(v), except that
3 the borrower shall annually repay a minimum
4 amount determined by the Secretary in accord-
5 ance with section 428(b)(1)(L); and”.

6 (c) ORIGINATION FEES.—

7 (1) FFEL PROGRAM.—Paragraph (2) of section
8 438(c) (20 U.S.C. 1087–1(c)) is amended—

9 (A) by striking the designation and head-
10 ing of such paragraph and inserting the fol-
11 lowing:

12 “(2) AMOUNT OF ORIGINATION FEES.—

13 “(A) IN GENERAL.—”; and

14 (B) by adding at the end the following new
15 subparagraph:

16 “(B) SUBSEQUENT REDUCTIONS.—Sub-
17 paragraph (A) shall be applied to loans made
18 under this part (other than loans made under
19 sections 428C and 439(o))—

20 “(i) by substituting ‘2.0 percent’ for
21 ‘3.0 percent’ with respect to loans for
22 which the first disbursement of principal is
23 made on or after July 1, 2006, and before
24 July 1, 2007;



1 “(ii) by substituting ‘1.5 percent’ for
2 ‘3.0 percent’ with respect to loans for
3 which the first disbursement of principal is
4 made on or after July 1, 2007, and before
5 July 1, 2008;

6 “(iii) by substituting ‘1.0 percent’ for
7 ‘3.0 percent’ with respect to loans for
8 which the first disbursement of principal is
9 made on or after July 1, 2008, and before
10 July 1, 2009;

11 “(iv) by substituting ‘0.5 percent’ for
12 ‘3.0 percent’ with respect to loans for
13 which the first disbursement of principal is
14 made on or after July 1, 2009, and before
15 July 1, 2010; and

16 “(v) by substituting ‘0.0 percent’ for
17 ‘3.0 percent’ with respect to loans for
18 which the first disbursement of principal is
19 made on or after July 1, 2010.”.

20 (2) DIRECT LOAN PROGRAM.—Subsection (c) of
21 section 455 (20 U.S.C. 1087e(c)) is amended—

22 (A) by striking “(c) LOAN FEE.—” and in-
23 serting the following:

24 “(c) LOAN FEE.—

25 “(1) IN GENERAL.—”; and



1 (B) by adding at the end the following:

2 “(2) SUBSEQUENT REDUCTION.—Paragraph
3 (1) shall be applied to loans made under this part,
4 other than Federal Direct Consolidation loans and
5 Federal Direct PLUS loans—

6 “(A) by substituting ‘3.0 percent’ for ‘4.0
7 percent’ with respect to loans for which the first
8 disbursement of principal is made on or after
9 the date of enactment of the Higher Education
10 Reconciliation Act of 2005, and before July 1,
11 2007;

12 “(B) by substituting ‘2.5 percent’ for ‘4.0
13 percent’ with respect to loans for which the first
14 disbursement of principal is made on or after
15 July 1, 2007, and before July 1, 2008;

16 “(C) by substituting ‘2.0 percent’ for ‘4.0
17 percent’ with respect to loans for which the first
18 disbursement of principal is made on or after
19 July 1, 2008, and before July 1, 2009;

20 “(D) by substituting ‘1.5 percent’ for ‘4.0
21 percent’ with respect to loans for which the first
22 disbursement of principal is made on or after
23 July 1, 2009, and before July 1, 2010; and

24 “(E) by substituting ‘1.0 percent’ for ‘4.0
25 percent’ with respect to loans for which the first



1 disbursement of principal is made on or after
2 July 1, 2010.”.

3 (3) CONFORMING AMENDMENT.—Section
4 455(b)(8)(A) (20 U.S.C. 1087e(b)(8)(A)) is amend-
5 ed by inserting “or origination fee” after “reduc-
6 tions in the interest rate”.

7 **SEC. 8009. CONSOLIDATION LOAN CHANGES.**

8 (a) CONSOLIDATION BETWEEN PROGRAMS.—Section
9 428C (20 U.S.C. 1078–3) is amended—

10 (1) in subsection (a)(3)(B)(i)—

11 (A) by inserting “or under section 455(g)”
12 after “under this section” both places it ap-
13 pears;

14 (B) by inserting “under both sections”
15 after “terminates”

16 (C) by striking “and” at the end of sub-
17 clause (III);

18 (D) by striking the period at the end of
19 subclause (IV) and inserting “; and”; and

20 (E) by adding at the end the following new
21 subclause:

22 “(V) an individual may obtain a subse-
23 quent consolidation loan under section 455(g)
24 only for the purposes of obtaining an income
25 contingent repayment plan, and only if the loan



1 has been submitted to the guaranty agency for
2 default aversion.”; and

3 (2) in subsection (b)(5), by striking the first
4 sentence and inserting the following: “In the event
5 that a lender with an agreement under subsection
6 (a)(1) of this section denies a consolidation loan ap-
7 plication submitted to the lender by an eligible bor-
8 rower under this section, or denies an application
9 submitted to the lender by such a borrower for a
10 consolidation loan with income-sensitive repayment
11 terms, the Secretary shall offer any such borrower
12 who applies for it, a Federal Direct Consolidation
13 loan. The Secretary shall offer such a loan to a bor-
14 rower who has defaulted, for the purpose of resolv-
15 ing the default.”.

16 (b) REPEAL OF IN-SCHOOL CONSOLIDATION.—

17 (1) DEFINITION OF REPAYMENT PERIOD.—Sec-
18 tion 428(b)(7)(A) (20 U.S.C. 1078(b)(7)(A)) is
19 amended by striking “shall begin—” and all that
20 follows through “earlier date.” and inserting the fol-
21 lowing: “shall begin the day after 6 months after the
22 date the student ceases to carry at least one-half the
23 normal full-time academic workload (as determined
24 by the institution).”.



1 (2) CONFORMING CHANGE TO ELIGIBLE BOR-
 2 ROWER DEFINITION.—Section 428C(a)(3)(A)(ii)(I)
 3 (20 U.S.C. 1078–3(a)(3)(A)(ii)(I)) is amended by
 4 inserting “as determined under section
 5 428(b)(7)(A)” after “repayment status”.

6 (c) ADDITIONAL AMENDMENTS.—Section 428C (20
 7 U.S.C. 1078–3) is amended—

8 ~~(1) in subsection (a)(3), by striking subpara-~~
 9 graph (C) ~~and~~

10 ~~(2) in subsection (b)(1) —~~

11 ~~(A) by striking everything after “under~~
 12 ~~this section” the first place it appears in sub-~~
 13 ~~paragraph (A) and inserting a semicolon;~~

14 ~~(B) by striking “(i) which” and all that~~
 15 ~~follows through “and (ii)” in subparagraph (C);~~

16 ~~(C) by striking “and” at the end of sub-~~
 17 ~~paragraph (E);~~

18 ~~(D) by redesignating subparagraph (F) as~~
 19 ~~subparagraph (C); and~~

20 ~~(E) by inserting after subparagraph (D)~~
 21 ~~the following new subparagraph:~~

22 ~~“(E) that the lender of the consolidation~~
 23 ~~loan shall, upon application for such loan, pro-~~
 24 ~~vide the borrower with a clear and conspicuous~~
 25 ~~notice of at least the following information:~~



1 “(i) ~~the effects of consolidation on~~
2 ~~total interest to be paid, fees to be paid,~~
3 ~~and length of repayment;~~

4 “(ii) ~~the effects of consolidation on a~~
5 ~~borrower's underlying loan benefits includ-~~
6 ~~ing loan forgiveness, cancellation,~~
7 ~~deferral, reduced interest rates on those~~
8 ~~underlying loans and benefits described in~~
9 ~~sections 464 and 465;~~

10 “(iii) ~~the ability of the borrower to~~
11 ~~prepay the loan, pay on a shorter schedule,~~
12 ~~and to change repayment plans;~~

13 “(iv) ~~that borrower benefit programs~~
14 ~~may vary among different loan holders,~~
15 ~~and a description of how the borrower ben-~~
16 ~~efits may vary among different loan hold-~~
17 ~~ers;~~

18 “(v) ~~the tax benefits for which bor-~~
19 ~~rowers may be eligible;~~

20 “(vi) ~~the consequences of default, and~~

21 “(vii) ~~that by making the application~~
22 ~~the applicant is not obligated to agree to~~
23 ~~take the consolidation loan, and”.~~

24 (d) CONFORMING AMENDMENTS TO DIRECT LOAN
25 PROGRAM.—Section 455 (20 U.S.C. 1087e) is amended



1 (1) in subsection (a)(1) by inserting "428C,"
2 after "428B,";

3 (2) in subsection (a)(2)—

4 (A) by striking "and" at the end of sub-
5 paragraph (B);

6 (B) by redesignating subparagraph (C) as
7 subparagraph (D); and

8 (C) by inserting after subparagraph (B)
9 the following:

10 "(C) section 428C shall be known as 'Fed-
11 eral Direct Consolidation Loans'; and "; and

12 (3) in subsection (g)—

13 (A) by striking the second sentence; and

14 (B) by adding at the end the following new
15 sentences: "To be eligible for a consolidation
16 loan under this part, a borrower shall meet the
17 eligibility criteria set forth in section
18 428C(a)(3). The Secretary, upon application for
19 such a loan, shall comply with the requirements
20 applicable to a lender under section
21 428C(b)(1)(F).".

22 ~~(e) CONFORMING AMENDMENT CONCERNING DIS-~~

23 ~~CLOSURE. Section 405(d) (28 U.S.C. 1092) is amended~~

24 ~~by adding at the end the following:~~

1 ~~“(1) Each eligible institution shall, during the~~
2 ~~exit interview required by this subsection, provide a~~
3 ~~borrower of a loan made under part B, D, or F with~~
4 ~~a clear and conspicuous notice of at least the fol-~~
5 ~~lowing information:~~

6 ~~“(A) the effects of consolidation on total~~
7 ~~interest to be paid, fees to be paid, and length~~
8 ~~of repayment;~~

9 ~~“(B) the effects of consolidation on a bor-~~
10 ~~rower’s underlying loan benefits, including loan~~
11 ~~forgiveness, cancellation, deferment, reduced in-~~
12 ~~terest rates on those underlying loans, and ben-~~
13 ~~efits described in sections 464 and 465.~~

14 ~~“(C) the ability of the borrower to prepay~~
15 ~~the loan, pay on a shorter schedule, and to~~
16 ~~change repayment plans;~~

17 ~~“(D) that borrower benefit programs may~~
18 ~~vary among different loan holders, and a de-~~
19 ~~scription of how the borrower benefits may vary~~
20 ~~among different loan holders;~~

21 ~~“(E) the tax benefits for which borrowers~~
22 ~~may be eligible, and~~

23 ~~“(F) the consequences of default.”~~



1 **SEC. 8010. REQUIREMENTS FOR DISBURSEMENTS OF STU-**
2 **DENT LOANS.**

3 Section 428G (20 U.S.C. 1078-7) is amended—

4 (1) in subsection (a)(3), by adding at the end
5 the following: “Notwithstanding section 422(d) of
6 the Higher Education Amendments of 1998, this
7 paragraph shall be effective beginning on the date of
8 enactment of the Higher Education Reconciliation
9 Act of 2005.”;

10 (2) in subsection (b)(1), by adding at the end
11 the following: “Notwithstanding section 422(d) of
12 the Higher Education Amendments of 1998, the sec-
13 ond sentence of this paragraph shall be effective be-
14 ginning on the date of enactment of the Higher
15 Education Reconciliation Act of 2005.”; and

16 (3) in subsection (e), by striking “, made to a
17 student to cover the cost of attendance at an eligible
18 institution outside the United States”.

19 ~~SEC. 8011. REPORTS TO CREDIT BUREAUS AND INSTI-~~
20 ~~TIONS OF HIGHER EDUCATION.~~

21 ~~Section 4304(a) (20 U.S.C. 1080a(a)) is amended—~~

22 ~~(1) in the first sentence, by striking “with cred-~~
23 ~~it bureau organizations” and inserting “with each~~
24 ~~consumer reporting agency that compiles and main-~~
25 ~~tains files on consumers on a nationwide basis (a)~~



1 ~~defined in section 809(p) of the Fair Credit Report~~
2 ~~ing Act (15 U.S.C. 1681a(p))~~;

3 ~~(2) by redesignating paragraphs (1), (2), and~~
4 ~~(3) as paragraphs (2), (3), and (4), respectively;~~

5 ~~(2) by inserting before paragraph (2) (as red-~~
6 ~~esignated by paragraph (2)), the following:~~

7 ~~“(1) the type of loan made, insured, or guaran-~~
8 ~~teed under this title,”~~

9 ~~(4) in paragraph (2) (as redesignated by para-~~
10 ~~graph (2)), by striking “and” after the semicolon,~~

11 ~~(5) in paragraph (4) (as redesignated by para-~~
12 ~~graph (2)), by striking the period and inserting “,~~
13 ~~and” and~~

14 ~~(6) by adding at the end the following:~~

15 ~~“(5) any other information required to be re-~~
16 ~~ported by Federal law”.~~

17 **SEC. 8012. SCHOOL AS LENDER.**

18 Paragraph (2) of section 435(d) (20 U.S.C.
19 1085(d)(2)) is amended to read as follows:

20 “(2) REQUIREMENTS FOR ELIGIBLE INSTITU-
21 TIONS.—

22 “(A) IN GENERAL.—To be an eligible lend-
23 er under this part, an eligible institution—

24 “(i) shall employ at least one person
25 whose full-time responsibilities are limited



1 to the administration of programs of finan-
2 cial aid for students attending such institu-
3 tion;
4 “(ii) shall not be a home study school;
5 “(iii) shall not—
6 “(I) make a loan to any under-
7 graduate student;
8 “(II) make a loan other than a
9 loan under section 428 or 428H to a
10 graduate or professional student; or
11 “(III) make a loan to a borrower
12 who is not enrolled at that institution;
13 “(iv) shall award any contract for fi-
14 nancing, servicing, or administration of
15 loans under this title on a competitive
16 basis;
17 “(v) shall offer loans that carry an
18 origination fee or an interest rate, or both,
19 that are less than such fee or rate author-
20 ized under the provisions of this title;
21 “(vi) shall not have a cohort default
22 rate (as defined in section 435(m)) greater
23 than 10 percent;
24 “(vii) shall, for any year for which the
25 institution engages in activities as an eligi-



1 ble lender, provide for a compliance audit
2 conducted in accordance with section
3 428(b)(1)(U)(iii)(I), and the regulations
4 thereunder, and submit the results of such
5 audit to the Secretary;

6 “(viii) shall use any proceeds from
7 special allowance payments and interest
8 payments from borrowers, interest sub-
9 sidies received from the Department of
10 Education, and any proceeds from the sale
11 or other disposition of loans, for need-
12 based grant programs; and

13 “(ix) shall have met the requirements
14 of subparagraphs (A) through (F) of this
15 paragraph as in effect on the day before
16 the date of enactment of the Higher Edu-
17 cation Reconciliation Act of 2005, and
18 made loans under this part, on or before
19 April 1, 2006.

20 “(B) ADMINISTRATIVE EXPENSES.—An el-
21 igible lender under subparagraph (A) shall be
22 permitted to use a portion of the proceeds de-
23 scribed in subparagraph (A)(viii) for reasonable
24 and direct administrative expenses.



1 “(C) SUPPLEMENT, NOT SUPPLANT.—An
2 eligible lender under subparagraph (A) shall en-
3 sure that the proceeds described in subpara-
4 graph (A)(viii) are used to supplement, and not
5 to supplant, non-Federal funds that would oth-
6 erwise be used for need-based grant pro-
7 grams.”.

8 **SEC. 8013. REPAYMENT BY THE SECRETARY OF LOANS OF**
9 **BANKRUPT, DECEASED, OR DISABLED BOR-**
10 **ROWERS; TREATMENT OF BORROWERS AT-**
11 **TENDING SCHOOLS THAT FAIL TO PROVIDE A**
12 **REFUND, ATTENDING CLOSED SCHOOLS, OR**
13 **FALSELY CERTIFIED AS ELIGIBLE TO BOR-**
14 **ROW.**

15 Section 437 (20 U.S.C. 1087) is amended—

16 (1) in the section heading, by striking
17 “CLOSED SCHOOLS OR FALSELY CERTIFIED AS
18 ELIGIBLE TO BORROW” and inserting “SCHOOLS
19 THAT FAIL TO PROVIDE A REFUND, ATTEND-
20 ING CLOSED SCHOOLS, OR FALSELY CERTIFIED
21 AS ELIGIBLE TO BORROW”; and

22 (2) in the first sentence of subsection (c)(1), by
23 inserting “or was falsely certified as a result of a
24 crime of identity theft” after “falsely certified by the
25 eligible institution”.



1 SEC. 8014. ELIMINATION OF TERMINATION DATES FROM
2 TAXPAYER-TEACHER PROTECTION ACT OF
3 2004.

4 (a) EXTENSION OF LIMITATIONS ON SPECIAL AL-
5 LOWANCE FOR LOANS FROM THE PROCEEDS OF TAX EX-
6 EMPT ISSUES.—Section 438(b)(2)(B) (20 U.S.C. 1087–
7 1(b)(2)(B)) is amended—

8 (1) in clause (iv), by striking “and before Janu-
9 ary 1, 2006,”; and

10 (2) in clause (v)(II)—

11 (A) by striking “and before January 1,
12 2006,” each place it appears in divisions (aa)
13 and (bb); and

14 (B) by striking “, and before January 1,
15 2006” in division (cc).

16 (b) ADDITIONAL LIMITATION ON SPECIAL ALLOW-
17 ANCE FOR LOANS FROM THE PROCEEDS OF TAX EXEMPT
18 ISSUES.—Section 438(b)(2)(B) (20 U.S.C. 1087–
19 1(b)(2)(B)) is further amended by adding at the end
20 thereof the following new clauses:

21 “(vi) Notwithstanding clauses (i), (ii), and (v),
22 but subject to clause (vii), the quarterly rate of the
23 special allowance shall be the rate determined under
24 subparagraph (A), (E), (F), (G), (H), or (I) of this
25 paragraph, as the case may be, for a holder of
26 loans—

1 “(I) that were made or purchased on or
2 after the date of enactment of the Higher Edu-
3 cation Reconciliation Act of 2005; or

4 “(II) that were not earning a quarterly
5 rate of special allowance determined under
6 clauses (i) or (ii) of subparagraph (B) of this
7 paragraph (20 U.S.C. 1087-1(b)(2)(b)) as of
8 the date of enactment of the Higher Education
9 Reconciliation Act of 2005.

10 “(vii) Clause (vi) shall be applied by sub-
11 stituting ‘December 31, 2010’ for ‘the date of enact-
12 ment of the Higher Education Reconciliation Act of
13 2005’ in the case of a holder of loans that—

14 “(I) was, as of the date of enactment of
15 the Higher Education Reconciliation Act of
16 2005, and during the quarter for which the spe-
17 cial allowance is paid, a unit of State or local
18 government or a nonprofit private entity;

19 “(II) was, as of such date of enactment,
20 and during such quarter, not owned or con-
21 trolled by, or under common ownership or con-
22 trol with, a for-profit entity; and

23 “(III) held, directly or through any sub-
24 sidiary, affiliate, or trustee, a total unpaid bal-
25 ance of principal equal to or less than



1 \$100,000,000 on loans for which special allow-
2 ances were paid under this subparagraph in the
3 most recent quarterly payment prior to Sep-
4 tember 30, 2005.”.

5 (c) ELIMINATION OF EFFECTIVE DATE LIMITATION
6 ON HIGHER TEACHER LOAN FORGIVENESS BENEFITS.—

7 (1) TECHNICAL CLARIFICATION.—The matter
8 preceding paragraph (1) of section 2 of the Tax-
9 payer-Teacher Protection Act of 2004 (Public Law
10 108–409; 118 Stat. 2299) is amended by inserting
11 “of the Higher Education Act of 1965” after “Sec-
12 tion 438(b)(2)(B)”.

13 (2) AMENDMENT.—Paragraph (3) of section
14 3(b) of the Taxpayer-Teacher Protection Act of
15 2004 (20 U.S.C. 1078–10 note) is amended by
16 striking “, and before October 1, 2005”.

17 (3) EFFECTIVE DATES.—The amendment made
18 by paragraph (1) shall be effective as if enacted on
19 October 30, 2004, and the amendment made by
20 paragraph (2) shall be effective as if enacted on Oc-
21 tober 1, 2005.

22 (d) COORDINATION WITH SECOND HIGHER EDU-
23 CATION EXTENSION ACT OF 2005.—



1 (1) REPEAL.—Section 2 of the Second Higher
2 Education Extension Act of 2005 is amended by
3 striking subsections (b) and (c).

4 (2) EFFECT ON AMENDMENTS.—The amend-
5 ments made by subsections (a) and (c) of this sec-
6 tion shall be effective as if the amendments made
7 subsections (b) and (c) of section 2 of the Second
8 Higher Education Extension Act of 2005 had not
9 been enacted.

10 (e) ADDITIONAL CHANGES TO TEACHER LOAN FOR-
11 GIVENESS PROVISIONS.—

12 (1) FFEL PROVISIONS.—Section 428J (20
13 U.S.C. 1078–10) is amended—

14 (A) in subsection (b)(1)(B), by inserting
15 after “1965” the following: “, or meets the re-
16 quirements of subsection (g)(3)”; and

17 (B) in subsection (g), by adding at the end
18 the following new paragraph:

19 “(3) PRIVATE SCHOOL TEACHERS.—An indi-
20 vidual who is employed as a teacher in a private
21 school and is exempt from State certification re-
22 quirements (unless otherwise applicable under State
23 law), may, in lieu of the requirement of subsection
24 (b)(1)(B), have such employment treated as quali-
25 fying employment under this section if such indi-



1 vidual is permitted to and does satisfy rigorous sub-
2 ject knowledge and skills tests by taking competency
3 tests in the applicable grade levels and subject areas.
4 For such purposes, the competency tests taken by
5 such a private school teacher shall be recognized by
6 5 or more States for the purpose of fulfilling the
7 highly qualified teacher requirements under section
8 9101 of the Elementary and Secondary Education
9 Act of 1965, and the score achieved by such teacher
10 on each test shall equal or exceed the average pass-
11 ing score of those 5 States.”.

12 (2) DIRECT LOAN PROVISIONS.—Section 460
13 (20 U.S.C. 1087j) is amended—

14 (A) in subsection (b)(1)(A)(ii), by inserting
15 after “1965” the following: “, or meets the re-
16 quirements of subsection (g)(3)”;

17 (B) in subsection (g), by adding at the end
18 the following new paragraph:

19 “(3) PRIVATE SCHOOL TEACHERS.—An indi-
20 vidual who is employed as a teacher in a private
21 school and is exempt from State certification re-
22 quirements (unless otherwise applicable under State
23 law), may, in lieu of the requirement of subsection
24 (b)(1)(A)(ii), have such employment treated as
25 qualifying employment under this section if such in-



1 dividual is permitted to and does satisfy rigorous
2 subject knowledge and skills tests by taking com-
3 petency tests in the applicable grade levels and sub-
4 ject areas. For such purposes, the competency tests
5 taken by such a private school teacher shall be rec-
6 ognized by 5 or more States for the purpose of ful-
7 filling the highly qualified teacher requirements
8 under section 9101 of the Elementary and Sec-
9 ondary Education Act of 1965, and the score
10 achieved by such teacher on each test shall equal or
11 exceed the average passing score of those 5 States.”.

12 **SEC. 8015. ADDITIONAL ADMINISTRATIVE PROVISIONS.**

13 (a) **INSURANCE PERCENTAGE.**—

14 (1) **AMENDMENT.**—Subparagraph (G) of sec-
15 tion 428(b)(1) (20 U.S.C. 1078(b)(1)(G)) is amend-
16 ed to read as follows:

17 “(G) insures 98 percent of the unpaid
18 principal of loans insured under the program,
19 except that—

20 “(i) such program shall insure 100
21 percent of the unpaid principal of loans
22 made with funds advanced pursuant to sec-
23 tion 428(j) or 439(q);

24 “(ii) for any loan for which the first
25 disbursement of principal is made on or



1 after July 1, 2006, the preceding provi-
2 sions of this subparagraph shall be applied
3 by substituting '97 percent' for '98 per-
4 cent'; and

5 “(iii) notwithstanding the preceding
6 provisions of this subparagraph, such pro-
7 gram shall insure 100 percent of the un-
8 paid principal amount of exempt claims as
9 defined in subsection (c)(1)(G);”.

10 (2) EFFECTIVE DATE OF AMENDMENT.—The
11 amendment made by this subsection shall apply with
12 respect to loans for which the first disbursement of
13 principal is made on or after July 1, 2006.

14 (b) FEDERAL DEFAULT FEES.—

15 (1) IN GENERAL.—Subparagraph (H) of section
16 428(b)(1) (20 U.S.C. 1078(b)(1)(H)) is amended to
17 read as follows:

18 “(H) provides—

19 “(i) for loans for which the date of
20 guarantee of principal is before July, 1,
21 2006, for the collection of a single insur-
22 ance premium equal to not more than 1.0
23 percent of the principal amount of the
24 loan, by deduction proportionately from
25 each installment payment of the proceeds



1 of the loan to the borrower, and ensures
2 that the proceeds of the premium will not
3 be used for incentive payments to lenders;
4 or

5 “(ii) for loans for which the date of
6 guarantee of principal is on or after July
7 1, 2006, for the collection, and the deposit
8 into the Federal Student Loan Reserve
9 Fund under section 422A of a Federal de-
10 fault fee of an amount equal to 1.0 percent
11 of the principal amount of the loan, which
12 fee shall be collected either by deduction
13 from the proceeds of the loan or by pay-
14 ment from other non-Federal sources, and
15 ensures that the proceeds of the Federal
16 default fee will not be used for incentive
17 payments to lenders;”.

18 (2) UNSUBSIDIZED LOANS.—Section 428H(h)
19 (20 U.S.C. 1078–8(h)) is amended by adding at the
20 end the following new sentences: “Effective for loans
21 for which the date of guarantee of principal is on or
22 after July 1, 2006, in lieu of the insurance premium
23 authorized under the preceding sentence, each State
24 or nonprofit private institution or organization hav-
25 ing an agreement with the Secretary under section



1 428(b)(1) shall collect and deposit into the Federal
2 Student Loan Reserve Fund under section 422A, a
3 Federal default fee of an amount equal to 1.0 per-
4 cent of the principal amount of the loan, which fee
5 shall be collected either by deduction from the pro-
6 ceeds of the loan or by payment from other non-Fed-
7 eral sources. The Federal default fee shall not be
8 used for incentive payments to lenders.”.

9 (3) VOLUNTARY FLEXIBLE AGREEMENTS.—Sec-
10 tion 428A(a)(1) (20 U.S.C. 1078–1(a)(1)) is
11 amended—

12 (A) by striking “or” at the end of subpara-
13 graph (A);

14 (B) by striking the period at the end of
15 subparagraph (B) and inserting “; or”; and

16 (C) by adding at the end the following new
17 subparagraph:

18 “(C) the Federal default fee required by
19 section 428(b)(1)(H) and the second sentence
20 of section 428H(h).”.

21 (c) TREATMENT OF EXEMPT CLAIMS.—

22 (1) AMENDMENT.—Section 428(c)(1) (20
23 U.S.C. 1078(c)(1)) is amended—



1 (A) by redesignating subparagraph (G) as
2 subparagraph (H), and moving such subpara-
3 graph 2 em spaces to the left; and

4 (B) by inserting after subparagraph (F)
5 the following new subparagraph:

6 “(G)(i) Notwithstanding any other provisions of
7 this section, in the case of exempt claims, the Sec-
8 retary shall apply the provisions of—

9 “(I) the fourth sentence of subparagraph
10 (A) by substituting ‘100 percent’ for ‘95 per-
11 cent’;

12 “(II) subparagraph (B)(i) by substituting
13 ‘100 percent’ for ‘85 percent’; and

14 “(III) subparagraph (B)(ii) by substituting
15 ‘100 percent’ for ‘75 percent’.

16 “(ii) For purposes of clause (i) of this subpara-
17 graph, the term ‘exempt claims’ means claims with
18 respect to loans for which it is determined that the
19 borrower (or the student on whose behalf a parent
20 has borrowed), without the lender’s or the institu-
21 tion’s knowledge at the time the loan was made, pro-
22 vided false or erroneous information or took actions
23 that caused the borrower or the student to be ineli-
24 gible for all or a portion of the loan or for interest
25 benefits thereon.”.



1 (2) EFFECTIVE DATE OF AMENDMENTS.—The
2 amendments made by this subsection shall apply
3 with respect to loans for which the first disburse-
4 ment of principal is made on or after July 1, 2006.

5 (d) CONSOLIDATION OF DEFAULTED LOANS.—Sec-
6 tion 428(c) (20 U.S.C. 1078(c)) is further amended—

7 (1) in paragraph (2)(A)—

8 (A) by inserting “(i)” after “including”;
9 and

10 (B) by inserting before the semicolon at
11 the end the following: “and (ii) requirements es-
12 tablishing procedures to preclude consolidation
13 lending from being an excessive proportion of
14 guaranty agency recoveries on defaulted loans
15 under this part”;

16 (2) in paragraph (2)(D), by striking “para-
17 graph (6)” and inserting “paragraph (6)(A)”; and

18 (3) in paragraph (6)—

19 (A) by redesignating subparagraphs (A)
20 and (B) as clauses (i) and (ii), respectively;

21 (B) by inserting “(A)” before “For the
22 purpose of paragraph (2)(D),”; and

23 (C) by adding at the end the following new
24 subparagraphs:

25 “(B) A guaranty agency shall—



1 “(i) on or after October 1, 2006—

2 “(I) not charge the borrower collec-
3 tion costs in an amount in excess of 18.5
4 percent of the outstanding principal and
5 interest of a defaulted loan that is paid off
6 through consolidation by the borrower
7 under this title; and

8 “(II) remit to the Secretary a portion
9 of the collection charge under subclause (I)
10 equal to 8.5 percent of the outstanding
11 principal and interest of such defaulted
12 loan; and

13 “(ii) on and after October 1, 2009, remit
14 to the Secretary the entire amount charged
15 under clause (i)(I) with respect to each de-
16 faulted loan that is paid off with excess consoli-
17 dation proceeds.

18 “(C) For purposes of subparagraph (B), the
19 term ‘excess consolidation proceeds’ means, with re-
20 spect to any guaranty agency for any Federal fiscal
21 year beginning on or after October 1, 2009, the pro-
22 ceeds of consolidation of defaulted loans under this
23 title that exceed 45 percent of the agency’s total col-
24 lections on defaulted loans in such Federal fiscal
25 year.”.



1 (e) DOCUMENTATION OF FORBEARANCE AGREE-
2 MENTS.—Section 428(c) (20 U.S.C. 1078(c)) is further
3 amended—

4 (1) in paragraph (3)(A)(i)—

5 (A) by striking “in writing”; and

6 (B) by inserting “and documented in ac-
7 cordance with paragraph (10)” after “approval
8 of the insurer”; and

9 (2) by adding at the end the following new
10 paragraph:

11 “(10) DOCUMENTATION OF FORBEARANCE
12 AGREEMENTS.—For the purposes of paragraph (3),
13 the terms of forbearance agreed to by the parties
14 shall be documented by confirming the agreement of
15 the borrower by notice to the borrower from the
16 lender, and by recording the terms in the borrower’s
17 file.”.

18 (f) VOLUNTARY FLEXIBLE AGREEMENTS.—Section
19 428A(a) (20 U.S.C. 1078–1(a)) is further amended—

20 (1) in paragraph (1)(B), by striking “unless the
21 Secretary” and all that follows through “designated
22 guarantor”;

23 (2) by striking paragraph (2);

24 (3) by redesignating paragraph (3) as para-
25 graph (2); and



1 (4) by striking paragraph (4).

2 (g) FRAUD: REPAYMENT REQUIRED.—Section
3 428B(a)(1) (20 U.S.C. 1078-2(a)(1)) is further
4 amended—

5 (1) by striking “and” at the end of subpara-
6 graph (A);

7 (2) by redesignating subparagraph (B) as sub-
8 paragraph (C); and

9 (3) by inserting after subparagraph (A) the fol-
10 lowing new subparagraph:

11 “(B) in the case of a graduate or profes-
12 sional student or parent who has been convicted
13 of, or has pled nolo contendere or guilty to, a
14 crime involving fraud in obtaining funds under
15 this title, such graduate or professional student
16 or parent has completed the repayment of such
17 funds to the Secretary, or to the holder in the
18 case of a loan under this title obtained by
19 fraud; and”.

20 (h) DEFAULT REDUCTION PROGRAM.—Section
21 428F(a)(1) (20 U.S.C. 1078-6(a)(1)) is amended—

22 (1) in subparagraph (A), by striking “consecu-
23 tive payments for 12 months” and inserting “9 pay-
24 ments made within 20 days of the due date during
25 10 consecutive months”;



1 (2) by redesignating subparagraph (C) as sub-
2 paragraph (D); and

3 (3) by inserting after subparagraph (B) the fol-
4 lowing new subparagraph:

5 “(C) A guaranty agency may charge the
6 borrower and retain collection costs in an
7 amount not to exceed 18.5 percent of the out-
8 standing principal and interest at the time of
9 sale of a loan rehabilitated under subparagraph
10 (A).”

11 ~~(d) FINANCIAL AND ECONOMIC LITERACY.~~

12 ~~(1) DEFAULT REDUCTION PROGRAM. Section~~
13 ~~420F is further amended by adding at the end the~~
14 ~~following.~~

15 ~~“(c) FINANCIAL AND ECONOMIC LITERACY. Where~~
16 ~~appropriate, each program described under subsection (b)~~
17 ~~shall include making financial and economic education ma-~~
18 ~~terials available to the borrower, including making the ma-~~
19 ~~terials available before, during, or after rehabilitation of~~
20 ~~a loan.”.~~

21 ~~(2) PROGRAM ASSISTANCE FOR BORROWERS.~~

22 ~~Section 432(R)(1) (20 U.S.C. 1002(1)(1)) is amend-~~
23 ~~ed by striking “and offering” and all that follows~~
24 ~~through the period and inserting “offering loan re-~~
25 ~~payment matching provisions as part of employe-~~



1 ~~benefit packages, and providing employees with fi-~~
2 ~~nanacial and economic education and counseling.”.~~

3 (j) EXCEPTIONAL PERFORMANCE INSURANCE
4 RATE.—Section 428I(b)(1) (20 U.S.C. 1078–9(b)(1)) is
5 amended—

6 (1) in the heading, by striking “100 PERCENT”
7 and inserting “99 PERCENT”; and

8 (2) by striking “100 percent of the unpaid” and
9 inserting “99 percent of the unpaid”.

10 (k) UNIFORM ADMINISTRATIVE AND CLAIMS PROCE-
11 DURE.—Section 432(l)(1)(H) (20 U.S.C. 1082(l)(1)(H))
12 is amended by inserting “and anticipated graduation
13 date” after “status change”.

14 ~~(l) DIRECTOR PERSONNEL MANAGEMENT. Section~~
15 ~~422 is further amended~~

16 ~~(1) by striking subsection (n), and~~

17 ~~(2) by redesignating subsections (o) and (p) as~~
18 ~~subsections (r) and (s), respectively.~~

19 ~~(m) ADDITIONAL TECHNICAL AMENDMENTS~~

20 ~~(1) Section 428(a)(2)(A) (20 U.S.C.~~
21 ~~1078(a)(2)(A)) is amended~~

22 ~~(A) by striking “and” at the end of sub-~~
23 ~~clause (II) of clause (i), and~~

24 ~~(B) by moving the margin of clause (iii)~~
25 ~~two ems to the left.~~



1 (2) Section 428(a)(3)(A)(v) (20 U.S.C.
2 1078(a)(3)(A)(v)) is amended—

3 (A) by striking “or” at the end of sub-
4 clause (I);

5 (B) by striking the period at the end of
6 subclause (II) and inserting “; or”; and

7 (C) by adding after subclause (II) the fol-
8 lowing new subclause:

9 “(III) in the case of a loan disbursed
10 through an escrow agent, 3 days before the first
11 disbursement of the loan.”

12 (3) Section 428(c)(1)(A) (20 U.S.C.
13 1078(c)(1)(A)) is amended by striking “45 days” in
14 the last sentence and inserting “30 days”.

15 (4) Section 428(i)(1) (20 U.S.C. 1078(i)(1)) is
16 amended by striking “21 days” in the third sentence
17 and inserting “10 days”.

18 ~~(5) Section 428(m)(1)(B) (20 U.S.C.
19 1082(m)(1)(B)) is amended—~~

20 ~~(A) in clause (i), by inserting “and” after
21 the semicolon at the end, and~~

22 ~~(B) in clause (ii), by striking “, and” and
23 inserting a period.~~

24 (6) Section 438(b)(4)(B) (20 U.S.C. 1087-
25 1(b)(4)(B)) is amended by striking “shall be com-



1 ~~puted” and all that follows through “to the loan”~~
2 ~~and inserting “described in subparagraph (A) shall~~
3 ~~be computed using the interest rate described in sec-~~
4 ~~tion 2002(a) of title 31, United States Code,”.~~

5 **SEC. 8016. FUNDS FOR ADMINISTRATIVE EXPENSES.**

6 Section 458 is amended to read as follows:

7 **“SEC. 458. FUNDS FOR ADMINISTRATIVE EXPENSES.**

8 **“(a) ADMINISTRATIVE EXPENSES.—**

9 **“(1) MANDATORY FUNDS FOR FISCAL YEAR**
10 **2006.—For fiscal year 2006, there shall be available**
11 **to the Secretary, from funds not otherwise appro-**
12 **priated, funds to be obligated for—**

13 **“(A) administrative costs under this part**
14 **and part B, including the costs of the direct**
15 **student loan programs under this part; and**

16 **“(B) account maintenance fees payable to**
17 **guaranty agencies under part B and calculated**
18 **in accordance with subsections (b) and (c),**
19 **not to exceed (from such funds not otherwise appro-**
20 **priated) \$820,000,000 in fiscal year 2006.**

21 **“(2) AUTHORIZATION FOR ADMINISTRATIVE**
22 **COSTS BEGINNING IN FISCAL YEARS 2007 THROUGH**
23 **2011.—For each of the fiscal years 2007 through**
24 **2011, there are authorized to be appropriated such**
25 **sums as may be necessary for administrative costs**



1 under this part and part B, including the costs of
2 the direct student loan programs under this part.

3 “(3) CONTINUING MANDATORY FUNDS FOR AC-
4 COUNT MAINTENANCE FEES.—For each of the fiscal
5 years 2007 through 2011, there shall be available to
6 the Secretary, from funds not otherwise appro-
7 priated, funds to be obligated for account mainte-
8 nance fees payable to guaranty agencies under part
9 B and calculated in accordance with subsection (b).

10 “(4) ACCOUNT MAINENANCE FEES.—Account
11 maintenance fees under paragraph (3) shall be paid
12 quarterly and deposited in the Agency Operating
13 Fund established under section 422B.

14 “(5) CARRYOVER.—The Secretary may carry
15 over funds made available under this section to a
16 subsequent fiscal year.

17 “(b) CALCULATION BASIS.—Account maintenance
18 fees payable to guaranty agencies under subsection (a)(3)
19 shall not exceed the basis of 0.10 percent of the original
20 principal amount of outstanding loans on which insurance
21 was issued under part B.

22 “(c) BUDGET JUSTIFICATION.—No funds may be ex-
23 pended under this section unless the Secretary includes
24 in the Department of Education’s annual budget justifica-
25 tion to Congress a detailed description of the specific ac-



1 tivities for which the funds made available by this section
2 have been used in the prior and current years (if applica-
3 ble), the activities and costs planned for the budget year,
4 and the projection of activities and costs for each remain-
5 ing year for which administrative expenses under this sec-
6 tion are made available.”.

7 **SEC. 8017. COST OF ATTENDANCE.**

8 Section 472 (20 U.S.C. 108711) is amended—

9 (1) by striking paragraph (4) and inserting the
10 following:

11 “(4) for less than half-time students (as deter-
12 mined by the institution), tuition and fees and an al-
13 lowance for only—

14 “(A) books, supplies, and transportation
15 (as determined by the institution);

16 “(B) dependent care expenses (determined
17 in accordance with paragraph (8)); and

18 “(C) room and board costs (determined in
19 accordance with paragraph (3)), except that a
20 student may receive an allowance for such costs
21 under this subparagraph for not more than 3
22 semesters or the equivalent, of which not more
23 than 2 semesters or the equivalent may be con-
24 secutive;”;

1 (2) in paragraph (11), by striking “and” after
2 the semicolon;

3 (3) in paragraph (12), by striking the period
4 and inserting “; and”; and

5 (4) by adding at the end the following:

6 “(13) at the option of the institution, for a stu-
7 dent in a program requiring professional licensure or
8 certification, the one time cost of obtaining the first
9 professional credentials (as determined by the insti-
10 tution).”.

11 **SEC. 8018. FAMILY CONTRIBUTION.**

12 (a) FAMILY CONTRIBUTION FOR DEPENDENT STU-
13 DENTS.—

14 (1) AMENDMENTS.—Section 475 (20 U.S.C.
15 1087oo) is amended—

16 (A) in subsection (g)(2)(D), by striking
17 “\$2,200” and inserting “\$3,000”; and

18 (B) in subsection (h), by striking “35” and
19 inserting “20”.

20 (2) EFFECTIVE DATE.—The amendments made
21 by paragraph (1) shall apply with respect to deter-
22 minations of need for periods of enrollment begin-
23 ning on or after July 1, 2007.



1 (b) FAMILY CONTRIBUTION FOR INDEPENDENT STU-
2 DENTS WITHOUT DEPENDENTS OTHER THAN A
3 SPOUSE.—

4 (1) AMENDMENTS.—Section 476 (20
5 U.S.C.1087pp) is amended—

6 (A) in subsection (b)(1)(A)(iv)—

7 (i) in subclause (I), by striking
8 “\$5,000” and inserting “\$6,050”;

9 (ii) in subclause (II), by striking
10 “\$5,000” and inserting “\$6,050”; and

11 (iii) in subclause (III), by striking
12 “\$8,000” and inserting “\$9,700”; and

13 (B) in subsection (c)(4), by striking “35”
14 and inserting “20”.

15 (2) EFFECTIVE DATE.—The amendments made
16 by paragraph (1) shall apply with respect to deter-
17 minations of need for periods of enrollment begin-
18 ning on or after July 1, 2007.

19 (c) FAMILY CONTRIBUTION FOR INDEPENDENT STU-
20 DENTS WITH DEPENDENTS OTHER THAN A SPOUSE.—

21 (1) AMENDMENT.—Section 477(c)(4) (20
22 U.S.C. 1087qq(c)(4)) is amended by striking “12”
23 and inserting “7”.

24 (2) EFFECTIVE DATE.—The amendment made
25 by paragraph (1) shall apply with respect to deter-

1 minations of need for periods of enrollment begin-
2 ning on or after July 1, 2007.

3 (d) REGULATIONS; UPDATED TABLES.—Section
4 478(b) (20 U.S.C. 1087rr(b)) is amended—

5 (1) in paragraph (1), by adding at the end the
6 following: “For the 2007–2008 academic year, the
7 Secretary shall revise the tables in accordance with
8 this paragraph, except that the Secretary shall in-
9 crease the amounts contained in the table in section
10 477(b)(4) by a percentage equal to the greater of
11 the estimated percentage increase in the Consumer
12 Price Index (as determined under the preceding sen-
13 tence) or 5 percent.”; and

14 (2) in paragraph (2)—

15 (A) by striking “2000–2001” and inserting
16 “2007–2008”; and

17 (B) by striking “1999” and inserting
18 “2006”.

19 (e) EMPLOYMENT EXPENSE ALLOWANCE.—Section
20 478(h) (20 U.S.C. 1087rr(h)) is amended—

21 (1) by striking “476(b)(4)(B),”; and

22 (2) by striking “meals away from home, apparel
23 and upkeep, transportation, and housekeeping serv-
24 ices” and inserting “food away from home, apparel,



1 transportation, and household furnishings and oper-
2 ations”.

3 **SEC. 8019. SIMPLIFIED NEED TEST AND AUTOMATIC ZERO**
4 **IMPROVEMENTS.**

5 (a) **AMENDMENTS.**—Section 479 (20 U.S.C. 1087ss)
6 is amended—

7 (1) in subsection (b)—

8 (A) in paragraph (1)—

9 (i) in subparagraph (A), by striking
10 clause (i) and inserting the following:

11 “(i) the student’s parents—

12 “(I) file, or are eligible to file, a
13 form described in paragraph (3);

14 “(II) certify that the parents are
15 not required to file a Federal income
16 tax return; or

17 “(III) received, or the student re-
18 ceived, benefits at some time during
19 the previous 12-month period under a
20 means-tested Federal benefit program
21 as defined under subsection (d); and”;

22 and

23 (ii) in subparagraph (B), by striking
24 clause (i) and inserting the following:

1 “(i) the student (and the student’s
2 spouse, if any)—

3 “(I) files, or is eligible to file, a
4 form described in paragraph (3);

5 “(II) certifies that the student
6 (and the student’s spouse, if any) is
7 not required to file a Federal income
8 tax return; or

9 “(III) received benefits at some
10 time during the previous 12-month
11 period under a means-tested Federal
12 benefit program as defined under sub-
13 section (d); and”; and

14 (B) in the matter preceding subparagraph
15 (A) of paragraph (3), by striking “A student or
16 family files a form described in this subsection,
17 or subsection (c), as the case maybe, if the stu-
18 dent or family, respectively, files” and inserting
19 “In the case of an independent student, the stu-
20 dent, or in the case of a dependent student, the
21 family, files a form described in this subsection,
22 or subsection (c), as the case may be, if the stu-
23 dent or family, as appropriate, files”;

24 (2) in subsection (c)—

25 (A) in paragraph (1)—



1 (i) by striking subparagraph (A) and
2 inserting the following:

3 “(A) the student’s parents—

4 “(i) file, or are eligible to file, a form
5 described in subsection (b)(3);

6 “(ii) certify that the parents are not
7 required to file a Federal income tax re-
8 turn; or

9 “(iii) received, or the student received,
10 benefits at some time during the previous
11 12-month period under a means-tested
12 Federal benefit program as defined under
13 subsection (d); and”;

14 (ii) by striking subparagraph (B) and
15 inserting the following:

16 “(B) the sum of the adjusted gross income
17 of the parents is less than or equal to \$20,000;
18 or”;

19 (B) in paragraph (2)—

20 (i) by striking subparagraph (A) and
21 inserting the following:

22 “(A) the student (and the student’s
23 spouse, if any)—

24 “(i) files, or is eligible to file, a form
25 described in subsection (b)(3);



1 “(ii) certifies that the student (and
2 the student’s spouse, if any) is not re-
3 quired to file a Federal income tax return;
4 or

5 “(iii) received benefits at some time
6 during the previous 12-month period under
7 a means-tested Federal benefit program as
8 defined under subsection (d); and”;

9 (ii) by striking subparagraph (B) and
10 inserting the following:

11 “(B) the sum of the adjusted gross income
12 of the student and spouse (if appropriate) is
13 less than or equal to \$20,000.”;

14 (3) by adding at the end the following:

15 “(d) DEFINITION OF MEANS-TESTED FEDERAL
16 BENEFIT PROGRAM.—In this section, the term ‘means-
17 tested Federal benefit program’ means a mandatory
18 spending program of the Federal Government, other than
19 a program under this title, in which eligibility for the pro-
20 gram’s benefits, or the amount of such benefits, are deter-
21 mined on the basis of income or resources of the individual
22 or family seeking the benefit, and may include such pro-
23 grams as—



1 “(1) the supplemental security income program
2 under title XVI of the Social Security Act (42
3 U.S.C. 1381 et seq.);

4 “(2) the food stamp program under the Food
5 Stamp Act of 1977 (7 U.S.C. 2011 et seq.);

6 “(3) the free and reduced price school lunch
7 program established under the Richard B. Russell
8 National School Lunch Act (42 U.S.C. 1751 et
9 seq.);

10 “(4) the program of block grants for States for
11 temporary assistance for needy families established
12 under part A of title IV of the Social Security Act
13 (42 U.S.C. 601 et seq.);

14 “(5) the special supplemental nutrition program
15 for women, infants, and children established by sec-
16 tion 17 of the Child Nutrition Act of 1966 (42
17 U.S.C. 1786); and

18 “(6) other programs identified by the Sec-
19 retary.”.

20 (b) EVALUATION OF SIMPLIFIED NEEDS TEST.—

21 (1) ELIGIBILITY GUIDELINES.—The Secretary
22 of Education shall regularly evaluate the impact of
23 the eligibility guidelines in subsections (b)(1)(A)(i),
24 (b)(1)(B)(i), (c)(1)(A), and (c)(2)(A) of section 479
25 of the Higher Education Act of 1965 (20 U.S.C.

1 1087ss(b)(1)(A)(i), (b)(1)(B)(i), (c)(1)(A), and
2 (c)(2)(A)).

3 (2) MEANS-TESTED FEDERAL BENEFIT PRO-
4 GRAM.—For each 3-year period, the Secretary of
5 Education shall evaluate the impact of including the
6 receipt of benefits by a student or parent under a
7 means-tested Federal benefit program (as defined in
8 section 479(d) of the Higher Education Act of 1965
9 (20 U.S.C. 1087ss(d)) as a factor in determining eli-
10 gibility under subsections (b) and (c) of section 479
11 of the Higher Education Act of 1965 (20 U.S.C.
12 1087ss(b) and (c)).

13 SEC. 8020. ADDITIONAL NEED ANALYSIS AMENDMENTS.

14 ~~(a) DISCRETION OF STUDENT FINANCIAL AID AD-~~
15 ~~JUSTIFIERS. Section 479A(c) (20 U.S.C. 1087u(a))~~
16 ~~is amended—~~

17 ~~(1) by striking “(a) IN GENERAL—” and in-~~
18 ~~serting the following:~~

19 ~~“(a) AUTHORITY TO MAKE ADJUSTMENTS—~~

20 ~~“(1) ADJUSTMENTS FOR SPECIAL CIR-~~
21 ~~CUMSTANCES.”~~

22 ~~(2) by inserting before “Special circumstances~~
23 ~~may” the following:~~

24 ~~“(2) SPECIAL CIRCUMSTANCES DEFINED—”;~~



1 ~~(2) by inserting "or an independent student"~~
2 ~~after "unemployment of a family member",~~

3 ~~(4) by inserting "a student's status as a ward~~
4 ~~of the court at any time prior to attaining 18 years~~
5 ~~of age, a student's status as an individual who was~~
6 ~~adopted at or after age 18, a student's status as a~~
7 ~~homeless or unaccompanied youth (as defined in sec-~~
8 ~~tion 725 of the McKinney-Vento Homeless Assist-~~
9 ~~ance Act)." after "187";~~

10 ~~(5) by inserting before "Adequate documenta-~~
11 ~~tion" the following:~~

12 ~~"(2) DOCUMENTATION AND USE OF SUPPLI-~~
13 ~~MENTARY INFORMATION," and~~

14 ~~(6) by inserting before "No student" the fol-~~
15 ~~lowing:~~

16 ~~"(4) FEES FOR SUPPLEMENTARY INFORMATION~~
17 ~~PROHIBITED."~~

18 (b) TREATING ACTIVE DUTY MEMBERS OF THE
19 ARMED FORCES AS INDEPENDENT STUDENTS.—Section
20 480(d)(3) (20 U.S.C. 1087vv(d)(3)) is amended by insert-
21 ing before the semicolon at the end the following: "or is
22 currently serving on active duty in the Armed Forces for
23 other than training purposes".

24 (c) DEFINITION OF ASSETS.—Section 480(f)(1) (20
25 U.S.C. 1087vv(f)(1)) is amended by inserting "qualified



1 education benefits (except as provided in paragraph (3)),”
2 after “tax shelters.”

3 (d) TREATMENT OF FAMILY OWNERSHIP OF SMALL
4 BUSINESSES.—Section 480(f)(2) (20 U.S.C.
5 1087vv(f)(2)) is amended—

6 (1) in subparagraph (A), by striking “or”;

7 (2) in subparagraph (B), by striking the period
8 at the end and inserting “; or”; and

9 (3) by adding at the end the following new sub-
10 paragraph:

11 “(C) a small business with not more than 100
12 full-time or full-time equivalent employees (or any
13 part of such a small business) that is owned and
14 controlled by the family.”

15 (e) ADDITIONAL DEFINITIONS.—Section 480(f) is
16 further amended by adding at the end the following new
17 paragraphs:

18 “(3) A qualified education benefit shall not be consid-
19 ered an asset of a student for purposes of section 475.

20 “(4) In determining the value of assets in a deter-
21 mination of need under this title (other than for subpart
22 4 of part A), the value of a qualified education benefit
23 shall be—



1 “(A) the refund value of any tuition credits or
2 certificates purchased under a qualified education
3 benefit; and

4 “(B) in the case of a program in which con-
5 tributions are made to an account that is established
6 for the purpose of meeting the qualified higher edu-
7 cation expenses of the designated beneficiary of the
8 account, the current balance of such account.

9 “(5) In this subsection:

10 “(A) The term ‘qualified education benefit’
11 means—

12 “(i) a qualified tuition program (as defined
13 in section 529(b)(1)(A) of the Internal Revenue
14 Code of 1986) or other prepaid tuition plan of-
15 fered by a State; and

16 “(ii) a Coverdell education savings account
17 (as defined in section 530(b)(1) of the Internal
18 Revenue Code of 1986).

19 “(B) The term ‘qualified higher education ex-
20 penses’ has the meaning given the term in section
21 529(e) of the Internal Revenue Code of 1986.”.

22 (f) DESIGNATED ASSISTANCE.—Section 480(j) (20
23 U.S.C. 1087vv(j)) is amended—

24 (1) in the subsection heading, by striking “;
25 TUITION PREPAYMENT PLANS”;



1 (2) by striking paragraph (2);

2 (3) by redesignating paragraph (3) as para-
3 graph (2); and

4 (4) by adding at the end the following new
5 paragraph:

6 “(3) Notwithstanding paragraph (1) and section 472,
7 assistance not received under this title may be excluded
8 from both estimated financial assistance and cost of at-
9 tendance, if that assistance is provided by a State and is
10 designated by such State to offset a specific component
11 of the cost of attendance. If that assistance is excluded
12 from either estimated financial assistance or cost of at-
13 tendance, it shall be excluded from both.”.

14 **SEC. 8021. GENERAL PROVISIONS.**

15 (a) **ACADEMIC YEAR.**—Paragraph (2) of section
16 481(a) (20 U.S.C. 1088(a)) is amended to read as follows:

17 “(2)(A) For the purpose of any program under this
18 title, the term ‘academic year’ shall—

19 “(i) require a minimum of 30 weeks of instruc-
20 tional time for a course of study that measures its
21 program length in credit hours; or

22 “(ii) require a minimum of 26 weeks of instruc-
23 tional time for a course of study that measures its
24 program length in clock hours; and



1 “(iii) require an undergraduate course of study
2 to contain an amount of instructional time whereby
3 a full-time student is expected to complete at least—

4 “(I) 24 semester or trimester hours or 36
5 quarter credit hours in a course of study that
6 measures its program length in credit hours; or

7 “(II) 900 clock hours in a course of study
8 that measures its program length in clock
9 hours.

10 “(B) The Secretary may reduce such minimum of 30
11 weeks to not less than 26 weeks for good cause, as deter-
12 mined by the Secretary on a case-by-case basis, in the case
13 of an institution of higher education that provides a 2-
14 year or 4-year program of instruction for which the insti-
15 tution awards an associate or baccalaureate degree.”.

16 (b) DISTANCE EDUCATION: ELIGIBLE PROGRAM.—
17 Section 481(b) (20 U.S.C. 1088(b)) is amended by adding
18 at the end the following new paragraphs:

19 “(3) An otherwise eligible program that is offered in
20 whole or in part through telecommunications is eligible for
21 the purposes of this title if the program is offered by an
22 institution, other than a foreign institution, that has been
23 evaluated and determined (before or after the date of en-
24 actment of the Higher Education Reconciliation Act of
25 2005) to have the capability to effectively deliver distance



1 education programs by an accrediting agency or associa-
2 tion that—

3 “(A) is recognized by the Secretary under sub-
4 part 2 of part H; and

5 “(B) has evaluation of distance education pro-
6 grams within the scope of its recognition, as de-
7 scribed in section 496(n)(3).

8 “(4) For purposes of this title, the term ‘eligible pro-
9 gram’ includes an instructional program that, in lieu of
10 credit hours or clock hours as the measure of student
11 learning, utilizes direct assessment of student learning, or
12 recognizes the direct assessment of student learning by
13 others, if such assessment is consistent with the accredita-
14 tion of the institution or program utilizing the results of
15 the assessment. In the case of a program being determined
16 eligible for the first time under this paragraph, such deter-
17 mination shall be made by the Secretary before such pro-
18 gram is considered to be an eligible program.”.

19 (c) CORRESPONDENCE COURSES.—Section 484(l)(1)
20 (20 U.S.C. 1091(l)(1)) is amended—

21 (1) in subparagraph (A)—

22 (A) by striking “for a program of study of
23 1 year or longer”; and



1 (B) by striking “unless the total” and all
2 that follows through “courses at the institu-
3 tion”; and

4 (2) by amending subparagraph (B) to read as
5 follows:

6 “(B) EXCEPTION.—Subparagraph (A)
7 shall not apply to an institution or school de-
8 scribed in section 3(3)(C) of the Carl D. Per-
9 kins Vocational and Technical Education Act of
10 1998.”.

11 **SEC. 8022. STUDENT ELIGIBILITY.**

12 (a) **FRAUD: REPAYMENT REQUIRED.**—Section
13 484(a) (20 U.S.C. 1091(a)) is amended—

14 (1) by striking the period at the end of para-
15 graph (5) and inserting “; and”; and

16 (2) by adding at the end the following new
17 paragraph:

18 “(6) if the student has been convicted of, or has
19 pled nolo contendere or guilty to, a crime involving
20 fraud in obtaining funds under this title, have com-
21 pleted the repayment of such funds to the Secretary,
22 or to the holder in the case of a loan under this title
23 obtained by fraud.”.



