XIV. Limits on self-insurance would be established

A. Employers with 1,000 full-time employees or less would be prohibited from self-insuring

1. A multiemployer plan, as defined under ERISA, which has more than 1,000 active participants, or a multiemployer plan which is maintained by one or more affiliates of the same labor organization or one or more labor organizations representing the same industry, covering more than 1,000 employees could self-insure

2. A rural electric cooperative or rural telephone cooperative association which provides a group health plan with more than 1,000 full time eligible employees could self-insure

B. Multiple Employer Welfare Arrangements (MEWAs) and would be prohibited from self-insuring. MEWAs could provide health insurance, but only to the extent that they met all applicable standards as health insurers in each State, including financial solvency requirements

XV. Federal standards for self-insured employer plans would be established in regulation by the Secretary of Health and Human Services (HHS) and effective January 1, 1996 enforced by sanctions applied by the Department of the Treasury, based upon determinations of the Secretary of HHS

A. Plans would be certified annually by the Secretary of HHS

B. A Federal excise tax penalty would be established for non-compliance

1. Tax would be equal to 50 percent of the expenditures of the plan during the period for which the plan was in violation of the requirements

C. Self-insured employer plans would be required to provide the guaranteed national benefit package

1. Plans may provide additional benefits

D. Self-insured employer plans must make available to employees the choice of a managed care plan, if available, and a plan that provides unlimited choice of providers

   1. The requirements for unlimited choice of providers could be met through a fee-for-service plan or a managed care plan providing a point-of-service option

      a) Cost sharing requirements could not exceed those provided under the fee-for-service cost sharing schedule

   2. Managed care plans would be required to meet Federal standards with respect to availability and accessibility of services, coverage of out-of-area services, and emergency services

E. Self-insured employer health plans could not deny coverage or vary premium contributions charged to any eligible individual due to health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability or medical condition

F. Self-insured employer plans could not exclude or condition coverage of eligible individuals based on a pre-existing health condition

G. No waiting periods for coverage would be permitted

H. Self-insured plans would be required to meet additional requirements specified by the Secretary in the following areas:

   1. Grievance procedures

   2. Quality assurance requirements

   3. Confidentiality, data management and reporting requirements

I. Self-insured plans would be required to disclose utilization review standards to enrollees

J. Self-insured employer plans would be required to issue health cards, comply with requirements of administrative simplification and perform other functions needed to coordinate coverage between public and private health plans, in accordance with regulations developed by the Secretary

XVI. Supplemental policies

A. Supplemental policy benefits would be restricted to those provided in up to ten supplemental benefit packages defined by the Secretary

1. Benefits could not duplicate benefits in the national guaranteed benefit package

2. The Secretary would be required to take into account current State benefit mandates in determining benefits to be included in the standardized supplemental benefit packages

B. Supplemental policies would be required to meet Federal standards and could not be sold unless certified by the State

C. Additional Federal standards for supplemental policies would be established:

1. Non-discrimination based upon health status, occupational status or claims history of applicant, and open enrollment

2. Community rating, with price differences between supplemental benefit packages based only on differences in the actuarial value of benefits, not claims experience or health status, consistent with standards established by the Secretary

3. Prohibition on tying sale of supplemental policy to purchase of basic insurance or any other policy

a) Managed care plans would be prohibited from selling supplemental coverage to anyone not enrolled in the managed care plan for the guaranteed national benefit package

4. Marketing materials for supplemental policies would be approved in advance, be made available uniformly throughout the State, and could not be used to attract or limit enrollment of certain individuals or groups

D. Standardized benefit packages for Medicare supplemental insurance plans would be conformed to changes in benefits provided under Medicare Parts A and B

E. Medicare supplemental insurance policies could not deny coverage to any eligible individual due to health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability or medical condition

F. Disease specific and hospital indemnity policies would be required to meet the same loss ratio standard applied to Medicare supplemental insurance

XVII. Managed Care Grants

A. $25 million a year in grants would be authorized to support the development and initial operation of staff and group model HMOs in underserved areas, for fiscal years 1995 through 1999

1. Grants could be used for market surveys, initial enrollment activities, working capital, physician recruitment, and acquisition of buildings and equipment

2. Grants would be made to public or non-profit organizations

XVIII. State laws that require health plans to offer benefits in addition to the guaranteed national benefit package would be pre-empted

A. In defining supplemental benefit packages, the Secretary would be directed to take into account current State laws

B. Laws relating to the provision of benefits by specific types of providers would also be pre-empted and Medicare's definitions of providers would be used instead

TITLE VI. COST CONTAINMENT IN THE PRIVATE SECTOR

I. National Health Expenditure Estimates

A. National health expenditure targets would be set by statute for total spending for health services for private plans

1. The Secretary would make separate estimates of expenditures for services covered under Medicare (see outline on Medicare Cost Containment) and private sector plans, beginning for 1996

a. Estimates would be published by October 1 of each year for the following year, beginning in 1995

2. Annual growth limits for spending by private plans would be set beginning in 1996 at the current trend minus two percentage points and phase down by an additional one percentage point each year until growth is limited to the increase in the nominal gross domestic product (GDP)

a. The initial limits would be based on the most recent actual data (1993) inflated forward at the baseline rate of growth to 1995, and at the target rate of growth thereafter.

i. The estimates would be measured on a per capita basis to reflect and adjust for changes in enrollment between the public and private plans

b. The initial estimates for private health spending would reflect current spending patterns; estimates for years beginning after 1996 would be adjusted to reflect:

i. Changes in enrollment between public and private insurers

ii. Any net change in private health spending related to implementation of universal coverage; and

iii. Reductions to remove from the base private payments under the current system to reimburse for (1) uncompensated care, and (2) the shortfall in payments under the current Medicaid program

c. Subsequent per capita limits would be adjusted to reflect changes in the mix of enrollments across public and private plans, and to correct errors in estimation of initial spending relative to the estimated baseline levels of inflation in 1994 and 1995, baseline levels of spending for services within each category, and errors in estimation of volume responses relating to universal coverage

3. The target rates of increase in the limit for private sector spending would be based on the five-year moving average rate of growth in the GDP, plus a growth adjustment

   a. The growth adjustment would be set such that the limit on growth in spending would decrease two percentage points in 1996, three percentage points in 1997, four percentage points in 1998, and so on until the growth limit is equal to the growth in the GDP in each subsequent year

   b. Secretary would estimate and publish the growth targets for a year by October 1 of the preceding year, beginning in 1995

4. The private sector estimates would include all payments (including cost sharing) made for the types of services covered under the nationally guaranteed benefit package, including:

   a. Inpatient and outpatient hospital services

   b. Physician services

   c. Diagnostic testing services, including laboratory and x-ray services

   d. Prescription drugs

   e. Home health, durable medical equipment, orthotics and prosthetics

   f. Mental health services, including inpatient and outpatient drug and alcohol treatment

   g. Rehabilitation services

5. Expenditures for services provided in managed care plans would be included within the estimates

B. Monitoring Health Spending

1. All providers who submit claims to either the public plan or to private payers would be required to submit annual reports to the Secretary of DHHS to be used in monitoring and enforcing compliance with the national health spending targets

   a. Hospitals and other institutions would provide cost and revenue data; other providers would submit only revenue data

   b. Reports would be submitted by April 15 of each year for the preceding calendar year

      i. The initial report, covering payments made for services provided in 1996, would be due on April 15, 1997.

   c. The reports would include information on all revenues received during the preceding calendar year relating to medical services provided to all patients, broken down separately by type of payer (Medicare A, B and C, Medicaid, CHAMPUS, private insurance plans, and direct patient out-of-pocket costs)

   d. Revenues for activities not related to the provision of direct patient care, such as teaching or research, would be reported separately

2. Hospitals' reports for inpatient and outpatient services would be part of the uniform hospital reporting system

3. Physicians and other providers would submit reports in a form to be specified by the Secretary

II. Allocation of Private Health Spending to States

A. State level estimates of private health spending would be used to monitor the States' success in controlling costs

B. The Secretary of HHS would estimate the amount of private health spending for each State without regard to the implementation of a State plan

1. The estimate would be based on prices in the State as determined under maximum payment rate system (see description below)

2. The estimate would be based on private sector utilization patterns within each State

3. States' spending would be permitted to grow at the same rate as the national health estimates

4. In estimating the initial targets, the Secretary would adjust the data to reflect use of services by out-of-state residents who are not Medicare beneficiaries

C. The initial allocation for each State would be estimated for 1995, based on the most recent data available

1. The estimate of the 1995 spending would be adjusted for estimation errors when actual data become available

D. Each State's allocation for 1996 would be equal to the 1995 allocation, increased by the private sector target rate of growth in health spending

1. States could apply to the Secretary to exclude certain health care spending from being considered in determining whether a State is within its growth limits in the case of cost related to demands of a sudden and temporary nature, such as epidemics or natural disasters

III. Cost Containment

A. Beginning for calendar year 1996, HHS would set maximum rates of payment, at levels estimated to keep private health spending within the private sector spending estimate

1. The maximum payment rates would <u>not</u> be binding on providers with regard to payments for services covered by private insurers during 1996 and 1997

2. The maximum payment rates would first apply to services covered by private insurers beginning with the first year (and all subsequent years) following 1997 that, as determined by the Secretary, health spending in the private sector during the second preceding year is greater than the target amount of spending for such year

3. HHS would separately allocate the initial private health spending estimate among health sectors (hospitals, physicians, etc.)

    a. Initial sector allocations would be based on baseline spending patterns; projected changes in sector allocations would also be based on baseline patterns of change

    b. Once established, the sector allocations could not be changed without specific authorizing legislation

    c. ProPAC, PhysPRC, and DrugPAC would jointly study and recommend changes in sector definitions and allocations to Congressional Committees

4. The maximum allowable payment rates for private payers would be set based on Medicare methodologies

    a. The national maximum payment rates would be adjusted between types of providers and geographic areas in the same manner as under the Medicare program

    b. Providers would be required to accept the maximum payment rates as payment in full; private insurers would be prohibited from paying more than these amounts, adjusted for cost-sharing

    c. ProPAC, PhysPRC, and DrugPAC would study and recommend any necessary changes in provider payment policies to the Congressional Committees

        (i) Recommendations would include the allocation of national expenditures between public and private payers, and among hospitals, physicians and other sectors of the health care system

IV. Maximum Payment Rates

A. Maximum provider payments would be based on Medicare methodologies

1. Specific rates of payment for providers would be set by HHS at levels estimated to meet the expenditure targets for each sector of the health care system

2. The rates would not apply in States which opted to operate their own provider payment or cost containment systems, and would not initially apply to services covered by private insurers

a. States electing to operate their own systems would be required to keep spending within their own target for health spending

3. If the private sector limits are triggered and apply to private sector payers, the rates would be the maximum rates which providers could be paid for a service, including extra-billing

a. Payers could negotiate lower payment amounts

4. Rates would be set separately for Medicare and for all other payers

B. Adjusted Medicare-type DRG rates for hospitals

1. Initial level of payment amounts

a. Maximum payment rates, including all adjustments, would be set initially at the average level currently paid by private insurers in serving the under-65 population

i. Costs would be determined using Medicare's definition of allowable costs, adjusted for necessary differences in the scope of services

ii. The maximum payment rates would include an average allowance for bad debt associated with nonpayment of co-payments and deductibles

b. Rates would be updated taking the following factors into account:

i. Adjustments for changes in case mix and case mix coding

ii. Changes in the volume of hospital services

c. Updates would be limited such that total payments would not exceed the target amount allocated to hospitals under the private sector health spending estimates

d. Rates would be published each October 1 and would be effective the following January 1

2. Benefits included in the base payment amounts

a. Base payment rates would be based upon the nationally guaranteed hospital benefit package

b. Specific percentage adjustments to the base payment rates to reflect benefits covered by the supplemental policies would be defined by HHS

c. Hospitals would be prohibited from charging patients any additional amounts, except for the following:

i. Deductibles and co-payments defined in the nationally guaranteed benefit package

ii. Private room charges

iii. Convenience items such as telephone and television rentals

iv. Experimental procedures not included in the standard benefit package

3. General adjustments to the base maximum payment amounts

a. Base maximum payment amounts would be adjusted as needed to reflect any new DRGs and new DRG weights established for an under-65 population, as for services provided under Medicare Part C

b. Base maximum payment amounts would be adjusted by geographic area for wages and for non-labor input prices

i. A separate cost-of-living adjustment would not be used, except in the case of hospitals in Hawaii and Alaska, as under Medicare

c. Separate maximum payment amounts would be set for large urban and for all other hospitals

d. Additional payments would be made for cases with exceptionally high costs or long stays

e. Transfer cases would be paid using Medicare's methodology for transfer payments

f. Maximum payment rates to all hospitals would be adjusted for the indirect costs of graduate medical education, as described in the outline on Academic Health Centers based on Medicare's policy as amended by this proposal

g. Base payments would be adjusted for the costs of serving a disproportionate share of uncovered patients, using Medicare's formula as amended by this proposal

