SUMMARY OF

THE HEALTH CARE COST CONTAINMENT AND REFORM ACT OF 1993

H.R. 200

January 5, 1993

TITLE I: COST CONTAINMENT

Subtitle A.--National Health Budget

1. National Health Expenditure Budget

A national health expenditure budget would be set by statute for total national spending for health services in each year, beginning with 1995.

In general, the national health expenditures budget for each year would be based on the national health expenditure budget for the preceding year, increased by the sum of the five-year moving average of the annual rate of growth in the gross domestic product (GDP) plus an adjustment factor.

The national health expenditures budget would reduce the rate by which health spending growth exceeded the rate of growth in nominal GDP by one percentage point each year. Health spending growth would phase down to the rate of growth in GDP by 1999.

To achieve this result, health spending would equal the rate of growth in the GDP plus 3.7 percent in 1995, GDP plus 2.7 percent in 1996, GDP plus 1.7 percent in 1997, GDP plus 0.7 percent in 1998, and GDP plus 0 percent thereafter.

Under these growth limits, health care expenditures are estimated to stabilize at slightly more than 15% of the GDP in 1999.

Expenditures covered by the national health expenditures budget would include payments for health services from all payers, including direct patient out-of-pocket payments.

Other expenditures excluded from the budget would include: non-operating revenues for personal comfort items, research funds, facility and services of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service.

The national health expenditure budget would be divided into two sectors: a Medicare sector and a non-Medicare sector. Each sector would be subject to the same annual limits on growth.

2. Classes of Services within the Budget

The Medicare and non-Medicare national budget secotrs would each be divided into separate "classes" of services. The classes would initially be specified as: inpatient hospital services, outpatient hospital services, diagnostic services, physician services, home health services, rehabilitation services including physical and occupational therapy, durable medical equipment, prescription drugs, nursing facility services, and mental health services.

The Secretary would publish a proposed specification of the classes by April 1, 1994, and final specifications by July 1, 1994. Once established, the classes could be changed only by statute. The Secretary would periodically submit a report to Congress recommending changes in the classes.

ProPAC and PhysPRC would submit recommendations to Congress on the specifications of the classes, and on the Secretary's proposed classes.

3. Allocation of the Health Budgets by Class of Service

In general, the Medicare and non-Medicare national health expenditure budgets would annually be allocated to each class of health services in order to provide for the establishment of maximum payment rates for each type of service.

The initial allocation of the budgets to the classes would be based on the historic allocation of health care spending to each class, within each budget sector. The Secretary would establish and publish the initial allocations, but, except as specifically provided in this bill, could not subsequently change the allocations.

In order to determine the allocation by class of service, the Secretary, after determining the amount attributable to each class in each sector in the base year of 1993, would trend spending for each class to 1994, based upon the historic rate of growth within each class.

The resulting amount for each class would be compared to the sum of the estimated amounts for all classes within each sector, and the percentage of the sum attributable to each class would be determined. That percentage would then be applied to the Medicare and non-Medicare national health expenditure budgets respectively to determine the 1995 budget for each class.

In subsequent years, the allocation to each class and sector would be equal to the amount allocated during the preceding year, increased by the historic rate of growth for the class within each sector, expressed as a percentage of the sum of the resulting amounts for all classes. The percentages so determined would then be applied to the Medicare and non-Medicare national health expenditure budgets respectively for the year to determine the budget for each class for the year.

The trend factors used to allocate the national health expenditure budget would be estimated based on the historic rates of growth for each class over the five-year period ending with 1993.

ProPAC and PhysPRC annually would review and submit recommendations to the Congress on the allocation of health expenditures to the different classes of health services.

In determining the allocations of the Medicare and non-Medicare national health expenditure budgets and the trends in spending by class of service, the Secretary would compute and apply the budget allocations and historic growth trends separately to expenditures for services covered by Medicare and to all other expenditures.

4. Adjustments for Changes in Medicare Benefits

With respect to the changes in benefits under the Medicare program provided in Title IV of this bill, the Secretary would be permitted to change the Medicare and non-Medicare health expenditure budgets, allocations and trend factors to reflect the shift of the benefits from the non-Medicare to Medicare sectors of the national health expenditure budget.

5. National Health Expenditures Reporting System

The Secretary would establish a national health expenditure reporting system for the purposes of: establishing the national health expenditure budgets; allocating budgets among classes of services; determining maximum payment rates; and monitoring State provider payment control systems. Providers of health services, including health maintenance organizations would be required to report such information as the Secretary specifies in regulation. To the extent possible, the reporting system would use existing data systems.

Subtitle B.--State Provider Payment Control Systems

1. Establishment of State Programs

States could establish payment programs for hospital and/or for physician services or for all services. The maximum rates of payment established by the Secretary would not apply to providers in States with approved programs.

The State would be required to provide assurances to the Secretary that the expenditures for services covered under the State program would not exceed expenditures if the maximum payment rates applied in the State. The Secretary would be required to reply to an application of a State to operate a program within ninety days of receipt, or the program would be deemed to be approved. States currently operating a statewide hospital payment program under Medicare would be deemed to be approved under this provision for purposes of operating a hospital payment program.

2. Standards for State Programs

The State program would be required to cover all payers and provide for equitable treatment of payers, although payment differentials between Medicare, Medicaid, and private payers would be authorized. States could provide for negotiated rates for HMOs, but could specify minimum payment rates for all payers. The State program would be required to be operated directly by the State or by a public authority. The State would be required to assure that operation of the program would not impair access for those patients unable to pay, or pay the full amount, for services or for those patients expected to require unusually costly treatment.

3. Termination of State Programs

The Secretary could terminate a State program if, during a rolling three-year period, aggregate expenditures, or Medicare expenditures, for the types of services covered under the program exceeded the expenditures which would have occurred if the State program were not in effect. If the State program provided for negotiated rates for HMOs, expenditures associated with HMOs would not be taken into account.

To recoup any excess spending in the State, the Secretary could provide for continuation of the State program with a lower limit, or for a reduction in the Federal maximum payment rates in subsequent years.

4. Use of Medicare Savings

If the Secretary determined that a State program produced savings to the Medicare program over a period of three consecutive years, the Secretary would pay the savings attributable to the first year of that period to the State in the following year.

Subtitle C.--Maximum Payment Rates for Services Not Subject to State Provider Payment Control Systems or Provided by Staff or Group Model Health Maintenance Organizations

Part 1-Establishment and Application of Maximum Payment Rates

1. Exemption for Services Subject to Approved State Provider Payment Control Systems or Provided by Staff or Group Model Health Maintenance OrganizationsT

Services provided in States with approved State provider payment control systems would not be subject to either the maximum payment rates established under this Subtitle, or to the reductions in Medicare as provided under this Subtitle.

Services provided by group or staff model HMOs would also be exempt from the maximum payment rate system.

2. Process

The Secretary would set maximum payment rates for each type of health service for non-Medicare services at levels estimated not to exceed the share of the non-Medicare national health expenditure budget for the relevant class. Rates would generally be set using Medicare methods.

The maximum payment rates determined by the Secretary would not apply to providers in states with an approved State provider payment control system or to providers associated with staff and group model health maintenance organizations. The budget allocation for each class used in determining the maximum payment rates would be adjusted to reflect services provided within each class that are exempt from the system of maximum payment rates.

The maximum payment rates determined by the Secretary would be the maximum which providers could charge for services payable by insurers, other than Medicare, or by individuals. Providers could agree to accept less than the maximum payment rates, such as in the case of Preferred Provider Organizations (PPOs), but could not increase charges to make up any shortfall resulting from agreeing to accept amounts less than the maximum payment rates.

Civil money penalties equal to three times the excess amount charged would be imposed on providers who charged in excess of the maximum payment amounts.

Part 2-Methodologies for Determining Maximum Rates

1. Hospital Services

(a) General Rule for Hospital Payment. -- The maximum payment rates for inpatient hospital services would be determined based upon an average payment per admission adjusted for case mix using diagnosis-related groups (DRGs).

The Secretary would determine a standardized amount for non-Medicare patients which would be based upon current average payments made by private payers. This would produce an average payment set at approximately 125% of costs.

Rates would be set separately for hospitals in large urban areas and for all other hospitals. New DRGs would be developed as necessary for the under-65 population, and new weights would be developed for all DRGs to reflect different resource consumption patterns among this population.

In determining the standardized amount, the Secretary would include revenues associated with services provided on an outpatient basis during the three days immediately prior to a hospital admission if the services are related to the admission.

A standard hospital benefit package would be defined to facilitate DRG reimbursement. The Secretary would develop a table of adjustment factors to reflect the actuarial differences between the standard benefit package and other benefit packages.

(b) Adjustments to Hospital Payments. -- A series of adjustments would be made to the standardized amounts. Payment rates would be adjusted: (i) by geographic area for wages and for non-labor input prices; (ii) for the higher costs of teaching hospitals; (iii) for the costs of capital; and, (iv) for certain high-cost or long length-of-stay cases known as outliers.

Payment rates would be adjusted on a hospital-specific basis for the level of uncompensated care, and for the Medicaid payment level in a State.

Payments would also be adjusted for direct medical education costs based on the number of FTE residents. The adjustment would be based on a modification of the current Medicare methodology that would encourage training of primary care physicians.

Specifically, in determining the number of FTE residents under Medicare and for the purposes of determining the maximum payment rates, primary care residents in family practice, general internal medicine and general pediatrics would be counted as 1.1 FTE resident. Other non-primary care residents in internal medicine and pediatrics would be counted as 1.0 FTE. Other non-primary care residents would be counted as 0.9 FTE during their first 3 years of residency. Other non-primary care residents beyond the initial three years of training in any specialty would be counted as 0.8 FTE.

Positions in general internal medicine would be designated by the Secretary as meeting criteria set by regulations following application by a hospital.

(c) Exempt Hospital Payments. -- Hospitals currently exempt from the prospective payment system under Medicare would not be paid using the DRG-based payment method. These hospitals would be paid using a rate-of-increase limit until prospective methods were developed. In developing a prospective payment system for children's hospitals, the Secretary would be required to meet certain requirements.

2. Physician and Other Professional Medical Services

In general, the maximum payment rates would be determined using a resource-based relative value scale (RB RVS) for physician and other professional medical services following the methodology established under Medicare.

The Secretary would establish and publish new relative value units for services not currently covered under Medicare.

The maximum payment rates for services would be determined by establishing a maximum conversion factor which, when multiplied by the relative value units of services estimated to be provided, would result in expenditures equal to the proportion of the budget allocated to this class during the year.

The maximum payment rates would include allowed extra-billing, determined based on the limits applicable under Medicare. In addition, the maximum rates would be adjusted geographically in the same manner as physician services under Medicare.

3. Other Services

Maximum payment rates for other ambulatory services would be determined using the methodologies established for such services under Medicare.

(a) Outpatient Hospital and Other Services Reimbursed on a Cost-related Basis under Medicare.--Outpatient hospital fees and fees for other cost-related services under Medicare would be set by limits on a year to year basis, pending development of prospective payment systems.

(b) Clinical laboratories fees.--Maximum payment rates would be set using the Medicare laboratory fee schedule. All services covered by a third party payer would be directly billed to the insurer.

(c) Durable Medical Equipment.--Maximum rates for durable medical equipment would be set based on Medicare policies and rates.

(d) Prescription Drugs.--The methodology for establishing the maximum payment rates for prescription drugs would follow the methodology for limiting Medicare payment for prescription drugs (as provided in this bill.)

(e) Dialysis Services.--The methodology for establishing the maximum payment rates for renal dialysis and related services would follow the Medicare methodologies for payments for such services.

(f) Other Services.--The maximum payment rates for other services paid on a reasonable charge basis under Medicare would be based on the methodologies used in establishing such limits. Such limits could be based on prevailing charge limits or fee schedules, as provided under Medicare.

(f) Development of Prospective Payment Methodologies. --The Secretary would, within 3 years of enactment, develop prospective payment methodologies for setting maximum payment rates for services for which an appropriate methodology does not exist currently under Medicare.

4. Conforming Medicare Payment Rates to Medicare Health Expenditure Allocations

Rates under the Medicare program would be determined based upon existing provisions of Medicare law and would be reduced as needed to assure that Medicare payments to providers conform to the Medicare national health expenditure budget.

TITLE II. MANAGED CARE AND MANAGED COMPETITION

Subtitle A.--Managed Care

1. Authorization for Health Care Plans to Pay Less Than Maximum Payment Rates

All health care plans would be free to negotiate rates below those set under the maximum payment rates

2. Staff and Group Model HMOs Exempted from Maximum Payment Rates

Qualified staff and group model HMOs would not be required to pay for services using the maximum payment rates. The overall budget and other payment policies would take expenditures by qualified HMOs into account but rates would not apply to these plans.

Qualified staff and group model HMOs would be those plans with a contract with Medicare under section 1876 of the Social Security Act or a qualified HMO under Title XIII of the Public Health Service Act for which ninety percent of the services are provided through members of the staff of the organization or through a medical group or groups.

3. Assistance for Establishment and Initial Operation of Staff and Group Model HMOs

$25 million in grants would be made available as grants to support the development and initial operation of staff and group model HMOs. Grants could be used for market surveys, initial enrollment activities, working capital, physician recruitment, and acquisition of buildings and equipment

4. Incentives for Expansion of Qualified HMOs

Mandatory "dual choice" requirements would be retained and expanded to "multiple choice." If requested by an HMO serving an area, an employer would be required to make the HMO available to employees as an option under the employer's health benefits, if any. Marketing materials for qualified HMOs would be provided to every employee of every company in the service area.

5 Preemption of State laws

State laws that mandate that any "willing provider" be allowed to participate in qualified HMOs would be pre-empted. This would allow network and other plans to enroll only those providers willing to manage health resources according to the plan of the HMO.

6. Increase in Payments to Medicare HMOs

Medicare payments to risk contract HMOs would be adjusted for the lack of enrollment in HMOs of beneficiaries where Medicare is the secondary payer.

7. GAO Study on HMO expansion

GAO would study and recommend additional measures to encourage the development and expansion of qualified HMOs.

Subtitle B.--Managed Competition

1. Establishment of Health Plan Purchasing Cooperatives

Health Plan Purchasing Cooperatives (HPPCs) would be established in each State for each HPPC area. Grants would be available to States to assist in the planning, development, and initial operation of HPPCs. The grant period could not exceed five years and total amount of assistance could not exceed $5 million. $150 million would be authorized for the five-year period beginning with 1994.

Each HPPC would be established pursuant to a specific State law authorizing its organization and operation. Each HPPC would be a not-for-profit public benefit corporation with its board appointed by the Governor of the State, pursuant to the State's Administrative Procedure Act.

States could provide for division of the State into more than one HPPC area so long as all portions of each Metropolitan Statistical Area (MSA) in a State were within the same HPPC area, and every portion of the State was within a HPPC area. One or more contiguous States could provide for the establishment of an interstate HPPC area, provided that the interstate HPPC included all portions of an MSA. If a State did not establish a HPPC for an area, the Secretary could establish a HPPC in that area.

2. Responsibilities of Health Plan Purchasing Cooperatives

HPPCs would have the following responsibilities: (i) to enter into agreements with qualified Health Maintenance Organizations (HMOs) and other qualified health plans that provide services in the HPPC area; (ii) to enter into agreements with employers in the HPPC area to provide comparable health insurance benefits to employees of participating employers; (iii) to enroll employees of participating employers with qualified health plans; (iv) to provide information to each employee of participating employers regarding health benefits available from each qualified health plan; (v) to enroll individuals purchasing health coverage directly on behalf of themselves or their immediate family; (vi) to receive and forward premiums; and (vii) to provide for coordination with other HPPCs. Participation in a HPPC by employers and employees would be voluntary.

Within one year after its establishment, a HPPC would be required to inventory and to inform all small employers in the HPPC area, including employers in rural areas, of the health benefits available through the HPPC. Small employers would be those with 100 employees or less. The HPPC could provide benefits to other employers and directly to individuals, at the option of the HPPC.

3. Operation of HPPCs

Health plans provided through HPPCs would generally be qualified HMOs providing services in the HPPC area. The Secretary could qualify other types of plans of they met additional standards relating to physician incentives payments, living wills, and beneficiary grievance procedures. Each such qualified health plan would meet the insurance standards established under this bill.

Each health plan would provide for an open enrollment process for employees of participating employers and other for individuals. HPPCs could impose a minimum participation requirement regarding the percentage of employees who receive health benefits on participating employers.

4. HPPC Core Benefit Packages

Each health plan would be required to provide a core benefit package that meets defined national standards. In addition a health plan could make available incremental benefit packages, but would be required to price such benefit packages separately from the core benefit package.

The core group of benefits would generally follow Medicare benefits. Benefits would include unlimited inpatient hospital coverage without spell-of-illness restrictions, outpatient hospital services, physician services, clinical laboratory and radiology, and other services with a single deductible of $300 per individual/$600 per family and an out-of-pocket limit of $2,500 per individual and $3,000 per family; and maternity, well-child and prevention benefits without cost-sharing.

The core benefit packages would not be required to include benefits or services mandated by States in addition to the benefits included in the core benefit package.

In the case of HMOs, nominal copayments and deductibles for benefits would be consistent with those specified pursuant to Title XIII of the Public Health Service Act.