1 (b) VERIFICATION OF INCOME DATE.—Paragraph
2 (1) of section 484(q) (20 U.S.C. 1091(q)) is amended to
3 read as follows:

4 “(1) CONFIRMATION WITH IRS.—The Secretary
5 of Education, in cooperation with the Secretary of
6 the Treasury, is authorized to confirm with the In-
7 ternal Revenue Service the information specified in
8 section 6103(l)(13) of the Internal Revenue Code of
9 1986 reported by applicants (including parents)
10 under this title on their Federal income tax returns
11 for the purpose of verifying the information reported
12 by applicants on student financial aid applications.”.

13 (c) SUSPENSION OF ELIGIBILITY FOR DRUG OF-
14 FENSES.—Section 484(r)(1) (20 U.S.C. 1091(r)(1)) is
15 amended by striking everything preceding the table and
16 inserting the following:

17 “(1) IN GENERAL.—A student who is convicted
18 of any offense under any Federal or State law in-
19 volving the possession or sale of a controlled sub-
20 stance for conduct that occurred during a period of
21 enrollment for which the student was receiving any
22 grant, loan, or work assistance under this title shall
23 not be eligible to receive any grant, loan, or work as-
24 sistance under this title from the date of that convic-



1 tion for the period of time specified in the following
2 table.”.

3 **SEC. 8023. INSTITUTIONAL REFUNDS.**

4 Section 484B (20 U.S.C. 1091b) is amended—

5 (1) in the matter preceding clause (i) of sub-
6 section (a)(2)(A), by striking “a leave of” and in-
7 serting “1 or more leaves of”;

8 (2) in subsection (a)(3)(B)(ii), by inserting “(as
9 determined in accordance with subsection (d))” after
10 “student has completed”;

11 (3) in subsection (a)(3)(C)(i), by striking
12 “grant or loan assistance under this title” and in-
13 serting “grant assistance under subparts 1 and 3 of
14 part A, or loan assistance under parts B, D, and
15 E,”;

16 (4) in subsection (a)(4), by amending subpara-
17 graph (A) to read as follows:

18 “(A) IN GENERAL.—After determining the
19 eligibility of the student for a late disbursement
20 or post-withdrawal disbursement (as required in
21 regulations prescribed by the Secretary), the in-
22 stitution of higher education shall contact the
23 borrower and obtain confirmation that the loan
24 funds are still required by the borrower. In
25 making such contact, the institution shall ex-



1 plain to the borrower the borrower's obligation
2 to repay the funds following any such disburse-
3 ment. The institution shall document in the
4 borrower's file the result of such contact and
5 the final determination made concerning such
6 disbursement.”;

7 (5) in subsection (b)(1), by inserting “not later
8 than 45 days from the determination of withdrawal”
9 after “return”;

10 (6) in subsection (b)(2), by amending subpara-
11 graph (C) to read as follows:

12 “(C) GRANT OVERPAYMENT REQUIRE-
13 MENTS.—

14 “(i) IN GENERAL.—Notwithstanding
15 subparagraphs (A) and (B), a student
16 shall only be required to return grant as-
17 sistance in the amount (if any) by which—

18 “(I) the amount to be returned
19 by the student (as determined under
20 subparagraphs (A) and (B)), exceeds

21 “(II) 50 percent of the total
22 grant assistance received by the stu-
23 dent under this title for the payment
24 period or period of enrollment.



1 “(ii) MINIMUM.—A student shall not
2 be required to return amounts of \$50 or
3 less.”;

4 (7) in subsection (d), by striking “(a)(3)(B)(i)”
5 and inserting “(a)(3)(B)”; and

6 (8) in subsection (d)(2), by striking “clock
7 hours—” and all that follows through the period and
8 inserting “clock hours scheduled to be completed by
9 the student in that period as of the day the student
10 withdrew.”.

11 **SEC. 8024. COLLEGE ACCESS INITIATIVE.**

12 Part G is further amended by inserting after section
13 485C (20 U.S.C. 1092c) the following new section:

14 **“SEC. 485D. COLLEGE ACCESS INITIATIVE.**

15 “(a) STATE-BY-STATE INFORMATION.—The Sec-
16 retary shall direct each guaranty agency with which the
17 Secretary has an agreement under section 428(c) to pro-
18 vide to the Secretary the information necessary for the de-
19 velopment of Internet web links and access for students
20 and families to a comprehensive listing of the postsec-
21 ondary education opportunities, programs, publications,
22 Internet web sites, and other services available in the
23 States for which such agency serves as the designated
24 guarantor.

25 “(b) GUARANTY AGENCY ACTIVITIES.—



1 “(1) PLAN AND ACTIVITY REQUIRED.—Each
2 guaranty agency with which the Secretary has an
3 agreement under section 428(c) shall develop a plan,
4 and undertake the activity necessary, to gather the
5 information required under subsection (a) and to
6 make such information available to the public and to
7 the Secretary in a form and manner as prescribed
8 by the Secretary.

9 “(2) ACTIVITIES.—Each guaranty agency shall
10 undertake such activities as are necessary to pro-
11 mote access to postsecondary education for students
12 through providing information on college planning,
13 career preparation, and paying for college. The guar-
14 anty agency shall publicize such information and co-
15 ordinate such activities with other entities that ei-
16 ther provide or distribute such information in the
17 States for which such guaranty agency serves as the
18 designated guarantor.

19 “(3) FUNDING.—The activities required by this
20 section may be funded from the guaranty agency’s
21 Operating Fund established pursuant to section
22 422B and, to the extent funds remain, from earn-
23 ings on the restricted account established pursuant
24 to section 422(h)(4).



1 “(4) RULE OF CONSTRUCTION.—Nothing in
2 this subsection shall be construed to require a guar-
3 anty agency to duplicate any efforts under way on
4 the date of enactment of the Higher Education Rec-
5 onciliation Act of 2005 that meet the requirements
6 of this section.

7 “(c) ACCESS TO INFORMATION.—

8 “(1) SECRETARY’S RESPONSIBILITY.—The Sec-
9 retary shall ensure the availability of the information
10 provided, by the guaranty agencies in accordance
11 with this section, to students, parents, and other in-
12 terested individuals, through Internet web links or
13 other methods prescribed by the Secretary.

14 “(2) GUARANTY AGENCY RESPONSIBILITY.—
15 The guaranty agencies shall ensure that the infor-
16 mation required by this section is available without
17 charge in printed format for students and parents
18 requesting such information.

19 “(3) PUBLICITY.—Not later than 270 days
20 after the date of enactment of the Higher Education
21 Reconciliation Act of 2005, the Secretary and guar-
22 anty agencies shall publicize the availability of the
23 information required by this section, with special
24 emphasis on ensuring that populations that are tra-
25 ditionally underrepresented in postsecondary edu-



1 cation are made aware of the availability of such in-
2 formation.”

3 ~~SEC. 8025. PROGRAM PARTICIPATION AGREEMENTS.~~

4 ~~Section 487 (20 U.S.C. 1091) is amended~~

5 ~~(1) by redesignating subsections (d) and (e) as~~
6 ~~subsections (e) and (f), respectively, and~~

7 ~~(g) by inserting after subsection (c) the fol-~~
8 ~~lowing:~~

9 ~~“(d) INSTITUTIONAL REQUIREMENTS FOR TEACH-~~
10 ~~OUTS.—~~

11 ~~“(1) IN GENERAL.—In the event the Secretary~~
12 ~~initiates the limitation, suspension, or termination of~~
13 ~~the participation of an institution of higher edu-~~
14 ~~cation in any program under this title under the au-~~
15 ~~thority of subsection (c)(1)(F) or initiates an emer-~~
16 ~~gency action for termination under the authority of~~
17 ~~subsection (c)(1)(C) and its prescribed regulations,~~
18 ~~the Secretary shall require that institution to pre-~~
19 ~~pare a teach-out plan for submission to the institu-~~
20 ~~tion’s accrediting agency or association in compli-~~
21 ~~ance with section 496(c)(4), the Secretary’s regula-~~
22 ~~tions on teach-out plans, and the standards of the~~
23 ~~institution’s accrediting agency or association.~~

24 ~~“(2) TEACH-OUT PLAN DEFINED.—In this sub-~~
25 ~~section, the term ‘teach-out plan’ means a written~~



1 ~~plan that provides for the equitable treatment of stu-~~
2 ~~dents if an institution of higher education ceases to~~
3 ~~operate before all students have completed their pro-~~
4 ~~gram of study, and may include, if required by the~~
5 ~~institution's accrediting agency or association, an~~
6 ~~agreement between institutions for such a teach-out~~
7 ~~plan'.~~

8 **SEC. 8026. WAGE GARNISHMENT REQUIREMENT.**

9 Section 488A(a)(1) (20 U.S.C. 1095a(a)(1)) is
10 amended by striking "10 percent" and inserting "15 per-
11 cent".

12 ~~SEC. 8027. ADMINISTRATIVE CAPACITY STANDARDS.~~

13 ~~Section 498 (20 U.S.C. 1099c) is amended—~~

14 (1) ~~in subsection (d)(1)(B), by inserting "and"~~
15 ~~after the semicolon, and~~

16 (2) ~~by adding at the end the following:~~

17 ~~"(e) TREATMENT OF TEACH-OUTS AT ADDITIONAL~~
18 ~~LOCATIONS.—~~

19 ~~"(1) IN GENERAL.—A location of a closed insti-~~
20 ~~tution of higher education shall be eligible as an ad-~~
21 ~~ditional location of an eligible institution of higher~~
22 ~~education, as defined pursuant to regulations of the~~
23 ~~Secretary, for the purposes of a teach-out, if such~~
24 ~~teach-out has been approved by the institution's ac-~~
25 ~~crediting agency.~~



1 “~~(2) SPECIAL RULE. An institution of higher~~
2 ~~education that conducts a teach-out through the es-~~
3 ~~tablishment of an additional location described in~~
4 ~~paragraph (1) shall be permitted to establish a per-~~
5 ~~manent additional location at a closed institution~~
6 ~~and shall not be required~~
7 “~~(A) to meet the requirements of sections~~
8 ~~102(b)(1)(E) and 102(c)(1)(C) for such addi-~~
9 ~~tional location; or~~
10 “~~(B) to assume the liabilities of the closed~~
11 ~~institution.”~~



~~John J. Smith~~
H.L.C.
~~John J. Smith~~

~~_____~~

~~_____~~

1 **Subtitle B—Pensions**

2 **SECTION 8201. INCREASES IN PBGC PREMIUMS.**

3 (a) **FLAT-RATE PREMIUMS.—**

4 (1) **SINGLE-EMPLOYER PLANS.—**

5 (A) **IN GENERAL.—**Clause (i) of section
6 4006(a)(3)(A) of the Employee Retirement In-
7 come Security Act of 1974 (29 U.S.C.
8 1306(a)(3)(A)) is amended by striking “\$19”
9 and inserting “\$30”.

10 (B) **ADJUSTMENT FOR INFLATION.—**Sec-
11 tion 4006(a)(3) of such Act (29 U.S.C.
12 1306(a)(3)) is amended by adding at the end
13 the following new subparagraph:

14 “(F) For each plan year beginning in a calendar year
15 after 2006, there shall be substituted for the premium rate
16 specified in clause (i) of subparagraph (A) an amount
17 equal to the greater of—

18 “(i) the product derived by multiplying the pre-
19 mium rate specified in clause (i) of subparagraph
20 (A) by the ratio of—



1 “(I) the national average wage index (as
2 defined in section 209(k)(1) of the Social Secu-
3 rity Act) for the first of the 2 calendar years
4 preceding the calendar year in which such plan
5 year begins, to

6 “(II) the national average wage index (as
7 so defined) for 2004; and

8 “(ii) the premium rate in effect under clause (i)
9 of subparagraph (A) for plan years beginning in the
10 preceding calendar year.

11 If the amount determined under this subparagraph is not
12 a multiple of \$1, such product shall be rounded to the
13 nearest multiple of \$1.”.

14 (2) **MULTIEMPLOYER PLANS.—**

15 (A) **IN GENERAL.—**Section 4006(a)(3)(A)
16 of such Act (29 U.S.C. 1306(a)(3)(A)) is
17 amended—

18 (i) in clause (iii)—

19 (I) by inserting “and before Jan-
20 uary 1, 2006,” after “Act of 1980,”;
21 and

22 (II) by striking the period at the
23 end and inserting “, or”; and

24 (ii) by adding at the end the fol-
25 lowing:



1 “(iv) in the case of a multiemployer plan, for
2 plan years beginning after December 31, 2005,
3 \$8.00 for each individual who is a participant in
4 such plan during the applicable plan year.”.

5 (B) ADJUSTMENT FOR INFLATION.—Sec-
6 tion 4006(a)(3) of such Act (29 U.S.C.
7 1306(a)(3)), as amended by this subsection, is
8 amended by adding at the end the following
9 new subparagraph:

10 “(G) For each plan year beginning in a calendar year
11 after 2006, there shall be substituted for the premium rate
12 specified in clause (iv) of subparagraph (A) an amount
13 equal to the greater of—

14 “(i) the product derived by multiplying the pre-
15 mium rate specified in clause (iv) of subparagraph
16 (A) by the ratio of—

17 “(I) the national average wage index (as
18 defined in section 209(k)(1) of the Social Secu-
19 rity Act) for the first of the 2 calendar years
20 preceding the calendar year in which such plan
21 year begins, to

22 “(II) the national average wage index (as
23 so defined) for 2004; and



1 “(ii) the premium rate in effect under clause
2 (iv) of subparagraph (A) for plan years beginning in
3 the preceding calendar year.

4 If the amount determined under this subparagraph is not
5 a multiple of \$1, such product shall be rounded to the
6 nearest multiple of \$1.”.

7 (b) PREMIUM RATE FOR CERTAIN TERMINATED SIN-
8 GLE-EMPLOYER PLANS.—Subsection (a) of section 4006
9 of such Act (29 U.S.C. 1306) is amended by adding at
10 the end the following:

11 “(7) PREMIUM RATE FOR CERTAIN TERMINATED
12 SINGLE-EMPLOYER PLANS.—

13 “(A) IN GENERAL.—If there is a termination of
14 a single-employer plan under clause (ii) or (iii) of
15 section 4041(c)(2)(B) or section 4042, there shall be
16 payable to the corporation, with respect to each ap-
17 plicable 12-month period, a premium at a rate equal
18 to \$1,250 multiplied by the number of individuals
19 who were participants in the plan immediately before
20 the termination date. Such premium shall be in ad-
21 dition to any other premium under this section.

22 “(B) SPECIAL RULE FOR PLANS TERMINATED
23 IN BANKRUPTCY REORGANIZATION.—In the case of
24 a single-employer plan terminated under section
25 4041(c)(2)(B)(ii) or under section 4042 during



1 pendency of any bankruptcy reorganization pro-
2 ceeding under chapter 11 of title 11, United States
3 Code, or under any similar law of a State or a polit-
4 ical subdivision of a State (or a case described in
5 section 4041(c)(2)(B)(i) filed by or against such per-
6 son has been converted, as of such date, to such a
7 case in which reorganization is sought), subpara-
8 graph (A) shall not apply to such plan until the date
9 of the discharge or dismissal of such person in such
10 case.

11 “(C) APPLICABLE 12-MONTH PERIOD.—For
12 purposes of subparagraph (A)—

13 “(i) IN GENERAL.—The term ‘applicable
14 12-month period’ means—

15 “(I) the 12-month period beginning
16 with the first month following the month
17 in which the termination date occurs, and

18 “(II) each of the first two 12-month
19 periods immediately following the period
20 described in subclause (I).

21 “(ii) PLANS TERMINATED IN BANKRUPTCY
22 REORGANIZATION.—In any case in which the
23 requirements of subparagraph (B)(i)(I) are met
24 in connection with the termination of the plan
25 with respect to 1 or more persons described in



1 such subparagraph, the 12-month period de-
2 scribed in clause (i)(I) shall be the 12-month
3 period beginning with the first month following
4 the month which includes the earliest date as of
5 which each such person is discharged or dis-
6 missed in the case described in such clause in
7 connection with such person.

8 “(D) COORDINATION WITH SECTION 4007.—

9 “(i) Notwithstanding section 4007—

10 “(I) premiums under this paragraph
11 shall be due within 30 days after the be-
12 ginning of any applicable 12-month period,
13 and

14 “(II) the designated payor shall be the
15 person who is the contributing sponsor as
16 of immediately before the termination date.

17 “(ii) The fifth sentence of section 4007(a)
18 shall not apply in connection with premiums de-
19 termined under this paragraph.

20 “(E) TERMINATION.—Subparagraph (A) shall
21 not apply with respect to any plan terminated after
22 December 31, 2010.”.

23 (c) CONFORMING AMENDMENT.—Section
24 4006(a)(3)(B) of such Act (29 U.S.C. 1306(a)(3)(B)) is



1 amended by striking “subparagraph (A)(iii)” and insert-
2 ing “clause (iii) or (iv) of subparagraph (A)”.

3 (d) EFFECTIVE DATES.—

4 (1) IN GENERAL.—Except as otherwise pro-
5 vided in this subsection, the amendments made by
6 this section shall apply to plan years beginning after
7 December 31, 2005.

8 (2) PREMIUM RATE FOR CERTAIN TERMINATED
9 SINGLE-EMPLOYER PLANS.—

10 (A) IN GENERAL.—Except as provided in
11 subparagraph (B), the amendment made by
12 subsection (b) shall apply to plans terminated
13 after December 31, 2005.

14 (B) SPECIAL RULE FOR PLANS TERMI-
15 NATED IN BANKRUPTCY.—The amendment
16 made by subsection (b) shall not apply to a ter-
17 mination of a single-employer plan that is ter-
18 minated during the pendency of any bankruptcy
19 reorganization proceeding under chapter 11 of
20 title 11, United States Code (or under any simi-
21 lar law of a State or political subdivision of a
22 State), if the proceeding is pursuant to a bank-
23 ruptcy filing occurring before October 18, 2005.



~~W. J. ...~~
H.L.L.
~~Paul ...~~
(H)

1 **TITLE X—LIHEAP PROVISIONS**

9001.)

2 ~~SECTION 10701.~~ **FUNDING AVAILABILITY.**

3 (a) **IN GENERAL.**—In addition to amounts otherwise
4 made available, there are appropriated, out of any money
5 in the Treasury not otherwise appropriated, to the Sec-
6 retary of Health and Human Services for a 1-time only
7 obligation and expenditure—

8 (1) \$250,000,000 for fiscal year 2007 for allo-
9 cation under section 2604(a) through (d) of the
10 Low-Income Home Energy Assistance Act of 1981
11 (42 U.S.C. 8623(a) through (d)); and

12 (2) \$750,000,000 for fiscal year 2007 for allo-
13 cation under section 2604(e) of the Low-Income
14 Home Energy Assistance Act of 1981 (42 U.S.C.
15 8623(e)).

16 (b) **SUNSET.**—The provisions of this section shall ter-
17minate, be null and void, and have no force and effect
18 whatsoever after September 30, 2007. No monies provided
19 for under this section shall be available after such date.



1 **TITLE XI—JUDICIARY RELATED**
2 **PROVISIONS**

3 ~~SEC. 11000. TABLE OF CONTENTS.~~

~~TITLE XI—JUDICIARY RELATED PROVISIONS~~

~~Sec. 11000. Table of Contents.~~

~~Subtitle A—Civil Filing Adjustments~~

~~Sec. 11001. Civil case filing fee increases.~~

~~Subtitle B—Bankruptcy Fees~~

~~Sec. 11101. Bankruptcy fees.~~

~~Sec. 11102. Court administration fee.~~

4 **Subtitle A—Civil Filing**
5 **Adjustments**

[Handwritten signatures and dates: 12/17/05]

10001)

6 **SEC. 11001. CIVIL CASE FILING FEE INCREASES.**

7 (a) CIVIL ACTIONS FILED IN DISTRICT COURTS.—

8 Section 1914(a) of title 28, United States Code, is amend-
9 ed by striking “\$250” and inserting “\$350”.

10 (b) APPEALS FILED IN COURTS OF APPEALS.—The

11 \$250 fee for docketing a case on appeal or review, or dock-
12 eting any other proceeding, in a court of appeals, as pre-
13 scribed by the Judicial Conference, effective as of January
14 1, 2005, under section 1913 of title 28, United States
15 Code, shall be increased to \$450.

16 (c) EXPENDITURE LIMITATION.—Incremental

17 amounts collected by reason of the enactment of this sec-
18 tion shall be deposited in a special fund in the Treasury



1 to be established after the enactment of this Act. Such
2 amounts shall be available for the purposes specified in
3 section 1931(a) of title 28, United States Code, but only
4 to the extent specifically appropriated by an Act of Con-
5 gress enacted after the enactment of this Act.

6 (d) EFFECTIVE DATE.—This section and the amend-
7 ment made by this section shall take effect 60 days after
8 the date of the enactment of this Act.

9 **Subtitle B—Bankruptcy Fees**

10 ~~SEC. FEES.~~ **BANKRUPTCY FEES.**

11 (a) BANKRUPTCY FILING FEES.—Section 1930(a) of
12 title 28, United States Code, is amended—

13 (1) in paragraph (1)—

14 (A) in subparagraph (A) by striking
15 “\$220” and inserting “\$245”; and

16 (B) in subparagraph (B) by striking
17 “\$150” and inserting “\$235”; and

18 (2) in paragraph (2) by striking “\$1,000” and
19 inserting “\$2,750”.

20 (b) EXPENDITURE LIMITATION.—Incremental
21 amounts collected by reason of the amendments made by
22 subsection (a) shall be deposited in a special fund in the
23 Treasury to be established after the enactment of this Act.
24 Such amounts shall be available for the purposes specified
25 in section 1931(a) of title 28, United States Code, but



1 only to the extent specifically appropriated by an Act of
2 Congress enacted after the enactment of this Act.

3 (c) EFFECTIVE DATE.—This section and the amend-
4 ments made by this section shall take effect 60 days after
5 the date of the enactment of this Act.

6 ~~SEC. 11100. COMPENSATION OF CHAPTER 7 DEBTORS.~~

7 (a) ~~AMENDMENTS.~~ Section 530(b)(2) of title 11,
8 United States Code, is amended—

9 (1) by striking “\$15” each place it appears and
10 inserting “\$55”, and

11 (2) by striking “Beginning 1 year after the date
12 of the enactment of the Bankruptcy Reform Act of
13 1994, each” and inserting “Such”.

14 (b) ~~EFFECTIVE DATE.~~ This section and the amend-
15 ments made by this section shall take effect 150 days after
16 the date of the enactment of this Act.



And the House agree to the same.

S. 1932

*Managers on the part of the
HOUSE*

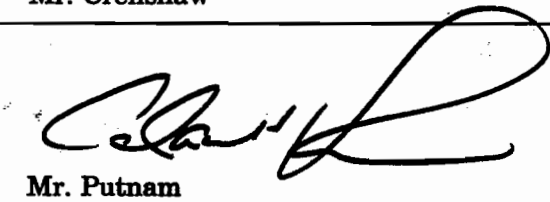
*Managers on the part of the
SENATE*

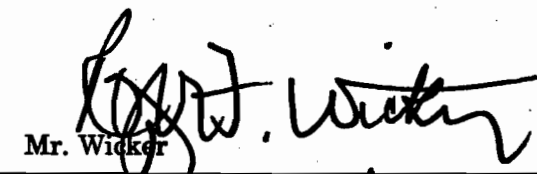
For consideration of the Senate bill, and the House amendment thereto, and modifications committed to conference:


Mr. Nussle

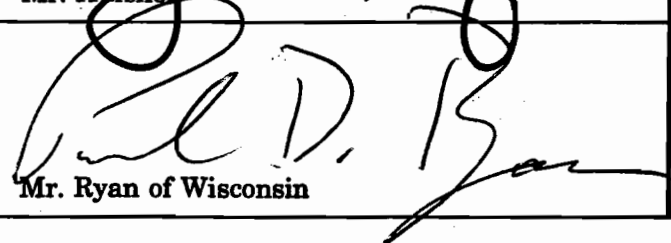

Mr. Ryun of Kansas


Mr. Crenshaw


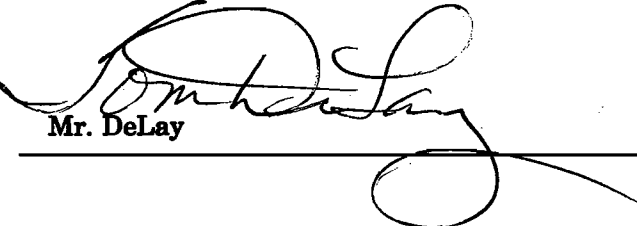

Mr. Putnam


Mr. Wicker


Mr. Hulshof


Mr. Ryan of Wisconsin

S. 1932—Continued

<i>Managers on the part of the HOUSE</i>	<i>Managers on the part of the SENATE</i>
 Mr. Blunt	
 Mr. DeLay	
Mr. [Redacted]	
Mr. [Redacted]	
Mr. [Redacted] Massachusetts	
Mr. [Redacted]	
Mr. [Redacted]	
Mr. [Redacted]	

S. 1932—Continued

*Managers on the part of the
HOUSE*

*Managers on the part of the
SENATE*

From the Committee on Agriculture, for consideration of title I of the Senate bill and title I of the House amendment, and modifications committed to conference:



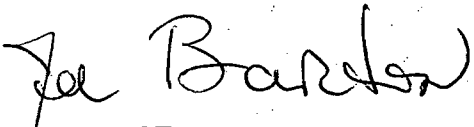


Mr. Goodlatte



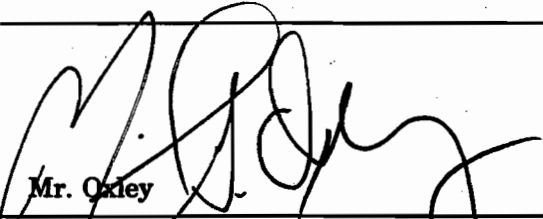
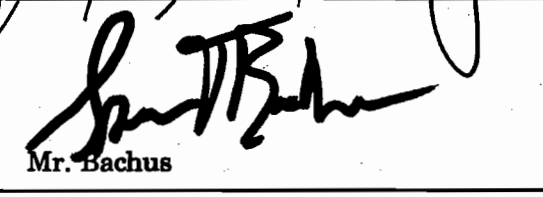
Mr. Lucas

~~Mr. [Redacted]~~

S. 1932—Continued

<i>Managers on the part of the HOUSE</i>	<i>Managers on the part of the SENATE</i>
From the Committee on Energy and Commerce, for consideration of title III and title VI of the Senate bill and title III of the House amendment, and modifications committed to conference:	
 Mr. Barton of Texas	
 Mr. Deal of Georgia	
	

S. 1932—Continued

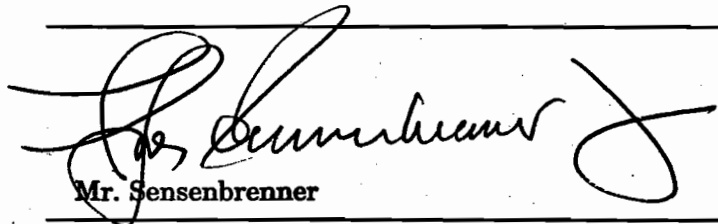
<i>Managers on the part of the HOUSE</i>	<i>Managers on the part of the SENATE</i>
<p>From the Committee on Financial Services, for consideration of title II of the Senate bill and title IV of the House amendment, and modifications committed to conference:</p>	
 <p>Mr. Oxley</p>	
 <p>Mr. Bachus</p>	
<p>Mr. Ney</p>	
<p>Provided that Mr. Ney is appointed in lieu of Mr. Bachus for consideration of subtitles C and D of title II of the Senate bill and subtitle B of title IV of the House amendment:</p>	
<p>Mr. Ney</p>	

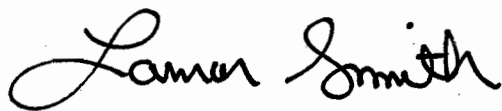
S. 1932—Continued

Managers on the part of the
HOUSE

Managers on the part of the
SENATE

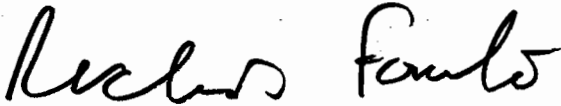

From the Committee on the Judiciary, for consideration of title VIII of the Senate bill and title V of the House amendment, and modifications committed to conference:


Mr. Sensenbrenner




Mr. Smith of Texas

~~Mr. Company~~


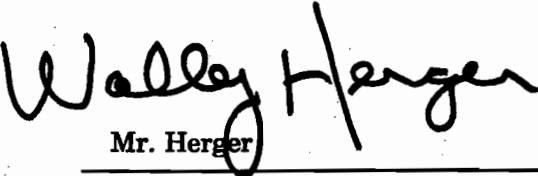
S. 1932—Continued

<i>Managers on the part of the HOUSE</i>	<i>Managers on the part of the SENATE</i>
From the Committee on Resources, for consideration of title IV of the Senate bill and title VI of the House amendment, and modifications committed to conference:	
	
Mr. Pombo	
	
Mr. Gibbons	
Mr. [unclear]	


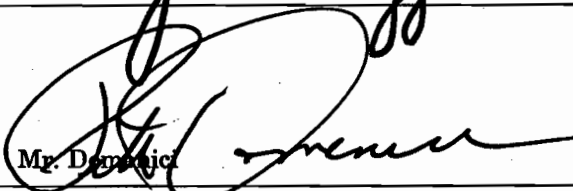


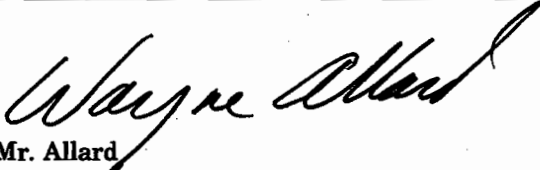
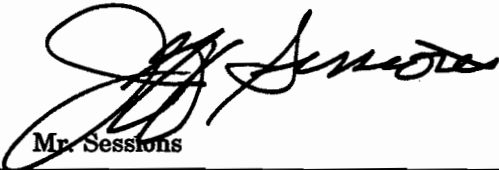
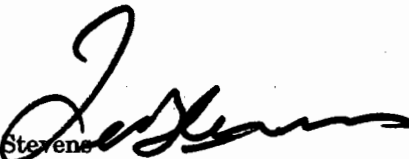
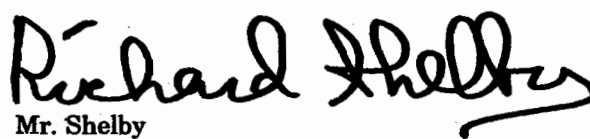
S. 1932—Continued

<i>Managers on the part of the</i> HOUSE	<i>Managers on the part of the</i> SENATE
From the Committee on Transportation and Infrastructure, for consideration of title V and division A of the Senate bill and title VII of the House amendment, and modifications committed to conference:	
 Mr. Young of Alaska	
 Mr. LoBiondo	
Mr. St...	

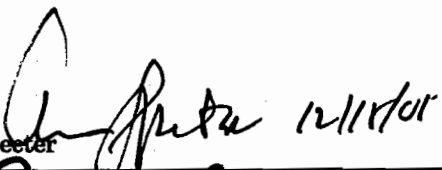
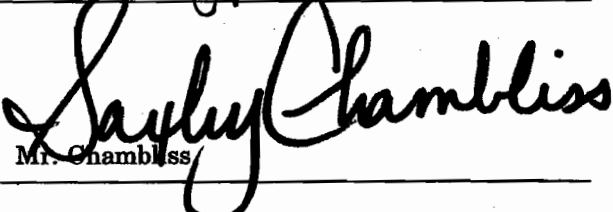






S. 1932—Continued

<i>Managers on the part of the HOUSE</i>	<i>Managers on the part of the SENATE</i>
From the Committee on Ways and Means, for consideration of sections 6039, 6071, and subtitle B of title VI of the Senate bill and title VIII of the House amendment, and modifications committed to conference:	
	
Mr. Thomas	
 Mr. Hergert	
Mr. Hergert	

S. 1932—Continued

<i>Managers on the part of the HOUSE</i>	<i>Managers on the part of the SENATE</i>
	Mr. Gregg 
	Mr. Domenici 
	Mr. Grassley 
	Mr. Enzi 
	Mr. Allard 
	Mr. Sessions 
	Mr. Stevens 
	Mr. Shelby 

S. 1932—Continued

<i>Managers on the part of the HOUSE</i>	<i>Managers on the part of the SENATE</i>
	 Mr. Specter
	 Mr. Chambliss
	 Mr. McConnell
	
	
	
	
	

S. 1932—Continued

<i>Managers on the part of the HOUSE</i>	<i>Managers on the part of the SENATE</i>
	M. R. [REDACTED]
	[REDACTED]
	M. H. [REDACTED]
	[REDACTED]

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF
CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the House to the bill (S. 1932), to provide for reconciliation pursuant to section 202(a) of the concurrent resolution on the budget for fiscal year 2006 (H. Con. Res. 95), submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The House amendment struck all of the Senate bill after the enacting clause and inserted a substitute text.

The Senate recedes from its disagreement to the amendment of the House with an amendment that is a substitute for the Senate bill and the House amendment. The differences between the Senate bill, the House amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clarifying changes.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the House to the concurrent resolution (S. Con. Res. 95) setting forth the congressional budget for the United States Government for fiscal year 2006 and setting forth appropriate budgetary levels for fiscal years 2006 through 2010, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The House amendment struck all out of the Senate resolution after the resolving clause and inserted a substitute text.

The Senate recedes from its disagreement to the amendment of the House with an amendment that is a substitute for the Senate resolution and the House amendment. The differences between the Senate resolution, the House amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clarifying changes.

The managers representing authorizing committees submitted separate joint statements explaining the provisions within their respective jurisdictions:

Committee on Agriculture

Committee on Education and the Workforce

Committee on Energy and Commerce

Committee on Financial Services

Committee on Transportation and Infrastructure

Committee on Ways and Means

TITLE I – COMMITTEE ON AGRICULTURE

(1) *Short Title*

The *Senate* bill cites this Title as the “Agricultural Reconciliation Act of 2005.”
(Section 1001)

The *House* amendment cites this Title as the “Agricultural Reconciliation Act of 2005” and contains a table of contents. (Section 1001)

The *Conference* substitute adopts the *Senate* provision.

SUBTITLE A – COMMODITY PROGRAMS

(2) *Reduction of Commodity Program Payments*

The *Senate* bill adds a new section to Title I of the Farm Security and Rural Investment Act to reauthorize direct payments, counter-cyclical payments and marketing assistance loans through 2011 and reduce these program payments 2.5% for crop years 2006 through 2010. It also reduces by 2.5% payments to dairy producers pursuant to section 1502 of the Farm Security and Rural Investment Act (known as “MILC”) during the period of October 1, 2005, through September 30, 2007. The reauthorization does not include 1104(f) and 1304(g) which specify the times at which the Secretary is required to make partial counter-cyclical payments. It also does not include section 1307(a)(6) which requires the Secretary to pay storage, handling, and other costs for peanut crops. Further, the *Senate* bill extends the period during which the prevailing world market price for upland cotton must be further adjusted to July 31, 2012, and extends the extra long staple competitiveness program through July 31, 2012. (Section 1101)

The *House* amendment amends section 1103 of the Farm Security and Rural Investment Act to reduce the total amount of direct payments to be paid to producers of covered commodities by 1% for crop years 2006 and 2007, and for crop years 2008 and 2009 if direct payments are made in these years. The *House* amendment also amends section 1303 of the Farm Security and Rural Investment Act to reduce the total amount of the direct payments to be paid to producers of peanuts by 1% for crop years 2006 and 2007, and for crop years 2008 and 2009 if direct payments are made in these years.
(Section 1101)

The *Conference* substitute adopts neither provision.

(3) *Forfeiture Penalty for Nonrecourse Sugar Loans*

The *Senate* bill amends the Federal Agriculture Improvement and Reform (FAIR) Act of 1996 to require that a penalty be assessed on the forfeiture of any sugar from the 2006 through 2010 crops of sugar beets and sugarcane pledged as collateral for a nonrecourse loan. It provides that the penalty is 1.2% of the loan rate established under section 156 of the FAIR Act. Further, it reduces payments owed to a producer by a processor that forfeits sugar pledged as collateral in proportion to the penalty incurred by the processor. (Section 1102)

The *House* amendment has no comparable provision.

The *Conference* substitute deletes the *Senate* provision.

(4) *Cotton Competitiveness Provisions*

The *Senate* bill amends the Farm Security and Rural Investment Act to eliminate authority for the establishment of the upland cotton user marketing certificate program known as "Step 2." It also repeals section 136 of the Federal Agriculture Improvement and Reform Act of 1996 which has duplicate language for the establishment of Step 2. Further, it provides that the above amendments take effect on August 1, 2006. (Section 1103)

The *House* amendment has identical language. (Section 1103)

The *Conference* substitute adopts the *Senate* provision with an amendment that eliminates the language repealing section 136 of the Federal Agriculture Improvement and Reform Act of 1996.

(5) *National Dairy Market Loss Payments*

The *Senate* bill amends the MILC Program (section 1502 of the Farm Security and Rural Investment Act) by extending until September 30, 2007, the period during which the Secretary must offer to enter into contracts with producers. It also includes a new provision that decreases the multiplier used to calculate payments from 45% to 34% during the period of October 1, 2005, through September 30, 2007. In addition it extends until September 30, 2007, the period during which eligible production must be covered in any contract entered into by a producer. It also strikes section 1502(h) of the Farm Security and Rural Investment Act and strikes an obsolete reference to section 1502. (Section 1104)

The *House* amendment has no comparable provision.

The *Conference* substitute adopts the *Senate* provision with an amendment that will decrease the multiplier used to calculate payments from 45% to 34% during the period from October 1, 2005, through August 31, 2007, and from 34% to 0% after September 1, 2007.

(6) *Advance Direct Payments*

The *Senate* bill reduces the direct payment amounts that producers are eligible to receive in advance for the 2006 through 2011 crop years. It gives producers the option of receiving up to 40% of their direct payments in advance for the 2006 crop year and up to 29% of their direct payments in advance for any of the 2007 through 2011 crop years.

The *Senate* bill provides for a corresponding reduction in the direct payment amount that peanut producers may receive in advance for any of the 2006 through 2011 crop years. It gives peanut producers the option of receiving up to 40% of their direct payments in advance for the 2006 crop year and up to 29% of their direct payments in advance for any of the 2007 through 2011 crop years. (Section 1105)

The *House* amendment reduces the direct payment amounts that producers are eligible to receive in advance for the 2006 and 2007 crop years. It gives producers the option of receiving up to 40% of their direct payments in advance for the 2006 and 2007 crop years.

The *House* amendment provides for a corresponding reduction in the direct payment amounts that producers of peanuts are eligible to receive in advance for the 2006 and 2007 crop years. It gives peanut producers the option of receiving up to 40% of their direct payments in advance for the 2006 and 2007 crop years. (Section 1102)

The *Conference* substitute adopts the *House* provision with an amendment that reduces the direct payment amounts that producers are eligible to receive in advance from 50% to 40% for the 2006 crop year and to 22% for the 2007 crop year. Advance direct payments to peanut producers are reduced in an identical fashion.

SUBTITLE B—CONSERVATION

(7) *Conservation Reserve Program*

The *Senate* bill extends the Conservation Reserve Program (CRP) through 2011. It decreases the amount of acres that the Secretary is authorized to maintain in the conservation reserve program to 36.4 million acres through calendar year 2010, and 38.3 million acres in 2011. It extends the period during which the Secretary may enroll acres, and it extends the requirement to enroll wetland and buffer acreage in reserve through 2011.

It also requires the Secretary, in implementing the amendments made by this section, to achieve the new maximum acreage enrollment limit not later than 2 years after the date of enactment of the bill without affecting conservation reserve existing contracts. (Section 1201)

The *House* amendment has no comparable provision.

The *Conference* substitute deletes the *Senate* provision.

(8) *Conservation Security Program*

The *Senate* bill extends the authorization for the Conservation Security Program (CSP) through 2011. It strikes the current limitation on funding and inserts a new limitation with two restraints. The new limits are \$1,954,000,000 for fiscal years 2006 through 2010 and \$5,200,000,000 for fiscal years 2006 through 2015. (Section 1202).

The *House* amendment extends the authorization for the Conservation Security Program through 2011, strikes the current limitation on funding and inserts a new limitation with two restraints. The new limits are \$2,213,000,000 for fiscal years 2006 through 2010 and \$5,729,000,000 for fiscal years 2006 through 2015. (Section 1202)

The *Conference* substitute adopts the *Senate* provision with an amendment that provides for a limit of \$5,650,000,000 for fiscal years 2006 through 2015.

(9) *Environmental Quality Incentives Program*

The *Senate* bill extends the authorization for the Environmental Quality Incentives Program (EQIP) through 2011, and extends the aggregate payment limit for all EQIP payments through 2011. It also amends the funding provisions to provide: \$1,017,000,000 for fiscal year 2005; \$1,185,000,000 for fiscal year 2006; \$1,270,000,000 for fiscal year 2007 through 2010; and \$1,300,000,000 for fiscal year 2011. (Section 1203)

The *House* amendment has no comparable provision.

The *Conference* substitute adopts the *Senate* provision with an amendment that provides for \$1,270,000,000 in each of fiscal years 2007 and 2009 and \$1,300,000,000 in fiscal year 2010, limits payments under this program to \$450,000 during any six-year period, and extends the authorization for EQIP through fiscal year 2010.

(10) Limitation on Use of Commodity Credit Corporation Funds to Carry Out Watershed Rehabilitation Program

The *Senate* bill has no comparable provision.

The *House* amendment removes the requirement that funds for the watershed rehabilitation program remain available to the Secretary until expended. It reduces funding for the watershed rehabilitation program by \$15 million in fiscal year 2007, and it rescinds funds that are previously made available and are unobligated as of September 30, 2006. (Section 1201)

The *Conference* substitute adopts the *House* provision with an amendment that cancels the authority to obligate funds previously made available for a fiscal year and unobligated as of October 1, 2006, but permits funding to remain available until expended and maintains funding at \$65,000,000 for fiscal year 2007.

(11) Limitation on Use of Commodity Credit Corporation Funds to Carry out the Agricultural Management Assistance Program

The *Senate* bill has no comparable provision.

The *House* amendment eliminates funding for the agricultural management assistance program in 2007. (Section 1203)

The *Conference* substitute deletes the *House* provision.

SUBTITLE C—MISCELLANEOUS (SENATE BILL)

SUBTITLE E—RESEARCH (HOUSE AMENDMENT)

(12) Initiative for Future Agriculture and Food Systems

The *Senate* bill reduces the amount of funds the Secretary is required to transfer on October 1, 2005, to \$104 million and on October 1, 2006 through 2009 to \$130 million. It provides \$200,000,000 of funding in 2010 and in subsequent fiscal years, and provides that the amendments take effect on October 1, 2005. (Section 1301)

The *House* amendment eliminates funding for the Initiative for Future Agriculture and Food Systems in fiscal years 2007, 2008, and 2009. It provides \$200,000,000 of funding in 2010 and in subsequent fiscal years, and limits availability of fiscal year 2006 funds to the one year period beginning on October 1, 2005, while maintaining the two-year period of availability for funds made available in other fiscal years. (Section 1501)

The *Conference* substitute adopts the *House* provision.

SUBTITLE C-- ENERGY

(13) Termination of Use of Commodity Credit Funds to Carry Out Renewable Energy Systems and Energy Efficiency Improvement Program.

The *Senate* bill has no comparable provision.

The *House* amendment eliminates the requirement that the Secretary make funding available for loans and grants under the renewable energy systems and energy efficiency improvements program. (Section 1301)

The *Conference* substitute adopts the *House* provision with an amendment that maintains \$3,000,000 of funding for this program in fiscal year 2007.

SUBTITLE D—RURAL DEVELOPMENT

(14) *Enhanced Access to Broadband Telecommunication Services in Rural Areas*

The *Senate* bill has no comparable provision.

The *House* amendment eliminates the requirement that the Secretary provide loans for enhanced broadband access in fiscal year 2007, prohibits funding for this program from remaining available until expended, and rescinds all funding that is available and unobligated as of September 30, 2006. (Section 1401)

The *Conference* substitute adopts the *House* provision with an amendment that cancels funding previously made available for a fiscal year and unobligated as of October 1, 2006, but permits funding to remain available until expended and maintains the funding for fiscal year 2007.

(15) *Value-Added Agricultural Product Market Development Grants*

The *Senate* bill has no comparable provision.

The *House* amendment eliminates funding for value-added agricultural product grants in fiscal year 2007, prohibits funding for this program from remaining available until expended, and rescinds all funding that is available and unobligated as of September 30, 2006. (Section 1402)

The *Conference* substitute adopts the *House* provision with an amendment that cancels funding previously made available for a fiscal year and unobligated as of October 1, 2006, but permits funding to remain available until expended and maintains the funding for fiscal year 2007.

(16) *Rural Business Investment Program*

The *Senate* bill has no comparable provision.

The *House* amendment eliminates funding for the rural business investment program in fiscal year 2007, prohibits funding for this program from remaining available until expended, and rescinds all funding that is available and unobligated as of September 30, 2006. (Section 1403)

The *Conference* substitute adopts the *House* provision with an amendment that eliminates funding in fiscal year 2007 and rescinds all funding that is available and unobligated as of October 1, 2006, but permits funding to remain available until expended.

(17) *Rural Business Strategic Investment Grants*

The *Senate* bill has no comparable provision.

The *House* amendment eliminates funding for rural business strategic investment grants in fiscal year 2007 and rescinds all funding that is available and unobligated as of September 30, 2006. (Section 1404)

The *Conference* substitute adopts the *House* provision with an amendment that cancels funding previously made for a fiscal year and unobligated as of October 1, 2006, but maintains the funding for fiscal year 2007.

(18) Rural Firefighters and Emergency Personnel Grants

The *Senate* bill has no comparable provision.

The *House* amendment eliminates funding for rural firefighter and emergency personnel grants in fiscal year 2007, prohibits funding for this program from remaining available until expended, and rescinds all funding that is available and unobligated as of September 30, 2006. (Section 1405)

The *Conference* substitute adopts the *House* provision with an amendment that permits funding to remain available until expended, but eliminates funding in fiscal year 2007, and rescinds all funding that is available and unobligated as of October 1, 2006.

SUBTITLE F—NUTRITION

(19) Eligible Households

The *Senate* bill has no comparable provision.

The *House* amendment amends the Food Stamp Act to restrict categorical eligibility status, during fiscal years 2006 through 2010, to only those households in which each member receives cash benefits under the Temporary Assistance for Needy Families program (TANF). It provides an exception to the “cash benefits” rule for households in which each member receives substantial and ongoing non-cash benefits under TANF. It further provides that such non-cash benefits must be provided for purposes of shelter, utilities, child care, health care, transportation, or job training, and it requires that such households must have a monthly income that does not exceed 150 percent of the poverty line.

The *House* amendment reauthorizes provisions in the Food Stamp Act through 2011 (except assistance for community food projects (section 25(b)) and innovative programs for addressing common community problems (section 25(h))). It also amends the eligibility categories for free school lunch and breakfast to provide a new eligibility category that will include a child who is a member of a household: (1) in which each member receives or is eligible to receive non-cash or in-kind benefits under TANF; and (2) that has a gross monthly income at or below 200 percent of the Federal poverty level. (Section 1601)

The *Conference* substitute deletes the *House* provision.

(20) Availability of Commodities for the Emergency Food

The *Senate* bill has no comparable provision.

The *House* amendment reauthorizes the purchase of \$140,000,000 worth of commodities per year for the Emergency Food Assistance Program through 2011, and it authorizes the purchase of an additional \$12,000,000 worth of commodities in 2006 to be distributed to States affected by Hurricanes Katrina and Rita. (Section 1602)

The *Conference* substitute deletes the *House* provision.

(21) Residency Requirement

The *Senate* bill has no comparable provision.

The *House* amendment amends the Personal Responsibility and Work Opportunity Reconciliation Act to require that, until fiscal year 2010, non-citizens must reside in the U.S. for 7 years or more before becoming eligible for food stamp benefits. It provides an exemption, however, for aliens who currently receive food stamp benefits and who are 60 years of age or older or have petitioned for naturalization as a U.S. citizen. It also provides that on October 1, 2010, these provisions will expire. (Section 1603)

The *Conference* substitute deletes the *House* provision.

(22) Disaster Food Stamp Program

The *Senate* bill has no comparable provision.

The *House* amendment authorizes the Secretary of Agriculture to pay to state agencies 100% of the administrative costs incurred in the delivery of food stamp benefits under the disaster food stamp program initiated in response to Hurricanes Katrina and Rita (Section 1604)

The *Conference* substitute deletes the *House* provision.

Title II-Senate Committee on Banking and House Committee on Financial Services

Subtitle A-FHA Asset Disposition

Summary of FHA Reconciliation language

December 15, 2005

The House Financial Services and Senate Banking Committees approved reconciliation language that will make several FHA multifamily authorities subject to appropriations. This move to discretionary spending will enable the Administration and Congress to set the level of activity for these FHA authorities and better control their use. This legislation authorizes \$100 Million to be appropriated for fiscal year 2006 to make these reforms.

Bill Summary

Originally proposed in the President's budget, the FHA Asset Disposition Act of 2005 will make several FHA multifamily authorities subject to appropriations, including 1) discount property sales; 2) discount loan sales; and 3) up-front grant assistance.

The Congressional Budget Office estimate of total savings in outlays are as follows (in Millions):

FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	Total
\$30	\$60	\$60	\$60	\$60	\$270

The savings from this proposal, taken together with Deposit Insurance Reform, constitute the reconciliation recommendations of the House Financial Services and Senate Banking Committees. Together the proposals will save an estimated \$520 million over fiscal years 2006-10, with \$30 million in fiscal 2006. This amount is the savings target for these committees contemplated in the budget resolution.

Background

Since 1934, FHA and HUD have insured almost 33 million home mortgages and multifamily project mortgages. Within HUD, FHA provides mortgage insurance to lenders to protect against losses as a result of borrower default. Currently, FHA has the authority to sell, at below-market rates, properties taken over by the agency because of mortgage defaults. FHA also has the authority to sell discount loans. This legislation will make these mandatory authorities discretionary and subject to appropriations. Additionally, FHA can provide up-front grants to rehabilitate dilapidated multifamily properties. Funding for the grants currently comes from the General Insurance Fund, which collects money from premiums and servicing of insured mortgages. The amount spent on the grants is left to the discretion of FHA. Under this legislation, funding for these grants will no longer be drawn from the General Insurance Fund and would be subject to appropriations. Finally, this proposal is effective during fiscal years 2006 through 2010.

SUBTITLE B-DEPOSIT INSURANCE

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 2101. Short title; table of contents

This section establishes the short title of the subtitle, the 'Federal Deposit Insurance Reform Act of 2005,' and provides a table of contents.

Section 2102. Merging the BIF and SAIF

This section amends provisions of the Federal Deposit Insurance Act to merge the Bank Insurance Fund and the Savings Association Insurance Fund no later than the first day of the first calendar quarter that begins after the end of the 90-day period beginning on the date of the enactment of this Act.

Section 2103. Increase in deposit insurance coverage

This section provides for an inflation index for general depositors and a higher level of deposit insurance coverage for certain individual retirement accounts. Credit unions are provided with complete parity in coverage with other insured depository institutions.

The section also retains the \$100,000 deposit insurance limit on accounts at insured depository institutions, to be known as the "standard maximum deposit insurance amount," subject to future cost of living adjustments.

Beginning April 1, 2010, and every succeeding five years, the Board of Directors of the FDIC and the National Credit Union Administration Board shall jointly determine whether an increase in the standard maximum deposit insurance is appropriate after considering certain factors. If appropriate, the new standard maximum deposit insurance limit would be increased by a cost of living adjustment. This adjustment would be calculated according to the Personal Consumption Expenditures Chain-Type Index (PCE) published by the Department of Commerce and rounded down to the nearest \$10,000. The FDIC and National Credit Union Administration (NCUA) Boards of Directors are required to publish the new standard maximum deposit insurance amount in the Federal Register and provide a corresponding report to Congress by April 5, 2010, and April 5 of every succeeding fifth year. The approved adjustment in the standard maximum deposit insurance amount would automatically occur unless a Congressional act provides otherwise and would take effect on January 1 of the year immediately succeeding the calendar year in which the new amount is calculated.

The section also provides pass-through coverage to certain employee benefit plans, even if the institution is not authorized to accept employee benefit plan deposits because it is not well-capitalized or adequately capitalized.

The section also increases the deposit insurance limit for certain retirement accounts to \$250,000, also subject to future cost-of-living adjustments.

Section 2104. Setting assessments and repeal of special rules relating to minimum assessments and free deposit insurance

This section allows the FDIC Board to set assessments in such amounts as it may determine to be necessary or appropriate. This provision also eliminates the existing restrictions on the FDIC's authority to levy assessments on any institution above amounts needed to achieve and maintain the existing DRR of 1.25 percent. The minimum statutory rate (23 basis point cliff rate) applicable in certain circumstances is eliminated.

This section also provides that under the FDIC's risk-based assessment system, no depository institution shall be barred from the lowest-risk category solely because of size.

The section also requires insured depository institutions to maintain all records that the FDIC may require for verifying the accuracy of any assessment for 3 years or, in the case of disputed assessments, until the dispute has been resolved, and increases the fees that the FDIC can impose for late payments of premium assessments from \$100 to 1 percent of assessments per day, for institutions with assessments greater than \$10,000. Institutions with assessments lower than \$10,000 would face a maximum penalty of \$100 for each day they were delinquent in paying their premium assessments.

The bill repeals a number of provisions requiring the FDIC to set premiums on a semiannual basis, replacing them with a provision granting the FDIC greater flexibility in the timing of those evaluations.

Section 2105. Replacement of fixed designated reserve ratio with reserve range

This section eliminates the current 1.25 percent 'hard target' DRR and provides the FDIC Board with the discretion to set the DRR within a range of 1.15 to 1.50 percent for any given year, using the following criteria as a basis for making these determinations:

- (1) present and future risk of losses to the deposit insurance fund;
- (2) economic conditions; and
- (3) any other factors the Board may determine to be appropriate.

In designating the reserve ratio, the FDIC must follow notice-and-comment rulemaking procedures, and is required to publish a thorough analysis of the data and projections if it proposes to change the DRR.

Section 2106. Requirements applicable to the risk-based assessment system

This section directs the FDIC to collect information from all appropriate sources in determining risk of losses to the DIF. This provision does not authorize the FDIC to impose additional recordkeeping requirements on insured depository institutions.

The FDIC is required to consult with the appropriate Federal banking agency in assessing the risk of loss to the DIF with respect to any insured depository institution. This risk of loss evaluation may be done on an aggregate basis for institutions that are determined to be well-capitalized and well-managed.

The FDIC is also required to provide notice and opportunity for comment prior to revising or modifying the risk-based assessment system.

Section 2107. Refunds, dividends, and credits from Deposit Insurance Fund

This section provides for refunds or credits of any assessment payment that was made by an insured depository institution in excess of the amount due the FDIC.

The section specifies two circumstances under which the FDIC is required to pay dividends to insured depository institutions: (1) whenever the reserve ratio of the DIF equals or exceeds 1.35 percent of estimated insured deposits and is less than or equal to 1.5 percent of such deposits, the FDIC is required to pay dividends equal to 50 percent of the amount in excess of what is required to maintain the reserve ratio at 1.35 percent unless the FDIC determines that a significant risk of losses to the DIF exists and such losses justify the growth of the reserve ratio; and (2) whenever the reserve ratio of the DIF exceeds 1.5 percent of estimated insured deposits, the FDIC is required to pay dividends in the amount of the excess of what is necessary to maintain the ratio at 1.5 percent.

The section also provides for a transitional credit of 10.5 basis points of the total assessment base as of December 31, 2001 (or about \$4.7 billion) to eligible insured depository institutions based on their respective percentage of total industry assessable deposits held as of December 31, 1996. Eligible insured depository

institutions had to be in existence at December 31, 1996, or be a successor to such an institution, and to have paid a deposit insurance assessment prior to that date.

For purposes of allocating dividends, the FDIC is required to determine each insured depository institution's relative contribution to the DIF (or any predecessor deposit insurance fund), taking into account the institution's share of the assessment base as of December 31, 1996; the total amount of deposit insurance assessments paid by the institution after December 31, 1996; that portion of assessments paid by an institution that reflects higher levels of risk assumed by the institution; and such other factors as the FDIC deems appropriate. The FDIC's calculation, declaration and payment of dividends are made subject to notice-and-comment rulemaking.

For any insured depository institution that exhibits financial, operational or compliance weaknesses ranging from moderately severe to unsatisfactory at the beginning of the assessment period, credits may not exceed the amount calculated by applying to that institution the average assessment rate on all insured depository institutions for that assessment period.

In promulgating regulations establishing a system for dividends and credits, the FDIC is required to include provisions allowing insured depository institutions a reasonable opportunity to challenge administratively the amount of their dividends or credits.

In determining the appropriate distribution of dividends, the FDIC must weigh a number of factors in its rulemaking process. The calculation should recognize past contributions to the deposit insurance funds by incorporating the ratio determined for an institution in the calculation of the institution's one-time credit based on total assessment base at year-end 1996, as well as the actual assessments paid since that time. In establishing the dividend system, the FDIC should also take into account and make adjustments that reflect the higher risk profiles of some institutions so that they are not rewarded for riskier behavior. The FDIC is given the discretion to incorporate additional factors, through the rulemaking process, as it deems appropriate.

Section 2108. Deposit Insurance Fund restoration plans

Whenever the reserve ratio falls or is projected to fall below the low end of the range within which the FDIC is authorized to set the DRR, the FDIC is required, within 90 days, to establish and implement a plan for restoring the DIF to that level within five years or a longer period in extraordinary circumstances. While such a restoration plan is in effect, the FDIC has the authority to restrict the use of assessment credits by insured depository institutions, but is required to apply to an institution's assessment an amount that is the lesser of the institution's assessment or 3 basis points of an institution's assessment base. The FDIC must publish the details of its restoration plan in the Federal Register within 30 days of its implementation.

Section 2109. Regulations required

This section provides that the FDIC has 270 days after the date of enactment to prescribe final regulations, after notice and opportunity for public comment, establishing the DRR, implementing increases in deposit insurance coverage, implementing the dividend requirement and the one-time assessment credit, and providing for premium assessments under the amended Act.