4. Capital adjustment

a. Capital costs would be paid as part of the DRG payment rates, as under Medicare policy

b. Hospitals would receive a hospital-specific capital payment adjustment during the current transition to fully-prospective capital payment

5. Adjustment for direct costs of graduate medical education per admission would be made, as described in the outline on Academic Health Centers

6. Payments to hospitals and units currently exempt from the PPS system

a. Hospitals and units currently exempt from the PPS payment system would be subject to a rate of increase limit similar to the TEFRA limits

i. Hospitals and units currently exempt are children's hospitals, long-term hospitals, cancer hospitals, rehabilitation hospitals, and psychiatric hospitals

b. For purposes of determining payment in the first year, 1993 revenues would be updated to 1996 using baseline growth in spending for exempt hospitals and units

c. Growth thereafter would be constrained based upon a limit determined to be consistent with the target growth in national health spending estimates

d. The maximum payment rates for 1997 would be adjusted for the changes in the annual estimate described in A.2.b. above

e. The rate of growth limit would be replaced with prospective methodologies as new methodologies were developed

f. With respect to children's hospitals, the prospective method would be hospital-specific and would be based on the resource requirements of pediatric populations and would be developed using pediatric-specific inpatient data

C. Physician services

1. Adjusted Medicare-type RB RVS rates for physicians

a. The Secretary of HHS would define new procedure codes and estimate RB RVS units as necessary for under-65 patients, consistent with the changes defined for Medicare Part C

b. Definitions and payment policies necessary for private payers to adopt RB RVS payment system would be published by HHS

c. Rates would be published each October 1 and effective January 1

d. The maximum payment rate RB RVS fees would be geographically adjusted in the same manner as under Medicare

2. Initial rates for private payers would be set at the level that would provide the same aggregate amount of payments to physicians from private payers as under current payment systems in 1996 and would be adjusted to reflect the changes in the annual estimate described in A.2.b. above

a. The rates would be adjusted to reflect patient out-of-pocket payments and to keep total payments within the sector allocations

3. Updates to initial conversion factor would be determined such that expenditures would be consistent with the national health spending estimates

D. Other ambulatory services

1. Adjusted Medicare-type rates for other services

a. Laboratories fees would be set at Medicare rates, and all services would be required to be directly billed to insurers, as provided under Medicare

b. Fees for rental and purchase of durable medical equipment would be based on Medicare reimbursement rates

c. Fees would be published each October 1 and effective January 1

2. Hospital outpatient services would be subject to a rate of increase limit similar to the TEFRA limits

a. For purposes of determining payment in the first year, 1993 revenues would be updated to 1995 using average growth rates for hospital outpatient services

b. Growth thereafter would be constrained based upon a limit which is determined to be consistent with the private health expenditure estimates

c. The rate of growth limit would be replaced with a prospective payment methodology as soon as current work to develop one is complete.

E. Prescription drugs

1. Maximum rates of payment for each drug would be set, consistent with the allocation to the drug sector within the private health spending estimate by HHS

2. Annual increases in maximum payment rates would be determined so that total payments would be consistent with the private health spending growth targets

3. See outline on drug benefits for detailed description of methodology

F Medicare limits on extra-billing to patients

1. Extra-billing limits for private insurance coverage would follow current law Medicare policies

   a. No extra-billing by hospitals, nursing homes, ambulatory surgery centers, and other facilities

   b. 15% limit on extra-billing by physicians

   c. Other services would have the same limits as provided under Medicare

   d. Health insurance plans, and self-insuring employers, could negotiate assignment agreements with physicians that would prohibit extra-billing

G. Limits on payments to Managed Care Plans

1. Premium growth limits for Managed Care Plans

   a. The maximum allowable per capita premium charged by each HMO would be subject to a national average rate of growth, consistent with spending under the private health spending estimate

   b. The rate of growth limit would be applied to an adjusted per capita premium amount

      i. The per capita premium would be 95 percent of a base amount calculated using Medicare's AAPCC methodology and payments made for services covered in the private sector

      ii. The limit would be applied to premium amount adjusted to reflect the effects of actual enrollment related to the factors included within the AAPCC calculations

IV. Reference to Limitation on Administrative and Judicial Review of Certain Determinations

A. There would be no administrative or judicial review of:

1. Maximum payment rates

2. DRG or RB RVS values established for services

3. Estimates of initial national health spending estimates or the allocation of such estimates to health sectors or States

TITLE VII. PUBLIC HEALTH INITIATIVES

1. Health Workforce Priorities

I. The Secretary would develop a national healthcare workforce plan.

A. The plan would specify the total number of physicians that should be trained, and how this total should be allocated among specialties

1. The plan would provide that at least 53 percent of all residents beginning training on or after July 1, 1998 would be in primary care specialties, including obstetrics and gynecology

B. The Secretary would submit a report to Congress on the plan by December 31, 1995.

C. In developing the plan, the Secretary would consult with consumers, experts in health workforce needs, teaching physicians, physicians in private practice, representatives of health insurers, including HMOs and other managed care plans, and other organizations representing physician

II. The Secretary would develop a methodology for a national program to accredit or otherwise limit the number of residency positions in a specialty that would be considered for the purpose of determining adjustments in payments or maximum payment rates under Medicare and private health plans

A. The methodology would include specific criteria that would be used to "accredit" such positions

1. The criteria should include consideration of the geographic distribution of physicians and assure the training of minority physicians

B. The methodology developed would include a method for limiting, or reducing, the number of residency positions that would be considered for the purpose of payment adjustments, consistent with the national healthcare workforce plan develop above.

C. The Secretary would submit a report, and detailed proposal regarding the implementation of this methodology to the Congress by December 31, 1995.

1. The report would include an analysis of the impact on teaching hospitals and other training programs of limiting support for training, consistent with the national healthcare workforce plan.

D. In developing the methodology, the Secretary shall consult with experts in graduate training and education, including the Accreditation Council for Graduate Medical Education, and other organizations involved in the accreditation of residency positions

III. The Secretary would implement a program to limit the number of training positions in accordance with the national health care workforce plan

A. Beginning with residents whose training begins on or after July 1, 1998, Medicare payments and adjustments under the national payment limit system would be based on those approved residency slots designated by the Secretary

B. Teaching hospitals that lose residency slots would be eligible for transition payments, as provided under H.R. 3600

IV. Primary Care Incentives

A. Bonuses for providing primary care services in medically underserved areas under Medicare (including Part C) would be increased, consistent with H.R. 3600

B. Consistent with H.R. 3600, the authorization of funding for the National Health Service Corp would be increased to $200 million per year by the year 1997

2. Academic Health Centers

I. The maximum payment rates to all hospitals would be adjusted for the indirect costs of graduate medical education (IME), based on Medicare's policy as amended by this proposal

   A. The number of residents that would be used in computing the adjustment for IME would include only those residents in positions approved by the Secretary as consistent with the national health care workforce objectives

II. Adjustment for direct costs of graduate medical education

   A. The maximum payment rate per case would be adjusted on a hospital-specific basis for the direct costs of medical education based on the number of FTE residents times the allowable costs per resident determined for Medicare in the base year, updated to the current year

      1. The number of FTE residents would be determined using a weighted count of residents

      2. The payment adjustment per admission for each FTE resident would be based on the rates and adjustments used by Medicare, but paid on a per admission basis

      3. The number of residents that would be used in computing the adjustment for the direct costs of graduate medical education would include only those residents in positions approved by the Secretary as consistent with the national health care workforce objectives

3. Essential Health Facilities

I. Medicare's Essential Access Community Hospital (EACH) program for rural health networks would be expanded from seven States to all States

   A. Authorization for grants to hospitals, facilities and consortia for the establishment of rural health networks would be increased from $15 million to $40 million per year

   B. Authorization of funds available for State planning activities for the creation of rural health networks would be increased from the current level of $10 million per year to $50 million per year

II. An Essential Community Provider (ECP) program would be created to facilitate the organization and delivery of primary, preventive and acute care services for medically underserved populations in urban areas by fostering networks of essential community providers

   A. The Secretary would make grants to States, local governments and eligible health care facilities

   B. Grants could be used for the expansion of primary care sites, development of information, billing and reporting systems, or health promotion and outreach to underserved populations

   C. Grants to States and local governments would be used for activities related to planning and implementing community health networks

   D. To be eligible for a grant, a State or local government would be required to prepare a community health plan designed to create community health networks, promote integration of health services, and improve access to hospital and other services for urban residents

      1. State or unit local government would be required to designate non-profit or public hospitals and facilities as essential community providers within community health networks

2. A State would be required to consider local input in developing a State plan, and the State plan would be required to address the needs of all underserved communities in the State

3. In the case of a State that develops a community health plan after a unit of local government has been awarded a Federal grant, the State would be required to take into account the local government plan in developing the State plan

E. When a State and a unit of local government within the State both seek a Federal grant, the local government community health plan would be required to be approved by the State

1. This requirement would not apply in the case of a local government in a State that is not seeking a Federal grant, or in a State that develops a community health plan after a unit of local government has been awarded a Federal grant

F. Facilities eligible for designation as essential community providers include

1. Facilities that are members of community health networks (defined below)

2. Hospitals that would qualify for a Medicare disproportionate share adjustment under section 1886(d)(5)(F)(i)(II) or 1886(d)(5)(F)(vii)(I) of the Social Security Act

3. Federally Qualified Health Centers, except that the governance requirements need not be met with respect to membership of the Board of Directors if the facility provides assurances of significant consumer input

G. A community health network would be defined as a public or nonprofit entity which would provide primary care and acute care services to medically underserved populations in the entity's service area

1. The network would have to substantially provide these services directly or through limited contracting with non-network providers

2. The network would consist of at least one hospital and at least three non-hospital essential community providers that are located in an urban area

3. At the election of the network members, any other entity that provides primary care or other health care services to the medically underserved populations served by the network could be a member of the network

4. To be considered a community health network, each member hospital would be required to provide staff privileges to physicians providing care at non-hospital sites, and each member would be required to

   a) provide appropriate emergency and medical support services to other members,

   b) accept referrals from other members, and

   c) share in the same communications system, including, where appropriate, the electronic sharing of patient data, medical records, and billing services

H. A hospital or facility would be eligible to receive a grant if the hospital or facility is located in a State or locality with an approved community health plan, is designated as an essential community provider by the State in which it is located and is a member of a community health network

   1. Hospitals and facilities would be required to be certified by the State in which the facility is located that the receiving of such grant by the hospital or facility is consistent with the State's or locality's community health plan, and that the State has approved the application

I. A consortium of hospitals and facilities, each of which is part of the same community health network, is eligible to receive a grant if each of its members would be individually eligible to receive a grant.