5. HPPC Agreements with Employers

HPPCs would enter into agreements with participating employers to provide health insurance benefits to employees. Agreements would provide for payment by employers of the HPPC premiums for the core benefit package plus any additional incremental benefits for which the employer has chosen to be responsible. Participation in a HPPC by employers would be voluntary.

The employer would provide the HPPC with the names, names of dependents, addresses, and other identifying information required by the HPPC, for each employee, including part-time and seasonal employees.

6. Premiums for HPPC Health Plans

HPPCs would receive payments from employers and individuals participating in the HPPC. The payments would, in the case of employers, be the community-rated group premium, or in the case of individuals, be the community-rated individual premium, of each HMO or other qualified health plan in the HPPC area. An additional amount would be added in each case to the annual premium as a standard percentage overhead charge to provide revenues equal to the annual budget for the HPPC. The overhead percentage could not exceed five percentage points.

Each HPPC would make available to employers participating in the HPPC, and each such employer would make available to employees, information in comparative form on the benefits provided by HMOs and on outcomes and enrollee satisfaction for each plan based on information contained in the annual outcomes and enrollee satisfaction report described below.

Each HPPC would coordinate its activities with other HPPCs. Each HPPC would provide information about HMOs providing services in its area to other HPPCs which request the information. HPPCs would provide health benefits to employees who reside in the HPPC area but whose employer's place of business is outside of the area. Such services would be provided in coordination with the HPPC for the area in which the principal place of business of the employer is located

Subtitle C.--National Patient Outcomes and Enrollee Satisfaction Reporting Program

1. National patient outcomes program

The Secretary would establish a national patient outcomes data base. In order to collect uniform information on outcomes, the Secretary would define tbe data to be collected and establish reporting requirements for the routine collection of such data. All HMOs, other health benefit plans and providers would begin reporting such data by January 1, 1996.

The Secretary would publish and distribute an annual report on patient outcomes, including data on individual providers.

2 Enrollee satisfaction with health plans

The Secretary would establish a national data base on enrollee satisfaction with health benefit plans, including self-insured plans.

The Secretary would develop and publish a standard enrollee satisfaction survey instrument to be used by health plans. By January 1, 1996, all health plans would report data on enrollee satisfaction to the Secretary on an annual basis.

The Secretary would publish and distribute an annual report on enrollee satisfaction with health plans.

3. Research and demonstrations

The Secretary would provide for research and demonstration projects concerning new methods for collecting and analyzing outcome and enrollee satisfaction data, and the use of outcomes information systems by health maintenance organizations, health benefit plans, and providers of health care services. The Secretary may also provide for research and demonstration projects concerning the collection and analysis of indicators of system performannce, including health status of communities served, prevention of illness, and capacity of delivery systems with respect to integrated health care delivery systems. The bill provides for an authorization of $20 million annually for fiscal years 1994 through 1998.

Subtitle D.--Study of Universal Health Insurance Coverage

1. Study

A study of the costs and benefits of universal health insurance coverage and cost containment would (i) analyze options for establishing universal coverage and (ii) assess the effectiveness of alternative strategies for controlling costs under such plans. The study would be conducted by the Congressional Budget Office with assistance from the staff of the Joint Committee on Taxation. The CBO would submit a report by January 1, 1994 to the Committees on Ways and Means and on Energy and Commerce of the House and the Committee on Finance of the Senate.

TITLE III. HEALTH SYSTEM REFORMS

Subtitle A.--Health Insurance Reform

1. Anti-discrimination and Anti-Job Lock Requirements

(a) Anti-discrimination Requirements.--Health insurance for all employer groups, including self-insured groups, could not deny coverage to any eligible group or individual member of an eligible group based on health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability or medical condition. The same requirement would apply to insurance offered to individuals.

For insurance offered through Taft-Hartley Trusts, the plan could restrict membership to those eligible under the terms of the Trust, but could not deny coverage to any person otherwise eligible.

Health insurance premiums paid by members of employer groups could not be adjusted for an individual's medical status.

(b) Anti-job-lock and Pre-existing Conditions.--Any worker changing jobs with less than a three-month break in insurance coverage, including coverage under COBRA, could not have a new exclusion period applied. Pre-existing condition exclusions would otherwise be limited to six months. Pre-existing conditions limits could not be applied to new-borns.

2. Requirements for Insured Health Plans

(a) Open-enrollment.--Health insurers, other than self-insured groups and Taft-Hartley Trusts, would be required to provide year-round open enrollment for groups and individuals.

Insurers offering coverage through an association or multiple employer arrangement could restrict membership in that plan to the members of the association or arrangement. To qualify for this restriction, the association or arrangement would have to be formed for a purpose other than the purchase of health insurance.

Health Maintenance Organizations would be required to offer open enrollment, but only up to the capacity of the plan to absorb new members.

(b) Guaranteed Renewability of Coverage.--Insurers would be required to guarantee renewability of coverage, and could only refuse to renew coverage due to nonpayment of premiums and to fraud. Plans would be required to provide notice of the terms of renewal at least thirty days prior to the expiration of the plan, and could not charge higher renewal rates. Plans would be required to provide coverage for twelve-month periods.

(c) Community Rating.--Health insurers would be required to set family and individual premiums for coverage purchased by employer groups based upon community rates. Insurers would also be required to set premiums for insurance purchased directly by individuals on a community basis, but individual rates could be set differently from group rates. The limits on community rating would be phased in over three years in equal increments. For purposes of this provision, a community could be no smaller than a Metropolitan Statistical Area (MSA).

(d) Payment of Commissions.--A plan could not pay premiums to agents based upon the claims experience of a group.

3. Limits on Self-insurance.

(a) Limits on Small Employer Self-insurance. -- The bill would provide that employers with 100 full-time employees or less would be prohibited from self-insuring.

(b) Limits on MEWAs. -- Multiple Employer Welfare Arrangements (MEWAs) and similar multiple employer plans would be prohibited from self-insuring. Such groups could provide health insurance, but only to the extent that the plans met all applicable standards as health insurers in each State.

4. Continuation Coverage Offered by Universities.

The bill would pre-empt State laws that prohibit universities from offering graduating students health insurance.

5. Enforcement

(a) Federal standards. -- The standards would be established in regulations by the Secretary of Health and Human Services (HHS), and enforced by HHS with sanctions applied by the Department of the Treasury, based upon determinations of the Secretary of HHS.

(b) State certification. -- The Secretary of HHS could delegate authority to State governments meeting Federal standards to certify and supervise these requirements, although sanction authority would remain with the Federal government.

(c) Sanctions. -- The sanctions would be Federal excise taxes which would be imposed on insurers and employers (in the case of self-insured plans) which violate the standards. The excise tax would not be otherwise tax deductible.

Subtitle B.--Administrative Simplification

1. Universal Health Insurance Cards

Each beneficiary of a health insurance plan, including public plans, would be issued a universal health insurance card by plans participating in the health insurance claims network. Cards would be similar to ATM cards, and would be readable by electronic card readers.

Each card would include a universal health insurance identification number, which would be the social security number of the beneficiary.

2. Verification of Eligibility and Benefits

Each health benefit plan would be required to provide for an electronic system through which providers could inquire regarding the benefits under the plan to which an individual was entitled, the individual's status with respect to cost sharing. and any restrictions on services covered such as a limited list of eligible proviers and utilization control requirements such as pre-admission certification. Each health plan's electronic verification system would be required to accept inquiries from providers through electronic transmission of information from uniform health claims cards, through computer modems, or through touch-tone telephones. No fees could be imposed on providers unless the inquiry from the provider was not in an electronic form.

3. Uniform Electronic Claims for Health Services

(a) Uniform electronic format. -- All claims submitted by providers would be transmitted using a uniform electronic format to be developed by the Secretary. The format would be required to be consistent with the standards for electronic claims developed by the American National Standards Institute, and would be developed in consultation with various groups which are currently working to develop standards for uniform claims. The standards for clinical laboratory claims would provide that claims must be submitted directly by the entity which performs the tests.

(b) Uniform coding of procedures and diagnoses. -- Coding of procedures and diagnoses would follow uniform formats.

(c) Unique Provider Identifier. -- Each provider would be required to submit claims using a unique provider identification number similar to the UPIN used for Medicare;

4. Electronic Medical Records and Reporting

The Secretary would establish standards for an electronic patient care information system with data obtained at the point of care to replace paper medical records. The Secretary would define a uniform hospital clinical data set based on the patient information system for use by utilization and quality control organizations as well as standards for electronic transmission of the data set. The system would include standards for the protection of confidentiality of data.

As of January 1, 1996 hospitals would be required to maintain the uniform hospital clinical data set in an electronic form and, upon request of a Peer Review Organization (PRO), to transmit electronically data from the data set. On or after that date no health benefit plan, including Medicare and Medicaid, could require, for utilization review or as a condition of payment, that a hospital provide any data not in the hospital clinical data set or transmit the data in a manner which is not consistent with the standards established for electronic transmission of the data set.

5. Public Domain Software

The Secretary would develop public domain software which could be used by hospitals, physicians, other providers, and health plans to submit claims to health plans and to verify elgibility and benefits or to respond to inquiries.

6. Pre-emption of State Quill Pen Laws

State laws requiring medical information or claims to be maintained in written form would be preempted.

7. Enforcement

All health benefit plans, including employer-sponsored plans would be required to issue universal health insurance cards. Providers would be required to use, and health plans to accept, the uniform claim. Civil money penalties would apply to plans and to providers, if they did not comply. The penalties would sunset three years after the requirements applied to plans and to providers.

10. Effective Dates

The Secretary would be required to develop standards for uniform cards and uniform electronic claims within twelve months of enactment and payers and providers would be required to use them within six months after the standards were released. Clearinghouse agreements would be required to be developed within 12 months of enactment.

11. Uniform Hospital Reporting

Beginning during FY 1993, all Medicare-participating hospitals would be required to submit cost-reporting data based on uniform hospital reports required to be developed under OBRA '87.

Subtitle C.--Fraud and Abuse

Part 1--National Health Care Fraud and Abuse Program

1. All-payer Fraud and Abuse Control Program

(a) Establishment and Coordination of Program.--The bill would require the Secretary of Health and Human Services to establish and coordinate an all-payer national health care fraud control program to restrict fraud and abuse in private and public health care programs. The Secretary would be authorized to conduct investigations, audits, evaluations and inspections relating to the delivery of and payment for health care. The administration of the national program would include the coordination of the Medicare and Medicaid fraud and abuse programs.

The fraud and abuse staff within the Office of the Inspector General of the Department of HHS would be increased to administer the national health care fraud control program. The bill provides authorizations of $300 million in 1995, $350 million in FY 1996, $400 million in FY 1997, and $450 million in FY 1998.

(b) Reporting of information.--The bill would require all qualified health insurance plans, providers and others to cooperate with the national fraud control program and to provide such information necessary for the investigation of fraud and abuse. The Secretary would establish procedures to assure the confidentiality of the information required by the national fraud and abuse program and the privacy of individuals receiving health care services.

In applying for unique provider numbers for use in the electronic claims network, providers would be required to disclose information that the Secretary deems appropriate including information relating to the ownership of a health care entity. The Secretary would, to the extent possible, coordinate the information to be collected with the requirements for the collection of similar data and information under the Medicare and Medicaid programs.

The national fraud and abuse program would provide information on criminal violations and civil money penalties to State entities responsible for licensing and certification of health care providers.

The Inspector General of the Department of Health and Human Services is authorized access to documentation in accordance with the Inspector General Act of 1978. Any individual or entity who fails to comply with a request of the Office of the Inspector General of the Department of HHS 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.

(c) Civil Money Penalties.--The bill would establish civil money penalties on providers for specified fraud and abuse violations. The penalties would apply to services covered by all payers. The violations would include billing for services not provided, submitting fraudulent claims for payment, hospitals giving financial incentives to physicians to reduce or limit care provided to hospital inpatients, and other violations currently included under the Medicare program. In addition, the bill would prohibit, and establish civil money penalties for the payment of incentives to encourage employees to induce individuals to receive covered services under Medicare, Medicaid, or private health plan.

Providers would be given the same notices, and have the same rights for consideration and appeals of the civil money penalties as currently are available under the Medicare program.

The bill provides that civil money penalties would be deposited in a trust fund. The assets of the fund would be used, in addition to such appropriated amounts, to meet the operating costs of the national health care fraud control program.

(d) Criminal penalties.--The bill would establish criminal penalties relating to services covered by all payers. For providers who violate specified fraud and abuse provisions penalties would include fines, triple damages, and imprisonment. 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. The violations would include willful submission of false information or claims and acceptance of kickbacks, bribes or rebates in return for referral for services and other violations currently included under the Medicare program.

The fines and damages assessed would be deposited in a trust fund and used in the same manner as the civil money penalties.

(e) Medicare Fraud and Abuse Amendments.--

(1) HMO Intermediate Sanctions.--The bill provides that the Secretary may impose intermediate sanctions on Medicare-qualified HMOs for violations of Medicare contracting requirements.

(2) Inducements to Individuals to Receive Covered Services.--Providing items or services at less than the fair market value would be prohibited and subject to civil money penalties.

Part 2--Ban on Improper Physician Referrals

1. Application of Ban on Self-Referral to All Payers

The bill provides that any physician, whether participating in a public or private health care program, including Medicare, Medicaid, Blue Cross/Blue Shield, any commercial carrier, or any Health Maintenance Organization (HMO), would not be able to refer patients to any entity for the furnishing of "Designated Health Services" with which the physician has a financial relationship.

2. Extension of Ban to Designated Health Services

The bill provides that "Designated Health Services" include the following: Clinical laboratory services , physical therapy services, occupational therapy services, radiology services (including magnetic resonanace imaging, computerized axial tomography, and ultrasound services), furnishing of durable medical equipment, furnishing of parenteral and enteral nutrition equipment and supplies, furnishing of outpatient prescription drugs, ambulance, home infusion therapy, and inpatient and outpatient hospital services (including rehabilitation and psychiatric hospital services.)

3. Continuation of Current Exceptions to the General Rule

The exceptions in current law to the general ban on referrals would be continued with additional changes noted below. General exceptions to both the ownership and compensation bans include; (i) physicians' services provided by (or under the personal supervision of) the physician or another physician in the same group practice; or (ii) in-office ancillary services provided by the physician or another physician in the same group practice. To be exempted from the referral ban the services must be provided in a building in which the physician or other member of the group practice provides services unrelated to laboratory services, or in a central building set up by the group to perform ancillary services for its members. The services must be billed by the physician performing or supervising the services, or by that physician's group, or by an entity entirely owned by the physician or group practice.

Also excepted from the ban on ownership and compensation are: (i) services provided by a prepaid health plan to its enrollees; or (ii) other financial relationships, specified by the Secretary in regulations, that do not pose a risk of program or patient abuse.

Exceptions to the ownership or investment prohibition include: (i) ownership of publicly-traded investment securities purchased in a corporation listed on a major stock exchange, if that corporation has total assets exceeding $100 million; (ii) services provided by a hospital in Puerto Rico; (iii) services provided by a rural entity; and (iv) services provided by a hospital where the referring physician is a member of the hospital's staff and the ownership or investment interest is in the hospital as a whole as opposed to a subdivision of the hospital.

Exceptions relating to compensation arrangements include: (i) payments for rental of office space meeting specified standards; (ii) employment and services arrangements with hospitals if the arrangement is for administrative services; (iii) services arrangements with entities other than hospitals if the arrangement is for specific identifiable services as a medical director or member of a medical advisory board, specific identifiable physicians' services for certain hospice services, specific physicians' services furnished to a non-profit blood center, or other identifiable administrative services under exceptional circumstances specified by the Secretary; (iv) physician recruitment arrangements meeting specified standards; (v) isolated transactions such as a one-time sale of property; and (vi) salaried physicians of a group practice.

4. Modifications of Current Law Exceptions

A series of modifications would be made to the exceptions to the general ban on referrals in current law:

Treatment of group practices: Ancillary services provided by a group practice with multiple locations would be exempted from the prohibition on referrals. In addition to the current law standards relating to group practices, groups would be required to bill under a billing numer assigned to the group. The definition of a faculty practice plan would be expanded to include faculty of an institution or higher learning or a medical school.

Rental of office space and equipment: The current law exceptions relating to compensation arrangements would be clarified and expanded. An exception would be provided for rental of office space or of equipment if: (i) the lease arrangement were set out in writing and signed by the parties; (ii) the lease specifies the premises or equipment covered; (iii) if the lease is intended to provide the lessee with access to the premises or equipment for periodic intervals of time, the lease specifies exactly the schedule of such intervals, their precise length, and the exact rent for such intervals; and (iv) the aggregate rental charge is set in advance, is consistent with fair market value in arms-length transactions, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.

Bona fide employment relationships: The exception for employment and service arrangements with hospitals would be broadened to include any amounts paid by any employer (including providers other than hospitals) to an employee with a bona fide employment relationship for the provision of services. The standards for the exception relating to service arrangements between physicians and hospitals under current law also would apply to this broader provision.

Periodic, sporadic, or part-time services: An exception would be provided for payments by a provider to a physician not employed by the provider for certain other items or services provided on a periodic, sporadic, or part-time basis.