Section 2010. Studies of FDIC structure and expenses and certain activities and further possible changes to deposit insurance system

This section provides that within one year of enactment, reports must be submitted to Congress on the following issues:

(1) The efficiency and effectiveness of the administration of the prompt corrective action (PCA) program, including the degree of effectiveness of the Federal banking agencies in identifying troubled depository institutions and the degree of accuracy of the risk assessments made by the FDIC;

- (2) The appropriateness of the FDIC's organizational structure for the mission of the FDIC, to take into account the current size and complexity of the business of insured depository institutions; the extent to which the organizational structure contributes to or reduces operational inefficiencies that increase operational costs; and the effectiveness of internal controls;
- (3) The feasibility of establishing a voluntary deposit insurance system for deposits in excess of the maximum amount of deposit insurance for any depositor;
- (4) The feasibility of increasing the limit on deposit insurance for deposits of municipalities and other units of general local government;
- (5) The feasibility of privatizing all deposit insurance at insured depository institutions and insured credit unions; and,
- (6) The feasibility of using an alternative to estimated insured deposits in calculating the DIF's reserve ratio and the DRR.
- (7) The section directs the FDIC to conduct a study of the reserve methodology and loss accounting for insured depository institutions in a troubled condition over the period January 1, 1992 through December 31, 2004, and report its findings and conclusions to Congress within one year of the date of enactment. The FDIC is required to obtain comments on the design of this study from the Government Accountability Office (GAO), and to provide a draft of the final report to GAO prior to its submission to Congress.
- (8) The section directs the Comptroller General to report to the Committee on Financial Services of the House and the Committee on Banking, Housing, and Urban Affairs in the Senate, the potential impact on the United States financial system, the implementation of the new Basel Capital Accord and the proposed revisions to current reserve requirement regulations for non-Basel II banks.

Section 2111. Bi-annual FDIC survey and report on increasing the deposit base by encouraging use of depository institutions by the unbanked

This section requires the FDIC to conduct a bi-annual survey on efforts by insured depository institutions to bring the 'unbanked' into the conventional finance system, and report its findings and conclusions to the House Committee on Financial Services and the Senate Committee on Banking, Housing and Urban Affairs, together with any recommendations for legislative or administrative action.

Section 2112. Technical and Conforming Amendments to the Federal Deposit Insurance Act relating to the merger of the BIF and SAIF

This section makes numerous amendments to ensure the technical conformity of the Federal Deposit Insurance Reform Act to various provisions in the Federal Deposit Insurance Act and other banking laws, to include the authority of the DIF to borrow from insured depository institutions and the Federal Home Loan Banks.

In particular, this section repeals section 5(d)(2) of the Federal Deposit Insurance Act, dealing with exit fees collected from institutions leaving the Savings Association Insurance Fund (SAIF). These funds will be returned to the DIF upon the repeal of this provision.

Section 2113. Other Technical and Conforming Amendments relating to the merger of the BIF and SAIF

This section ensures the technical conformity of the Federal Deposit Insurance Reform Act to various provisions in the Federal Deposit Insurance Act and other banking laws.

stations, may continue broadcasting in analog format after February 18, 2009, subject to future decisions by the FCC on how to complete the digital television transition for such stations. Low-power stations other than Class A stations may also continue such analog broadcasting above channel 51, subject to future FCC decisions, so long as those stations' use of those channels is secondary to the use of those channels by the auction winners and public safety officials.

Section 3003. Auction of recovered spectrum

Section 3003 would amend the Communications Act of 1934 to require the FCC to conduct an auction of the recovered spectrum commencing by January 28, 2008. The FCC's auction authority would be extended through September 30, 2011.

Sec. 3004. Reservation of Auction Proceeds.

This provision requires that the proceeds from the auction of analog spectrum be deposited in a single separate fund in the Treasury, to be called the "Digital Television Transition and Public Safety Fund," in order to fund several programs. On September 30, 2009, \$7,363,000,000 shall be transferred from the Digital Television Transition and Public Safety Fund to the general fund of the Treasury.

Section 3005. Digital Transition and Public Safety Fund

To help consumers who wish to continue receiving broadcast programming over the air using analog-only televisions not connected to cable or satellite service, the bill authorizes the National Telecommunications and Information Administration (NTIA) to create a digital-to-analog converter box assistance program. Under the program, the NTIA is initially allocated up to \$990 million of the spectrum auction revenues to send by U.S. mail up to two \$40 coupons to each U.S. household that requests to participate in the program. Consumers may use the coupons toward the purchase of eligible digital-to-analog converter-boxes. Such boxes, and over-the-air digital televisions in general, can work with the antennas consumers already use in their homes for analog over-the-air broadcasts. The NTIA may use up to \$100 million of the \$990 million for administrative costs. Up to \$5,000,000 of the administrative funds may be used to educate consumers about the digital television transition and the digital-to-analog converter-box program. If, as the program progresses, it appears the NTIA will need additional funds, the NTIA may certify to Congress that it cannot operate the program without more money, at which point the funds available for the program shall increase to \$1.5 billion and the cap on administrative expenses shall increase to \$160 million. The NTIA would be allowed access to the additional funds 60 days after the certification.

Even if NTIA spends \$100 million on administrative costs, the remaining \$890 million in converter-box program proceeds would fund 22,250,000 coupons. And each additional \$40 the NTIA does not spend on administration is another coupon it can make available to consumers. Thus, the Managers expect in any NTIA certification to raise the caps that the NTIA explain in detail why access to additional funds is necessary, whether those

funds are to be used for administrative costs or for the coupons themselves, and why the NTIA was unable to operate the program within the \$990 million overall cap and \$100 million administrative cap.

The Managers note that the February 17, 2009, firm deadline will have little impact on most television households. Only consumers relying on over-the-air broadcasts should need to participate in the converter-box program. Only 14.86 percent of U.S. television households relied exclusively on over-the-air transmission as of June 2004, according to the FCC. By contrast, the FCC reports that 92.3 million households, representing 85.14 percent, subscribed to a multichannel video programming distribution (MVPD) service, such as those offered by a cable or satellite operator.

The coupon structure of the program and requiring consumers to make affirmative requests for coupons takes into account that many consumers will neither need nor want a subsidized converter box. By contrast, if converter-boxes were made directly available at subsidized rates at stores, or coupons were automatically sent to every U.S. household, impulse participation by consumers who do not really need either a converter-box or a subsidy would cause the program to run out of funds before consumers who really do need a subsidized box avail themselves of the program.

The Managers expect NTIA to promulgate regulations within nine months of enactment governing: (1) the content and distribution of coupon request forms and coupons; (2) consumer redemption of, and retailer reimbursement for, the coupons; (3) the types of converter boxes that shall be eligible for purchase with a coupon; (4) certification, education, and auditing of retailers involved in the program; and (5) consumer and retailer appeals. The requirement to send the coupons through the U.S. mail is designed to help NTIA administer the two-coupon per household limit. That limit would be much more difficult to implement if the coupons themselves were distributed electronically or simply made available at government buildings such as post offices. The U.S. mail requirement is also intended to reduce fraud that might occur with electronically distributed coupons. The Managers expect NTIA to take additional measures to reduce fraud and abuse, such as including anti-counterfeit measures and perhaps unique serial numbers on the coupons. The Managers do expect NTIA to use the efficiencies of electronic media and networks, however, to make other aspects of the program more efficient, such as outreach efforts, the distribution of coupon request forms, and the reimbursement of retailers for coupons that consumers redeem. NTIA should also take measures to protect consumer privacy in the use of information provided in conjunction with participation in the program.

Sec. 3006. Public Safety Interoperable Communications.

Section 3006 provides funding in the amount of \$1,000,000,000 to help ensure interoperability for our nation's first responders. In order to obtain a grant under this section, a public safety agency shall—(1) submit an application to the Assistant Secretary at such time, in such form, and containing or accompanied by such information and assurances as the Assistant Secretary shall require; (2) agree that, if awarded a grant, the

public safety agency will submit annual reports to the Assistant Secretary for the duration of the grant award period with respect to— (A) the expenditure of grant funds; and (B) progress toward acquiring and deploying interoperable communications systems funded by the grant; and (3) agree to remit to the Assistant Secretary any grant funds that remain unexpended at the end of the 3-year period of the grant.

Grants under this section shall be awarded in the form of a single grant for a period of not more than 3 years. At the end of 3 years, any grant funds that remain unexpended should be remitted by the grantee to the Assistant Secretary, and, may be awarded to other eligible grant recipients. At the end of fiscal year 2010, any such re-awarded grant funds that remain unexpended shall be remitted by the grantee to the Assistant Secretary and may not be re-awarded to other grantees.

In order to ensure consistency amongst various federal interoperable communications grant programs, the Managers expect the Assistant Secretary, in consultation with the Secretary of the Department of Homeland Security, to administer the grant program in a manner consistent with the recommended guidance for public safety communications and interoperability grants established by the Office of Grant and Training of the Preparedness Directorate and the SAFECOM Program of the Office for Interoperability and Compatibility of the Science and Technology Directorate of the Department of Homeland Security. In addition, the Managers expect that the Assistant Secretary, in consultation with the Secretary of the Department of Homeland Security, will ensure that the grants awarded under this program are utilized by public safety agencies in a manner which is consistent with applicable state interoperable communications plans, state and urban area homeland security strategies, and the National Preparedness Goal and accompanying guidance.

Moreover, in order to minimize the paperwork and administrative burden of public safety agencies applying for funds under this grant program, the Managers expect the Assistant Secretary, in consultation with the Secretary of the Department of Homeland Security, to enable a public safety agency to utilize, to the maximum extent practicable, the identical application such public safety agency may have submitted to the Department of Homeland Security for any interoperable communications funding from the Department of Homeland Security and to take any other steps to minimize the administrative burden of public safety agencies that may be applying both for funds under this grant program and funds for interoperable communications from the Department of Homeland Security.

The Managers intend that grants under this section may be used for the acquisition costs associated with designing an interoperable communications system so that the system is properly engineered based upon the topography, population density, or other characteristics of the area in which the system will operate. The Managers note that there is a diverse array of technological and engineering solutions that enable interoperable communications systems.

The Managers encourage the Assistant Secretary, in consultation with the Secretary of the Department of Homeland Security, to consider distributing a limited portion of grant

funds under this section in a manner that gives priority to those public safety agencies in areas designated as at high risk for natural disasters and threats of terrorism to the agriculture, food, banking, and chemical industries; the defense industrial base; emergency services; energy; government facilities; postal, shipping, public health, health care, information technology, telecommunications, and transportation systems; water; dams; commercial facilities; and national monuments and icons.

Section 3007. NYC 9/11 Digital Transition

The funding provided under this section, \$30,000,000, would enable New York City broadcasters can build interim facilities to ensure that the New York metropolitan area could receive an adequate digital broadcast signal until the new facilities atop the Freedom tower can be completed. The Managers do not intend this program to alter or affect the FCC's authority with respect to licensing, interference, or other regulation.

Sec. 3008. Low-Power television and translator digital to analog conversion.

Section 3008 provides funding to facilitate continued service for the viewers of low power television stations over their analog TVs. The Assistant Secretary shall determine the maximum amount of compensation such a low-power television station may receive based on the average cost of such digital-to-analog conversion devices during the time period such low-power broadcast television station purchased the digital-to-analog conversion device, but in no case shall such compensation exceed \$1,000.

Section 3009. Low-power and translator upgrade program.

The funding provided under this section would make available \$65,000,000 for a program to convert low-power television stations and television translator stations from analog to digital transmissions.

Sec. 3010. National alert and tsunami warning program.

The funding provided under this section, \$156,000,000, will provide for a modern all hazards alert and warning program to provide alerts in response to natural disasters, man-made accidents, and terrorist incidents. The program will encourage, but not mandate, new technologies such as wireless communication devices, satellite radios, and personal computers to enhance the nation's current emergency warning capability. The goal of the program will be to help ensure that regardless of what communication technology an individual relies upon they will get an alert to a threat to public safety.

The funding will be used to develop technologies to allow emergency managers to precisely geographically target their alerts to only populations at risk. Research and development will be encouraged, but not mandated, to be conducted through a cooperative research program with the telecommunications industry.

The funds should also be used to provide emergency managers with the tools necessary to input alerts into a national alerting system and have them retransmitted across all

appropriate communication mediums. There should be established a procedure to provide credentials to emergency managers who wish to use the system to ensure the integrity of emergency alert communications to the public. The office responsible for managing the system should also ensure that personnel using the system are appropriately trained on how and when to use the system and understand that the system should only be used for grave threats to public safety. Personnel should also be trained to issue alerts that provide the public with information on what to do to protect themselves from the threat.

Section 3011. ENHANCE 911.

The funding provided under this section would make available \$43,500,000 in grants to implement the ENHANCE 911 Act of 2004.

Section 3012. Essential Air Service program.

The funding provided under this section would make \$30,000,000 in grants to the Essential Air Service program.

Section 3013. Supplemental License Fees.

This section provides for additional fees to be assessed by the Federal Communications Commission in the aggregate amount of \$10,000,000 during fiscal year 2006.

~~AA~~ ~~SS~~ ~~HW~~

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TITLE V — Medicare

Subtitle A- Part A

Hospital Quality Improvement (Section 5001 of the Conference Agreement, Section 6110 of the Senate Bill and no provision in the House Bill).

Current Law

Each year, Medicare's operating payments to hospitals are increased or updated by a factor that is determined in part by the projected annual change in the hospital market basket (MB), a measure that estimates price inflation affecting hospitals. Congress establishes the update for Medicare's inpatient prospective payment system (IPPS) for operating costs in acute care hospitals, often several years in advance. Currently, through FY2007, the IPPS operating update has been established as the MB for hospitals that submit specific quality information and as the MB minus 0.4 percentage points for hospitals that do not provide such information. The required data are those ten quality indicators established by the Secretary of the Department of Health and Human Services (the Secretary) as of November 1, 2003. Starting in FY2008, the IPPS update will be the hospital MB. Any MB reduction does not apply when computing the applicable percentage increase in subsequent years.

Outlier payments are intended to protect IPPS hospitals from the risk of financial losses associated with patients with exceptionally high costs or unusually long stays. Medicare cases qualify for outlier payments if they exceed a threshold or fixed loss amount that is established each year. As directed by statute, the total amount of any outlier payments for any year should equal no less than 5% nor more than 6% of total projected operating diagnosis related group (DRG) payments. Outlier payments are financed by a reduction in the national average standardized amount, typically set at 5.1%.

For the purpose of establishing the correct IPPS payment, Medicare discharges are classified into diagnosis related groups (DRGs) primarily on the basis of the diagnosis and procedure code information included on the beneficiary's claim. The information includes the principal diagnosis (or main problem requiring inpatient care), up to eight secondary diagnoses codes as well as up to six procedures performed during the stay. Medicare pays for inpatient hospital services using per discharge rates that will vary by the DRG (and its calculated weight) to which a patient's stay is assigned. Each DRG weight represents the average resources required to provide care for cases in that specific DRG relative to the average resources used to treat cases in all DRGs. The Center for Medicare and Medicaid Services (CMS) annually reviews the DRG definitions and relative weights to (1) reflect changes in treatment patterns and technology improvements and (2) ensure that cases with clinically similar conditions requiring comparable resources are grouped together.

Under the DRG classification system, certain secondary diagnoses are considered to be complications or comorbidities (CC). When present as a secondary condition (with a specific principal diagnosis), these diagnosis codes are considered to increase the length of stay by at least one day in at least 75% of the patients. In FY2006, there are 3,285 diagnosis codes on the CC list. 524 DRGs are used for Medicare payment purposes and 121 paired DRGs are split into higher and lower paid DRGs on the presence or the absence of a CC. CMS has added and deleted codes from the standard list of CCs, but has never conducted a comprehensive review of the list. It is planning to review systematically the CC list for FY2007 Medicare payments.

Senate Bill

The Medicare statute would be amended by adding a new Section 1860E-2 which establishes the hospital value-based purchasing program for inpatient hospital services, starting FY2007. The program would make value-based payments to hospitals based on data reported under the quality measurement system established by the Secretary. Hospitals paid under Medicare's prospective payment system (PPS) that have substantially improved the quality of care over the prior year or exceeded an established quality threshold would receive a value-based payment as determined by the Secretary. A majority of the total amount available for value-based payments in any fiscal year would be paid to hospitals that are receiving such payments for exceeding a quality threshold. Starting in FY2008, the percentage of the total amount for value-based payments in any fiscal year that is paid to such hospitals would be greater than the equivalent percentage paid in the previous year. Hospitals would be required to comply with all the quality data reporting requirements and attest to the accuracy of the data in order to be eligible for a value-based payment. The total amount of value-based payments in a fiscal year would equal the total amount of available funding for such payments for that year. The payments would be based on the methods determined by the Secretary and would be made to hospitals no later than the close of the following fiscal year. No later than January 1, 2007, the Secretary would provide each hospital with a description of how its payments for FY2006 would have been affected had the value-based payment program been in effect that fiscal year.

Value-based payments in a fiscal year would be made from Medicare's Part A Trust fund and would equal specified reductions in those trust fund expenditures as established in Section 6110(b) of the bill. Specifically, IPPS outlier payments would be established as no less than 5% and no more than 6% for fiscal years prior to 2007. In FY2007, outlier payments would be established as no less than 4% and no more than 5%. In FY2008, outlier payments would be established as no less than 3.75% and no more than 4.75%. In FY2009, outlier payments would be established as no less than 3.5% and no more than 4.5%. In FY2010, outlier payments would be established as no less than 3.25% and no more than 4.25%. In FY2011 and in subsequent years, outlier payments would be established as no less than 3% and no more than 4%.

The Secretary would be directed to reduce the average standardized amount by certain percentages to fund outlier payments and the hospital value-based purchasing program. The reduction factor would be equal to a calculation where the numerator is the sum of the additional outlier payments (as discussed in the preceding paragraph) plus a specified percentage of total projected DRG prospective payment rates divided by the total projected DRG prospective payment rates. The specific percentages would be 0% for fiscal years prior to 2007, 1% in FY2007, 1.25% in FY2008, 1.5% in FY2009, 1.75% in FY2010, and 2% in FY2011 and in subsequent years.

Acute care hospitals that do not submit required quality data would receive the MB minus 2 percentage points for FY2007 and each subsequent fiscal year. The reduction would apply only with respect to the fiscal year involved and would not be taken into account when computing subsequent updates. The required quality data would be that determined by the Secretary to be appropriate for the measurement of health care quality, including data necessary for the operation of the IPPS hospital value-based purchasing program.

House Bill

No provision.

Conference Agreement

Hospitals that do not submit the required data in FY2007 and each subsequent year will have the applicable MB percentage increase reduced by 2 percentage points. Each IPPS hospital is required to submit data on measures selected by the Secretary in the established form, manner, and specified time. Any reduction applies only to the fiscal year in question and does not affect subsequent fiscal years

The conference agreement establishes that the Secretary will expand the number of quality indicators required to be reported by acute care hospitals. Beginning October 1, 2006 the Secretary will begin to adopt the baseline set of performance measures set forth in the November 2005 Institute of Medicine report that was required by section 238(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. Beginning October 1, 2007, the Secretary will add other measures that reflect consensus among the affected parties. To the extent feasible and practicable, these measures will include those established by national consensus building entities. The Secretary is permitted to vary and replace any measures in appropriate cases, such as where all hospitals are effectively in compliance or where measures have been shown not to represent the best clinical practice.

The Secretary is required to establish procedures for making the submitted quality data available to the public. These procedures will ensure that a hospital has the opportunity to review the data before they are made available to the public. The Secretary is required to report quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care that relate to inpatient services on the Internet website of CMS.

The Secretary is required to develop a plan to implement a value-based purchasing program for IPPS payments to acute care hospitals beginning with FY2009. The plan will include consideration of (1) the on-going development, selection, and modification process for measures of quality and resource use in hospital inpatient settings; (2) the reporting, collection, and validation of the data; (3) the structure of value-based payment adjustments such as the determination of thresholds for a payment adjustment, the size of the payment adjustment and the sources of funding for the value-based payments; and (4) the disclosure of information on hospital performance. The Secretary will consult with relevant affected parties and consider experience with applicable demonstration programs.

The Secretary is required to submit a report to Congress on the plan for the value-based purchasing program no later than August 1, 2007. The Medicare Payment Advisory Commission (MedPAC) is required to submit a report with detailed recommendations on the structure of the valued based payment adjustments no later than June 1, 2007. The report will include (1) a determination of thresholds, size of payments, sources of funds, and relationship of payments to quality measures; (2) analyses of hospital efficiency measures such as costs per discharge, related services (including physician services) within an episode of care; and (3) an identification of other changes that are needed within the IPPS payment structure.

Starting for discharges on October 1, 2007, hospitals are required to report any secondary diagnosis codes applicable to patients at their admission. By October 1, 2007, the Secretary is required to identify at least 2 high cost or high volume (or both high cost and high volume) diagnoses codes with a DRG assignment that has a higher payment

weight when present with secondary diagnoses. These diagnoses codes represent conditions, including certain hospital acquired infections, that could reasonably have been prevented through the application of evidence-based guidelines. Starting for discharges on October 1, 2008, the DRG assigned to a discharge with the identified diagnosis codes will be the DRG that does not result in higher payments based on the presence of these secondary diagnosis codes. This assignment of the lower paid DRG applies to discharges, where, at the time of the patient's admission, the beneficiary had none of the identified diagnosis codes. Adjustments to the relative weight that occur because of this action are not budget neutral. Specifically, aggregate payments for discharges in a fiscal year could be changed as a result of such adjustments.

The list of selected diagnosis may be revised from time to time as long as there are at least two conditions selected for discharges occurring during any fiscal year. The Secretary is required to consult with the Centers for Disease Control and Prevention and other appropriate entities when selecting and revising the identified diagnosis codes. The list of diagnosis codes and DRGs are not subject to judicial review.

Clarification of Determination of Medicaid Patient Days for DSH Computation (Section 5002 of the Conference Agreement, no provision in the Senate Bill and no provision in the House Bill) .

Current Law

Hospitals that serve a certain number of low income Medicare and Medicaid beneficiaries will receive a disproportionate share hospital (DSH) adjustment that increases their Medicare IPPS payments. Most DSH hospitals receive the additional payments based on their DSH patient percentage which is the proportion of the hospital's total days provided to Medicaid recipients added to the proportion of the hospital's Medicare inpatient days provided to poor Medicare beneficiaries (those who are eligible for Part A and receive Supplemental Security Income.) After a minimum threshold of 15 percent is met, a hospital's DSH adjustment will vary by the hospital's bed size or urban or rural location.

The policy of whether inpatient days provided to a patient covered under a demonstration project established by Section 1115 waivers could be included in the Medicare DSH calculation has changed over time. Prior to January 20, 2000, hospitals could not include the inpatient hospital days attributable to patients made eligible for Medicaid pursuant to a state's Social Security Act Section 1115 waiver. Starting on January 20, 2000, hospitals could include days for populations under the section 1115 waiver who were or could have been made eligible under a State Medicaid plan. This policy was corrected for discharge starting on October 1, 2003, when hospital inpatient days attributed to patients who do not receive coverage for inpatient benefits under Section 1115 demonstration projects could not be counted in the Medicare DSH calculation. These policies were established by regulation in January, 2000 and August, 2003.

Senate Bill

No provision.

House Bill

No provision.

Conference Agreement

The conference agreement permits the Secretary to include inpatient hospital days of patients eligible for medical assistance under a Section 1115 demonstration waiver in the Medicare DSH calculation. These days will be counted as if they were provided to patients who were eligible for medical assistance under an approved Medicaid state plan. The existing regulations and their effective date are ratified. No hospital cost reports that are closed on the enactment date will be reopened to implement this provision.

Improvements to the Medicare-Dependent Hospital (MDH) Program (Section 5003 of the Conference Agreement, Section 6101 of the Senate Bill, and no provision in the House Bill).

Current Law

Certain rural hospitals with 100 beds or less that have at least 60% of its inpatient days or discharges during FY1987 or during two of the three most recently audited cost reporting periods (for which there is a settled cost report) are attributed to patients covered under Medicare qualify for special treatment under the inpatient prospective payment system as Medicare dependent hospitals (MDH). MDH hospitals are paid at national standardized rate or, if higher, 50% of their adjusted FY1982 or FY1987 hospital-specific costs. This special treatment will lapse for discharges starting on October 1, 2006.

Certain hospitals that serve a high proportion of Medicaid patients or poor Medicare beneficiaries qualify for a disproportionate share hospital (DSH) adjustment to their inpatient payments. Small urban and most rural hospitals (except for rural referral centers) have their DSH adjustment capped at 12%.

Senate Bill

The MDH status for qualifying rural hospitals would be extended through discharges occurring before October 1, 2011. Starting for discharges on October 1, 2006, a MDH would be able to elect payments based of its FY2002 hospital-specific costs if that would result in higher Medicare payments. MDH's payments would be based on 75% of their adjusted hospital-specific costs starting for discharges on October 1, 2006. MDH's that qualify for a disproportionate share hospital (DSH) adjustment would not have the adjustment capped at 12%

House Bill

No provision.

Conference Agreement

The conference agreement adopts the Senate provision.

Reduction in Payments to Skilled Nursing Facilities for Bad Debt (Section 5004 of the Conference Agreement, Section 6102 of the Senate Bill, and no provision in the House Bill).

Current Law

Medicare pays for the costs of certain items outside of the Prospective Payment System on a reasonable costs basis. Section 1861(v)(1)(A)(I) of the Social Security Act states that the costs for individuals covered by the Medicare program must not be borne by individuals not covered by the program, and the costs for individuals not covered by the program must not be borne by Medicare. Under this authority, the Secretary adopted a bad debt policy in 1966. Under this policy, Medicare reimburses certain providers for debt unpaid by beneficiaries for coinsurance and deductibles. Historically, CMS has reimbursed certain providers for 100% of this bad debt. SNFs are among the Medicare entities that are currently being reimbursed for 100% of beneficiary's bad debt.

Effective beginning with cost reports starting in FY2001, Medicare began reimbursing hospitals for 70% of the reasonable costs associated with beneficiaries' bad debt. In 2003, CMS issued a proposed rule (42 CFR Part 413, Medicare Program; Provider Bad Debt Payment) in which it described its intent to reduce reimbursement of bad debt for certain providers, including SNFs, by 30%. Within the rule, CMS explained that it believed that reducing the amount of Medicare debt reimbursement would encourage accountability and foster an incentive to be more efficient in bad debt collection efforts. It also stated that it believed that Medicare bad debt policy should be applied consistently and fairly among all providers eligible to receive bad debt reimbursement.

Senate Bill

The provision would amend Section 1861(v)(1) of the Social Security Act to reduce the payment for the allowable bad debts attributable to Medicare deductibles and coinsurance amounts by 30% for services furnished in SNFs on or after October 1, 2005.

House Bill

No provision.

Conference Agreement

The conference agreement reduces payments for allowable bad debts attributable to Medicare coinsurance by 30% for those individuals who are not dually eligible for Medicare and Medicaid. Bad debt payments for individuals who are dually eligible for Medicare and Medicaid remain at 100%.

Extended Phase-in of the Inpatient Rehabilitation Facility Classification Criteria (Section 5005 of the Conference Agreement, Section 6103 of the Senate Bill, and no provision in the House Bill).

Current Law

Inpatient rehabilitation facilities (IRFs) are either freestanding hospitals or distinct part units of other hospitals that are exempt from Medicare's inpatient prospective payment system (IPPS) used to pay short-term general hospitals. The Medicare statute gives the Secretary discretion to establish the criteria that facilities must meet in order to be considered an IRF. Since 1983, CMS has required that a facility must treat a certain proportion of patients with specified medical conditions in order to qualify as an IRF and receive higher Medicare payments. The rule was suspended temporarily and reissued in 2004 with a revised set of qualifying conditions and a transition period for the compliance threshold as follows: at 50% from July 1, 2004 and before July 1, 2005; at 60% from July 1, 2005 and before July 1, 2006; at 65 % from July 1, 2006 and before

July 1, 2007; and at 75% from July 1, 2007 and thereafter. In April 2005, the Governmental Accountability Office issued a final report recommending that the Centers for Medicare and Medicaid Services (CMS) refine the rule to describe more thoroughly the subgroups of patients within a condition that require IRF services, possibly using functional status or other factors in addition to condition, to help ensure that IRFs can be classified appropriately and that only patients needing IRF services are admitted.

Senate Bill

The provision would establish the compliance threshold at 50% from July 1, 2005 through June 30, 2007. The Secretary would not be permitted to change the designation of an IRF that is in compliance with that threshold. The Secretary would be required to restore the status of a facility as an IRF from July 1, 2005 through the effective date of this provision because of not meeting the 60% threshold. The Secretary would be required to make appropriate payments to those facilities. IRFs that failed to meet the 50% compliance threshold would be deemed to meet that threshold while an additional 6 months of claims data is examined. If the review of the new data indicates that the IRF is not in compliance with the 50% threshold, the IRF's deemed status would be revoked retroactively to the beginning of the 6 month period. The Secretary would collect any overpayments made to the IRF. The Inspector General would be required to analyze the types of patients treated in IRFs that have a compliance rate between 50% and 60%. A report would be submitted to Congress and the Secretary by January 1, 2005. A Rehabilitation Advisory Council would be established until September 30, 2010 to provide advice and recommendations concerning coverage of rehabilitation services under the Medicare program.

House Bill

No provision.

Conference Agreement

The conference agreement establishes the compliance threshold at 60% during the 12-month period beginning on July 1, 2006; at 65% during the 12-month period beginning on July 1, 2007; and at 75% beginning on July 1, 2008 and subsequently. The conferees encourage CMS to conduct additional research and study on this issue.

Development of a strategic plan regarding physician investment in specialty hospitals (Section 5006 of the Conference Agreement, Section 6104 of the Senate Bill, and no provision in the House Bill).

Current Law

Physicians are generally prohibited from referring Medicare and Medicaid patients to facilities in which they (or their immediate family member) have financial interests. Physicians, however, are not prohibited from referring patients to hospitals where they have ownership or investment interest in the whole hospital itself (and not merely in a subdivision of the hospital). Section 507 of the Medicare Prescription Drug Improvement, and Modernization Act of 2003 (MMA) established that the exception for physician investment and self-referral would not extend to specialty hospitals for a period of 18-months from enactment (or until June 8, 2004). In this instance, a specialty hospital is primarily or exclusively engaged in the care and treatment of patients with a cardiac condition, an orthopedic condition, those receiving a surgical procedure, or other

specialized category of patient or cases that the Secretary designates as inconsistent with the purpose of permitting physician investment in a hospital. A specialty hospital does not include any hospital that is determined by the Secretary to be in operation or under development as of November 18, 2003, with the same number of physician investors as of such date that meets other specified requirements. For instance, an increase in the number of beds could only occur on the main campus of the hospital and could not exceed the greater of 50% of the number of beds in the hospital as of November 18, 2003, or 5 beds. The Secretary was directed to consider the certain factors in determining whether a hospital is under development, such as the completion of architectural plans, and the status of funding, zoning requirements, and necessary approvals from State agencies.

Senate Bill

The prohibition on Medicare and Medicaid referrals to specialty hospitals by physician investors would be effective on and after December 8, 2003. The exception to the definition of specialty hospital would be modified to include those: (1) where the percent investment by physician investors is no greater than the percentage on June 8, 2005; (2) where the percent investment by any physician investor is no greater than the percentage on June 8, 2005; and (3) where the number of operating rooms is not greater than the number on June 8, 2005. The existing requirement concerning permissible changes in the number of beds in order to qualify for the specialty hospital exception would be modified. From December 8, 2003 through June 7, 2005, an acceptable increase in the number of beds would only occur on the main campus of the hospital and could not exceed the greater of 50% of the number of beds in the hospital as of November 18, 2003, or 5 beds. After June 8, 2005, the number of beds at the specialty hospital would not be able to increase. These amendments would be effective on June 8, 2005.

House Bill

No provision.

Conference Agreement

The conference agreement directs the Secretary to develop a strategic and implementing plan regarding physician investment in specialty hospitals that addresses issues related to proportionality of investment return, bona fide investments, annual disclosure of investment information, and the provision of Medicaid and charity care by specialty hospitals. An interim report is due within three months and a final report no later than six months after date of enactment. The Secretary will continue the suspension on enrollment of new specialty hospitals until the earlier of the date of submission of the report or 6 months after date of enactment. If the Secretary fails to comply with the statutory requirement to submit the final report within the six month time period, then the suspension on enrollment will be extended an additional two months. In developing the strategic and implementing plan the Secretary may waive certain requirements under the Administrative Procedures Act.

Medicare demonstration projects to permit gainsharing arrangements (Section 5007 of the Conference Agreement, no provision in the Senate bill, and no provision in the House Bill).

Current Law

No provision.

Senate Bill

No provision.

House Bill

No provision.

Conference Agreement

The conference agreement establishes a gainsharing demonstration project to test and evaluate arrangements between hospitals and other providers, including physicians, and practitioners, that govern the utilization of inpatient hospital resources to improve the quality and efficiency of care provided to Medicare beneficiaries and to improve operational efficiency and performance. The Secretary will solicit applications 90 days after enactment, will approve not more than 6 demonstration projects with at least 2 of which will be in a rural area, and will begin on January 1, 2007.

The projects will meet certain requirements to maintain or improve quality while achieving cost savings. Such requirements include arrangements that provide remuneration as a share of savings, a written plan agreement, patient notification, quality and efficiency monitoring, independent review, and referral limitations. Restrictions on incentive payments in a project are waived, and similar protections extend to existing arrangements.

Not later than December 1, 2006, the Secretary will report to Congress on the number of demonstration projects. Not later than December 1, 2007, the Secretary will provide a project update to Congress including improvements toward quality and efficiency. By December 1, 2008, the Secretary will report to Congress on quality improvement and savings from the program. A final report will be submitted to Congress by May 1, 2010.

Post-acute care payment reform demonstration (Section 5008 of the Conference Agreement, no provision in the Senate bill, and no provision in the House Bill).

Current Law

No provision.

Senate Bill

No provision.

House Bill

No provision.

Conference Agreement

By January 1, 2008, the Secretary shall establish a demonstration program to better understand costs and outcomes across different post-acute care sites. Under the program,

for certain diagnoses specified by the Secretary, an individual receiving treatment for such diagnosis shall receive a comprehensive assessment on the date of discharge of clinical characteristics and patient needs, to determine appropriate placement of the patient in a post-acute care site. The Secretary shall use a standardized patient assessment instrument across all post-acute sites, to measure functional status and other factors during treatment and discharge from each provider. Participants shall provide information on the fixed and variable cost for each individual, and an additional comprehensive assessment shall be provided at the end of the individual's episode of care. The program will operate for a three year period, and shall be conducted with sufficient numbers to determine statistically reliable results.

No later than 6 months after the end of the program, the Secretary will submit a report to Congress on results and recommendations.

Subtitle B - Provisions Relating to Part B

Chapter 1-Payment Provisions .

Beneficiary Ownership of Certain DME (Section 5101 of the Conference Agreement, Sections 6109 and Section 6116 of Senate bill, no provision in the House bill) .

Current Law

Medicare Part B pays for certain items of durable medical equipment such as hospital beds, nebulizers and power-driven wheelchairs under the capped rental category. Most items in this category are provided on a rental basis for a period that cannot exceed fifteen months. After using the equipment for ten months, beneficiaries must be given the option of purchasing it effective thirteen months after the start of the rental period. If they choose the purchase option, the title to the equipment is transferred to beneficiaries. If the purchase option is not chosen, the supplier retains ownership of the equipment. Beneficiaries can continue to use it, but Medicare rental payments to the supplier are terminated. In the case of a power-driven wheelchair, the supplier must offer the beneficiary the option of purchasing the equipment when it is first furnished.

Medicare payments to suppliers for maintenance and servicing differ based on whether the beneficiary has purchased the equipment or whether the supplier continues to own it. In the case of a purchase agreement, payment for repairs and extensive maintenance recommended by the manufacturer is covered. When the equipment remains in the ownership of the supplier and continues to be used by a beneficiary after the fifteen month rental period, Medicare makes a payment to the supplier every six months for servicing and maintenance regardless of whether any maintenance and servicing is performed.

Senate Bill

The Senate bill would require the supplier to transfer the title of durable medical equipment in the capped rental category to the beneficiary after a thirteen month rental period. The option for a fifteen month rental period with the supplier retaining ownership of the item would be eliminated. The option for beneficiaries to purchase power-driven wheelchairs when initially furnished would be retained.

Automatic payments to the supplier every six months for maintenance and servicing would be eliminated. Such payments (for parts and labor not covered by the supplier's or manufacturer's warranty) would only be made if the Secretary determined them to be reasonable and necessary. This amendment would apply to items for which the first rental month occurred on or after January 1, 2006.

House Bill

No provision

Conference Agreement

The conference agreement includes the Senate bill. The provisions apply to items for which the first rental month occurs on or after January 1, 2006

The agreement further provides that rental payments for oxygen equipment (including portable oxygen equipment) are converted to ownership at 36 months. The supplier is required to transfer the title of the equipment to the beneficiary after an 36 month rental period. After transfer of the title, monthly payments for oxygen contents (in the case of gaseous and liquid oxygen) will continue to be made, as provided for under current law, for the period of medical need. Payments for maintenance and servicing (for parts and labor not covered by the supplier's or manufacturer's warranty) will be made if the Secretary determines them to be reasonable and necessary. The agreement specifies that the provision takes effect on January 1, 2006. In the case of an individual receiving oxygen equipment as of December 31, 2005, the 36-month period begins January 1, 2006.

Adjustments in Payments for Imaging Services (Section 5102 of the Conference Agreement, no provision in the Senate Bill and no provision in the House Bill).

Current Law

Medicare has a long-standing policy of reducing payment for multiple surgical procedures performed by the same physician, on the same patient on the same day. Full payment is made for the highest priced procedure, with any subsequent procedure paid at 50%. In 1995, the policy was extended to certain nuclear medicine diagnostic procedures.

Under the physician fee schedule, diagnostic imaging procedures are priced as follows: (1) the professional component (PC) represents the physician work, i.e. the interpretation; (2) the technical component (TC) represents practice expenses including clinical staff, supplies, and equipment; and (3) the global service which represents both the PC and TC. Diagnostic imaging services, even those paid on contiguous body parts, are generally paid at 100% for each procedure.

In its March 2005 report, *Medicare Payment Policy*, the Medicare Payment Advisory Commission recommended that CMS expand its coding edit policy to help the program pay more accurately for multiple imaging services performed during the same encounter. It noted that a number of private plans use coding edits to adjust payments for multiple imaging services performed on contiguous body parts. Private insurers usually pay the full amount for the first service but a reduced amount (usually half) for the technical component of any additional study that is of the same modality. This is based on the premise that there are savings in clerical time, preparation, and supplies.

In August 2005, CMS issued its proposed physician fee schedule for 2006 (*Federal Register*, vol. 70, no. 151, 45764-46064). CMS noted that its analysis supported a 50% reduction in the TC for the subsequent imaging procedure performed on contiguous body parts. It did not propose to apply the multiple procedure reduction to PC services because it believed that physician work is not significantly affected for multiple procedures. When a global service code is billed, the TC portion, but not the PC portion, would be reduced. CMS identified 11 families of imaging procedures by imaging modality. It recommended extending the multiple procedure TC payment reduction only to procedures involving contiguous body parts within a family of codes, not across families.

On November 21, 2005, CMS issued its final physician fee schedule regulation for 2006 (*Federal Register*, vol 70, no. 223,70116-70476). It retained the proposed reduction with modifications. The payment reduction is to be phased-in with a 25% reduction in 2006 and a 50% reduction in 2007. Further, the budget neutrality adjustment is to be applied only to practice expense relative value units rather than to both work and practice expense relative value units.

When the Secretary revises the relative values for the work, practice expense and malpractice components of physician payments, the revisions may not change the amount of physician expenditures by more than \$20 million. Thus, changes must be budget neutral. When reducing practice expenses for imaging, the Secretary is required to increase practice expenses for other physician services to maintain budget neutrality.

Senate Bill

No provision.

House Bill

No provision.

Conference Agreement

The conference agreement specifies that, effective for fee schedules established beginning with 2007, the reduced expenditures attributable to the multiple procedure payment reduction for imaging (under the final rule published November 21, 2005) will not be taken into account for purposes of the budget neutrality calculation for fee schedules for 2006 and 2007.

The agreement further provides that for specified imaging services furnished on or after January 1, 2007, the technical component (including the technical component of the global fee) for a service will be reduced if it exceeds (without regard to the geographic wage adjustment factor) the outpatient department (OPD) fee schedule amount for the service established under the prospective payment system for hospital outpatient departments. In such cases, the Secretary will provide for the use of that OPD amount, adjusted by the geographic adjustment factor under the physician fee schedule. The services this policy applies to are: imaging and computer-assisted imaging services, including X-ray, ultrasound (including echocardiography), nuclear medicine (including positron emission tomography), magnetic resonance imaging, computed tomography, and fluoroscopy. Not included are diagnostic and screening mammography. This change will not be taken into account for purposes of the budget neutrality calculation beginning in 2007.

This provision moves toward payment neutrality across sites of service delivery.

Limitation on Payments for Procedures in Ambulatory Surgical Centers (Section 5103 of the Conference Agreement, no provision in the Senate Bill, and no provision in the House Bill) .

Current Law

Medicare uses a fee schedule to pay for the facility services related to a surgery provided in an ambulatory care surgery center (ASC). The associated physician services (surgery and anesthesia) are reimbursed under the physician fee schedule. CMS maintains a list of approved ASC procedures which is required to be updated every two years. The approved ASC procedures are categorized into one of nine payment groups that comprise the ASC facility fee schedule. The nine payment rates reflect the national median cost of procedures in that group adjusted to reflect geographic price variation.

The Secretary is required under the MMA to implement a new payment system for ASCs no later than January 2008.

Medicare reimbursement for hospital outpatient department (OPD) services is based on a fee schedule established by a separate prospective payment system (OPPS). Under OPPS, the unit of payment is the individual service or procedure as assigned to an ambulatory payment classification (APC). The payment rate for each service is determined by multiplying the relative weight for the service's APC by the conversion factor.

Senate Bill

No provision.

House Bill

No provision.

Conference Agreement

Beginning on January 1, 2007, when the ASC facility payment (without application of any geographic price differences) is greater than the Medicare OPD fee schedule amount established under OPPS (without application of any geographic adjustment) for the same service, the ASC will be paid the OPD fee schedule amount. This adjustment applies to ASC payments until the revised ASC payment system is implemented. Total payments to ASCs will be held budget neutral between the year prior to implementation of the new payment system and the first year of the new payment system.

This provision moves toward payment neutrality across sites of service delivery.

Update for Physicians' Services for 2006 (Section 5104 of the Conference Agreement, Section 6105 of Senate bill, and no provision in the House Bill) .

Current Law

Medicare payments for services of physicians and certain nonphysician practitioners are made on the basis of a fee schedule. The fee schedule assigns relative values to services that reflect physician work (i.e., the time, skill, and intensity it takes to provide

the service), practice expenses, and malpractice costs. The relative values are adjusted for geographic variations in costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor. The conversion factor for 2005 is \$37.8975.

The conversion factor is the same for all services. It is updated each year according to a formula specified in law. The intent of the formula is to place a restraint on overall spending for physicians' services. Several factors enter into the calculation of the formula. These include: (1) the sustainable growth rate (SGR) which is essentially a cumulative target for Medicare spending growth over time (with 1996 serving as the base period); (2) the Medicare economic index (MEI) which measures inflation in the inputs needed to produce physicians services; and (3) the update adjustment factor which modifies the update, which would otherwise be allowed by the MEI, to bring spending in line with the SGR target. In no case can the adjustment factor be less than minus seven percent or more than plus three percent.

The law specifies a formula for calculating the SGR. It is based on changes in four factors: (1) estimated changes in fees; (2) estimated change in the average number of Part B enrollees (excluding Medicare Advantage beneficiaries); (3) 10-year rolling average change in real gross domestic product (GDP) growth per capita; and (4) estimated change in expenditures due to changes in law or regulations.

The SGR target is not a limit on expenditures. Rather, the fee schedule update reflects the success or failure in meeting the target. If expenditures exceed the target, the update for a future year is reduced. This is what occurred for 2002. It was also slated to occur in 2003 and 2004; however, the MMA prevented this from occurring through 2005. A negative 4.4 percent update is slated to occur in 2006.

Senate Bill

The Senate bill would specify that the update to the conversion factor in 2006 could not be less than one percent. The provision would further specify that these amendments would not be considered as a change in law for purposes of calculating the SGR.

House Bill

No provision.

Conference Agreement

The conference agreement specifies that the update for 2006 is zero percent. These amendments are not considered as a change in law for purposes of calculating the SGR.

MedPAC is required to report to Congress by March, 2007 on mechanisms to replace the Sustainable Growth Rate system.

Three-year Transition of the Hold Harmless Payments for Small Rural Hospitals Under the Prospective Payment System For Hospital Outpatient Department Services (Section 5105 of the Conference Agreement, Section 6106 of the Senate Bill, and no provision of the House Bill) .

Current Law

The prospective payment system for services provided by hospital outpatient departments (OPD) was implemented in August 2000 for most acute care hospitals. Under hold harmless provisions, as modified by the MMA, rural hospitals with no more than 100 beds and sole community hospitals (SCH) located in rural areas are paid no less under this payment system than they would have received under the prior reimbursement system for covered OPD services provided before January 1, 2006.

Senate Bill

The hold harmless provisions governing OPD reimbursement for small rural hospitals and rural SCH would be extended to January 1, 2007.

House Bill

No provision.

Conference Agreement

The conference agreement establishes that small rural hospitals (with no more than 100 beds that are not SCHs) can receive additional Medicare payments, if their outpatient payments under the prospective payment system are less than under the prior reimbursement system. For calendar year (CY) 2006, these hospitals will receive 95% of the difference between the prospective payment system and the prior reimbursement system. The hospitals will receive 90% of the difference in CY2007 and 85% of the difference in CY2008.

On November 10, 2005, CMS issued its final hospital outpatient prospective payment system regulation for CY 2006 (*Federal Register*, vol 70, no. 217, 68516-68980). Under this rule, rural sole community hospitals will receive a 7.1 percent increase on January 1, 2006.

Update to the Composite Rate Component of the Basic Case-Mix Adjusted Prospective Payment System for Dialysis Services (Section 5106 of the Conference Agreement, Section 6107 of the Senate Bill, no provision in the House Bill) .

Current Law

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) required the Secretary to establish a basic case-mix adjusted prospective payment system for dialysis services furnished either at a facility or in a patient's home, for services furnished beginning on January 1, 2005. The basic case-mix adjusted system has two components: (1) the composite rate, which covers services, including dialysis; and (2) a drug add-on adjustment for the difference between the payment amounts for separately billable drugs and biologicals and their acquisition costs, as determined by the Inspector General Report.

The Secretary is required to update the basic case-mix adjusted payment amounts annually beginning with 2006, but only for that portion of the case-mix adjusted system that is represented by the add-on adjustment and not for the portion represented by the composite rate.

Senate Bill

The provision would increase the composite rate component of the basic case-mix adjusted system for services beginning January 1, 2006 by 1.6% above the amount paid for such services furnished on December 31, 2005.

House Bill

No provision.

Conference agreement

The conference agreement follows the Senate bill.

Revisions to Payments for Therapy Services (Section 5107 of the Conference Agreement, Section 6108 of Senate Bill and no provision in the House Bill).

Current Law

The Balanced Budget Act of 1997 established annual per beneficiary payment limits for all outpatient therapy services provided by non-hospital providers. The limits applied to services provided by independent therapists as well as to those provided by comprehensive outpatient rehabilitation facilities (CORFs) and other rehabilitation agencies. The limits did not apply to outpatient services provided by hospitals.

Beginning in 1999, there were two beneficiary limits. The first was a \$1,500 per beneficiary annual cap for all outpatient physical therapy services and speech language pathology services. The second was a \$1,500 per beneficiary annual cap for all outpatient occupational therapy services. Beginning in 2002, the amount would increase by the Medicare economic index (MEI) rounded to the nearest multiple of \$10.

The Balanced Budget Refinement Act of 1999 (BBRA) suspended application of the limits for 2000 and 2001. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) extended the suspension through 2002. Implementation of the provision was delayed until September 2003. The caps were implemented from September 1, 2003 through December 7, 2003. MMA reinstated the moratorium from December 8, 2003 through December 31, 2005. The caps are slated to go into effect beginning January 1, 2006. In the November 2005 final physician fee schedule regulation for 2006 CMS announced that the caps would be \$1,740 in 2006.

Senate Bill

The Senate bill would extend the moratorium for an additional year, through 2006.

House Bill

No provision.

Conference Agreement

The conference agreement would not extend the therapy cap moratorium. However, the Secretary would be required to implement an exceptions process for expenses incurred in 2006. Under the process, a Part B enrollee, or a person acting on behalf of the enrollee, may request an exception from the physical therapy/speech language pathology and occupational therapy caps. The individual may obtain such exception if the provision of services is determined medically necessary. If the Secretary does not make a decision

on a request within 10 business days of receipt, the Secretary is deemed to have found the services medically necessary. The provision may be implemented by program instruction or otherwise. The agreement specifies that there can be no administrative or judicial review of the exceptions process (including establishment of the process).

The agreement requires the Secretary, by July 1, 2006, to implement clinically appropriate coding edits for physical therapy services, occupational therapy services, and speech language pathology services. The edits are to identify and eliminate improper payments. The edits are to include edits of clinically illogical combinations of procedure codes and other edits to control inappropriate billings.

Chapter 2- Miscellaneous .

Accelerated Implementation of Income-Related Reduction in Part B Premium Subsidy (Section 5111 of the Conference Agreement, no provision in the Senate Bill, no provision in the House Bill) .

Current Law

The MMA increased the Part B premiums for higher income enrollees beginning in 2007. In 2007, individuals whose modified adjusted gross income (AGI) exceeds \$80,000 and couples whose modified AGI exceeds \$160,000 will be subject to higher premium amounts. The increase will be phased-in over five years. During the first year, higher income enrollees will pay premiums ranging from 27% to 36% of the value of Part B. When fully phased-in, higher income individuals will pay premiums ranging from 35% to 80% of the value of Part B.

Senate Bill

No provision.

House Bill

No provision.

Conference Agreement

The agreement accelerates the phase-in period from five years to three years, with the provision fully effective in 2009. In 2007, higher income enrollees will pay total premiums ranging from 28% to 43% of the total value of Part B. In 2008, enrollees will pay total premiums ranging from 32% to 62% of the total value of Part B. When fully phased-in in 2009, higher income individuals will pay total premiums ranging from 35% to 80% of the total value of Part B.

Medicare Coverage of Ultrasound Screening for Abdominal Aortic Aneurysms; (Section 5112 of the Conference Agreement, Section 6117 of Senate Bill and no provision in the House Bill) .

Current Law

Medicare provides coverage for services which are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. In addition, Medicare covers certain preventive services specified in law.

Senate Bill

The Senate bill would authorize Medicare coverage of ultrasound screening for abdominal aortic aneurysms for individuals who: 1) received referrals for such screenings as a result of an initial preventive physical exam performed for new Medicare enrollees; 2) who had not previously had such a test covered by Medicare; and 3) who had a family history of abdominal aortic aneurysms or who manifested risk factors included in a beneficiary category (not related to age) identified by the United States Preventive Services Task Force.

An ultrasound screening for abdominal aortic aneurysms would be defined as a procedure using sound waves provided for the early detection of abdominal aortic aneurysms. The Secretary could specify other procedures using alternative technologies which were of commensurate accuracy and cost. The term would include the physician's interpretation of the results of the procedure. Ultrasound screening for abdominal aortic aneurysms would be included in the package of services (including related education, counseling and referral) provided in the initial preventive service exam offered to new Medicare enrollees.

Payment for services would be made under the physician fee schedule. The provision would specify that payment would not be made for screenings performed more frequently than specified above. The Part B deductible would not apply to these services.

The Secretary would be required to establish quality assurance standards, in consultation with national medical, vascular technologist and sonographer societies, with respect to individuals (other than physicians) performing ultrasound screening for abdominal aortic aneurysms and diagnostic laboratories. Such standards would specify that the individual or laboratory was certified by the appropriate state licensing or certifying agency or (in the case of a state which did not license or certify such individuals or laboratories) by a national accreditation agency recognized by the Secretary. Medicare payment would not be made where individuals or laboratories performing the screening did not meet the quality assurance standards.

The bill would require the Secretary (after consultation with national medical, vascular technologist and sonographer societies) to conduct a national education and information campaign to promote awareness among health care practitioners and the general public with respect to the importance of early detection and treatment of abdominal aortic aneurysms. The section would authorize the appropriation of such funds as may be necessary, beginning in FY 2006 and each fiscal year thereafter. The Secretary could use such amounts to make grants to national medical, vascular technologist and sonographer societies to enable them to educate practitioners and providers about matters relating to such aneurysms. Such grants would be made in accordance with procedures and criteria specified by the Secretary.

The amendments would apply to ultrasound screenings for abdominal aortic aneurysms performed on or after January 1, 2007.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate bill with modifications. The agreement does not specify that beneficiary categories recommended for screening cannot include categories related to age. The agreement does not provide for the development of quality assurance standards. Further, it does not include the national education and information campaign.

Improving Patient Access to, and Utilization of, Colorectal Cancer Screening Under Medicare (Section 5113 of the Conference Agreement, Section 6118 of the Senate Bill and no provision in the House Bill) .

Current Law

Medicare covers certain cancer screening tests, subject to coverage limitations based on the type of test and the individual's level of risk. Covered tests are fecal occult blood test, flexible sigmoidoscopy, screening colonoscopy, and barium enema. Payments for services are made under the physician fee schedule which assigns relative values to services based on physician work, practice expense costs, and malpractice costs. The relative values are then adjusted for geographic variations in costs. These adjusted relative values are converted into dollar payment amounts by a conversion factor.

The Secretary is required to review and adjust relative values for specific services periodically, and has established a process for this review and adjustment.

Senate Bill

The Senate bill would require the Secretary to establish minimum payment amounts for CPT codes 45378, (diagnostic colonoscopy), 45380 (colonoscopy and biopsy), and 45385 (lesion removal, colonoscopy) and HCPCS codes G0105 (colorectal screen, high risk individual) and G0121 (colon cancer screen, not high risk individual) for items and services furnished after January 1, 2007. The amounts would reflect a 5 percent increase above the relative value units in effect as the non-facility rates for such codes on December 31, 2006; the revised payment levels would apply to items and services furnished in non-facility settings. Similarly, the provision would require the Secretary to establish minimum payment amounts for the same CPT and HCPCS codes for items and services furnished after January 1, 2007 which would reflect a 5 percent increase above the relative value units in effect as the facility rates for such codes on December 31, 2006; the revised payment levels would apply to items and services furnished in facility settings. The payment amounts would be adjusted annually in accordance with the payment update rules under the fee schedule. The Secretary would not take into account the revised payment amounts in determining the amount of payment under the prospective payment system for covered hospital outpatient department services.

The bill would also authorize Medicare coverage for an office visit or consultation prior to a screening colonoscopy or in connection with a beneficiary's decision to obtain such a screening. The visit or consultation would be for the purpose of beneficiary education, assuring selection of the proper screening test, and securing information relating to the procedure and sedation of the beneficiary. The visit or consultation would be covered regardless of whether the screening was medically indicated for the beneficiary. Payments would equal 80 percent of the lesser of the actual charge or the amount established under the physician fee schedule. Payment amounts established under

the fee schedule would be consistent with those established for CPT codes 99203 (office/outpatient visit, new patient) and 99243 (office consultation). The provision would apply to services furnished on or after January 1, 2007.

The Part B deductible would not apply to colorectal cancer screening tests, effective January 1, 2007.

House Bill

No provision.

Conference Agreement

The conference agreement only includes the Senate provision waiving the Part B deductible.

Delivery of Services at Federally Qualified Health Centers (Section 5114 of the Conference Agreement, Section 6115 of the Senate Bill, and no provision in the House Bill)

Current Law

The Omnibus Budget Reconciliation Act (OBRA) of 1989 amended the Social Security Act (SSA) to create a new category of facility under Medicare and Medicaid known as a federally qualified health center (FQHC). An FQHC is required to provide certain primary care services by physicians and appropriate mid-level practitioners as well as other preventive health services including those required under certain sections of the Public Health Service (PHS) Act (specifically Sections 329, 330, and 340 of the PHS).

Prior to the enactment of MMA, FQHC services were covered by a skilled nursing facility's (SNF) consolidated billing requirement. FQHC services were bundled into the SNF comprehensive per diem payment for the covered stay and not separately billable. MMA specified that a SNF Part A resident who receives FQHC services from a physician or appropriate practitioner would be excluded from SNF consolidated billing and be paid separately.

Senate Bill

The provision would add diabetes self-management training and nutrition therapy benefits, as covered under Medicare, as additional services that may be covered under the all-inclusive per visit payment rate for FQHCs. It would allow FQHCs to receive payments for services provided through a health care professional who contracts with the center and would remove restrictions on receipt of homeless grants.

House Bill

No provision.

Conference Agreement

The conference agreement adopts the Senate provision.

Waiver of Part B Late Enrollment Penalty for Certain International Volunteers (Section 5115 of the Conference Agreement, Section 6114 of the Senate Bill and no provision in the House Bill).

Current Law

Medicare Part B is a voluntary program. Individuals generally enroll in Part B when they turn 65. Individuals who delay enrollment in the program after their initial enrollment period are subject to a premium penalty. This penalty is a surcharge equal to 10% of the premium amount for each 12 months of delayed enrollment. There is no upper limit on the amount of the surcharge that may apply. Further, the penalty continues to apply for the entire time the individual is enrolled in Part B. The law establishes certain exceptions to the delayed enrollment penalty. One exception applies to the "working aged." Delayed enrollment is also permitted for certain disabled persons who have group health insurance coverage based on their own or a family member's current employment with a large group health plan.

Individuals who are permitted to delay enrollment have their own special enrollment periods. A special enrollment period begins when current employment ends or when coverage under the plan ends. The special enrollment period ends eight months later. Individuals who fail to enroll in this period are considered to have delayed enrollment and could become subject to the penalty.