J. Grants to hospitals, facilities, and consortia would be used to finance the costs incurred in planning, implementing and joining community health networks, including costs related to

1. Development of primary care service sites

2. Development of information, billing and reporting systems

3. Planning and needs assessment

4. Recruitment and training of health professionals and administrative staff, and

5. Health promotion outreach to underserved populations in the service area

K. A grant made to a hospital or facility could not exceed $200,000 and the total amount of a grant paid to a consortia of hospitals and facilities could not exceed $1 million

L. Funding of $160 million per year for each of the fiscal years 1995 through 1999 would be made available by the Secretary for the Essential Community Provider program

1. $80 million would be payable from the Federal Hospital Insurance Trust Fund for grants to hospitals for the purpose of becoming a part of a community health network

2. $80 million would be payable from the Capital Financing Trust Fund (established below) for grants to non-hospital facilities for the purpose of becoming a part of a community health network

III. The Secretary of HHS would provide capital financing assistance to eligible facilities in the form of loan guarantees, interest rate subsidies, direct matching loans, and (in cases of urgent life and safety needs) direct grants

A. Eligible hospitals include Essential Access Community Hospitals, Rural Primary Care Hospitals, and hospitals that would qualify for Medicare disproportionate share payments under section 1886(D)(5)(F)(vii)(I) with a disproportionate share patient percentage of 40 percent or more, except that investor-owned facilities would not be eligible

B. Non-hospital facilities that are designated as essential community providers (see above) would be generally eligible for capital financing assistance

C. Applications filed with the Secretary would be required to have been determined by the State in which the project is located to be consistent with any relevant community health plan developed as part of the Essential Community Provider grant program or rural health care plan under the Essential Access Community Hospital program

1. In the case of a State determined by the Secretary to have a plan and process for review and approval of capital expenditures, the application would be required to be determined by the State to be consistent with the State capital expenditure plan

D. The Secretary would give preference to assistance needed to bring a facility into compliance with Federal, State or local regulatory standards, improve the provision of essential services, or provide access to otherwise unavailable essential health services

E. Preference would also be given to projects that include non-Federal assurances of financial support, would be unlikely to be financed without assistance, and to projects involving essential community providers (see above)

F. Any health care facility accepting capital financing under this section would agree to provide a significant volume of services to persons unable to pay

IV. A Capital Financing Trust Fund would be created to finance capital assistance, and administered by the Secretary of HHS

A. A Capital Financing Trust Fund Board would be created to advise the Secretary on the program and would meet quarterly

1. Board would be composed of the Secretary, the Secretary of the Treasury, the Assistant Secretary for Health, the Administrator of the Health Care Financing Administration, and 5 public members appointed by the President to serve 4 year terms

2. Board would be responsible for approving regulations, establishing program criteria, and recommending and approving expenditures by the Secretary under the Program

B. The Secretary of Treasury would be required to transfer funds from general revenue to the Trust Fund to meet the requirements of items V through X below, and to provide for payments to non-hospital providers under the Essential Community Provider program

1. Repayments of loans made by hospitals and facilities would be allocated to the Trust Fund

V. Loan guarantees would be available to qualified health care facilities for repayment of loans to non-Federal lenders making loans for health care facility replacement, modernization and renovation projects, and capital acquisitions

A. Facilities would be required to demonstrate that a Federal loan guarantee is essential to obtaining bond financing from non-Federal lenders at a reasonably affordable rate of interest

B. Facilities would be required to demonstrate an ability to meet debt service, assume the public service responsibilities, operate the facility in accordance with a management plan approved by the Trust Fund Board, and continuation of any State or local support

C. Up to $150,000,000 would be annually allocated within the Trust Fund to finance loan guarantees

1. At least ten percent of the dollar value of the loan guarantees would be allocated for eligible rural health care facilities, to the extent a sufficient number of applications are made

2. No more than twenty percent of the amount allocated each year to the loan guarantee program would be available to guarantee refinancing of loans during that year

D. The principal amount of any guaranteed loan could not exceed 95 percent of the total cost of the project, including land, and the Trust Fund Board would be able to institute additional terms and conditions

E. The Trust Fund Board would determine a reasonable loan insurance premium to be charged for loan guarantees and would be authorized to collect sufficient amounts to cover the costs of appraisals and inspections of the property

1. The Board could waive premium for financially distressed facilities

F. The Board would be authorized to pursue to final collection all claims assigned and transferred to the Trust Fund as a result of any property secured by any defaulted loans

G. Loans guaranteed through this legislation would be included in Section 149(b)(3)(A) of the Internal Revenue Code in order to maintain, where applicable, the tax exempt status of the loans guaranteed

VI. Interest subsidies would be available to reduce the cost of financing qualifying projects by providing partial Federal subsidy of debt service payments where state and local entities have issued bonds

A. Up to $220,000,000 in interest rate subsidies would be made available annually

1. At least ten percent of the total value of the all interest subsidies awarded in any given year would be awarded to rural health care facilities, provided that a sufficient number of applications are approved, with any one State limited to receive no more than 25 percent of the total value of all interest subsidies made during that year

B. Interest subsidies would be made in the amount of three percentage points for qualifying non-Federal loans and, interest subsidy grants in an amount of up to five percentage points would be made for qualifying Federal loans made under the program if the project would not be otherwise financially viable

C. Subsidies could be provided to assist in refinancing if the health care facility were unable to secure permanent financing at an affordable current market rate

D. Eligible health care facilities would have had to issue bonds for capital projects, or would have to be obligated to pay debt service on bonds, after December 31, 1992

E. No federal subsidy would be provided unless State or local participation was in an amount at least equal to the amount of the federal subsidy to be provided

VII. Direct matching loans would be made available to eligible facilities otherwise unable to obtain financing

A. Financing would be for the purpose of essential facility replacement (either construction or acquisition), modernization, and renovation

B. Direct matching loans would be provided primarily for smaller projects where the transaction costs of securing financing from other sources may be disproportionately onerous in relationship to the amount financed

C. Up to $200,000,000 in direct matching loans would be made available annually, with priority given to projects designed to achieve compliance with governmental regulatory standards

1. Eligible applicants could receive a project loan of up to $50,000,000

2. Not more than 75 percent of the cost of the project could come from Federal sources, except in instances the Trust Fund Board waives the requirement for financially distressed health care facilities

3. Not less than ten percent of the total value of the loans made under the program would be made to rural health care facilities, provided that a sufficient number of applications are approved

4. Loans would be made for a period equal to the construction period plus up to 39 years

5. The interest rate will be a market rate determined by the Trust Fund Board to be no higher than the most recent applicable index for revenue bonds

6. Loans for refinancing may be granted, although the total amount of assistance provided for refinancing could not exceed twenty percent of the total amount made available for direct matching loans in the year

7. Prior to beginning collection proceedings in the case of a default of a loan, the Trust Fund Board could attempt to negotiate a revised repayment schedule to avoid foreclosing on property services by such loan.

VIII Direct grants would be made available to eligible facilities for urgent capital needs

A. Direct grants would be available for three types of projects

1. Health care facilities threatened with closure or loss of accreditation or certification of a facility or of essential services as a result of life or safety code violations or similar facility or equipment failures

2. Health care facilities requiring renovation, expansion, or replacement necessary to the maintenance or expansion of essential safety and health services such as obstetrics, perinatal, emergency and trauma, primary care and preventive health services

3. Health care facilities requiring pre-approval assistance to meet regulatory requirements, in the form of planning grants to be used to apply for other assistance under the Program

B. Priority would be given to financially distressed health care facilities as defined by the Secretary

C. Up to $400,000,000 in grants for capital expenditures would be made available annually

1. Assistance would be limited to $25,000,000 per eligible health care facility

2. At least half of the projects funded in a year would be required to receive fifty percent of their funding from state or local sources, with the remaining projects eligible for a combination of Federal grants and loans equal to 90 percent of total funding

3. Not less than ten percent of the grant funds would be reserved for rural health care facilities, provided that a sufficient number of applications are approved

IX. Applicants who can demonstrate general qualifications for a direct matching loan or loan guarantee would be eligible for a grant of up to $200,000 to assist in implementation of key budgetary and financial systems

X. Adjustments would be made to the level of reimbursement under the Medicare program where appropriate to take into account the extent to which capital-related costs incurred by a hospital are costs with respect to which the hospital received financial assistance under this legislation

XI. For purposes of determining payments for indirect medical education under the Medicare program, the Secretary would count services of residents under a medical residency training program conducted at a facility other than the teaching hospital if:

A. The hospital is designated as an essential community provider,

B. The hospital incurs all or substantially all the costs of the training program, and

C. The facility is a member of the same community health network

TITLE VIII. MEDICARE AND MEDICAID

1. Medicare Part C

I. Establishment of Medicare Part C

A. The Social Security Act would be amended to add Title XXII to establish a new health insurance program

II. Eligibility and Enrollment

A. All individuals not otherwise covered under a private health plan would enroll in Medicare Part C

B. An eligible individual would be defined to include any individual who is residing in the United States, and who is:

a. a citizen or national of the United States;

b. an alien permanently residing in the United States under color of law; or

c. a long-term nonimmigrant

C. An initial special enrollment period would be established

1. Unless covered by a family member enrolled in a private health plan that meets defined Federal standards individuals would be enrolled automatically at birth

2. During the first six months prior to implementation of Medicare Part C, continuing for 6 months after implementation of Medicare Part C, for all individuals eligible to enroll in Medicare Part C

3. A continuous special enrollment period would be provided for individuals whose coverage under a private health plan is terminated

D. Employment-based enrollment

1. Employers with 100 or fewer employees would be required to make contributions, on behalf of employees, to Medicare Part C, unless the employer provided health insurance coverage to employees under a private plan that meets defined Federal standards

    a. An employer with 100 or fewer employees that did not provide private health insurance would provide for payments of premiums imposed under Medicare Part C, and would be prohibited from collecting more than twenty percent of the Medicare premium from a full-time worker

2. If an employer with 100 or fewer employees elects to offer employees coverage under a private health plan, employees of the employer would enroll in a plan offered by the employer, and would not be permitted to enroll in Medicare Part C

3. Any employer with 100 or fewer employees that elects to offer employees the opportunity to enroll in a private health plan, would be required to give employees notification two years prior to the termination of the private health plan

4. Penalties would be imposed on any employer that fails to comply with the mandate to provide health insurance

    a. The employer would be assessed an excise tax equal to $250 per day for each employee for every day the employer was not in compliance

    b. Effective upon implementation of Medicare Part C, employees of non-compliant employers would be permitted to enroll in Medicare Part C, and the employer would be obligated to pay 100 percent of the Medicare Part C premium

E. Low income employees would be permitted to elect coverage under an employer plan or Medicare Part C

III. Coverage Period

A. In general, coverage under Medicare Part C would be continued until the individual is covered under a private health plan

1. Individuals enrolled at birth would be covered under Medicare Part C as of the date of birth, unless otherwise covered under a private health plan

B. Individuals terminated from another health plan who enroll during a special enrollment period would be covered under Medicare Part C as of the date of termination to avoid gaps in coverage

IV. Benefits under Medicare Part C (see Title VIII)

A. Medicare Part C benefits would be consistent with benefits provided under the guaranteed national benefit package

V. Additional benefits would be provided under Medicare Part C for low income individuals up to 200 percent of the Federal poverty level (see low income outline)

VI. Determination of Medicare Part C Premium Amounts

A. The Secretary would compute a premium for Medicare Part C on a state-by-state basis

1. The premium would be set to cover the full actuarial cost of benefits covered under the national guaranteed benefit package, plus all administrative costs

(a) The Secretary would exclude from such calculations the cost of services provided to the SSI disabled population

(b) Additional general revenues would be used to fund additional costs incurred by the SSI disabled population, that are not otherwise covered by premium payments and low income subsidies under Medicare Part C

(c) Premium obligations for SSI disabled individuals would not differ from premium obligations required of the non-SSI disabled population

2. Premiums would be established for families with one adult, and families with more than one adult, with the cost of children averaged into each premium

B. The Secretary would publish applicable premiums by September 30th of each year (beginning in 1995) for the succeeding year

C. Premiums would be paid to the IRS, in a manner specified by the Secretary of the Treasury

D. All individuals would be required to make premium payments to the IRS, unless the individual files proof of coverage with tax form

1. Most individuals would receive a W-2 which would have a box checked to indicate that they are enrolled in a qualified health plan and that their share of the premium had been met through withholding, thus requiring no further action or payment by the individual

E. The Secretary of the Treasury would transfer payments to the Secretary of HHS, for deposit in the Medicare Part C Trust Fund

VII. Establishment of Medicare Part C Trust Fund

A. A new Medicare Part C Trust Fund would be established

B. Premiums collected by the IRS from individuals and employers would be deposited in the Trust Fund

VIII. Additional funds would be appropriated from general revenues to assure that funds are sufficient to cover low income subsidies and supplemental low-income benefits -- net of State-maintenance-of-effort payments

IX. Payments for services covered under Medicare Part C would be consistent with the payment rates and methodologies specified under Medicare Parts A and B, with appropriate adjustment in payment amounts to reflect the population served by Medicare Part C

A. The Secretary would establish standardized amounts for inpatient hospital services under Part C by adjusting the Part A standardized amount to reflect differences in the average cost of treating enrollees under the two programs

1. The Secretary would be authorized to develop separate DRG categories and weights to reflect resource needs of the Medicare Part C population

B. Payment amounts for services (other than prescription drugs) not currently covered under either Part A or Part B would be established by the Secretary of HHS, in consultation with ProPAC and PhysPRC

1. Payments for prescription drugs would be determined as described in the specifications of the prescription drug benefit (see Title II)

C. The Secretary would make necessary changes to the AAPCC for payments on behalf of non-aged Medicare Part C beneficiaries who elect to enroll in HMOs with risk contracts under section 1876

X. An individual enrolled in Medicare Part C would have the same opportunity as current Medicare beneficiaries to elect enrollment in an HMO which contracts with Medicare

A. Current requirements would be amended to authorize the Secretary to withhold payment to a risk contractor on behalf of an individual enrollee until the contractor established an initial medical record on behalf of the enrollee

XI. In general, the following current Medicare program provisions would be applied to the operations of Medicare Part C in the same manner as they apply to Parts A and B

A. Use of carriers and intermediaries

B. Definitions of services and providers

C. Certification of facilities and provider qualifications

D. Health Maintenance Organizations

E. Peer Review and Fraud and Abuse

XII. Funds would be appropriated to the Internal Revenue Service, the Social Security Administration, and the Health Care Financing Administration related to the cost of administering the program.

