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Final Cleared

Summary of
Title VII
Medicare/Medicaid portions of the
Senate budget reconciliation bill (S. 1357)
(as reported by the Senate Finance Committee)
with discussion of related issues

October 1995

Subtitle A -- Medicare

Chapter 1 -- Medicare Choice Plans

SUBCHAPTER A -- ESTABLISHMENT OF MEDICARE CHOICE PLANS

Sec. 7001. Medicare choice plans.

"Sec. 1895A. Definitions.

- A Medicare Choice eligible individual is defined as a person entitled to Medicare Part A and enrolled in Part B, except those with end stage renal disease (ESRD).
  - Medicare Part B-only enrollees would be excluded.
  - By December 1999, the Secretary would provide recommendations regarding enrollment of beneficiaries with ESRD.
- Medicare Choice plans are defined to include:
  - private fee-for-service plans;
  - coordinated care plans including: HMOs, preferred provider organizations (PPOs), point-of-service (POS) plans, and provider sponsored organization (PSO) plans;
  - high-deductible/medical savings account (called Medicare Choice Accounts (MCA)) plans, which require a minimum annual per person deductible of $3,000 and have an annual limit on total cost sharing of $6,000;
  - Taft-Hartley, union or association sponsored plans; and
  - any other plan that meets the Medicare Choice plan standards.
- Payments and service areas are defined as MSAs, PMSAs and the rest of a state outside of MSAs/PMSAs.

"Sec. 1895B. Entitlement to Medicare choices.

All Medicare Choice eligible individuals would be entitled to receive their Medicare benefits through Medicare fee-for-service or through a Medicare Choice plan.

Issues:

- Beneficiaries enrolling in Medicare Choice plans would have less protections than beneficiaries enrolling in a Medicare managed care plan today:

  - There is no limit on plan premiums. Under current law, beneficiaries enrolling in private plans can be no worse off financially than if they stayed in fee-for-service. There is no similar guarantee under the Senate bill. Plans could be established that mirror Medicare except for the fact that physicians and providers are paid more.

  - Extra-billing protections are absent for physician services in private fee-for-service plans, MCA/high deductible plans and coordinated care plans (for authorized non-network services).

  - It is unclear if beneficiaries enrolled in network plans would have extra billing protection for in-network services. There is no specific provision which would prohibit physicians and other providers from extra billing beneficiaries for in-network services.

  If a significant portion of physicians in an area begin serving beneficiaries only through these alternative plans in order to avoid extra-billing limits under traditional Medicare or to receive higher payment, choosing to remain in traditional Medicare will not be a "real" option for beneficiaries.

- There would be a high potential for dramatic risk segmentation between four coverage options -- traditional Medicare, coordinated care plans, union/association plans, and MCAs. In clear contrast to this approach, employers in recent years have moved to eliminate the risk segmentation they experienced between their fee-for-service plans and HMOs. No major employer allows the risk segmentation that would result from MSAs.

  - Under such a system, risk adjustment would be critical to ensure that plans are not penalized if their enrollee population is sicker than average or rewarded if their enrollment is healthier than average. However, the development of reliable risk adjustment methods is in its early stages.

- The proposal would create a seriously fragmented insurance market, bringing many problems, such as aggressive marketing aimed at "cream skimming" or incentives not to seek preventive care.

- **ISSUES WITH MEDICARE CHOICE ACCOUNTS.** The MCA option is untested and could lead to a self-selection bias against fee-

for-service Medicare and Medicare HMOs, with healthy individuals choosing the MCA and others left in fee-for-service Medicare or Medicare HMOs.

- ▶ During any given year, fifteen percent of Part B beneficiaries do not receive any Medicare reimbursement. More significantly, looking at data for a four-year period (1990 - 93), 35 percent of beneficiaries had less than $1,000 in program reimbursement in each of the four years, and 5.7 percent had no program reimbursement. These beneficiaries are the ones most likely to elect a MCA. Medicare's payments for them would exceed what the program would have paid had they remained in traditional Medicare. Thus, MCAs would generate costs to the program rather than savings. (CBO has estimated that the MCA provision cost $3.5 billion through 2002 assuming only two percent of beneficiaries selecting the option.)