Items and services included under this provision are: (i) consultative services that relate to test results that are outside established parameters, are furnished by a physician other than the referring physician (or by a member of the referring physician's group practice), and for which the physician furnishes a written report for that patient; (ii) interpretation of tissue pathology, Pap smear slides, or other cytology services; (iii) phlebotomy services for paternity or toxicology testing where the services are furnished by a physician other than the physician referring the patient for such testing (or by another physician which is a member of the same group practice); (iv) employment-related health care services; (v) services required by local, State, or Federal licensure (including those relating to the function of clinical consultant as required by Medicare and the Clinical Labortary Improvement Act (CLIA)), accreditation, or other health and safety provisions; or (vi) services provided by a specialist physician under contract to a group practice to provide services not otherwise available directly through physician-members of the group.

To qualify for this exception, the terms of the compensation agreement would be required to be set out in writing, and the agreement would have to specify the services covered, the compensation for each unit of service provided under the agreement, and the schedule for the provision of such services. The aggregate compensation paid over the term of the agreement would be required to be consistent with the fair market value of the services in arms-length transactions. The services performed under the agreement could not involve the counseling or promotion of a business arrangement or other activity that violates any State or Federal law.

Payments by a physician: An exception would be provided for payments by a physician to an entity as compensation for an item or service, if the item or service is furnished at a price that is consistent with the fair market value established in arms-length transactions and are generally available to referrers and non-referrers alike on similar terms and conditions.

An exception would be provided for payments by a physician to a clinical laboratory in exchange for the provision of clinical laboratory services.

Payments for pathology services of a group practice: An exception would be provided for payments by a provider to a group practice for pathology services, subject to similar standards to those provided for bona fide employment relationships.

Clinical laboratory services furnished under arrangements: An exception would be provided for clinical laboratory services provided by a group practice under arrangements with a hospital if the arrangement began prior to December 19, 1989 and meets standards similar to those provided for bona fide employement relationships.

Rural providers: Compensation arrangements relating to the provision of services in rural areas (as defined for purposes of the hospital prospective payment system) would be exempt from the ban on referrals.

Minor remuneration: An exception would be provided for certain minor remuneration, including (i) the forgiveness of amounts for inaccurate or mistakenly performed tests or procedures, correction of minor billing errors; (ii) the provision of items, devices, or supplies used to collect, transport, process, or store specimens or to communicate test results; or (iii) the furnishing of clinical laboratory services to a group practice affiliated with an entity, if the entity provides all or substantially all of the group's laboratory services.

5. Effective Date

The extension of the ban on referrals to all payers and to designated health services would be effective two years after the date of enactment. The changes in exceptions would apply to referrals made on or after January 1, 1992.

Subtitle D.--Other Provisions

1. Malpractice Reform

The bill provides that the Physician Payment Review Commission would conduct a study and make recommendations regarding reforms of the malpractice system, including tort reforms and the use of alternative dispute resolution mechanisms. The Commission would report its findings and recommendations by March 31, 1993.

TITLE IV: EXPANSION OF HEALTH BENEFITS AND OTHER HEALTH INITIATIVES

Subtitle A.--Medicaid Benefit Improvements

1. Medicaid Payment Floor for Hospitals and Physicians

(a) Payment floor for inpatient and outpatient hospitals.--A payment floor would be set for Medicaid payments for hospital inpatient and outpatient services. Medicaid payments for inpatient and outpatient services in each State could not be lower than the floor in the applicable year.

The floor would be based on payments which would otherwise be paid using Medicare-level DRG payments. The floor would be set to 80 percent of the Medicare levels in 1997, 85 percent in 1998, and 90 percent thereafter. States with hospital payment rates above the floor would be prohibited from reducing their rates below the 1993 relative level of such rates compared to Medicare-level rates.

(b) Payment floor for physician services.--A payment floor would be set for Medicaid payments for physician services. Medicaid payments for physician services in each State could not be lower than the floor in the applicable year.

The floor would be based on payments which would otherwise be paid using Medicare-level RB RVS payments. The floor would be set to 60 percent in 1997, 75 percent in 1998, and 90 percent thereafter. States with physician payment rates above the floor would be prohibited from reducing their rates below the 1993 relative level of such rates compared to Medicare-level rates.

(c) Financing.--The additional costs of the Medicaid payment floors would be fully supported by Federal funds.

2. Medicaid Eligibility Expansion

Eligibility under the Medicaid program would be expanded, on a phased-in basis, to cover individuals with family income up to 200 percent of the Federal poverty level.

All pregnant women and children to age 18 with family income up to 200% of the Federal poverty level would be eligible to be covered under the Medicaid program, beginning with pregnant women and children to age 6 on or after October 1, 1996, children to age 10 on or after October 1, 1997, and children to age 18 on or after October 1, 1998.

Coverage of non-aged adults would be phased-in, beginning with non-aged adults with family income up to 50% of the Federal poverty level on or after October 1, 1999, non-aged adults with family income to 100% of the Federal poverty level on or after October 1, 2000, non-aged adults with family income to 150% of the Federal poverty level on or after October 1, 2001, and all non-aged adults with family income to 200% of the Federal poverty level on or after October 1, 2002.

For purposes of determining eligibility, family income would be determined in accordance with a methodology that is no more restrictive than the methodology currently used under the Aid to Families with Dependent Children (AFDC) program. A resource test would not be used to determine eligibility.

3. Full Federal Payment for Increased Costs

Full Federal payments would be provided to cover the increase in costs for persons required to be covered under this provision. However, such payments would not apply to long-term care services, including nursing facility services, home and community-based services, services in an intermediate care facility for the mentally retarded or community supported living arrangements.

Subtitle B.--Expansion of Medicare Benefits

1. Prevention Benefits

(a) Coverage of Colorectal Screening.--The bill would provide for coverage of fecal occult blood tests (FOBT) and screening sigmoidoscopies for the early detection of colorectal cancer. The FOBT would be covered on an annual basis; the screening sigmoidoscopies would be covered every 5 years. Payment for the FOBT would be under the laboratory fee schedule, subject to a $5 limit in 1995. The screening of sigmoidoscopies would be reimbursed under the RB RVS, without regard to the RB RVS transition provisions. That is, the sigmoidoscopies would be paid based fully on the RB RVS rates.

The Secretary would be permitted to modify the frequency criteria after 1996.

(b) Coverage of Immunizations.--The bill would provide for coverage of annual influenza vaccinations, and for tetanus-diphtheria vaccinations every ten years.

(c) Coverage of Well-Child Care.--The bill would provide for coverage of pediatric well-child care, including appropriate immunizations for Medicare beneficiaries up through age 6. In general, beneficiaries eligible for these benefits would be children entitled to Medicare benefits who have kidney failure as a result of end-stage renal disease.

(d) Annual Screening Mammography.--The bill would provide for Medicare coverage of screening mammography on a annual basis for individuals ages 65 and older. Under current law, screening mammography is covered on a biannual basis for women ages 65 and older, and on an annual basis for women ages 50 through 64.

(e) Demonstration Projects for Coverage of Other Preventive Services.--The bill would provide for the establishment of an ongoing series of demonstrations that would evaluate the appropriateness of coverage of additional services under Medicare.

(f) OTA Study of Process for Review of Medicare Coverage of Preventive Services.--The Office of Technology Assessment, subject to the approval of the Technology Assessment Board, would conduct a study and recommend a process for determining when other preventive services should be covered under Medicare.

(g) Effective Date.--The benefits would apply to services provided on or after January 1, 1995. All other provisions would be effective on enactment.

2. Coverage of Outpatient Prescription Drugs

(a) Coverage of Expenses for Prescription Drugs and Insulin.--The bill would add "covered outpatient drugs" to services covered under Part B, effective July 1, 1997. A covered outpatient drug is defined as one that: (1) is dispensed only based on a prescription; (2) is approved for safety and effectiveness under the Federal Food, Drug, and Cosmetic Act; (3) in the case of biological products, is licensed under the Public Health Service Act; (4) insulin; (5) drugs that are identical, or similar, to drugs used or sold prior to the Drug Amendments of 1962; and (6) so-called "DESI" drugs for which the Secretary has not issued a notice for a hearing.

Drugs provided as part of, or incident to hospital, nursing home, hospice and physician services, dialysis supplies, vaccinations, and certain other services, would not be covered under this provision. These drugs are, generally, covered under other provisions of the Medicare program.

Drugs that are intravenously provided in the home would not be covered.

(b) Drug Deductible.--The bill provides that no payment would be made until the enrollee has met the annual drug benefit deductible, except that the deductible would not apply to immunosuppressive drugs provided in the first year following a transplant operation. These immunosuppressives are already covered under Part B.

The deductible would be set at $850 in 1997, $900 in 1998, $950 in 1999 and would be indexed to the rate of growth in the prescription drug sector thereafter.

(c) Payment Limits.--The bill would provide for the establishment of Medicare payment limits for prescription drugs. The Medicare limits would vary depending upon whether the drug is a single or multiple source drug. The limits would be calculated for 1994, the base year, and then updated under the global budgeting system.

The payment limit for single source drugs, and for multiple source drugs with restrictive prescriptions, would be the lesser of: (1) the 90th percentile of actual charges for the drug within a geographic area in 1994, and (2) the sum of an administrative allowance plus the average wholesale price in 1994.

In the case of a multiple source drug without a restrictive prescription, the payment limit would be the administrative allowance plus the median of the average wholesale prices for the drug in 1994.

The Secretary would conduct surveys to determine the average wholesale prices of both single and multiple source drugs in the most recent year for which data are available. These data would then be updated to 1994.

The Secretary would publish a list of comparative wholesale prices of commonly prescribed outpatient drugs, and distribute the list to hospitals, physicians, Social Security offices, senior citizen centers and other appropriate places.

(d) Payment Amounts. Program payments would be at 80 percent of the lesser of the actual charge for the drug and the Medicare drug payment limits.

The Medicare limits would be adjusted to provide for a differential between the Medicare recognized administrative allowances for participating and non-participating pharmacies. The administrative allowance for non-participating pharmacies would be 60 percent of the allowance for participating pharmacies.

The bill would permit the Secretary to reduce Medicare administrative allowance for drugs dispensed through a mail service pharmacy.

In addition, the bill would require the Secretary to establish a program to assure appropriate prescribing and dispensing practices under Medicare. The program would identify inappropriate prescribing and dispensing practices, substandard care and potential adverse reactions.

(e) Participating pharmacies; civil money penalties.--The bill would provide for the establishment of a participating pharmacy program. Pharmacies would enter into annual agreements with the Secretary to be participating pharmacies. Such pharmacies would agree to accept assignment on all Medicare claims for covered outpatient drugs, keep appropriate records, provide Medicare beneficiaries with information on drugs, and advise beneficiaries on the availability of therapeutically equivalent covered outpatient drugs.

The Secretary would establish, by not later than July 1, 1997, a point-of-sale electronic system for use by carriers and participating pharmacies to use to submit claims for covered outpatient drugs.

The Secretary would provide each participating pharmacy with a distinctive emblem, and, on request, such electronic equipment and technical assistance as the Secretary determines may be necessary for the pharmacy to submit claims electronically.

The bill would establish civil money penalties for pharmacies who violate participation agreements, who charge Medicare patients more than they charge the general public, or who fail to provide information to the Secretary through the surveys used to determine wholesale prices of covered drugs.

(f) Limitation on Length of Prescription. -- Payments for covered outpatient drugs would be prohibited when the drug is dispensed in a quantity exceeding a 30-day supply. The Secretary may, in exceptional cases, authorize payments for a quantity of up to a 90-day supply.

(g) Use of Carriers, Fiscal Intermediaries, and Other Entities in Administration. -- The bill would authorize the use of contracts with entities other than carriers and fiscal intermediaries to process claims for covered outpatient drugs. The functions of carriers would be amended to include the provision of information to pharmacies as to whether an beneficiary has met the annual deductible. An electronic claims processing system would be established. Claims would be processed and paid on a monthly basis. If claims are not paid within five days of the time payment is required to be made under the contract with the Secretary, interest would be paid on the same basis as interest is paid for other Medicare claims.

(h) Modification of HMO Contracts and Other Conforming Amendments. -- The bill would provide for certain technical amendments to coordinate the covered outpatient drug benefit with contracts with health maintenance organizations.

(i) Prescription Drug Payment Review Commission. -- An 11 member Prescription Drug Payment Review Commission would be established in 1995. The Commission would submit an annual report to Congress regarding increases in drug prices, use of covered drugs, and administrative costs relating to covered drugs. In addition, the Commission would submit annual recommendations to the Congress regarding payments for prescription drugs under the national system of global budgets for health care, including recommendations on the allocation of the global budget to the prescription drug sector.

The Commission would conduct a study on the desirability and feasibility of developing and implementing a national drug formulary.

(j) Adjustment in the Part B Premium.--The bill would provide for a special add-on to the Part B premium to finance 25 percent of the cost of the program.

Payments for benefits would be administered through the Part B trust fund.

(k) Effective dates.-- Benefits under the outpatient prescription drug benefit program would first be provided beginning July 1, 1997.

(l) Benefits for Low-Income Medicare Beneficiaries.-- Beginning in fiscal year 1996, Qualified Medicare Beneficiaries (QMBs) would be eligible for prescription drug benefits otherwise available to eligible beneficiaries under the State Medicaid program.

The increase in Medicaid program costs attributable to prescription drug benefits for QMBs would be fully funded with Federal payments.

3. Qualified Medicare Beneficiary Enrollment.--The Secretary would collect information sufficient to determine if an individual is eligible for benefits under the Qualified Medicare Beneficiary (QMB) program when an individual becomes entitled to benefits under Part A or enrolled in Part B. If the Secretary determines that the individual is eligible for such benefits, the individuals would be deemed to be enrolled in the applicable State plan.

The Secretary would include a clear, simple description of the QMB program and the application process in the annual Medicare notice.

Subtitle C.--Health Insurance Deduction for the Self-Employed

The current 25 percent deduction for health insurance for the self-employed is scheduled to expire on June 30, 1992. This deduction would be extended through December 31, 1993. Beginning in 1994, self-employed individuals would be permitted to deduct 100 percent of health insurance expenses.

Subtitle D.--Health Insurance Program for Children

A Federal health insurance program would be established for children under 19 years of age.

1. Eligibility

All children legally residing in the U.S. would be eligible for benefits under the new program until reaching their 19th birthday.

2. Enrollment

In general, eligible children would be permitted to enroll into the program during a one-month open enrollment period in September of each year, with coverage beginning on January 1 of the following year.

A special enrollment period would be provided for children born subsequent to the general enrollment period and to children who obtain lawful residence subsequent to the general enrollment period. In addition, eligible children who were covered under a group health plan during the general enrollment period, but subsequently lost coverage, would be able to enroll during a special enrollment period for continuation of coverage.

Employers would be permitted to offer eligible dependent children the option of coverage under the new Federal health insurance program, provided the following conditions are met. If the employer elects to provide for coverage under the new Federal health insurance program, the employer would be required to offer such coverage to every eligible child of employees covered under the employer's group health plan. In addition, the employer would provide for 80 percent of the premium.

Employees would not be required to accept the employer's offer to cover eligible children under the new Federal health insurance program.

Employers that provide health insurance in any year would not be permitted to elect to provide coverage to eligible dependent children under the new Federal health insurance program for the following 2-year period.

3. Scope of Benefits

All benefits under the Medicare program would be covered under the new Federal health insurance program. The program would provide coverage for newborn, well-baby and well-child care, without copayments. In addition, outpatient prescription drugs would be covered, with a 20% coinsurance.

4. Payments for Benefits

Inpatient and outpatient hospital services would be reimbursed using Medicare payment methodologies. Inpatient services in general hospitals would be reimbursed using Medicare's hospital prospective payment system (PPS). Hospitals currently exempt from PPS would be reimbursed using the system of target amounts and rate-of-increase limits known as the TEFRA limits. Other services reimbursed under the hospital portion of the program would be reimbursed consistent with Medicare cost-related and fee schedule reimbursement methodologies, until appropriate prospective payment systems are established.

Physician services would be reimbursed using the Resource-Based Relative Value Scale (RB RVS). Other services, that are currently covered under Medicare Part B, would be reimbursed in a manner consistent with Medicare payment methodologies.

5. Premiums

Monthly payments would be established through 1997, based on the actuarial value of the benefit, assuming all eligible children participated in the program for all months in the year. The premiums would be adjusted for family size and geographic region.

For years subsequent to 1997, the rate of growth in the premiums would be indexed by the applicable rate of growth in the the national health budget.

The Secretary would publish premiums by July 1 before each year in which coverage would be provided.

6. Administration of the Program

The Heath Insurance Program for Children would be administered by the Health Care Financing Administration (HCFA). HCFA would apply the Medicare reimbursement methodologies, survey and certification system, quality assurance system (including utilization review) and data requirements to operate the new program for children.

7. Establishment of Children's Health Insurance Trust Fund

A new Children's Health Insurance Trust Fund would be established. Premiums collected by the Secretary would be deposited into the Trust Fund. In addition, the bill authorizes the appropriations of funds of amounts necessary to cover expenditures for the program, reduced by the amount deposited into the Trust Fund.

The Trustees of the Medicare Trust fund would oversee the Children's Health Insurance Trust Fund.

Funds from the current Medicare trust funds could not be commingled with funds from the Children's Health Insurance Trust Fund.