Senate Bill

The Senate bill would permit certain individuals to delay enrollment in Part B without a delayed enrollment penalty. Those individuals who volunteer outside of the United States for at least 12 months through a program sponsored by a tax-exempt organization defined under section 501(c)(3) of the Internal Revenue Code would be permitted to delay enrollment under Medicare Part B. They would have a 6 month special Part B enrollment period beginning on the first day of the month the individual was no longer in the program. Coverage would begin the month after the individual enrolled. This section would apply to months and special enrollment periods beginning January 2007.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate bill with a modification. The provision applies to individuals who can demonstrate health insurance coverage while volunteering outside the United States..

Coverage of Marriage and Family Therapist Services and Mental Health Counselor Services Under Part B of the Medicare Program (No provision in the Conference Agreement, Section 6119 of the Senate bill and no provision in the House Bill).

Current Law

Medicare provides coverage for mental health services, subject to certain limitations. Medicare Part B will make direct payments to physicians, psychologists, and clinical social workers for such services. Medicare does not make direct payments for services provided by marriage and family therapists and mental health counselors. Their services are generally paid as incident to a physician's professional services. They may also be included as part of covered facility services such as those provided by a skilled nursing facility.

Senate Bill

The Senate bill would include "marriage and family therapist services" and "mental health counselor services" within the definition of "medical and other health services" covered under Medicare Part B. The term marriage and family therapist services would be defined as services performed by marriage and family therapists for the diagnosis and treatment of mental illnesses. Such services would be those which the individual was legally authorized to perform under state law (or the state regulatory mechanism provided by state law) of the state in which the services were performed. Such services would also have to be of the type which would otherwise be covered if furnished by a physician or as incident to a physician's professional services. Payment would only be made if no facility or other provider charged or was paid for such services.

The term marriage and family therapist would be defined as an individual who: 1) possessed a master's or doctoral degree which qualified the individual for licensure or certification as a marriage and family therapist pursuant to state law; 2) performed at least 2 years of clinical supervised experience in marriage and family therapy after obtaining the degree; 3) was licensed or certified as a marriage and family therapist in the state if such state provided for licensure and certification of marriage and family therapists.

The provision would define mental health counselor services as services performed by mental health counselors for the diagnosis and treatment of mental illnesses. Such services would be those which the individual was legally authorized to perform under state law (or the state regulatory mechanism provided by state law) of the state in which the services were performed. Such services would also have to be of the type which would otherwise be covered if furnished by a physician or as incident to a physician's professional services. Payment would only be made if no facility or other provider charged or was paid for such services.

The term mental health counselor would be defined as an individual who: 1) possessed a master's or doctoral degree in mental health counseling or a related field; 2) performed at least 2 years of supervised mental health counselor practice after obtaining the degree; 3) was licensed or certified as a mental health counselor or professional counselor in the state if such state provided for licensure and certification of mental health counselors or professional counselors.

Payment for covered services would be made under Medicare Part B. Payment would equal the lesser of 80% of the actual charge for the service or 75% of the amount paid to a psychologist for such services. All services provided by marriage and family therapists and mental health counselors would be paid on an assignment basis. Further, services provided by marriage and family therapists and mental health counselors would be added to the list of services excluded from payment as part of the skilled nursing facility prospective payment system.

The bill would include services provided by marriage and family therapists and mental health counselors in the definition of covered rural health clinic services. It would modify the definition of the required interdisciplinary team for a hospice program to permit a marriage or family therapist to be on the team instead of a social worker.

The provision would apply to services provided on or after January 1, 2007.

House Bill

No provision.

Conference Agreement

No provision.

Subtitle C - Provisions Relating to Parts A and B

Home Health Payments. (Section 5201 of the Conference Agreement, Section 6110 of the Senate Bill – with respect to quality of home health services, and no provision in the House Bill) .

Current Law

The Medicare home health prospective payment system, which was implemented on October 1, 2000, provides a standardized payment for a 60-day episode of care furnished to a Medicare beneficiary. Medicare's payment is adjusted to reflect the type and intensity of care furnished and area wages as measured by the hospital wage index.

Each year Medicare's payment to home health agencies is updated by the projected annual change in the home health market basket (HHMB), with specified reductions in some years. For the last three calendar quarters of 2004 through 2006, the home health update is the HHMB minus 0.8 percentage points. In 2007 and subsequent years, the payment update for home health agencies is equal to the full HHMB.

The Medicare Prescription Drug Improvement and Modernization act of 2003 provided for a one-year 5% additional payment for home health services furnished in rural areas. The temporary payment began for episodes and visits ending on or after April 1, 2004 and before April 1, 2005. It was made without regard to certain budget neutrality provisions and was not included in the base for determination of payment updates.

Senate Bill

The Medicare statute would be amended by adding a new Section 1860E-6 which establishes the Home Health Agency Value-Based Purchasing Program. In 2008 and in subsequent years, the Secretary would make value-based payments to those home health agencies that, based on data submitted under the quality measurement system, have either substantially improved quality of care over the prior year, or exceed a threshold established by the Secretary. A majority of the total amount available for value-based payments in any fiscal year would be paid to home health agencies that qualify for payments because they exceed a quality threshold. Starting in 2009 and in each subsequent year, the percentage of total value-based payments made to agencies that exceed the quality threshold would be greater than the percentage made in the previous

year. To be eligible for a value-based payment, home health agencies would be required to submit the required quality data and attest that it is complete and accurate.

The total amount of value-based payments made in a year would equal the total funds available for such payments. The Secretary would determine the most appropriate method for making payments. Payments for a year would be required to be made no later than December 31 of the subsequent year. By January 1, 2008, the Secretary would be required to provide each home health agency with a description of how its payments for 2007 would have been affected had the value-based purchasing system been in effect that year.

Value-based payments would be made from Part A and Part B in the same proportion as payments for home health services are made.

In 2007 and subsequent years, a home health agency that does not submit to the Secretary the required quality data would receive an update of the market basket minus two percentage points. This reduction would only apply to the fiscal year in question. For 2007 and subsequently, each home health agency would be required to submit data necessary for a value-based purchasing system in the form, manner, and time period specified by the Secretary. Procedures for making the data available to the public would be established.

To fund the program, spending under the trust funds for home health services would be reduced by a percent applied to the standard prospective payment amount made to all agencies that comply with the data submission requirements. The percent reduction would be 1% in 2008, 1.25% in 2009, 1.5% in 2010, 1.75% in 2011, and 2% in 2012 and subsequent years.

House Bill

No provision.

Conference Agreement

The conference agreement eliminates the update for home health payments in 2006. It also provides for a one-year 5% additional payment for home health episodes or visits furnished in a rural area during calendar year 2006.

The Conference agreement accepts the Senate language with respect to (1) the collection of health care quality data, as determined appropriate by the Secretary, (2) procedures for making the data available to the public, and (3) the reduction of payments to home health agencies that do not submit quality data in 2007 and beyond. The reduction in payments is equal to the market basket minus two percentage points. However the reduction will not be taken into account for calculation of the payment rate in subsequent years.

The conference agreement directs the Medicare Payment Advisory Commission to submit a report to Congress no later than June 1, 2007 on a value-based purchasing program for home health services. The report is to include recommendations on the structure of the program, the determination of thresholds, the size of value-based payments, sources of funds, and the relationship of payments for improvements in health care quality.

Revision of Period for Providing Payment for Claims that are not Submitted Electronically (Section 5202 of the Conference Agreement, no provision in the Senate Bill, and no provision in the House Bill).

Current Law

Mandatory electronic claims submission went into effect on July 1, 2005 for all providers, with a few exceptions. The exceptions include: (1) small providers with fewer than 25 full-time equivalent (FTEs) employees and physicians, practitioners, or suppliers with fewer than 10 FTEs, (2) dentists, and (3) other providers as specified by the Centers for Medicare and Medicaid Services (CMS). Medicare contractors must pay 95% of all "clean" paper claims within 27-30 days of receipt.

Senate Bill

No provision.

House Bill

No provision.

Conference Agreement

The Conference agreement directs Medicare contractors to delay the payment of claims that are not submitted electronically. The contractors are directed to pay 95% of all "clean" claims within 29-30 days of receipt for paper claims.

Timeframe for Part A and B Payments (Section 5203 of the Conference Agreement, Section 6112(b) of the Senate Bill, and no provision in the House Bill) .

Current Law

Medicare contractors accept, process and pay claims submitted by providers for Medicare-covered services. Medicare contractors must pay interest on claims that are not promptly paid. The contractors must pay 95% of all "clean" claims within 14-30 days of receipt for electronically submitted claims, or within 27-30 days of receipt for paper claims. If the payment is not made within that time, interest begins accruing on the day after the required payment date and ends on the date on which the payment is made. The interest rate is set at the higher of the "private consumer rate," or the "current value of the funds."

Senate Bill

The Senate bill would delay Medicare Part A and B payments by 9 days. Claims that would otherwise be paid on September 22, 2006, through September 30, 2006 would be paid on the first business day of October 2006. No interest or late penalty would be paid to an entity or individuals for any delay in a payment during the period.

House Bill

No provision.

Conference agreement

The conference agreement accepts the Senate provision.

Medicare Integrity Program Funding (Section 5204 of the Conference Agreement, no provision in the Senate Bill and no provision in the House Bill) .

Current Law

As part of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Congress acted to increase and stabilize federal funding for anti-fraud activities. As required by Section 1817(k) of the Medicare law, an expenditure account was established within the Federal Hospital Insurance Trust Fund (the HCFAC account). Certain amounts were appropriated from the Trust Fund for specific activities, including the Medicare Integrity Program (MIP). These amounts have been established as not less than \$710 million and not more than \$720 million for FY2002 and subsequently.

Senate Bill

No provision.

House Bill

No provision.

Conference Agreement

The conference agreement would increase MIP funding amounts by \$100 million for FY2006.

Subtitle D- Provisions Relating to Part C

Phase-out of Risk adjustment budget neutrality in determining the amount of payments to Medicare Advantage organizations. (Section 5301 of the Conference Agreement, Section 6111 of the Senate Bill, and no provision in the House Bill) .

Current Law

Medicare Advantage payment rates are risk adjusted to control for the variation in the cost of providing health care among beneficiaries. Rates are adjusted by demographic and health status indicators. In the report language to the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Congress urged the Secretary to implement a more clinically-based risk adjustment methodology without reducing overall payments to plans. To keep payments from being reduced overall, the Secretary applied a budget neutrality adjustment to the risk adjusted rates. However, the Secretary has proposed to phase-out the budget neutrality adjustment citing studies that show a difference in the reported health status of Medicare Advantage enrollees compared to the reported health status of beneficiaries in traditional Medicare.

Senate Bill

Beginning in 2007, this section would specify an adjustment to the benchmarks to phase-out overall increases in MA rates that result from the budget neutral implementation of risk adjustment. In 2007, if the Secretary does not rebase rates to 100% of per capita fee-for-service costs, the MA benchmarks would be equal to the 2006

rates as announced by the Secretary on April 4, 2005, with four adjustments — (1) exclusion of any national adjustments for coding intensity, (2) exclusion of risk adjustment budget neutrality, (3) increase based on the national per capita MA growth percentage, and (4) omission of any adjustments to account for errors in previous years' projections of the national per capita MA growth percentage. If the Secretary does rebase the rates in 2007, the MA benchmark would be set at the greater of either the rate calculated above, or 100% of per capita fee-for-service spending in the area. After 2007, if the Secretary does not rebase rates, the MA benchmarks would be the previous year's benchmark increased by the national per capita MA growth percentage without adjusting for errors in the estimation of the growth percentage for a year before 2004. After 2007, if the Secretary rebases rates, the benchmark would be equal to the greater of either the rate calculated above, or 100% of per capita fee-for-service spending.

The benchmarks described above would be free of the budget neutral risk adjustment. However, the benchmarks would be adjusted so that budget neutrality would be phased-out over 4 years. The applicable phase-out factors would be equal to .55 in 2007, .40 in 2008, .25 in 2009 and .05 in 2010. This means that in 2007, 55% of the payment to plans would be based on payment rates including the budget neutral risk adjustment, and 45% of the payment to plans would be based on a rate without the budget neutral adjustment. The budget neutrality factor is calculated through a formula that equals the Secretary's estimate of the total amount of payments that would have been made to plans under the demographic risk adjustment system, minus the Secretary's estimate of the payments that would have been made to plans under the health status risk adjustment system without the budget neutrality adjustment, divided by the Secretary's estimate of the total amount of payments that would be made under the health status risk adjustment system without the budget neutrality adjustment. When making this calculation, the Secretary would (a) use a complete set of the most recent and representative MA risk scores available, (b) adjust the risk scores to reflect changes in treatment and coding practices in fee-for-service, and (c) adjust the risk scores for differences in coding patterns under Medicare Part A and B compared to Medicare Part C, to the extent the Secretary has identified differences and (d) as necessary, adjust for late data submissions, lagged cohorts, and changes in MA enrollment. The Secretary could take into account estimated health risk of enrollees in preferred provider organizations (including MA regional plans) for the year. The Secretary would be required to conduct an analysis of differences in coding patterns between MA plans and providers under Parts A and B of Medicare using data starting in 2004, and incorporate, to the extent such differences are identified, the findings into calculations of MA benchmarks no later than 2008. Adjustments would be terminated if the total amount of payments adjusted for health status exceeded payments adjusted for demographics.

The Secretary could not make any adjustments to the budget neutrality factor, other than those specified above. The Secretary's authority to risk adjust MA benchmarks based on 100% of per capita fee-for-service spending would not be limited by these changes.

This section also refines adjustments for health status when plans are paid based on their bid amounts (rather than the benchmark). The Secretary would ensure that such risk adjustments reflect changes in the treatment and coding practices between Medicare Part A and Part B relative to Medicare Part C to the extent that the Secretary has identified differences.

House Bill

No provision.

Conference Agreement

The conference agreement accepts the Senate language in part, with modifications. The conference agreement codifies the phase-out of the budget neutrality factor over 2006 to 2010 and outlines the adjustments that can be made to that factor. Under the agreement, the Secretary must conduct an analysis to identify differences in coding patterns between Medicare Advantage plans and fee for service. To the extent that the Secretary identifies any differences, they are to be incorporated into calculations of the risk rates and the budget neutrality factor in 2008, 2009, and 2010. The conferees intend that any adjustments made for differences in coding patterns be made for differences resulting from inaccurate coding. The conference agreement makes no permanent change to Medicare Advantage payment calculations.

Rural Pace Provider Grant Program (Section 5302 in the Conference Agreement, Section 6113 of the Senate Bill, and no provision in the House Bill) .

Current Law

PACE is a program providing comprehensive Medicare and Medicaid services under a managed care arrangement to individuals over age 55 who are eligible for a nursing home level of care. PACE organizations, which are public or private non-profit entities, receive a fixed monthly Medicare and Medicaid payment to cover a comprehensive set of services for PACE participants. The PACE service package must include all Medicare and Medicaid covered services, and other services determined necessary by the multidisciplinary team for the care of the PACE participant.

Senate Bill

This provision would create site development grants, provide technical assistance to established rural PACE providers, and establish a fund to reimburse rural PACE providers for certain outlier costs. A rural area would be a county that is not part of a Metropolitan Statistical Area (as defined by the Office of Management and Budget) as established for Medicare IPPS payments to acute care hospitals. The Secretary would establish a procedure to award site development grants to be used for expenses incurred in relation to establishing or delivering services in rural areas. Up to 15 qualified PACE providers that serve a rural area, in whole or in part can receive a grant not to exceed \$750,000. The Secretary would be appropriated \$7.5 million in FY2006 and FY2007 out of the Treasury for these development grants. The appropriated funds would remain available for expenditure until FY2010. The Secretary would establish a technical assistance program to provide 1) outreach and education to specified entities interested in starting rural PACE programs, and 2) technical assistance necessary to support rural PACE pilot sites. The Secretary would establish an outlier fund for inpatient and related physician and ancillary costs incurred for an eligible participant within a given 12-month period. Outlier costs would be those costs for inpatient and related physician and ancillary services in excess of \$50,000 incurred within a given 12-month period for an eligible participant who resides in a rural area. For the first 3 years of its operation, a rural PACE site would receive 80% of the outlier costs in excess of \$50,000 for that period. Total outlier payments for an eligible participant could not exceed \$100,000 for the 12 month period used to calculate the payment. No site may receive more than \$500,000 in total outlier expense payments in a 12-month period. A rural PACE pilot site would be required to access and exhaust risk reserves held or arranged for the provider and any working capital established through a site development grant prior to receiving any payment from the outlier fund. The Secretary would be appropriated \$10

million for FY2006 and FY2007 for the outlier fund. These outlier appropriations would remain available for expenditure through FY2010. The Secretary would be required to submit a report to Congress on the evaluation of the rural PACE pilot sites no later than 60 months from the date of enactment. Any amount paid under this authority would be in addition to Medicare PACE funds paid under Section 1894 of the Social Security Act or Medicaid PACE funds paid for under Section 1934 of the same act.

Conference Agreement

The conference agreement adopts the Senate provision with certain exceptions. The Secretary is required to establish a process and criteria to award site development grants to qualified PACE providers that have been approved to serve a rural area. The Secretary is appropriated \$7.5 million for FY2006 for the rural site development grants. These appropriated funds would remain available for expenditure through FY2008. The Secretary is appropriated \$10 million for FY2006 for the outlier funds. These appropriated funds would remain available for expenditure through FY2010. Rural PACE pilot sites must apply to receive outlier funds and document their incurred costs for the outlier participant in a manner specified by the Secretary.

Elimination of Medicare Advantage Regional Plan Stabilization Fund (No provision in Conference agreement, Section 6112(a) of the Senate Bill, and no provision in the House Bill) .

Current Law

The Secretary must establish an MA Regional Plan Stabilization Fund to provide incentives for plan entry in each region and plan retention in certain MA regions with below average MA penetration. Initially, \$10 billion will be available for expenditures from the Fund beginning on January 1, 2007 and ending on December 31, 2013. Additional funds will be available in an amount equal to 12.5% of average per capita monthly savings from regional plans that bid below the benchmark.

Senate Bill

The Senate bill would repeal the stabilization fund retrospectively as of the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

House Bill

No provision.

Conference agreement

No provision.

Establishment of Medicare Value-based Purchasing Programs. (No provision in the Conference Agreement, Section 6110 of Senate Bill and no provision in the House Bill) .

Subsection (a) Establishment of Medicare Value-Based Purchasing Programs

Part E Value-Based Purchasing Programs — Quality Measurement Systems for Value-Based Purchasing Programs. (No provision in the Conference Agreement, Section 6110 of the Senate Bill and no provision in the House Bill)

Current Law

No provision.

Senate Bill

Section 6110 would amend the Medicare statute by redesignating the existing Section 1860E as Section 1860F and by adding a new Section 1860E which requires the Secretary to establish value-based purchasing systems for different providers.

Subsection (a) of Section 6110 would create Section 1860E-1 in the Medicare statute and would require the Secretary to develop provider-specific quality measurement systems for making value-based payments to hospitals, physicians and practitioners, Medicare Advantage (MA) and Part D prescription drug plans, end stage renal disease providers and facilities, and home health agencies. Measures for each quality system would be required to (1) be evidence-based; (2) be easy to collect and report; (3) address process, structures, outcomes, beneficiary experience, efficiency, equity, and overuse and underuse of health care; and (4) include at least one measure of health information technology infrastructure during the first year of implementation. Additional measures would be added in subsequent years. Measures would include those that assess the quality of care furnished to older, frail individuals and those with multiple complex chronic conditions. By 2008, hospital quality systems would be required to include at least 5 measures that take into account the unique characteristics of small hospitals located in rural areas and frontier areas.

Before a measure would be used to determine whether a provider receives a value-based payment, data on the measure must have been collected for at least a twelve month period. Each set of quality measures selected for specific categories of providers would be able to vary in their application to an individual or entity depending of the type, size, scope and volume of services provided by the individual or entity.

The Secretary would be required to establish risk adjustment procedures to control for differences in beneficiaries' health status and characteristics and to assign weights to measures used by each quality system. If appropriate, measures of clinical effectiveness would be weighted more heavily than measures of beneficiary experience; and measures of risk adjusted outcomes would be weighted more heavily than measures of process. The Secretary would be required to update the quality measurement system, but not more often than every twelve months. The update would permit a comparison of data from one year to the next. The Secretary would be required to use the most recent quality data for a provider type. However, if the Secretary determines that there is insufficient data because of the low service volume, the Secretary would be able to aggregate data across more than one fiscal or calendar year.

In developing and updating each quality measurement system, the Secretary would be required to consult with provider-based groups and clinical specialty societies. The Secretary would also take into account quality measures developed by nationally recognized entities, existing quality measurement systems, reports by MedPAC required by this Act, results of relevant demonstrations, and the report on Health Care Performance Measures being developed by the Institute of Medicine under section 238 (b) of the MMA. In implementing each quality measurement system, the Secretary

would be required to consult with entities that have developed strategies for quality measurement and reporting as well as a wide range of stakeholders.

By July 1, 2006, the Secretary would be required to have in place an arrangement with an entity that will provide the Secretary with advice and recommendations about the development and updating of the quality measurement systems established by this Act. This arrangement, with a private nonprofit entity, would meet a specific set of requirements. For FY2006 and FY2007, \$3,000,000 is authorized for this purpose, with the amount in subsequent years increased by the Consumer Price Index for urban consumers.

House Bill

No provision.

Conference Agreement

No provision.

Physician and practitioner value-based purchasing program

Current Law

No provision.

Senate Bill

A new Section 1860E-3 would direct the Secretary to establish a program under which value-based payments are provided each year to physicians and practitioners that demonstrate the provision of high quality health care to individuals enrolled under part B. In addition, MedPAC would be required to conduct five studies evaluating the new program.

The first study would examine how the Medicare value-based purchasing programs under this section will affect Medicare beneficiaries, Medicare providers, and Medicare financing, including the impact of these programs on the access of such beneficiaries to items and services, the volume and utilization of such items and services, and low-volume providers. The initial report would be due to Congress and the Secretary no later than March 1, 2008, and a final report due no later than June 1, 2012.

The second study would examine the advisability and feasibility of establishing a value-based purchasing program for critical access hospitals (CAHs). This report would be due to Congress and the Secretary no later than March 1, 2007.

The third study would address the advisability and feasibility of including renal dialysis facilities in the value-based purchasing program described in this section or establishing a separate value-based purchasing program for renal dialysis facilities under this title. This report would be required to be submitted to Congress and the Secretary no later than June 1, 2007.

The fourth study would be a report on the implementation of an end-stage renal disease (ESRD) provider and facility value-based purchasing program. This report would take into account the results to date of the demonstration of bundled case-mix adjusted payment system for ESRD services under Section 623(e) of MMA and would include

issues for the Secretary to consider in operating the ESRD provider and facility value-based purchasing program as well as recommendations on such issues. This report would be required to be submitted to Congress and the Secretary no later than June 1, 2008.

The fifth study, due to Congress and the Secretary by June 1, 2007, would report on the advisability and feasibility of establishing a value-based purchasing program for skilled nursing facilities (SNFs).

The value-based purchasing program would be established so that value-based payments will be made initially in 2009 and in each subsequent year. The definition of a physician would not be changed as a result of this section and would remain as given in current law (section 1861(r)). The term 'practitioner' would mean: (i) a practitioner defined under current law; (ii) a physical therapist; (iii) an occupational therapist; and (iv) a qualified speech-language pathologist. The Secretary would be charged with establishing procedures for the identification of physicians and practitioners for payment purposes under this section, such as through physician or practitioner billing units or other units.

The value-based payments would be based on either relative or absolute standards. The Secretary would be able to make a value-based payment to a physician or a practitioner if both the quality and efficiency of care to an individual enrolled under Part B has improved substantially or has exceeded an established threshold. In determining which physicians and practitioners would qualify for a value-based payment, the Secretary would be required to use both the quality measurement system developed for this section with respect to the quality of the care provided by the physician or practitioner and the comparative utilization system developed under this section with respect to the efficiency of such care.

In determining the amount of award and the allocation of awards under the value-based purchasing program, the Secretary would determine both the amount of a value-based payment provided to a physician or a practitioner and the allocation of the total amount available for value-based payments for any year between payments with respect to physicians and practitioners that meet the quality threshold requirements described above.

In determining the amount and allocation of the value-based payments for physicians and practitioners who exceed the threshold that allows them to receive such payments, the Secretary would ensure that a majority of the total amount available for value-based payments for any year is provided to physicians and practitioners who meet the threshold for receiving such payments. Additionally, the percentage of value-based payments would not be able to decrease. For every year beginning in 2010, the Secretary would be required to ensure that the percentage of the total amount available for value-based payments for any year that is used to make payments to physicians and practitioners is greater than the previous year's percentage.

In order for a physician or a practitioner to be eligible for a value-based payment for a year, the physician or practitioner would be required to submit quality data with respect to that year, and provide the Secretary (under procedures established by the Secretary) with an attestation that the data submitted is complete and accurate.

The Secretary would be required to establish value-based payments such that the estimated total amount of the value-based payments is equal to the total amount of available funding for value-based payments for the year. The payment of value-based payments would be based on such a method as the Secretary determines appropriate, and

the Secretary would ensure that value-based payments with respect to a year are made by not later than December 31 of the subsequent year.

The Secretary, in consultation with relevant unnamed stakeholders, would develop a comparative utilization system for purposes of providing value-based payments. The resulting comparative utilization system would measure the efficiency of the care provided by a physician or practitioner. Under this comparative utilization system, the Secretary would select the measures of efficiency and review the most recent claims data with respect to services furnished or ordered by physicians and practitioners to determine utilization patterns and efficiency. The Secretary would establish risk adjustment procedures, as appropriate, to control for differences in beneficiary health status and beneficiary characteristics.

Beginning in 2007, the Secretary would provide physicians and practitioners with annual reports on the utilization of items and services under this title based upon the review of claims data. The 2007 and 2008 reports would be confidential and not be made available to the public. Not later than March 1, 2009, the Secretary would provide each physician and practitioner with a description of the Secretary's estimate of how payments to the physician or practitioner would have been affected with respect to items and services furnished in 2008 if the value-based payment program had been in effect in 2008.

Payments to physicians and practitioners under the value-based payment program would be made from the Federal Supplementary Medical Insurance (Part B) Trust Fund. The total amount available for value-based payments with respect to a year would be equal to the amount of the reduction in expenditures under the Federal Supplementary Medical Insurance Trust Fund in the year as a result of the amendments made by Section 6110(c)(2) of the bill, as estimated by the Secretary.

House Bill

No provision.

Conference Agreement

No provision.

Subsection (c) Physicians and Practitioners

(1) Voluntary Submission of Physician and Practitioner Quality Data.

Current Law

No provision.

Senate Bill

In 2007 and in subsequent years, physicians and providers who do not submit the required quality data would receive an update to the conversion factor minus two percentage points. This reduction would only apply to the fiscal year in question. In 2007 and subsequently, physicians and practitioners would be required to submit appropriate data necessary for a value-based purchasing system in the specified form, manner, and time of the data submission as determined by the Secretary. Procedures for making the data available to the public would be established. These procedures would be

required to provide the physicians and practitioners with an opportunity to review the data before it is released to the public. The Secretary would be allowed to make exceptions to the requirement for making data available to the public and would take into account the size and specialty representation of the practice involved when providing such exceptions.

House Bill

No provision.

Conference Agreement

No provision.

(2) Reduction in Conversion Factor for Physicians and Practitioners that Submit Quality Data in order to Fund Program

Current Law

Medicare payments under Part B are based on a fee schedule. The fee schedule reflects a set of weights that vary across the many procedures that encompass the range of activities and services that physicians and practitioners provide. These relative weights are converted to dollar amounts for payment under Medicare by applying a multiplicative conversion factor. The conversion factor is updated each year according to a formula that aims to place a restraint on overall increases in Medicare spending for Part B services.

Senate Bill

To fund the value-based purchasing program for physicians and practitioners, the conversion factor would be reduced as follows: 1.0% in 2009, 1.25% in 2010, 1.5% in 2011, 1.75% in 2012, and 2.0% in 2013 and subsequent years.

House Bill

No provision.

Conference Agreement

No provision.

ESRD Provider and Facility Value-Based Purchasing Program

Current Law

No provision.

Senate Bill

Section 1680E-5. Beginning in 2007, the Secretary would establish a program under which value-based payments are provided each year to providers of services and renal dialysis facilities that provide services to ESRD individuals enrolled under part B and that demonstrate the provision of high quality health care. Facilities with at least 50% of

their patients under the age of 18, as well as those providers and facilities currently participating in the bundled case-mix demonstration are excluded from this program.

Value-based payments would be made to a provider or facility, if the Secretary determines that the quality of care in that year has substantially improved over the prior year or exceeds a threshold established by the Secretary, using the quality measurement system.

The Secretary would determine the amount of a value-based payment and the allocation of the total amount available for all such payments, subject to certain requirements. The Secretary would ensure that the majority of the total amount available is awarded to those providers of services and renal dialysis facilities who provide high quality services. For 2007, the entire amount would be available for those who meet the requirements. Beginning in 2009, the percentage of the total amount available would be provided to those who improved in meeting such requirements relative to the previous year.

Beginning in 2007, each provider of services and renal dialysis facility would be required to submit data that the Secretary determines is appropriate for the measurement of health outcomes and other indices of quality, including data necessary for the operation of the program. A provider or facility would be required to submit this data, in order to be eligible for a value-based payment for a year. The Secretary would establish procedures for making submitted data available to the public in a clear and understandable form and would ensure that a provider or facility first has the opportunity to review the data. The provider or facility would be required to provide an attestation that the data is complete and accurate.

The Secretary would establish payment amounts so that, as estimated by the Secretary, the total amount of value-based payments made in a year is equal to the total amount available. The payment of the awards would be based on a method as determined by the Secretary and must be paid no later than December 31 of the subsequent year. The amount available for value-based payments would be equal to the amount of the reduction in expenditures under the Federal Supplementary Medical Insurance (SMI) Trust Fund, as estimated by the Secretary. Payments to providers of services and renal dialysis facilities, under this section, would be made from the Federal SMI Trust Fund.

House Bill

No provision.

Conference Agreement

No provision.

Subsection (e) ESRD

Providers and facilities

Current Law

No provision.

Senate Bill

No later than July 31, 2006, the Secretary would establish procedures for providers of services and renal dialysis facilities, who are paid based on the case-mix adjusted prospective payment system, to submit data that permits the measurement of health outcomes and other indices of quality.

In the case of any payment for an item or service furnished on or after January 1, 2007, the case-mix adjusted prospective payment amount would be reduced by the applicable percent, but only for those providers of services or renal facilities included in the value-based program. The applicable percent would be 1% for 2007, 1.25% for 2008, 1.5% for 2009, 1.75% for 2010, and 2% for each year thereafter.

Beginning January 1, 2007, the Secretary would implement a value-based purchasing program for providers and facilities participating in the bundled case-mix demonstration (as established under Section 623 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003), in a manner similar to the value-based program established under Section 1860E-5 of this bill, including the funding of the program.

House Bill

No provision.

Conference Agreement

No provision.

PPS Hospital Value-Based Purchasing Program

Current Law

No provision.

Senate Bill

The Medicare statute would be amended by adding a new Section 1860E-2 which establishes the hospital value-based purchasing program for inpatient hospital services, starting FY2007. The program would make value-based payments to hospitals based on data reported under the quality measurement system established by the Secretary. Hospitals paid under Medicare's prospective payment system (PPS) that have substantially improved the quality of care over the prior year or exceeded an established quality threshold would receive a value-based payment as determined by the Secretary. A majority of the total amount available for value-based payments in any fiscal year would be paid to hospitals that are receiving such payments for exceeding a quality threshold. Starting in FY2008, the percentage of the total amount for value-based payments in any fiscal year that is paid to such hospitals would be greater than the equivalent percentage paid in the previous year. Hospitals would be required to comply with all the quality data reporting requirements and attest to the accuracy of the data in order to be eligible for a value-based payment. The total amount of value-based payments in a fiscal year would equal the total amount of available funding for such payments for that year. The payments would be based on the methods determined by the Secretary and would be made to hospitals no later than the close of the following fiscal year. No later than January 1, 2007, the Secretary would provide each hospital with a description of how its payments for FY2006 would have been affected had the value-based payment program been in effect that fiscal year.

Value-based payments in a fiscal year would be made from Medicare's Part A Trust fund and would equal specified reductions in those trust fund expenditures as established in Section 6110(b) of the bill.

House Bill

No provision.

Conference Agreement

See Section 5001 of the Conference Agreement

Plan Value-Based Purchasing Program

Current Law

No provision.

Senate Bill

A new Section 1860E-4 would require the Secretary would establish a program to award value-based payments to Medicare Advantage (MA) organizations that provide high quality health care. Payments would start in 2009, and continue each year thereafter. The program would apply to both MA regional and local plans. It also would apply to reasonable cost contract plans, except for provisions that would require plans to submit data two years prior to the start of the program, and provisions relating to plan bids.

The Secretary would make payments for each plan offered by an MA organization if the plan substantially improved over the prior year, or exceeded a minimum threshold. The Secretary would use measures of quality developed for the plan value-based payments system (Section 1860E-1) and ensure that awards are based on data from a full 12-months when making a comparison against a threshold, and 24-months when measuring improvement over a prior year.

The Secretary would determine the amount of the value-based payments, but must ensure that the majority of funds go to plans that receive a payment because their health measures exceeded a threshold. In 2010 and each subsequent year, the percentage of the total amount available is greater than the percentage in a previous year.

Value-based payments may only be used to invest in quality improvement programs or to enhance beneficiary benefits.

To be eligible for value-based payments, an MA plan or reasonable cost contract would be required have collected, analyzed and reported the required data for the two previous years. Also, an MA plan would be required to provide the Secretary with an attestation that the value-based payment program including payment adjustments made by reason of Section 6110(d)(2)(A)) had no effect on the integrity and actuarial soundness of the plan's bid.

The Secretary would ensure that the total of value-based payments is equal to the amount made available for those payments. Payments for a particular year would be required to be made not later than March 1 of the subsequent year, in a manner determined by the Secretary.

By March 1, 2009, the Secretary would provide each MA organization with an estimate of how plan payments would have been affected if the value-based payment system had been in effect in 2008.

The amount available for value-based payments would be equal to the amount of the reduction in expenditures under the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund as a result of amendments to fund the value-based payment system, as estimated by the Secretary. Payments to MA organizations would be drawn from the two trust funds in proportion to the relative weight that part A and part B benefits represent of the total actuarial value of Medicare benefits.

House Bill

No provision.

Conference Agreement

No provision.

Home Health Agency Value-based Purchasing Program

Current Law

No provision.

Senate Bill

The Medicare statute would be amended by adding a new Section 1860E-6 which establishes the Home Health Agency Value-Based Purchasing Program. In 2008 and in subsequent years, the Secretary would make value-based payments to those home health agencies that, based on data submitted under the quality measurement system, have either substantially improved quality of care over the prior year, or exceed a threshold established by the Secretary. A majority of the total amount available for value-based payments in any fiscal year would be paid to home health agencies that qualify for payments because they exceed a quality threshold. Starting in 2009 and in each subsequent year, the percentage of total value-based payments made to agencies that exceed the quality threshold would be greater than the percentage made in the previous year. To be eligible for a value-based payment, home health agencies would be required to submit the required quality data and attest that it is complete and accurate.

The total amount of value-based payments made in a year would equal the total funds available for such payments. The Secretary would determine the most appropriate method for making payments. Payments for a year would be required to be made no later than December 31 of the subsequent year. By January 1, 2008, the Secretary would be required to provide each home health agency with a description of how its payments for 2007 would have been affected had the value-based purchasing system been in effect that year.

Value-based payments would be made from Part A and Part B in the same proportion as payments for home health services are made.

House Bill

No provision

Conference Agreement

No provision.

Subsection (b). Hospitals

(1) Voluntary Submission of Hospital Quality Data.

Current Law

Each year, Medicare's operating payments to acute general hospitals are increased or updated by a factor that is determined, in part, by the projected annual change in the hospital market basket (MB). Congress establishes the update for Medicare's inpatient prospective payment system (IPPS) for operating costs, often several years in advance. An IPPS hospital will receive an operating update of the MB from FY2005 through FY2007 if it submits data on the 10 quality indicators established by the Secretary as of November 1, 2003. The Secretary will specify the form, manner, and time of the data submission. A hospital that does not submit data to the Secretary will receive an update of the MB minus 0.4 percentage points for the fiscal year in question. The Secretary will not take into account this reduction when computing the applicable percentage increase in subsequent years. For FY2008 and subsequent fiscal years, hospitals will receive an update of the MB.

Senate Bill

In FY2007 and subsequent years, an IPPS hospital that does not submit the required quality data would receive an update of the MB minus two percentage points. This reduction would only apply to the fiscal year in question. In FY2007 and subsequently, an IPPS hospital would be required to submit appropriate data necessary for a value-based purchasing system in the specified form, manner, and time of the data submission as determined by the Secretary. Procedures for making the data available to the public would be established. These procedures would be required to provide the hospitals with an opportunity to review the data before it is released to the public.

House Bill

No provision.

Conference Agreement

No provision.

(2) Reduction in Outlier Payments in order to Fund Program

Current Law

Outlier payments are intended to protect IPPS hospitals from the risk of financial losses associated with patients with exceptionally high costs or unusually long stays. Medicare cases qualify for outlier payments if they exceed a threshold or fixed loss amount that is established each year. As directed by statute, the total amount of any outlier payments for any year should equal no less than 5% nor more than 6% of total projected operating diagnosis related group (DRG) payments. Outlier payments are financed by a reduction in the national average standardized amount, typically set at 5.1%.

Senate Bill

Outlier payments would be established as no less than 5% and no more than 6% for fiscal years prior to 2007. In FY2007, outlier payments would be established as no less than 4% and no more than 5%. In FY2008, outlier payments would be established as no less than 3.75% and no more than 4.75%. In FY2009, outlier payments would be established as no less than 3.5% and no more than 4.5%. In FY2010, outlier payments would be established as no less than 3.25% and no more than 4.25%. In FY2011 and in subsequent years, outlier payments would be established as no less than 3% and no more than 4%.

The Secretary would be directed to reduce the average standardized amount by certain percentages to fund outlier payments and the hospital value-based purchasing program. The reduction factor will be equal to a calculation where the numerator is the sum of the additional outlier payments (as discussed in the preceding paragraph) plus a specified percentage of total projected DRG prospective payment rates divided by the total projected DRG prospective payment rates. The specific percentages would be 0% for fiscal years prior to 2007, 1% in FY2007, 1.25% in FY2008, 1.5% in FY2009, 1.75% in FY2010, and 2% in FY2011 and in subsequent years.

House Bill

No provision.

Conference Agreement

No provision.

(3) Value-Based Purchasing Demonstration Program for Critical Access Hospitals

Current Law

No provision.

Senate Bill

The Secretary, within six months from enactment, would be required to establish a two-year value-based payment demonstration program at six representative CAHs, using such funds as are necessary from the Part A trust fund. The Secretary would be required to report to Congress with recommendations within six months of completing the demonstration.

House Bill

No provision.

Conference Agreement

No provision.

Subsection (d) Plans

(1) Submission of Quality Data.

Current Law

Each Medicare Advantage (MA) organization has an ongoing quality improvement program. MA private fee-for-service plans, MSA plans and Medicare cost reimbursement plans are exempt from this requirement. Each MA organization collects, analyses and reports health outcomes and quality data. The quality improvement program for local preferred provider organizations only applies to providers that have contracts with the organization. The Secretary can collect only the types of data that were collected by the Secretary as of November 1, 2003. The Secretary can collect other types of data only after consulting with MA organizations and private accrediting bodies, and submitting a report to Congress.

Senate Bill

Beginning on or after January 1, 2006, the Secretary would also collect data necessary for the plan value-based purchasing program (Section 1860E-4). The Secretary would establish requirements for MA private fee-for-service plans and cost reimbursement plans with respect to the collection, analysis and reporting of data on health outcomes and quality. The Secretary would establish procedures for making health outcomes and quality data available to the public in a clear and understandable form. Prior to the data being made public, the Secretary would ensure that an MA organization has the opportunity to review the data for the plans it offers. The Secretary may change the type of data collected for the value-based purchasing program after complying with requirements for the development, update and implementation of the program.

The Secretary would take into account the data reporting requirements that plans must comply with under other federal and state programs and in the commercial market when establishing a time frame for data reporting requirements under the new program.

House Bill

No provision.

Conference Agreement

No provision.

(2) Reduction in Payments to Organizations in order to Fund Program

Current Law

No provision.

Senate Bill

For those providers included in the value-based program, including reasonable cost contracts, the monthly payment to plans would be reduced by 1% in 2009, 1.25% in 2010, 1.5% in 2011, 1.75% in 2012, and 2.0% for 2013 and each subsequent year. These reductions would not have any effect on determining whether the risk adjusted benchmark exceeds a plan's risk adjusted bid, or the amount of the difference.

House Bill

No provision.

Conference Agreement

No provision.

(3) Requirements for Reporting on Use of Value-Based Payments

Current Law

No provision.

Senate Bill

Beginning on or after January 1, 2011, MA plans would submit information describing how the organization will use any value-based payments received under the program. This information would be submitted by plans at the same time they submit plan bids. Beginning in 2010, not later than July 1 of each year, any reasonable cost reimbursement contract that received a value-based payment would submit a report to the Secretary describing how the organization will use the value-based payment.

House Bill

No provision.

Conference Agreement

No provision.

Subsection (f) Home Health Agencies

Value-based purchasing program for home health agencies.

Current Law

No provision.

Senate Bill

In 2007 and subsequent years, a home health agency that does not submit to the Secretary the required quality data would receive an update of the market basket minus two percentage points. This reduction would only apply to the fiscal year in question. For 2007 and subsequently, each home health agency would be required to submit data necessary for a value-based purchasing system in the form, manner, and time period

specified by the Secretary. Procedures for making the data available to the public would be established.

To fund the program, spending under the trust funds for home health services would be reduced by a percent applied to the standard prospective payment amount made to all agencies that comply with the data submission requirements. The percent reduction would be 1% in 2008, 1.25% in 2009, 1.5% in 2010, 1.75% in 2011, and 2% in 2012 and subsequent years.

House Bill

No provision.

Conference Agreement

See Section 5201 of the Conference Agreement.

Subsection (g) Skilled Nursing Facilities

(1) Requirement for Skilled Nursing Facilities to Report Functional Capacity of Medicare Residents Upon Admission and Discharge.

Current Law

Medicare law requires nursing homes to conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. Under the law, this assessment must describe the resident's capability of performing daily life functions and significant impairments in functional capacity and be based on a uniform minimum data set specified by the Secretary, or specified by the state with the Secretary's approval. If specified by a state, it must be consistent with the minimum data set of core elements, common definitions, and utilization guidelines.

As a result, the Minimum Data Set (MDS), designed by the Secretary, consists of a core set of screening, clinical and functional status elements, including common definitions and coding categories which form the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare or Medicaid. The items in the MDS standardize communication about resident problems and conditions within facilities, between facilities, and between facilities and outside agencies. MDS is designed to facilitate and standardize resident assessments, which are structured, problem-oriented frameworks for organizing MDS information, and examining additional clinically relevant information about an individual. These resident assessments help identify social, medical and psychological problems and form the basis for individualized care planning. MDS is also used as a data collection tool to classify Medicare and Medicaid residents into the Resource Utilization Groups (RUG-III). The RUG-III Classification system is used in the PPS for nursing facilities, hospital swing bed programs, and in many State Medicaid case mix payment systems to group residents into similar resource usage categories for the purposes of reimbursement.

In general, MDS resident assessments are conducted on the 5th, 14th, 30th, 60th, and 90th days of post-hospital SNF care. SNFS also conduct other assessments that may be needed to account for changes in patient care needs.

Senate Bill

This provision would amend section 1819(b) of the Social Security Act by adding a requirement that on or after October 1, 2006, a SNF would be required to submit a report to the Secretary on the functional capacity of each resident who is entitled to SNF benefits at the time of his or her admission and discharge. This report would be required to be submitted within 10 days of the admission or discharge as the case may be.

House Bill

No provision.

Conference Agreement

No provision.

(2) Voluntary Submission of Skilled Nursing Facility Data

Current Law

As described above, the MDS submitted to CMS by states is intended to provide information on the quality of care provided to residents in SNFs. In recent years, CMS has attempted to make available additional quality measures. CMS posts data on nursing home's care records from complaint surveys, staffing levels, and number and types of residents, facility ownership and 15 quality measure scores on a website entitled Nursing Home Compare. This site is available to the public and is intended to assist individuals in choosing a Medicare- and Medicaid-certified nursing home by state, county, city, zip code, or by facility name. Additional research into the development of quality measures, staffing, and best practices is currently underway through CMS contracts with Quality Improvement Organizations (QIOs).

Senate Bill

This provision would also require SNFs to submit quality data for the measurement of health outcomes and other indices of quality to the Secretary for FY 2009 and each subsequent fiscal year. Data required would be determined by the Secretary after conducting a study in consultation with certain nationally recognized quality measurement entities, researchers, health care provider organizations, and other appropriate groups and consult with, and take into account, recommendations of, the entity that the Secretary has an arrangement with based on criteria specified in section 6110(e) of this bill. The Secretary would also be required to consult with entities that have joined together to develop strategies for quality measurement and reporting, including the feasibility of collecting and reporting meaningful data on quality measures and that involve representatives of health care providers, health plans, consumers, employers, purchasers, quality experts, government agencies, and other individuals and groups that are interested in quality of care.

For FY 2009 and each subsequent year, SNF market basket percentage changes would be reduced by two percentage points for SNFs that do not submit this data. Such reductions would apply only with respect to the fiscal year involved and the Secretary would be prohibited from taking into account a reduction in the Federal per diem rate.

The Secretary would be required to establish procedures for making this data available to the public in a clear and understandable form. Such procedures would be required to ensure that a facility has the opportunity to review the data that is to be made public with respect to the facility prior to such data being made public.

House Bill

No provision.

Conference Agreement

No provision.

TITLE VI – Medicaid and SCHIP

Subtitle A- Medicaid

Chapter 1 – Payment for Prescription Drugs

Federal Upper Payment Limit for Multiple Source Drugs and Other Drug Payment Provisions (Section 6001 of the Conference Agreement, Section 6001 of the Senate Bill, and Section 3101 of the House Bill).

a. Modification of Federal Upper Payment Limit for Multiple Source Drugs; Definition of Multiple Source Drugs. –

Current Law

States set the amounts to pay pharmacies for outpatient prescription drugs provided to Medicaid enrollees. States pay those amounts to pharmacies and then seek reimbursement of the federal share of those payments. Federal reimbursements to states for state spending for certain outpatient prescription drugs are subject to ceilings called federal upper limits (FULs). The FUL applies, in the aggregate, to payments for multiple source drugs — those that have at least three therapeutically equivalent drug versions. The Centers for Medicare and Medicaid Services (CMS) calculates the FUL to be equal to 150% of the published price for the least costly therapeutic equivalent. The published prices that CMS uses as a basis for calculating the FULs are the lowest of the average wholesale prices (AWP) for each group of drug equivalents. Brand name drugs are subject to an upper limit equal to the amount that pharmacists must pay to acquire the drug (the acquisition cost) as estimated by the states.

Pharmaceutical manufacturers whose drugs are available to Medicaid beneficiaries must provide state Medicaid programs with rebates. Rebates are calculated based on the average manufacturer's price (AMP) of each product, and for certain other products, the best price at which the manufacturers sell the drug. The AMP is defined as the average price paid to a manufacturer by wholesalers for drugs distributed to retail pharmacies. Certain federal drug purchases as well as several other specific kinds of sales are exempt from the AMP and from the best price calculation. Sales at prices that are "nominal" in amount are excluded from the computation of best price. CMS defines nominal prices to be those that are below 10% of the AMP.

Senate Bill

The Senate bill would specify that FULs for multiple source drugs provided in pharmacies that are not critical access pharmacies would be calculated to be equal to 115% of the weighted AMP for those drugs. The FULs for multiple source drugs provided in critical access pharmacies would be calculated to be equal to the lesser of 140% of the AMP or the wholesale acquisition cost (WAC) for the drug. The bill would establish FULs for single source drugs. For those single source drugs provided in pharmacies that are not critical access pharmacies, the FUL would be calculated to be equal to 105% of the AMP. FULs for those single source drugs provided in critical access retail pharmacies would be calculated to be equal to the lesser of 108% of the AMP or the WAC for the drug.

Exceptions to the FUL would be for drugs sold during an initial sales period in which data on sales for the drug are not sufficiently available from the manufacturer to compute the AMP or the weighted AMP, and for drugs for which alternatives would not be as effective. For drugs sold during an initial sales period, the Senate bill would establish a transitional upper payment limit to apply only during such period. For a period not to exceed 2 calendar quarters, the upper limit for single source drugs would be calculated to be equal to the wholesale acquisition cost

(WAC) for the drug. The bill would define WAC - the definition would be identical to the current law Medicare definition. For first non-innovator multiple source drugs, the upper limit during the transition period would be equal to the AMP for the single source drug rated as therapeutically equivalent minus 10%. For subsequent non-innovator multiple source drugs, if the Secretary has sufficient data to determine AMP, the FUL during the transition period would be equal to the weighted AMP for the therapeutically equivalent and bioequivalent form of the drug. If the Secretary does not have sufficient data, the FUL would be the AMP for the single source drug that is therapeutically equivalent and bioequivalent minus 10%.

In the case of an innovator multiple source drug that a prescribing health care provider determines is necessary for treatment of a condition and that a non-innovator multiple source drug would not be as effective for the individual or would have adverse effects for the individual or both, and for which the provider obtains prior authorization in accordance with the states' program, the upper payment limit for the innovator multiple source drug shall be equal to 105% of the AMP for such drug.

The Secretary would be required to update FULs on a quarterly basis, taking into account the most recent data collected for the purposes of determining such limits and the FDA's most recent publication of "Approved Drug Products with Therapeutic Equivalence Evaluations."

The Senate FUL provisions would become effective on the later of January 1, 2007 or the date that is 6 months after the close of the first regular session of the State legislature that begins after the date of enactment.

The Senate bill would establish interim FULs to apply during calendar year 2006, before the new FULs become effective. During the period January 1, 2006 through the effective date of the FUL provisions, the Secretary would apply the FUL as under current law and regulations except that instead of limiting federal matching to 150% of AWP, it would be limited to 125% of AWP. In the case of covered outpatient drugs that are marketed as of July 1, 2005 and are subject to FULs under current law, the Secretary would be required to use the AWP, direct prices, and WACs as of that date to calculate the applicable FUL. New drugs first marketed between July 1, 2005 and January 1, 2007 would be subject to this interim FUL calculation.

House Bill

The House bill would specify that the FUL for the ingredient cost of a multiple source drug would be equal to 120% of the volume weighted average RAMP for that drug. The bill would establish upper limits for single source drugs as well. The FUL for the ingredient cost of a single source drug would be equal to the 106% of the RAMP for that drug. A drug product that is a single source drug and that becomes a multiple source drug would continue to be treated as a single source drug, with respect to the applicable FUL, until the Secretary determines that there is sufficient data to compile the volume weighted average RAMP.

The House bill would provide the Secretary with an option to develop an alternative methodology setting the FUL based on the most recently reported retail survey price instead of a percentage of RAMP or the volume weighted average RAMP. The House bill would allow the Secretary to use this methodology, in 2007, for a limited number of covered outpatient drugs, including both single source and multiple source drugs selected to be representative of the classes of drugs dispensed under Medicaid.

The House bill provides exceptions to the FULs for drugs sold during an initial sales period and for drugs dispensed by specialty pharmacies. For those drugs sold during an initial sales period for which data for computation of the RAMP may not be available, the House bill includes a provision similar to the Senate provision, except it would apply only to single source drugs sold during the initial sales period and the provision does not include any specification for

first innovator multiple source drugs. The bill includes a definition of WAC, to be used during the initial sales period, that is identical to the definition of WAC in the Senate bill. The House bill would also allow a state to elect not to apply the new FUL to covered outpatient drugs dispensed by specialty pharmacies, such as those that dispense only immunosuppressive drugs, as defined by the Secretary, or drugs administered by a physician in a physician's office.

The House bill would require the Secretary to update the FULs at least on a quarterly basis. Otherwise, the provision regarding FUL updates is identical to the Senate provision.

The effective date for the House FUL provisions would be on the later of January 1, 2007 or the date that is 6 months after the close of the first regular session of the state legislature that begins after the date of enactment of this Act.

The House bill would provide the Secretary with the authority to delay the implementation of the new FUL limits for a period of not more than 1 year, if the Comptroller General finds that the estimated average payment amount to pharmacies for covered outpatient drugs under the new FULs are below the average prices paid by pharmacies for acquiring such drugs. If the Secretary delays the implementation of the FULs then the Secretary would be required to transmit to Congress, prior to the termination of the period of delay, a report containing specific recommendations for legislation to establish a more equitable payment system.

The House bill would clarify that the FULs would not affect maximum allowable cost limits as established by states and rebates would continue to be paid without regard to whether or not states' payments are subject to such a limit. In addition, it would prohibit administrative and judicial reviews of the Secretary's determinations of FULs, RAMPs, volume weighted average RAMPs including the:

- assignment of National Drug Codes to billing and payment classes;
- Secretary's disclosure to states of AMP, RAMP, volume weighted average RAMP, and retail survey prices;
- determinations by the Secretary of covered outpatient drugs dispensed by specialty pharmacies or administered in physicians' offices;
- contracting and calculations under these provisions; and
- methods of allocating rebates, chargebacks, or other price concessions if specified by the Secretary.

The House bill would require the Comptroller General of the U.S. to provide a report to Congress no later than nine months after the date of enactment on the appropriateness of payment levels to pharmacies for dispensing fees under the Medicaid program and on whether the estimated average payment amounts to pharmacies for covered outpatient drugs under the new FUL method are below the average prices paid by pharmacies for acquiring such drugs. The bill would also require the Inspector General of HHS to provide a report to Congress, no later than two years after the date of enactment, on the appropriateness of using RAMP and retail survey prices rather than the AMP or other price measures, as the basis for establishing a FUL for reimbursement of outpatient drugs under Medicaid.

Conference Agreement

The conference agreement applies FULs to multiple source drugs for which the FDA has rated 2 or more products to be therapeutically and pharmaceutically equivalent. For those drugs, the FUL would be equal to 250% of the average manufacturer price computed without regard to prompt pay discounts for the lowest cost drug. Effective January 1, 2007.

The agreement modifies the definition of multiple source drug so that a drug qualifies as a multiple source drug if there is at least one other drug sold and marketed during the period that is rated as therapeutically equivalent and bioequivalent to it.

b. Disclosure of Price Information to States and the Public

Current Law

AMP and best price data are required to be reported by manufacturers to CMS no later than 30 days after the date of entering into a rebate agreement and then no later than 30 days after the last day of each rebate period. Those prices are required to be kept confidential except for the purpose of carrying out the requirements of Medicaid rebates, or to permit the Comptroller General and the Director of the Congressional Budget Office to review the information.

Senate Bill

The Senate bill would modify the confidentiality requirements to allow states access to reported price information and would require the Secretary to make available to states, beginning with the first quarter of FY2006, the most recently reported AMP and weighted AMPs. The Secretary would be required to devise and implement a means of electronic distribution for these prices to state Medicaid agencies.

House Bill

The House bill would modify the confidentiality requirements to allow states access to reported price information. In addition, the bill would require the Secretary to devise and implement a means for electronic distribution to state Medicaid agencies, of retail survey prices.

Conference Agreement

The conference agreement would increase the required reporting of AMP and best prices. AMP would be reported and calculated on a monthly basis. In addition, the agreement allows states to have access to reported AMP data for multiple source drugs for the purpose of carrying out the Medicaid programs and would require the Secretary to disclose such information through a website accessible to the public. In addition, the provision requires the Secretary to provide AMPs to States on a monthly basis and to update information posted to the website on at least a quarterly basis.

c. Definition of Average Manufacturer Price. --

Current Law

The AMP is defined as the average price paid to a manufacturer by wholesalers for drugs distributed to retail pharmacies. CMS instructs manufacturers to exclude certain federal drug purchases as well as free goods from the computation of AMP. Sales at nominal prices are excluded from the best price computation. Manufacturers are required to report, for each rebate period, the AMP for all Medicaid covered outpatient drug products and the best price for single source and innovator multiple source drugs to CMS.

Senate Bill

The Senate bill would modify the definition of AMP and require the modified AMP to be used to calculate the FUL for single source drugs in addition to rebates, as under current law. The provision would specify that sales exempted from inclusion in the determination of best price, nominal price sales (except for those contingent on purchase requirements or agreements), and bona fide service fees would be exempted from the computation of the AMP. Computation

of AMP would include cash and volume discounts; nominal price sales contingent on a purchase agreement or requirement; free goods; chargebacks or rebates to a pharmacy (excluding mail order, nursing home pharmacies and pharmacy benefit managers), or any other direct or indirect discounts; and any other price concessions which may be based on recommendations of the Inspector General of HHS. Bona fide user fees would be defined as expenses for a service actually performed by an entity for a manufacturer that would have generally been paid for by the manufacturer at the same rate had these services been performed by another entity.

The Senate bill would define the weighted AMP, to be used in calculating the FUL for multiple source drugs, with respect to the rebate period, as the volume-weighted average of manufacturers' reported prices for all drug products that are therapeutically equivalent and bioequivalent. It would be computed by summing, for all therapeutic equivalents and bioequivalent forms of the drug, the products of the AMP and the number of units sold. The sum of those amounts would be divided by the sum of all units sold for all NDCs assigned to such products. In cases in which there is a lag in the reporting of information on rebates and chargebacks so that adequate data are not available on a timely basis to update the weighted AMP for a multiple source drug, the manufacturer of such drug would apply a methodology based on a 12-month rolling average to estimate costs attributable to rebates and chargebacks for such drugs. For years after 2006, the Secretary would be required to establish a uniform methodology to estimate and apply such costs.

The Senate bill would modify the existing price reporting requirements so that manufacturers would be required to report the modified AMP and the weighted AMP to the Secretary of CMS as well as information and data on any sales made during the reporting period at a nominal price. The bill would provide the Secretary with the authority to enter into contracts with appropriate entities to determine AMP, prices, volume, and other data necessary to calculate the FUL and payment limits for covered drugs.

The Senate modifications to the definition of AMP would become effective as if enacted on July 1, 2005 except for the provisions related to the exclusion of nominal prices from AMP. Those provisions would become effective on the later of the expiration date of a contract in effect on the date of enactment or October 1, 2006 and would apply to sales made and rebate periods beginning on or after that date.