- ▶ This feature interacts with the benefit expenditure limiting tool (BELT) mechanism. Since the costs of care for sicker beneficiaries would be spread across a smaller and sicker base, the per capita cost of providing care in traditional Medicare would escalate dramatically. This escalation in per capita spending resulting from adverse selection could trigger provider cuts under the BELT provisions, further destabilizing traditional Medicare.

Self-selection of the healthiest beneficiaries into the MCA could also have an adverse impact on private coordinated care, fee-for-service, and provider service network plans.

Beneficiaries would be allowed in and out of the MCA option, thus dramatically increasing the potential for adverse selection against Medicare fee-for-service Medicare. (Adverse selection would be a problem even with a one-time selection.)

No adequate risk adjuster applicable to an individual selection process is available at this time to ensure that HCFA pays appropriately less for healthier beneficiaries.

- ♦ Self-funded union and association sponsored plans would have access to the medical history of their members. Thus, plans would be able to determine if, based on the Medicare payment amount and their members' medical histories, they would be able to make a profit. Only those groups that believe they could make a profit would choose to contract with the Medicare program.

- ♦ It appears that HMOs would be able to contract on a cost basis and beneficiaries will be able to enroll in cost plans. HCFA has found it difficult to establish limits on reasonable costs for cost HMOs, and Medicare's total costs for enrollees in

many cost plans exceeds 100 percent of the AAPCC. The cost option could become very popular in a world where payment increases in other options do not reflect actual cost growth.

"Sec. 1895C. Enrollment procedures.

- Beneficiaries could generally enroll in a Medicare Choice plan at initial eligibility, during the annual open enrollment period, and during the additional periods described below.

- Enrollment in and disenrollment from Medicare Choice plans would be through the Secretary. To the extent possible, the Secretary would allow notification of enrollment or disenrollment by telephone, through the mail, or in person at Social Security offices. The Secretary would promptly notify the Medicare Choice plan of the beneficiaries' enrollments and disenrollments.

- The Secretary could enter into an agreement with the Social Security Commissioner to administer the Medicare Choice enrollment and disenrollment process.

- The Secretary (or a private organization contracting with the Secretary) would develop and distribute informational materials to beneficiaries describing the Medicare Choice plans available in the area. The information would be distributed to each beneficiary no later than 30 days before the annual open enrollment period (beginning in September 1995). The Secretary would also be required to provide newly eligible beneficiaries with this information two months prior to their eligibility date.

- The informational materials should be in understandable terms and would include:

  + general information: cost-sharing and benefits under traditional Medicare; Medicare's payment amount for the area; instructions on how to enroll in Medicare Choice plans; quality indicators for traditional Medicare; and

  + plan specific information: plan availability including premiums charged, the difference between the plan premium and the Medicare payment amount, restrictions on coverage, out-of area and emergency services coverage, appeal rights, explanation of extra-billing liability, supplemental coverage and the associated additional premiums.

Issues:

- The requirement for the Secretary to administer an annual enrollment process for 37 million people would be a significant new responsibility, and adequate time to implement

would be necessary. One of the reasons that HCFA is initiating HMO competitive pricing demonstrations, which involve an open enrollment process, is to learn how best to run such an enrollment process, but these demonstrations are only starting.

- In order for beneficiaries to compare competing alternative plans under the Medicare Choice system, they would need comparative information on quality as well as price, network composition, benefits, cost-sharing, and other factors. Comparative information on the quality of care provided by competing plans is difficult to measure -- but of vital importance to potential enrollees, particularly if they can only change plans on a yearly basis, as proposed. The need for reliable quality of care assessments is of particular concern to Medicare beneficiaries, because they are more likely to be alone and frail and, thus, unable to navigate the bureaucracy of a managed care plan or to have others do so on their behalf. However, development of reliable methods to measure quality of care is still in its early stages.

- The Secretary's information development and dissemination activities would require substantial personnel and financial resources. The bill does not indicate if trust fund or appropriated monies would be available to carry out these required duties.

- The Senate bill provides for enrollment through the Secretary, which in contrast to the House bill, which provides enrollment through plans. Enrollment through the Secretary should reduce favorable selection somewhat.

"Sec. 1895D. Effect of enrollment.

- If the beneficiary enrolled in a Medicare Choice plan whose premium exceeded the standardized Medicare payment amount, the beneficiary would pay the difference between the two amounts to the plan. If the beneficiary enrolled in a Medicare Choice plan whose premium was less than the standardized Medicare payment amount, the beneficiary would receive a rebate equal to the difference between the two amounts.