8. Effective Date

Benefits under the program would be effective for services provided on or after January 1, 1996

SUMMARY OF

THE HEALTH CARE COST CONTAINMENT AND REFORM ACT OF 1993

H.R. 200

January 5, 1993

TITLE I: COST CONTAINMENT

Subtitle A.--National Health Budget

1. National Health Expenditure Budget

A national health expenditure budget would be set by statute for total national spending for health services in each year, beginning with 1995.

In general, the national health expenditures budget for each year would be based on the national health expenditure budget for the preceding year, increased by the sum of the five-year moving average of the annual rate of growth in the gross domestic product (GDP) plus an adjustment factor.

The national health expenditures budget would reduce the rate by which health spending growth exceeded the rate of growth in nominal GDP by one percentage point each year. Health spending growth would phase down to the rate of growth in GDP by 1999.

To achieve this result, health spending would equal the rate of growth in the GDP plus 3.7 percent in 1995, GDP plus 2.7 percent in 1996, GDP plus 1.7 percent in 1997, GDP plus 0.7 percent in 1998, and GDP plus 0 percent thereafter.

Under these growth limits, health care expenditures are estimated to stabilize at slightly more than 15% of the GDP in 1999.

Expenditures covered by the national health expenditures budget would include payments for health services from all payers, including direct patient out-of-pocket payments.

Other expenditures excluded from the budget would include: non-operating revenues for personal comfort items, research funds, facility and services of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service.

The national health expenditure budget would be divided into two sectors: a Medicare sector and a non-Medicare sector. Each sector would be subject to the same annual limits on growth.

2. Classes of Services within the Budget

The Medicare and non-Medicare national budget secotrs would each be divided into separate "classes" of services. The classes would initially be specified as: inpatient hospital services, outpatient hospital services, diagnostic services, physician services, home health services, rehabilitation services including physical and occupational therapy, durable medical equipment, prescription drugs, nursing facility services, and mental health services.

The Secretary would publish a proposed specification of the classes by April 1, 1994, and final specifications by July 1, 1994. Once established, the classes could be changed only by statute. The Secretary would periodically submit a report to Congress recommending changes in the classes.

ProPAC and PhysPRC would submit recommendations to Congress on the specifications of the classes, and on the Secretary's proposed classes.

3. Allocation of the Health Budgets by Class of Service

In general, the Medicare and non-Medicare national health expenditure budgets would annually be allocated to each class of health services in order to provide for the establishment of maximum payment rates for each type of service.

The initial allocation of the budgets to the classes would be based on the historic allocation of health care spending to each class, within each budget sector. The Secretary would establish and publish the initial allocations, but, except as specifically provided in this bill, could not subsequently change the allocations.

In order to determine the allocation by class of service, the Secretary, after determining the amount attributable to each class in each sector in the base year of 1993, would trend spending for each class to 1994, based upon the historic rate of growth within each class.

The resulting amount for each class would be compared to the sum of the estimated amounts for all classes within each sector, and the percentage of the sum attributable to each class would be determined. That percentage would then be applied to the Medicare and non-Medicare national health expenditure budgets respectively to determine the 1995 budget for each class.

In subsequent years, the allocation to each class and sector would be equal to the amount allocated during the preceding year, increased by the historic rate of growth for the class within each sector, expressed as a percentage of the sum of the resulting amounts for all classes. The percentages so determined would then be applied to the Medicare and non-Medicare national health expenditure budgets respectively for the year to determine the budget for each class for the year.

The trend factors used to allocate the national health expenditure budget would be estimated based on the historic rates of growth for each class over the five-year period ending with 1993.

ProPAC and PhysPRC annually would review and submit recommendations to the Congress on the allocation of health expenditures to the different classes of health services.

In determining the allocations of the Medicare and non-Medicare national health expenditure budgets and the trends in spending by class of service, the Secretary would compute and apply the budget allocations and historic growth trends separately to expenditures for services covered by Medicare and to all other expenditures.

4. Adjustments for Changes in Medicare Benefits

With respect to the changes in benefits under the Medicare program provided in Title IV of this bill, the Secretary would be permitted to change the Medicare and non-Medicare health expenditure budgets, allocations and trend factors to reflect the shift of the benefits from the non-Medicare to Medicare sectors of the national health expenditure budget.

5. National Health Expenditures Reporting System

The Secretary would establish a national health expenditure reporting system for the purposes of: establishing the national health expenditure budgets; allocating budgets among classes of services; determining maximum payment rates; and monitoring State provider payment control systems. Providers of health services, including health maintenance organizations would be required to report such information as the Secretary specifies in regulation. To the extent possible, the reporting system would use existing data systems.

Subtitle B.--State Provider Payment Control Systems

1. Establishment of State Programs

States could establish payment programs for hospital and/or for physician services or for all services. The maximum rates of payment established by the Secretary would not apply to providers in States with approved programs.

The State would be required to provide assurances to the Secretary that the expenditures for services covered under the State program would not exceed expenditures if the maximum payment rates applied in the State. The Secretary would be required to reply to an application of a State to operate a program within ninety days of receipt, or the program would be deemed to be approved. States currently operating a statewide hospital payment program under Medicare would be deemed to be approved under this provision for purposes of operating a hospital payment program.

2. Standards for State Programs

The State program would be required to cover all payers and provide for equitable treatment of payers, although payment differentials between Medicare, Medicaid, and private payers would be authorized. States could provide for negotiated rates for HMOs, but could specify minimum payment rates for all payers. The State program would be required to be operated directly by the State or by a public authority. The State would be required to assure that operation of the program would not impair access for those patients unable to pay, or pay the full amount, for services or for those patients expected to require unusually costly treatment.

3. Termination of State Programs

The Secretary could terminate a State program if, during a rolling three-year period, aggregate expenditures, or Medicare expenditures, for the types of services covered under the program exceeded the expenditures which would have occurred if the State program were not in effect. If the State program provided for negotiated rates for HMOs, expenditures associated with HMOs would not be taken into account.

To recoup any excess spending in the State, the Secretary could provide for continuation of the State program with a lower limit, or for a reduction in the Federal maximum payment rates in subsequent years.

4. Use of Medicare Savings

If the Secretary determined that a State program produced savings to the Medicare program over a period of three consecutive years, the Secretary would pay the savings attributable to the first year of that period to the State in the following year.

Subtitle C.--Maximum Payment Rates for Services Not Subject to State Provider Payment Control Systems or Provided by Staff or Group Model Health Maintenance Organizations

Part 1-Establishment and Application of Maximum Payment Rates

1. Exemption for Services Subject to Approved State Provider Payment Control Systems or Provided by Staff or Group Model Health Maintenance OrganizationsT

Services provided in States with approved State provider payment control systems would not be subject to either the maximum payment rates established under this Subtitle, or to the reductions in Medicare as provided under this Subtitle.

Services provided by group or staff model HMOs would also be exempt from the maximum payment rate system.

2. Process

The Secretary would set maximum payment rates for each type of health service for non-Medicare services at levels estimated not to exceed the share of the non-Medicare national health expenditure budget for the relevant class. Rates would generally be set using Medicare methods.

The maximum payment rates determined by the Secretary would not apply to providers in states with an approved State provider payment control system or to providers associated with staff and group model health maintenance organizations. The budget allocation for each class used in determining the maximum payment rates would be adjusted to reflect services provided within each class that are exempt from the system of maximum payment rates.

The maximum payment rates determined by the Secretary would be the maximum which providers could charge for services payable by insurers, other than Medicare, or by individuals. Providers could agree to accept less than the maximum payment rates, such as in the case of Preferred Provider Organizations (PPOs), but could not increase charges to make up any shortfall resulting from agreeing to accept amounts less than the maximum payment rates.

Civil money penalties equal to three times the excess amount charged would be imposed on providers who charged in excess of the maximum payment amounts.

Part 2-Methodologies for Determining Maximum Rates

1. Hospital Services

(a) General Rule for Hospital Payment. -- The maximum payment rates for inpatient hospital services would be determined based upon an average payment per admission adjusted for case mix using diagnosis-related groups (DRGs).

The Secretary would determine a standardized amount for non-Medicare patients which would be based upon current average payments made by private payers. This would produce an average payment set at approximately 125% of costs.

Rates would be set separately for hospitals in large urban areas and for all other hospitals. New DRGs would be developed as necessary for the under-65 population, and new weights would be developed for all DRGs to reflect different resource consumption patterns among this population.

In determining the standardized amount, the Secretary would include revenues associated with services provided on an outpatient basis during the three days immediately prior to a hospital admission if the services are related to the admission.

A standard hospital benefit package would be defined to facilitate DRG reimbursement. The Secretary would develop a table of adjustment factors to reflect the actuarial differences between the standard benefit package and other benefit packages.

(b) Adjustments to Hospital Payments. -- A series of adjustments would be made to the standardized amounts. Payment rates would be adjusted: (i) by geographic area for wages and for non-labor input prices; (ii) for the higher costs of teaching hospitals; (iii) for the costs of capital; and, (iv) for certain high-cost or long length-of-stay cases known as outliers.

Payment rates would be adjusted on a hospital-specific basis for the level of uncompensated care, and for the Medicaid payment level in a State.

Payments would also be adjusted for direct medical education costs based on the number of FTE residents. The adjustment would be based on a modification of the current Medicare methodology that would encourage training of primary care physicians.

Specifically, in determining the number of FTE residents under Medicare and for the purposes of determining the maximum payment rates, primary care residents in family practice, general internal medicine and general pediatrics would be counted as 1.1 FTE resident. Other non-primary care residents in internal medicine and pediatrics would be counted as 1.0 FTE. Other non-primary care residents would be counted as 0.9 FTE during their first 3 years of residency. Other non-primary care residents beyond the initial three years of training in any specialty would be counted as 0.8 FTE.

Positions in general internal medicine would be designated by the Secretary as meeting criteria set by regulations following application by a hospital.

(c) Exempt Hospital Payments. -- Hospitals currently exempt from the prospective payment system under Medicare would not be paid using the DRG-based payment method. These hospitals would be paid using a rate-of-increase limit until prospective methods were developed. In developing a prospective payment system for children's hospitals, the Secretary would be required to meet certain requirements.

2. Physician and Other Professional Medical Services

In general, the maximum payment rates would be determined using a resource-based relative value scale (RB RVS) for physician and other professional medical services following the methodology established under Medicare.

The Secretary would establish and publish new relative value units for services not currently covered under Medicare.

The maximum payment rates for services would be determined by establishing a maximum conversion factor which, when multiplied by the relative value units of services estimated to be provided, would result in expenditures equal to the proportion of the budget allocated to this class during the year.

The maximum payment rates would include allowed extra-billing, determined based on the limits applicable under Medicare. In addition, the maximum rates would be adjusted geographically in the same manner as physician services under Medicare.

3. Other Services

Maximum payment rates for other ambulatory services would be determined using the methodologies established for such services under Medicare.

(a) Outpatient Hospital and Other Services Reimbursed on a Cost-related Basis under Medicare.--Outpatient hospital fees and fees for other cost-related services under Medicare would be set by limits on a year to year basis, pending development of prospective payment systems.

(b) Clinical laboratories fees.--Maximum payment rates would be set using the Medicare laboratory fee schedule. All services covered by a third party payer would be directly billed to the insurer.

(c) Durable Medical Equipment.--Maximum rates for durable medical equipment would be set based on Medicare policies and rates.

(d) Prescription Drugs.--The methodology for establishing the maximum payment rates for prescription drugs would follow the methodology for limiting Medicare payment for prescription drugs (as provided in this bill.)

(e) Dialysis Services.--The methodology for establishing the maximum payment rates for renal dialysis and related services would follow the Medicare methodologies for payments for such services.

(f) Other Services.--The maximum payment rates for other services paid on a reasonable charge basis under Medicare would be based on the methodologies used in establishing such limits. Such limits could be based on prevailing charge limits or fee schedules, as provided under Medicare.

(f) Development of Prospective Payment Methodologies. --The Secretary would, within 3 years of enactment, develop prospective payment methodologies for setting maximum payment rates for services for which an appropriate methodology does not exist currently under Medicare.

4. Conforming Medicare Payment Rates to Medicare Health Expenditure Allocations

Rates under the Medicare program would be determined based upon existing provisions of Medicare law and would be reduced as needed to assure that Medicare payments to providers conform to the Medicare national health expenditure budget.

TITLE II. MANAGED CARE AND MANAGED COMPETITION

Subtitle A.--Managed Care

1. Authorization for Health Care Plans to Pay Less Than Maximum Payment Rates

All health care plans would be free to negotiate rates below those set under the maximum payment rates

2. Staff and Group Model HMOs Exempted from Maximum Payment Rates

Qualified staff and group model HMOs would not be required to pay for services using the maximum payment rates. The overall budget and other payment policies would take expenditures by qualified HMOs into account but rates would not apply to these plans.

Qualified staff and group model HMOs would be those plans with a contract with Medicare under section 1876 of the Social Security Act or a qualified HMO under Title XIII of the Public Health Service Act for which ninety percent of the services are provided through members of the staff of the organization or through a medical group or groups.

3. Assistance for Establishment and Initial Operation of Staff and Group Model HMOs

$25 million in grants would be made available as grants to support the development and initial operation of staff and group model HMOs. Grants could be used for market surveys, initial enrollment activities, working capital, physician recruitment, and acquisition of buildings and equipment

4. Incentives for Expansion of Qualified HMOs

Mandatory "dual choice" requirements would be retained and expanded to "multiple choice." If requested by an HMO serving an area, an employer would be required to make the HMO available to employees as an option under the employer's health benefits, if any. Marketing materials for qualified HMOs would be provided to every employee of every company in the service area.

5 Preemption of State laws

State laws that mandate that any "willing provider" be allowed to participate in qualified HMOs would be pre-empted. This would allow network and other plans to enroll only those providers willing to manage health resources according to the plan of the HMO.

6. Increase in Payments to Medicare HMOs

Medicare payments to risk contract HMOs would be adjusted for the lack of enrollment in HMOs of beneficiaries where Medicare is the secondary payer.

7. GAO Study on HMO expansion

GAO would study and recommend additional measures to encourage the development and expansion of qualified HMOs.

Subtitle B.--Managed Competition

1. Establishment of Health Plan Purchasing Cooperatives

Health Plan Purchasing Cooperatives (HPPCs) would be established in each State for each HPPC area. Grants would be available to States to assist in the planning, development, and initial operation of HPPCs. The grant period could not exceed five years and total amount of assistance could not exceed $5 million. $150 million would be authorized for the five-year period beginning with 1994.

Each HPPC would be established pursuant to a specific State law authorizing its organization and operation. Each HPPC would be a not-for-profit public benefit corporation with its board appointed by the Governor of the State, pursuant to the State's Administrative Procedure Act.

States could provide for division of the State into more than one HPPC area so long as all portions of each Metropolitan Statistical Area (MSA) in a State were within the same HPPC area, and every portion of the State was within a HPPC area. One or more contiguous States could provide for the establishment of an interstate HPPC area, provided that the interstate HPPC included all portions of an MSA. If a State did not establish a HPPC for an area, the Secretary could establish a HPPC in that area.

2. Responsibilities of Health Plan Purchasing Cooperatives

HPPCs would have the following responsibilities: (i) to enter into agreements with qualified Health Maintenance Organizations (HMOs) and other qualified health plans that provide services in the HPPC area; (ii) to enter into agreements with employers in the HPPC area to provide comparable health insurance benefits to employees of participating employers; (iii) to enroll employees of participating employers with qualified health plans; (iv) to provide information to each employee of participating employers regarding health benefits available from each qualified health plan; (v) to enroll individuals purchasing health coverage directly on behalf of themselves or their immediate family; (vi) to receive and forward premiums; and (vii) to provide for coordination with other HPPCs. Participation in a HPPC by employers and employees would be voluntary.

Within one year after its establishment, a HPPC would be required to inventory and to inform all small employers in the HPPC area, including employers in rural areas, of the health benefits available through the HPPC. Small employers would be those with 100 employees or less. The HPPC could provide benefits to other employers and directly to individuals, at the option of the HPPC.

3. Operation of HPPCs

Health plans provided through HPPCs would generally be qualified HMOs providing services in the HPPC area. The Secretary could qualify other types of plans of they met additional standards relating to physician incentives payments, living wills, and beneficiary grievance procedures. Each such qualified health plan would meet the insurance standards established under this bill.

Each health plan would provide for an open enrollment process for employees of participating employers and other for individuals. HPPCs could impose a minimum participation requirement regarding the percentage of employees who receive health benefits on participating employers.

4. HPPC Core Benefit Packages

Each health plan would be required to provide a core benefit package that meets defined national standards. In addition a health plan could make available incremental benefit packages, but would be required to price such benefit packages separately from the core benefit package.

The core group of benefits would generally follow Medicare benefits. Benefits would include unlimited inpatient hospital coverage without spell-of-illness restrictions, outpatient hospital services, physician services, clinical laboratory and radiology, and other services with a single deductible of $300 per individual/$600 per family and an out-of-pocket limit of $2,500 per individual and $3,000 per family; and maternity, well-child and prevention benefits without cost-sharing.

The core benefit packages would not be required to include benefits or services mandated by States in addition to the benefits included in the core benefit package.

In the case of HMOs, nominal copayments and deductibles for benefits would be consistent with those specified pursuant to Title XIII of the Public Health Service Act.