House Bill

The House bill would not change AMP. Instead it would establish a measure of price referred to as RAMP for the purpose of calculating the FUL for single source drugs. RAMP would be defined as the average price paid to a manufacturer for the drug in the U.S. in the quarter by wholesalers for drugs distributed to retail pharmacies, excluding service fees. For this purpose, retail pharmacies would be defined to exclude mail-order only pharmacies and pharmacies at nursing facilities and homes. Specified items to be excluded from RAMP are similar to those to be excluded from AMP in the Senate bill except that the House bill allows the Secretary to define nominal sales, and free goods contingent on purchase requirements would not be excluded from RAMP. In addition, service fees that represent fair market value for a bona-fide service provided by the entity would be excluded from RAMP. Items to be included in RAMP are also similar to those included in AMP in the Senate bill except that RAMP includes free goods contingent upon a purchase requirement; and does not provide for an exception for mail order, nursing home pharmacies and pharmacy benefit managers.

The volume weighted average RAMP would be defined, for all drug products in the same multiple source drug billing and payment code (or other methodology as specified by the Secretary), as the volume weighted average of the reported RAMPs. It would be computed by summing the products of the RAMPs for all product with an NDC code and multiplying by the total number of units of the drug product sold. Those amounts would be summed together and divided by the total number of units sold for all NDC codes assigned to such products.

The House bill would establish reporting requirements of drug manufacturers. Manufacturers would be required, beginning after July 1, 2006, to submit the RAMP, the total number of units required to compute the volume weighted average RAMP, the WAC for drugs sold during an initial sales period, and information on nominal price sales. The reporting would be by National Drug Code (NDC). In addition, the bill would provide the Secretary with the authority to enter into contracts with appropriate entities to determine RAMPs and other data necessary to calculate the FULs and payment limits and would modify the confidentiality provisions allowing states access to reported price information.

Conference Agreement

The conference agreement amends the definition of AMP to exclude customary prompt pay discounts extended to wholesalers from those amounts. In addition, the agreement modifies the price reporting requirements so that manufacturers would be required to submit, not later than 30 days after the last day of each rebate period, the customary prompt pay discounts extended to wholesalers in addition to the AMP and best price reporting required under current law.

The conference agreement requires the Inspector General of the Department of Health and Human Services (HHS) to, no later than June 1, 2006, review the requirements for, and the manner in which AMP is determined and to submit to the Secretary and Congress any recommendations for changes as determined to be appropriate.

The agreement also requires the Secretary of HHS to promulgate a regulation clarifying the requirements for and the manner in which AMPs are to be determined, taking into consideration the recommendations of the Inspector General.

d. Exclusion of Sales at a Nominal Price from Determination of Best Price --

Current Law

In addition to the AMP, pharmaceutical manufacturers are required to report to the Secretary of HHS the "best price" at which the manufacturer sells each of its drug products to certain purchasers for the purpose of calculating the rebate amounts. Prices that are nominal in amount are excluded from best price reporting. Nominal prices are defined by CMS to be those that are below 10% of the average manufacturer's price.

Senate Bill

The Senate bill would exclude, for the purposes of computing the AMP, sales by a manufacturer of covered outpatient drugs that are single source, innovator multiple source drugs, or are authorized generics that are made available at nominal prices to the following listed entities: a) entities eligible for discounted prescription drug prices under Section 340(B) of the Public Health Service Act; b) intermediate care facilities for the mentally retarded, c) state-owned or operated nursing facilities, d) any other facility or entity that the Secretary determines is a safety net provider to which sales of such drugs at nominal prices would be appropriate based on the type of facility, the services it provides, the patients served and the number of other such facilities eligible for nominal pricing in the area. The nominal price limitations would not apply to nominal drug purchases pursuant to a master agreement for procurement of drugs on the Federal Supply Schedule. In addition, the bill would modify manufacturers' price reporting requirements to include, for calendar quarters beginning on or after January 1, 2006 information on sales made at a nominal price.

House Bill

The House bill would exclude, for the purpose of computing the RAMP, sales as the Secretary identifies, that are nominal in amount. In addition, the bill would modify manufacturers' price reporting requirements to include, for calendar quarters beginning on or after July 1, 2006 information on sales made at a nominal price.

Conference Agreement

The conference agreement modifies the manufacturer price reporting requirements so that for calendar quarters beginning on or after January 1, 2007, manufacturers would be required to report information on sales of Medicaid covered drugs that are made at a nominal price.

In addition, the agreement defines the sales are to be considered nominal for the purpose of reporting nominal price sales and for computing and reporting the best price. (The agreement does not amend the AMP vis-a-vis nominal prices.) Nominal sales are those made by a manufacturer of covered drugs at nominal prices to a) entities eligible for discounted prescription drug prices under Section 340(B) of the Public Health Service Act; b) intermediate care facilities for the mentally retarded, c) state-owned or operated nursing facilities, d) any other facility or entity that the Secretary determines is a safety net provider to which sales of such drugs at nominal prices would be appropriate based on the type of facility, the services it provides, the patients served and the number of other such facilities eligible for nominal pricing in the area. The nominal price limitations do not apply to nominal drug purchases pursuant to a master agreement for procurement of drugs on the Federal Supply Schedule.

e. Retail Survey Prices; State Payment and Utilization Rates; and Performance Rankings. --

Current Law

No provision.

Senate Bill

No provision.

House Bill

The House bill would allow the Secretary to contract with a vendor to obtain retail survey prices for Medicaid covered outpatient drugs that represent a nationwide average of pharmacy sales costs for such drugs, net of all discounts and rebates. Such a contract would be awarded for a term of 2 years.

The Secretary would be required to competitively bid for an outside vendor with a demonstrated history in surveying and determining on a representative nationwide basis, retail prices for ingredient costs of prescription drugs; working with retail pharmacies, commercial payers, and states in obtaining and disseminating price information; and collecting and reporting price information on at least a monthly basis. The contract would include the terms and conditions specified by the Secretary and would include a requirement that the vendor monitor the marketplace and report to the Secretary each time there is a new covered outpatient drug available nationwide; update the Secretary no less often than monthly on the retail survey prices for multiple source drugs and on the computed upper payment limit for those drugs; to independently confirm retail survey prices. Information on the retail survey prices obtained through this process, including information on single source drugs would be required to be provided to states on an ongoing and timely basis.

Conference Agreement

The conference agreement includes a provision similar to the House provision. The agreement allows the Secretary to contract for services for the determination of retail survey prices for covered outpatient drugs that represent a nationwide average of consumer purchase prices for such drugs. The conference agreement adds a provision allowing such a contract to include notification of the Secretary when a drug product that is therapeutically and pharmaceutically equivalent and bioequivalent becomes generally available. The vendor must update the Secretary no less often than monthly on the retail survey prices for covered outpatient drugs. The contract shall be effective for a term of two years. If the Secretary were to be notified that such a product has become generally available, the Secretary would be required to make a determination within 7 days as to whether the drug meets the definition of a multiple source drug subject to the application of the FUL. The agreement allows the Secretary to waive those provisions the Secretary determines are appropriate to waive, of the Federal Acquisition Regulation, for the efficient implementation of the contract.

The agreement does not require the contractor to independently confirm retail survey prices, as in the House bill, and does not require the Secretary to provide for electronic distribution to states. On the other hand, the Secretary would be required to devise and implement a means for providing access to each state Medicaid agency of collected price information and to provide information on retail survey prices, including information on single source drugs, to states at least monthly.

The agreement requires an annual report from each state agency. States are required to provide to the Secretary, the payment rates for all covered drugs, dispensing fees and utilization of innovator multiple source drugs under the state Medicaid plan. The Secretary is required to compare, on an annual basis, for the 50 most widely prescribed drugs, the national retail sales price data for each state. In addition, the Secretary is required to submit full information regarding the annual rankings to Congress. The provision becomes effective on January 1, 2007.

(f) Miscellaneous Amendments. --

Current Law

States are required to have in place a program of prospective drug review wherein before each prescription is filled, the use of the prescription is screened for potential drug therapy problems. The requirement includes language clarifying that nothing in the provision is intended to require a pharmacist to provide this consultation when a beneficiary refuses such a consultation.

Senate Bill

No provision.

House Bill

No provision.

Conference Agreement

The conference agreement clarifies that the requirement to provide prospective drug reviews is not intended to require verifications that consultations were offered or refused.

Effective on the date of enactment.

(g) Effective Date

Current Law

No provision.

Senate Bill

No provision.

House Bill

No provision.

Conference Agreement

Unless otherwise specified, the provisions in Section 6001 take effect on January 1, 2007, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date.

Collection and Submission of Utilization Data for Certain Physician Administered Drugs (Section 6002 of the Conference Agreement, Section 6004 of the Senate Bill, and Section 3102 of the House Bill).

Current Law

Manufacturers are required to provide rebates to states for all outpatient prescription drugs with some exceptions. Outpatient prescription drugs provided through managed care organizations are explicitly exempted from the rebate requirement. In addition, outpatient drugs dispensed by a hospital and billed at no more than the hospital's purchasing costs are exempt from the rebate requirement. Certain drugs administered by physicians in their offices or in another outpatient setting, such as chemotherapy, have often been excluded from the drug rebate program although there is no specific statutory exclusion. This is because providers use Healthcare Common Procedure Coding System (HCPCS) J-codes to bill the Medicaid program for injectable prescription drugs, including cancer drugs. The HCPCS J-codes do not, however, provide States with the specific manufacturer information necessary to enable them to seek rebates. The NDC number is necessary for the state to bill manufacturers for rebates. CMS has requested that states identify Medicaid drugs, specifically those using HCPCS J-codes, by their NDC codes so that rebates can be collected for these drugs (Letter to State Medicaid Director, SMDL #03-002, dated March 14, 2003). CMS has concluded that because of this coding, many state Medicaid programs have not collected rebates on these drugs, resulting in millions of dollars in uncollected rebates.

Senate Bill

As a condition of receiving Medicaid payment, states would be required to submit, to the Secretary of HHS, utilization data and coding information for physician administered outpatient drugs. The Secretary would determine the drugs for which such reporting information would be required. The reporting would include J-codes and National Drug Code numbers. The purpose of the reporting would be to allow the Secretary to secure rebates for such drugs.

Effective upon enactment.

House Bill

As a condition of receiving Medicaid payment, and in order to secure rebates for physician administered drugs states would be required to submit:

— No later than January 1, 2006, utilization data and coding information for single source drugs or biologicals that are physician administered outpatient drugs. The Secretary would determine the drugs for which such reporting information would be required.

— No later than January 1, 2007, utilization data and coding information by NDC (unless the Secretary identifies an alternative coding system) for multiple source drugs.

— No later than January 1, 2008, utilization and coding information for those drugs on the list of 20 high volume physician administered drugs.

No later than January 1, 2007, the Secretary would be required to publish a list of the 20 physician administered multiple source drugs that have the highest volume of physician administered dispensing under Medicaid. The Secretary would be able to modify such list from year.

The Secretary would be permitted to delay the application of the reporting requirements in the case of a State to prevent hardship to States that require additional time to implement such a reporting system.

Conference Agreement

The agreement includes a provision similar to the House provision. For drugs administered on or after January 1, 2006, states are required to provide for the collection and submission of utilization and coding information for each Medicaid single source drug that is physician administered. For drugs administered on or after January 1, 2008, states are required to provide for the collection and submission of utilization and coding information for each Medicaid multiple source drug that is physician administered. Submissions from states will be based on National Drug Codes unless the Secretary specified an alternative coding system. All other provisions are identical to the House bill.

Improved Regulation of Drugs Sold Under a New Drug Application Approved Under Section 505(c) of the Federal Food, Drug, and Cosmetic Act (Section 6003 of the Conference Agreement, Section 6003 of the Senate Bill, and Section 3103 of the House Bill).

Current Law

Prescription drug manufacturers participating in the Medicaid program are required to report, to the Secretary of HHS, the AMP for each pharmaceutical product offered under Medicaid and, for each brand name drug product, the best price available to any wholesaler, retailer, provider, health maintenance organization (HMO), nonprofit entity, or governmental entity. The term 'best price' is defined in the Medicaid statute but only with respect to single source and innovator multiple source drugs since the best price is part of the rebate computation for only those drugs. These reported prices are used to calculate rebates - which are generally calculated separately for brand name drug products and for generics.

Sometimes manufacturers produce both a brand name version of a prescription drug and also sell or license a second manufacturer (or a subsidiary) to produce some of the same product to be sold or re-labeled as a generic. These generics, called "authorized generics," are subject to a separate rebate calculation. Rebates for brand name products, take into account the best price reported for each drug. Such price often does not include the price of the product sold as the authorized generic.

Current law defines best price with respect only to a single source drug or innovator multiple source drug, as the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, HMO, nonprofit entity, or governmental entity within the U.S. excluding prices charged to specified governmental purchasers. The AMP is defined as the average price paid to a manufacturer by wholesalers for drugs distributed to retail pharmacies. Certain federal drug purchases as well as several other specific kinds of sales are exempt from the AMP and from the best price calculation.

Senate Bill

The Senate bill would modify the existing drug price reporting requirements to include, for single source drugs, innovator multiple source drugs, authorized generic drugs, and any other drugs sold under a new drug application approved (under Section 505c of the Federal Food, Drug and Cosmetic Act, FDCA) by FDA, both the average manufacturer's price and the manufacturer's best price for such drugs. An authorized generic drug would be defined as a listed drug that has been approved by the FDA under Section 505(c) of such Act and is marketed, sold or distributed directly or indirectly to retail class of trade under a different labeling, packaging (other than repackaging the listed drug for use in institutions), product code, labeler code, trade name, or trade mark than the listed drug.

The definition of best price would be modified so that, in the case of a manufacturer that approves, allows or otherwise permits an authorized generic or any other drug to be sold under an NDA, it is inclusive of the lowest price such drug is sold to any wholesaler, retailer, provider, HMO, nonprofit or governmental entity. The definition of AMP would be modified to include, in the case of a manufacturer that approves, allows, or otherwise permits an authorized generic or any other drug of the manufacturer to be sold under an NDA to be inclusive of the average price paid for such drugs. The provision would become effective on January 1, 2006.

House Bill

The provision would modify the existing drug price reporting requirements for pharmaceutical manufacturers. No later than 30 days after the last day of each rebate period, manufacturers would be required to report,

- for each covered outpatient drug, including those sold under a new drug application approved by the FDA, the average manufacturer's price for such drugs; and,
- for single source drugs, innovator multiple source drugs, and any other drug sold under a new drug application approved by the FDA, the manufacturers best price for such drugs during the applicable rebate period.

Not later than 30 days after the date of entering into a drug rebate agreement, manufacturers would be required to report on the average manufacturer price for each of the manufacturer's covered outpatient drugs, including those sold under a new drug application approved by the FDA.

The definition of best price would be changed to apply, not only to each single source drug and innovator multiple source drug, but also to drugs sold under a new drug application (NDA) approved by (under Section 505c of FDCA) FDA. In addition, the definition would be modified so that the best price, in the case of a manufacturer that approves, allows or otherwise permits an authorized generic or any other drug of the manufacturer to be sold under an NDA, is inclusive of the lowest price such authorized generic or other drug is sold to any wholesaler, retailer, provider, HMO, nonprofit or governmental entity except for those entities excluded under current law. The provision would modify the current law definition of AMP to include, in the case of a manufacturer that approves, allows, or otherwise permits a drug of the manufacturer

to be sold under an NDA to be inclusive of the average manufacturer price paid for such drugs. The provision would become effective on January 1, 2006.

Conference Agreement

The agreement includes a provision similar to the Senate provision. The provision is different from the Senate provision in that it does not refer to the affected drugs as "authorized generics". Instead, the agreement uses the phrase "any drug of the manufacturer sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act" to include authorized generics. The conference agreement does not include a definition of "authorized generics." In addition, the definition of best price would be modified so that it is inclusive, in the case of a manufacturer that approves, allows, or otherwise permits any other drug of the manufacturer to be sold under a new drug application approved under section 505(c) of the FDCA, of the lowest price for an authorized drug available from the manufacturer during the rebate period to any manufacturer, wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the U.S. The effective date would be January 1, 2007.

Children's Hospital Participation in Drug Discount Program (Section 6004 of the Conference Agreement, no provision of the Senate Bill, and Section 3104 of the House Bill).

Current Law

Section 340(B) of the Public Health Service Act allows certain health care providers, including community health centers and disproportionate share hospitals, access to prescription drug prices that are similar to the prices paid by Medicaid agencies after being reduced by manufacturer rebates.

Senate Bill

No provision.

House Bill

The House bill would include a provision adding Children's Hospitals to the list of providers that may have access to 340(B) discounted prices. The provision would become effective for drugs purchased on or after the date of enactment.

Conference Agreement

The conference agreement includes the House provision.

Dispensing Fees (No provision in the Conference Agreement, Section 6001 of the Senate Bill, and Section 3101 of the House Bill).

Current Law

States are allowed to pay pharmacies reasonable dispensing fees.

Senate Bill

The Senate bill would require states to establish dispensing fees that are (a) greater for non-innovator multiple source drugs than those for innovator multiple source drugs that are therapeutically equivalent and bioequivalent; and (b) that take into account requirements established by the Secretary to include reasonable costs associated with a pharmacist's time checking an individual's coverage or performing quality assurance; measuring or mixing of a

drug; filing the container; providing the completed prescription; delivery; special packaging; physical overhead and salaries of pharmacists and other pharmacy workers; geographic factors that impact costs; patient counseling; and drugs requiring specialty pharmacy management services.

The Senate bill would require, no later than 15 months after the date of enactment, with quarterly updates thereafter, the Secretary to establish of list of covered outpatient drugs requiring specialty pharmacy care management services. The list would include only those drugs for which the Secretary determines that access to the drug would be seriously impaired without the provision of such care management services. Specialty pharmacy care management services would be defined as those services provided in connection with the dispensing of a covered drug that requires:

- significant caregiver contact, education about the disease state, prevention, treatment, drug indications, benefits, risks, complications, pharmacy counseling and explanation;
- patient compliance services including coordination of provider visits with drug delivery, compliance with dosing regimen, mailing or telephone call reminders, compiling compliance data, assistance providers with compliance programs;
- tracking services, referral processes, screening referrals, and tracking patient weight for dosage.

In addition, the Senate bill would require states to consider, in establishing dispensing fees, the costs associated with operating a critical access retail pharmacy.

House Bill

The House bill would require states to pay a dispensing fee for each covered outpatient drug. States would be allowed to vary dispensing fees to take into account the special circumstances of pharmacies serving rural and underserved areas and sole community pharmacies. Dispensing fees for drugs defined as multiple source drugs under the FUL policy would be required to be no less than \$8 per prescription unit. The Secretary would be required to define what constitutes a prescription unit for this purpose.

Conference Agreement

No provision.

Increase in rebates for covered outpatient drugs (No provisions of the Conference Agreement, Sections 6001, 6002 and 6039D of the Senate Bill, and no provisions of the House Bill) ..

Current Law

Basic Medicaid rebates for single source and innovator multiple source drugs are equal to the greater of 15.1% of the AMP or the difference between the reported AMP and best price for each drug. In addition, if the prices of single source or innovator multiple source drugs rise faster than inflation, additional rebates are due. Rebates for all other multiple source drugs is equal to 11% of the AMP.

Senate Bill

The Senate bill would modify the formulas for prescription drug rebates under the Medicaid program. Beginning on January 1, 2006, rebates for single source and innovator multiple source drugs would be equal to the greater of 18.1% of the AMP or the difference between the reported AMP and the best price for each drug. (Sections 6002(a)(3) and 6001(b)(2).)

Rebates for single source and innovator multiple source drugs equal to 17.8% of the AMP or the difference between the reported AMP and the best price for each drug. (Section 6039D.)

Rebates for all other drugs would be equal to 17%. Changes to the rebate formula would begin on January 1, 2006.

House Bill

No provision.

Conference Agreement

No provision.

Extension of rebates to Medicaid MCOs (No provisions of the Conference Agreement, Sections 6001 and 6038 of the Senate Bill, and no provisions of the House Bill).

Current Law

Rebates are not required for drugs dispensed by Medicaid managed care organizations (MCO) when the drugs are paid as part of the MCO capitation rate, to drugs provided in hospitals, and sometimes in physicians', or dentists' offices.

Senate Bill

Section 6001(a)(5) of the Senate bill would establish rebates for drugs dispensed by Medicaid MCOs. States would have the option of collecting rebates directly from manufacturers or allowing the MCO to collect the rebates in exchange for a reduction in the prepaid payment made to the entity for Medicaid enrollees. The provision would become effective on the date of enactment and would apply to Medicaid rebate agreements entered into or renewed on or after that date.

Section 6038 would establish rebates for drugs dispensed by Medicaid MCOs except for those drugs purchased at discounted prices under the Public Health Service Act Sec. 340B drug discount program.

House Bill

No provision.

Conference Agreement

No provision.

Improving Patient Outcomes (No provision of the Conference Agreement, no provision of the Senate Bill, and Section 3105 of the House Bill).

Current Law

States may establish a prior authorization program as long as the system provides a response for a request for approval within 24 hours, and as long as the program allows for a dispensing of at least a 72 hour supply of a covered drug in an emergency situation. Other restrictions may be imposed if they are necessary to discourage waste, fraud or abuse.

Senate Bill

No provision.

House Bill

The provision would limit the ability of states to place atypical antipsychotic or antidepressant single source drugs on prior authorization lists imposing other restrictions unless a drug use review board has determined that doing so is not likely to harm patients or increase overall medical costs. It also would require states to pay for a 30 day supply of such drugs in cases where a request for authorization is not responded to within 24 hours after the prescription is transmitted. The provision would be effective on January 1, 2007.

Conference Agreement

No provision.

Chapter 2 – Long-Term Care Under Medicaid

Subchapter A- Reform of Asset Transfer Rules Lengthening Look-Back Period; Change in Beginning Date for Period of Ineligibility.

Lengthening Look-back Period for all Disposals to 5 years (Section 6011(a) of the Conference Agreement, no provision in the Senate Bill, and Section 3111(a) of the House Bill).

Current Law

Current law requires states to impose penalties on individuals who transfer assets (all income and resources of the individual and of the individual's spouse) for less than fair market value (an estimate of the value of an asset if sold at the prevailing price at the time it was actually transferred). Specifically, the rules require states to delay Medicaid eligibility for certain Medicaid long-term care services for individuals applying for care in a nursing home, and, at state option, for certain people receiving care in community-based settings, who have transferred assets for less than fair market value on or after a "look-back date." The "look-back date" is 36 months prior to application for Medicaid for income and most assets disposed of by the individual, and 60 months in the case of certain trusts.

Ineligibility for Medicaid coverage is limited to only certain long-term care services, not all services covered under the program. The services for which the penalty applies include nursing facility care; services provided in any institution in which the level of care is equivalent to those provided by a nursing facility; Section 1915(c) home and community-based waiver services; home health services; and personal care furnished in a home or other locations. States may choose to apply this ineligibility period to other state plan long-term care services. (They also currently apply to home and community care for functionally disabled elderly individuals under section 1929 of the Act. This is an optional coverage group which operates only in Texas.) In general, states do not extend the penalty to Medicaid's acute care services.

Senate Bill

No provision.

House Bill

The House bill would amend section 1917(c)(1)(B)(i) of the Social Security Act to lengthen the look-back date to 5 years, or 60 months, for all income and assets disposed of by the individual after this Act's date of enactment. For income and assets disposed of prior to the

enactment date, the look back periods of 36 months for income and assets and 60 months for certain trusts would apply. The House bill would become effective on the date of the enactment of this Act.

Conference Agreement

The conference agreement includes the House provision.

Change in Beginning Date for Period of Ineligibility (Section 6011(b) of the Conference Agreement, no provision in the Senate Bill, and Section 3111(b) of the House Bill).

Current Law

The period of ineligibility, or penalty period, begins on the first day of the first month during or after which assets have been improperly transferred and which does not occur in any other period of ineligibility. There is no limit to the length of the penalty period. Some penalties imposed on applicants who made improper transfers within the look-back period and prior to the date of Medicaid application may expire before the date of Medicaid application. For example, an improper transfer of \$100,000 made 2 years prior to Medicaid application could result in a 20-month penalty period (\$100,000 divided by the private rate for a nursing home state in a state of \$5,000). Since the individual applies to Medicaid two years, or 24 months, after having made the transfer, the penalty has already expired before the individual applies to Medicaid. However, if the transfer of \$100,000 is made one year prior to Medicaid application, the penalty of 20 months would not have expired before the applicant needed Medicaid coverage, but rather would continue for eight months after Medicaid application.

Senate Bill

No provision.

House Bill

The House bill would amend section 1917(c)(1)(D) of the Social Security Act by changing the start date of the ineligibility period for all transfers made on or after the date of the enactment, to the first day of a month during or before which assets have been transferred for less than fair market value, or the date on which the individual is eligible for Medicaid and is receiving certain long-term care services, whichever is later and which does not occur during any period of ineligibility as a result of an asset transfer policy. For transfers made prior to this Act's enactment, current law applies.

Conference Agreement

The conference agreement includes the House provision but specifies that the start date begins on the first day of a month during or after which assets have been transferred for less than fair market value, or the date on which the individual is eligible for Medicaid and would otherwise be receiving institutional level care based on an approved application for such care but for the application of the penalty period, whichever is later, and which does not occur during any period of ineligibility as a result of an asset transfer policy.

Effective Date (Sections 6011(c) of the Conference Agreement, no provision in the Senate Bill, and Section 3111(c) of the House Bill).

Current Law

Currently effective.

Senate Bill

No provision.

House Bill

The amendments made by this section would apply to transfers made on or after the date of enactment.

Conference Agreement

The conference agreement includes the House provision.

Availability of Hardship Waivers (Sections 6011(d) and (e) of the Conference Agreement, Section 6011(f) of the Senate Bill, and Sections 3111(d) and (e) of the House Bill).

Current Law

To protect beneficiaries from unintended consequences of the asset transfer penalties, current law requires states to establish procedures for not imposing penalties on persons who, according to criteria established by the Secretary, can show that a penalty would impose an undue hardship. CMS guidance specifies that undue hardship can occur when application of the penalty would deprive the individual of medical care so that his or her health or life would be endangered, or when it would deprive the individual of food, clothing, shelter, or other necessities of life. The guidance explains that undue hardship does not exist when application of the penalty would merely cause the individual inconvenience or when it might restrict his or her lifestyle but would not put him or her at risk of serious deprivation.

CMS guidance requires that state procedures, at a minimum, provide for and discuss: (1) a notice to recipients that an undue hardship exception exists; (2) a timely process for determining whether an undue hardship waiver will be granted; and (3) a process under which an adverse determination can be appealed.

Senate Bill

The Senate bill would amend Section 1917(c) of the Social Security Act by adding a requirement that states establish undue hardship procedures (in accordance with standards specified by the Secretary) that would provide for: (1) a notice that an undue hardship exception exists before the imposition of a penalty period to an applicant for Medicaid who would be subject to such a penalty; (2) a timely process before the imposition of a penalty for determining whether an undue hardship waiver will be granted for the individual; (3) a process under which an adverse determination can be appealed; and (4) an application of criteria that specifies that undue hardship exists when application of the ineligibility period or counting of trusts would deprive the individual of medical care so that the individual's health or life would be endangered or when it would deprive the individual of food, clothing, shelter, or other necessities of life.

House Bill

The House bill would amend section 1917(c)(2)(D) of the Social Security Act to specify the criteria by which an application for an undue hardship waiver would be approved. Approval would be subject to a finding that the application of an ineligibility period would deprive the individual of medical care such that the individual's health or life would be endangered, or that the individual would be deprived of food, clothing, shelter, or other necessities of life. States would also be required to provide for: (A) notice to recipients that an undue hardship exception

exists; (B) a timely process for determining whether an undue hardship waiver will be granted; and (C) a process under which an adverse determination can be appealed.

This provision would also amend section 1917(c)(2) of the Social Security Act to permit facilities in which institutionalized individuals reside to file undue hardship waiver applications on behalf of the individual, with the institutionalized individual's consent or the consent of his or her guardian. If the application for undue hardship of nursing facility residents meets criteria specified by the Secretary, the state would have the option of providing payments for nursing facility services to hold the bed for these individuals at a facility while an application is pending. Such payments could not be made for longer than 30 days.

Conference Agreement

The conference agreement includes the House provision.

Disclosure and Treatment of Annuities and of Large Transactions (Section 6012 of the Conference Agreement, Section 6011(d) of the Senate Bill, and Section 3112 of the House Bill).

Current Law

Current law provides that the term "trust," for purposes of asset transfers and the look-back period, includes annuities only to the extent that the Secretary of DHHS defines them as such. CMS guidance (Transmittal Letter 64) asks states to determine the ultimate purpose of an annuity in order to distinguish those that are validly purchased as part of a retirement plan from those that abusively shelter assets. To be deemed valid in this respect, the life of the annuity must coincide with the average number of years of life expectancy for the individual (according to tables in the transmittal). If the individual is not reasonably expected to live longer than the guarantee period of the annuity, the individual will not receive fair market value for the annuity based on the projected return; in this case, the annuity is not "actuarially sound" and a transfer of assets for less than fair market value has taken place. The State Medicaid Manual provides life expectancy tables to be used by states for determining whether an annuity is actuarially sound.

States and courts interpret this guidance differently. In *Mertz v. Houston*, 155 F. Supp.2d 415 (E.D. Pa. 2001), for example, the court held that if an annuity was actuarially sound then the intent of the transfer was not relevant under federal law. In a recent case in Ohio, a state court ruled that it was proper to look at the intent of asset transfers, even if the annuity was actuarially sound. (*Bateson v. Ohio Dept. of Job and Family* (Ohio Ct. Appl., 12th, No. CA2003-09-093, Nov. 22, 2004).

Medicaid Estate Recovery. Current law requires states to recover the private assets (e.g., countable and non-countable assets) of the estates of deceased beneficiaries who have received certain long-term care services. Recovery of Medicaid payments may be made only after the death of the individual's surviving spouse, and only when there is no surviving child under age 21 and no surviving child who is blind or has a disability. Estate recovery is limited to the amounts paid by Medicaid for services received by the individual and is limited to only certain assets that remain in the estate of the beneficiary upon his or her death. As a result, estate recovery is generally applied to a beneficiary's home, if available, and certain other assets within a beneficiary's estate.

For purposes of these recovery requirements, estates are defined as all real and personal property and other assets in an estate as defined in state probate law. At the option of the state, recoverable assets also may include any other real and personal property and other assets in which the person has legal title or interest at the time of death, including assets conveyed to a survivor, heir, or through assignment through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangement. Thus assets such as living trusts, life insurance

policies, certain annuities, which may pass to heirs outside of probate, would be subject to Medicaid recovery only if a state expanded its definition of "estate."

Senate Bill

The Senate bill would amend section 1917(c)(1) of the Social Security Act to include, in the definition of assets subject to transfer penalties, an annuity purchased by or on behalf of an annuitant who has applied for Medicaid-covered nursing facility or other long-term care services. Annuities that would not be subject to asset transfer penalties would include an annuity as defined in section 408(b) or (q) of the Internal Revenue Code (IRC), or purchased with proceeds from: (1) an account or trust described in section 408(a)(c)(p) of the IRC; (2) a simplified employee pension as defined in section 408(k) of the IRC; or (3) a Roth IRA defined in section 408A of the IRC. Annuities would also be excluded from penalties if they are irrevocable and non-assignable, actuarially sound (as determined by actuarial publications of the Office of the Chief Actuary of the Social Security Administration), and provide for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments.

The Senate bill would amend section 1917(c)(1) of the Social Security Act by adding that the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless the state is named as the remainder beneficiary in the first position for at least the total amount of Medicaid expenditures paid on behalf of the annuitant or is named as such a beneficiary in the second position after the community spouse and such spouse does not dispose of any such remainder for less than fair market value.

The Senate bill would amend Section 1917(b)(4) of the Social Security Act to include an annuity in the definition of estate that is subject to estate recovery unless the annuity was purchased from a financial institution or other business that sells annuities in the state as part of its regular business.

House Bill

The House bill would amend section 1917 of the Social Security Act by adding a new subsection that would require individuals, at the initial application or recertification for certain Medicaid long-term care services, to disclose to the state the following:

(A) A description of any interest the individual has in an annuity (or similar financial instrument which provides for the conversion of a countable asset to a noncountable assets, as specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset;

(Applications or recertification forms shall include a statement that designates the state as the remainder beneficiary under such an annuity or similar financial instrument, subject to the following provisions:

(A) For institutionalized individuals who receive certain Medicaid-covered long-term care services, the state would become the remainder beneficiary in the first position of an annuity (in which he or she has an interest) for the total amount paid by Medicaid on behalf of the individual; The state becomes the remainder beneficiary in the second position when there is a spouse, minor, or disabled child as a named beneficiary.

(B) In the case of disclosure concerning an annuity, the state would notify the annuity's issuer of the state's right as a preferred remainder beneficiary in the annuity for Medicaid services furnished to the individual. This provision would not prevent the issuer from notifying persons with any other remainder of the state's interest in the remainder.

(C) The state may require an issuer to notify when there is a change in the amount of income or principal being withdrawn from the amount being withdrawn at the time of the most recent disclosure, as specified above. A state would take such information into account when determining the amount of the state's obligations for Medicaid or the individual's eligibility. Such a change in amount would be deemed as a transfer of an asset for less than fair market value unless the individual demonstrates, to the state's satisfaction, that the asset transfer was for fair market value.

The Secretary may provide guidance to states on categories of arms length transactions (such as the purchase of a commercial annuity) that could be generally treated as an asset transfer for fair market value.

The House bill would not prevent a state from denying Medicaid eligibility for an individual based on the income or resources derived from an annuity.

The House bill would apply to transactions (including the purchase of an annuity) occurring on or after the date of the enactment.

Conference Agreement

The conference agreement requires individuals, upon Medicaid application and recertification of eligibility, to disclose to the state, a description of any interest the individual or community spouse has in an annuity (or similar financial instrument, as specified by the Secretary), regardless of whether the annuity is irrevocable or is treated as an asset. Such application or recertification form includes a statement naming the state as the remainder beneficiary. In the case of disclosure concerning an annuity, the state notifies the annuity's issuer of the state's right as a preferred remainder beneficiary for Medicaid assistance furnished to the individual. Issuers may notify persons with any other remainder interest of the state's remainder interest.

States may require an issuer to notify the state when there is a change in the amount of income or principal withdrawn from the amount withdrawn at the point of Medicaid application or recertification. States take this information into account when determining the amount of the state's financial share of costs or in the individual's eligibility for Medicaid.

The Secretary may provide guidance to states on categories of transactions that may be treated as a transfer of asset for less than fair market value. States may deny eligibility for medical assistance for an individual based on the income or resources derived from an annuity.

The conference agreement amends section 1917(c)(1) of the Social Security Act by adding that the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless the state is named as the remainder beneficiary in the first position for at least the total amount of Medicaid expenditures paid on behalf of the annuitant or is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder for less than fair market value.

The conference agreement amends section 1917(c)(1) of the Social Security Act to include, in the definition of assets subject to transfer penalties, an annuity purchased by or on behalf of an annuitant who has applied for Medicaid-covered nursing facility or other long-term care services. Annuities that would not be subject to asset transfer penalties would include an annuity as defined in subsection (b) and (q) of section 408 of the Internal Revenue Code (IRC), or purchased with proceeds from: (1) an account or trust described in subsections (a), (c), and (p) of section 408 of the IRC; (2) a simplified employee pension as defined in section 408(k) of the IRC; or (3) a Roth IRA defined in section 408A of the IRC. Annuities would also be excluded from penalties if they are irrevocable and non-assignable, actuarially sound (as determined by

actuarial publications of the Office of the Chief Actuary of the Social Security Administration), and provide for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments.

The amendments apply to transactions, including the purchase of annuity, occurring on or after the date of this Act's enactment.

Application of Income-First Rule in Applying Community Spouse's Income Before Assets in Providing Support of Community Spouse (Section 6013 of the Conference Agreement, no provision in the Senate Bill, and Section 3113 of the House Bill).

Current Law

Current law includes provisions intended to prevent impoverishment of a spouse whose husband or wife seeks Medicaid coverage for long-term care services. These provisions were added by the Medicare Catastrophic Coverage Act (MCCA) of 1988 to address the situation that would otherwise leave the spouse not receiving Medicaid (community spouse) with little or no income or assets when the other spouse is institutionalized or, at state option, receives Medicaid's home- and community-based services. Before MCCA, states could consider all of the assets of the community spouse, as well as the spouse needing Medicaid coverage, to be available to pay for care for the spouse needing Medicaid coverage. These rules created hardships for the spouse living in the community who was forced to spend down virtually all of the couple's assets to Medicaid eligibility levels so that the other spouse could qualify for coverage. MCCA established new rules for the treatment of income and assets of married couples, allowing the community spouse to retain higher amounts of income and assets (on top of non-countable assets such as a house, car, etc.) than allowed under general Medicaid rules.

Regarding income, current law exempts all of the community spouse's income (e.g., pension or Social Security) from being considered available to the other spouse for purposes of Medicaid eligibility. For community spouses with more limited income, section 1924(d) of the Social Security Act provides for the establishment of a minimum monthly maintenance needs allowance for each community spouse to try to ensure that the community spouse has sufficient income to meet his or her basic monthly needs. (The community spouse's minimum monthly maintenance needs allowance is set at a level that is higher than the official federal poverty level.) Once income is attributed to each of the spouses according to their ownership interest, the community spouse's monthly income is compared against the minimum monthly maintenance needs allowance. If the community spouse's monthly income amount is less than the minimum monthly maintenance needs allowance, the institutionalized spouse *may* choose to transfer an amount of his or her income or assets to make up for the shortfall (i.e. the difference between the community spouse's monthly income and the state- specified minimum monthly maintenance needs allowance). This transfer allows more income to be available to the community spouse, while Medicaid pays a larger share of the institutionalized spouse's care costs. Within federal limits, states set the maximum monthly income level that community spouses may retain. Federal requirements specify that this amount may be no greater than \$2,377.50 per month, and no less than \$1,561.25 per month in 2005.

Regarding assets, federal law allows states to select the amount of assets a community spouse may be allowed to retain. This amount is referred to as the community spouse resource allowance (CSRA). Federal requirements specify that this amount may be no greater than \$95,100 and no less than \$19,020 in total countable assets in 2005. When determining eligibility, all assets of the couple are combined, counted, and split in half, regardless of ownership. If the community spouse's share of the assets is less than the state-specified maximum, then the Medicaid beneficiary *must* transfer his or her share of the assets to the community spouse until the community-spouse's share reaches the maximum. All other non-exempt assets must be depleted before the applicant can qualify for Medicaid.

States have some flexibility in the way they apply these rules at the time in which a person applies through the fair hearing process to raise his or her minimum maintenance needs allowance. At this point, a state may decide to allocate more income or resources from the institutionalized spouse to the community spouse. In doing so, states have employed two divergent methods. Under the method used by most states, known as the "income-first" method, the state requires that the institutionalized spouse's income is first allocated to the community spouse to enable the community spouse sufficient income to meet or, if approved by the state, exceed the minimum monthly maintenance needs allowance; the remainder, if any, is applied to the institutionalized spouse's cost of care. Under this method, the assets of an institutionalized spouse (e.g. an annuity or other income producing asset) cannot be transferred to the community spouse to generate additional income for the community spouse unless the income transferred by the institutionalized spouse would not enable the community spouse's total monthly income to reach the state-approved monthly maintenance needs allowance. This method generally requires a couple to deplete a larger share of their assets than the resources-first method.

In contrast, under the other method, known as the "resources-first" method, the couple's resources can be protected first for the benefit of the community spouse to the extent necessary to ensure that the community spouse's total income, including income generated by the CSRA, meets or, if approved by the state, exceeds the community spouse's minimum monthly maintenance needs allowance. Additional income from the institutionalized spouse that may be, but has not been, made available for the community spouse is used toward the cost of care for the institutionalized spouse. This method generally allows the community-spouse to retain a larger amount of assets than the income-first method.

On September 7, 2001, the Secretary issued a proposed rule (Federal Register Vol. 66, No. 174) that would have codified state practices. The proposed rule would have allowed states to choose between using either the income-first or resources-first method when determining whether the community spouse has sufficient income to meet the minimum monthly maintenance needs allowance. Under the proposed rule, states would not have been able to apply different rules to different individuals, on a case-by-case basis. The Secretary has not issued a final rule.

Senate Bill

No provision.

House Bill

The House bill would amend section 1924(d) of the Social Security Act to require that any transfer or allocation made from an institutionalized spouse to meet the need of a community spouse for a community spouse's monthly income allowance be first made from income of the institutionalized spouse. Only when sufficient income is not available, could resources of the institutionalized spouse be transferred or allocated.

The House bill would apply to transfers and allocations made on or after the date of this Act's enactment by individuals who become institutionalized spouses on or after such date.

Conference Agreement

The conference agreement amends section 1924(d), and therein sections (c) and (e), of the Social Security Act to require that states consider that all income of the institutionalized spouse that could be made available to the community spouse, in accordance with the calculation of the post-eligibility allocation of income or additional income allowance allocated at a fair hearing, has been made before states allocate the community spouse an amount of resources adequate to provide the difference between the minimum monthly maintenance needs allowance and all income available to the community spouse. These amendments apply to transfers and allocations

made on or after the date of this Act's enactment by individuals who become institutionalized spouses on or after such date.

Disqualification for Long-Term Care Assistance for Individuals with Substantial Home Equity (Section 6014 of the Conference Agreement, no provision in the Senate Bill, and Section 3114 of the House Bill).

Current Law

Within federal law, states set asset standards that applicants must meet to qualify for Medicaid coverage. Among other things, these standards specify a limit on the amount of countable assets a person may have to qualify, as well as define which types of assets are counted and not counted. In general, countable assets cannot exceed \$2,000 for an individual applicant. States generally follow SSI rules for computing both countable and non-countable assets.

Under Medicaid and SSI rules, the value of an item may be totally or partially excluded when calculating countable resources. For example, the entire value of a car, regardless of its worth, is excluded, but life insurance is counted to the extent that the cash surrender value exceeds \$1,500 (if the total value of all life insurance policies on any person does not exceed \$1,500, no part of the cash surrender value of such life insurance will be counted for eligibility purposes).

Current Medicaid and SSI asset counting practices general exclude the entire value of an applicant's home. A home is defined as any property in which an individual (and spouse, if any) has an ownership interest and which serves as the individual's principal place of residence. This property includes the shelter in which an individual resides, the land on which the shelter is located and related outbuildings. If an individual (and spouse, if any) moves out of his or her home without the intent to return, the home becomes a countable resource because it is no longer the individual's principal place of residence. However, if an individual leaves his or her home to live in an institution, the home is still considered to be the individual's principal place of residence, irrespective of the individual's intent to return, as long as a spouse or dependent relative of the eligible individual continues to live there. The individual's equity in the former home becomes a countable resource effective with the first day of the month following the month it is no longer his or her principal place of residence.

Senate Bill

No provision.

House Bill

The House bill would amend section 1917 of the Social Security Act to exclude from Medicaid eligibility for nursing facility or other long-term care services, certain individuals with an equity interest in their home of greater than \$750,000. (The Secretary would establish a process to waive application of this provision for demonstrated cases of hardship.) This amount would be increased, beginning in 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items, United States city average), rounded to the nearest \$1,000.

Individuals whose spouse, child under age 21, or child who is blind or disabled (as defined by the section 1614 of the Social Security Act) lawfully resides in the individual's home would not be excluded from eligibility. This provision would not prevent an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

The House bill would apply to individuals who are determined eligible for Medicaid with respect to nursing facility or other long-term care services based on an application filed on or after January 1, 2006.

Conference Agreement

The Conference agreement amends section 1917 of the Social Security Act to exclude from Medicaid eligibility for nursing facility or other long-term care services, certain individuals with an equity interest in their home of greater than \$500,000. A state may elect an amount that exceeds \$500,000, but does not exceed \$750,000. These dollar amounts are increased, beginning in 2011, from year to year based on the percentage increase in the consumer price index for all urban consumers (all items, United States city average), rounded to the nearest \$1,000.

Individuals whose spouse, child under age 21, or child who is blind or disabled (as defined by the section 1614 of the Social Security Act) lawfully resides in the individual's home would not be excluded from eligibility. This provision would not prevent an individual from using a reverse mortgage or home equity loan to reduce the individual's total equity interest in the home.

The House bill would apply to individuals who are determined eligible for Medicaid with respect to nursing facility or other long-term care services based on an application filed on or after January 1, 2006.

Enforceability of Continuing Care Retirement Communities (CCRC) and Life Care Community Admission Contracts (Section 6015 of the Conference Agreement, no provision in the Senate Bill, and Section 3115 of the House Bill).

Current Law

Continuing Care Retirement Communities (CCRCs) offer a range of housing and health care services to serve older persons as they age and as their health care needs change over time. CCRCs generally offer independent living units, assisted living, and nursing facility care for persons who can afford to pay entrance fees and who often reside in such CCRCs throughout their older years. The services generally offered include meals, transportation, emergency response systems, and on-site nursing and physician services. Many also offer home care, maid services and laundry. CCRCs were developed, in large part, in response to an interest among many elderly persons to age-in-place. CCRCs can be either for-profit or not-for-profit CCRCs. They are paid primarily with private funds, but a number also accept Medicaid payment for nursing facility services. Although the majority of CCRC residents do not meet the financial criteria for Medicaid, some do. Under current law, section 1919(c)(5)(A)(i)(II) of the Social Security Act prohibits a Medicaid-certified nursing facility from requiring that individuals provide them with oral or written assurance that they are not eligible for, or will not apply for, Medicaid or Medicare benefits.

Senate Bill

No provision.

House Bill

The House bill would amend section 1919(c)(5)(A)(i)(II) of the Social Security Act to provide an exception for state-licensed, registered, certified, or equivalent continuing care retirement communities (CCRCs) or a life care community (including nursing facility services provided as part of that community) that are certified to accept Medicaid and/or Medicare payment to allow them to require in their admissions contracts that residents spend their resources (subject to Medicaid's rules concerning the resources allowance for community

spouses, described above), declared for the purposes of admission, on their care before they apply for Medicaid.

The House bill would also amend section 1917 of the Social Security Act to consider certain entrance fees for CCRCs or life care communities to be countable resources, and thus available to the applicant, for purposes of the Medicaid eligibility determination. For applicants with community spouses, only that part of the entrance fee that is not protected for by the community spouse's resource allowance would be considered in the computation of the spousal share available to Medicaid. Entrance fees that would be considered a resource available to the individual would meet the following criteria:

(A) the individual would have the ability to use the entrance fee, or the contract provides that the entrance fee could be used, to pay for care should other resources or income of the individual be insufficient to pay for care;

(B) the individual would be eligible for a refund of any remaining entrance fee when the individual dies or terminates the CCRC or life care community contracts and leaves the community; and

(C) the entrance fee does not confer an ownership interest in the continuing care retirement community or life care community

Conference Agreement

The conference agreement includes the House provision except that a CCRC or life care community cannot retain a portion of an entrance fee, otherwise made available to spend on care before applying for Medicaid, on account of a community spouse's resource allowance.

Additional Reforms of Medicaid Asset Transfer Rules.

Requirement to Impose Partial Months of Ineligibility (Section 6016(a) of the Conference Agreement, Section 6011(a) of the Senate Bill, and no provision in the House Bill).

Current Law

Current law requires states to impose penalties on individuals applying for Medicaid who transfer assets (all income and resources of the individual and of the individual's spouse) for less than fair market value (an estimate of the value of an asset if sold at the prevailing price at the time it was actually transferred). Specifically, the rules require states to delay Medicaid eligibility for individuals receiving care in a nursing home, and, at state option, certain people receiving care in community-based settings, who have transferred assets for less than fair market value on or after a "look-back date." The look-back date is 36 months prior to application for Medicaid for income and most assets disposed of by the individual, and 60 months in the case of certain trusts.

The length of the delay is determined by dividing the total cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) on or after the look-back date by the average monthly cost to a private patient of a nursing facility in the state (or, at the option of the state, in the community in which the individual is institutionalized) at the time of application. For example, a transferred asset worth \$60,000, divided by a \$5,000 average monthly private pay rate in a nursing home, results in a 12-month period of ineligibility for Medicaid long-term care services. The period of ineligibility begins the first day of the first month during or after which assets have been improperly transferred and which does not occur in any other period of ineligibility. There is no limit to the length of the penalty period.

When calculating the length of the penalty period when assets are transferred for less than fair market value, current law allows states to "round down," or not include in the ineligibility period the quotient amounts (resulting from the division of the value of the transferred asset by the average monthly private pay rate in a nursing home) that are less than one month. For example, in a state with an average private stay in a nursing home of \$4,100, an ineligibility period for an improper transfer of \$53,000 could be 12.92 months (i.e. $\$53,000/\$4,100=12.92$). Although some states would impose an ineligibility period of 12 months and 28 days (of a 31 day month), other states may round down the quotient to an ineligibility period of 12 months only.

Senate Bill

The Senate bill would amend Section 1917(c)(1)(E) of the Social Security Act by adding that a state shall not round down, or otherwise disregard any fractional period of ineligibility when determining the ineligibility period.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate provision.

Authority for States to Accumulate Multiple Transfers into One Penalty Period (Section 6016(b) of the Conference Agreement, Section 6011(b) of the Senate Bill, and no provision in the House Bill).

Current Law

Current law and additional CMS guidance provides that when a number of assets are transferred for less than fair market value on or after the look-back date during the same month, the penalty period is calculated using the total cumulative uncompensated value of all assets transferred during that month by the individual (or individual's spouse) divided by the average monthly cost to a private patient of a nursing facility in the state (or, at the option of the state, in the community in which the individual is institutionalized) at the time of application. When a number of assets are transferred during *different* months, then the rules vary based upon whether the penalty periods overlap. If a penalty period for each transfer overlaps with the beginning of a new penalty period, then states may either add together the value of the transferred assets and calculate a single penalty period or impose each penalty period sequentially. If the penalty period for each transfer does not overlap, then states must treat each transfer as a separate event and impose each penalty period starting on the first day of the month in which each transfer was made.

Senate Bill

The Senate bill would amend Section 1917(c)(1) of the Social Security Act by adding that for an individual or an individual's spouse who disposes of multiple assets in more than one month for less than fair market value on or after the applicable look-back date, states may determine the penalty period by treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) during all months as one transfer. States would be allowed to begin such penalty periods on the earliest date which would apply to such transfers.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate provision but refers to the disposal of multiple fractional transfers of assets instead of multiple assets.

Inclusion of Transfer of Certain Notes and Loans Assets (Section 6016(c) of the Conference Agreement, Section 6011(c) of the Senate Bill, and no provision in the House Bill).

Current Law

Under current law, states set standards, within federal parameters, for the amount and type of assets that applicants may have to qualify for Medicaid. In general, countable assets cannot exceed \$2,000 for an individual. However, not all assets are counted for eligibility purposes. The standards states set also include criteria for defining non-countable, or exempt, assets. States generally follow rules for the Supplemental Security Income (SSI) program for computing both countable and non-countable assets.

Under state Medicaid and SSI rules, countable assets may include, but are not limited to, funds in a savings or money market account, stocks or other types of equities, accelerated cash benefits from certain types of insurance policies, and funds from certain types of trusts that can be obtained by the individual, the individual's spouse, or anyone acting for the individual or the individual's spouse, to pay for the individual's medical or nursing facility care, even if the funds or payments are not distributed. Under Medicaid and SSI rules, non-countable assets include an individual's primary place of residence, one automobile, household goods and personal effects,¹ property essential to income-producing activity, up to \$1,500 in burial funds, life insurance policies whose total face value is not greater than \$1,500, and miscellaneous other items.

Other rules defining countable and non-countable assets apply only in particular states. Their rules are generally intended to restrict the use of certain financial instruments (e.g. annuities, promissory notes, or trusts) to protect assets so that applicants can qualify for Medicaid earlier than they might otherwise.

Senate Bill

The Senate bill would amend Section 1917(c)(1) of the Social Security Act to make additional assets subject to the look-back period, and thus a penalty, if established or transferred for less than fair market value. Such assets would include funds used to purchase a promissory note, loan or mortgage, unless the repayment terms are actuarially sound, provide for payments to be made in equal amounts during the term of the loan and with no deferral nor balloon payments, and prohibit the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not satisfy these requirements, their value shall be the outstanding balance due as of the date of the individual's application for certain Medicaid long-term care services.

House Bill

No provision.

¹ Under former SSI rules, there were restrictions placed on the value of the automobile and household goods and personal effects that could be excluded from countable assets. As of March 9, 2005, one automobile and all household goods and personal effects are excluded, regardless of their value. 70 *Federal Register* 6340, no. 24, Feb. 7, 2005.

Conference Agreement

The conference agreement includes the Senate provision.

Inclusion of Transfers to Purchase Life Estates (Section 6016(d) of the Conference Agreement, Section 6011(e) of the Senate Bill, and no provision in the House Bill).

Current Law

Current law does not specify whether life estates should be treated as countable or noncountable assets for purposes of applying the Medicaid asset transfer rules. In CMS guidance, however, the Secretary specifies that the establishment of a life estate constitutes a transfer of assets. The guidance also explains that a transfer for less than fair market value occurs whenever the value of the transferred asset is greater than the value of the rights conferred by the life estate. According to CMS, a life estate is involved when an individual who owns property transfers ownership to another individual while retaining, for the rest of his or her life (or the life of another person), certain rights to that property. Generally, a life estate entitles the grantor to possess, use, and obtain profits from the property as long as he or she lives, even though actual ownership of the property has passed to another individual.

Senate Bill

The Senate bill would amend Section 1917(c)(1) of the Social Security Act to add a provision that would redefine the term 'assets,' with respect to the Medicaid asset transfer rules, to include the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for at least one year after the date of purchase.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate provision.

Effective Date (Section 6016(e) of the Conference Agreement, Section 6011(g) of the Senate Bill, and no provision in the House Bill).

Current Law

No provision.

Senate Bill

This provision would apply to payment made under the Medicaid program for calendar quarters beginning on or after the date of this Act's enactment, without regard to whether or not final regulations to carry out such amendments have been promulgated by such date. Amendments made by this provision would not apply to Medicaid assistance provided for services before the date of enactment, with respect to assets disposed of on or before the date of enactment, or with respect to trusts established on or before the date of enactment.

In the case of a state that the Secretary of Health and Human Services determines requires state legislation to meet the additional requirements of this provision, the state Medicaid plan would not be regarded as failing to comply with the requirements solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter

beginning after the close of the first regular session of the state legislature that begins after the date of enactment of this Act. In the case of a state that has a two-year legislative session, each year of the session would be considered to be a separate regular session of the state legislature. This amendment applies to provision under section 6011 of the Senate bill.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate provision with respect to amendments made by section 6016.

Subchapter B- Expanded Access to Certain Benefits

Expansion of State Long-Term Care Partnership Program (Section 6021 of the Conference Agreement, and Section 6012 of the Senate Bill, and Section 3133 of the House Bill).

Current Law

Under Medicaid's long-term care (LTC) insurance partnership program, certain persons who have exhausted (or used at least some of) the benefits of a private long-term care insurance policy may access Medicaid without meeting the same means-testing requirements as other groups of Medicaid eligibles. For these individuals, means-testing requirements are relaxed at: (1) the time of application to Medicaid; and (2) the time of the beneficiary's death when Medicaid estate recovery is generally applied.

In general, states allow individuals to retain no more than \$2,000 in countable assets and exempt certain non-countable assets such as an individual's primary place of residence, one automobile, household goods and personal effects. Under section 1902 of the Social Security Act, a state may request the Secretary's permission to amend its Medicaid state plans to allow certain applicants to retain greater amounts of countable assets than other applicants and still qualify for Medicaid. Specifically, states that obtain the Secretary's approval may disregard some or all of the assets of persons applying for Medicaid who have purchased long-term care insurance policies.

Section 1917 of the Social Security Act (amended by the Omnibus Budget Reconciliation Act of 1993, P.L. 103-66) allows only those states with an approved state plan amendment as of May 14, 1993 to exempt individuals from Medicaid estate recovery who apply to Medicaid after exhausting their private long-term care insurance benefits. By that date, five states (California, Connecticut, Indiana, Iowa, and New York) had received CMS approval. All of these states, except Iowa, have implemented partnership programs.

The four partnership states with active programs have different models for determining the amount of assets that an eligible participant may protect. Connecticut and California use a *dollar-for-dollar* model, in which the amount of the assets protected is equivalent to the value of the benefit package paid by the policy purchased (e.g., \$100,000 of nursing-home or assisted living benefits paid enables that individual to retain up to \$100,000 in assets and still qualify for Medicaid coverage in that state). New York uses a *total asset protection* model in which persons who purchase certain state-approved policies may qualify for Medicaid without having to meet any of Medicaid's asset criteria. Indiana uses a hybrid model, offering both dollar-for-dollar and total asset protection (Indiana switched from the dollar-for-dollar model to the hybrid model in 1998).

Federal oversight of long-term care insurance is largely limited to provisions established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191). HIPAA established new rules regarding the tax treatment of LTC insurance and expenses, and defined the requirements for a tax-qualified LTC insurance policy. LTC insurance products are largely regulated by states. Every state and the District of Columbia has some laws governing LTC insurance. Many of these laws reflect guidance provided by the National Association of Insurance Commissioners (NAIC), an organization of state insurance regulators. This guidance, provided in the form of a Model Act and Model Regulations for LTC insurance, addresses a number of areas, including the following.

Model Regulations:

- Application forms and replacement coverage;
- Reporting requirements;
- Filing requirements for marketing;
- Standards for marketing;
- Appropriateness of recommended purchase;
- Standard format outline of coverage; and
- Requirements to deliver shopper's guide.

Model Act:

- Outline of coverage;
- Requirements for certificates under group plans;
- Policy summary;
- Accelerated death benefits; and
- Incontestability period.

HIPAA also includes requirements that tax-qualified policies comply with consumer protections regarding the delivery of policies, information on denials of claims, and disclosure. While many state laws and regulations are based largely on the NAIC standards, others have adopted only some of these standards. As a result, there is significant variation in regulatory practices across states.

National Clearinghouse for Long-Term Care. No provision in current law requires the establishment of a long-term care consumer clearinghouse.