- In general, beneficiaries could disenroll from Medicare Choice or traditional Medicare only during annual coordinated open enrollment periods except for "qualifying events" (e.g., when the beneficiary moves to a new service area or other events determined by the Secretary) and "for cause" (e.g., when the plan fails to meet quality or capacity standards or for other causes determined by the Secretary). Also, beneficiaries could disenroll within ninety days of their initial enrollment in a Medicare Choice plan.

- Beneficiaries would continue in the Medicare Choice plan of the previous year if they fail to notify the Secretary of an alternative choice.

- Beneficiaries enrolled in high deductible plans generally could not disenroll unless they gave 12 months notice during the annual open enrollment period.

- The Secretary would establish special enrollment rules for union, Taft-Hartley and association plans.

- A cash rebate creates incentives to choose plans for reasons other than insuring access to high quality care and could cause seniors to elect insufficient coverage.

"Sec. 1895G. Availability and enrollment.

- Medicare Choice plans would be required to enroll beneficiaries on a first-come-first-serve basis, subject to capacity limits. Beneficiaries could only join Medicare Choice plans that served the geographic area in which they resided. Union, Taft-Hartley and association plans would limit enrollment to full-fledged members.

- The annual enrollment and disenrollment period would occur in November of each year. Additional enrollment periods would include the period at initial eligibility, periods following disenrollment from a plan for qualifying events and for cause, or following disenrollment within ninety days of initial enrollment in a Choice plan.

- In addition to information provided by the Secretary, Medicare Choice plans could develop and distribute their own marketing materials, provided that they meet certain requirements. The marketing materials should accurately compare benefits under traditional Medicare and the plan; should not be distributed so as to violate anti-discrimination requirements; should not contain false or misleading information; and should adhere to other fair marketing and advertising standards.

- All marketing materials would have to be submitted to the Secretary 45 days before distribution. If the Secretary does not disapprove the Medicare Choice plan's marketing materials for a particular area with 45 days of submission, the materials would be deemed to be approved for distribution in <u>all</u> areas covered by the plan.

"Sec. 1895H. Benefits provided to individuals.

- Medicare Choice plans would offer a <u>basic</u> benefit package including the Medicare benefit package and any mandatory additional health services approved by the Secretary. The

Secretary would approve these additional health services as long as the inclusion of such services would not discourage enrollment by beneficiaries.

- The Medicare Choice plan could offer optional supplemental benefits for an additional premium. The additional premium amount would be the same for all enrolled beneficiaries in a payment area if the sale of the supplement was limited to enrollees in the plan. The optional supplemental benefits could be marketed outside of the enrollment process.

- Except for high deductible plans, the average total amount of deductibles, coinsurance and copayments charged to the individual under a Medicare Choice plan could not exceed the average total amount of deductibles, coinsurance and copayments charged under traditional Medicare. (Unlike current law, plan premiums are not included in the comparison.)

- While high deductible plans could not require annual costs (deductible, coinsurance, and copayments) for Medicare covered items and services in excess of $6,000 per year, this limit does not include extra-billing.

Issues:

- The review of the reasonableness of plan premiums as is currently done through the adjusted community rate process would be eliminated. Plans may opt for higher profits in lieu of providing additional benefits.

- As delineated above (1895B issues), beneficiaries enrolling in Medicare Choice plans would have less protections than beneficiaries enrolling in a Medicare managed care plan today:

  - There is no limit on plan premiums.

  - Extra-billing protections are absent for physician services in private fee-for-service plans, MCA/high deductible plans and coordinated care plans (for authorized non-network services).

  - It is unclear if beneficiaries enrolled in network plans would have extra billing protection for in-network services.

- To the extent that private fee-for-service plans integrate coverage for coinsurance and/or deductibles into the basic benefit they offer, they could escape regulation as a Medigap product and the applicable loss ratio requirements.

"Sec. 1895I. Licensing and financial requirements.

- All Medicare Choice plans (except union, Taft-Hartley, association plans and coordinated care plans (including PSOs)) would be required to be licensed by each state in which they wish to enroll beneficiaries. (A temporary process for coordinated care plans is described under sec. 1895R.)

- All plans would assume full financial risk for providing Medicare benefits except for specified reinsurance or risk-sharing with providers.

- Plans could either meet federal solvency standards established by the Secretary or state solvency standards that the Secretary determines are at least as stringent as the federal standards.