5. HPPC Agreements with Employers

HPPCs would enter into agreements with participating employers to provide health insurance benefits to employees. Agreements would provide for payment by employers of the HPPC premiums for the core benefit package plus any additional incremental benefits for which the employer has chosen to be responsible. Participation in a HPPC by employers would be voluntary.

The employer would provide the HPPC with the names, names of dependents, addresses, and other identifying information required by the HPPC, for each employee, including part-time and seasonal employees.

6. Premiums for HPPC Health Plans

HPPCs would receive payments from employers and individuals participating in the HPPC. The payments would, in the case of employers, be the community-rated group premium, or in the case of individuals, be the community-rated individual premium, of each HMO or other qualified health plan in the HPPC area. An additional amount would be added in each case to the annual premium as a standard percentage overhead charge to provide revenues equal to the annual budget for the HPPC. The overhead percentage could not exceed five percentage points.

Each HPPC would make available to employers participating in the HPPC, and each such employer would make available to employees, information in comparative form on the benefits provided by HMOs and on outcomes and enrollee satisfaction for each plan based on information contained in the annual outcomes and enrollee satisfaction report described below.

Each HPPC would coordinate its activities with other HPPCs. Each HPPC would provide information about HMOs providing services in its area to other HPPCs which request the information. HPPCs would provide health benefits to employees who reside in the HPPC area but whose employer's place of business is outside of the area. Such services would be provided in coordination with the HPPC for the area in which the principal place of business of the employer is located

Subtitle C.--National Patient Outcomes and Enrollee Satisfaction Reporting Program

1. National patient outcomes program

The Secretary would establish a national patient outcomes data base. In order to collect uniform information on outcomes, the Secretary would define tbe data to be collected and establish reporting requirements for the routine collection of such data. All HMOs, other health benefit plans and providers would begin reporting such data by January 1, 1996.

The Secretary would publish and distribute an annual report on patient outcomes, including data on individual providers.

2 Enrollee satisfaction with health plans

The Secretary would establish a national data base on enrollee satisfaction with health benefit plans, including self-insured plans.

The Secretary would develop and publish a standard enrollee satisfaction survey instrument to be used by health plans. By January 1, 1996, all health plans would report data on enrollee satisfaction to the Secretary on an annual basis.

The Secretary would publish and distribute an annual report on enrollee satisfaction with health plans.

3. Research and demonstrations

The Secretary would provide for research and demonstration projects concerning new methods for collecting and analyzing outcome and enrollee satisfaction data, and the use of outcomes information systems by health maintenance organizations, health benefit plans, and providers of health care services. The Secretary may also provide for research and demonstration projects concerning the collection and analysis of indicators of system performannce, including health status of communities served, prevention of illness, and capacity of delivery systems with respect to integrated health care delivery systems. The bill provides for an authorization of $20 million annually for fiscal years 1994 through 1998.

Subtitle D.--Study of Universal Health Insurance Coverage

1. Study

A study of the costs and benefits of universal health insurance coverage and cost containment would (i) analyze options for establishing universal coverage and (ii) assess the effectiveness of alternative strategies for controlling costs under such plans. The study would be conducted by the Congressional Budget Office with assistance from the staff of the Joint Committee on Taxation. The CBO would submit a report by January 1, 1994 to the Committees on Ways and Means and on Energy and Commerce of the House and the Committee on Finance of the Senate.

TITLE III. HEALTH SYSTEM REFORMS

Subtitle A.--Health Insurance Reform

1. Anti-discrimination and Anti-Job Lock Requirements

(a) Anti-discrimination Requirements.--Health insurance for all employer groups, including self-insured groups, could not deny coverage to any eligible group or individual member of an eligible group based on health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability or medical condition. The same requirement would apply to insurance offered to individuals.

For insurance offered through Taft-Hartley Trusts, the plan could restrict membership to those eligible under the terms of the Trust, but could not deny coverage to any person otherwise eligible.

Health insurance premiums paid by members of employer groups could not be adjusted for an individual's medical status.

(b) Anti-job-lock and Pre-existing Conditions.--Any worker changing jobs with less than a three-month break in insurance coverage, including coverage under COBRA, could not have a new exclusion period applied. Pre-existing condition exclusions would otherwise be limited to six months. Pre-existing conditions limits could not be applied to new-borns.

2. Requirements for Insured Health Plans

(a) Open-enrollment.--Health insurers, other than self-insured groups and Taft-Hartley Trusts, would be required to provide year-round open enrollment for groups and individuals.

Insurers offering coverage through an association or multiple employer arrangement could restrict membership in that plan to the members of the association or arrangement. To qualify for this restriction, the association or arrangement would have to be formed for a purpose other than the purchase of health insurance.

Health Maintenance Organizations would be required to offer open enrollment, but only up to the capacity of the plan to absorb new members.

(b) Guaranteed Renewability of Coverage.--Insurers would be required to guarantee renewability of coverage, and could only refuse to renew coverage due to nonpayment of premiums and to fraud. Plans would be required to provide notice of the terms of renewal at least thirty days prior to the expiration of the plan, and could not charge higher renewal rates. Plans would be required to provide coverage for twelve-month periods.

(c) Community Rating.--Health insurers would be required to set family and individual premiums for coverage purchased by employer groups based upon community rates. Insurers would also be required to set premiums for insurance purchased directly by individuals on a community basis, but individual rates could be set differently from group rates. The limits on community rating would be phased in over three years in equal increments. For purposes of this provision, a community could be no smaller than a Metropolitan Statistical Area (MSA).

(d) Payment of Commissions.--A plan could not pay premiums to agents based upon the claims experience of a group.

3. Limits on Self-insurance.

(a) Limits on Small Employer Self-insurance. -- The bill would provide that employers with 100 full-time employees or less would be prohibited from self-insuring.

(b) Limits on MEWAs. -- Multiple Employer Welfare Arrangements (MEWAs) and similar multiple employer plans would be prohibited from self-insuring. Such groups could provide health insurance, but only to the extent that the plans met all applicable standards as health insurers in each State.

4. Continuation Coverage Offered by Universities.

The bill would pre-empt State laws that prohibit universities from offering graduating students health insurance.

5. Enforcement

(a) Federal standards. -- The standards would be established in regulations by the Secretary of Health and Human Services (HHS), and enforced by HHS with sanctions applied by the Department of the Treasury, based upon determinations of the Secretary of HHS.

(b) State certification. -- The Secretary of HHS could delegate authority to State governments meeting Federal standards to certify and supervise these requirements, although sanction authority would remain with the Federal government.

(c) Sanctions. -- The sanctions would be Federal excise taxes which would be imposed on insurers and employers (in the case of self-insured plans) which violate the standards. The excise tax would not be otherwise tax deductible.

Subtitle B.--Administrative Simplification

1. Universal Health Insurance Cards

Each beneficiary of a health insurance plan, including public plans, would be issued a universal health insurance card by plans participating in the health insurance claims network. Cards would be similar to ATM cards, and would be readable by electronic card readers.

Each card would include a universal health insurance identification number, which would be the social security number of the beneficiary.

2. Verification of Eligibility and Benefits

Each health benefit plan would be required to provide for an electronic system through which providers could inquire regarding the benefits under the plan to which an individual was entitled, the individual's status with respect to cost sharing. and any restrictions on services covered such as a limited list of eligible proviers and utilization control requirements such as pre-admission certification. Each health plan's electronic verification system would be required to accept inquiries from providers through electronic transmission of information from uniform health claims cards, through computer modems, or through touch-tone telephones. No fees could be imposed on providers unless the inquiry from the provider was not in an electronic form.

3. Uniform Electronic Claims for Health Services

(a) Uniform electronic format. -- All claims submitted by providers would be transmitted using a uniform electronic format to be developed by the Secretary. The format would be required to be consistent with the standards for electronic claims developed by the American National Standards Institute, and would be developed in consultation with various groups which are currently working to develop standards for uniform claims. The standards for clinical laboratory claims would provide that claims must be submitted directly by the entity which performs the tests.

(b) Uniform coding of procedures and diagnoses. -- Coding of procedures and diagnoses would follow uniform formats.

(c) Unique Provider Identifier. -- Each provider would be required to submit claims using a unique provider identification number similar to the UPIN used for Medicare;

4. Electronic Medical Records and Reporting

The Secretary would establish standards for an electronic patient care information system with data obtained at the point of care to replace paper medical records. The Secretary would define a uniform hospital clinical data set based on the patient information system for use by utilization and quality control organizations as well as standards for electronic transmission of the data set. The system would include standards for the protection of confidentiality of data.

As of January 1, 1996 hospitals would be required to maintain the uniform hospital clinical data set in an electronic form and, upon request of a Peer Review Organization (PRO), to transmit electronically data from the data set. On or after that date no health benefit plan, including Medicare and Medicaid, could require, for utilization review or as a condition of payment, that a hospital provide any data not in the hospital clinical data set or transmit the data in a manner which is not consistent with the standards established for electronic transmission of the data set.

5. Public Domain Software

The Secretary would develop public domain software which could be used by hospitals, physicians, other providers, and health plans to submit claims to health plans and to verify elgibility and benefits or to respond to inquiries.

6. Pre-emption of State Quill Pen Laws

State laws requiring medical information or claims to be maintained in written form would be preempted.

7. Enforcement

All health benefit plans, including employer-sponsored plans would be required to issue universal health insurance cards. Providers would be required to use, and health plans to accept, the uniform claim. Civil money penalties would apply to plans and to providers, if they did not comply. The penalties would sunset three years after the requirements applied to plans and to providers.

10. Effective Dates

The Secretary would be required to develop standards for uniform cards and uniform electronic claims within twelve months of enactment and payers and providers would be required to use them within six months after the standards were released. Clearinghouse agreements would be required to be developed within 12 months of enactment.

11. Uniform Hospital Reporting

Beginning during FY 1993, all Medicare-participating hospitals would be required to submit cost-reporting data based on uniform hospital reports required to be developed under OBRA '87.

Subtitle C.--Fraud and Abuse

Part 1--National Health Care Fraud and Abuse Program

1. All-payer Fraud and Abuse Control Program

(a) Establishment and Coordination of Program.--The bill would require the Secretary of Health and Human Services to establish and coordinate an all-payer national health care fraud control program to restrict fraud and abuse in private and public health care programs. The Secretary would be authorized to conduct investigations, audits, evaluations and inspections relating to the delivery of and payment for health care. The administration of the national program would include the coordination of the Medicare and Medicaid fraud and abuse programs.

The fraud and abuse staff within the Office of the Inspector General of the Department of HHS would be increased to administer the national health care fraud control program. The bill provides authorizations of $300 million in 1995, $350 million in FY 1996, $400 million in FY 1997, and $450 million in FY 1998.

(b) Reporting of information.--The bill would require all qualified health insurance plans, providers and others to cooperate with the national fraud control program and to provide such information necessary for the investigation of fraud and abuse. The Secretary would establish procedures to assure the confidentiality of the information required by the national fraud and abuse program and the privacy of individuals receiving health care services.

In applying for unique provider numbers for use in the electronic claims network, providers would be required to disclose information that the Secretary deems appropriate including information relating to the ownership of a health care entity. The Secretary would, to the extent possible, coordinate the information to be collected with the requirements for the collection of similar data and information under the Medicare and Medicaid programs.

The national fraud and abuse program would provide information on criminal violations and civil money penalties to State entities responsible for licensing and certification of health care providers.

The Inspector General of the Department of Health and Human Services is authorized access to documentation in accordance with the Inspector General Act of 1978. Any individual or entity who fails to comply with a request of the Office of the Inspector General of the Department of HHS 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.

(c) Civil Money Penalties.--The bill would establish civil money penalties on providers for specified fraud and abuse violations. The penalties would apply to services covered by all payers. The violations would include billing for services not provided, submitting fraudulent claims for payment, hospitals giving financial incentives to physicians to reduce or limit care provided to hospital inpatients, and other violations currently included under the Medicare program. In addition, the bill would prohibit, and establish civil money penalties for the payment of incentives to encourage employees to induce individuals to receive covered services under Medicare, Medicaid, or private health plan.

Providers would be given the same notices, and have the same rights for consideration and appeals of the civil money penalties as currently are available under the Medicare program.

The bill provides that civil money penalties would be deposited in a trust fund. The assets of the fund would be used, in addition to such appropriated amounts, to meet the operating costs of the national health care fraud control program.

(d) Criminal penalties.--The bill would establish criminal penalties relating to services covered by all payers. For providers who violate specified fraud and abuse provisions penalties would include fines, triple damages, and imprisonment. 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. The violations would include willful submission of false information or claims and acceptance of kickbacks, bribes or rebates in return for referral for services and other violations currently included under the Medicare program.

The fines and damages assessed would be deposited in a trust fund and used in the same manner as the civil money penalties.

(e) Medicare Fraud and Abuse Amendments.--

(1) HMO Intermediate Sanctions.--The bill provides that the Secretary may impose intermediate sanctions on Medicare-qualified HMOs for violations of Medicare contracting requirements.

(2) Inducements to Individuals to Receive Covered Services.--Providing items or services at less than the fair market value would be prohibited and subject to civil money penalties.

Part 2--Ban on Improper Physician Referrals

1. Application of Ban on Self-Referral to All Payers

The bill provides that any physician, whether participating in a public or private health care program, including Medicare, Medicaid, Blue Cross/Blue Shield, any commercial carrier, or any Health Maintenance Organization (HMO), would not be able to refer patients to any entity for the furnishing of "Designated Health Services" with which the physician has a financial relationship.

2. Extension of Ban to Designated Health Services

The bill provides that "Designated Health Services" include the following: Clinical laboratory services , physical therapy services, occupational therapy services, radiology services (including magnetic resonanace imaging, computerized axial tomography, and ultrasound services), furnishing of durable medical equipment, furnishing of parenteral and enteral nutrition equipment and supplies, furnishing of outpatient prescription drugs, ambulance, home infusion therapy, and inpatient and outpatient hospital services (including rehabilitation and psychiatric hospital services.)

3. Continuation of Current Exceptions to the General Rule

The exceptions in current law to the general ban on referrals would be continued with additional changes noted below. General exceptions to both the ownership and compensation bans include; (i) physicians' services provided by (or under the personal supervision of) the physician or another physician in the same group practice; or (ii) in-office ancillary services provided by the physician or another physician in the same group practice. To be exempted from the referral ban the services must be provided in a building in which the physician or other member of the group practice provides services unrelated to laboratory services, or in a central building set up by the group to perform ancillary services for its members. The services must be billed by the physician performing or supervising the services, or by that physician's group, or by an entity entirely owned by the physician or group practice.

Also excepted from the ban on ownership and compensation are: (i) services provided by a prepaid health plan to its enrollees; or (ii) other financial relationships, specified by the Secretary in regulations, that do not pose a risk of program or patient abuse.

Exceptions to the ownership or investment prohibition include: (i) ownership of publicly-traded investment securities purchased in a corporation listed on a major stock exchange, if that corporation has total assets exceeding $100 million; (ii) services provided by a hospital in Puerto Rico; (iii) services provided by a rural entity; and (iv) services provided by a hospital where the referring physician is a member of the hospital's staff and the ownership or investment interest is in the hospital as a whole as opposed to a subdivision of the hospital.

Exceptions relating to compensation arrangements include: (i) payments for rental of office space meeting specified standards; (ii) employment and services arrangements with hospitals if the arrangement is for administrative services; (iii) services arrangements with entities other than hospitals if the arrangement is for specific identifiable services as a medical director or member of a medical advisory board, specific identifiable physicians' services for certain hospice services, specific physicians' services furnished to a non-profit blood center, or other identifiable administrative services under exceptional circumstances specified by the Secretary; (iv) physician recruitment arrangements meeting specified standards; (v) isolated transactions such as a one-time sale of property; and (vi) salaried physicians of a group practice.

4. Modifications of Current Law Exceptions

A series of modifications would be made to the exceptions to the general ban on referrals in current law:

Treatment of group practices: Ancillary services provided by a group practice with multiple locations would be exempted from the prohibition on referrals. In addition to the current law standards relating to group practices, groups would be required to bill under a billing numer assigned to the group. The definition of a faculty practice plan would be expanded to include faculty of an institution or higher learning or a medical school.

Rental of office space and equipment: The current law exceptions relating to compensation arrangements would be clarified and expanded. An exception would be provided for rental of office space or of equipment if: (i) the lease arrangement were set out in writing and signed by the parties; (ii) the lease specifies the premises or equipment covered; (iii) if the lease is intended to provide the lessee with access to the premises or equipment for periodic intervals of time, the lease specifies exactly the schedule of such intervals, their precise length, and the exact rent for such intervals; and (iv) the aggregate rental charge is set in advance, is consistent with fair market value in arms-length transactions, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.

Bona fide employment relationships: The exception for employment and service arrangements with hospitals would be broadened to include any amounts paid by any employer (including providers other than hospitals) to an employee with a bona fide employment relationship for the provision of services. The standards for the exception relating to service arrangements between physicians and hospitals under current law also would apply to this broader provision.

Periodic, sporadic, or part-time services: An exception would be provided for payments by a provider to a physician not employed by the provider for certain other items or services provided on a periodic, sporadic, or part-time basis.