In related activities, DHHS has funded some states to establish state-based consumer-friendly access to information about long-term care services. In FY2003 and FY2004, the Centers for Medicare and Medicaid (CMS) and AoA awarded approximately \$19 million in grants to states for the purpose of assisting their efforts to create a single, coordinated system of information and access for all persons seeking long term care to minimize confusion, enhance individual choice, and support informed decision-making. In FY2005, \$15 million was awarded. A total of 43 states have received grants for this purpose. Some of the common activities under this grants program include information and referral, outreach, counseling about public benefits and long-term care options, and case management. States' methods for implementing the grant may vary; some states have established an actual physical location, and other states have established a statewide clearinghouse through a toll-free number or a web-based information site.

In addition, CMS has made available to the public, via its website, a comparison of Medicare and Medicaid-certified nursing homes and home health agencies. The information provides detailed facility and agency information and characteristics, and contains several measures of quality (e.g., improvement in mobility). This website does not cover assisted living facilities, group homes and other residential facilities that are not nursing facilities; nor does it cover non-medical, non-certified, home and community-based long-term care services.

Senate Bill

The Senate bill would exempt an additional group of persons with certain long-term care insurance plans from Medicaid estate recovery. This group would include individuals who received Medicaid under a Qualified State Long-Term Care Insurance Partnership plan meeting requirements A through G described below. The provision would also require that existing LTC insurance partnership programs satisfy requirements B through G below for LTC insurance policies sold on or after 2 years after enactment.

The Senate bill would define LTC insurance policies as including, but not be limited to, certificates issued under group insurance contracts [also would include individual and other LTC insurance contracts]. The term "Qualified State LTC Insurance Partnership," would mean a state with an approved Medicaid State plan amendment meeting the following requirements:

(A) the disregard of any assets or resources in an amount equal to the amount of payments made to, or on behalf of, an individual who is a beneficiary under any LTC insurance policy sold under such plan amendment;

(B) a state would treat benefits paid under any LTC partnership insurance policy sold under another states' Qualified LTC Insurance Partnership" or a long-term care insurance policy, the same as the state treats benefits paid under such a policy under the state's plan amendment;

(C) any long-term care insurance policy sold would be required to be a tax-qualified policy (Meeting specifications defined in section 7702B(b) of the Internal Revenue Code of 1986) and meet the consumer protection requirements described below;

(D) any policy would be required to provide for compound annual inflation protection of at least 5 percent and asset protection that does not exceed \$250,000. This amount would be increased, beginning with 2007, from year-to-year based on the percentage increase in the medical care expenditure category of the Consumer Price Index for Urban Consumers (United States city average), published by the Bureau of Labor Statistics rounded to the nearest \$100;

(E) an insurer would be allowed to rescind a LTC insurance policy in effect for at least 2 years or deny an otherwise valid LTC insurance claim only upon a showing (1) of misrepresentation that is material to the acceptance of coverage; (2) pertains to the claim made; and (3) could not have been known by the insurer at the time the policy was sold;

(F) any individual who sells these policies would be required to receive training and demonstrate evidence of an understanding of the policy and how it relates to other public and private LTC coverage; and

(G) the issuer would be required to report, to the Secretary required information, and to report to the state: (1) the information or data reported to the Secretary, (2) the information or data required under the minimum reporting requirements developed under section 103(c)(1)(B) of the Improving LTC Choices Act of 2005, and (3) such additional information or data as the state may require. If a LTC insurance policy is exchanged for another such policy, the effective date of coverage under the first policy would determine when coverage first becomes effective.

LTC insurance policies would be required to meet the following requirements specified in the National Association of Insurance Commissioner's (NAIC) Long-Term Care Insurance Model Regulations and Long-Term Care Insurance Model Act (as adopted as of October 2000). The requirements include the following topics described below.

Model Regulations:

- Guaranteed renewal or noncancellability;
- Prohibitions on limitations and exclusions;
- Extension of benefits;
- Continuation or conversion of coverage;

- Discontinuance and replacement of policies;
- Unintentional lapse;
- Disclosure;
- Required disclosure of rating practices to consumer;
- Prohibitions against post-claims underwriting;
- Minimum standards;
- Application forms and replacement coverage;
- Reporting requirements;
- Filing requirements for marketing;
- Standards for marketing, including inaccurate completion of medical histories;
- Suitability;
- Prohibition against preexisting conditions and probationary periods in replacement policies or certificates;
- Contingent nonforfeiture benefits if the policyholder declines the offer of a nonforfeiture provision;
- Standard format outline of coverage; and
- Deliver shopper's guide.

Model Act:

- Preexisting conditions;
- Prior hospitalization;
- Contingent nonforfeiture benefits;
- Right of return;
- Outline of coverage;
- Requirements for certificates under group plans;
- Policy summary; and
- Monthly reports on accelerated death benefits.

These provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act would be treated as including any other provision the Regulation or Act necessary to implement the provision. The determination of whether any requirement under the Model Act or Regulation have been met would be made by the Secretary.

No later than one year after enactment, the Secretary, in consultation with the NAIC, issuers of LTC insurance policies, states with experience with LTC insurance partnership plans, other states, and representatives of consumers of LTC insurance policies would be required to develop uniform standards for:

- *Reciprocity.* These standards would ensure that LTC insurance policies issued under the state LTC partnership (described in this provision) would be portable to other states with such LTC insurance partnerships;
- *Minimum reporting requirements.* These standards would be required to specify the data and information that each issuer of LTC insurance policies under State LTC insurance partnerships shall report to the state with which it has such a partnership. The requirements developed would be required to specify the type and format of the data and information to be reported and the frequency with which such reports are to be made. States would be permitted to require an issuer of LTC insurance policy sold in the state (regardless of whether the policy is issued under a State LTC insurance partnership) to require the issuer to report information or data to the state that is in addition to the information or data required under these minimum reporting requirements;
- *Suitability.* These standards would be for determining whether a long-term care insurance policy is appropriate for the needs of an applicant (based on guidance of the NAIC regarding suitability).

The Secretary, in consultation with those listed above, would also be required to submit recommendations to Congress with respect to the following:

- *Incontestability.* Recommendations regarding whether the requirements relating to incontestability for LTC insurance policies sold under a state partnership program should be modified based on NAIC guidance;
- *Nonforfeiture.* Recommendations regarding whether requirements relating to nonforfeiture for issuers of LTC insurance policies under a state LTC insurance partnership program should be modified to reflect changes in an insured's financial circumstances;
- *Independent certification for benefits assessment.* Recommendations regarding whether uniform standards for requiring benefits assessment evaluations to be conducted by independent entities should be established for issuers of LTC insurance policies under such a state partnership program, and if so, what such standards should be;
- *Rating requirements.* Recommendations regarding whether uniform standards for the establishment of, and annual increases in, premiums for LTC insurance policies sold under such a state partnership program should be established and if so, what such standards should be; and
- *Dispute Resolution.* Recommendations regarding whether uniform standards are needed to ensure fair adjudication of coverage disputes under LTC insurance policies sold under such a state partnership program and the delivery of the benefits promised under such policies.

The DHHS Secretary would be required to annually report to Congress on the LTC insurance partnerships. Such reports would be required to include analyses of the extent to which such partnerships expand or limit access of individuals to LTC and the impact of such partnerships on Federal and State Medicaid expenditures and federal Medicare expenditures.

Effective Date. These amendments would become effective on October 1, 2007 and apply to long-term care insurance policies sold on or after that date.

House Bill

The House bill would amend section 1917(b)(1)(C)(ii) of the Social Security Act to allow additional groups of individuals in states with state plan amendments approved after May 14, 1993 to be exempt from estate recovery requirements if the amendment provides for a qualified state long-term care insurance partnership program. The term "Qualified State LTC Insurance Partnership," would mean a Medicaid State plan amendment that provides for the disregard of any assets or resources in the amount equal to the amount of insurance benefit made to or on behalf of an individual who is a beneficiary under a long-term care policy (including a certificate issued under a group insurance contract), if the following requirements are met:

(I) The policy covers an insured who was a resident of such state when coverage first became effective under the policy. (In the case of a long-term care insurance policy exchanged for another such policy, this requirement would apply based on the coverage of the first such policy that was exchanged);

(II) The policy is a qualified long-term care insurance policy (meeting specifications defined in section 7702B(b) of the Internal Revenue Code of 1986) issued on or after the first day of the first calendar quarter in which the plan amendment was submitted to the Secretary;

(III) If the policy does not provide some level of inflation protection, the insured was offered, before the policy was sold, a long-term care insurance policy that provides some level of inflation protection;

(IV) The state Medicaid agency provides information and technical assistance to the state insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training or demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care;

(V) The issuer of the policy provides regular reports to the Secretary that include, in accordance with the Secretary's regulations (promulgated after consultation with the states), notification regarding when all benefits provided under the policy have been paid and the amount of such benefits paid, when the policy otherwise terminates, and such other information as the Secretary determines appropriate to the administration of such partnerships;

(VI) The state does not impose any requirement affecting the terms or benefits of such a policy unless the state imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

The Secretary, as appropriate, would provide copies of the state reports to the state involved and would promote the education of consumers regarding qualified state long-term care insurance partnerships. In addition, in consultation with other appropriate Federal agencies, issuers of long-term care insurance, and the National Association of Insurance Commissioners, the Secretary would develop recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified state long-term care insurance partnerships to a secure, centralized electronic query and report generating mechanism that State, the Secretary, and other Federal agencies can access.

To permit portability in long-term care insurance policies purchased under state long-term care insurance partnerships, the Secretary may develop, in consultation with the states and the National Association of Insurance Commissioners, uniform standards for reciprocal recognition of such policies among states with qualified state long-term care insurance partnerships.

Effective Date. A state plan amendment that provides for a qualified state long-term care insurance partnership would be effective for long-term care insurance policies issued on or after a date, specified in the amendment, that is not earlier than the first day of the first calendar quarter in which the plan amendment was submitted to the Secretary.

Conference Agreement

The conference agreement amends section 1917(b)(1)(C)(ii) of the Social Security Act to: 1) require that existing partnership programs not allow consumer protection standards, as defined in a Medicaid state plan amendment, to be less stringent (determined by the Secretary) than those applying under the state plan amendment as of December 31, 2005; and 2) allows certain individuals in states with state plan amendments approved after May 14, 1993 to be exempt from estate recovery requirements if the amendment provides for the disregard of any assets or resources in the amount equal to the amount of insurance benefits made to or on behalf of an individual who is a beneficiary under a long-term care policy (including a certificate issued under a group insurance contract), if the following requirements are met:

(I) The policy covers an insured who was a resident of such state when coverage first became effective under the policy. In the case of a long-term care insurance policy exchanged for another such policy, this requirement applies based on the coverage of the first such policy that was exchanged;

(II) The policy is a qualified long-term care insurance policy (meeting specifications defined in section 7702B(b) of the Internal Revenue Code of 1986) issued not earlier than the effective date of the Medicaid state plan amendment;

(III) The policy meets the following requirements specified in the National Association of Insurance Commissioner's (NAIC) Long-Term Care Insurance Model Regulations and Long-Term Care Insurance Model Act (as adopted as of October 2000).

Model Regulations relating to:

- Guaranteed renewal or noncancellability (including some sections of the Model Act);
- Prohibitions on limitations and exclusions;
- Extension of benefits;
- Continuation or conversion of coverage;
- Discontinuance and replacement of policies;
- Unintentional lapse;
- Disclosure;
- Required disclosure of rating practices to consumer;
- Prohibitions against post-claims underwriting;
- Minimum standards;
- Application forms and replacement coverage;
- Reporting requirements;
- Filing requirements for marketing;
- Standards for marketing, including inaccurate completion of medical histories;
- Prohibition against preexisting conditions and probationary periods in replacement policies or certificates;
- Contingent nonforfeiture benefits if the policyholder declines the offer of a nonforfeiture provision;
- Appropriateness of recommended purchase;
- Standard format outline of coverage; and
- Delivery of shopper's guide.

Model Act relating to:

- Preexisting conditions;
- Prior hospitalization;
- Contingent nonforfeiture benefits;
- Right of return;
- Outline of coverage;
- Requirements for certificates under group plans;
- Policy summary; and
- Monthly reports on accelerated death benefits.

These provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act are treated as including any other provision of the Regulation or Act necessary to implement the provision. Long-term care insurance policies issued in a state shall be deemed as meeting the requirements of the model regulation or the Model Act if the state plan amendment provides that the State insurance commissioner for the state certifies (in a manner satisfactory to the Secretary) that the policy meets such requirements.

(IV) If at the date of purchase the purchaser is younger than age 61, the policy must provide for compound inflation; if the purchaser is at least age 61 but not older than age 76, the policy must provide some level of inflation protection; and if the purchaser is age 76 or older, the policy may, but is not required to, provide some level of inflation protection.

(V) The state Medicaid agency provides information and technical assistance to the state insurance department on the insurance department's role of assuring that any individual who sells a long-term care insurance policy under the partnership receives training or demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care;

(VI) The issuer of the policy provides regular reports to the Secretary that include, in accordance with the Secretary's regulations (after consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, states with experience with long-term care insurance partnership plans, other states, and representatives of consumers of long-term care insurance policies) notification regarding when all benefits and their amounts under the policy have been paid, when the policy otherwise terminates, and other information that the Secretary determines is appropriate to the administration of the partnership programs. These regulations shall specify the data format and information to be reported, and the frequency with which such reports are to be made. The Secretary, as appropriate, provides copies of the reports to the state involved;

(VII) The state does not impose any requirement affecting the terms or benefits of such a policy unless the state imposes such requirement on long-term care insurance policies without regard to whether the policy is covered under the partnership or is offered in connection with such a partnership.

In consultation with other appropriate Federal agencies, issuers of long-term care insurance, and the National Association of Insurance Commissioners, state insurance commissioners, states with experience with long-term care insurance partnership plans, other states, and representatives of consumers of long-term care insurance policies, the Secretary develops recommendations for Congress to authorize and fund a uniform minimum data set to be reported electronically by all issuers of long-term care insurance policies under qualified state long-term care insurance partnerships to a secure, centralized electronic query and report generating mechanism that State, the Secretary, and other Federal agencies can access.

Not later than 12 months after the National Association of Insurance Commissioners issues a revision, update or other modification of a model regulation or model act provision listed above or substantially related those listed above, the Secretary reviews these changes, determines whether incorporating such changes into the corresponding provision would improve qualified state long-term care insurance partnerships, and, if so, incorporate the changes into the provision.

States may require issuers of long-term care insurance policies sold in that state (regardless of whether the policy is issued under a qualified state long-term care insurance partnership) to report additional information or data to the state.

To permit portability in long-term care insurance policies purchased under state long-term care insurance partnerships, the Secretary develops no later than January 1, 2007, in consultation with the National Association of Insurance Commissioners, states with experience with long-term care insurance partnership plans, other state, and representatives of consumers of long-term care insurance policies, standards for uniform reciprocal recognition of such policies among states with qualified state long-term care insurance partnerships which have benefits paid under such policies will be treated the same by all such states, and states with such partnerships shall be subject to such standards unless the state notifies the Secretary of the State's election to be exempt from such standards.

The Secretary annually reports to Congress on the long-term care insurance partnerships. Such reports would include analyses of the extent to which partnership programs expand or limit access of individuals to long-term care and the impact of such partnerships on federal and state expenditures under Medicare and Medicaid. Nothing in this provision shall require the Secretary

to conduct an independent review of each long-term care insurance policy offered under or in connection with a state partnership program.

A state plan amendment that provides for a qualified state long-term care insurance partnership may provide that the amendment be effective for long-term care insurance policies issued on or after a date that is not earlier than the first day of the first calendar quarter in which the plan amendment was submitted to the Secretary.

With respect to policy exchanges, Conferees expect existing policy holders will be able to exchange existing policies for Partnership policies in accordance with policy provisions and state law after a State's plan amendment is effective.

National Clearinghouse for Long-Term Care. The Secretary establishes a National Clearinghouse for Long-Term Care Information (this may be done through a contract or interagency agreement). The National Clearinghouse for Long-Term Care: 1) educates consumers with respect to the availability and limitations of Medicaid long-term care coverage, including state Medicaid eligibility and estate recovery requirements; 2) provides objective information to assist consumers with the decision-making process for determining whether to purchase long-term care insurance or to pursue other private market alternatives for purchasing long-term care; 3) provide contact information for additional objective sources on planning for long-term care services needs; and 4) maintain a list of states with state long-term care insurance partnerships.

In providing information to consumers on long-term care, the National Clearinghouse for Long-Term Care Information shall not advocate in favor of a specific long-term care insurance provider or a specific long-term care insurance policy.

Out of any funds in the Treasury not otherwise appropriated, there is appropriated to carry out for the National Clearinghouse for Long-Term Care \$3 million for each of fiscal years 2006 through 2010.

Expanded Access to Home and Community-based Services for the Elderly and Disabled (Section 6022 of the Conference Agreement, no provision in the Senate Bill, and Section 3131 of the House Bill).

Current law

Medicaid home and community-based service (HCBS) waivers authorized by Section 1915(c) of the Social Security Act allow states to provide home and community-based services to Medicaid beneficiaries who would otherwise need the level of care provided in a nursing facility, intermediate care facility for persons with mental retardation (ICF-MR) or hospital. HCBS waiver services can include case management, homemaker/home health aide services, personal care, psychosocial rehabilitation, home health, private duty nursing, adult day care, habilitation, respite care, day treatment, and any other service requested by the state and approved by the Secretary. As part of the waiver, states may define the services that will be offered, target a specific population (e.g., individuals with developmental disabilities) or a specific geographic region, and limit the number of waiver participants (resulting in a waiting list for services in many states).

Approval for a HCBS waiver is contingent on a state documenting the cost-neutrality of the waiver. Cost-neutrality is met if, on average, the per person cost under the HCBS waiver is no higher than the cost if the person were residing in one of the three types of institutions identified in Medicaid law, (hospital, nursing facility or ICF-MR). The state determines which type of institution(s) it will use to make the cost-neutrality calculation.

A HCBS waiver is generally approved for a 3- or 5-year time period and is subject to additional oversight from the Centers for Medicare and Medicaid Services (CMS). In July 2003, there were 275 HCBS waivers nationwide in all states (except Arizona which offers HCBS services under a Section 1115 waiver).

Senate Bill

No provision.

House Bill

The House bill would allow states to cover a broad range of home and community-based services (HCBS) as an optional benefit under the state Medicaid plan *without* requiring a waiver. States would be able to define which HCBS services will be covered and could include any service authorized by federal law for existing HCBS waiver programs (as defined in Section 1915(c)(4)(B) of the Social Security Act). Similar to the existing HCBS waiver program, paying for an individual's room and board would not be permitted under this new benefit.

To qualify for this benefit the individual must meet the following criteria: 1) age 65 or older or disabled (as defined under the Medicaid state plan) but who is not an individual with a developmental disability, mental retardation or a related condition; 2) have had a determination that, but for the provision of such services, the individual would require the level of care provided in a hospital or nursing facility (the cost of which could be reimbursed under Medicaid); and 3) meet the Medicaid eligibility standards in effect in the state (which may include an approved Medicaid waiver) as of the date of enactment of this provision.

A state would be able to cover this benefit under the Medicaid state plan if certain conditions are met: 1) any state waiver or demonstration under Sections 1915 or 1115 of the Social Security Act with respect to such services for individuals described in this provision must have expired; and 2) the state must monitor and report to the Secretary of the Department of Health and Human Services (DHHS) on a quarterly basis the enrollment and expenditures for services provided under this option.

A state would not be required to comply with existing Medicaid requirements regarding the statewide availability of the service, the comparability of services, and the income and resource rules applicable in the community. A state may also limit the number of individuals who are eligible for services, establish waiting lists for the receipt of these services, and limit the amount, duration, and scope of services.

This section would be effective for home and community-based services furnished on or after October 1, 2006.

Conference Agreement

The conference agreement establishes home and community-based services as an optional Medicaid benefit that would not require a waiver and that meets certain other requirements for individuals whose income does not exceed 150% of the federal poverty level. The scope of services may include any services permitted under Section 1915(c)(4)(B) of the Social Security Act which the Secretary has the authority to approve, and would not include an individual's room and board. The state may provide this option to individuals *without* determining that but for the provision of such services, the person would require the level of care provided in a hospital, nursing home, or ICF-MR.

States are required to establish *needs-based criteria* for determining an individual's eligibility for the HCBS option established by this provision, and the specific HCBS the individual will receive. The State must also establish needs-based criteria for determining

whether an individual requires the level of care provided in a hospital, nursing home, ICF-MR, or under a waiver of the state plan, that is more stringent than the needs-based criteria for the HCBS option established by this provision.

The state is also required to submit to the Secretary a projection of the number of individuals to be served under the option, and may limit the number of individuals who are eligible for such services.

The needs-based criteria must be based on an assessment of an individual's support needs and capabilities, and may take into account the inability of the individual to perform two or more activities of daily living (ADLs) as defined in the Internal Revenue Service (IRS) code (i.e., bathing, dressing, transferring, toileting, eating, and continence), or the need for significant assistance to perform these activities, and other risk factors determined to be appropriate by the state.

A state is allowed to modify the needs-based criteria described above in the event that enrollment of individuals for the HCBS option exceeds projected enrollment. The state is not required to seek prior approval of the Secretary if the state wishes to modify the needs-based criteria, but must give the Secretary and the public at least 60 days notice of the proposed modification. If a state modifies the needs-based criteria, existing recipients of the HCBS optional state plan services will continue to be eligible to receive those services for at least 12 months beginning on the date the individual first received medical assistance for HCBS services. After such a modification, the state, at a minimum, must apply the level of care determination for hospitals, nursing facilities, and ICF-MRs that were in effect prior to the application of more stringent criteria.

The state is required to use an independent evaluation for determining an individual's eligibility for HCBS. The independent evaluation must include an assessment of the needs of the individual to: (1) determine a necessary level of services and supports consistent with the individual's physical and mental capacity; (2) prevent unnecessary or inappropriate care, and (3) establish an individualized care plan for the individual.

The assessment must include: (1) an objective evaluation of an individual's inability or need for significant assistance to perform two or more activities of daily living as defined in the Internal Revenue Service code; (2) a face-to-face evaluation of the individual by an individual trained in the assessment and evaluation of individuals whose physical or mental conditions trigger a potential need for HCBS; (3) where appropriate, consultation with the individual's family, spouse, guardian, or other responsible individual; (4) consultation with all treating and consulting health and support professionals caring for the individual; (5) an examination of the individual's relevant history and medical records, and care and support needs guided by best practices and research on effective strategies that result in improved health and quality of life outcomes. The assessment must also evaluate the ability of the individual or individual's representative to self-direct the purchase and control of HCBS if he/she elects this option, and if such an option is covered by the state.

The independent evaluation is to establish a written individualized plan of care. The plan must be developed in consultation with the individual, the individual's treating physician, health care or support professionals, or other appropriate individuals, and the family caregiver or individual representative if appropriate; (2) to take into account the extent, and the need for, any family or other supports for the individual; (3) to identify the HCBS services to be provided (or purchase, if the individual elects to self-direct his/her care); (4) to be reviewed at least annually or as needed when there is a significant change in circumstances.

States may allow individual (or the individual's representative) to elect to self-direct the purchase and control of state plan HCBS. Under the self-directed option, the individual's needs, preferences, and capabilities are assessed, and based on the assessment, a service plan is

developed jointly with the individual (or representative) that is approved by the state. The service plan must include certain activities such as a person-centered planning process and risk management techniques. States may also include an individualized budget that identifies a dollar value for the services and supports under the control and direction of the individual or his or her representative. States are required to provide information in the state plan amendment about how an individualized budget is developed and implemented.

The state must ensure that the provision of home and community-based services meets federal and state guidelines for quality assurance. The state must establish standards for the conduct of the independent evaluation to prevent conflicts of interest, and must allow for at least annual redetermination of eligibility and appeals using the process for appeals under the State Plan.

States may elect to provide for a period of presumptive eligibility (not to exceed 60 days) for individuals that the state has reason to believe may be eligible for home and community-based services. The covered activities include carrying out the independent evaluation and assessment and, if eligible, the specific services the individual will receive.

In covering this benefit, a state may elect not to comply with existing Medicaid requirements related to statewideness and the income and resource rules applicable in the community, but only for purposes of providing home and community-based services in accordance with this benefit. This option should not be construed as applying to those receiving Medicaid in an institution as a result of a determination that the individual requires the level of care in a hospital, nursing facility or ICF/MR.

Federal Medicaid funding will continue to be available for individuals who are receiving Medicaid in an institution or home and community-based setting (under a HCBS waiver program or Section 1115 demonstration) as of the effective date of the Medicaid state plan amendment, without regard to whether the individuals satisfy the more stringent eligibility criteria established under that paragraph until the individual is discharged from the institution or waiver program, or no longer requires such level of care.

The provision requires the Secretary acting through the Director of the Agency for Healthcare Research and Quality, to consult with consumers and health and social service providers and other professionals knowledgeable about long-term care services and supports to develop program performance indicators, client function indicators, and measures of client satisfaction regarding HCBS offered under Medicaid.

The Secretary is required to use the indicators and measures to assess HCBS and outcomes, particularly with respect to a recipient's health and welfare, and the overall system for HCBS under Medicaid. The Secretary is also required to make best practices and comparative analyses of system features available to the public.

This provision will be effective on January 1, 2007.

Optional Choice of Self-directed Personal Assistance Services (Cash and Counseling) (Section 6023 of the Conference Agreement, and no provision in the Senate Bill, and Section 3132 of the House Bill).

Current law

Under current law, state Medicaid programs offer several types of long-term care services to individuals who, because of disability or chronic illness, need assistance with activities such as eating, bathing, and dressing. Medicaid programs have the option of covering personal care services and may also cover a broad set of other services through a home and community-based

(HCBS) waiver authorized under Section 1915(c) of the Social Security Act. To qualify for a HCBS waiver, the individual must require the level of care of a hospital, nursing facility or intermediate care facility for persons with mental retardation (ICF/MR).

Traditionally, Medicaid personal care and other related services have been provided to individuals through local public or private agencies. However, in the last decade, Medicaid beneficiaries with disabilities or chronic conditions and federal and state policymakers have been increasing the discretion that beneficiaries have over key elements of the service (e.g., what time a personal care worker comes to the home to help the beneficiary, who provides the service, etc.) These types of programs are broadly known as "self-directed" or "consumer-directed" programs. The specific elements that a Medicaid beneficiary can control vary widely depending upon the state and the type of service covered. Currently, Medicaid law allows certain types of self-directed programs to be implemented through the normal Medicaid state plan and HCBS waiver process. Other types of self-directed programs require a research and demonstration waiver under Section 1115 of the Social Security Act.

Under the Medicaid personal care benefit, the Centers for Medicare and Medicaid Services (CMS) explicitly permits self-direction of personal care services. The CMS State Medicaid Manual specifies, "Medicaid beneficiaries may hire their own provider, train the provider according to their personal preferences, supervise and direct the provision of the personal care services and, if necessary, fire the provider." However, the state Medicaid agency maintains responsibility for monitoring service delivery and ensuring that qualified providers are delivering the personal care services. The state is not permitted to provide Medicaid funds directly to a consumer to pay for the personal care services.

Generally, CMS policy has been that payments for personal care (or similar) services delivered by *legally responsible individuals* (e.g., the parent of a minor child or a spouse) are not eligible for federal Medicaid matching funds. However, CMS has recently amended its policy so that under a HCBS waiver (though not the Medicaid personal care benefit), states have the option of paying legally responsible relatives in extraordinary circumstances when the provision of personal care services is determined to be necessary to ensure the health and welfare of the waiver participant and so long as the parent or spouse meets the Medicaid provider requirements established by the state.

Senate Bill

No provision.

House Bill

This proposal would allow a state to cover, under the Medicaid program, payment for part or all of the cost of self-directed personal assistance services (other than room and board) based on a written plan of care to individuals for whom there has been a determination that, but for the provision of such services, the individuals would require and receive personal care services under Medicaid state plan or home and community-based services under a HCBS waiver. Self-directed personal assistance services may not be provided to individuals who reside in a home or property that is owned, operated, or controlled by a provider of services, not related by blood or marriage.

The Secretary must not approve a state's self-directed personal assistance services program unless the state assures that the necessary safeguards have been taken to protect the health and welfare of individuals receiving these services and that financial accountability exists for funds expended for these services.

The state must also evaluate the need for personal care under the Medicaid state plan or personal services under a HCBS waiver for individuals who 1) are entitled to Medicaid personal care under the state plan or receive HCBS waiver services; 2) may require self-directed personal assistance services; and 3) may be eligible for self-directed personal assistance services. If covered by the state and at the choice of the individual, those who are likely to require personal care or HCBS waiver services must be informed of the feasible alternatives in the provision of Medicaid personal care services or personal assistance services under a HCBS waiver. The state must also provide a support system that ensures participants in the program are appropriately assessed and counseled prior to enrollment and are able to manage their budgets. Additional counseling and management support may be provided at the request of the participant.

The state will be required to submit an annual report to the Secretary which includes the number of individuals served and total expenditures on their behalf, in the aggregate. The state must also provide an evaluation of overall impact on the health and welfare of participants compared to non-participants every three years.

A state may provide self-directed personal assistance services under the state plan without regard to the Medicaid requirements for statewideness (under Section 1902(a)(1) of the Social Security Act), and may limit the population eligible to receive these services and the number of persons served without regard to Medicaid requirements regarding comparability (Section 1902(a)(10)(B) of the Social Security Act).

Under this provision, the term "self-directed personal assistance services" means personal care and related services, or HCBS waiver services that are provided to an eligible participant. Individuals participating in such services will be permitted, within an approved self-directed services plan and budget, to purchase personal assistance and related services, and hire, fire, supervise, and manage the individuals providing such services.

At the election of the state, a participant will be allowed to 1) choose as a paid service provider, any individual capable of providing the assigned tasks including legally liable relatives, and 2) use the individualized budget to acquire items that increase independence or substitute (such as a microwave oven or an accessibility ramp) for human assistance, to the extent that expenditures would otherwise be made for the human assistance.

An approved self-directed services plan and budget under this provision must meet the following requirements: 1) The participant (or his/her guardian or authorized representative if appropriate) exercises choice and control over the budget, planning, and purchase of self-directed personal assistance services, including the amount, duration, scope, provider and location of service provision; 2) There is an assessment of the needs, strengths, and preferences of the participants for such service; 3) An individual's plan for self-directed services and supports, which has been developed and approved by the state, is based on a person-centered assessment process that builds upon the participant's capacity to engage in activities that promote community life; respects the participant's preferences, choices and abilities; and involves families, friends, and professionals in the planning or delivery of services or supports as desired or required by the participant.

The budget for self-directed services and supports must be developed and approved by the state based on the assessment and plan (described above), and on a methodology that uses valid, reliable cost data, is open to public inspection, and includes a calculation of the expected cost of such services if those services were not self-directed. The budget may not restrict access

to other medically necessary care and services furnished under the plan and approved by the state but not included in the budget

In establishing and implementing the self-directed services plan and budget, appropriate quality assurance and risk management techniques must be used which recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and which assure the appropriateness of the plan and the budget, based on the individual's resources and capabilities.

A state may employ a financial management entity to make payments to providers, track costs, and make reports under this program. Payment for the activities of the financial management entity will be reimbursed at the same rate as other Medicaid administrative activities (generally federal Medicaid administrative reimbursement is 50%, though certain activities may be eligible for 75% reimbursement).

This provision will apply to services furnished on or after January 1, 2006.

Conference Agreement

The conference agreement follows the House provision except that the effective date has been changed to January 1, 2007.

Authority to continue providing certain adult day health care services or medical adult day care services (No provision in Conference Agreement, Section 6039B of Senate Bill, and no provision in the House Bill).

Current Law

Most states currently offer adult day care services to Medicaid beneficiaries through either the rehabilitation or clinic benefits of the Medicaid state plan (in about 8 states), or through a home and community-based (HCBS) waiver under Section 1915(c) of Medicaid law (in about 44 states through 102 separate HCBS programs).

Senate Bill

The Senate bill would prohibit the Secretary of HHS from denying federal Medicaid funding or withdrawing federal approval for adult day health care services or medical adult day care services under the Medicaid state plan, as defined by the state and approved by the Secretary on or before 1982.

House Bill

No provision.

Conference Agreement

No provision.

Chapter 3 – Eliminating Fraud, Waste, and Abuse in Medicaid

Limitation on Use of Contingency Fee Arrangements (Section 6031 of the Conference Agreement, Section 6022 of the Senate Bill, and no provision in the House Bill).

Current Law

Federal law requires each state to designate a single state agency to administer or supervise the administration of its Medicaid program. This agency, which is usually part of a welfare, health, or human resources umbrella agency, will often contract with other public or private entities (e.g., other state agencies or departments, consulting firms) to perform various administrative functions. In some cases, contingency fee arrangements are used to pay contractors based on Medicaid dollars saved, recovered, or otherwise obtained for the state (e.g., a fee equal to 10% of third party liability collections). The federal reimbursement rate for most Medicaid administrative costs is 50%.

In determining the amount of administrative costs — including contingency fees — that may be eligible for federal reimbursement, states must comply with a number of federal statutes and regulations. In general, federal Medicaid law requires states to use methods of administration that are found by the Secretary of HHS to be necessary for the proper and efficient operation of their Medicaid programs. With regard to contingency fee contracts, guidance issued by the Centers for Medicare and Medicaid Services (CMS) to its regional offices in 2002 notes that in order to be eligible for federal reimbursement, contingency fees must: (1) be based on Medicaid cost avoidance savings or recoveries in which the federal government shares, (2) be intended to produce Medicaid program savings, not additional expenditures reported for federal reimbursement, and (3) not be contingent upon recoveries from the federal government. CMS guidance also notes that states may not claim federal reimbursement for contingency fee payments made to another government unit for Medicaid administrative activities.

Additional federal guidance is contained in Office of Management Budget (OMB) Circular A-87, which establishes principles and standards for determining allowable costs for states (and other governmental units) under federal grant programs such as Medicaid. The circular specifies that the cost of professional and consultant services are allowable when reasonable in relation to the services rendered and when not contingent upon recovery of the costs from the federal government.

Senate Bill

Under the Senate bill, states would not be eligible for federal reimbursement of amounts expended in connection with a contract or agreement (other than a Medicaid managed care contract) between the state Medicaid agency (or any state or local agency that administers a portion of the Medicaid program) and a consultant or other contractor if the terms of compensation for the consultant or other contractor do not meet standards established by the Inspector General (IG) of HHS.

Such standards would be designed by the IG to ensure prudent purchasing and program integrity with respect to federal funds. The IG would annually review the standards and revise them as necessary to promptly address new compensation arrangements that may present a risk

to Medicaid program integrity. The standards would be issued no later than six months after enactment of the provision.

The provision would be effective January 1, 2007, except that in the case of a state which the Secretary of HHS determines that state legislation is required for compliance, the state would not be regarded as failing to comply solely on the basis of its failure to meet the requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment of the bill.

House Bill

No provision.

Conference Agreement

The conference agreement follows the ^{House bill} ~~Senate bill and conference agreement~~

Encouraging the Enactment of State False Claims Acts (Section 6032 of the Conference Agreement, Section 6023 of the Senate Bill, and no provision in the House Bill).

Current Law

Under the federal False Claims Act, anyone who knowingly submits a false claim to the federal government is liable for damages up to three times the amount of the government's damages plus mandatory penalties of \$5,500 to \$11,000 for each false claim submitted. Under *qui tam* (whistleblower) provisions of the act, private citizens with knowledge of potential violations ("relators") may file suit on behalf of the government and are entitled to receive a share of the proceeds of the action or settlement of the claim (ranging from 15% to 30%, depending on whether or not the government elects to participate in the case).

States may have a variety of laws in place to facilitate prosecution of Medicaid fraud, and some have established their own versions of a false claims act. With limited exceptions, a state must repay the federal share (generally determined by the federal medical assistance percentage, or FMAP) of any provider overpayment within 60 days of discovering the overpayment, regardless of whether or not the state has recovered the overpayment.

Senate Bill

Under the Senate bill, if a state has in effect a law relating to false or fraudulent claims that meets certain requirements (described below), the federal medical assistance percentage, with respect to any amounts recovered under a state action brought under such a law, would be decreased by 10 percentage points.

The state law relating to false and fraudulent claims must be determined by the Inspector General of HHS, in consultation with the Attorney General, to: (1) establish liability to the state

Conference Agreement

The conference agreement follows the Senate provision.

Development and Support of Family-to-family Health Information Centers (Section 6064 of the Conference Agreement, Section 6044 of the Senate Bill, and no provision in the House Bill).

Current Law

Family-to-family health centers provide information and assistance to help families of children with special health care needs navigate the system of care and make decisions about the needs and available supports for their child. No provision in current law specifically authorizes a dedicated amount of funds for these family-to-family health information centers. However, since 2002, the Department of Health and Human Services (HHS) has awarded approximately \$6.9 million to develop these information centers in 36 states under various program authorities including: (1) Special Projects of Regional and National Significance Program (SPRANS) of the Maternal and Child Services Block Grant (Title V of the Social Security Act) operated by the Health Resources Services Administration (HRSA); (2) the Real Choice Systems Change grant program operated by the Centers for Medicare and Medicaid Services (CMS); and (3) a one-year direct Congressional appropriation to an organization in Iowa. Federal funding for these projects is time-limited. Except for the one-year direct appropriation, state projects have generally been funded for a three or four-year period. HRSA intends to fund additional family-to-family health information centers awarding up to \$2.4 million to six projects for a four-year period starting in FY2006.

Senate Bill

The Senate bill would increase funding under the SPRANS program of Title V of the Social Security Act for the development and support of new family-to-family health information centers (described below). This proposal would appropriate an additional \$3 million for FY2007, \$4 million for FY2008, and \$5 million for FY2009 for this new purpose. For each of fiscal years 2010 and 2011, the bill would authorize to be appropriated to the Secretary \$5 million for this purpose. Funds would remain available until expended.

The family-to-family health information centers would: (1) assist families of children with disabilities or special health care needs to make informed choices about health care so as to promote good treatment decisions, cost-effectiveness, and improved health outcomes for such children; (2) provide information regarding the health care needs of, and resources available for children with disabilities or special health care needs; (3) identify successful health delivery models; (4) develop a model for collaboration between families of such children and health professionals; (5) provide training and guidance with regard to the care of such children; and (6) conduct outreach activities to the families of such children, health professionals, schools, and other appropriate entities and individuals. The family-to-family health information center would be staffed by families who have expertise in public and private health care systems and by health professionals.

The Secretary would be required to develop family-to-family health information centers in at least 25 states in FY2007, 40 states in FY2008, and all states in FY2009.

House Bill

No provision.

Conference Agreement

The conference agreement follows the Senate provision.

Restoration of Medicaid Eligibility for Certain SSI Beneficiaries (Section 6065 of the Conference Agreement, Section 6045 of the Senate Bill, and no provision in the House Bill).

Current Law

SSI and Medicaid eligibility is effective on the later of (1) the first day of the month following the date the application is filed, or (2) the first day of the month following the date that the individual is determined eligible.

Senate Bill

The Senate bill would extend Medicaid eligibility to persons who are under age 21 and who are eligible for SSI, effective on the later of: (1) the date the application was filed, or (2) the date SSI eligibility was granted. This provision would be effective one year after the date of enactment.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate bill provision.

Subchapter B — Money Follows the Person Rebalancing Demonstration

Money Follows the Person Rebalancing Demonstration (Section 6071 of the Conference Agreement, Section 6061 of the Senate Bill, and no provision in the House Bill).

Current law

Under Medicaid, states can offer a variety of home and community-based services to Medicaid beneficiaries who need long-term care. Some of these services may be offered

for false or fraudulent claims described in the federal False Claims Act, with respect to Medicaid expenditures, (2) contain provisions that are at least as effective in rewarding and facilitating *qui tam* actions as those in the federal False Claims Act, (3) contain a requirement for filing an action under seal for 60 days with review by the state Attorney General, (4) contain a civil penalty that is not less than the amount authorized by the federal False Claims Act, (5) contain provisions that are designed to prevent a windfall recovery for a *qui tam* relator that files a federal and state action for the same false or fraudulent claim.

The provision would be effective January 1, 2007.

House Bill

No provision.

Conference Agreement

The conference agreement follows the Senate bill, but excludes language regarding windfall recoveries for *qui tam* relators.

Employee Education About False Claims Recovery (Section 6033 of the Conference Agreement, Section 6024 of the Senate Bill, and no provision in the House Bill).

Current Law

No provision.

Senate Bill

Under the Senate bill, a state would be required to provide that any entity that receives annual Medicaid payments of at least \$1 million, as a condition of receiving such payments, must: (1) establish written policies, procedures, and protocols for training of all employees of the entity, and of any contractor or agent of the entity, that includes a detailed discussion of the federal False Claims Act, federal administrative remedies for false claims and statements, any state laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs, (2) include in such written materials detailed provisions and training regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse, (3) include in any employee handbook for the entity a specific discussion of such laws, the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse, and (4) require mandatory training for all employees of the entity and of any contractor or agent of the entity, at the time of hiring, with respect to such laws and the entity's policies and procedures for detecting fraud, waste, and abuse.

The provision would be effective January 1, 2007, except that in the case of a state which the Secretary of HHS determines that state legislation is required for compliance, the state would not be regarded as failing to comply solely on the basis of its failure to meet the requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment of the bill.

House Bill

No provision.

Conference Agreement

The conference agreement follows the Senate bill, but applies only to entities receiving annual Medicaid payments of at least \$5 million and does not require the establishment of protocols and procedures for training of employees (i.e., only written policies are required).

Prohibition on Restocking and Double Billing of Prescription Drugs (Section 6034 of the Conference Agreement, and Section 6025 of the Senate Bill, and no provision in the House Bill).

Current Law

No provision.

Senate Bill

The Senate bill would prohibit federal matching payments for the ingredient cost of a covered outpatient drug for which the pharmacy has already received payment (other than a reasonable re-stocking fee). It would become effective on the first day of the first fiscal quarter beginning after enactment.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate provision.

Medicaid Integrity Program (Section 6035 of the Conference Agreement, Section 6026 of the Senate Bill, and no provision in the House Bill).

Current Law

States and the federal government share in the responsibility for safeguarding Medicaid program integrity. States must comply with federal requirements designed to ensure that Medicaid funds are properly spent (or recovered, when necessary). The Centers for Medicare and Medicaid Services (CMS) is the primary federal agency responsible for providing oversight of states' activities and facilitating their program integrity efforts. The HHS Office of Inspector General (OIG) also plays a role in Medicaid fraud and abuse detection and prevention efforts

through its investigations, audits, evaluations, issuances of program recommendations, and other activities.

As part of its program integrity activities, CMS operates a Medicare-Medicaid (Medi-Medi) data match project that analyzes claims data from both programs together to detect aberrant patterns that may not be evident when billings are viewed in isolation (e.g., providers submitting claims to both programs for procedures that add up to more than 24 hours of patient care in a single day). The Medi-Medi project began with one state in 2001, and was subsequently expanded to include eight others. It is primarily supported by "wedge" funds from the Health Care Fraud and Abuse Control (HCFAC) account within the federal Hospital Insurance (Medicare Part A) trust fund. HCFAC wedge funds are divided between the Department of Justice, the HHS Office of Inspector General, CMS, and other HHS agencies. The HCFAC account also funds the Medicare Integrity Program and activities of the Federal Bureau of Investigation related to health care fraud. Annual minimum and maximum HCFAC appropriations are specified in statute.

Senate Bill

The Senate bill would establish a Medicaid Integrity Program under title XIX. The Secretary of HHS would enter into contracts with eligible entities to carry out the program's activities, which would include: (1) review of the actions of individuals or entities furnishing items or services for which a Medicaid payment may be made, (2) audit of claims for payment for items or services furnished or for administrative services rendered, (3) identification and recovery of overpayments to individuals or entities receiving federal funds under Medicaid, (4) education of service providers, managed care entities, beneficiaries, and other individuals with respect to payment integrity and benefit quality assurance issues.

An entity would be eligible to enter into a contract to carry out Medicaid Integrity Program activities if it meets eligibility and contracting requirements similar to those under the Medicare Integrity Program. Beginning in FY2006 and every five years, the Secretary of HHS — in consultation with the Attorney General, the Director of the Federal Bureau of Investigation, the Comptroller General of the United States, the Inspector General of HHS, and state officials with responsibility for controlling provider fraud and abuse under Medicaid — would establish a comprehensive plan for ensuring Medicaid program integrity by combating fraud, waste, and abuse.

Appropriations for the Medicaid Integrity Program would total \$50 million in FY2006, \$49 million in each of FY2007 and FY2008, \$74 million in each of FY2009 and FY2010, and \$75 million in FY2011 and each fiscal year thereafter. No later than 180 days after the end of each fiscal year (beginning with FY2006), the Secretary of HHS would submit a report to Congress that identifies the use and effectiveness of the use of such funds.

A Medicaid Chief Financial Officer (CFO) and Medicaid Program Integrity Oversight Board would also be established under title XIX. The Medicaid CFO would be appointed by and would report directly to the Administrator of CMS. The duties and authority of the Medicaid CFO would be comparable to those of other CFOs with respect to the management and expenditure of federal funds under federal health care programs. A Medicaid Program Integrity Oversight Board would also be established by the Secretary of HHS. The duties and authority of the board would be comparable to those of the Medicare Contractor Oversight Board, and would include responsibility for identifying vulnerabilities and developing strategies for minimizing integrity risks to state Medicaid programs.

States would be required to comply with any requirements determined by the Secretary of HHS to be necessary for carrying out the Medicaid Integrity Program, or the duties of the Medicaid CFO and the Medicaid Program Integrity Oversight Board.

In each of fiscal years 2006 through 2010, \$25 million would be appropriated for Medicaid activities of the HHS Office of Inspector General (in addition to any other amounts appropriated or made available for its Medicaid activities, to remain available until expended). No later than 180 days after the end of each fiscal year (beginning with FY2006), the Inspector General of HHS would submit a report to Congress that identifies the use and effectiveness of the use of such funds.

The Secretary of HHS would significantly increase the number of full-time equivalent CMS employees whose duties consist solely of ensuring the integrity of the Medicaid program.

House Bill

No provision.

Conference Agreement

The conference agreement generally follows the Senate bill, but excludes recovery of overpayments from the list of Medicaid Integrity Program activities and does not establish a Medicaid CFO or oversight board. It appropriates \$5 million in FY2006, \$50 million in each of FY2007 and FY2008, and \$75 million in each fiscal year thereafter for Medicaid Integrity Program activities.

The conference agreement also establishes a national expansion of the Medicare-Medicaid data match project (referred to as the Medi-Medi Program) as a required activity of the Medicare Integrity Program under Title XVIII of the Social Security Act. The Secretary of HHS shall enter into contracts with eligible entities to ensure that the Medi-Medi Program is conducted for the purpose of: (1) identifying program vulnerabilities in Medicare and Medicaid through the use of computer algorithms to look for payment anomalies, (2) working with states, the Attorney General, and the Inspector General of HHS to coordinate appropriate actions to protect Medicare and Medicaid expenditures, and (3) increasing the effectiveness and efficiency of both programs through cost avoidance, savings, and recoupment of fraudulent, wasteful, or abuse expenditures. At least quarterly, the Secretary shall make available in a timely manner any data and statistical information collected by the Medi-Medi Program to the Attorney General, the Director of the Federal Bureau of Investigation, the Inspector General of HHS, and the states.

In addition to HCFAC appropriations for the Medicare Integrity Program (which have a statutory floor and ceiling), the Medi-Medi Program would receive \$12 million in FY2006, \$24 million in FY2007, \$36 million in FY2008, \$48 million in FY2009, and \$60 million in FY2010 and each fiscal year thereafter.

Enhancing Third Party Identification and Payment (Section 6036 of the Conference Agreement, Section 6021 of the Senate Bill, and Section 3144 of the House Bill).

Current Law

Third-party liability (TPL) refers to the legal obligation of third parties — individuals, entities, or programs — to pay all or part of the expenditures for medical assistance furnished under a Medicaid state plan. In general, federal law requires Medicaid to be the payor of last resort, meaning that all other available third parties must meet their legal obligation to pay claims before the Medicaid program pays for the care of an individual. Examples of third parties which may be liable to pay for services include employment-related health insurance, court-ordered medical support (including health insurance) from noncustodial parents, workers' compensation, long-term care insurance, and other state and federal programs (with certain exceptions, such as the Indian Health Service).

States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the state Medicaid plan. To this end, they must: (1) collect health insurance information from individuals at the time of initial application for Medicaid and during any subsequent redeterminations of eligibility, (2) match data provided by Medicaid applicants and recipients to certain files maintained by government agencies (e.g., state wage and income, Social Security Administration wage and earnings, state workers' compensation, state motor vehicle accident reports), (3) identify claims with diagnosis codes that would indicate trauma-related injury for which a third party may be liable for payment, and (4) follow up on TPL leads identified through these information-gathering activities.

If the state has determined that probable third party liability exists at the time a claim for reimbursement is filed, it generally must reject the claim and return it to the provider for a determination of the amount of third party liability (referred to as "cost avoidance"). If probable liability has not been established or the third party is not available to pay the individual's medical expenses, the state must pay the claim and then attempt to recover the amount paid (referred to as "pay and chase"). States are generally required to cost avoid claims unless they have an approved waiver that allows them to use the pay and chase method.

As a condition of eligibility for Medicaid, individuals are required to assign to the state Medicaid agency their rights to medical support and payment for medical care from any third party. This assignment of rights facilitates TPL recovery by allowing the state to collect, on behalf of Medicaid enrollees, amounts owed by third parties for claims paid by Medicaid.

Senate Bill

The Senate bill would amend the list of third parties named in Section 1902(a)(25) of the Social Security Act for which states must take all reasonable measures to ascertain the legal liability to include: (1) self-insured plans, (2) pharmacy benefit managers, and (3) other parties that are legally responsible (by statute, contract, or agreement) for payment of a claim for a health care item or service. It would also amend that section to include these entities in the list of health insurers that states must prohibit from taking an individual's Medicaid status into account when enrolling the individual or making payments for benefits to or on behalf of the individual.

In addition, it would require a state to provide assurances satisfactory to the Secretary of HHS that it has laws in effect requiring health insurers (including parties that are legally responsible for payment of a claim for a health care item or service), as a condition of doing business in the state, to: (1) provide, upon request of the state, eligibility and claims payment data with respect to individuals who are eligible for or receiving Medicaid, (2) accept an individual's or other entity's assignment of rights (i.e., rights to payment from the parties) to the

state, (3) respond to any inquiry from the state regarding a claim for payment for any health care item or service submitted not later than three years after the date such item or service was provided, and (4) agree not to deny a claim submitted by the state solely on the basis of the date of submission of the claim

The provision would be effective January 1, 2006, except that in the case of a state which the Secretary of HHS determines that state legislation is required for compliance, the state would not be regarded as failing to comply solely on the basis of its failure to meet the requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the state legislature that begins after the date of enactment of the bill.

House Bill

The House bill is similar to the Senate bill.

Conference Agreement

The conference agreement generally follows the Senate and House bills, but substitutes the term "managed care organization" for "health maintenance organization" in Section 1902(a)(25) of the Social Security Act and specifies that states must require parties legally responsible for payment of a claim to provide, upon request of the state, information to determine during what period an individual or their spouses and dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary of HHS.

Chapter 4 – Flexibility in Cost Sharing and Benefits

State Option for Alternative Medicaid Premiums and Cost Sharing (Section 6041 of the Conference Agreement, no provision in the Senate Bill, and Sections 3121 and 3126 of the House Bill).

Current Law

With some exceptions, premiums and enrollment fees are generally prohibited under Medicaid. When applicable, nominal amounts for such charges are between \$1 and \$19 depending on family income. States are allowed to establish nominal service-related cost-sharing requirements that are generally between \$0.50 and \$3, depending on the cost of the service provided. The regulations that specify nominal premium and service-related cost-sharing amounts were published and amended in the late 1970s and the early 1980s. These amounts are not adjusted by any factor. Specific services and groups are exempted from such cost-sharing. Waiver authority is required to change these rules.

Under certain circumstances, families qualifying for transitional Medicaid, pregnant women and infants with income over 150% FPL, medically needy groups, and workers with disabilities may be charged premiums for Medicaid coverage.

All service-related cost-sharing is prohibited for: (1) children under 18 years of age; (2) pregnant women for any services that relate to the pregnancy or to any other medical condition which may complicate pregnancy; (3) services furnished to individuals who are inpatients in a

hospital, or are residing in a long term care facility or in another medical institution if the individual is required to spend most of their income for medical care; (4) services furnished to individuals receiving hospice care; (5) emergency services; and (6) family planning services and supplies. For most other beneficiaries and services, states may impose nominal service-related cost-sharing (described above). For workers with disabilities, service-related cost-sharing may be required that exceeds nominal amounts as long as they are set on a sliding scale based on income.

Under the state Medicaid plan, providers must not deny care or services to Medicaid beneficiaries due to the individual's inability to pay a cost-sharing charge. However, this requirement does not eliminate the beneficiary's liability for payment of such charges. For certain groups of pregnant women and infants for which monthly premiums may be charged, states must not require prepayment and must not terminate Medicaid eligibility for failure to pay such premiums until such failure continues for at least 60 days. States may waive those premiums when such payments would cause undue hardship.

States may offer Medicaid to certain uninsured women who are under age 65, and are in need of treatment for breast or cervical cancer based on screening services provided by an early detection program run by the CDC. This group has access to the same Medicaid services offered to the categorically needy in a given state, and are subject to Medicaid's nominal cost-sharing rules.

Senate Bill

No provision.

House Bill

The House Bill would allow states to impose premiums and cost-sharing for any group of individuals for any type of service, through Medicaid state plan amendments (rather than waivers), subject to specific restrictions. Premiums and cost-sharing imposed under this option would be allowed to vary among classes or groups of individuals, or types of service, including through the use of tiered cost-sharing for prescription drugs. Generally, the total amount of annual cost-sharing for all individuals in a family would be capped at 5% of family income for all families regardless of income. Individuals in families with income below 100% FPL would not be subject to premiums but could be subject to nominal service-related cost-sharing. Individuals in families with income exceeding 100% FPL may be subject to premiums and higher than nominal cost-sharing amounts.

Premiums would not be permitted for: (1) mandatory groups of children under 18, including individuals receiving adoption or foster care assistance under Title IV-E regardless of age; (2) pregnant women; (3) terminally ill persons receiving Medicaid hospice care; (4) individuals in institutions who are required to spend for costs of care all but a minimal amount of their income for personal needs. States may exempt additional groups from premiums.

Service related cost-sharing would not be permitted for: (1) services provided to mandatory groups of children under 18, including individuals receiving adoption or foster care assistance under Title IV-E regardless of age; (2) preventive services provided to children under 18 regardless of family income; (3) services provided to pregnant women that relate to pregnancy or to other medical conditions that may complicate pregnancy; (4) services provided

to individuals receiving Medicaid hospice services; (5) services provided to individuals in institutions who are required to spend for costs of care all but a minimal amount of their income for personal needs; (6) emergency services; and (7) family planning services and supplies. States may exempt additional individuals or services from service-related cost-sharing.

In applying limits on cost-sharing amounts under this option that states may impose on individuals under 100% FPL, beginning with 2006, the Secretary would be required to increase nominal amounts of service-related cost-sharing by the annual percentage increase in the medical care component of the consumer price index (CPI) for all urban consumers (U.S. city average), as rounded up in an appropriate manner.

The bill further specifies that these provisions would not prevent states from further limiting cost sharing, affect the authority of the Secretary to waive limits on premiums or cost-sharing, nor affect waivers in effect before the date of enactment.

The bill would allow states to condition the provision of medical assistance on the payment of premiums, and to terminate Medicaid eligibility on the basis of failure to pay a premium if that failure continues for at least 60 days. States may apply this provision to some or all groups of beneficiaries, and may waive premium payments in cases where such payments would be an undue hardship. In addition, the provision would allow states to permit providers participating in Medicaid to require a Medicaid beneficiary to pay authorized cost-sharing as a condition for the provision of care or services. Providers would also be allowed to reduce or waive cost-sharing amounts.

The Government Accountability Office (GAO) would be required to conduct a study of the impact of premiums and cost-sharing under Medicaid on access to and utilization of services. The report would be required to be submitted to Congress no later than January 1, 2008.

These provisions would apply to cost-sharing for items and services furnished on or after January 1, 2006.

The House bill also specifies that none of the proposed cost-sharing (or benefit) provisions described above would apply to women who qualify for Medicaid under the breast and cervical cancer eligibility group.

Conference Agreement

The conference agreement includes the House bill, with modifications. It clarifies that rules with respect to optional cost sharing for prescribed drugs (see below) are separate from the rules for other optional cost sharing. Explicit cost sharing limits for individuals in families with income under 100% FPL are dropped in the conference agreement. For individuals in families with income between 100 and 150% FPL: (1) no premiums may be imposed, (2) cost sharing for any item or service cannot exceed 10% of the cost of the item or service, and (3) the total aggregate amount of all cost-sharing (including cost sharing for prescribed drugs and emergency room copayments for non-emergency care; see below) cannot exceed 5% of family income as applied on a quarterly or monthly basis as specified by the state. For individuals in families with income above 150% FPL: (1) the total aggregate amount of all cost sharing (including cost sharing for prescribed drugs and emergency room copayments for non-emergency care) cannot exceed 5% of family income as applied on a quarterly or monthly basis as specified by the state, and (2) cost-sharing for any item or service cannot exceed 20% of the cost of the item or service.

Two groups are added to the list of those exempt from paying premiums and cost-sharing under the House bill. In the conference agreement, these additional groups include (1) children in foster care who receive aid and assistance under Part B of Title IV (Child and Family Services) of the Social Security Act; and (2) women who qualify for Medicaid under the breast and cervical cancer eligibility group (a technical change from the House bill).

In addition, the agreement clarifies that providers could reduce or waive cost-sharing on a case-by-case basis.

Under the conference agreement, increases in the nominal cost-sharing amounts follow the House bill (i.e., annual adjustments using the medical CPI), but apply more broadly to existing cost-sharing provisions in statute (Section 1916) as well as to the new cost-sharing provisions in the House bill specific to prescription drugs and non-emergency care provided in an emergency room (described below).

Special Rules for Cost Sharing for Prescription Drugs (Section 6042 of the Conference Agreement, no provision in the Senate Bill, and Section 3122 of the House Bill).