- In developing solvency standards for coordinated care plans, the Secretary would consult with interested parties and would take into account the plan's delivery system assets and its ability to provide services directly through its providers. In addition, the Secretary may consider alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees from a financially strong party, organizational insurance coverage, partnership with a licensed entity, or other methods acceptable to the Secretary.

"Sec. 1895J. Health plan standards.

- All Medicare Choice plans must meet certain requirements for quality assurance, capacity and enrollment, access, provider compensation, advance directives, and consumer protections. Consumer protections include; guaranteed issue and renewal of coverage, appeals and grievance procedures, and provision of supplementary coverage by plans terminating Medicare contracts.

- In addition to internal quality assurance programs, all Medicare choice plans would be required to have an agreement with an external quality review organization approved by the Secretary.

- Medicare Choice plans would be required to meet accreditation standards for quality assurance or be accredited by a private entity recognized by the Secretary as establishing standards at least as stringent as federal standards.

- The Secretary would create incentives for Medicare Choice plans to report aggregate encounter data.

- Medicare Choice plans must provide access to appropriate providers, including credentialed specialists, for all medically necessary services.

- Except as provided by the Secretary on a case-by-case basis, coordinated care plans in rural areas must provide primary care services within 30 minutes or 30 miles from the enrollees place of residence.

- The Secretary would develop an expedited appeals process for situations in which failure to receive health care services or payment would result in "significant harm."

Issues:

- The Senate bill requires all Medicare Choice plans to meet internal and external quality review standards. The House bill applies the requirement only to network plans. The Senate bill maintains the Secretary's role of oversight. The House bill eliminates this role for managed care plans and turns it over to the States.

"Sec. 1895M. Medicare payment amounts.

- Within 30 days after enactment, the AAPCC for 1996 would be recalculated as a blended rate of the 1995 AAPCC updated by the revised increase in the USPCC (75 percent) and the adjusted USPCC for 1996 (25 percent). No rate, however can be less than the rate for 1995. **[Note: This rule is in sec. 7003 of the bill, but for purposes of presentation it is described here.]**

  - The adjustments to the USPCC would reflect the relative input price of services in a Medicare payment area relative to the national average input price of these services. This adjustment would narrow the current geographic variation in payment.

- In 1997, a new rate, the standardized Medicare payment amount, would be created based on the revised payment areas (MSAs, PMSAs and rest of state). The standardized Medicare payment amount would a blended rate of the adjusted USPCC for 1996 (50 percent) and the modified AAPCC for 1996 (50 percent) update by gross domestic product per capita.

  - Payment for graduate medical education and disproportionate share payments would be excluded from both pieces of the standardized payment amount. Fifty percent of these payments would be excluded in 1997 and 100 percent in 1998.

  - Payments for ESRD beneficiaries would not be taken into account when computing the standardized payment amount.

- In subsequent years, the standardized payment amount would be increased by the gross domestic product per capita.

- Medicare payment amounts would be adjusted for an individual enrollee's demographic and health status factors.

- In 2000 and 2001, the Secretary could make annual differential adjustments to the Medicare standardized payment amount to achieve "appropriate and equitable variation in payment amounts across payment areas" by 2002. These adjustments would be budget neutral. The adjustments would be based on an analysis conducted by the Secretary and developed in consultation with interested parties.

- The Secretary would conduct a demonstration to determine the standardized Medicare payment amount through a competitive bidding process and report to Congress on the demonstration no later than the end of 2001.

Issues:

- Because federal payments would be tied to the GDP per capita, the federal contribution will not keep pace with projected health care inflation or projected growth in private health insurance. Thus, over time, the fixed contribution could be insufficient for beneficiaries to purchase their plan of choice without incurring significant out-of-pocket expenses.

- While extremes in current geographic variation and the disposition of Medical education payments need to be addressed, the bill would do so over a very short transition period. Dramatic reductions in payment in some areas with significant enrollment would be disruptive.

- While managed care in Medicare is growing, enrollment rates are still below those in the commercial market. It is questionable how reducing payments to plans, which will result in reduced extra benefits, will lead to greater beneficiary participation in Medicare Choice plans. In addition, it is questionable whether adequate numbers of private plans would participate in the Medicare Choice system if the federal contribution is inadequate.