Items and services included under this provision are: (i) consultative services that relate to test results that are outside established parameters, are furnished by a physician other than the referring physician (or by a member of the referring physician's group practice), and for which the physician furnishes a written report for that patient; (ii) interpretation of tissue pathology, Pap smear slides, or other cytology services; (iii) phlebotomy services for paternity or toxicology testing where the services are furnished by a physician other than the physician referring the patient for such testing (or by another physician which is a member of the same group practice); (iv) employment-related health care services; (v) services required by local, State, or Federal licensure (including those relating to the function of clinical consultant as required by Medicare and the Clinical Labortary Improvement Act (CLIA)), accreditation, or other health and safety provisions; or (vi) services provided by a specialist physician under contract to a group practice to provide services not otherwise available directly through physician-members of the group.

To qualify for this exception, the terms of the compensation agreement would be required to be set out in writing, and the agreement would have to specify the services covered, the compensation for each unit of service provided under the agreement, and the schedule for the provision of such services. The aggregate compensation paid over the term of the agreement would be required to be consistent with the fair market value of the services in arms-length transactions. The services performed under the agreement could not involve the counseling or promotion of a business arrangement or other activity that violates any State or Federal law.

Payments by a physician: An exception would be provided for payments by a physician to an entity as compensation for an item or service, if the item or service is furnished at a price that is consistent with the fair market value established in arms-length transactions and are generally available to referrers and non-referrers alike on similar terms and conditions.

An exception would be provided for payments by a physician to a clinical laboratory in exchange for the provision of clinical laboratory services.

Payments for pathology services of a group practice: An exception would be provided for payments by a provider to a group practice for pathology services, subject to similar standards to those provided for bona fide employment relationships.

Clinical laboratory services furnished under arrangements: An exception would be provided for clinical laboratory services provided by a group practice under arrangements with a hospital if the arrangement began prior to December 19, 1989 and meets standards similar to those provided for bona fide employement relationships.

Rural providers: Compensation arrangements relating to the provision of services in rural areas (as defined for purposes of the hospital prospective payment system) would be exempt from the ban on referrals.

Minor remuneration: An exception would be provided for certain minor remuneration, including (i) the forgiveness of amounts for inaccurate or mistakenly performed tests or procedures, correction of minor billing errors; (ii) the provision of items, devices, or supplies used to collect, transport, process, or store specimens or to communicate test results; or (iii) the furnishing of clinical laboratory services to a group practice affiliated with an entity, if the entity provides all or substantially all of the group's laboratory services.

5. Effective Date

The extension of the ban on referrals to all payers and to designated health services would be effective two years after the date of enactment. The changes in exceptions would apply to referrals made on or after January 1, 1992.

Subtitle D.--Other Provisions

1. Malpractice Reform

The bill provides that the Physician Payment Review Commission would conduct a study and make recommendations regarding reforms of the malpractice system, including tort reforms and the use of alternative dispute resolution mechanisms. The Commission would report its findings and recommendations by March 31, 1993.

TITLE IV: EXPANSION OF HEALTH BENEFITS AND OTHER HEALTH INITIATIVES

Subtitle A.--Medicaid Benefit Improvements

1. Medicaid Payment Floor for Hospitals and Physicians

(a) Payment floor for inpatient and outpatient hospitals.--A payment floor would be set for Medicaid payments for hospital inpatient and outpatient services. Medicaid payments for inpatient and outpatient services in each State could not be lower than the floor in the applicable year.

The floor would be based on payments which would otherwise be paid using Medicare-level DRG payments. The floor would be set to 80 percent of the Medicare levels in 1997, 85 percent in 1998, and 90 percent thereafter. States with hospital payment rates above the floor would be prohibited from reducing their rates below the 1993 relative level of such rates compared to Medicare-level rates.

(b) Payment floor for physician services.--A payment floor would be set for Medicaid payments for physician services. Medicaid payments for physician services in each State could not be lower than the floor in the applicable year.

The floor would be based on payments which would otherwise be paid using Medicare-level RB RVS payments. The floor would be set to 60 percent in 1997, 75 percent in 1998, and 90 percent thereafter. States with physician payment rates above the floor would be prohibited from reducing their rates below the 1993 relative level of such rates compared to Medicare-level rates.

(c) Financing.--The additional costs of the Medicaid payment floors would be fully supported by Federal funds.

2. Medicaid Eligibility Expansion

Eligibility under the Medicaid program would be expanded, on a phased-in basis, to cover individuals with family income up to 200 percent of the Federal poverty level.

All pregnant women and children to age 18 with family income up to 200% of the Federal poverty level would be eligible to be covered under the Medicaid program, beginning with pregnant women and children to age 6 on or after October 1, 1996, children to age 10 on or after October 1, 1997, and children to age 18 on or after October 1, 1998.

Coverage of non-aged adults would be phased-in, beginning with non-aged adults with family income up to 50% of the Federal poverty level on or after October 1, 1999, non-aged adults with family income to 100% of the Federal poverty level on or after October 1, 2000, non-aged adults with family income to 150% of the Federal poverty level on or after October 1, 2001, and all non-aged adults with family income to 200% of the Federal poverty level on or after October 1, 2002.

For purposes of determining eligibility, family income would be determined in accordance with a methodology that is no more restrictive than the methodology currently used under the Aid to Families with Dependent Children (AFDC) program. A resource test would not be used to determine eligibility.

3. Full Federal Payment for Increased Costs

Full Federal payments would be provided to cover the increase in costs for persons required to be covered under this provision. However, such payments would not apply to long-term care services, including nursing facility services, home and community-based services, services in an intermediate care facility for the mentally retarded or community supported living arrangements.

Subtitle B.--Expansion of Medicare Benefits

1. Prevention Benefits

(a) Coverage of Colorectal Screening.--The bill would provide for coverage of fecal occult blood tests (FOBT) and screening sigmoidoscopies for the early detection of colorectal cancer. The FOBT would be covered on an annual basis; the screening sigmoidoscopies would be covered every 5 years. Payment for the FOBT would be under the laboratory fee schedule, subject to a $5 limit in 1995. The screening of sigmoidoscopies would be reimbursed under the RB RVS, without regard to the RB RVS transition provisions. That is, the sigmoidoscopies would be paid based fully on the RB RVS rates.

The Secretary would be permitted to modify the frequency criteria after 1996.

(b) Coverage of Immunizations.--The bill would provide for coverage of annual influenza vaccinations, and for tetanus-diphtheria vaccinations every ten years.

(c) Coverage of Well-Child Care.--The bill would provide for coverage of pediatric well-child care, including appropriate immunizations for Medicare beneficiaries up through age 6. In general, beneficiaries eligible for these benefits would be children entitled to Medicare benefits who have kidney failure as a result of end-stage renal disease.

(d) Annual Screening Mammography.--The bill would provide for Medicare coverage of screening mammography on a annual basis for individuals ages 65 and older. Under current law, screening mammography is covered on a biannual basis for women ages 65 and older, and on an annual basis for women ages 50 through 64.

(e) Demonstration Projects for Coverage of Other Preventive Services.--The bill would provide for the establishment of an ongoing series of demonstrations that would evaluate the appropriateness of coverage of additional services under Medicare.

(f) OTA Study of Process for Review of Medicare Coverage of Preventive Services.--The Office of Technology Assessment, subject to the approval of the Technology Assessment Board, would conduct a study and recommend a process for determining when other preventive services should be covered under Medicare.

(g) Effective Date.--The benefits would apply to services provided on or after January 1, 1995. All other provisions would be effective on enactment.

2. Coverage of Outpatient Prescription Drugs

(a) Coverage of Expenses for Prescription Drugs and Insulin.--The bill would add "covered outpatient drugs" to services covered under Part B, effective July 1, 1997. A covered outpatient drug is defined as one that: (1) is dispensed only based on a prescription; (2) is approved for safety and effectiveness under the Federal Food, Drug, and Cosmetic Act; (3) in the case of biological products, is licensed under the Public Health Service Act; (4) insulin; (5) drugs that are identical, or similar, to drugs used or sold prior to the Drug Amendments of 1962; and (6) so-called "DESI" drugs for which the Secretary has not issued a notice for a hearing.

Drugs provided as part of, or incident to hospital, nursing home, hospice and physician services, dialysis supplies, vaccinations, and certain other services, would not be covered under this provision. These drugs are, generally, covered under other provisions of the Medicare program.

Drugs that are intravenously provided in the home would not be covered.

(b) Drug Deductible.--The bill provides that no payment would be made until the enrollee has met the annual drug benefit deductible, except that the deductible would not apply to immunosuppressive drugs provided in the first year following a transplant operation. These immunosuppressives are already covered under Part B.

The deductible would be set at $850 in 1997, $900 in 1998, $950 in 1999 and would be indexed to the rate of growth in the prescription drug sector thereafter.

(c) Payment Limits.--The bill would provide for the establishment of Medicare payment limits for prescription drugs. The Medicare limits would vary depending upon whether the drug is a single or multiple source drug. The limits would be calculated for 1994, the base year, and then updated under the global budgeting system.

The payment limit for single source drugs, and for multiple source drugs with restrictive prescriptions, would be the lesser of: (1) the 90th percentile of actual charges for the drug within a geographic area in 1994, and (2) the sum of an administrative allowance plus the average wholesale price in 1994.

In the case of a multiple source drug without a restrictive prescription, the payment limit would be the administrative allowance plus the median of the average wholesale prices for the drug in 1994.

The Secretary would conduct surveys to determine the average wholesale prices of both single and multiple source drugs in the most recent year for which data are available. These data would then be updated to 1994.

The Secretary would publish a list of comparative wholesale prices of commonly prescribed outpatient drugs, and distribute the list to hospitals, physicians, Social Security offices, senior citizen centers and other appropriate places.

(d) Payment Amounts. Program payments would be at 80 percent of the lesser of the actual charge for the drug and the Medicare drug payment limits.

The Medicare limits would be adjusted to provide for a differential between the Medicare recognized administrative allowances for participating and non-participating pharmacies. The administrative allowance for non-participating pharmacies would be 60 percent of the allowance for participating pharmacies.

The bill would permit the Secretary to reduce Medicare administrative allowance for drugs dispensed through a mail service pharmacy.

In addition, the bill would require the Secretary to establish a program to assure appropriate prescribing and dispensing practices under Medicare. The program would identify inappropriate prescribing and dispensing practices, substandard care and potential adverse reactions.

(e) Participating pharmacies; civil money penalties.--The bill would provide for the establishment of a participating pharmacy program. Pharmacies would enter into annual agreements with the Secretary to be participating pharmacies. Such pharmacies would agree to accept assignment on all Medicare claims for covered outpatient drugs, keep appropriate records, provide Medicare beneficiaries with information on drugs, and advise beneficiaries on the availability of therapeutically equivalent covered outpatient drugs.

The Secretary would establish, by not later than July 1, 1997, a point-of-sale electronic system for use by carriers and participating pharmacies to use to submit claims for covered outpatient drugs.

The Secretary would provide each participating pharmacy with a distinctive emblem, and, on request, such electronic equipment and technical assistance as the Secretary determines may be necessary for the pharmacy to submit claims electronically.

The bill would establish civil money penalties for pharmacies who violate participation agreements, who charge Medicare patients more than they charge the general public, or who fail to provide information to the Secretary through the surveys used to determine wholesale prices of covered drugs.

(f) Limitation on Length of Prescription. -- Payments for covered outpatient drugs would be prohibited when the drug is dispensed in a quantity exceeding a 30-day supply. The Secretary may, in exceptional cases, authorize payments for a quantity of up to a 90-day supply.

(g) Use of Carriers, Fiscal Intermediaries, and Other Entities in Administration. -- The bill would authorize the use of contracts with entities other than carriers and fiscal intermediaries to process claims for covered outpatient drugs. The functions of carriers would be amended to include the provision of information to pharmacies as to whether an beneficiary has met the annual deductible. An electronic claims processing system would be established. Claims would be processed and paid on a monthly basis. If claims are not paid within five days of the time payment is required to be made under the contract with the Secretary, interest would be paid on the same basis as interest is paid for other Medicare claims.

(h) Modification of HMO Contracts and Other Conforming Amendments. -- The bill would provide for certain technical amendments to coordinate the covered outpatient drug benefit with contracts with health maintenance organizations.

(i) Prescription Drug Payment Review Commission. -- An 11 member Prescription Drug Payment Review Commission would be established in 1995. The Commission would submit an annual report to Congress regarding increases in drug prices, use of covered drugs, and administrative costs relating to covered drugs. In addition, the Commission would submit annual recommendations to the Congress regarding payments for prescription drugs under the national system of global budgets for health care, including recommendations on the allocation of the global budget to the prescription drug sector.

The Commission would conduct a study on the desirability and feasibility of developing and implementing a national drug formulary.

(j) Adjustment in the Part B Premium.--The bill would provide for a special add-on to the Part B premium to finance 25 percent of the cost of the program.

Payments for benefits would be administered through the Part B trust fund.

(k) Effective dates.-- Benefits under the outpatient prescription drug benefit program would first be provided beginning July 1, 1997.

(l) Benefits for Low-Income Medicare Beneficiaries.-- Beginning in fiscal year 1996, Qualified Medicare Beneficiaries (QMBs) would be eligible for prescription drug benefits otherwise available to eligible beneficiaries under the State Medicaid program.

The increase in Medicaid program costs attributable to prescription drug benefits for QMBs would be fully funded with Federal payments.

3. Qualified Medicare Beneficiary Enrollment.--The Secretary would collect information sufficient to determine if an individual is eligible for benefits under the Qualified Medicare Beneficiary (QMB) program when an individual becomes entitled to benefits under Part A or enrolled in Part B. If the Secretary determines that the individual is eligible for such benefits, the individuals would be deemed to be enrolled in the applicable State plan.

The Secretary would include a clear, simple description of the QMB program and the application process in the annual Medicare notice.

Subtitle C.--Health Insurance Deduction for the Self-Employed

The current 25 percent deduction for health insurance for the self-employed is scheduled to expire on June 30, 1992. This deduction would be extended through December 31, 1993. Beginning in 1994, self-employed individuals would be permitted to deduct 100 percent of health insurance expenses.

Subtitle D.--Health Insurance Program for Children

A Federal health insurance program would be established for children under 19 years of age.

1. Eligibility

All children legally residing in the U.S. would be eligible for benefits under the new program until reaching their 19th birthday.

2. Enrollment

In general, eligible children would be permitted to enroll into the program during a one-month open enrollment period in September of each year, with coverage beginning on January 1 of the following year.

A special enrollment period would be provided for children born subsequent to the general enrollment period and to children who obtain lawful residence subsequent to the general enrollment period. In addition, eligible children who were covered under a group health plan during the general enrollment period, but subsequently lost coverage, would be able to enroll during a special enrollment period for continuation of coverage.

Employers would be permitted to offer eligible dependent children the option of coverage under the new Federal health insurance program, provided the following conditions are met. If the employer elects to provide for coverage under the new Federal health insurance program, the employer would be required to offer such coverage to every eligible child of employees covered under the employer's group health plan. In addition, the employer would provide for 80 percent of the premium.

Employees would not be required to accept the employer's offer to cover eligible children under the new Federal health insurance program.

Employers that provide health insurance in any year would not be permitted to elect to provide coverage to eligible dependent children under the new Federal health insurance program for the following 2-year period.

3. Scope of Benefits

All benefits under the Medicare program would be covered under the new Federal health insurance program. The program would provide coverage for newborn, well-baby and well-child care, without copayments. In addition, outpatient prescription drugs would be covered, with a 20% coinsurance.

4. Payments for Benefits

Inpatient and outpatient hospital services would be reimbursed using Medicare payment methodologies. Inpatient services in general hospitals would be reimbursed using Medicare's hospital prospective payment system (PPS). Hospitals currently exempt from PPS would be reimbursed using the system of target amounts and rate-of-increase limits known as the TEFRA limits. Other services reimbursed under the hospital portion of the program would be reimbursed consistent with Medicare cost-related and fee schedule reimbursement methodologies, until appropriate prospective payment systems are established.

Physician services would be reimbursed using the Resource-Based Relative Value Scale (RB RVS). Other services, that are currently covered under Medicare Part B, would be reimbursed in a manner consistent with Medicare payment methodologies.

5. Premiums

Monthly payments would be established through 1997, based on the actuarial value of the benefit, assuming all eligible children participated in the program for all months in the year. The premiums would be adjusted for family size and geographic region.

For years subsequent to 1997, the rate of growth in the premiums would be indexed by the applicable rate of growth in the the national health budget.

The Secretary would publish premiums by July 1 before each year in which coverage would be provided.

6. Administration of the Program

The Heath Insurance Program for Children would be administered by the Health Care Financing Administration (HCFA). HCFA would apply the Medicare reimbursement methodologies, survey and certification system, quality assurance system (including utilization review) and data requirements to operate the new program for children.

7. Establishment of Children's Health Insurance Trust Fund

A new Children's Health Insurance Trust Fund would be established. Premiums collected by the Secretary would be deposited into the Trust Fund. In addition, the bill authorizes the appropriations of funds of amounts necessary to cover expenditures for the program, reduced by the amount deposited into the Trust Fund.

The Trustees of the Medicare Trust fund would oversee the Children's Health Insurance Trust Fund.

Funds from the current Medicare trust funds could not be commingled with funds from the Children's Health Insurance Trust Fund.