Current Law

States are allowed to establish nominal service-related cost-sharing requirements (defined in regulation) that are generally between \$0.50 and \$3, depending on the cost of the service provided. Specific services and groups are exempted from such cost-sharing. Waiver authority is required to change these rules. As with other Medicaid benefits, nominal cost-sharing may be imposed on prescribed drugs, and states may vary nominal cost-sharing amounts for preferred and non-preferred drugs. States may also implement prior authorization for prescribed drugs.

Senate Bill

No provision.

House Bill

The House bill would allow states to impose cost-sharing amounts that exceed the proposed state option limits described above for certain state-identified non-preferred drugs if the cost sharing plan meets the following characteristics. Under this option, states may impose higher cost-sharing amounts for non-preferred drugs within a class; waive or reduce the cost-sharing otherwise applicable for preferred drugs within such class; and must not apply such cost-sharing for preferred drugs to persons exempt from cost-sharing (identified above).

Cost-sharing for non-preferred drugs would be based on multiples of the nominal amounts based on family income. For persons with family income below 100% of FPL, nominal cost sharing would apply. For those with family income at or above 100% but below 150% of FPL, the multiple is equal to two times the applicable nominal amount, and for those with income equal to or exceeding 150% of FPL, the multiple is equal to three times the applicable

nominal amount. For persons generally exempt from cost-sharing (identified above), cost-sharing for non-preferred drugs may be applied. Such cost-sharing may not exceed nominal amounts, and aggregate caps on cost-sharing (in terms of nominal amounts and maximum-cost-sharing based on the specified percentage of family income identified above) would still apply.

For Medicaid purposes, states would not be allowed to treat a preferred drug under the TRICARE pharmacy benefit program as a non-preferred drug, nor could states impose cost-sharing that exceeds the standards under this program that are in effect on the date of enactment for this provision.

In cases in which a prescribing physician determines that the preferred drug would not be effective or would have adverse health effects or both, the state may impose the cost-sharing amount for preferred drugs on the prescribed non-preferred product.

The House bill would not prevent states from excluding specified drugs or classes of drugs from these special cost-sharing rules.

States would be prohibited from implementing these special cost-sharing rules for prescription drugs unless the state has instituted a system for prior authorization and related appeals processes for outpatient prescription drugs.

These provisions would become effective for cost-sharing imposed for items and services furnished on or after October 1, 2006.

Conference Agreement

The conference agreement includes the House bill, with modifications. Cost-sharing for non-preferred drugs may not exceed: (1) nominal amounts for individuals in families with income below or equal to 150% FPL, and (2) 20% of the cost of the drug for individuals in families with income above 150% FPL.

The conference agreement also drops both the TRICARE and the prior authorization/appeals process provisions in the House bill. It also changes the effective date of these provisions to January 1, 2007.

Emergency Room Copayments for Non-Emergency Care (Section 6043 of the Conference Agreement, no provision in the Senate Bill, and Section 3123 of the House Bill).

Current Law

Waivers may be used to allow states to impose up to twice the otherwise applicable nominal cost-sharing amounts for non-emergency services provided in a hospital emergency room (ER). States may impose these higher amounts if they have established that Medicaid beneficiaries have available and accessible alternative sources of non-emergency, outpatient services.

Senate Bill

No provision.

House Bill

The House bill would allow states, through a state plan amendment, to impose increased cost-sharing on state-specified groups for non-emergency services provided in an ER, when certain conditions are met. First, alternative non-emergency providers must be available and accessible to the person seeking care. Second, after initial screening but before the non-emergency care is provided at the ER, the beneficiary must be told: (1) the hospital can require a higher copayment, (2) the name and location of an alternative non-emergency provider and that this provider and that a lower copayment may apply, and (3) the hospital can provide a referral. When these conditions are met, states could apply or waive cost-sharing for services delivered by the alternate provider.

For persons with income below 100% FPL, cost-sharing for non-emergency services in an ER could not exceed twice the nominal amounts. Individuals exempt from premiums or service-related cost-sharing under other provisions of this bill may be subject to nominal copayments for non-emergency services in an ER, only when no cost-sharing is imposed for care in hospital outpatient departments or by other alternative providers in the area served by the hospital ER. Aggregate caps on cost-sharing established under this bill (described in Sec. 3121(a)) would still apply.

These provisions would have no impact on a hospital's obligations with respect to screening and stabilizing emergency medical conditions, nor would they modify the application of the prudent-layperson standard with respect to payment or coverage of emergency services by any managed care organization. In addition, no hospital or physician that makes a cost-sharing determination would be liable in any civil action or proceeding, absent a finding by clear and convincing evidence of gross negligence. Liabilities related to the provision of care (or failure to do so) would not be affected by these provisions.

"Non-emergency services" would mean any care or services furnished in an ER that the physician determines does not constitute an appropriate medical screening examination or stabilizing examination and treatment screening required for hospitals under Medicare law (regarding examination and treatment for emergency medical conditions and women in labor). "Alternative non-emergency services provider" would mean a Medicaid-participating health care provider, such as a physician's office, health care clinic, community health center, hospital outpatient department, or similar health care provider that provides clinically appropriate services for such diagnosis or treatment of the condition within a clinically appropriate time of the provision of such non-emergency services.

The Secretary would be required to provide for payments to states for the establishment of alternate non-emergency providers, or networks of such providers. The House bill also authorizes and appropriates \$100 million for paying such providers for the 4-year period beginning with 2006. The Secretary would be required to give a preference to states that establish or provide for alternate non-emergency services providers (or networks) that serve rural or underserved areas where beneficiaries may have limited access to primary care providers, or in partnership with local community hospitals. To access these funds, states would be required to file an application meeting requirements set by the Secretary.

These amendments would apply to non-emergency services furnished on or after the date of enactment of this Act.

Conference Agreement

The conference agreement includes the House bill, with modifications. This provision allows states to permit a hospital to impose cost sharing for non-emergency care delivered in an ER under the same conditions identified in the House bill. But the conditions defining the beneficiary notification process are expanded to explicitly include a medical screening examination for emergency medical conditions as defined in Medicare law and a determination that such an emergency does not exist, prior to the delivery of non-emergency care in the ER. In addition, the hospital (not the physician or hospital) is responsible for the notification process.

The conference agreement clarifies that no hospital or physician can be held liable in any civil action or proceeding for the imposition of cost sharing under this new option, absent a finding of gross negligence by the hospital or physician. This provision does not affect liability with respect to examination and treatment for emergency medical conditions (including women in labor) as specified in Medicare law or otherwise applicable under state law based on the provision of (or failure to provide) care.

The conference agreement also slightly modifies the definition of an alternative non-emergency services provider by specifying that such providers be able to diagnose or treat a condition contemporaneously with (rather than within a clinically appropriate time of) the provision of similar non-emergency services that would be provided in an ER.

The conference agreement also changes the effective date of these provisions to January 1, 2007.

Use of Benchmark Packages (Section 6044 of the Conference Agreement, no provision in the Senate Bill, and Section 3124 of the House Bill).

Current Law

Categorically needy (CN) eligibility groups include families with children, the elderly, certain persons with disabilities, and certain other pregnant women and children who meet applicable financial standards. Medically needy (MN) groups include the same types of individuals, but different, typically higher financial standards apply. Some benefits are mandatory for the CN (e.g., inpatient and outpatient hospital care, lab and x-ray services, physician services, nursing facility care for persons age 21 and over). Other benefits are optional for the CN (e.g., other practitioner services, routine dental care, physical therapy). Benefits offered to CN groups must be the same statewide, and in amount, duration and scope. States may offer a more restrictive benefit package to the MN, but must offer prenatal and delivery services, ambulatory services for persons under 21 and those entitled to institutional services, and home health services for those entitled to nursing facility care. Benefits offered to MN groups must be the same statewide, and in amount, duration and scope. Changes in comparability or statewideness for benefits for CN and MN groups require a waiver.

As described above, some benefits are mandatory for the CN (e.g., inpatient and outpatient hospital care, lab and x-ray services, physician services, FQHC services, nursing facility care for persons age 21 and over). Other benefits are optional for the CN (e.g., other practitioner services, routine dental care, physical therapy). Benefits offered to CN groups must be the same statewide, and in amount, duration and scope. States may offer a more restrictive benefit package to the MN, but must offer prenatal and delivery services, ambulatory services for persons under 21 and those entitled to institutional services, and home health services for those entitled to nursing facility care. Benefits offered to MN groups must be the same statewide, and in amount, duration and scope. Changes in comparability or statewideness for benefits for CN and MN groups require a waiver.

Under the Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) benefit, Medicaid children in CN groups are guaranteed access to all federally coverable routine and follow-up dental services necessary to treat a dental problem. EPSDT may be offered to MN children.

Both the services provided by rural health clinics (RHCs) and federally qualified health services (FQHCs) are required benefits for CN groups under Medicaid. Among other mandatory benefits for MN groups, states must offer ambulatory services for persons under 21 and those entitled to institutional services. Such ambulatory services may include RHC and FQHC services at state option. In general, RHCs and FQHCs are paid on a per visit basis, using a prospective payment system that takes into account costs incurred and changes in the scope of services provided. Per visit payment rates are also adjusted annually by the Medicare Economic Index applicable to primary care services.

Senate Bill

No provision.

House Bill

The House bill would give states the option to provide Medicaid to state-specified groups through enrollment in benchmark and benchmark-equivalent coverage (described below). States could only apply this option to eligibility categories established before the date of enactment of this provision. States may choose to provide wrap-around and additional benefits.

Enrollment in benchmark and benchmark-equivalent coverage could be required for "full benefit eligible individuals," including persons eligible for all services covered for the CN, or any other category of eligibility for all covered services as determined by the Secretary. Certain individuals would be excluded from the definition of a full-benefit eligible, including (1) the MN; (2) CN individuals in certain states who are required to pay for medical expenses from their income until their remaining net income meets SSI financial standards in effect in 1972; and (3) other individuals who qualify for Medicaid when costs incurred for medical expenses or other remedial care are subtracted from income to meet financial eligibility requirements (also known as spend-down populations).

The House bill would require that specified groups be exempted from this option, including: (1) mandatory pregnant women and children; (2) dual eligibles (i.e., Medicaid beneficiaries also entitled to benefits under Medicare); (3) terminally ill persons receiving Medicaid hospice services; (4) individuals in medical institution who are required, as a condition

of receiving institutional care, to pay for costs of medical care except for a minimal amount retained from their income for personal needs; (5) individuals who are medically frail or who have special medical needs, as identified in accordance with regulations of the Secretary; and (6) individuals who qualify for Medicaid long-term care services (i.e., nursing facility services, a level of care in any institution equivalent to nursing facility services, home and community-based waiver services, home health services, home and community care for functionally disabled elderly individuals, personal care, and other optional long-term care services offered by the state).

Benchmark and benchmark-equivalent packages would be nearly identical to those offered under SCHIP, with some additions. Benchmark coverage would include: (1) the standard Blue Cross/Blue Shield preferred provider plan under FEHBP; (2) health coverage for state employees; and (3) health coverage offered by the largest commercial HMO. Benchmark-equivalent coverage would have the same actuarial value as one of the benchmark plans. Such coverage would include: (1) inpatient and outpatient hospital services, (2) physician services, (3) lab and x-ray services, (4) well child care, including immunizations, and (5) other appropriate preventive care (designated by the Secretary). Such coverage must also include at least 75% of the actuarial value of coverage under the benchmark plan for: (1) prescribed drugs, (2) mental health services, (3) vision care, and (4) hearing services. Determination of actuarial value would follow generally accepted actuarial principles and methodologies and would be conducted by a member of the American Academy of Actuaries.

Both benchmark and benchmark-equivalent coverage would include "qualifying child benchmark dental coverage." A qualifying child would include individuals under 18 with family income below 133% FPL. Benchmark dental coverage would be equivalent to or better than the dental plan that covers the greatest number of individuals in the state who are not eligible for Medicaid.

States could only enroll eligible beneficiaries in benchmark and benchmark-equivalent coverage if such persons have access to services provided by RHCs and FQHCs, and the Medicaid prospective payment system for both types of providers remains in effect.

These provisions would be effective upon the date of enactment.

Conference Agreement

The conference agreement includes the House bill, with modifications. For any child under age 19 in one of the major mandatory and optional eligibility groups (defined in Section 1902(a)(10)(A)) under the state Medicaid plan, wrap-around benefits to the benchmark or benchmark-equivalent coverage consists of early and periodic screening, diagnostic and treatment services as defined in current Medicaid law. The agreement drops benchmark dental coverage and accompanying provisions defining the children who would qualify for such benchmark dental coverage.

Also, under the conference agreement, states may exercise this option only for eligibility groups that were established under the state plan before the date of enactment of this option.

The conference agreement drops mandatory children under 18 (under Section 1902(a)(10)(A)(i)) from the list of groups exempted from this option.

The conference agreement also expands the list of specified groups that would be exempted from benchmark coverage to include: (1) individuals who qualify for Medicaid under the state plan on the basis of being blind or disabled regardless of whether the individual is eligible for SSI on such basis, including children with disabilities that meet SSI disability standards who require institutional care, but for whom care is delivered outside the institution, and the cost of that care does not exceed the otherwise applicable institutional care (also known as Katie Beckett or TEFRA children); (2) children in foster care receiving child welfare services (under Part B of Title IV) and children receiving foster care or adoption assistance under Part E of Title IV without regard to age; (3) individuals who qualify for Medicaid on the basis of receiving assistance under TANF (as in effect on or after the welfare reform effective date); (4) women in the breast and cervical cancer eligibility group (a technical change from the House bill); and (5) other "limited services beneficiaries," including certain tuberculosis-infected individuals, and legal and undocumented non-citizens who meet the financial and categorical requirements for Medicaid eligibility without regard to time in the U.S. and are eligible only for emergency medical services.

The conference agreement also adds to the set of three benchmark benefit packages, a fourth option called "secretary approved coverage" which may include any other health benefits coverage that the Secretary determines will provide appropriate coverage for the population targeted to receive such coverage.

Finally, the conference agreement changes the effective date of these provisions to January 1, 2007.

Chapter 5 – State Financing Under Medicaid

Managed Care Organization Provider Tax (Section 6051 of the Conference Agreement, and Section 6033 of the Senate Bill, and Section 3142 of the House Bill).

Current Law

States' ability to use provider-specific taxes to fund Medicaid expenditures is limited. If a state establishes provider-specific taxes to fund the state's share of program costs, reimbursement of the federal share will not be available unless the tax program meets the following three rules: the taxes collected cannot exceed 25% of the state (or non-federal) share of Medicaid expenditures; the state cannot provide a guarantee to the providers that the taxes will be returned to them; and the tax must be "broad-based." A broad-based tax is a tax that is uniformly applied to all providers or services within the provider class. The federal statute identifies each of the classes of providers or services for the purpose of determining whether a tax is broad-based.

Medicaid managed care organizations (MCOs) are identified as a separate class of providers for the purposes of determining if a tax is broad-based. This class is unlike all of the other classes of providers or services because it is limited to only Medicaid providers. Other classes of providers or services identified in statute, such as inpatient hospital services, outpatient hospital services, physicians — are not restricted to Medicaid providers or Medicaid services.

Senate Bill

The Senate bill would expand the Medicaid MCO provider class to include all MCOs. To qualify for federal reimbursement, a state's provider tax would need to apply to both

Medicaid and non-Medicaid MCOs. This would make the MCO provider class more consistent with the other provider classes for purposes of determining if a provider tax is broad-based.

The provision would become effective on January 1, 2006 except in States that have, as of December 31, 2005, a tax on the Medicaid MCO class of providers as defined under current law. The provision would not apply to those states.

House Bill

Similar to Senate provision except the provision would become effective upon enactment except for in states with taxes based on the current law Medicaid MCO provider class. For those states, the prohibition would become effective on October 1, 2008 and the reduction in Medicaid reimbursement due to this provision would be 50% for the fiscal year beginning on that day.

Conference Agreement

The conference agreement expands the Medicaid MCO provider class to include all MCOs. To qualify for federal reimbursement, a state's provider tax would need to apply to both Medicaid and non-Medicaid MCOs. The provision becomes effective upon enactment except in states with taxes based on the current law Medicaid MCO provider class as of December 8, 2005. In those states, the provision becomes effective on October 1, 2009.

Reforms of Case Management and Targeted Case Management Services (Section 6052 of the Conference Agreement, and Section 6031 of the Senate Bill, and Section 3146 of the House Bill).

Current Law

Under current Medicaid law (Section 1915(g)(2) of the Social Security Act), case management is defined as including services to assist a Medicaid beneficiary in gaining access to needed medical, social, educational and other services. Case management services are an optional benefit under the Medicaid state plan. The term "targeted case management" (TCM) refers to situations in which these services are not provided statewide to all Medicaid beneficiaries but rather are provided only to specific classes of Medicaid eligible individuals as defined by the state (e.g., those with chronic mental illness), or persons who reside in a specific area.

Several states extend the Medicaid TCM benefit to individuals who may also be receiving case management services as a component of another state and/or federal program. For example, a state may provide TCM services for Medicaid beneficiaries in foster care – defined in the Medicaid state plan as "children in the state's custody and who are placed in foster homes." As part of the foster care program, children receive certain case management services regardless of whether or not they are a Medicaid beneficiary.

In addition, the existing federal guidance is conflicting with respect to the process states should follow to claim Medicaid reimbursement for TCM services when another program also covers case management services for the same beneficiary. The State Medicaid Manual (Section 4302.2) states that claims for targeted case management services must be fully documented for a

specific Medicaid beneficiary in order to receive payment. In addition, documentation that includes time studies and cost allocation plans "are not acceptable as a basis for Federal participation in the costs of Medicaid services." Cost allocation plans are a narrative description of the procedures that a state agency uses in identifying, measuring, and allocating the state agency's administrative costs incurred for supervising or operating programs. Per federal regulations (45 CFR 95.505), the cost allocation plan does not include payments for services and goods provided directly to program recipients. However, a State Medicaid Director's (SMD) letter dated January 19, 2001, which discusses targeted case management services for children in foster care under the federal Title IV-E program, requires states to "properly allocate case management costs between the two programs in accordance with OMB Circular A-87 under an approved cost allocation program." Thus, this letter extended the application of cost allocation plans to claim reimbursement for case management services when a child is receiving these services under both the Title IV-E (foster care) and Medicaid programs.

Senate Bill

This proposal would further define the Medicaid TCM benefit under Section 1915(g)(2) of the Social Security Act, and would codify the ability of states to use an approved cost allocation plan (as outlined under OMB Circular A-87, or other related or subsequent guidance) for determining the amount that can be billed as Medicaid TCM services when case management is also reimbursable by another federally-funded program.

Specifically, the proposal would clarify that the TCM benefit includes the following: 1) assessment of an eligible individual to determine service needs by taking a client history, identifying an individual's needs and completing related documentation, and if needed, gathering information from other sources; 2) development of a specific care plan based on the information collected through an assessment that specifies the goals and actions to address the individual's needs; 3) referral and related activities to help an individual obtain needed services; and 4) monitoring and follow-up activities including activities and contacts to ensure the care plan is effectively implemented and adequately addressing the individual's needs.

The proposal would also specify certain activities that are not reimbursable as TCM services. First, the TCM benefit would *not* include the direct delivery of an underlying medical, educational, social or other services to which an eligible individual has been referred. In addition, with respect to the direct delivery of foster care services, the TCM benefit would *not* cover: research gathering and completion of required foster care documentation, assessing adoption placements, recruiting or interviewing potential foster care parents, serving legal papers, home investigations, providing transportation, administering foster care subsidies, and making placement arrangements.

In cases where a TCM provider contacts individuals who are not Medicaid eligible or who are not part of the TCM target population, the activity could be billed as TCM services if the purpose of the contact is directly related to the management of the *eligible* individual's care. If the contact is related to the identification and management of the non-eligible or non-targeted individual's needs and care, the activity may not be billed as TCM services.

Finally, consistent with existing Medicaid law, this proposal would also specify that federal Medicaid funding would only be available for TCM services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program.

This provision would take effect January 1, 2006.

House Bill

Same as Senate provision.

Conference Agreement

The conference agreement modifies the Senate and House bills to differentiate between *case management* and *targeted case management services*. It would define case management services in federal law as services that will assist Medicaid-eligible individuals in gaining access to needed medical, social, educational, and other services including: 1) assessment of an eligible individual to determine service needs by taking a client history, identifying an individual's needs and completing related documentation, and if needed, gathering information from other sources; 2) development of a specific care plan based on the information collected through an assessment that specifies the goals and actions to address the individual's needs; 3) referral and related activities to help an individual obtain needed services; and 4) monitoring and follow-up activities including activities and contacts to ensure the care plan is effectively implemented and adequately addressing the individual's needs.

The conference agreement also establishes those activities that are not reimbursable as case management services including the direct delivery of an underlying medical, educational, social or other services to which an eligible individual has been referred. With respect to the direct delivery of foster care services, case management would not include research gathering and completion of required foster care documentation, assessing adoption placements, recruiting or interviewing potential foster care parents, serving legal papers, home investigations, providing transportation, administering foster care subsidies, and making placement arrangements.

The term 'targeted case management services' is defined as case management services that are provided to specific classes of individuals or to individuals who reside in specific areas.

In cases where a case management provider contacts individuals who are not Medicaid eligible, or who are not part of the TCM target population, the activity could be billed as case management services if the purpose of the contact is directly related to the management of the *eligible* individual's care. If the contact is related to the identification and management of the non-eligible or non-targeted individual's needs and care, the activity may not be billed as case management services.

Consistent with existing Medicaid law, this proposal would also specify that federal Medicaid funding would only be available for case management (or TCM) services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program. If case management (or TCM) services are reimbursable by another federally-funded program the state would be required to allocate the costs of these services using OMB Circular A-87 (or any related or successor guidance or regulations).

Finally, the conference agreement established that (1) nothing in the provision would affect the application of rules with respect to third party liability under programs or activities carried out under Title XXVI of the Public Health Service Act (the HIV Health Care Services Program) or the Indian Health Service; and (2) the Secretary would be required to promulgate

regulations to carry out the changes made by this provision. The effective date of this provision would be January 1, 2006.

Additional FMAP Adjustments (Section 6053 of the Conference Agreement, Sections 6032 and 6037 of the Senate Bill, and Sections 3148 and 3205 of the House Bill).

Current Law

The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa); it has a statutory minimum of 50% and maximum of 83%. An enhanced FMAP is available for both services and administration under the State Children's Health Insurance Program (SCHIP), subject to the availability of funds from a state's SCHIP allotment. In addition to Medicaid and SCHIP, the FMAP is used in determining federal reimbursement for a number of other programs, including foster care and adoption assistance under Title IV-E of the Social Security Act.

When state FMAPs are calculated by HHS for an upcoming fiscal year, the state and U.S. amounts used in the formula are equal to the average of the three most recent calendar years of data on per capita personal income available from the Department of Commerce's Bureau of Economic Analysis (BEA). For example, to calculate FMAPs for FY2006, HHS used per capita personal income data for 2001, 2002, and 2003 that became available from BEA in October 2004.

BEA revises its most recent estimates of state per capita personal income on an annual basis to incorporate revised Census Bureau population figures and newly available source data. It also undertakes a comprehensive data revision — reflecting methodological and other changes — every few years that may result in upward and downward revisions to each of the component parts of personal income, which include: wages and salaries, supplements to wages and salaries (such as employer contributions for employee pension and insurance funds), proprietors' income, and dividends, interest, and rent.

As a result of these annual and comprehensive revisions, it is often the case that the value of a state's per capita personal income for a given year will change over time. For example, the 2001 per capita personal income data published by BEA in October 2003 (used in the calculation of FY2005 FMAPs) differed from the 2001 per capita personal income published in October 2004 (used in the calculation of FY2006 FMAPs).

P.L. 106-554 (Consolidated Appropriations Act, 2001), provided that for fiscal years 2001 through 2005, the Medicaid and SCHIP FMAPs for Alaska would be calculated using the state's per capita income divided by 1.05. Dividing by 1.05 lowered the state's per capita income, thereby increasing its FMAP.

Senate Bill

Under the Senate bill, FY2006 FMAPs for Medicaid and SCHIP would be re-computed for all states so that no FY2006 FMAP would be less than the greater of: (1) a state's FY2005 FMAP minus 0.5 percentage points (0.1 in the case of Delaware and Michigan, 0.3 in the case of

Kentucky) or (2) the FY2006 FMAP that would have been determined for a state if per capita incomes for 2001 and 2002 that were used to calculate the state's FY2005 FMAP were used.

In a separate provision, if Alaska's calculated FY2006 or FY2007 FMAP for Medicaid or SCHIP is less than its FY2005 FMAP, the FY2005 FMAP would apply.

House Bill

Under the House bill, for purposes of computing Medicaid FMAPs beginning with FY2006, employer contributions toward pensions that exceed 50% of a state's total increase in personal income for a period would be excluded from the per capita income of a state, but not from U.S. per capita income.

In a separate provision, for purposes of computing Medicaid and SCHIP FMAPs for any year after 2006 for a state that the Secretary of HHS determines has a significant number of individuals who were evacuated to and live in the state as a result of Hurricane Katrina as of October 1, 2005, the Secretary would disregard such evacuees and their incomes.

Conference Agreement

The conference agreement follows the Alaska provision in the Senate bill and the Katrina provision in the House bill.

DSH Allotment for the District of Columbia (Section 6054 of the Conference Agreement, and Section 6035 of the Senate Bill, and no provision in the House Bill).

Current Law

States and the District of Columbia are required to recognize, in establishing hospital payment rates, the situation of hospitals that serve a disproportionate number of Medicaid beneficiaries and other low-income patients with special needs. Under broad federal guidelines, each state determines which hospitals receive DSH payments and the payment amounts to be made to each qualifying hospital. The federal government shares in the cost of state DSH payments at the same federal matching percentage as for most other Medicaid services. Total federal reimbursement for each state's DSH payments, however, are capped at a statewide ceiling, referred to as the state's DSH allotment.

Senate Bill

The Senate bill would raise the allotments for the District of Columbia for FY 2000, 2001, and 2002 from \$ 32 million to \$ 49 million. The higher allotments would be used to calculate DSH allotments beginning with FY 2006 amounts. The provision would take effect as if enacted on October 1, 2005 and would apply to expenditures made on or after that date.

House Bill

No provision.

Conference Agreement

The conference agreement includes a provision similar to the Senate provision. The agreement clarifies that the increased amounts calculated based on the modified allotments for FY 2000, 2001, and 2002 only apply to DSH expenditures applicable to fiscal year 2006 and subsequent fiscal years that are paid on or after October 1, 2005.

Increase in Medicaid Payments to Insular Areas. (Section 6055 of the Conference Agreement, no provision in the Senate Bill, and Section 3141 of the House Bill).

Current Law

In the 50 states and the District of Columbia, Medicaid is an individual entitlement. There are no limits on the federal payments for Medicaid as long as the state is able to contribute its share of the matching funds. In contrast, Medicaid programs in the territories are subject to spending caps. For fiscal year 1999 and subsequent fiscal years, these caps are increased by the percentage change in the medical care component of the Consumer Price Index (CPI-U) for all Urban Consumers (as published by the Bureau of Labor Statistics). The federal Medicaid matching rate, which determines the share of Medicaid expenditures paid for by the federal government, is statutorily set at 50 percent of the territories. Therefore, the federal government pays 50% of the cost of Medicaid items and services in the territories up to the spending caps.

Senate Bill

No provision.

House Bill

For each of fiscal years 2006 and 2007, the House bill would increase the total annual cap on federal funding for the Medicaid programs in each of the Virgin Islands, Guam, the Northern Marianas, and American Samoa. Puerto Rico would not receive additional federal Medicaid funding from this provision.

For the Virgin Islands and Guam, the FY2006 total annual Medicaid caps would be increased by \$2.5 million and the FY2007 caps would be increased by \$5.0 million. For the Northern Marianas, the FY2006 total annual Medicaid cap would be increased by \$1.0 million and the FY2007 cap would be increased by \$2.0 million. For American Samoa, the FY2006 total annual Medicaid cap would be increased by \$2.0 million and the FY2007 cap would be increased by \$4.0 million. For fiscal year 2008 and subsequent fiscal years, the total annual cap on federal funding for the Medicaid programs in each of the Virgin Islands, Guam, the Northern Marianas, and American Samoa would be calculated by increasing the FY2007 ceiling, as modified by this provision, by the percentage change in the medical care component of the Consumer Price Index (CPI-U) for all Urban Consumers (as published by the Bureau of Labor Statistics).

Conference Agreement

The conference agreement follows the House bill.

Demonstration Project Regarding Medicaid Coverage of Low-income HIV-infected individuals (No provision in the Conference Agreement, Sec. 6039 (c) of the Senate Bill, and no provision in the House Bill).

Current Law

Section 1115 gives the Secretary of HHS authority to modify virtually all aspects of the Medicaid (and SCHIP) programs. Among other projects, the Secretary has used the Section 1115 waiver authority to approve benefit-specific demonstrations that provide targeted services to certain individuals. For example, under existing Medicaid HIV/AIDS Section 1115 demonstration waivers, the Secretary approved programs that provide a limited set of Medicaid benefits (e.g., case management, and pharmacy services) to individuals with HIV/AIDS who would not otherwise be eligible for Medicaid. Approved Section 1115 waivers are deemed to be part of a state's Medicaid (or SCHIP) state plan for purposes of federal reimbursement. Project costs associated with waiver programs granted under the Medicaid (or SCHIP) programs are subject to that state's FMAP (or enhanced-FMAP). Unlike regular Medicaid (or SCHIP), CMS waiver guidance specifies that costs associated with waiver programs must be budget neutral (or allotment neutral) to the federal government over the life of the waiver program whereby the federal and state government negotiate a spending cap beyond which the federal government has no fiscal responsibility.

Senate Bill

The Senate Bill would require the Secretary of HHS to allow states to seek approval for time limited (i.e., 5-year) Section 1115 demonstration projects that provide full Medicaid coverage to specified HIV-infected individuals. For fiscal years 2006 through 2010, \$450,000,000 in federal funds would be appropriated for such demonstrations. From this amount, the Secretary would allocate money to states and territories (without regard to existing federal Medicaid spending caps applicable in the territories) with approved HIV Section 1115 demonstrations based on the availability of such funds. Allotment of funds among states (or territories) with approved demonstrations would be based on an amount equal to the state's SCHIP Enhanced Federal Medical Assistance Percentage (Enhanced-FMAP) for quarterly expenditures associated with medical assistance provided to individuals under the waiver up to the specified cap. The Secretary would be required to submit a program evaluation to Congress not later than December 31, 2010. This provision would be effective on January 1, 2006.

House Bill

No provision.

Conference Agreement

The conference agreement does not include the Senate bill.

Inclusion of Podiatrists As Physicians (no provision in the Conference Agreement, Section 6034 of the Senate Bill, and no provision in the House Bill).

Current Law

Under Medicaid, services provided by podiatrists may be covered under the optional "other practitioners" benefit category. "Physician services" are a mandatory Medicaid benefit.

Senate Bill

The Senate bill would treat podiatrists as physicians, as is the case under Medicare. Thus, states would be required to cover the medical services of podiatrists (i.e., doctors of podiatric medicine) under Medicaid. This provision would apply to all such services furnished on or after January 1, 2006.

House Bill

No provision.

Conference Agreement

The conference agreement does not include this provision.

Demonstration Project Regarding Medicaid Reimbursement for Stabilization of Emergency Medicaid Conditions by Non-Publicly Owned or Operated Institutions for Mental Diseases (no provision in the Conference Agreement, Section 6036 of the Senate Bill, and no provision in the House Bill).

Current Law

An IMD is defined as a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. The 1950 amendments to the Social Security Act established the prohibition of federal assistance for IMD residents as well as for patients diagnosed with a psychosis found in other medical institutions. When Medicaid was established in 1965, the law included a state option to allow Medicaid funding for inpatient psychiatric care rendered in general hospitals as well as funding for specific services provided to residents age 65 years and older in IMDs. The 1972 amendments allowed for optional coverage, under certain circumstances, for IMD residents under age 21 or, in some cases, under age 22. In general, reimbursement for services obtained in IMDs by Medicaid beneficiaries ages 22 to 64 years remains prohibited. The term "State" includes the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

Under Medicare, "emergency medical condition" means a medical condition with acute symptoms of sufficient severity such that the absence of immediate medical attention could result in (1) placing the health of the individual in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any organ. Under Medicare, the term "stabilize" means medical treatment as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Senate Bill

The Senate bill would require the Secretary to establish a 3-year demonstration project in eligible states to provide Medicaid coverage for certain IMD services (not publicly-owned or operated) for Medicaid eligible individuals who are between the ages of 21 and 64, and who require IMD services to stabilize an emergency medical condition. Upon approval of an application, eligible states would include Arizona, Arkansas, Louisiana, Maine, North Dakota, Wyoming, and four additional states to be selected by the Secretary to provide geographic diversity. The provision would appropriate \$30 million for FY2006 for the demonstration which would be available through December 31, 2008. The Secretary would allocate funds to eligible states based on their applications and the availability of funds. Payments to states would be drawn from these allocations, based on the federal matching rate (FMAP) for benefits.

For purposes of the demonstration, the Secretary would be required to waive current law limitations on payments for services delivered to persons under 65 who are patients in an IMD. The Secretary would have the option to also waive other requirements in Sections XI and XIX, including requirements relating to statewideness and comparability of benefits, only to the extent necessary to carry out the demonstration project. The terms "emergency medical condition" and "stabilize," as defined under Medicare, would apply to the demonstration described in this provision.

The Senate bill would also require the Secretary to submit annual reports to Congress on the progress of the demonstration project. No later than March 31, 2009, the Secretary would submit to Congress a final report describing whether the demonstration: (1) resulted in increased access to Medicaid inpatient mental health services, (2) produced a significant reduction in the use of higher cost emergency room services for Medicaid beneficiaries, (3) impacted the costs of providing Medicaid inpatient psychiatric care, and (4) should be continued after December 31, 2008, and expanded nationwide.

House Bill

No provision.

Conference Agreement

The conference agreement does not include this provision.

Chapter 6 – Other Provisions

Subchapter A – Family Opportunity Act

Opportunity for Families of Disabled Children to Purchase Medicaid Coverage for Such Children (Section 6062 of the Conference Agreement, Section 6042 of the Senate Bill, and no provision in the House Bill).

Current Law

For children with disabilities, there are a number of potentially applicable Medicaid eligibility groups, some mandatory but most optional. For some of these groups, disability status or medical need is directly related to Medicaid eligibility (e.g., children receiving SSI with family income below 75% FPL). But there are other pathways through which such children may qualify for Medicaid coverage for which disability status and/or medical need are irrelevant (e.g., children under age 6 with family income below 133% FPL). All of the Medicaid eligibility pathways for children require income levels that are generally below 300% of the federal poverty level (FPL) with some state-specific exceptions.

States may require Medicaid beneficiaries to apply for coverage in certain employer-sponsored group health plans (in which such persons are eligible) when it is cost-effective to do so (defined below). This requirement may be imposed as a condition of continuing Medicaid eligibility, except that failure of a parent to enroll a child must not affect the child's continuing eligibility for Medicaid. If all members of the family are not eligible for Medicaid, and the group health plan requires enrollment of the entire family, Medicaid will pay associated premiums for full family coverage if doing so is cost-effective. Medicaid will not pay deductibles, coinsurance or other cost-sharing for family members ineligible for Medicaid. Third party liability rules apply to coverage in a group health plan; that is, such plans, not Medicaid, must pay for all covered services under the plan. Cost-effectiveness means that the reduction in Medicaid expenditures for Medicaid beneficiaries enrolled in a group health plan is likely to be greater than the additional costs for premiums and cost-sharing required under the group health plan.

For certain eligibility categories, states may not impose enrollment fees, premiums or similar charges. States are specifically prohibited from requiring payment of deductions, cost-sharing or similar charges for services furnished to children under 18 (up to age 21, or reasonable subcategories, at state option). Also, in certain circumstances, states may impose monthly premiums for Medicaid. For example, states may require certain workers with disabilities to pay premiums and cost-sharing set on a sliding scale based on income. For one of these groups, states may require those with income between 250% and 450% FPL to pay the full premium. But the sum of such payments may not exceed 7.5% of income. For other groups, states may not require prepayment of premiums and may not terminate eligibility due to failure to pay premiums, unless such failure continues for at least 60 days. States may also waive premiums when such payments would cause undue hardship.

Unless otherwise specified for a given coverage group, Medicaid eligibility for children is limited to those in families with income up to 133 and 1/3% of the applicable AFDC payment standard in place as of July 16, 1996. In addition, targeted low-income children under SCHIP statute are defined as those who would not qualify for Medicaid under the state plan in effect on

March 31, 1997. Payments for services provided to children who receive Medicaid benefits through an expansion of eligibility under SCHIP authority are reimbursed by the federal government at the enhanced federal medical assistance percentage (E-FMAP) rate, and funds based on this rate are drawn from annual SCHIP allotments. The SCHIP E-FMAP builds on the Medicaid FMAP. The FMAP formula is designed to provide a higher federal matching rate for states with lower average per capita income, compared to the national average.

Senate Bill

The Senate bill would create a new optional Medicaid eligibility group for children with disabilities under age 19 who meet the severity of disability required under the Supplemental Security Income (SSI) program with family income that exceeds SSI financial standards but is below 300% FPL. Medicaid coverage would be phased in by age group, beginning with children through age 6 in the second through fourth quarters of FY2008, then covering children through age 12 beginning in FY2009, and finally, covering children through age 18 during FY2010 and thereafter.

The Senate bill would require states to require certain parents of children eligible for Medicaid under the new optional coverage group to enroll in family coverage through employer-sponsored insurance (ESI) if certain conditions are met. When the employer offers family coverage, the parent is eligible for such coverage, and the employer contributes at least 50% of the total cost of annual premiums for such coverage, states must require participation in such coverage as a condition of continuing Medicaid eligibility for the child. Also, if such coverage is obtained, states must reduce premiums by an amount that reasonably reflects the premium contribution made by the parent for private coverage on behalf of a child with a disability. States could pay any portion of required premiums on behalf of eligible children under such plans. Medicaid would be the secondary payer to these ESI plans. Benefits offered by Medicaid but not offered by the ESI plans would be covered under Medicaid.

States would be permitted, within certain limits, to require families with children that qualify for Medicaid under the new optional eligibility category to pay monthly premiums on a sliding scale based on income, but only if specific caps on aggregate payments for cost-sharing (premiums plus other charges) for employer-sponsored family coverage are met. These caps specify that cost-sharing would not exceed 5% of income for families with income up to 200% FPL, and would not exceed 7.5% of income for families with income between 200% and 300% FPL. States could not require prepayment of premiums, nor would states be allowed to terminate eligibility of an enrolled child for failure to pay premiums unless lack of payment continues for a minimum of 60 days beyond the due date. States could waive payment of premiums when such payment would cause undue hardship.

The Senate bill would permit the income level for the new optional coverage group (set at 300% FPL) to exceed the otherwise applicable AFDC-related income standard for children under Medicaid. This section also stipulates that children with disabilities made eligible for Medicaid through the new optional coverage group would not be considered to be targeted low-income children as defined under SCHIP. Thus, the regular Medicaid FMAP, rather than the higher SCHIP E-FMAP, would apply for determining the federal share of Medicaid expenditures for the new optional coverage group. In addition, federal payments would be drawn from the open-ended Medicaid account and not the capped SCHIP account.

These provisions would be effective for items and services furnished on or after January 1, 2008.

House Bill

No provision.

Conference Agreement

The conference agreement includes the Senate bill, with modifications. First, the agreement defines qualifying children as those considered disabled under the SSI program without regard to any income or asset eligibility requirements that apply under SSI for children and whose family income does not exceed 300 % FPL. In addition, the agreement moves up the start date by one year for phasing in Medicaid coverage for this new group. That is, Medicaid coverage would be phased in, beginning with children through age 6 in the second through fourth quarters of FY2007 (rather than FY2008), then covering children through age 12 beginning in FY2008 (rather than FY2009), and finally, covering children through age 18 beginning in FY2009 (rather than FY2010) and thereafter.

As under the Senate bill, the conference agreement allows states to impose income-related premiums under this option. But the agreement changes the aggregate amount of cost sharing for families based on income levels.

For children in families with income that does not exceed 200% FPL, the aggregate amount of premiums for Medicaid coverage and any premium for employer-sponsored family coverage (in order to cover the disabled child) plus other cost-sharing cannot exceed 5% of family income. For children in families with income between 200% FPL and 300% FPL, the aggregate amount of premiums for Medicaid coverage and any premium for employer-sponsored family coverage (in order to cover the disabled child) plus other cost-sharing cannot exceed 7.5% of family income.

Finally, the conference agreement changes the effective date of these provisions to January 1, 2007.

Demonstration Projects Regarding Home and Community-based Alternative to Psychiatric Residential Treatment Facilities for Children (Section 6063 of the Conference Agreement, Section 6043 of the Senate Bill, and no provision in the House Bill).

Current Law

Medicaid home and community-based service (HCBS) waivers authorized by Section 1915(c) of the Social Security Act allows states to provide a broad range of home and community-based services to Medicaid beneficiaries who would otherwise need the level of care provided in a hospital, nursing facility, or intermediate care facility for individuals with mental retardation (ICF-MR). Federal approval for these waivers is contingent on the state's documentation of the waiver's cost-neutrality. Cost-neutrality is met if, on average, the per person cost with the HCBS waiver is no higher than the cost if the person were residing in a hospital, nursing home, or ICF-MR. The state determines which type of institution(s) it will use to make the cost-neutrality calculation.

For children with psychiatric disabilities, many states provide Medicaid funding for inpatient psychiatric residential treatment facilities. However, because the waiver cost-neutrality calculation does not allow a comparison of HCBS waiver expenditures to expenditures in these psychiatric residential treatment facilities, most states have had difficulty covering HCBS waiver services for children with psychiatric disabilities. Four states (Indiana, Kansas, New York and Vermont) have been able to offer HCBS waiver services for children with psychiatric disabilities by documenting the cost-neutrality of the waiver compared to the state's hospital expenditures. However given the cost-neutrality requirement, those states that have limited the use of hospitals for children with psychiatric disabilities may be unable to develop HCBS waivers for this population.

Senate Bill

The Senate bill would authorize the Secretary to conduct demonstration projects in up to 10 states during the period from FY2007 through FY2011 to test the effectiveness of improving or maintaining the child's functional level, and cost-effectiveness of providing coverage of home and community-based alternatives to psychiatric residential treatment, for children enrolled in Medicaid. These demonstration projects will develop home and community-based services as an alternative to a psychiatric residential treatment facility. However, these projects must also follow the requirements of the HCBS waiver program. Specifically, demonstration participants would be required to meet the level of care of a psychiatric residential treatment facility, and the average, per-person project expenditures may not exceed the average, per-person cost of a psychiatric residential treatment facility.

The demonstration states would be selected through a competitive bidding process. At the end of the demonstration period, the state may allow children enrolled in the demonstration project to continue receiving the Medicaid home and community-based waiver services provided under the demonstration; however, no new children could be added to the project.

As part of the demonstration, the following conditions would apply: (1) projects must meet the same terms and conditions that apply to all HCBS waivers; (2) the Secretary must ensure that the projects are budget neutral; that is, total Medicaid expenditures under the demonstration projects will not be allowed to exceed the amount that the Secretary estimates would have been paid in the absence of the demonstration projects; and (3) applications for a demonstration project must include an assurance to conduct an interim and final evaluation by an independent third party and any reports that the Secretary may require.

This proposal would appropriate \$218 million for FY2007 through FY2011 for the state demonstration projects and the federal evaluations and report. Total expenditures for state demonstration projects would not be allowed to exceed \$21 million in FY2007, \$37 million in FY2008, \$49 million in FY2009, \$53 million in FY2010, and \$57 million in FY2011. Funds not expended in a given fiscal year would continue to be available in subsequent fiscal years. An additional \$1 million would be available to the Secretary to complete a *required* interim and final evaluation of the project and report the conclusions of the evaluations to the President and Congress within 12 months of completing these evaluations.

House Bill

No provision.

statewide as part of the Medicaid state plan (e.g., home health services and personal care services). Other services may be offered through a home and community-based services (HCBS) waiver under Section 1915(c) of the Social Security Act. These waivers allow states to provide a broad range of home and community-based services to individuals who would otherwise require the level of care provided in certain types of institutions (i.e., a hospital, nursing facility or intermediate care facility for individuals with mental retardation (ICF-MR)). For example, HCBS waiver services could include respite, personal care, adult day care, or therapy. As part of the HCBS waiver, states have the ability to define the specific services that will be offered, to target a specific population (e.g., elderly individuals) and to limit the number of individuals who can participate in the waiver.

Approval for an HCBS waiver is contingent on a state documenting the cost-neutrality of the waiver. Cost-neutrality is met if the average per person cost under the HCBS waiver is no higher than the average per person cost of receiving care in a hospital, nursing facility or ICF-MR. The state determines which type of institution(s) it will use to make the cost-neutrality calculation.

Under current law, Medicaid beneficiaries who are residents of an institution (such as a nursing home) and who would like to leave that institution would be entitled to receive those Medicaid services covered by the Medicaid state plan. However, individuals may not be able to access the broader range of services under an HCBS waiver because many states have waiting lists for the waiver.

Medicaid expenditures for services (including the Medicaid state plan and HCBS waiver) are generally shared between the federal and state governments. In FY2003 (the latest expenditure data available), the federal government covered 59% of the cost of services; states covered the remaining 41% of expenditures. The specific federal share of a state is based on the state's federal medical assistance percentage (FMAP) rate which can range from 50% to 83%.

Senate Bill

The Senate provision would authorize the Secretary to conduct a demonstration project in states to increase the use of home and community-based care instead of institutions. States awarded a demonstration would receive 90% of the costs of home and community-based, long-term care services (under a HCBS waiver and/or the state plan) for 12 months following a demonstration participant's transition from an institution into the community. In a given fiscal year, funding would be capped at the amount of a state's grant award. After the 12 months of grant funding, the state would be required to continue providing services through a Medicaid home and community-based long-term care program, as described below.

Individuals will be eligible to participate in the demonstration if they meet the following criteria: they are residents of a hospital, nursing facility, ICF-MR, or an institution for mental disease (IMD) (but only to the extent that the IMD benefit is offered as part of the existing state Medicaid plan); they have resided in the facility for no less than six months or for a longer time period specified by the state (up to a maximum of two years); they are receiving Medicaid benefits for the services in this facility; and they will continue to require the level of care of the facility but for the provision of HCBS services.

The state's application for a demonstration project will be required to include, at a minimum, the following information: (1) assurance that the project was developed and will be operated through a public input process; (2) assurance that the project will operate in conjunction with an existing Medicaid home and community-based program; (3) the duration of

the project, which must be for at least two consecutive fiscal years in a five-year period starting in FY2009; (4) the service area, which may be statewide or less-than-statewide; (5) the target groups and the projected number to be enrolled and the estimated total expenditures for each fiscal year; (6) assurance that the project defers to individual choice and that the state will continue services for participants after the demonstration ends, as long as the state offers such services and the individual remains eligible; (7) information on recent Medicaid expenditures for long-term care and home and community-based services and proposed methods to increase the state's investment in home and community-based services; (8) methods the state will use to eliminate barriers to paying for long-term care services for participants in the setting(s) of their choice; (9) assurance that the state will meet a maintenance of effort for Medicaid HCBS expenditures and will continue to operate a HCBS waiver that meets the statutory requirements for cost-neutrality.

A state will also be required to describe a plan for quality assurance and improvement of HCBS services under Medicaid; any requested waivers of Medicaid law; if applicable, the process for participants to self-direct his or her own services (meeting standards outlined in this proposal); and compliance with reports and evaluation, as required by the Secretary.

In addition to evaluating the merits of a state's application, in selecting demonstration projects, the Secretary will be required to consider a national balance of target groups and geographic distribution and to give a preference to states that cover multiple groups or offer project participants the opportunity to self-direct their services. The Secretary will be authorized to waive certain sections of Medicaid law to achieve the purpose of the demonstration.

To qualify for grant awards after year one, states will be required to meet numerical benchmarks measuring the increased investment in services under this proposal and the number of individuals transitioned into the community. States will also be required to demonstrate that they are assuring the health and welfare of project participants. For states that do not meet these requirements, the Secretary will be required to rescind the grant award for future grant periods and will be allowed to re-award unused funding.

The proposal would require the Secretary to provide technical assistance and oversight to state grantees and may use up to \$2.4 million of the amounts appropriated for the portion of fiscal year 2009 that begins on January 1, 2009, and ends on September 30, 2009, and for fiscal year 2010, to carry out these activities during the period beginning on January 1, 2009 and ending on September 30, 2013. The Secretary would also be required to conduct a national evaluation and report its findings to the President and Congress no later than September 30, 2012 and may use up to \$1.1 million each year from FY2010 through FY2013 to carry out these activities.

This proposal would appropriate \$250 million for the portion of FY2009 which begins on January 1, 2009, and ends on September 30, 2009; \$300 million in FY2010; \$350 million in FY2011; \$400 million in FY2012; and \$450 million in FY2013 to carry out the demonstration project. Funds not awarded to states in a given fiscal year would continue to be available in subsequent fiscal years through September 30, 2013.

Payments for home and community-based long-term care services under the demonstration project would be in lieu of payment with respect to expenditures that could otherwise be paid for by Medicaid. However, if a state exhausts its grant funding in a particular year, the state is not prevented from using Medicaid to pay for home and community-based long

term care services. Finally, a state that does not use all of its funding in a given fiscal year will continue to have access to that funding for four subsequent fiscal years.

House Bill

No provision.

Conference Agreement

The conference agreement follows the Senate provision, but makes several changes to the Senate bill. First, to be eligible an individual must continue to require the level of care in an institution. However, in any case where a state would apply a more stringent level of care standard as a result of implementing a Medicaid state plan option under section 1915(I), established under this conference agreement, the individual must continue to require the level of care which had resulted in admission to the institution.

A state must assure that it will continue services for participants after the demonstration ends, as long as the state offers such services and the individual remains eligible. If the state chooses to apply a more stringent level of care as a result of covering the state plan option under Section 1915(I), established under this conference agreement, the individual must continue to meet the requirement for the level of care that had resulted in his or her admission to the institution.

In addition, those states awarded a demonstration would receive an enhanced FMAP rate (referred to as the "MFP-enhanced FMAP") equal to the current FMAP rate for the state increased by a number of percentage points equal to 50% of the difference between 100% and the normal FMAP rate. However, in no case can the FMAP rate exceed 90% for a state. The state will receive the MFP-enhanced FMAP for the costs of home and community-based, long-term care services for 12 months following a demonstration participant's transition from an institution into the community.

Finally, demonstration grants would be awarded starting in 2007, instead of 2009 which changes all relevant dates within this provision including:

- The duration of the project must be for at least two consecutive fiscal years in a five-year period starting in FY2007; and
- The Secretary would be able to use up to \$2.4 million of the amounts appropriated for the portion of fiscal year 2007 that begins on January 1, 2007, and ends on September 30, 2007, and for fiscal year 2008, to carry out technical assistance and quality assurance activities during the period beginning on January 1, 2007 and ending on September 30, 2011; and
- The Secretary will also be required to report evaluation and findings to the President and Congress no later than September 30, 2011 and may use up to \$1.1 million each year from FY2008 through FY2011 to carry out these activities; and
- The provision would appropriate \$250 million for the portion of FY2007 which begins on January 1, 2007, and ends on September 30, 2007; \$300 million in FY2008; \$350 million in FY2009; \$400 million in FY2010; and \$450 million in FY2011 to carry out the demonstration project; and
- Funds not awarded to states in a given fiscal year would continue to be available in subsequent fiscal years through September 30, 2011.

Subchapter C – Miscellaneous

Medicaid Transformation Grants (Section 6081 of the Conference Agreement, no provision in the Senate Bill, and Section 3143 of the House Bill).

Current Law

Section 1903(a) of the Social Security Act describes the level of federal reimbursement available to states for various Medicaid program functions. The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa); it has a statutory minimum of 50% and maximum of 83%. The federal reimbursement rate for Medicaid administrative expenditures does not vary by state and is generally 50%, but certain administrative functions receive enhanced (usually 75%) reimbursement.

Senate Bill

No provision.

House Bill

Under the House bill, in addition to the normal federal Medicaid reimbursement received by states under section 1903(a), the Secretary of HHS would provide for payments to states for the adoption of innovative methods to improve the effectiveness and efficiency in providing medical assistance under Medicaid.

Examples of innovative methods for which such funds may be used include: (1) methods for reducing patient error rates through the implementation and use of electronic health records, electronic clinical decision support tools, or e-prescribing programs, (2) methods for improving rates of collection from estates of owed to Medicaid, (3) methods for reducing waste, fraud, and abuse under Medicaid, such as reducing improper payment rates as measured by the annual payment error rate measurement (PERM) project rates, (4) implementation of a medication risk management program as part of a drug use review program, and (5) methods for reducing, in clinically appropriate ways, Medicaid expenditures for covered outpatient drugs, particularly in the categories of greatest drug utilization, by increasing the utilization of generic drugs through the use of education programs and other incentives to promote greater use of generics.

No payments would be made to a state unless the state applied to the Secretary of HHS for such payments in a form, manner, and time specified by the Secretary. Payments would be made under such terms and conditions consistent with the subsection as the Secretary prescribes. Payment to a state under the subsection would be conditioned on the state submitting to the Secretary an annual report on the programs supported by such payment. The reports would include information on: (1) the specific uses of such payment, (2) an assessment of the quality improvements and clinical outcomes under such programs, and (3) estimates of the cost savings resulting from such programs.

Total payments would equal and not exceed \$50 million in each of FY2007 and FY2008. The Secretary would specify a method for allocating the funds among states. Such method would provide preference for states that design programs that target health providers that treat significant numbers of Medicaid beneficiaries. The method would also allocate at least 25% of the funds among states whose populations as of July 1, 2004 were more than 105% of their populations as of April 1, 2000.

Conference Agreement

The conference agreement follows the House bill, but would increase total payments to equal and not exceed \$75 million in each of FY2007 and FY2008. The agreement also adds, as an additional option for use of funds, methods for improving access to primary and specialty physician care for the uninsured using integrated university-based hospital clinic systems. Conferees believe that it is important to develop new models to meet the needs of the uninsured. University based physicians are uniquely qualified to assume this task. Bringing the resources of academia and health care system together to serve the poor and medically needy will create new opportunities to develop strategies that can be used on a broader scale.

Improved Enforcement of Documentation Requirements (Section 6082 of the Conference Agreement, no provision in the Senate Bill, and Section 3145 of the House Bill).

Current Law

To be eligible for the full range of benefits offered under Medicaid, an individual must be a citizen or national of the United States or a qualified alien (e.g., a legal permanent resident, refugee, alien granted asylum or related relief) who meets all other Medicaid program eligibility criteria. Non-qualified aliens (e.g., those who are unauthorized or illegally present, non-immigrants admitted for a temporary purpose such as education or employment, short-term parolees) who would otherwise be eligible for Medicaid except for their immigration status may only receive Medicaid care and services that are necessary for the treatment of an emergency medical condition and are not related to an organ transplant procedure.

As a condition of an individual's eligibility for Medicaid benefits, Section 1137(d) of the Social Security Act requires a state to obtain a written declaration, under penalty of perjury, stating whether the individual is a citizen or national of the United States. If an individual declares that he or she is a citizen or national, the state is not required to obtain additional documentary evidence but may choose to do so. According to a 2005 report from the Department of Health and Human Services' Office of Inspector General, 46 states and the District of Columbia allow or sometimes allow self-declaration of United States citizenship, while four states require Medicaid applicants to submit documentary evidence to verify citizenship statements.

If an individual declares that he or she is *not* a citizen or national, the individual must declare that he or she is a qualified alien and must present: (1) alien registration documentation or other proof of immigration registration from the Department of Homeland Security's United States Citizenship and Immigration Services Bureau (DHS/USCIS, formerly the Immigration and Naturalization Service) or (2) other documents determined by the state to constitute reasonable evidence of satisfactory immigration status. If an individual presents DHS/USCIS

documentation, the state must verify the individual's immigration status with DHS/USCIS through the automated Systematic Alien Verification for Entitlements (SAVE) system, or by using an alternative verification system approved by the Secretary of Health and Human Services. States receive 100% federal reimbursement for the operation of such systems.

Senate Bill

No provision.

House Bill

Under the House bill, states would be prohibited from receiving federal reimbursement for medical assistance provided under Medicaid to an individual who has not provided satisfactory documentary evidence of citizenship or nationality.

Such evidence would include one of the following documents:

- a United States passport;
- Form N-550 or N-570 (Certificate of Naturalization);
- Form N-560 or N-561 (Certificate of United States Citizenship);
- such other document that the Secretary may specify, by regulation, that provides proof of United States citizenship or nationality and that provides a reliable means of documentation of personal identity.

Satisfactory documentary evidence would also include a document from each of the following lists:

- a certificate of birth in the United States;
- Form FS-545 or Form DS-1350 (Certificate of Birth Abroad);
- Form I-97 (United States Citizen Identification Card);
- Form FS-240 (Report of Birth Abroad of a Citizen of the United States); or
- such other document as the Secretary may specify (excluding a document specified by the Secretary as described above) that provides proof of United States citizenship or nationality;

AND

- any identity document described in section 274A(b)(1)(D) of the Immigration and Nationality Act; or
- any other documentation of personal identity of such other type as the Secretary finds, by regulation, provides a reliable means of identification.

The documentary requirements would not apply to an alien who is: (1) eligible for Medicaid and is entitled to or enrolled for Medicare benefits, (2) eligible for Medicaid on the basis of receiving Supplemental Security Income benefits, or (3) eligible for Medicaid on such other basis as the Secretary may specify under which satisfactory documentary evidence of citizenship or nationality had been previously presented.

The provision would apply to determinations of initial eligibility for Medicaid made on or after July 1, 2006, and to redeterminations made after such date in the case of individuals for whom the new documentary requirements were not previously met.

Conference Agreement

The conference agreement follows the House bill, but allows a state-issued driver's license or other identity document described in section 274(A)(b)(1)(D) of the Immigration and Nationality Act as satisfactory evidence, but only if the state issuing the license or such document requires proof of U.S. citizenship before issuance or obtains a Social Security number from the applicant and verifies before certification that such number is valid and assigned to an applicant who is a citizen.