2. Low-Income Coverage

I. Low-income individuals would be permitted to enroll in Medicare Part C, unless such an individual elects coverage under a plan offered by an employer

   A. Low-income individuals would include those with family income up to 200 percent of the Federal poverty level

II. Premium obligations for low-income individuals would be based upon reported income, as determined by the Internal Revenue Service

   A. The premium obligation for non-filers would be deemed to be zero

   B. The premium obligation for AFDC and SSI recipients would be deemed to be zero

   C. The premium obligation would increase, on a sliding-scale basis, for individuals with income up to 2-times the poverty level

   D. The premium obligation for low-income workers would be reduced by the amount contributed on behalf of such worker by an employer(s)

   E. Low-income employees would be permitted to adjust their withholding to contribute to the individual's share of the premium obligation

      1. The amount of FICA tax withheld could be reduced for individuals expecting nominal or no income tax liability

         (a) The IRS would transfer funds to SSA at end of year to reconcile for reduced FICA withholding

2. To the extent that low-income workers withheld more than the premium amount required, such individual would receive an adjustment, as appropriate, through an EITC-type mechanism

F. The value of the premium subsidy for low income individuals would be capped at the lower of (1) the subsidy amount for enrollment under Medicare Part C, or (2) the employee obligation under the plan offered by the employer

G. A low-income worker that elects coverage under a plan offered by an employer would be liable for the excess premium amount, if the employee share of the employer-plan premium exceeds the value of the premium subsidy amount

III. A wrap-around benefit package would be provided under Medicare Part C for all low-income individuals with family income up to 100 percent of the Federal poverty level

A. Deductibles and copayments would be waived

B. All EPSDT services not otherwise included in the guaranteed benefit package would be covered for children to age 18

C. Vision and hearing care, including eyeglasses and hearing aids would be covered

IV. A wrap-around benefit package would also be provided under Medicare Part C for defined categories of low income individuals:

A. Pregnant women and children to age 18 with income up to 200 percent of poverty

B. AFDC and SSI recipients with income up to 200 percent of poverty

V. Wrap-around benefits would be covered under Medicare Part C for a low-income individual that elects coverage under a plan offered by an employer

   A. A low-income employee covered under an employer plan would be able to receive Medicare Part C subsidies and benefits, that are covered under Medicare Part C, if such benefits were not otherwise covered by the employer

      1. Non-discrimination rules would require employers to offer the same benefits to low income employees, as all other employees

   B. Medicare Part C would become the secondary payer to a plan offered by an employer, if an eligible low income individual elected coverage under a plan offered by the employer that did not cover the supplemental benefits to which the individual would otherwise be entitled

VI. Providers would be compensated by Medicare Part C for the deductibles, copayments or coinsurance not paid by low income Medicare Part C beneficiaries

VII. Medicaid could continue to provide optional benefits not covered under the guaranteed national benefit package, or covered under the Medicare Part C wrap-around benefit package.

   A. State Medicaid payments for such services would continue to be subject to the current Federal matching payment rate

   B. States would be permitted to use more generous income standards to cover individuals and families with income up to 100 percent of the poverty level

   C. Long-term care and other institutional services, including services for the mentally retarded and services provided in nursing facilities would continue to be covered under Medicaid

VIII. The Secretary, through the Health Care Financing Administration, the Social Security Administration, and other appropriate agencies, would perform enrollment and eligibility functions necessary to administer the Medicare Part C program

A. The Secretary would establish a process to determine eligibility for Medicare part C benefits, including supplemental low income benefits, and a process to facilitate enrollment in Medicare Part C

   1. The Secretary would develop alternative strategies through which individuals could enroll, and would coordinate with existing programs and agencies to streamline the enrollment process

   2. The Secretary would develop outreach programs to ensure participation of all eligible individuals in Medicare Part C

B. Hospitals, rural primary care hospitals and Federally Qualified Health Centers, and any other health center or clinic receiving Federal funds, would be required to make applications for Medicare Part C available to individuals, and would assist in the process of enrollment for individuals without a valid health security card

   1. Such hospitals, centers or clinics would have access to information pertaining to source of health insurance coverage through the electronic verification system

   2. Such hospitals, centers or clinics would be required to report to the Secretary information to assist in the enrollment and coverage of individuals under Medicare Part C

   3. Upon verification that the individual is not otherwise covered under a private health plan, the Secretary would issue a health security card

C. Low-income individuals would apply to the Secretary for coverage of supplemental benefits, on an annual basis

   1. Individuals who were not required to file with the IRS in the most recent year prior to application for supplemental benefits would be deemed to be eligible for such benefits under Medicare Part C

   2. Individuals who, at the time of application, are AFDC or SSI cash recipients, would be deemed to be eligible for supplemental benefits under Medicare Part C

a. Such individuals would be required to report a change in benefit status, with respect to AFDC and SSI benefits

3. Individuals with income up to 100 percent of poverty and pregnant women and children to age 18 with income up to 200 percent of poverty would be eligible for supplemental benefits

4. Eligibility would be based upon annualized income

a. Uniform, national eligibility criteria would be established by the Secretary

b. No asset test would be applied

c. In general, eligibility for low-income benefits would be for a one-year period

D. Penalties would be imposed for misrepresentation of income

1. Civil penalties would be imposed on individuals who knowingly misrepresent income for the purpose of obtaining benefits to which they are not entitled

2. Criminal penalties would be imposed on individuals who knowingly and willfully misrepresent income for the purpose of obtaining benefits to which they are not entitled

E. Verification of income eligibility would be required, as the Secretary deems appropriate

1. The Secretary, in consultation with the Secretary of the Treasury, would verify eligibility for supplemental benefits with eligibility for premium subsidies

a. The Secretary of HHS would provide information needed to IRS for the purpose of verifying subsidy eligibility

2. Offices administering AFDC and SSI benefits would report recipients, on a semi-annual basis to the Secretary, to verify eligibility based upon receipt of cash assistance benefits

3. Premium obligations and subsidies would be determined through the income tax system

F. An individual would have a right to appeal a denial of low-income benefits, and a right to an explanation for the denial

IX. State Maintenance of Effort

A. Continuation of Current Medicaid Coverage for Long-term Care and other Services not Covered Under Federal Plan

1. Medicaid would continue to function as under current law

a. The Secretary would be prohibited from approving any change in a State's Medicaid program that would take effect prior to the implementation of Medicare Part C and that would substantially reduce a State's obligations under the maintenance of effort provisions that follow

2. Payments made under Medicaid would be secondary to payments made under any Federal program, including Medicare Parts A, B and C, and to any Federal supplemental coverage provided to low-income beneficiaries

a. States would continue to provide Medicaid coverage for services, and to individuals, not covered under Medicare Part C, including long-term care services for beneficiaries that would qualify under current law

B. State Maintenance of Effort Payments to Medicare Part C

1. States would make "maintenance-of-effort" payments to Medicare Part C to partially offset need for Federal subsidies of low-income, non-cash recipients enrolled in Medicare Part C

a. Payments would be made in the same manner, and using the same process, as current State "buy-in" payments to Medicare Part B

2. Computation of State Maintenance-of-Effort Amount for Non-cash Recipients

   a. For each State, a 1993 baseline level of Medicaid expenditures for non-cash recipients (less Federal financial participation), not eligible for Medicare Part A, for covered Medicare Part C services, including deductibles and co-insurance

   b. State maintenance of effort payments in the initial year would be 95 percent of the 1993 baseline updated to 1996

   c. In subsequent years, the amount is updated by the allowable growth in per capita spending in Medicare, and growth in the general population under age 65

3. Computation of State Maintenance of Effort Amount for Cash Recipients

   a. States would make per capita payments to Medicare Part C for cash recipients (AFDC and SSI)

      (1) Payments are based on baseline per capita Medicaid spending for services covered under Medicare Part C made on behalf of AFDC and SSI individuals and families under current law

      (2) The State share of the per capita spending amount for cash recipients would be based on the State's share of Medicaid financing as determined under current law

   b. The State payments for cash recipients would be equal to 95 percent of the sum of the AFDC/SSI "per capita amounts" times the number of each such type of recipient

   c. The per capita payments for each State would be based on a 1993 baseline level of Medicaid expenditures for AFDC and SSI beneficiaries not entitled to Part A, for services and cost sharing covered under Part C and the Federal low-income plan

(1) The per capita payments would be computed separately for AFDC and SSI

(2) The per capita payments would reflect current Medicaid coverage of services that will be covered under the Federal low-income plan

d. The 1993 baseline AFDC or SSI per capita payments would be updated to 1996

e. In subsequent years, the per capita AFDC and SSI payments would be updated by the allowable increase in Medicare Part C spending

f. The Secretary would be given broad authority to alter these computations and requirements (and the non-cash maintenance of effort amounts) in applying these rules to Puerto Rico and other commonwealths and territories

4. Effective date

a. The maintenance of effort requirement would be effective in each State no later than on the first day of the first year following the close of the first regular session of the State's legislature that begins on or after enactment of this Act, and that individuals receive coverage under Medicare Part C

b. In the case of States for which this date would be after implementation of Medicare Part C, January 1, 1997, such States would be required to make payments to Medicare Part C of 100 percent of the Part C premium on behalf of each individual entitled to Medicaid under the State plan

C. Enforcement of State Maintenance of Effort Payments

1. States would be required to make payments to Medicare Part C on a timely basis

2. In the case of a State that fails to make required payments, the Secretary of HHS would withhold the required amount from Federal matching payments that would otherwise be paid to the State

3. In the case of a State for which the Federal matching payments are not equal to or greater than the State's maintenance of effort obligation, the Secretary of HHS would not make any other payments to the State for any program within HHS

   a. Federal payments made directly to individuals would continue to be made

3. Cost Containment in Medicare

I. Health Expenditure Estimates for Medicare

A. Health expenditure estimates would be set for total spending by Medicare, including Parts A through C

1. Estimates would be published by October 1 of each year for the following year, beginning in 1995

2. Annual growth limits would be set beginning in 1996 at the current trend minus two percentage points and phase down by an additional one percentage point each year until growth is limited to the increase in the nominal gross domestic product (GDP)

a. The initial limit would be based on the most recent actual data (1993) inflated forward at the baseline rate of growth to 1995, and at the target rate of growth thereafter.

i. The estimates would be measured on a per capita basis to reflect and adjust for changes in enrollment between the public and private plans

c. Subsequent per capita limits would be adjusted to reflect changes in the mix of enrollments between public and private plans, and to correct errors in estimation of initial spending relative to the estimated baseline levels of inflation in 1994 and 1995, baseline levels of spending for services within each category, and errors in estimation of volume responses relating to universal coverage

3. The target rates of increase in the spending limits would be based on the five-year moving average rate of growth in the GDP, plus a growth adjustment

a. The growth adjustment would be set such that the limit on growth in spending would decrease by two percentage points in 1996, three percentage points in 1997, four percentage points in 1998, and so on until the growth limit is equal to the growth in the GDP in each subsequent year

b. Secretary would estimate and publish the growth targets for a year by October 1 of the preceding year, beginning in 1995