8. Effective Date

Benefits under the program would be effective for services provided on or after January 1, 1996

FORTNEY H. (PETE) STARK
9TH DISTRICT, CALIFORNIA

COMMITTEES:
WAYS AND MEANS
DISTRICT OF COLUMBIA
SELECT NARCOTICS

CONGRESS OF THE UNITED STATES

HOUSE OF REPRESENTATIVES

WASHINGTON, D.C. 20515

Picture only

March 1, 1993

Hillary Rodman Clinton
The White House
Washington, DC 20500

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SA
SW

Dear Mrs. Clinton:

Congratulations on raising the issue of cigarette taxes--but I think you could gain even more of the moral high ground, if you treat it as an "assessment" on the cigarette companies at the end of each year for their share of the cost of treating smoking-related diseases.

I've proposed this for Medicare and Medicaid (HR 698 and 699). Enclosed is some material.

It makes this new "tax" even easier to justify!

Sincerely,

Pete

Pete Stark
Member of Congress

P.S. Thanks for your kind note.

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Virginia [Mr. WOLF] is recognized for 5 minutes.

[Mr. WOLF addressed the House. His remarks will appear hereafter in the Extensions of Remarks.]

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Utah [Mr. OWENS] is recognized for 5 minutes.

[Mr. OWENS of Utah addressed the House. His remarks will appear hereafter in the Extensions of Remarks.]

THE WORLD REQUIRES A STRONG AMERICA

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Ohio [Mr. MCEWEN] is recognized for 5 minutes.

Mr. MCEWEN. Mr. Speaker, 26 hours ago Saddam Hussein of Iraq took his forces, 700 tanks, 120,000 men, and marched boldly, in less than 6 hours, into Kuwait and took over a country while America slept.

This sort of activity reminds Members that we live in a dangerous world. We live in a world in which if a nation is not prepared to stand for its principles, it invites aggression. History has told Members that repeatedly.

Collectively, some months ago, the allies of freedom in NATO said that they would build an airport in Crotone, for our 401st Air Wing of the F-118 if the United States would but occupy it. It was going to be built and financed and paid for by our allies for less than half the price of 1 bomber. The F-18 would be stationed there on the lower flank of NATO for patrol of the Mediterranean.

Mr. Speaker, about 72 hours ago this House of Representatives said, "No, we don't need that, we will leave the Mediterranean unprotected by American air forces," and thereby invite those who wish to exert force in the area. Less than 24 hours later, the Committee on Armed Services said:

> Now only will we withdraw our bases from abroad, but we will also not finance a long projected strategic bomber. We will no longer finance the next generation of technology for our defenses, and will not answer the administration's request for a strategic bomber that could project forces around the globe.

Thus, the United States is withdrawing into fortress America, in which it will withdraw from the rest of the world, leave our allies exposed, not join hands in defense of freedom and invite the crazies of the world to move aggressively against their neighbors. Mr. Speaker, we will leave here in another day. When we come back, I hope that a certain amount of sensibilities will have settled upon the Congress. We will recognize that when our allies choose to give the United States an air base, that we should occupy it; that when we are flying strategic bombers, having reduced our bomber force from 2,300 to less than 300 over the last 25 years, that we should begin to replace the remaining 364 that we have in our inventory, that we should begin to replace those with the next generations of bombers, the B-2, and that we will understand that the world requires a strong America with the loudest and strongest forces for freedom and democracy in the world, should not cover its head in the sand and withdraw from the world because every time the Congress has done it, it has invited aggression and cost American lives.

In the interests of peace, in the interests of freedom, in the interests of stability, America should occupy on the lower flank of NATO, Crotone, and it should continue the production of next generation of freedom bomber, the B-2.

ORDER OF BUSINESS

Mr. DORNAN of California. Mr. speaker, I ask unanimous consent to vacate my special order for 60 minutes for a 5-minute special order.

The SPEAKER pro tempore. is there objection to the request of the gentleman from California?

There was no objection.

THE MEDICARE/MEDICAID REIMBURSEMENT ACT OF 1990

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from California [Mr. STARK] is recognized for 5 minutes.

Mr. STARK. Mr. Speaker, the people of the United States have long paid the bill for health costs incurred due to the use of cigarettes. Some of these costs are direct and measured in an unnecessary number of premature deaths and disabilities. Others are indirect and result in lost productivity to our economy. In dollars this means a cost to the Nation of $65 billion a year.

For 25 years now the Surgeon General has been advising us of the consequences of smoking. As a nation and as a Congress we have patronized, subsidized, and made exceptions for an industry whose products are responsible for more than one of every six deaths in the United States. It is time to make the tobacco industry accountable for part of the economic losses their products cause.

Therefore, Mr. Speaker, today I am introducing the Medicare/Medicaid Reimbursement Act of 1990 which assigns part of the health-related costs of smoking to the tobacco industry where it rightfully belongs. My proposal will permit the Secretary of Health and Human Services to recover funds expended in the care and treatment of Medicare and Medicaid patients with tobacco induced cancer, tobacco induced cardiovascular, and tobacco induced lung diseases.

Each year there are nearly 400,000 smoking-related deaths in the United States. Cancer due to smoking is the greatest cause of these deaths accounting for approximately 140,000 lives lost annually. Cigarette smoking causes 90 percent of all lung cancer cases in men, 79 percent in women. Lung cancer has surpassed breast cancer as the main cancer killer of women.

Cardiovascular disease, our No. 1 killer nationwide is the second most prevalent cause of smoking related mortality in the United States, accounting for 115,000 deaths annually. Smokers have more than twice the risk of heart attack as nonsmokers. Cigarette smoking causes up to 90 percent of all cases of chronic obstructive lung disease in the United States, killing another 57,000 persons each year.

The Federal Government spends more than $4.2 billion in Medicare and Medicaid payments annually to treat smoking-related illnesses. The tobacco industry's argument that people voluntarily choose to smoke in spite of the warning labels on cigarettes is not valid in a world where over 90 percent of all tobacco users begin while teenagers or younger, 70 percent of use has begun by age 15, and 50 percent by age 13. Thus we see that the majority of persons now creating the Medicare and Medicaid expenditures for cigarette-related health costs became addicted before the age of consent. We are talking about an addiction perpetrated upon children.

Even adults cannot be considered completely voluntary smokers because they remain uninformed participants. Our consumer safety laws, our hazardous substance laws and our toxic substance laws have all worked to protect the tobacco industry from disclosing the carcinogenic ingredients of cigarettes. Although the notification of risk of cancer appears on the cigarette packages, the specific information the consumer needs to make an informed consent is sadly missing. In this day and age, consumers often receive information about using possible cancer causing substances; recent examples are alar with apples and benzene with Perrier mineral water. Although immediate attention was given these substances to protect our health, few people realize that there is at least 50 times more benzene in a pack of cigarettes than in a single bottle of Perrier which was removed from the shelves. At this time no Federal agency has the authority to require that these additives be disclosed or even removed if they are found to be harmful. Smoking can hardly be called informed consent, nor is our Government acting responsibly to protect the consumers' health. Hopefully some of the important smoking advertising legislation introduced this session will be helpful in that regard.

In addition to those addicted to cigarette smoking, we now know that significant health care costs arise from the effects of passive smoking. The 1986 Surgeon General's Report stated that involuntary smoking is a cause of disease in healthy nonsmokers, resulting in approximately 4,000 lung cancer deaths a year. Also, the children of parents who smoke compared with the children of nonsmoking parents have an increased frequency of respiratory infections, doctor visits and hospitalizations.

Mr. Speaker, the cigarette manufacturers must become directly accountable for a portion of the health care costs they create. I propose that the tobacco industry's accountability be assigned in a very simple but fair and effective way. Every 3 years, the Secretary will be apprised of the Federal Government's averaged annual expenditure for the care and treatment of Medicare and Medicaid patients with tobacco induced disease. Each of the tobacco companies, domestic and for-

eign, will be assessed on an annual basis, payable quarterly, the percentage of that cost which their sales reflect for each of the next 3 years.

All of us recognize that much tobacco induced disease has long latency periods, and that the cigarettes sold today do not result in the cost of health care produced today. However, we are taking a clean slate and not assessing sales in the past. Sales today will result in lung cancer, cardiovascular disease and pulmonary disease in the future just as they always have. By averaging out the Medicare/Medicaid expenses and the industry sales over a period of years it will be equitable to both parties.

Mr. Speaker, the bill I am introducing today represents a most vivid way to bring to our level of awareness the very real responsibility the tobacco industry bears for the health tragedies and costs its products cause. That is why I have named it the Medicare/Medicaid Reimbursement Act. Congress must see in these critical times of health care cost containment that each responsible party pays his or her fair share of that cost. We must also enact legislation that will promote better health. I believe that my bill does both. By making the tobacco companies responsible for the actual paid-out costs of the Medicare/Medicaid program for smoking related diseases, the companies will realize the consequences of their activity. As this cost is passed along to the consumer it will have the positive effect of discouraging tobacco use.

In 1988, the top six cigarette manufacturers sold 556 billion cigarettes. If the $4.2 billion Medicare and Medicaid paid out for cigarette induced disease were divided among these producers it would cost them three/fourths of a cent per cigarette or 15 cents per pack.

It is estimated that a 16-cent increase in cost to the consumer would encourage almost 3.5 million Americans to forgo smoking habits. This figure includes more than 800,000 teenagers and almost 2 million young adults aged 20 to 35 years. Because adolescents usually have limited disposable income, their purchases are especially sensitive to increases in the price of cigarettes.

Unfortunately, use of tobacco among children and teenagers is at an alltime high. More than 3-million kids under the age of 18 are daily smokers, and another 2-million experimenters are at high risk of addiction. The tobacco industry needs to recruit children to replace the more than 3,000 adult smokers who quit or die every day. The young people becoming addicted today will be the cases of lung cancer and emphysema tomorrow.

Mr. Speaker, the occupational tax which I am proposing in the Medicare/Medicaid Reimbursement Act of 1990 must be considered in addition to the excise tax bills which are before Congress at this time. I myself have proposed such a tax and believe strongly in its merit. The bill which I am introducing today will provide for the recovery of economic loss to the people of the United States due to illness incurred by the use of tobacco and tobacco products.

The Medicare/Medicaid Reimbursement Act of 1990 can be a major step to make the 1990's the decade in which the tobacco industry will finally pay a measured amount of the true health care costs of cigarette smoking. It has taken us a long time to direct this cost to those responsible for it. However, just as the 1980's was the decade in which smoking became socially unacceptable, the 1990's can become the decade in which the tobacco industry pays for its costs to society. The end result will be a healthier nation.

ANNUNZIO CHALLENGES PROPOSED MEDICARE CUTS

The SPEAKER pro tempore. Under a previous order of the House, the gentleman from Illinois [Mr. ANNUNZIO] is recognized for 5 minutes.

Mr. ANNUNZIO. Mr. Speaker, an ill-wind is blowing over the Nation's Capital, and it bodes bad tidings for the elderly across the Nation. In its zeal to reduce the deficit, the Bush administration and some Members of Congress want to saddle senior citizens with the burden of trimming the debt by reducing the spending on Government benefit programs, primarily Medicare and Medicaid and Social Security.

I, too, want to cut spending and reduce the national debt which has grown to such extraordinary heights in the last decade that the average person cannot comprehend its magnitude until he or she sees how small their incomes have shrunk or how little they can buy with it.

However, I oppose any proposal that would place a further burden on the backs of our senior citizens, many of whom are currently living at or below the poverty line. Instead, I believe the negotiators should take a closer look and turn their budget ax to the Pentagon spending programs as a way of cutting $50 billion from next year's Federal budget deficit.

I wholeheartedly support the action of the House Armed Services Committee which this week voted to kill the B-2 Stealth bomber, drastically reduce the Star Wars antimissile program and cut into troop strength, thus slashing more than $24 billion from the Bush administration's $307 billion defense budget.

I believe more can be reduced from the defense budget. I personally believe that the Congress should make reductions in U.S. commitments abroad in order to make our trading competitors pick up a larger percentage of the costs of maintaining troops and weapons in Europe and the Far East.

Mr. Speaker, the threat of Social Security cuts has waned recently, but senior citizen groups have geared up to block any attempt to cut benefits as part of a deficit-cutting deal between the White House and the Congress. There are those, like myself, who believe that you don't have to touch cost-of-living increases in Social Security benefits to solve the budget deficit. There is no need for any change in Social Security because the trust fund is running a surplus and is not responsible for the deficit.

Despite the surplus, the administration has been able to cause problems for the elderly and the disabled on Social Security. According to news reports, the Social Security Administration has suspended hearings in September for people seeking disability benefits because money for administrative expenses are running short at the end of the fiscal year. Because the Social Security judges hear appeals under Medicare, the order to put off hearings also will affect beneficiaries of the Federal health insurance program for 33 million elderly and disabled people. Officials hope hearings will resume after October 1, the start of the next fiscal year, when they expect to receive an infusion of money. The Social Security Administration issued no announcement about the curtailment of hearings, which was made Monday, but administrative law judges, who hear the cases, brought it to the attention of the New York Times because, they said, they were concerned that justice would be delayed.

Mr. Speaker, these types of incidents are disheartening to me because it is not you, or I, or the bureaucrat who will be injured. It is the elderly in this country that must suffer.

A recent Gallup survey showed that Americans 18 or older oppose substantial cuts in Medicare to reduce the Federal deficit by an 88-percent to 8-percent margin. The survey also showed that 70 percent of the respondents believed that raising taxes on high-income people, on alcohol, tobacco, and gasoline, and on businesses that create pollution, would be excellent or good ways of reducing the deficit.

In addition to opposing Medicare cuts, 65 percent of those surveyed believed the proportion of gross national product spent on all U.S. health care should be increased over the 11 percent level now in effect. On average, the favored proportion was 19.9 percent. The survey also suggested most Americans would be willing to spend more than the 6 percent of family income they now spend on health. While 29 percent felt the figure should be under 6 percent, 51 percent thought it should be from 6 percent to 10 percent and 7 percent felt it should be higher.

Mr. Speaker, I am happy to note that this week we celebrate the 25th anniversary of the Medicare and Medicaid programs which were born under the great society of President Lyndon B. Johnson to deal with the health problems of the elderly, the disabled and the poor. I am proud to say that I was one of the original sponsors of the legislation that became law on July 30, 1965 as titles XVIII and XIX of the Social Security Act.

No one thought the programs were perfect solutions. However, few doubted that many people's lives would be much better as a result of that action. And there is no doubt that millions of Americans are better off due to Medicare and Medicaid.

At a hearing of the House Select Committee on Aging to commemorate the 25th anniversary, famed actor Burt Lancaster set the tone by calling the gathering a "bittersweet" celebration. He said Medicare and Medicaid have gone a long way toward meeting the needs of millions who qualify for help under these programs. But there is still an enormous amount left to do.

He said 50 million Americans are uninsured or underinsured. Of the 50 million, 37 million have no insurance at all, and many of those are the elderly. Thanks to Medicare and Medicaid, they have at least some coverage.

Any illness to these peoples' lives quickly becomes catastrophic, because of the crushing financial burdens they must face. Nursing home costs now average $30,000 and up a year. Families who try to provide care in their own home must suffer tens of thousands of dollars in lost income.

Mr. Lancaster said the United States, still the richest Nation on earth, must find a way to provide all of its people with universal, comprehensive health care. I agree, we must

102D CONGRESS
1ST SESSION

H. R. 699

To amend the Internal Revenue Code of 1986 to impose an additional occupational tax on manufacturers and importers of cigarettes and to provide that the amounts collected under this tax be used to reimburse the medicare program for providing care and treatment for smoking-related cancers, circulatory system diseases, and respiratory system diseases.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 29, 1991

Mr. STARK (for himself, Mr. LEHMAN of California, Mr. ANDREWS of Texas, Mrs. COLLINS of Illinois, Mr. LIPINSKI, and Ms. PELOSI) introduced the following bill; which was referred jointly to the Committees on Ways and Means and Energy and Commerce

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A BILL

To amend the Internal Revenue Code of 1986 to impose an additional occupational tax on manufacturers and importers of cigarettes and to provide that the amounts collected under this tax be used to reimburse the medicare program for providing care and treatment for smoking-related cancers, circulatory system diseases, and respiratory system diseases.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare Reimbursement Act of 1991".

SEC. 2. IMPOSITION OF ADDITIONAL TAX ON MANUFACTURERS AND IMPORTERS OF CIGARETTES.

(a) IN GENERAL.—Subchapter D of chapter 52 of the Internal Revenue Code of 1986 (relating to tobacco occupational tax) is amended by adding at the end the following new section:

"SEC. 5732. ADDITIONAL TAX ON MANUFACTURERS AND IMPORTERS OF CIGARETTES.

"(a) GENERAL RULE.—There is hereby imposed, for each calendar year, on each person engaged in business as a manufacturer or importer of cigarettes during the preceding calendar year, a tax equal to—

"(1) the amount of smoking-related medical costs (as determined under subsection (b)), multiplied by

"(2) the percentage (as determined by the Secretary) of the total amount of cigarettes sold during the preceding year for consumption in the United States which were manufactured or imported by such person.

"(b) SMOKING-RELATED MEDICAL COSTS.—

"(1) PERIOD BEGINNING AFTER DECEMBER 31, 1991.—With respect to the 3-year period beginning after December 31, 1991, the smoking-related medical

costs shall be $3,500,000,000 for each year in such period.