Health Opportunity Accounts (Section 6083 of the Conference Agreement, no provision in the Senate Bill, and Section 3134 of the House Bill).

Current Law

Medicaid is a joint federal-state entitlement program that finances health care coverage for certain low-income families, children, pregnant women, and individuals who are aged or disabled. To qualify for Medicaid, an individual must meet both categorical and financial eligibility requirements. The specific income and resource limitations that apply to each eligibility group are set through a combination of federal parameters and state definitions. Each state designs and administers its own program under broad federal guidelines. Variation exists among states in eligibility, covered services, and the delivery of, and reimbursement for services. States that wish to experiment with new approaches for providing health care coverage that promote the objectives of the Medicaid program may seek approval for Section 1115 demonstration waivers.

Medicaid's basic benefits rules require all states to provide certain "mandatory" services as listed in Medicaid statute. Federal matching payments are also available for optional services if states choose to include them in their Medicaid plans. States define the specific features of each service to be provided under that plan within broad federal guidelines including: (1) *Amount, duration, and scope*. Each covered service must be sufficient in amount, duration, and scope to reasonably achieve its purpose, (2) *Comparability*. With certain exceptions, services available to any categorically needy beneficiary in a state must be equal in amount, duration, and scope to those available to any other categorically needy beneficiary in the state. Similarly, services available to any medically needy beneficiary in a state must be equal in amount, duration, and scope to those available to any other medically needy beneficiary in the state, (3) *Stateness*. State plan services must be covered throughout an entire state, and (4) *Freedom of choice*. With certain exceptions, a state's Medicaid plan must allow recipients freedom of choice among health care providers or managed care entities participating in Medicaid.

States may generally impose nominal cost-sharing on beneficiaries, with certain exceptions. They are precluded from imposing cost sharing on services for children under 18, services related to pregnancy, family planning or emergency services, services provided to nursing facility residents who are required to spend all of their income for medical care except for a personal needs allowance, and services furnished to individuals receiving hospice care. States may require nominal copayments, coinsurance, or deductibles within federal limits from

other beneficiaries or for other services. Beneficiaries may be charged only one type of cost sharing per service. Providers may collect cost sharing amounts from beneficiaries and generally are not to be reimbursed by the state if they are unsuccessful in collecting cost sharing from beneficiaries. Providers generally may not deny services if beneficiaries are unable to pay cost sharing amounts.

For the most part, states establish their own rates to pay Medicaid providers for services. By regulation these rates must be sufficient to enlist enough providers so that covered services will be available to Medicaid beneficiaries at least to the extent they are available to the general population in a geographic area. All providers are required to accept payments under the program as payment in full for covered services except where states require nominal cost-sharing by beneficiaries.

Senate Bill

No provision.

House Bill

The House bill would require the Secretary of HHS to establish no more than 10 demonstration programs within Medicaid for health opportunity accounts (HOA), effective January 1, 2006. While demonstration programs described in the House bill have some of the elements of a Section 1115 demonstration waiver, "Health Opportunity Accounts," as defined by the provision, are not explicitly authorized under current law.

If successful during the initial 5-year test period, other demonstrations would be approved. HOAs would be used to pay (via electronic funds transfers) health care expenses specified by the state; payments could be restricted to licensed or otherwise authorized providers as well as to items and services that are medically appropriate or necessary. Eligibility for HOAs would be determined by the state, though individuals age 65 or older, or who are disabled, pregnant, or receiving terminal care or long-term care, would be among those who would be precluded from participating. Once account holders were no longer eligible for Medicaid they could continue to make HOA withdrawals under state-specified conditions, though accounts could then also be used to pay for health insurance or, at state option, for job training or education. Among other things, state demonstration programs would have to make patients aware of the high cost of medical care, provide incentives for them to seek preventive care, and reduce inappropriate uses of health care.

Demonstration participants would have both an HOA and coverage for medical items and services that, after an annual deductible is met, were available under the existing Medicaid state plan and/or Section 1115 waiver authorities. HOA contributions could be made by the state or by other persons or entities, including charitable organizations. Including federal shares, state contributions generally could not exceed \$2,500 for each adult and \$1,000 for each child.

Demonstration participants would be required to meet an annual deductible before they would be permitted to access coverage for medical items and services available under the existing Medicaid state plan and/or Section 1115 waiver authorities. The deductible would have to be at least 100%, but no more than 110%, of the annual state contributions to the HOA. Both the deductible and the maximum for out-of-pocket cost-sharing could vary among families. The deductible need not apply to preventive care.

The House bill would require demonstration participants to be able to obtain services from Medicaid providers or managed care organizations at the same payment rates that would be applicable if the coverage deductible did not apply, or from any provider for payment rates not exceeding 125% of those rates.

Conference Agreement

The House bill is agreed to with the following modifications. The conference agreement requires the Secretary of HHS to establish no more than 10 demonstration programs within Medicaid for health opportunity accounts (HOA), effective January 1, 2007. If successful (based on cost-effectiveness, quality of care and other Secretary-specified criteria) during the initial 5-year test period, such demonstrations may be extended or made permanent, and other demonstrations may be approved. Not later than 3 months prior to the end of the initial 5-year test period, the conference agreement requires the Comptroller General of the United States to submit an evaluation of the demonstration programs to Congress.

HOAs are used to pay (via electronic funds transfers) health care expenses specified by the state; payments could be restricted to licensed or otherwise authorized providers as well as to items and services that are medically appropriate or necessary. Eligibility for HOAs is determined by the state, though individuals age 65 or older, or who are disabled, pregnant, or receiving terminal care or long-term care, are among those who are precluded from participating. Once account holders are no longer eligible for Medicaid they may continue to make HOA withdrawals under state-specified conditions for a period of three years, though no additional account contributions will be made and the account balances will be reduced by 25%. For ineligible individuals who participated in the demonstration program for at least one year, accounts could then also be used to pay for health insurance or, at state option, for additional expenditures such as job training or education. The conference agreement adds a 1-year moratorium for reenrollment, whereby eligible individuals disenrolled from the state demonstration programs are not permitted to reenroll for a full year from such individual's disenrollment date. Among other things, state demonstration programs are required to make patients aware of the high cost of medical care, provide incentives for them to seek preventive care, and reduce inappropriate uses of health care.

The conference agreement requires demonstration participants have both an HOA and coverage for medical items and services that, after an annual deductible is met, are available under the existing Medicaid state plan and/or Section 1115 waiver authorities. HOA contributions could be made by the state or by other persons or entities, including charitable organizations as permitted under current law. Including federal shares, state contributions generally may not exceed \$2,500 for each adult and \$1,000 for each child.

The conference agreement requires demonstration participants to meet an annual deductible before they are permitted to access coverage for medical items and services available under the existing Medicaid state plan and/or Section 1115 waiver authorities. The deductible must be at least 100%, but no more than 110%, of the annual state contributions to the HOA without regard to state-specified limits on the HOA balance. Both the deductible and the maximum for out-of-pocket cost-sharing could vary among families. The deductible need not apply to preventive care.

The conference agreement requires demonstration participants to be able to obtain services from Medicaid providers, or Medicaid managed care organizations at the same payment

rates that are applicable if the coverage deductible did not apply, or from any other provider or managed care organization at payment rates not exceeding 125% of such Medicaid provider payment rates. The conference agreement requires that the payment rates for Medicaid providers or managed care organizations be computed without regard to any cost sharing that are otherwise applicable under current law (as modified by the conference agreement).

State Option to Establish Non-emergency Medical Transportation Program (Section 6084 of the Conference Agreement, no provision in the Senate Bill, and Section 3125 of the House Bill).

Current Law

Federal regulations require states to ensure necessary transportation for beneficiaries to and from providers. When states offer transportation as an optional benefit, federal reimbursement uses the federal assistance medical percentage (FMAP) rate which varies by state and ranges from 50% to 83%. FMAP reimbursement is only available if transportation is furnished by a provider to whom a direct payment can be made. Beneficiaries must have freedom of choice among transportation providers and such services must be equal in amount, duration and scope for all beneficiaries classified as categorically needy (CN). This comparability requirement also applies among medically needy (MN) groups. Other arrangements, such as payments to a broker who manages and pays transportation vendors, must be claimed as an administrative expense rather than as a benefit. Such costs are reimbursed by the federal government at 50%, and fewer federal requirements must be met.

Senate Bill

No provision.

House Bill

The House bill would allow states to establish a non-emergency medical transportation brokerage program for beneficiaries who need access to medical care but have no other means of transportation. The state would not be required to provide comparable services for all Medicaid enrollees, nor freedom of choice among providers. The program would include wheelchair van, taxi, stretcher car, bus passes and tickets, and other transportation methods deemed appropriate by the Secretary, and could be conducted under contract with a broker who: (1) is selected through a competitive bidding process that assesses the broker's experience, references, qualifications, resources and costs; (2) has oversight procedures to monitor beneficiary access and complaints and to ensure that transport personnel are licensed, qualified, competent and courteous; (3) is subject to regular auditing by the state to ensure quality of services and adequacy of beneficiary access to medical care; and (4) complies with requirements related to prohibitions on referrals and conflict of interest established by the Secretary. These provisions would be effective upon enactment.

The Office of the Inspector General (OIG) of DHHS would be required to submit a report to Congress examining the non-emergency medical transportation brokerage program implemented under this provision no later than January 1, 2007. This report must include findings regarding conflicts of interest and improper utilization of transportation services under this program, as well as recommendations for improvements.

Conference Agreement

The conference agreement includes the House bill, and specifies that non-emergency medical transportation brokerage programs do not have to be available statewide.

Extension of Transitional Medical Assistance (TMA) and Abstinence Education Program (Section 6085 of the Conference Agreement, no provision in the Senate Bill, no provision in the House Bill).

Current Law

States are required to continue Medicaid benefits for certain low-income families who would otherwise lose coverage because of changes in their income. This continuation of benefits is known as transitional medical assistance (TMA). States are currently required to provide TMA to families losing eligibility for Medicaid under two scenarios: one related to child or spousal support, and one related to work.

First, under 1931(c) of the Social Security Act, states must provide four months of TMA coverage to families losing Medicaid eligibility due to increased child or spousal support. This is a permanent provision of law with no sunset date.

Second, states are required to provide TMA to families losing Medicaid eligibility for work-related reasons. While Section 1902(e)(1) of the Social Security Act permanently requires states to provide four months of TMA to families losing Medicaid eligibility due to an increase in hours of work or income from employment, the Family Support Act (FSA) of 1988 expanded state TMA requirements under Section 1925 of the Social Security Act. As a result, states are currently required to provide at least six, and up to 12, months of TMA coverage to families losing Medicaid eligibility due to increased hours of work or income from employment, as well as to families who lose eligibility due to the loss of a time-limited earned income disregard (such disregards have the effect of increasing the income level at which a family may qualify for Medicaid). FSA originally authorized Section 1925 to replace the four-month requirement in Section 1902(e)(1) through FY1998. However, the sunset date for Section 1925 has been extended a number of times, most recently through December 31, 2005.

Under Section 510 of the Social Security Act, federal law appropriated \$50 million annually for each of the fiscal years 1998-2003 for matching grants to states to provide abstinence education and, at state option, mentoring, counseling, and adult supervision to promote abstinence from sexual activity, with a focus on groups that are most likely to bear children out-of-wedlock. Funds must be requested by states when they apply for Maternal and Child Health Services (MCH) Block Grant funds and must be used exclusively for the teaching of abstinence. States must match every \$4 in federal funds with \$3 in state funds.

A state's allotment of abstinence education block grant program funding is based on the proportion of low-income children in the state as compared to the national total. Funding for the abstinence education block grant has been extended through December 31, 2005 by temporary extension measures.

Senate Bill

No provision.

House Bill

No provision.

Conference Agreement

The conference agreement extends TMA under Section 1925 of the Social Security Act through December 31, 2006. It also extends the \$50 million annual appropriation for the abstinence education block grant program through fiscal year 2006 and provides an additional \$12.5 million for the program for the first quarter of fiscal year 2007 (i.e., through December 31, 2006).

Emergency Services Furnished by Non-Contract Providers for Medicaid Managed Care Entities (Section 6086 of the Conference Agreement, no provision in the Senate Bill, and Section 3147 of the House Bill).

Current Law

Medicaid law provides certain protections for beneficiaries enrolled in managed care, including assuring coverage of emergency services under each managed care contract awarded by the state.

Senate Bill

No provision.

House Bill

A Medicaid provider that does not have a contract with a Medicaid managed care entity (MCE) that furnishes emergency care to a beneficiary enrolled with that MCO must accept as payment in full the amount otherwise applicable outside of managed care (e.g., in the fee-for-service setting) minus any payments for indirect costs of medical education and direct costs of graduate medical education. The effective date of this provision would be January 1, 2007.

Conference Agreement

The conference agreement includes the House bill, but clarifies that the fee-for-service rate is the maximum payment rate. Also, in a state where rates paid to hospitals under the state plan are negotiated by contract and not publicly released, the payment amount applicable under this provision must be the average contract rate that would apply under the state plan for general acute care hospitals or the average contract rate that would apply under the plan for tertiary hospitals.

Subtitle B- SCHIP

Additional allotments to eliminate fiscal year 2006 funding shortfalls (Section 6101 Subsection a of the Conference Agreement, Section 6051 Subsection a of the Senate Bill, and no provision in the House Bill).

Current Law

In general, funds for the SCHIP program are authorized and appropriated for FY1998 through FY2007. From each year's appropriation, a state is allotted an amount determined by a formula set in law. Federal funds not drawn from a state's allotment by the end of each fiscal year continue to be available to that state for two additional fiscal years. At the end of the three-year period, unspent funds from the original allotment are reallocated in ways that vary depending on the fiscal year. The original SCHIP law, (i.e., BBA97), specifies that only those states that spend all of their original allotment by the applicable three-year deadline would receive redistributed funds from the other states' unspent allotments, based on a process determined by the Secretary of Health and Human Services (HHS); and these redistributed funds would be available for one year. However, later laws (i.e., P.L. 106-554 and P.L. 108-74) overrode how the reallocation of unspent FY1998 to FY2001 original allotments would occur. The redistribution of unspent FY2002 SCHIP original allotments was determined by the Secretary of HHS in accordance with the default redistribution provision in BBA97.

Under current law, unspent original allotments from FY2003 forward are to be redistributed according to the original BBA97 methodology. That is, redistributed funds will go only to those states that spend all of their original allotments by the applicable three-year deadline, with the redistributed amounts determined by the Secretary of HHS and made available for one year only.

Senate Bill

In general, the Senate bill would reduce the period of availability of the FY2004 and FY2005 original allotments from three years to two, and would specify rules for the reallocation of unspent FY2003, FY2004, and FY2005 SCHIP original allotments. The reallocated FY2003 and FY2004 funds would be available in FY2006; the reallocated FY2005 funds would be available in FY2007.

In FY2006, the Senate bill would require that unspent FY2003 original allotments remaining at the end of FY2005 (after a set-aside of 1.05% of the total unspent FY2003 funds for the territories) would be redistributed to states with an initial projected FY2006 shortfall. The initial projected shortfall is the amount by which a state's estimated federal SCHIP expenditures in FY2006 would exceed the amounts available from the state's FY2005 and FY2006 original allotments. Each state with an initial projected shortfall would receive a portion of the available unspent FY2003 original allotments in proportion to its contribution to the total pool of such shortfalls. From the 1.05% territory set-aside, each territory would receive an amount in proportion to its contribution to the total pool of FY2003 original allotments for the territories.

Also in FY2006, the Senate bill would require that the territories receive a set-aside of 1.05% of the total unspent FY2004 original allotments available at the end of FY2005. Described states would be permitted to extend the use of their unspent FY2004 original allotments in an amount equal to the shortfall still remaining after receiving redistributed FY2003 funds. Described states would be defined as states that: (1) spent all FY2003 original

allotments by the end of FY2005, (2) did not spend all of their FY2004 original allotment by the end of FY2005, and (3) reported an initial projected FY2006 shortfall. After the set-aside for the territories as well as the reduction of FY2004 extended funds for the described states, the remaining unspent FY2004 funds would be available to states with a net projected FY2006 shortfall, defined as each state's initial projected shortfall reduced by the redistributed FY2003 funds it received and by the extended FY2004 funds if it is a described state. Each state with a net projected shortfall would receive a redistribution of FY2004 funds to cover its net projected shortfall. Any remaining FY2004 unspent original allotments would then be extended proportionally to states that did not spend their FY2004 allotments by the end of the two-year period of availability. From the 1.05% territory set-aside, each territory would receive an amount in proportion to its contribution to the total pool of FY2004 original allotments for the territories.

In FY2007, the Senate bill would require that the territories receive a set-aside of 1.05% of the total unspent FY2005 original allotments available at the end of FY2006. Described states would be permitted to extend the use of their unspent FY2005 original allotments in an amount equal to their initial projected FY2007 shortfall. The initial projected shortfall is the amount by which a state's estimated federal SCHIP expenditures for FY2007 exceeds the amount available from the state's FY2006 and FY2007 original allotments. Described states would be defined as states that: (1) did not spend all of their FY2005 original allotment by the end of FY2006, and (2) reported an initial projected FY2007 shortfall. After the set-aside for the territories as well as the reduction of FY2005 extended funds for the described states, the remaining unspent FY2005 funds would be available to states with a net projected FY2007 shortfall, described as each state's initial projected shortfall reduced by the extended FY2005 funds for the described states. Each state with a net projected shortfall would receive a redistribution of FY2005 funds to cover its net projected shortfall or, if the remaining funds are inadequate to cover the FY2007 projected shortfalls, a portion of the available unspent FY2005 original allotments in proportion to the state's contribution to the total shortfall pool. If any FY2005 unspent original allotments remain, they would then be extended proportionally to states that did not spend their FY2005 allotments by the end of the two-year period of availability. From the 1.05% territory set-aside, each territory would receive an amount in proportion to its contribution to the total pool of FY2005 original allotments for the territories.

To calculate the amounts available for redistribution and retention in each formula described above, the Secretary would use expenditures reported by states not later than November 30, 2005, for the FY2003 and FY2004 redistributions, and November 30, 2006, for the FY2005 redistribution. To calculate states with projected shortfalls in each formula described above, the Secretary would use projected expenditures reported by the states not later than September 30, 2005, for the FY2003 and FY2004 redistributions, and not later than September 30, 2006, for the FY2005 redistribution. This provision of the Senate bill would be effective upon enactment of this Act.

House Bill

No provision.

Conference Agreement

Out of money not otherwise available in the Treasury, the conference agreement authorizes and appropriates \$283 million for the purpose of providing additional SCHIP allotments to shortfall states in FY2006. The conference agreement defines shortfall states as

those with an approved SCHIP plan for which (based on the most recent SCHIP data as of December 16, 2005) the Secretary estimates that such state's FY2006 projected expenditures exceed the sum of all funds available for expenditure by that state in FY2006 including: (1) the amount of such state's FY2004 and FY2005 original allotments that will not be expended in FY2005; (2) the amount, if any, that is redistributed to such state during FY2006; and (3) the amount of such state's FY2006 original allotment. From the additional SCHIP appropriation, each FY2006 shortfall state would receive an allotment to cover its projected shortfall or, if the appropriated funds are inadequate to cover the FY2006 projected shortfalls, the Secretary shall distribute the available funds on a pro rata basis based on each such state's estimated shortfall. Such additional SCHIP allotments are available for one year only. On October 1, 2006, any remaining unspent additional allotments will not be subject to redistribution, but will instead revert to the Treasury.

The conference agreement limits the types of payments that may be matched at the SCHIP enhanced matching rate for SCHIP expenditures drawn against the additional FY2006 appropriation available to shortfall states to include child health assistance payments made on behalf of targeted low-income children. The amendments made by this section of the conference agreement apply to items and services furnished on or after October 1, 2005, without regard to whether or not regulations implementing such amendments have been issued.

Prohibition against covering nonpregnant childless adults with SCHIP funds (Section 6102 of the Conference Agreement, and Section 6053 of the Senate Bill).

Current Law

Section 1115 of the Social Security Act gives the Secretary of HHS broad authority to modify virtually all aspects of the Medicaid and SCHIP programs. Under Section 1115, the Secretary may waive requirements in Section 1902 (usually, freedom of choice of provider, comparability, and statewideness). For SCHIP, no specific sections or requirements are cited as "waive-able." SCHIP statute simply states that Section 1115, pertaining to research and demonstration projects, applies to SCHIP.

With respect to SCHIP, the Clinton Administration issued a July 31, 2000, letter regarding treatment of adults. While this Administration was supportive of using the 1115 authority to expand SCHIP to parents of Medicaid or SCHIP-eligible children, as well as to certain pregnant women, it opposed coverage of childless adults. Under the Bush Administration, the Health Insurance Flexibility and Accountability (HIFA) Initiative was implemented using the 1115 waiver authority. The initiative was created to encourage states to increase the number of individuals with health insurance coverage (including childless adults) within current program resources.

Senate Bill

The Senate bill would limit the Secretary of Health and Human Services's Section 1115 waiver authority by prohibiting the approval of new waiver, experimental, pilot, or demonstration projects that allow federal SCHIP funds to be used to provide child health assistance or other health benefits coverage to nonpregnant childless adults. The provision would allow the Secretary to continue to approve projects that expand the SCHIP program to caretaker relatives of Medicaid or SCHIP-eligible children (as defined under Section 1931 of Medicaid statute), and to pregnant adults. Finally, the provision would allow for the continuation of existing Medicaid or SCHIP waiver projects (and/or extensions, amendments, or renewals to

such projects) affecting federal SCHIP funds that had been approved under the Section 1115 waiver authority before the date of enactment of this Act. This provision would be effective upon the enactment of this Act.

House Bill

No provision.

Conference Agreement

The Senate bill is agreed to.

Continued authority for qualifying states to use certain funds for Medicaid expenditures. (Section 6103 of the Conference Agreement, Section 6054 of the Senate Bill, and no provision in the House Bill).

Current Law

Current law permits qualifying states (i.e., states that on or after April 15, 1997, had an income eligibility standard for children, other than infants, of at least 184% of the FPL.— Other qualifications also apply to states with statewide waivers under Section 1115 of the Social Security Act.) to receive the SCHIP enhanced federal matching rate for the coverage of certain children enrolled in regular Medicaid. Specifically, for services delivered to Medicaid beneficiaries under the age of 19 who are not otherwise eligible for SCHIP and have family income that exceeds 150% of the FPL, federal SCHIP funds can be used to pay the difference between the SCHIP enhanced federal matching rate and the regular Medicaid federal matching rate. The maximum amount that qualifying states may claim under this allowance is the lesser of the following two amounts: (1) 20% of the state's available FY1998 through FY2001 original SCHIP allotments; and (2) the state's balance (calculated quarterly) of any available FY1998 to FY2001 federal SCHIP funds (original allotments or reallocated funds). If there is no balance, states may not claim 20% spending. No 20% spending will be permitted in FY2006 or any fiscal year thereafter.

House Bill

No provision.

Senate Bill

The Senate bill would continue the authority for qualifying states to apply federal SCHIP matching funds toward the coverage of certain children enrolled in regular Medicaid (not an SCHIP Medicaid expansion). Specifically, the bill would allow qualifying states to use any available FY2004 and FY2005 SCHIP funds (i.e., FY2005 original allotments, and/or FY2004 and FY2005 retained allotments or redistributed funds, as the case may be) for such Medicaid services made on or after October 1, 2005 under the 20% allowance. This provision of the Senate bill would be effective on or after October 1, 2005.

Conference Agreement

The Senate bill is agreed to.

Use of Redistributed Funds for Child Health Assistance for Targeted Low-income Children (No provision in the Conference Agreement, Section 6051_ Subsection b of the Senate Bill, and no provision in the House Bill).

Current Law

Like Medicaid, SCHIP is a federal-state matching program. For each dollar of state spending, the federal government makes a matching payment drawn from SCHIP accounts. The federal government contributes more toward the coverage of individuals in SCHIP than it does for those covered under Medicaid. All SCHIP assistance for targeted low-income children, including claims submitted to and approved by CMS for expenditures under the Section 1115 waiver authority, are matched at the enhanced federal medical assistance percentage (enhanced-FMAP).

Title XXI of the Social Security Act specifies that federal SCHIP funds can be used for child health assistance that meets certain requirements. Apart from these benefit payments, SCHIP payments at the enhanced FMAP rate for four other specific health care activities can be made, including: (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of targeted low-income children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs.

Senate Bill

The Senate bill would limit the types of payments that could be matched at the SCHIP enhanced matching rate for SCHIP expenditures drawn against the FY2003, FY2004, and FY2005 redistributed funds available to shortfall states. Specifically, the Senate bill would require the federal government to make matching payments at the SCHIP enhanced matching rate for child health assistance payments made on behalf of targeted low-income children. However, expenditures drawn against the FY2003, FY2004, and FY2005 redistributed SCHIP funds would occur at the regular Medicaid FMAP rate for all other approved SCHIP expenditures, consisting of the following: (1) benefit expenditures for adults (other than pregnant women) approved under the Section 1115 waiver authority; (2) health services initiatives to improve the health of targeted low-income children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs.

House Bill

No provision.

Conference Agreement

The conference agreement does not include this provision.

Authority to Use up to 10 Percent of Fiscal Year 2006 and 2007 Allotments for Outreach (No provision in the Conference Agreement, Section 6052 of the Senate Bill, and no provision in the House Bill).

Current Law

In general, Title XXI of the Social Security Act specifies that federal SCHIP funds can be used for child health assistance that meets certain requirements. Apart from these benefit payments, SCHIP payments at the enhanced FMAP rate can be made for the following four specific health care activities: (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of targeted low-income children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs. For a given fiscal year, payments for these four specific health care activities cannot exceed 10% of the total amount of expenditures for SCHIP insurance benefits and other specific health care activities combined. The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) created a special rule for the redistribution of unspent FY1998 and FY1999 original allotments. Under BIPA, states that did not use all of their original allotments for the year were permitted to use up to 10% of their retained FY1998 funds for outreach activities. This allowance is over and above spending for such activities under the general administrative cap, described above.

Senate Bill

The Senate bill would allow states to use up to 10% of their FY2006 and FY2007 original allotments for expenditures on outreach activities incurred during FY2006 and FY2007 respectively. This allowance would be over and above spending for such activities under the general administrative cap described under current law. Outreach activities would include: (1) activities to promote the coordination of the administration of SCHIP with other public and private health insurance programs; and (2) strategies to market the program to the target population and to simplify and expedite the eligibility determination and enrollment process. This provision would be effective upon enactment of this Act.

House Bill

No provision.

Conference Agreement

The conference agreement does not include this provision.

Grants to Promote Innovative Outreach and Enrollment Under Medicaid and SCHIP (No provision in the Conference Agreement, Section 6055 of the Senate Bill, and no provision in the House Bill).

Current Law

The federal and state governments share in the costs of both Medicaid and SCHIP, based on formulas defining the federal contribution in federal law. States are responsible for the non-federal share, using state tax revenues, for example, but can also use local government funds to

comprise a portion of the non-federal share. Generally, the non-federal share of costs under Medicaid and SCHIP cannot be comprised of other federal funds.

Under Medicaid, there are no caps on administrative expenses that may be claimed for federal matching dollars. Title XXI specifies that federal SCHIP funds can be used for SCHIP health insurance coverage, called child health assistance that meets certain requirements. Apart from these benefit payments, SCHIP payments for four other specific health care activities can be made, including: (1) other child health assistance for targeted low-income children; (2) health services initiatives to improve the health of SCHIP children and other low-income children; (3) outreach activities; and (4) other reasonable administrative costs. For a given fiscal year, payments for other specific health care activities cannot exceed 10% of the total amount of expenditures for SCHIP benefits and other specific health care activities combined.

Senate Bill

The Senate bill would establish a new grant program under SCHIP to (1) finance outreach and enrollment efforts to increase participation of eligible children in both SCHIP and Medicaid, and (2) promote understanding of the importance of health insurance coverage for prenatal care and children. The Secretary would be permitted to reserve a portion of the grant funds for the purpose of awarding performance bonuses to eligible entities (defined below) that meet enrollment goals or other criteria established by the Secretary.

In awarding grants, the Secretary would be required to give priority to: (1) entities that propose to target geographic areas with high rates of eligible but not enrolled children, or racial and ethnic minorities and health disparity populations, and (2) entities targeting the same populations that are federal health safety net organizations (defined below) or faith-based organizations or consortia. Of the funds appropriated for this grant program (see below), 10% would be set aside for grants to certain Indian health care providers for outreach and enrollment of Indian children. These Indian health care providers would include the Indian Health Service (IHS) and Urban Indian Organization (UIO) providers that receive funds under Title V of the Indian Health Care Improvement Act.

The Senate bill would require entities seeking a grant to submit an application to the Secretary containing information on the quality and outcome performance measures to be used to evaluate the effectiveness of grant activities to ensure that these activities are meeting their goals. In addition, the application must provide assurances that the entity would: (1) conduct an assessment of the effectiveness using such performance measures, and (2) collect and report enrollment data and other information from these assessments to the Secretary in a form and manner as required by the Secretary.

The Senate bill would require the Secretary to disseminate to eligible entities and make publicly available the enrollment data and information collected and reported by grantees. The Secretary would also be required to submit an annual report to Congress on the funded outreach activities.

The Senate bill would require that federal funds awarded under this new grant be used to supplement, not supplant, non-federal funds that are otherwise available for these grant activities.

Specific definitions would be applicable to the new grant program. Five types of entities would be eligible to receive these grants, including: (1) state or local governments, (2) federal

health safety net organizations, (3) national, local or community-based public or nonprofit private organization, (4) faith-based organizations or consortia, to the extent that a grant awarded to such an entity is consistent with the requirements of Section 1955 of the Public Health Service Act (relating to grant awards to non-governmental entities), and (5) elementary or secondary schools. Federal health safety net organizations include a number of different types of entities, including for example: (1) Indian tribes, tribal organizations, UIOs and IHS providers, (2) federally qualified health centers, (3) hospitals that receive disproportionate share hospital (DSH) payments, (4) entities described in Section 340B(a)(4) of the Public Health Service Act (e.g., certain family planning projects, certain grantees providing early intervention services for HIV disease, certain comprehensive hemophilia diagnostic treatment centers, and certain Native Hawaiian health centers), and (5) any other entity that serves children under a federally-funded program, including the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Head Start programs, school lunch programs, and elementary or secondary schools.

The Senate bill would appropriate \$25 million for fiscal year 2007 for these grants. These grants would be in addition to existing SCHIP appropriations, and would not be subject to restrictions on expenditures for outreach activities under current law.

These provisions would be effective with the FY2007 appropriation for this new grant program.

House Bill

No provision.

Conference Agreement

The conference agreement does not include this provision.

Subtitle C – Katrina Relief

Additional Federal Payments Under Hurricane-Related Multi-State Section 1115 Demonstrations (Section 6201 of the Conference Agreement, Sections 6032 and 6071 of the Senate Bill, and Sections 3100 and 3201 of the House Bill).

Current Law

The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa); it has a statutory minimum of 50% and maximum of 83%. An enhanced FMAP is available for both services and administration under SCHIP, subject to the availability of funds from a state's SCHIP allotment. In order for a state to receive federal Medicaid or SCHIP

reimbursement, it must have in effect a state plan approved by the Secretary of HHS that meets requirements set forth in federal statute and regulations.

Using an application template developed by the Centers for Medicare and Medicaid Service within HHS, a number of states (17 as of December 15, 2005) have been granted waivers under Section 1115 of the Social Security Act to provide Medicaid and SCHIP services to certain individuals affected by Hurricane Katrina (these waivers are referred to as being part of a multi-state demonstration project). For purposes of FMAP reimbursement, Section 1115 waivers are deemed to be part of a state's Medicaid or SCHIP state plan (i.e., its "regular" Medicaid or SCHIP program).

All of the waivers granted thus far under the Hurricane Katrina multi-state Section 1115 demonstration create a temporary eligibility period, not to exceed five months, during which certain Hurricane Katrina evacuees will be granted access to Medicaid and SCHIP services in the host state (i.e., the state that has been granted a Section 1115 waiver) based on simplified eligibility criteria. In addition to creating temporary Medicaid or SCHIP eligibility for evacuees, waivers for some states also create an uncompensated care pool that may be used through January 31, 2006, to augment Medicaid and SCHIP services for evacuees and to reimburse providers that incur uncompensated care costs for uninsured evacuees who do not qualify for Medicaid or SCHIP.

Disaster declarations were issued in the wake of Hurricane Katrina pursuant to the Robert T. Stafford Disaster Relief and Emergency Assistance Act, which authorizes the President to issue such declarations to speed a wide range of federal aid — including individual assistance (e.g., housing for individuals and families) and public assistance (e.g., repair of community infrastructure) — to states determined to be overwhelmed by hurricanes or other catastrophes. The Federal Emergency Management Agency (FEMA) makes the decision as to when a major disaster or emergency is "closed out" for administrative purposes.

Senate Bill

Under the Senate bill, for items and services furnished during the period August 28, 2005 through May 15, 2006, states would receive 100% FMAP reimbursement for Medicaid and SCHIP assistance provided to individuals who resided during the week preceding Hurricane Katrina in one of the parishes of Louisiana or counties of Mississippi and Alabama specified in the bill. Costs directly attributable to related administrative activities would also be reimbursed at 100%.

A separate provision would allow the state of Louisiana, Mississippi, or Alabama to elect to not have the Medicaid subtitle of the bill apply with respect to the state during any period for which a major disaster declared in accordance with the Stafford Act with respect to a parish (in the case of Louisiana) or a county (in the case of Mississippi or Alabama) as a result of Hurricane Katrina is in effect.

House Bill

Under the House bill, for items and services furnished during the period August 28, 2005 through May 15, 2006, states would receive 100% FMAP reimbursement for Medicaid and SCHIP assistance provided to: (1) any individual residing in a parish of Louisiana, a county of Mississippi, or a major disaster county of Alabama and (2) individuals who resided during the

week preceding Hurricane Katrina in a parish or county for which a major disaster has been declared as a result of the hurricane and for which the President has determined, as of September 14, 2005, warrants individual assistance under the Stafford Act. Costs directly attributable to related administrative activities would also be reimbursed at 100%.

A separate provision would allow the Medicaid subtitle of the bill to not apply during the 11-month period beginning September 1, 2005, to individuals entitled to Medicaid assistance by reason of their residence in a parish of Louisiana or a county of Mississippi or Alabama for which a major disaster has been declared as a result of Hurricane Katrina and for which the President has determined, before September 14, 2005, warrants individual and public assistance under the Stafford Act.

Conference Agreement

The conference agreement appropriates **\$2 billion** (in addition to any funds made available for the National Disaster Medical System under the Department of Homeland Security for health care costs related to Hurricane Katrina) for use by the Secretary of HHS to pay eligible states (those who have provided care to affected individuals or evacuees under a Section 1115 project) for the following purposes:

- the non-federal share of expenditures for health care provided to affected individuals (those who reside in a major disaster area declared as a result of Hurricane Katrina and continue to reside in the same state) and evacuees (affected individuals who have been displaced to another state) under approved multi-state Section 1115 demonstration projects;
- reasonable administrative costs related to such projects;
- the non-federal share of expenditures for medical care provided to individuals under existing Medicaid and SCHIP state plans; and
- other purposes, if approved by the Secretary, to restore access to health care in impacted communities.

The non-federal share paid to eligible states shall not be regarded as federal funds for purposes of Medicaid matching requirements. No payment obligations may be incurred under approved multi-state Section 1115 projects for costs of: (1) health care provided as Medicaid or SCHIP medical assistance incurred after June 30, 2006 and (2) uncompensated care or services and supplies beyond those included as Medicaid or SCHIP medical assistance incurred after January 31, 2006.

State High Risk Health Insurance Pool Funding (Section 6202 of the Conference Agreement, no provision in the Senate Bill, and Section 3202 of the House Bill).

Current Law

A majority of states have established high-risk health insurance pool programs as one approach to reduce the number of uninsured persons. These programs target individuals who cannot obtain or afford health insurance in the private health insurance market, primarily because of pre-existing health conditions. Many states also use their high-risk pools to provide access to health insurance to individuals eligible under the guaranteed issue and portability provisions of

the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191). In general, high-risk pools are operated through state-established nonprofit organizations that contract with private insurance companies to collect premiums, administer benefits, and pay claims. These programs tend to be small and enroll a small percentage of the uninsured. As of December 2004, 33 states operate high risk health insurance pool programs. Authorizing legislation for federal funding of these pools expired September 30, 2005.

Senate Bill

No provision.

House Bill

The House bill would amend the Public Health Service Act to reauthorize federal funding for state high risk health insurance pools. For FY2006, it would provide \$90 million in appropriations for grants to states to be used to cover up to 50% of operating expenses of existing state high risk pools.

Conference Agreement

The conference agreement would appropriate, for FY2006, \$75 million for the losses incurred by a State in connection with the operation of their qualified high risk pool. There is also \$15 million in FY2006 appropriated to fund seed grants to States to create, and initially fund, a high risk pool. This funding will also apply upon the enactment of the State High Risk Pool Funding Extension Act of 2005.

Recomputation of HPSA, MUA, and MUP Designations Within Hurricane Katrina Affected Areas (No provision in the Conference Agreement, no provision in the Senate Bill, and Section 3203 of the House Bill).

Current Law

The Public Health Service Act provides for the designation of areas underserved by healthcare personnel, providing federal loans, scholarships and grants to improve the distribution of healthcare workers. The program is authorized through 2006.

Senate Bill

No provision.

House Bill

The House bill would direct the Secretary of HHS to review all such shortage designations in Hurricane Katrina declared disaster areas (pursuant to the Stafford Act), considering potential new shortages of health care workers.

Conference Agreement

No provision.

Waiver of Certain Requirements Applicable to the Provision of Health Care in Areas Impacted by Hurricane Katrina (No provision in the Conference Agreement, no provision in the Senate Bill, and Section 3204 of the House Bill).

Current Law

The Public Health Service Act establishes requirements for federally qualified health centers and personnel in the National Health Service Corps. Programs are authorized through 2006.

Senate Bill

No provision.

House Bill

The House bill would direct the Secretary of HHS to relax certain requirements for the conduct of federally qualified health centers, and National Health Service Corps personnel staffing them, in areas directly affected by Hurricane Katrina, or indirectly affected by hosting large numbers of evacuees.

Conference Agreement

No provision.

House Bill

Section 7001 temporarily increases the vessel tonnage fees paid by vessels arriving in the United States. Specifically, section 7001 increases the vessel tonnage fees paid by vessels arriving in the U.S. from a place in North America, Central America, the West India Islands, the Bahama Islands, and Newfoundland, and by certain vessels returning from a "voyage to nowhere." The fees are increased from 2 cents per ton, not to exceed 10 cents per ton in a single year, to 4.5 cents per ton, not to exceed 22.5 cents per ton in a single year. In addition, section 7001 increases the vessel tonnage fees paid by vessels arriving from a foreign port anywhere else in the world from 6 cents per ton, not to exceed 30 cents per ton, to 13.5 cents per ton, not to exceed 67.5 cents per ton in a single year. These increased rates will be in effect for fiscal years 2006 through 2010.

~~AAAD~~ ~~HH~~ ~~HH~~ ~~HH~~ (211)
Title ~~VII~~. House Committee on Ways and Means

TANF — Temporary Assistance for Needy Families (Subtitle A)

Reauthorization of Grants.

Current Law:

The TANF block grant provides states with funding for a wide range of benefits and services to families with children, including cash welfare. Basic block grants are funded nationally at \$16.5 billion per year. The law also provides supplemental grants to certain states funded at \$319 million per year; performance bonus funds of \$200 million per year for meeting program goals and \$100 million per year for reducing out-of-wedlock pregnancies; contingency funds of \$2 billion for states experiencing economic downturns; and a loan fund. Funding authority for the program expires December 31, 2005.

Allows up to 30% of TANF block grants to be transferred to the Child Care and Development Block Grant (CCDBG) and Social Services Block Grant (SSBG), although limit on transfers to SSBG is set at 4.25% for FY2006 and later.

House Passed Bill:

Extends TANF block grant at current level through FY2010 and TANF supplemental grants at current levels through FY2009. Eliminates all bonus funds and the loan fund. (Some of these savings are used to finance grants to promote healthy marriages and responsible fatherhood, see below.) Continues a \$2 billion contingency fund through FY2010.

Raises overall transfer authority to 50% of the TANF block grant, and increases maximum transfer to SSBG to 10% (level allowed in the original 1996 welfare law).

Senate Passed Bill:

No provision.

Conference Report:

Recede to the House, with the modification that TANF supplemental grants are authorized at their current level for three fiscal years (through FY2008). Recede to the Senate with regard to transfer authority.

Work Participation Requirements.

Current Law:

States are required to make an assessment of the work-readiness of TANF assistance recipients and may establish an Individual Responsibility plan for them. States are required to sanction families with a recipient who does not comply with work

Recipients are required to visit their children's schools twice per year.

Senate Passed Bill:

No provision.

Conference Report:

Recede to the Senate with respect to self-sufficiency plans, sanctions, and the increase in work participation standard to 70%.

Recede to the House with regard to the caseload reduction credit, with the modification that the base year for this credit is changed to FY2005, effective October 1, 2006. Adds that families receiving assistance under separate state programs are included in the calculation of work participation rates; and the Secretary of Health and Human Services is to provide additional direction to and oversight of states related to activities that may be counted as work activities, how to count and verify reported hours of work, and determining who is a work-eligible individual, with a new penalty for states that fail to establish and maintain such improved work participation verification procedures.

Recede to the Senate on additional credits for states with large past caseload declines, hours of work, partial credits, special allowances or requirements, and changes in list of work activities and extent to which such activities may be counted as work.

Healthy Marriage Promotion Grants.

Current Law:

No special grants. States may use TANF funds for activities to promote the formation and maintenance of two-parent families.

House Passed Bill:

Establishes \$100 million per year in matching grants and \$100 million per year in demonstration grants to fund various activities to promote healthy marriages. Requires that marriage promotion activities be voluntary. Requires that grantees consult with organizations with experts in domestic violence.

Senate Passed Bill:

No provision.

Conference Report:

Recede to the House with the modification that the Secretary of HHS will award \$150 million per fiscal year in healthy marriage promotion, responsible fatherhood, and related grants in each of FYs 2006-2010. Of this amount, up to \$50 million per fiscal year may be awarded on a competitive basis for activities promoting responsible fatherhood, and up to \$2 million per fiscal year is available for demonstration projects for coordination of child welfare and TANF services to tribal families at risk of child abuse or neglect.

Conference Report:

Recede to the House with the modification that total child care funding will increase by \$1 billion above the current level over five years, appropriating \$2.917 billion in mandatory child care funding for each of FYs 2006-2010.

Child Support Enforcement (Subtitle C)

Current Law:

The Child Support Enforcement (CSE) program is a federal-state program that provides the following basic services to both welfare and nonwelfare families: parent location, review and modification of child support orders, collection of child support payments, establishment of medical child support, and distribution of child support payments. The CSE program is funded with both state and federal dollars. There are four funding mechanisms. First, states spend their own money to operate a CSE program. Second, the federal government reimburses each state 66% for most of its child support enforcement activities or services. The federal government reimburses states at a higher 90% matching rate for paternity determination expenditures. Third, states collect child support on behalf of families receiving welfare benefits to reimburse themselves (and the federal government) for the cost of welfare payments to the family. Fourth, an incentive payment is given to states for operating a good program (current law requires that states reinvest incentive payments back into the CSE program or related activities).

House Passed Bill:

Revises some child support enforcement collection mechanisms and add others.

Provides financial incentives to states that send more child support collected on behalf of families on welfare to the families themselves (rather than retain funds as reimbursement for welfare costs). The federal government would pay for a share of support passed-through to welfare families as long as that support did not reduce the family's welfare benefit. Also gives states financing incentives to send to former welfare families more of the child support payments collected on their behalf.

Includes a provision to gradually reduce (from FY2007-FY2010) the federal matching rate for child support administrative expenditures from its current 66% to 50%. Also, prohibits the federal government from matching child support incentive payments reinvested in the CSE program.

Senate Passed Bill:

No provision.

Conference Report:

Recede to the House with modifications that revise child support enforcement collection mechanisms, and provide financial incentives to states that pass through more child support to current and former TANF families. Recede to the House with respect to ending federal matching of state expenditure of federal child support incentive funds, effective in FY 2008. Recede to the Senate with regard to reducing the federal administrative matching rate. Includes provision changing to 66 percent the federal matching rate for laboratory costs incurred in determining paternity, effective October 1,

of the Social Security Act and determinations regarding foster care placement, termination of parental rights, and recognition of adoptions. Courts can also use these grant funds to implement changes found necessary as a result of the assessments.

House Passed Bill:

Restates the federal foster care eligibility rules to effectively nullify the *Rosales* decision. Restates adoption assistance eligibility to make the same clarification and to simplify the eligibility determination.

Senate Passed Bill:

No provision.

Conference Report:

Recede to the House, with the modification to include (1) new funds totaling \$100 million over the five-year period FY 2006-2010 for strengthening courts involved in child welfare proceedings, and (2) new funds for the Safe and Stable Families program, increasing mandatory funding to \$345 million in FY 2006 (and thus totaling \$200 million over the five-year period FY 2006-2010).

Limit Federal Foster Care Administrative Claims.

Current Law:

States may claim reimbursement for some administrative costs related to children who are at "imminent" risk of entering foster care. Some states, relying on prior HHS policy guidance, make additional administrative claims for children placed in unlicensed, or otherwise federally ineligible placement settings, provided the foster child meets all other federal foster care eligibility criteria.

House Passed Bill:

Specifies in which cases, and for how long, states may seek reimbursement of foster care administrative costs *only* on behalf of otherwise federally eligible children who are living with unlicensed relatives, in another ineligible setting, or who have not yet entered foster care.

Senate Passed Bill:

No provision.

Conference Report:

Recede to the House.

Supplemental Security Income (Subtitle E)

Review of State Agency Blindness and Disability Determinations.

Current Law:

No provision.

No provision.

Conference Report:
Recede to the Senate.

~~John Smith~~
~~Alvin Johnson~~

Statement of Managers
Title VIII – Education and Pension Benefit Provisions

With respect to Section 2201(d) of the House amendment, the managers on the Part of the House agree to request a study by the Government Accountability Office regarding the effect of the premium as provided under Section 4006(a)(7) of ERISA on persons who are a contributing sponsor of the plan or a member of such sponsor's controlled group and who has filed or has had filed against such person a petition seeking reorganization in a case under title 11 of the United States Code, or under any similar law of a State or a political subdivision of a State (or a case described in section 4041(c)(2)(B)(i) filed by or against such person and report the same to the Committees on Education and the Workforce and the Committee on the Judiciary within 18 months of enactment of this Act.

Allyssa Schur
Paul Anthony

STATEMENT OF MANAGERS
LIHEAP PROVISION

The Congress finds the following:

- (1) Hurricanes Katrina and Rita severely disrupted crude oil and natural gas production in the Gulf of Mexico. The Energy Information Administration estimates that as a result of these two hurricanes, the amount of shut in crude oil production nearly doubled to almost 1,600,000 barrels per day, and the amount of natural gas production shut in also doubled to about 8,000,000,000 cubic feet per day. The hurricanes also initially shut down most of the crude oil refinery capacity in the Gulf of Mexico region. These disruptions led to significantly higher prices for crude oil, refined oil products, and natural gas expected to continue in the foreseeable future.
- (2) These production and supply disruptions are expected to lead to significantly higher heating costs for consumers for the foreseeable future. These significant increases in home heating costs this winter and for the foreseeable future will particularly harm low-income consumers. The Low-Income Home Energy Assistance Program is designed to assist these low-income consumers in this situation. Accordingly, Congress seeks a one-time only supplement to the Low-Income Home Energy Assistance Program fund to assist low-income consumers with the additional home heating expenditures that they will face in the foreseeable future as a result of Hurricanes Katrina and Rita.

Section-by-Section Analysis of the Legislation

(9001)
~~Section 1001~~ Section 1. Funding Availability

This section appropriates to the Secretary of Health and Human Services for a 1-time only obligation and expenditure \$250,000,000 for fiscal year 2007 for allocation under section 2604(a) through (d) and \$750,000,000 for allotment of emergency funds under section 2604(e) of the Low-Income Home Energy Assistance Act of 1981 (42 U.S.C. 8623(a) through (e)), for the sole purpose of providing assistance to offset the anticipated higher energy costs caused by Hurricane Katrina and Hurricane Rita.

This section sunsets after September 30, 2007, and no monies provided for under this section shall be available after such date.

P.L. 109-58, the Energy Policy Act of 2005, reauthorized annual regular LIHEAP funds at \$5.1 billion per year from FY2005 to FY2007. The

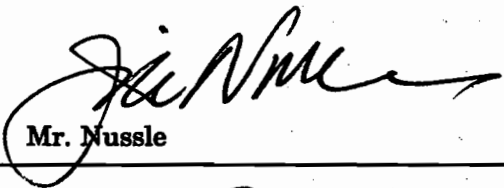
LIHEAP appropriation for FY2005 was \$2.182 billion for allocation pursuant to the formula set forth by law. No funds were appropriated for allotment of emergency funds.

S. 1932

*Managers on the part of the
HOUSE*

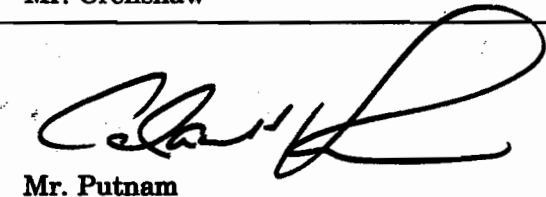
*Managers on the part of the
SENATE*

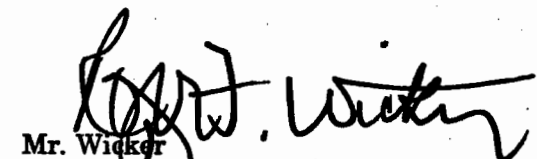
For consideration of the Senate bill, and the House amendment thereto, and modifications committed to conference:

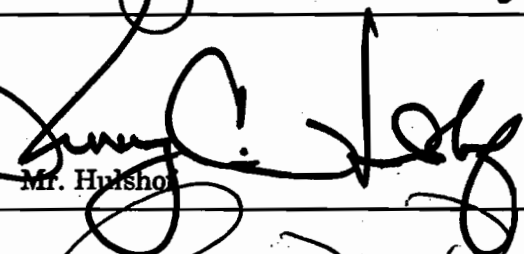

Mr. Nussle

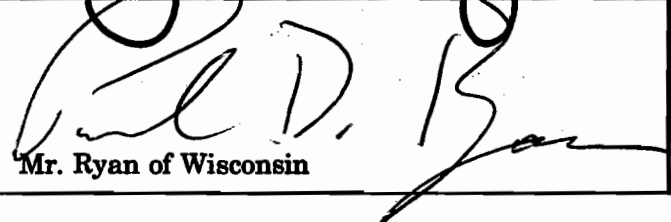

Mr. Ryun of Kansas


Mr. Crenshaw










Mr. Putnam


Mr. Wicker


Mr. Hulshof


Mr. Ryan of Wisconsin

S. 1932—Continued

<i>Managers on the part of the HOUSE</i>	<i>Managers on the part of the SENATE</i>
 Mr. Blunt	
 Mr. DeLay	
	
	
	
	
	
	

S. 1932—Continued

Managers on the part of the
HOUSE

Managers on the part of the
SENATE

From the Committee on Agriculture, for consideration of title I of the Senate bill and title I of the House amendment, and modifications committed to conference:




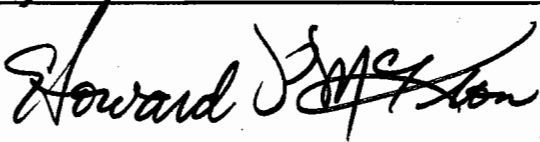
Mr. Goodlatte



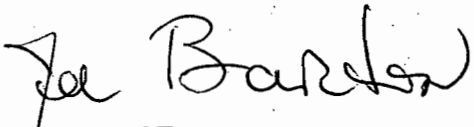
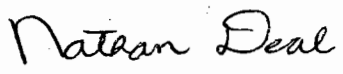

Mr. Lucas

~~Mr. [Redacted]~~

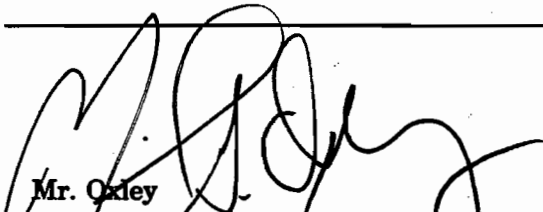
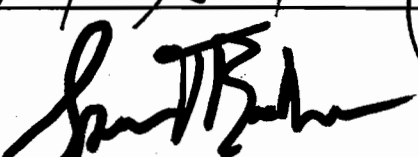
S. 1932—Continued

<i>Managers on the part of the</i> HOUSE	<i>Managers on the part of the</i> SENATE
From the Committee on Education and the Workforce, for consideration of title VII of the Senate bill and title II and subtitle C of title III of the House amendment, and modifications committed to conference:	
 Mr. Boehner	
 Mr. McKeon	
Mr. G. Miller of California	

S. 1932—Continued

<i>Managers on the part of the</i> HOUSE	<i>Managers on the part of the</i> SENATE
From the Committee on Energy and Commerce, for consideration of title III and title VI of the Senate bill and title III of the House amendment, and modifications committed to conference:	
 Mr. Barton of Texas	
 Mr. Deal of Georgia	
	

S. 1932—Continued

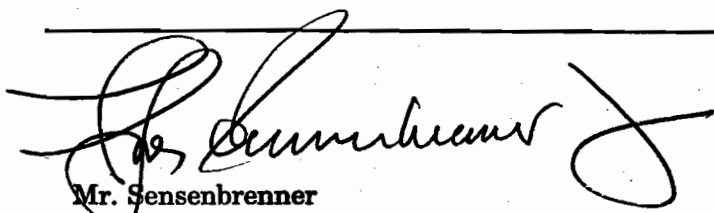
<i>Managers on the part of the HOUSE</i>	<i>Managers on the part of the SENATE</i>
From the Committee on Financial Services, for consideration of title II of the Senate bill and title IV of the House amendment, and modifications committed to conference:	
 Mr. Oxley	
 Mr. Bachus	
Mr. Ney	
Provided that Mr. Ney is appointed in lieu of Mr. Bachus for consideration of subtitles C and D of title II of the Senate bill and subtitle B of title IV of the House amendment:	
Mr. Ney	


S. 1932—Continued

*Managers on the part of the
HOUSE*

*Managers on the part of the
SENATE*

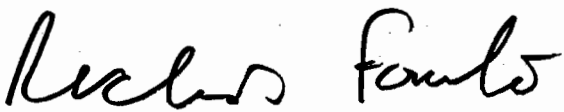

From the Committee on the Judiciary, for consideration of title VIII of the Senate bill and title V of the House amendment, and modifications committed to conference:


Mr. Sensenbrenner




Mr. Smith of Texas

~~Mr. [unclear]~~

S. 1932—Continued

<i>Managers on the part of the</i> HOUSE	<i>Managers on the part of the</i> SENATE
From the Committee on Resources, for consideration of title IV of the Senate bill and title VI of the House amendment, and modifications committed to conference:	
 Mr. Pombo	
 Mr. Gibbons	
Mr. [unclear]	

S. 1932—Continued

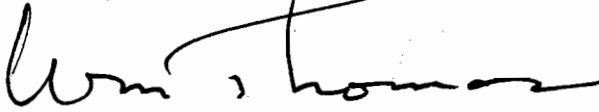
<i>Managers on the part of the</i> HOUSE	<i>Managers on the part of the</i> SENATE
From the Committee on Transportation and Infrastructure, for consideration of title V and division A of the Senate bill and title VII of the House amendment, and modifications committed to conference:	
 Mr. Young of Alaska	
 Mr. LoBiondo	
Mr. [Redacted]	

S. 1932—Continued

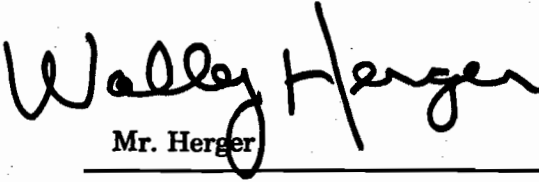
Managers on the part of the
HOUSE

Managers on the part of the
SENATE

From the Committee on Ways and Means, for consideration of sections 6039, 6071, and subtitle B of title VI of the Senate bill and title VIII of the House amendment, and modifications committed to conference:





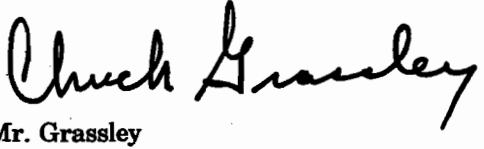


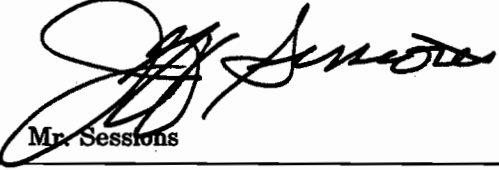

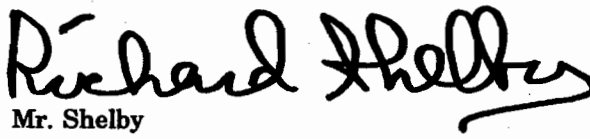
Mr. Thomas



Mr. Herger

~~Mr. [Name]~~

S. 1932—Continued

<i>Managers on the part of the HOUSE</i>	<i>Managers on the part of the SENATE</i>
	Mr. Gregg 
	Mr. Domenici 
	Mr. Grassley 
	Mr. Enzi 
	Mr. Allard 
	Mr. Sessions 
	Mr. Stevens 
	Mr. Shelby 

S. 1932—Continued

Managers on the part of the HOUSE	Managers on the part of the SENATE
	<p>Mr. Specter <i>[Signature]</i> 12/11/01</p>
	<p>Mr. Chambliss <i>[Signature]</i></p>
	<p>Mr. McConnell <i>[Signature]</i></p>
	<p>_____</p>
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S. 1932—Continued

<i>Managers on the part of the HOUSE</i>	<i>Managers on the part of the SENATE</i>
	M. D. [REDACTED]
	[REDACTED]
	M. H. [REDACTED]
	[REDACTED]