4. The estimate and limits would apply to the current Medicare plan, to services covered under the new Medicare Part C, and to wrap-around benefits under the supplemental benefit program for low-income persons

5. The estimate would include all payments (including cost sharing) made for services covered under Medicare Parts A through C, including:

   a. Inpatient and outpatient hospital services

   b. Physician services

   c. Diagnostic testing services, including laboratory and x-ray services

   d. Prescription drugs

   e. Home health, durable medical equipment, orthotics and prosthetics

   f. Mental health services, including inpatient and outpatient drug and alcohol treatment

   g. Rehabilitation services

6. Expenditures for services provided in risk-contracting managed care plans would be included within the estimates

B. Monitoring Health Spending

1. All Medicare claims would be submitted to Medicare carriers and fiscal intermediaries

2. All providers who submit claims to either the public plan or to private payers would be required to submit annual reports to the Secretary of DHHS to be used in monitoring and enforcing compliance with the national health spending estimates

   a. Hospitals and other institutions would provide cost and revenue data; other providers would submit only revenue data

   b. Reports would be submitted by April 15 of each year for the preceding calendar year

i. The initial report, covering payments made for services provided in 1996, would be due on April 15, 1997.

c. The reports would include information on all revenues received during the preceding calendar year relating to medical services provided to all patients, broken down separately by type of payer (Medicare A, B and C, Medicaid, CHAMPUS, private insurance plans, and direct patient out-of-pocket costs)

d. Revenues for activities not related to the provision of direct patient care, such as teaching or research, would be reported separately

3. Hospitals' reports for inpatient and outpatient services would be part of the uniform hospital reporting system

4. Physicians and other providers would submit reports in a form to be specified by the Secretary

II. Allocation of Medicare Spending to States

A. State level estimates of per capita health spending by Medicare beneficiaries would be used to monitor the States' success in controlling costs

B. The Secretary of HHS would estimate the amount of Medicare spending for each State without regard to the implementation of a State plan

1. States' spending for services provided to Medicare beneficiaries would be permitted to grow at the same rate as Medicare grows on a national basis

4. In estimating the initial States amounts, the Secretary would adjust the data to reflect use of services by Medicare beneficiaries who are out-of-State residents, and use of out-of-State services by in-State residents who are Medicare beneficiaries

C. The initial allocation for each State would be estimated for 1995, based on the most recent data available

1. The estimate of the 1995 spending would be adjusted for estimation errors when actual data become available

D. Each State's Medicare allocation for 1996 would be equal to the 1995 allocation, increased by the Medicare target rate of growth

1. States could apply to the Secretary to exclude certain health care spending from being considered in determining whether a State is within its growth limits in the case of costs related to demands of a sudden and temporary nature, such as epidemics or natural disasters

III. Cost Containment

A. Beginning for calendar year 1996, HHS would set payment rates under Medicare, at levels estimated to keep spending within the estimate

1. HHS would separately allocate the Medicare spending estimates among health sectors (hospitals, physicians, etc.)

a. Initial sector allocations would be based on baseline Medicare spending patterns; projected changes in sector allocations would also be based on baseline patterns of change

i. These allocations would serve as expenditure target type limits for prospectively setting reimbursement rates to keep spending within the target

b. Once established, the sector allocations and growth trends could not be changed without specific authorizing legislation

c. ProPAC, PhysPRC, and DrugPAC would jointly study and recommend changes in sector definitions and allocations to Congressional Committees

IV. Medicare Payment Rates

A. Provider payments would be based on Medicare methodologies

1. Specific rates of payment would be set by HHS at levels estimated to meet the expenditure targets for each sector of the health care system

2. The rates would not apply in States which operate their own provider payment or cost containment systems, and that meet Federal standards regarding inclusion of Medicare services, as described under the outline on State Responsibilities

    a. States electing to operate their own systems would be required to keep Medicare spending within its own target for spending after Medicare services and beneficiaries are integrated into the State system

3. Maintenance-of-effort by State and local governments during transition period

    a. States could not reduce Medicaid payments to hospitals below the level paid in 1992

        i. Test would be on a state-wide average basis

        ii. Test would compare actual Medicaid payments against amount which would have been paid using the Medicare-level DRG payment method expressed as a percentage

    b. Local governments could not reduce support for public and non-profit hospitals serving the indigent below the level paid in 1992

        i. Payment under the uncompensated care adjustment would be reduced dollar-for-dollar for reductions in local support

        ii. Time-limited grants initially granted prior to 1992 would be excluded from the test

4. Payments to hospitals and units currently exempt from the PPS system

    a. Hospitals and units currently exempt from the PPS payment system would be subject to a rate of increase limit similar to the TEFRA limits

        i. Hospitals and units currently exempt are children's hospitals, long-term hospitals, cancer hospitals, rehabilitation hospitals, and psychiatric hospitals

b. For purposes of determining payment in the first year, 1993 revenues would be updated to 1996 using baseline growth in spending for exempt hospitals and units

c. Growth thereafter would be constrained based upon a limit determined to be consistent with the target growth in national health spending estimates

d. The rate of growth limit would be replaced with prospective methodologies as new methodologies were developed

e. With respect to children's hospitals, the prospective method would be hospital-specific and would be based on the resource requirements of pediatric populations and would be developed using pediatric-specific inpatient data

C. Physician services

1. RB RVS rates for physicians

a. The Secretary of HHS would define new procedure codes and estimate RB RVS units as necessary for under-65 patients

b. Definitions and payment policies would be published by HHS

c. As under current law, rates would be published annually and would be effective the following January 1

2. The RB RVS conversion factors for Medicare Part C would be equal to the conversion factor under Medicare Part B

a. The rates would be adjusted to reflect patient out-of-pocket payments to keep total payments within Medicare's estimate

3. Updates to the conversion factor would be determined such that expenditures would be consistent with the national health spending estimates

E. Prescription drugs

1. Annual increases in payment rates would be determined so that total net Medicare and patient payments would be consistent with the Medicare growth targets

2. See outline on drug benefits for detailed description of methodology

F. Limits on payments to Managed Care Plans

1. Risk contracting payments under Medicare Part C

a. Rates would be established using the same methodologies as under current law

(1) Separate adjustments would be estimated for computing the AAPCC

(2) The Secretary of HHS would establish interim rates, which would be retrospectively adjusted to reflect actual spending in the fee for service system when such data become available

2. Growth limits for risk contracting HMOs would be implicitly imposed through the effects that limits on growth in payment rates have on growth in the AAPCC

IV. Reference to Limitation on Administrative and Judicial Review of Certain Determinations

A. There would be no administrative or judicial review of:

1. DRG or RB RVS values established for services

2. Estimates of Medicare health spending estimates or the allocation of such estimates to health sectors or States

4. Additional Medicare Savings

(to be added)

TITLE IX. PREMIUM-BASED FINANCING

1. Premiums for Medicare Part C

(to be added)

TITLE X. QUALITY AND CONSUMER PROTECTION

1. Quality Management and Improvement

I. Federal standards would be established for a national quality management program that would enhance the quality, appropriateness and effectiveness of health care services

A. The States would enforce the standards for the National Quality Management Program

1. States would be required to adopt the Federal standards within one year after they were issued by the Secretary

(a) States in which the legislature was not scheduled to meet during the year prior to the date by which the State must adopt the Federal standards would be required to adopt the standards by the first quarter after the close of the next scheduled meeting of the legislature

2. The Secretary of HHS would certify State compliance and would assume responsibility for enforcing the standards in a State that did not comply

3. Funding of $300 million per year for each of the fiscal years 1996 through 2000 would be available to States for consumer protection and quality oversight efforts

B. The Secretary would develop and update a set of national quality and performance measures which would apply to health plans, institutions and health care professionals

1. In developing and selecting national measures of quality of performance, the Secretary would consult with appropriate interested parties, including States, health plans, health care providers, and consumers

2. National measures of quality performance would be selected in a manner that provides information on the following subjects:

   (a) Access to health care services by enrollees

   (b) Appropriateness of health care services provided to consumers

   (c) Outcomes of health care services and procedures

   (d) Consumer satisfaction

C. The Secretary would adopt methodologies for profiling the patterns of practice of health care professionals and for identifying outliers

   1. An outlier would mean any health care provider whose pattern of practice suggests deficiencies in the quality of health care services

      (a) The Secretary would disseminate said methodologies to States

   2. The Secretary would develop standards for education and sanctions with respect to outliers so as to assure the quality of health care services

D. The Secretary would develop and approve a standard design for consumer surveys

   1. The Secretary would specify sampling strategies that would have to be used to ensure that survey samples adequately measured populations that are considered to be at risk of receiving inadequate health care

   2. Health plans, institutions and health care professionals would be required to conduct periodic surveys to gather information concerning access to care, use of health services, health outcomes and patient satisfaction

      (a) Summaries of survey results would be submitted to the States

E. All health plans, institutions and providers would be required to submit information, as provided by the Secretary, to the State in order to enable quality review and outcome analysis

1. The required information would be transmitted using a uniform electronic format

(a) The data required to be submitted would be developed by the Secretary

(b) The data required to be submitted would conform to the requirements under administrative simplification

2. The Secretary would establish rules by which the data in the data base would be made available

3. The Secretary would establish standards to protect the privacy and otherwise shield the identity of the patient

II. Outcomes research and guideline development

A. The Secretary would establish a procedure by which individuals and entities would be able to submit guidelines to the Agency for Health Care Policy and Research (AHCPR) for evaluation and certification

1. The Secretary would direct AHCPR to establish and oversee a clearinghouse for dissemination of approved practice guidelines

2. On the basis of data, including data from outcomes research AHCPR would develop practice guidelines

(a) AHCPR would be required to update on an annual basis such guidelines

(b) The guidelines would be required to be based on monitoring of outcomes research and on existing clinical knowledge

(c) The guidelines would be required to be based on the degree to which a process of care increases the probability of desired patient outcomes

3. AHCPR would develop guidelines for certain medical procedures to be performed only in facilities that meet certain criteria

   (a) Guidelines would be developed based on standards for frequency of procedure performance and intensity of support mechanisms that are consistent with the high probability of desired patient outcome

   (b) No payment would be required to be made for designated procedures provided in violation of the guidelines

   (c) The Secretary may exclude any person or entity from participation in Medicare if any person or entity provides such designated service that such person or entity knows or should know is in violation of this section

C. AHCPR would disseminate guidelines to the States

III. Evaluating and reporting of quality performance

A. The State would be required to monitor compliance of health plans, institutions and providers with standards established by the national quality management program

   1. A periodic, but no less than annual, independent, external review of the quality of the services provided under a health plan would be required

      (a) The review could be conducted by the State or independent entities under contract with the State

      (b) Health plans, through their internal quality assurance program, would be required to cooperate with the State or entity conducting the external review

2. If the State finds, after affording reasonable opportunities for improvement, that a provider, institution or plan fails to engage in quality improvement activities or continues to furnish services of poor technical quality, the State would be required to notify the appropriate federal and State board or boards responsible for the licensing and disciplining of providers and plans

B. The State would be required to update annually and make available to consumers, in a standard format the performance of each health plan, institution and provider within the State, including results of consumer surveys

1. Performance of health plans, institutions and providers would be based on measures established by the Secretary

2. States would be required to provide to the Secretary an annual report that outlines the performance of health plans, institutions and providers

V. Research on health care quality

A. The Secretary would direct the Agency for Health Care Policy and Research (AHCPR) to support research, including research with respect to:

1. Outcomes of health care services and procedures

2. Effective and efficient dissemination of information, standards and guidelines

3. Methods of measuring quality

4. Design and organization of quality of care components of automated health information systems

B. AHCPR would collect data from outcomes research and would disseminate any findings to the States

VI. Health plans would be required to meet standards established by the Secretary

A. Establish an internal quality assurance program

B. Make available to enrollees information about their rights and responsibilities

C. Provide a grievance process that provides for effective and timely responses to complaints

D. Establish procedures for taking appropriate remedial action whenever inappropriate or substandard services are provided

E. Verify providers' credentials

F. Establish a policy to identify and investigate sources of dissatisfaction, outline action steps to follow-up on the findings and inform practitioners and providers of assessment results

G. Ensure that the confidentiality of specified patient information and records is protected

1. Establish in writing policies and procedures on confidentiality, including confidentiality of medical records

2. Assure that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the medical care organization

B. Health plans may not operate a physician incentive plan as defined in section 1876(i)(8)(B) of the Social Security Act unless the following requirements are met:

1. No specific payment is made directly or indirectly under the plan to a physician or a physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the entity

2. In the case of a plan that places a physician or a physician group at substantial financial risk as determined by the Secretary pursuant to section 1876(i)(8)(A)(ii), for services not provided by the physician or physician group, the entity complies with the provisions of subclauses (I) and (II) of section 1876(i)(8)(A)(ii)

3. Upon request by the Secretary, the entity provides the Secretary with access to descriptive information regarding the plan, in order to permit the Secretary to determine whether the plan is in compliance with the requirements of this clause

VII. Grievance and appeals process

A. Health plans would be required to notify an enrollee of denial of payment or provision of benefits

1. The health plan would be required to provide such notice within 10 days

2. If the health plan fails to notify an enrollee within 10 days such failure would be treated as a plan approval

3. An enrollee would have 60 days, after receipt of notice of the denial, to request in writing a reconsideration of the claim

(a) The health plan would be required to complete any review and provide the enrollee notice of the plan's decision, within 30 days after receipt of the request for reconsideration

B. Health plans would be required to provide an expedited appeals process for denials or terminations relating to services that are urgently needed

1. A health plan would be required to make a determination within 24 hours

C. Health plans would be required to establish a grievance process for patients dissatisfied with the type or extent of services being provided by the plan

D. Each State would be required to establish a review office pursuant to standards established by the Secretary

1. A complaint may be made about a denial or delay of payment or provision of benefits under the health plan

2. Such complaints may only be filed after the claimant has exhausted the remedies under the plan

3. Each review office would be required to review a complaint relating to services that are urgently needed within 3-days

E. Any person aggrieved by a review office decision may seek a review of the decision in the court of competent jurisdiction

VIII. Additional remedies and enforcement provisions

A. Any health plan that engages in activity, either directly or through contractual arrangements, that has the effect of discriminating against any individual on the basis of race, national origin, gender, age, religion, language, disability, sexual orientation, income, health status or anticipated need for health services would be liable to that individual or entity

1. Any individual may commence a civil action in an appropriate United States District Court or state court to obtain relief for any violation

2. If the court finds that a violation has occurred, the court may grant as relief compensatory and punitive damages, injunctive relief and order such affirmative action as may be appropriate

(a) The court may allow the prevailing party, other than the United States, reasonable costs, including attorney's fees and expert witness fees

3. The Secretary of the U.S. Department of Health and Human Services would promulgate regulations that provide for the routine collection and reporting by race, national origin, sex, language, income, age, and residence

(a) The Secretary would compile, analyze and make publicly available, the date collected under this section

IX. Privacy of information standards would apply to the disclosure of protected health information

A. Standards would apply to any individual or entity who receives, collects, uses or maintains protected health information

B. Protected health information means any information in any form, that identifies an individual and relates to the physical or mental health of the individual, provision of health care to the individual, or payment for the provision of health care to the individual

C. Any individual or entity may disclose protected health information if such use or disclosure is:

1. For the purpose of providing health care to an individual

2. For the purpose of providing for the payment for health care services

3. For use by a health oversight agency for a purpose authorized by law

4. For use in disease reporting, public health surveillance, or public health investigations as authorized as by State law

5. To alleviate an emergency affecting the health or safety of an individual

6. Pursuant to the Federal Rules of Civil Procedure, the Federal Rules of Criminal Procedure, or comparable rules

7. Pursuant to a law requiring the reporting of specific medical information or child abuse or neglect information to law enforcement authorities

8. To a law enforcement agency for the use in an investigation or prosecution of health care fraud, as authorized by law

9. Pursuant to a subpoena, summons or warrant

10. For use in utilization, quality assurance and health research projects as required under the national quality and assurance program

11. For use in licensing, accrediting or certifying health facilities or health professional

D. Information may only be used for the purpose for which the information was collected or was obtained, or a related purpose

1. The use or disclosure of health information would be limited to the minimum amount of information necessary to accomplish the purpose for which the information is used or disclosed

2. The Secretary would develop standards with respect to protecting and shielding the identity of a patient

E. Health information may be disclosed if a patient has signed a patient authorization form

1. The authorization form must specify the individual authorized to disclose such information, the person to whom the information is to be disclosed and the information to be disclosed

2. The Secretary would develop standards with respect to patient authorizations for disclosures that are in electronic form

F. The privacy of information standards would not apply to individuals who are casual recipients of health information

G. Any individual who substantially fails to comply with the privacy of information standards would be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $10,000 for each such violation

H. Any individual aggrieved by any act of an individual or entity in violation of this section may bring a civil action in the district court of the United States

1. The court may award actual damages and grant equitable relief

(a) In an action where a complainant has prevailed because of a knowing violation, the court may award punitive damages and reasonable attorneys' fees and costs

2. No action may be brought unless such action is begun within two years from the date of the act complained of or the discovery of such act

2. Information Systems and Administrative Simplification

I. Uniform health claims card

A. Each beneficiary of a health benefit plan, including Medicare, would be issued a uniform health claims card

1. A health benefit plan that fails to issue a health claims card would be subject to civil monetary penalties

B. Each card would include a uniform health claims identification number which would be the Social Security number of the beneficiary

C. The Secretary would establish standards respecting the form and information to be contained on the cards

1. Information relating to organ donation would be included on the cards

D. The card would be in a form similar to that of a credit card and would have information encoded in electronic form

II. Requirement for entitlement verification systems

A. The Secretary would provide for an electronic system for the verification of an individual's enrollment in a health plan, including Medicare and entitlement to benefits

1. The Secretary would establish standards respecting the type of information that employers and health plans, including Medicare would be required to submit. Information reported would include:

a. Name, address and identification number of health plan elected

b. Name, address and social security number of the individuals enrolled

c. The type of coverage elected, and

d. The period during which such coverage is elected

e. Status of individuals with respect to deductibles, copayments and out-of-pocket limits

2. Information would have to be submitted periodically whenever eligibility for coverage changed

3. Employers and health plans that fail to provide enrollment information on a timely basis would be subject to civil monetary penalties

B. The Secretary would establish standards respecting the requirements for certification of entitlement verification systems

1. The system would be required to be able to coordinate benefit information among health plans and Medicare

2. The system would also be required to accept inquiries from health care providers and health benefit plans electronically through the use of electronic card readers, touch-tone telephones, or computer modems

(a) Each system would be required to respond to such inquiries electronically

3. Health benefit plans that fail to provide for an electronic verification system would be subject to civil monetary penalties

C. In developing a system the Secretary would take into account the recommendations of private sector task forces, including the Workgroup on Electronic Data Interchange, National Uniform Billing Committee, the Uniform Claim Task Force and national organizations representing healthcare financial managers

III. Uniform claims and electronic claims data set

A. All claims submitted by providers would be transmitted using a uniform electronic format to be developed by the Secretary

1. The standards would relate to the form and manner of submission of claims and would define the data elements to be contained in a uniform electronic claims data set

2. The electronic transmission standards would be consistent with the format developed by the American National Standards Institute (ANSI)

3. In adopting standards the Secretary would take into account the recommendations of private sector task forces, including the Workgroup on Electronic Data Interchange, National Uniform Billing Committee, the Uniform Claim Task Force and the Computer-based Patient Record Institute

B. The Secretary would develop a single, uniform coding system for procedures and diagnoses

C. The Secretary would provide for a unique identifier code for each health service provider and health plan

D. Health service providers and health plans that fail to submit a claim for payment in a form and manner consistent with the standards would be subject to civil monetary penalties

E. All claims for clinical laboratory tests would be submitted directly by the person or entity that performed the tests

IV. Electronic medical records and reporting

A. The Secretary would promulgate standards for hospitals concerning electronic medical records

1. The standards would include a definition of a uniform hospital clinical data set for claims adjudication and for quality review

(a) The development of these standards would be in consultation with the American National Standards Institute, hospitals, and health benefit plans

B. As a condition of Medicare participation each hospital would be required to maintain hospital clinical data in electronic form in accordance with these standards

1. Each hospital, upon request of the Secretary, a utilization and quality control peer review organization or fiscal intermediary or carrier, would be required to transmit electronically data requested

2. A health plan may not require that a hospital provide any data not in the uniform hospital clinical data set

C. The Secretary would promulgate standards, by January 1, 2000, for other providers concerning electronic patient care information

D. State quill pen laws that require medical or health information to be maintained in written form would be pre-empted

V. Uniform hospital cost reporting

A. Each hospital would be required to report information on costs to the Secretary in a uniform manner consistent with standards established by the Secretary

3. Medical Malpractice and Physician Recertification

I. General

A. The following reforms would apply with respect to any medical malpractice claim brought in Federal or State court, unless State law is more stringent

B. Any issue that is not governed by any provision of law established by or under this part would be governed by otherwise applicable State or Federal law

II. Tort reforms

A. Collateral source offset

1. The total amount of damages recovered by a plaintiff in a medical malpractice liability action would be reduced by the amount of "collateral source benefits" received in the past, or to be received in the future

B. Periodic payment of future damages

1. At the request of any party to a medical malpractice liability action, the defendant would be permitted to make such payments periodically based on a schedule established by the court

C. Frivolous suit penalty

1. The court could award reasonable attorney fees and costs where a meritless claim or defense is asserted

D. Limitation on contingency fees

1. An attorney who represents, on a contingency basis, a plaintiff in a medical malpractice liability action may not collect more than 33-1/3% of the total amount covered by a judgment or settlement

E. Affidavit and medical report must be attached to the complaint

1. An affidavit of the attorney filing suit must be attached to the complaint attesting to a reasonable and meritorious cause of action

2. A written report, by a medical professional who practices in the same specialty as the defendant, stating the reasons for the determination that a meritorious cause of action exists, must be attached to the affidavit accompanying the complaint

3. Two exceptions would exist that would allow for a 90-day delay in filing of the affidavit and medical report with the complaint

(a) When the statute of limitations prevents obtaining a consultation

(b) When the claimant has made a request for medical records and the parties to which the request was made failed to produce such records within 60 days of receipt of the request

III. Alternative dispute resolution demonstration projects

A. The Secretary would establish a demonstration project under which the Secretary would provide funds, to no more than 10 States, to determine the effect of various alternative dispute resolution systems

1. Demonstration projects would be conducted for a four year period

2. The Secretary would promulgate regulations that establish the criteria and procedures by which the Secretary would determine whether or not to certify a State's alternative dispute resolution system

3. In order to participate a State must submit an application to the Secretary assuring that the State has established an alternative dispute resolution system that meets specific requirements promulgated by the Secretary

4. Not later than four years after the date of certification the State would be required to prepare and submit to the Secretary appropriate information to enable the Secretary to report on the matters to Congress

IV. Pilot program applying practice guidelines to medical malpractice litigation

A. The Secretary would establish a demonstration project under which the Secretary would provide funds, to no more than 10 States, to determine the effects of applying practice guidelines in the resolution of medical malpractice liability actions

V. Physician recertification

A. Standards for the physician qualification evaluation program would be established by the Secretary of HHS

1. As a condition of payment under Medicare Part A, B, & C, a physician-

(a) Must have taken and passed, during the year or during any of the previous seven years, an approved examination offered by the Secretary or a qualified organization, or

(b) Must be licensed as a physician in a State with an approved physician licensure program

B. The Secretary would establish and periodically update standards for physician examinations

1. The standards would be established in consultation with the American Board of Medical Specialties, the National Board of Medical Examiners, the Federation of State Medical Boards, the American Osteopathic Association, and other organizations representative of physicians

2. Upon application and approval by the Secretary, a physician specialty certifying board which is a member board of the American Board of Medical Specialties, or the National Board of Medical Examiners, the American Osteopathic Association or a State medical board may offer the examination

C. The Secretary would develop and provide for the offering of an approved examination in the general practice of medicine and osteopathy

D. The Secretary would review and approve the physician licensure program of any State

1. Any program must provide for time-limited licenses for physicians and periodic relicensure of all physicians in the State

2. Any program must include an objective evaluation of the qualifications of physicians to practice medicine or osteopathy

VI. Miscellaneous provision

A. A enrollee aggrieved by an insurance contractor's failure to provide a benefit would be able to recover damages as specified under State law