"(2) PERIOD BEGINNING AFTER DECEMBER 31, 1994.—With respect to each 3-year period beginning after December 31, 1994, the smoking-related medical costs for each year in any such period shall be the amount determined by the Secretary, after consultation with the Secretary of Health and Human Services, to be equal to the average annual amount estimated to have been expended for the care and treatment of smoking-related cancers, circulatory system diseases, and respiratory diseases under parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395c et seq.) during the 3 years preceding the period for which the determination is being made under this paragraph.

"(c) PAYMENT OF TAX.—The tax imposed under this section shall be paid in 4 equal installments on the following dates:

"(1) April 15 of the calendar year for which the tax is imposed.

"(2) June 15 of the calendar year for which the tax is imposed.

"(3) September 15 of the calendar year for which the tax is imposed.

"(4) December 15 of the calendar year for which the tax is imposed.

"(d) ACCELERATION OF PAYMENTS.—If the taxpayer does not pay any installment under this section on or before the date prescribed for its payment, the whole of the unpaid tax shall be paid upon notice and demand from the Secretary.

"(e) ADDITIONAL TAX.—The tax imposed under this section shall be in addition to any other tax imposed under this chapter."

(b) CLERICAL AMENDMENT.—The table of sections for subchapter D of chapter 52 of such Code is amended by adding at the end the following new item:

"Sec. 5732. Additional tax on manufacturers and importers of cigarettes."

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1992.

SEC. 3. APPLICATION OF INCREASED CIGARETTE TAX REVENUES TO MEDICARE PROGRAMS.

(a) PORTION OF INCREASE IN REVENUES TO FEDERAL HOSPITAL INSURANCE TRUST FUND.—Section 1817 of the Social Security Act (42 U.S.C. 1395i(a)) is amended by adding at the end the following new subsection:

"(k)(1) There are hereby appropriated to the Trust Fund for each calendar year beginning with calendar year 1992, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to—

"(A) in the case of calendar years 1992, 1993, and 1994, $2,100,000,000 for each such year; and

"(B) in the case of calendar year 1995 and each calendar year thereafter, a percentage (as determined by the Secretary) of the taxes imposed for each such year by section 5732 of the Internal Revenue Code of 1986 which represents the percentage of the total smoking-related medical costs (as determined under subsection (b)(2) of such section) which are allocable to the Federal Hospital Insurance Trust Fund.

"(2) The amounts appropriated by the preceding sentence shall be transferred from time to time from the general fund of the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in the preceding sentence, paid to or deposited into the Treasury. Proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in the preceding sentence."

(b) PORTION OF INCREASE IN REVENUES TO FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—Section 1844 of the Social Security Act (42 U.S.C. 1395w) is amended by adding at the end the following new subsection:

"(c)(1) There are hereby appropriated to the Federal Supplementary Medical Insurance Trust Fund for each calendar year beginning with calendar year 1992, out of any moneys in the Treasury not otherwise appropriated, amounts equivalent to—

"(A) in the case of calendar years 1992, 1993, and 1994, $1,400,000,000 for each such year; and

"(B) in the case of calendar year 1995 and each calendar year thereafter, a percentage (as determined by the Secretary) of the taxes imposed for each such year by section 5732 of the Internal Revenue Code of 1986 which represents the percentage of the total smoking-related medical costs (as determined under subsection (b)(2) of such section) which are allocable to the Federal Supplementary Medical Insurance Trust Fund.

"(2) The amounts appropriated by paragraph (1) shall be transferred from time to time from the general fund of the Treasury to the Trust Fund, such amounts to be determined on the basis of estimates by the Secretary of the Treasury of the taxes, specified in paragraph (1), paid to or deposited into the Treasury. Proper adjustments shall be made in amounts subsequently transferred to the extent prior estimates were in excess of or were less than the taxes specified in paragraph (1)."

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the date prescribed for its payment, the whole of the unpaid tax shall be paid upon notice and demand from the Secretary.

"(e) ADDITIONAL TAX.—The tax imposed under this section shall be in addition to any other tax imposed under this chapter."

(b) CLERICAL AMENDMENT.—The table of sections for subchapter D of chapter 52 of such Code is amended by adding at the end the following new item:

"Sec. 5732. Additional tax on manufacturers and importers of cigarettes."

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 1992.

SEC. 3. APPLICATION OF INCREASED CIGARETTE TAX REVENUES TO MEDICAID PROGRAM.

There is authorized to be appropriated to make Federal expenditures under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), in addition to any other authorization of appropriation made for such purposes by any other law, for each calendar year beginning with calendar year 1992—

(1) in the case of calendar years 1992, 1993, and 1994, $700,000,000 for each such year, and

(2) in the case of calendar year 1995 and each calendar year thereafter, the amount of the taxes imposed for each such year by section 5732 of the Internal Revenue Code of 1986.

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102D CONGRESS
1ST SESSION

H. R. 698

To amend the Internal Revenue Code of 1986 to impose an additional occupational tax on manufacturers and importers of cigarettes and to provide that the amounts collected under this tax be used to reimburse the medicaid program for providing care and treatment for smoking-related cancers, circulatory system diseases, and respiratory system diseases.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 29, 1991

Mr. STARK introduced the following bill; which was referred jointly to the Committees on Ways and Means and Energy and Commerce

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A BILL

To amend the Internal Revenue Code of 1986 to impose an additional occupational tax on manufacturers and importers of cigarettes and to provide that the amounts collected under this tax be used to reimburse the medicaid program for providing care and treatment for smoking-related cancers, circulatory system diseases, and respiratory system diseases.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicaid Reimbursement Act of 1991".

SEC. 2. IMPOSITION OF ADDITIONAL TAX ON MANUFACTURERS AND IMPORTERS OF CIGARETTES.

(a) IN GENERAL.—Subchapter D of chapter 52 of the Internal Revenue Code of 1986 (relating to tobacco occupational tax) is amended by adding at the end the following new section:

"SEC. 5732. ADDITIONAL TAX ON MANUFACTURERS AND IMPORTERS OF CIGARETTES.

"(a) GENERAL RULE.—There is hereby imposed, for each calendar year, on each person engaged in business as a manufacturer or importer of cigarettes during the preceding calendar year, a tax equal to—

"(1) the amount of smoking-related medical costs (as determined under subsection (b)), multiplied by

"(2) the percentage (as determined by the Secretary) of the total amount of cigarettes sold during the preceding year for consumption in the United States which were manufactured or imported by such person.

"(b) SMOKING-RELATED MEDICAL COSTS.—

"(1) PERIOD BEGINNING AFTER DECEMBER 31, 1991.—With respect to the 3-year period beginning after December 31, 1991, the smoking-related medical costs shall be $700,000,000 for each year in such period.

"(2) PERIOD BEGINNING AFTER DECEMBER 31, 1994.—With respect to each 3-year period beginning

after December 31, 1994, the smoking-related medical costs for each year in any such period shall be the amount determined by the Secretary, after consultation with the Secretary of Health and Human Services, to be equal to the average annual amount of estimated Federal expenditures under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) for the care and treatment of smoking-related cancers, circulatory system diseases, and respiratory diseases during the 3 years preceding the period for which the determination is being made under this paragraph.

"(c) PAYMENT OF TAX.—The tax imposed under this section shall be paid in 4 equal installments on the following dates:

"(1) April 15 of the calendar year for which the tax is imposed.

"(2) June 15 of the calendar year for which the tax is imposed.

"(3) September 15 of the calendar year for which the tax is imposed.

"(4) December 15 of the calendar year for which the tax is imposed.

"(d) ACCELERATION OF PAYMENTS.—If the taxpayer does not pay any installment under this section on or before

INTRODUCTORY REMARKS OF THE HONORABLE PETE STARK

HEALTH CARE COST CONTAINMENT AND REFORM ACT OF 1993

H.R. 200

JANUARY 5, 1993

Mr. Speaker, today I am pleased to introduce H.R. 200, the Health Care Cost Containment and Reform Act of 1993.

This bill is the product of hard work and careful thought by the Democratic members of the Subcommittee on Health of the Committee on Ways and Means during the 102nd Congress.

H.R. 200 addresses the fundamental problems that plague our health care system today. It responds to the number one concern of the American people by establishing real and significant cost controls in the health care sector -- cost controls that really work, and are not just rhetoric.

Through a disciplined national health expenditure budget enforced through State cost containment programs and through local health maintenance organizations, the bill assures that skyrocketing health costs will finally be brought under control.

This bill provides for a managed competition system throughout the country to assure that consumers have a choice of cost-effective health plans. Under H.R. 200, individuals would have the freedom to elect coverage under a managed care plan; there are no requirements for enrollment under the bill.

H.R. 200 would also implement significant improvements in the health insurance system. These reforms are designed to assure the availability of private insurance at a fair price, regardless of health status or condition.

A uniform electronic system for health insurance would be created by the bill to minimize unnecessary and costly paperwork. It also imposes strict Federal standards to combat health care fraud and abuse.

This bill is a significant and important step forward toward universal health insurance coverage. Under this bill, 25 million of the 35 million uninsured Americans would be provided health insurance through the Medicaid program within the next decade.

This bill establishes a framework for universal health insurance coverage without prejudicing the discussion of future comprehensive reform plans. It is compatible with all of the major alternatives now under discussion including a Canadian-style comprehensive plan, a fully-public system, Medicare-for-all, and a pay-or-play plan.

It should be emphasized that H.R. 200 includes no new taxes. Savings achieved from cost containment are used to expand health insurance coverage and to improve benefits under the Medicare program.

All cost provisions are fully funded with savings achieved from cost containment, rather than taxes.

HEALTH CARE COST CONTAINMENT

The American people are justifiably concerned about the rising cost of health care.

Health care costs are out of control, increasing at more than twelve percent a year, more than three times the rate of general inflation.

Rising costs are driving up health insurance premiums by more than 15 percent each year. At the current rate of increase, health insurance premiums will double every four years.

Ever-increasing costs are the number one reason small businesses are not providing health insurance to their employees.

Rising costs restrict our ability to compete in international markets. The United States spends more on health care as a percent of its Gross Domestic Product (GDP) than any of our major trading partners.

The U.S. spends 14% of our GDP for health, whereas Canada is at 9%, Germany is at 8%, and Japan is at 6%. While health as a portion of the GDP remains relatively constant for many countries, in the United States health is expected to continue to grow to 18% of the GDP by the end of the decade.

Under this plan, a national health budget would be set for 1995 to reflect current spending plus one percent less than the projected increase. The annual increase would phase down over five years to equal the increase in the nominal GDP.

Total payments to hospitals and physicians would not be reduced. When the growth limits proposed in this bill are fully phased-in, hospital and physician payments would grow at the rate of increase of the economy as a whole, about 6% a year.

The annual increase in national health spending would be held to pre-set levels through a three-part system of State programs, qualified HMOs and a system of residual maximum payment rates.

Under this bill, States could establish their own payment programs for hospital and/or physician services, however, the total cost of services covered by a State program would be limited to the projected total costs for such services under the national rates.

It is anticipated that over several years, most States would establish State payment programs. The national payment rates would only apply to providers in States without approved programs.

The residual national maximum payment rates for hospitals, physicians, and other health services would be set annually following Medicare methods. The rates would be the maximum could be charged by providers for services payable by insurers or individuals.

MANAGED CARE AND MANAGED COMPETITION

The bill includes strong incentives to enhance the development of cost-effective managed care. The bill would also create a new system of health plan purchasing cooperatives to enhance competition in the health care financing system.

Under the bill, all health care plans, including HMOs, PPOs, and other types of managed care plans would be free to negotiate rates below those set under the national payment rates. In addition, staff and group model HMO plans could negotiate rates with hospitals and physicians directly, as they would be exempt from all of the provisions of the national payment rate program.

To assure the creation of more staff and group model HMOs, the bill would provide grants to develop and expand these cost-effective types of managed-care organizations. Staff and group model HMOs are the only types of managed care organizations for which there is solid evidence of effectiveness in controlling costs; therefore, developing organizations of this type is an important part of the bill's overall cost containment strategy.

The bill creates a new system of health plan purchasing cooperatives throughout the nation. These cooperatives will allow employers and employees to choose cost-effective health care plans on a competitive basis.

HEALTH SYSTEM REFORMS

H.R. 200 would provide for significant reforms of the private health insurance system, bringing fairness and reliability to the private market. It would greatly simplify the administration of the health care system, saving tens of billions of dollars in paperwork costs each year. It would set up tough Federal standards to combat fraud and abuse in the private sector.

It is not surprising that Americans are demanding a response to the problem of health insurance coverage. Our constituents are worried that they will lose their health insurance when they need it most or that their insurance will not be adequate to cover their medical expenses.

There is great fear about "job lock," not being able to change jobs because pre-existing condition exclusions at a new employer will curtail coverage for an existing illness.

The health insurance reforms of this proposal provide for real, comprehensive reform of the health insurance system. The reforms will apply to all insurers, not just those in the small group market.

The plan would impose non-discrimination requirements for all employer groups, including self-insured groups. Discrimination based upon health status or medical condition would be prohibited.

Health insurers, other than self-insured employer groups, would be required to provide year-round open enrollment for groups and individuals within a geographical area. Premiums would be based on community rates phased in over three years. Renewals of policies would be guaranteed.

Under the proposal, workers would be protected from "job lock". Pre-existing condition exclusions would be limited to the first six months a worker is employed. Any worker changing jobs with less than a three-month break in employment-based health insurance coverage, including coverage under COBRA, could not have a new exclusion period applied. Pre-existing exclusions would otherwise be limited to a six-month period.

The United States health care system is severely crippled by unnecessary paperwork requirements and multiple layers of rules imposed by 1,500 health insurance companies and thousands of self-insured plans.

The administrative simplifications proposed in this bill would virtually eliminate costly paperwork. Under this proposal, there would be uniform, electronic billing for all health insurance claims. Electronic billing will save doctors, hospitals and payers billions of dollars in claims processing costs.

A uniform system for processing claims would assure that all claims are processed in the same way. Uniformity in processing will allow doctors and hospitals to reduce their current staff assigned to billing by more than 60%. This would also have the benefit of assisting providers in meeting the cost containment targets of the bill.

The plan calls for universal health insurance identification cards. Coupled with computerized verification of eligibility and benefits, this reform would allow doctors and hospitals to know up front who to bill for services.

In addition to insurance reform and administrative simplification, the plan would establish a Federally coordinated program to fight fraud and abuse in the health care system.

Fraud and abuse wastes vast amounts of vital resources every year. According to the United States General Accounting Office, $80 billion each year is lost to fraud and abuse. The GAO report found there to be a general failure on the part of private payers to develop effective systems to control fraud.

The bill, in applying Medicare's proven and effective fraud and abuse policies, would establish a coordinated program to control health care fraud and abuse in both private and public health care programs.

EXPANSION OF BENEFITS

H.R. 200 would provide health insurance coverage to approximately 25 million low income Americans under a greatly-improved Medicaid program.

Under the plan, all pregnant women and children to age 18 with income up to 200% of the federal poverty line would be eligible to be covered under the Medicaid program on a phased-in schedule beginning October 1, 1997. All non-aged adults with family income up to 200% of the Federal poverty level would be eligible for benefits by fiscal year 2003, with phased-in coverage beginning on or after October 1, 1999.

The new benefits provided by this plan would be fully funded with Federal dollars, preventing further burdens on State budgets.

All of the Medicaid provisions of the bill are, of course, under the jurisdiction of the Committee on Energy and Commerce, and would be considered by that committee.

The bill would establish a new, voluntary health insurance program for children to age 19. Parents would be able to buy into the public plan in order to purchase reasonably priced health insurance for their children.

The plan would provide coverage for newborn, well-baby, and well-child care without copayments or deductibles. In addition, it would cover the usual Medicare-type services.

A second benefit funded with savings achieved from cost containment would be prescription drugs for the elderly.

Under this bill, coverage for outpatient prescription drugs would become a Part B benefit. It would be subject to a deductible -- $850 in 1997 -- and would be funded with the usual 25% premium.

In addition, the bill would establish special coverage for low-income senior citizens. Beneficiaries with income below 100% poverty, known as Qualified Medicare Beneficiaries, would be entitled to prescription drug benefits under the State Medicaid program, and would not be subject to the Medicare prescription drug copayments.

The bill would also improve Medicare coverage of essential preventive health services. It would provide Medicare coverage under Part B for annual mammography screening, colorectal cancer screening, and annual influenza and tetanus vaccinations.

Finally, this bill would help self-employed farmers and others who purchase health insurance on their own. It would allow such individuals to deduct up to 100% of their health insurance expenses effective January 1, 1993.

CONCLUSION

H.R. 200 will control the growth in the health care costs, greatly simplify the health care system, and provide coverage to more than half of the uninsured Americans.

Health care costs in the U.S. must be limited someday. We cannot afford to spend 18% in the year 2000 -- or 30% by 2020 -- of our economy for health care when our major trading partners like Canada spend 9% or Japan only 6%.

The costs to our society and to our economy as whole of spending hundreds of billions of additional dollars in health care are far too high.

I urge all my colleagues to join the support for the Health Care Cost Containment and Reform Act of 1993. A summary of the major provisions of the bill follows.