4. Fraud and Abuse

I. All-payer fraud and abuse program

A. The Secretary of Health and Human Services (acting through the Inspector General of HHS) and the Attorney General would establish and coordinate an all-payer national health care fraud and abuse control program

B. The Attorney General and Inspector General would be authorized to conduct investigations, audits, evaluations and inspections relating to the delivery of and payment for health care and to have access to all records available to health plans relating to the program

C. The administration of the national program would include the coordination of the Medicare and Medicaid fraud and abuse program

II. Coordination with law enforcement agencies and third party insurers

A. The Secretary and the Attorney General would be required to consult with, and arrange for the sharing of resource data with, State law enforcement agencies, State Medicaid fraud control units, State agencies responsible for the licensing and certification of health care providers, health plans, and public and private third party insurers

III. General provisions regarding all-payer fraud and abuse program

A. All health plans, providers, and others would be required to cooperate with the national fraud control program and to provide such information as is necessary for the investigation of fraud and abuse

(1) Procedures would be established to assure the confidentiality of the information required by the national fraud and abuse program and the privacy of individuals receiving health care services

B. Health plans and providers would be required to disclose information that the Secretary deems appropriate, including information relating to the ownership, control and management of a health care entity

C. In carrying out the duties and responsibilities under the program the Inspector General of the Department of Health and Human Services would be authorized to exercise all powers granted under the Inspector General Act of 1978 in the same manner and same extent as provided in the Act

(1) Any individual or entity who fails to comply with a request of the Office of the Inspector General of the Department of Health and Human Services for records, documents and other information necessary to carry out activities under the all-payer fraud and abuse control program may be excluded from participating in Medicare and State health care programs

D. A qualified immunity would be provided to persons providing information to the Secretary or Attorney General under the health care fraud and abuse program

IV. Authorization of appropriations

A. Additional amounts of money would be authorized to be appropriated to the Office of the Inspector General of the Department of Health and Human Services and the Attorney General

V. Establishment of fraud and abuse account

A. Civil money penalties, fines, forfeitures and damages assessed in criminal, civil or administrative health care cases, along with any gifts and bequests would be deposited in a "All-Payer Health Care Fraud and Abuse Control Account"

B. The assets in the Account would be used, in addition to such appropriated amounts, to meet the operating costs of the national health care fraud control program

VI. Amendments to anti-kickback statutory provisions

A. An intermediate civil monetary penalty of up to $50,000 would be established for anti-kickback violations

B. The current criminal fine would be increased to no more than $50,000

C. An assessment of three times the total amount of remuneration offered, paid, solicited or received would be established as an additional sanction for both administrative and criminal violations

D. Aspects of a kickback offense would be clarified:

(1) "In return for referring" would be stricken and "to refer" would be inserted

(2) A violation would exist if one or more purposes of the remuneration were unlawful

VII. Amendments to exceptions to anti-kickback statutory provisions

A. Current exception for discounts would be modified to prevent providers from:

(1) Giving discounts to induce the purchase of a different item or service

(2) Giving discounts in the form of a cash payment

B. Current exception for bona fide employment relationships would be modified to require that any remuneration be consistent with fair market value, and not be determined in a manner that takes into account the volume or value of any referral

(1) The exception would also be modified to allow employees to be paid remuneration in the form of a productivity bonus based on services personally performed by the employee

C. Current exception for waiver of coinsurance would be modified to allow for such arrangements if-

1. A waiver or reduction of coinsurance is made pursuant to a public schedule of discounts which the person is obligated as a matter of law to apply; or

(a) The person determines in good faith that the individual is indigent, or

(b) The person fails to collect coinsurance or deductible amounts after making reasonable efforts, and

2. The waiver is not offered as part of an advertisement or solicitation, and the person doesn't routinely waive coinsurance

D. An exception would be provided for certain arrangements where providers are paid wholly on a capitated basis

E. The Secretary would be authorized to impose by regulation such other requirements as needed to protect against program or patient abuse

VIII. Amendments to civil monetary penalty statutory provisions

A. A civil monetary penalty would be established for the following improper conduct:

(1) Offering inducements to individuals to receive from a particular provider an item or service

(2) Retention by an excluded individual of an ownership or control interest in a participating entity

(3) Engaging in a practice which has the effect of limiting or discouraging the utilization of health care services

(4) Substantially fails to cooperate with a quality assurance program or a utilization review activity

(5) Substantially fails to provide or authorize medically necessary items or services that are required to be provided under the health plan, if the failure has adversely affected (or had a substantial likelihood of adversely affecting) the individuals

(6) Employing or contracting with any individual or entity who is excluded under Medicare or Medicaid for the provision of health care services

(7) Submits false or fraudulent statements to any Federal or State agency relating to the national health care program

B. Civil monetary penalties would be increased to no more than $10,000 for each false or improper item or service

C. The assessment would be increased to three times the amount claimed and interest shall accrue on the penalties and assessments after a final decision

D. If within one year the Attorney General does not initiate a criminal or civil action the Secretary could initiate a civil monetary penalty proceeding

IX. Application of civil monetary statutory penalties to all payers

A. The provisions under the Medicare and Medicaid programs which provide for civil monetary penalties for specified fraud and abuse violations (as amended by this Act) would apply to similar violations with respect to all payers in the national health care system

B. Violations specifically tied to the Medicare and Medicaid programs would not, however, constitute violations under the all-payer fraud and abuse control program

(1) Such violations include overcharging under a Medicare assignment agreement and physician or supplier participation agreement

C. The following activity would be prohibited and subject to a civil monetary penalty not to exceed $10,000:

(1) Expelling or refusing to re-enroll an individual in violation of federal standards for health plans or State law

(2) Engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment in a health plan on the basis of a medical condition

(3) Engaging in any practice to induce enrollment in a health plan through representations which the person knows or should know are false

D. Any person that suffers harm as a result of any activity of an individual or entity which makes the individual or entity subject to a civil monetary penalty may bring a civil action

(1) A person may bring an action, if after the expiration of a sixty-day period, neither the Attorney General, or the Secretary, notifies the individual that they intend to pursue a civil monetary penalty

(2) If after one year, the Secretary has not proceeded with reasonable due diligence in investigating the matter, the individual may proceed with an action

(3) If the Secretary proceeds with the action, the individual may receive an amount the Secretary decides is appropriate restitution

(4) If the Secretary does not proceed with an action, 10 percent of the proceeds of the action or settlement of a claim would be deposited in the anti-fraud and abuse account

X. Amendments to exclusionary provisions in fraud and abuse program

A. The Secretary would have the authority to exclude entities and individuals from all federally funded health care programs, such as VA, Champus (in addition to Medicare and State health care programs)

B. The Secretary would have the additional authority to exclude individuals and entities based on felony convictions relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct in connection with the delivery of a health care item or service

C. The Secretary's current discretionary exclusion authority would be extended to permit the Secretary to exclude individuals who retain an ownership or control interest in a sanctioned entity

D. Minimum periods of exclusion for certain violations already specified in statute would be established

(1) In the case of an exclusion of an individual or entity for a misdemeanor conviction relating to fraud, the period of the exclusion would be three years unless the Secretary determines that a shorter or longer period is more appropriate

(2) In the case of an exclusion of an individual or entity relating to obstruction of an investigation or the unlawful manufacture, distribution, prescription or dispensing of a controlled substance, the period of the exclusion would be three years unless the Secretary determines that a shorter or longer period is more appropriate

(3) In the case of license revocation or suspension under a Federal or State Health care programs, the exclusion would be no less than the period during which the individual's license to provide health care is revoked or the individual is excluded from a program

(4) In the case of an exclusion for filing claims for excessive charges or unnecessary services and failure to furnish medically necessary services the minimum period of exclusion would be one year

(5) The minimum period of exclusion for practitioners failing to meet quality of care obligations would be one year

XI. Amendments to quality of care sanctions :

A. Practitioners or persons who violate quality of care obligations as determined by the Peer Review Organization would be subject to a civil monetary penalty of not more than $10,000

B. The additional requirement that the practitioner be shown to be "unwilling or unable" to meet PRO quality of care obligations before the Secretary may exclude the individual from participating in Medicare would be deleted

XII. HMO intermediate sanctions under Medicare

A. The Secretary would also be able to impose civil monetary penalties on Medicare-qualified HMOs for violation of Medicare contracting requirements

XIII. Application of criminal penalties to all payers

A. The provisions under the Medicare and Medicaid program which provide for criminal penalties for specified fraud and abuse violations would apply to similar violations for all payers in the national health care system

B. Violations specifically tied to the Medicare and Medicaid program would not, however, constitute violations under the all-payer fraud and abuse control program

C. For providers who violate specified fraud and abuse provisions, penalties would include fines, treble damages, and imprisonment

(1) The Secretary would also identify opportunities for the satisfaction of community service obligations that a court may impose upon the conviction of an offense under this section

XIV. Amendments to criminal and civil laws

A. A criminal violation for health care fraud would be created for the following crimes

(1) Whoever knowingly executes a scheme to defraud any health plan or person, in connection with the delivery of or payment for health care items or services

(2) Penalties would include a fine and a prison term of not more than 5 years

B. Forfeitures for violations of fraud statutes

(1) If the court determines that a Federal health care offense is of a type that poses serious threat to a person's health, or has significant detrimental impact on the health care system, the court could order the person to forfeit property used in or derived from proceeds from the offense and is of value proportionate to the offense

C. Injunctive relief relating to health care offenses

(1) Injunctive relief would be available against any individual who was committing or was about to commit a Federal health care offense

D. The civil false claims act would be amended to cover false claims submitted to health plans

5. Physician Ownership and Referral

I. Application of ban on self-referral to all payers

A. The physician ownership and referral ban would be extended beyond Medicare and Medicaid to all payers

II. Extension of ban to additional services

A. The physician ownership and referral ban would be extended to cover the following additional services:

(1) Diagnostic services

(2) Home infusion therapy

(3) Any other item or service not rendered by the physician personally or by a person under the physician's direct supervision

III. Continuation of current exceptions to the general rule

A. The exceptions in current law to the general ban on referrals would be continued with a series of modifications

IV. Exceptions related to both ownership and compensation arrangements

A. The exception for physicians' services would be repealed

B. The in-office ancillary service exception would be modified to separate provisions related to solo practitioners and for group practices. For solo practitioners, the exception would apply in the case of clinical laboratory services, x-ray services, ultrasound services, and other low cost services as determined by the Secretary, that are-

* Furnished using equipment wholly owned by the referring physician,

* Furnished personally by the referring physician, or personally by individuals who are directly supervised by the physician, and

* Furnished in an office location in which the referring physician furnishes physician services unrelated to the furnishing of designated health services

C. For group practices the in-office ancillary service exception would be further modified to provide an exception in the case of-

1. Clinical laboratory services, x-ray services, ultrasound services and other low cost services as the Secretary may determine, that are furnished-

   * Personally by a physician in the same group practice or personally by individuals who are directly supervised by a physician in the group practice, and

2. All other designated health services, that are furnished-

   * Personally by a physician in the same group practice or personally by individuals who are directly supervised by a physician in the group practice, and

   * In a building which is used by the group practice for the centralized provision of all of the group's designated health services within any given MSA, or

     -- For purposes of the standard the term "centralized location" would include any building which is located adjacent to another building

   * In any building used by the group practice in a rural area (outside MSAs)

D. An exception would be provided in the case of a designated health service, if the designated health service is included in the services for which a physician or physician group is paid wholly on an at-risk, prepaid, capitated bases by a health plan pursuant to a written arrangement

V. Exceptions related only to ownership or investment

A. The current standard under the publicly traded securities exception would require that at the time the security was acquired by the physician, the security could have been purchased on terms generally available to the public

B. The current exception for rural providers would be clarified to exempt entities providing 85% of their services to rural residents

VI. Exceptions related only to compensation arrangements

A. The exception for remuneration unrelated to the provision of designated health services would be repealed

B. The exception for isolated transactions would be clarified to prohibit the financing of the sale between the parties

VII. Referring physician

A. An exception would be provided for requests by nephrologists for any item or service administered in a renal dialysis facility

VIII. Miscellaneous and technical provisions

A. The current limitations would be clarified to prohibit a physician (in addition to an entity) from submitting a claim pursuant to a prohibited referral

B. The definition of financial relationship would be clarified to provide that an interest held indirectly (such as in a trust that holds an investment or ownership interest) is a financial relationship

C. The exception for payments by physician for items and services would be modified to require that the items and services be furnished at a price that is consistent with fair market value

D. Reporting requirements would be expanded to require physicians to report investment and compensation arrangements in addition to ownership information

E. The current standards used to define a group practice would be revised to explicitly allow the Secretary to impose by regulation requirements for the physical grouping of physician practices as may be reasonably required to prevent against program abuse

F. The applications of effective dates with respect to exceptions in current law would be clarified

G. The language of the sanction authority for circumvention schemes would be clarified

TITLE XI. LONG-TERM CARE

1. Federal Long-Term Care Insurance Standards

I. The Secretary of HHS would promulgate regulations to implement federal standards for private long-term care insurance policies within 12 months following the date of enactment.

A. States would enforce the standards for all long-term care insurance policies sold to individuals and employers

1. States would be required to adopt the Federal standards within one year after they were issued by the Secretary

a. States in which the legislature was not scheduled to meet during the year prior to the date by which the State must adopt the Federal standards would be required to adopt the standards by the first quarter after the close of the next scheduled meeting of the State legislature

2. The Secretary of HHS would certify State compliance and would assume responsibility for enforcing the standards in a State that did not comply

B. A Federal excise tax penalty would be established for non-compliance

1. The excise tax would be equal to 50 percent of the gross premiums received by the issuer of the policy attributed to the time period during which the policy was in violation of the requirements

II. Federal Standards and Requirements

A. Requirements to facilitate understanding and comparison of benefits would be established

1. The Secretary would develop and propose standardized formats and terminology to be used in long-term care insurance policies

2. Insurers would be required to provide to customers and beneficiaries information on the range of public and private long-term care coverage available

3. The Secretary would establish other requirements to promote consumer understanding and facilitate comparison of benefits

B. Uniform terms, definitions, and formats would be defined

1. Insurers would be required to use uniform terminology, definition of terms, and formats, in accordance with regulations promulgated by the Secretary

C. A standard outline of coverage would be required for all long-term care insurance policies

1. Insurers would be required to develop an outline of coverage in a uniform format for each long-term care insurance policy sold or issued, and make it available to each potential purchaser

2. The contents of the outline of coverage would include a description of:

a. Benefits

(1) A description of all benefits covered, including the extent to which benefits would be furnished in residential care facilities

(2) The principal exclusions from and limitations on coverage

(3) The terms and conditions, if any, upon which the insured individual may obtain upgraded benefits, and

(4) The conditions for entitlement to receive benefits

b. Continuation, renewal and conversion requirements

(1) A statement of the terms under which a policy may be returned (with premium refunded), continued or renewed, or converted to an individual policy

c. Cancellation limitations

(1) The outline would include a statement of the circumstances in which a policy may be terminated, and the refund or non forfeiture benefits applicable in each circumstance, including

(a) Death of the insured individual

(b) Non-payment of premium

(c) Election by the insured individual not to renew

(d) Any other circumstances

d. Premiums

(1) A statement of the total premium, and the portion of such premium attributable to each covered benefit

(2) Any reservation by the insurer of a right to change premiums

(3) Any limit on annual premium increases

(4) Any expected premium increases associated with automatic or optional benefit increases, including inflation protection

(5) Any circumstances under which the payment of the premium would be waived

e. A cost/value comparison

(1) The outline would include information on average costs (and variations in such costs) for nursing facility care and other covered benefits

(2) A comparison of benefits, over a period of 20 years for policies with and without inflation protection

(3) A declaration stating whether the amount of benefits will increase over time, and any limitations on and any premium increases for such benefit increases

3. Reporting to State insurance commissioners would be required of all insurers

a. Each insurer would be required to report at least annually to the State insurance commissioners in any State in which a policy is sold or issued, in a manner specified by the Secretary

b. Information to be reported would include:

(1) the standard outline of coverage

(2) lapse rates and replacement rates

(3) the ratio of premiums collected to benefits

(4) reserves

(5) written materials used in the sale or promotion of policies

4. Comparison of long-term care coverage alternatives would be provided to prospective purchasers

a. Each insurer would be required to furnish to prospective purchasers of a policy the conditions of eligibility for, and benefits under other policies sold by the insurers, and benefits covered under public programs, including but not limited to Medicare and Medicaid

D. Requirements relating to coverage would be established

1. The Secretary would promulgate regulations establishing requirements with respect to the terms of and benefits under long-term care insurance policies

2. Pre-existing condition exclusions would not be permitted

3. A long-term care insurance policy would not be permitted to condition eligibility for benefits:

   a. on the need for another type of service (such as prior hospitalization), or a higher level of care

   b. on any particular medical diagnosis, including any acute condition, or on one of the group of diagnoses

   c. on services furnished by licensed or certified providers on compliance by such providers with conditions not required by Federal or State law

   d. on the provision of such services by a provider, or in a setting, providing a higher level of care than that required by an insured individual

4. A long-term care insurance policy that provides benefits for home and community-based services provided in a setting other than a residential care facility:

   a. may not limit benefits to services provided by registered nurses or licensed practical nurses

   b. may not limit benefits to services provided by entities participating in Medicare and Medicaid

   c. must provide, at a minimum, benefits for personal assistance with activities of daily living, home health care, adult day care and respite care

5. A long-term care insurance policy that provides benefits for services in nursing facilities must provide benefits for services provided by all types of nursing facilities licensed by the State, and may provide benefits for care in other residential facilities

6. Long-term care insurance policies would not be permitted to discriminate with respect to eligibility for benefits or amount of benefits under the policy in the treatment of: Alzheimer's disease or other progressive degenerative dementia, any organic or inorganic mental illness, mental retardation or any other cognitive or mental impairment, or HIV infection or AIDS

E. Requirements pertaining to inflation protection would be established

1. An insurer would be required to offer the purchaser the option to obtain coverage under the policy for annual increases in benefits

2. The benefits under a policy would increase by not less than 5 percent per year compounded

3. Inflation protection would be excluded from the coverage only if the insured individual rejected in writing the option to obtain such coverage

F. Non-forfeiture benefits would be required for all policies

1. The Secretary would be required to promulgate regulations for an appropriate non-forfeiture benefit for policies that lapse -- including policies that lapse for nonpayment of premiums and non-renewal but excluding for reason of death, which could include:

a. Reduced paid-up benefits where indemnity level is reduced by a specific amount

b. Extended term benefits, where a policy remains in effect for an abbreviated period of time after policy lapses

2. The non-forfeiture benefit would increase proportionately to the amount of premiums paid

3. All long-term care insurance policies would be required to include defined non-forfeiture benefits, as specified by the Secretary

G. Requirements relating to premiums would be established

1. The Secretary would promulgate regulations with respect to State procedure for review and approval of premium rates and rate increases or decreases

2. The Secretary would promulgate regulations with respect to limitations on the amount of initial premiums, or on the rate or amount of premium increases

3. The Secretary would promulgate regulations with respect to the factors to be taken into consideration by an insurer in proposing, and by a State, in approving or disapproving premium rates and increases

4. Adjustments in premiums would be required, if a change in law is enacted that provides long-term care benefits to policy-holders

    a. The policy would provide a rebate that is actuarially equivalent to the benefits which would be provided under the new law

H. Requirements relating to sales practices would be established

1. Any insurer offering a long-term care policy would meet such requirements pertaining to content, format and use of application forms

2. Any insurer that sells or offers a policy could not offer such a policy through an agent who does not comply with the minimum standards with respect to training and certification established by the Secretary

3. The following sales practices would be prohibited:

    a. false and misleading representation

    b. inaccurate completion of medical history by insurer

    c. undue pressure

    d. cold lead advertising

4. The sale of duplicate benefits would be prohibited

a. An insurer or agent would be prohibited from selling a policy that the insurer or agent know duplicates coverage already provided to an individual under another long-term care insurance policy, unless the policy is intended to replace the other policy

I. Continuation, renewal, replacement, conversion and cancellation rules would be defined

1. In general, insurers would not be permitted to cancel, or refuse to renew any long-term care insurance policy for any reason other than for fraud, material misrepresentation, or for non-payment of premium, effective 6 months after date of enactment

2. Each policy would contain a provision that states the duration of the policy, the right of the insured individual to renewal, the date by which the option to renew must be exercised, and applicable restrictions, effective 6 months after date of enactment

3. Continuation and conversion rights would be established with respect to group policies

   a. Individuals would be permitted to continue or convert policies

   b. A group policy would meet the conversion requirements if it entitles individuals covered under the group policy to be issued a replacement policy providing benefits substantially equivalent to the benefits, or greater than the benefits, without requiring evidence of insurability, and at premium rates no higher than would apply if the individual had obtained it under a replacement policy

4. Each individual liable for the premium would have the unconditional right to return the policy within 30 days after the date of its issuance, and would be able to obtain a full refund of any premium paid, effective six months after date of enactment

5. Any insurer would have the right to cancel a policy, or to refuse to pay a claim, based on evidence that the insured made false representations or knowingly failed to disclose information on the application

6. Insurers have the right to cancel policies for non-payment of premiums, subject to non-forfeiture requirements

7. The insurers would be required to reinstate full coverage of an individual canceled due to non-payment of premiums, retroactive to the effective date of cancellation, if the insurer receives evidence, from a representative of the individual, that the individual was incapacitated, and receives payment of all premiums due and past due, and charges for late payment, effective 6 months after date of enactment

    a. At the time of sale, the issuer would require the insured individuals to designate a representative to communicate with the insurer, in the event the individual cannot be located or is incapacitated

J. Requirements relating to payments of benefits would be established

1. The Secretary would promulgate regulations establishing requirements with respect to claims for and payment of benefits under a policy

2. Each policy would specify the threshold for "triggering" eligibility for benefits, including levels of functional or cognitive status

3. The policy would provide for a procedure to determine whether threshold conditions have been met, which is based upon uniform assessment standards, procedures and formats

4. The policy would allow for an independent assessment selected by the insured individuals, as to whether the threshold conditions have been met

    a. The insurer would have the option for a re-evaluation by an independent assessor

b. In the event of a disagreement or inconsistencies, final resolution would be provided by a State agency or other impartial third party

5. Insurers would be required to provide an explanation in writing of the reasons for payment, partial payment or denial of such claims

7. Insurers would be required to provide an administrative procedure under which an individual may appeal any denial of a claim

III. Relation to State Law

A. States would be permitted to impose standards that are more protective of individuals, except that State standards may not be inconsistent with the specified Federal standards

TITLE XII. REVENUE PROVISIONS

I. Revenue Provisions

A. Increase in tax on tobacco products

1. The tax on cigarettes would be increased by $0.75 per pack

2. Increases also would be established for other products

B. Limitations on exclusion of health benefits through cafeteria plans

1. Contributions to cafeteria plans (or flexible spending arrangements) for health benefits would no longer be excludable from income

C. A payroll tax of 0.8 percent would be imposed on employers

D. Qualified long-term care services would be treated as medical care and subject to the 7.5 percent cap

E. Accelerated death benefits under life insurance

1. Benefits paid under a life insurance program under a policy of an individual who is terminally ill would be treated as an amount paid by reason of dealth.

F. Tax credit for disabled

1. Impaired with earned income would be allowed to take a non-refundable tax credit equal to 50 percent of expenses for certain personal assistance services

G. Long-term care insurance

1. Treatment of build-up for long-term care insurance would be made comparable to treatment under life insurance policies

H. Tax credits for health service shortage areas

1. Physicians who work in areas that are designated as being short of health professionals would be eligible for a non-refundable tax credit of up to $1,000 per month for up to 60 months

   a. Physicians must work at least 5 years in an area to receive the full credit; physicians who work in the area for more than 2 years but less than 5 would receive a partial credit

2. Certain other health professionals who work in areas that are designated as being short of health professionals would be eligible for a non-refundable tax credit of up to $500 per month for up to 60 months, subject to the same requirements as physicians

3. Physicians who work in areas that are designated as being short of health professionals would be eligible for additional expensing limits relating to expenses for medical equipment

I. Tax treatment of certain health care organizations

1. The tax treatment of Blue Cross and Blue Shield plans would be modified to equalize the treatment of these plans and other insurers

2. New standards would be established for determining whether health care providers would qualify as tax-exempt

II. Health Insurance Deduction for the Self-employed

A. Self-employed individuals would be permitted to deduct 100 percent of health insurance expenses