- It is unclear whether all or some of the savings from excluding disproportionate share and indirect medical education payments from the calculation will be returned to the hospitals, or whether it will be used for deficit reduction.

"Sec. 1895N. Premiums and rebates.

- The Medicare Choice plan would submit its monthly premium to the Secretary. The plan could not charge different premiums for beneficiaries in the same payment area.

- If the standardized Medicare payment is greater than the Medicare Choice plan premium, the beneficiary enrolled in other than a high deductible plan could either:

  - receive a rebate equal to 75 percent of the difference (the remaining 25 percent would be deposited to the HI Trust Fund);

  - have 100 percent of the difference applied towards the purchase of supplemental benefits under the plan; or

  - have 100 percent of the difference deposited in a Medicare Choice Account (MCA).

  If the beneficiary is enrolled in a high deductible plan, 100 percent of the difference would be deposited in a MCA.

- If the standardized Medicare payment is less than the Medicare Choice plan premium, the plan and the beneficiary would have to pay the difference.

Issues: It is misleading to have cash rebates if a plan is also permitted to have deductibles and coinsurance at Medicare levels or at the same actuarial level. The only Medicare beneficiaries who benefit from cash rebates in such a case are those who use no medical services or are low utilizers of services -- resulting in a compounding of the currently existing problem of favorable selection by Medicare HMOs.

"Sec. 1895O. Payments to plan sponsors.

The Secretary would make monthly payments to Medicare Choice plans on behalf of enrolled beneficiaries and could make retroactive adjustments. Payments would be made from the HI Trust Fund and the SMI Trust fund to reflect the proportion of Part A and Part B services of total Medicare benefits.

"Sec. 1895P. General permission to contract.

The Secretary would enter into contracts with Medicare Choice plans only if they met the plan standards set forth in the bill.

"Sec. 1895Q. Renewal and termination of contract.

- Contracts would be for one year and may be automatically renewable. The Secretary could not enter into a contract with a plan that was terminated at the request of the plan in the past five years.

- The Secretary could terminate contracts or impose intermediate sanctions if the Secretary determined that a plan does not

meet the established standards or terms of the contract. The Secretary may also impose sanctions for denial of medically necessary services, overcharging, enrollment violations, misrepresentation, failure to pay promptly for services, or employment of providers barred from Medicare participation.

- The Secretary would have the authority to inspect, audit or otherwise evaluate the plan's quality of care, ability to bear risk, and other requirements.

"Sec. 1895R. Temporary certification process for coordinated care plans.

- Coordinated care plans (federally qualified HMOs, PPOs, POS plans, PSNs or other coordinated care plans) would first make applications to the state for a license.

- If the State (1) fails to complete action on an application within 90 days or (2) denies an application and the Secretary determines that the state standards imposed unreasonable barriers to market entry, the plan could apply to the Secretary for federal certification. State standards are not viewed as unreasonable barriers if they are applied consistently to all coordinated care plans and are not in conflict with Federal standards.

- The Secretary would develop the standards for temporary certification. If the Secretary certifies a plan, the process must be completed within 120 days. A certificate granted by the Secretary would enable the plan to offer coverage for 36 months and could not be renewed. The plan would continue to obtain state licensure during the period the federal certificate is in effect. Federal certificates could not be issued after 2000 and could not be in effect beyond 2001.

- The Secretary would submit a report to Congress regarding the temporary certification system, including an analysis of State efforts to adopt licensing standards and review processes that take into account coordinated care plans which provide services directly to enrollees through affiliated providers

- Current risk contractors would be deemed to meet federal certification standards for any contract year prior to 2000.

- The Secretary would conduct a partial capitation demonstration and report to Congress by 12/31/98 on the administrative feasibility of partial capitation methods and the information necessary to implement such arrangements.

Issues: While this provision applies to all coordinated care plans, provider service networks would presumably be the majority of plans seeking temporary federal certification in lieu of state

licensure. This section appears to override a provision in **section 1895I** that deals with licensing and financial requirements. Section 1895I envision states being responsible for determining whether a plan has adequate provision against the risk of insolvency if the state's standards are at least as stringent as the Secretary's standards. However, if the standards are more stringent:

- would they be viewed as in conflict or inconsistent with the Federal standards thus triggering access to the Federal "licensing" process or
- would the approval of the State program indicate that it was consistent with Federal standards thus closing the door to PSOs that cannot obtain a state license?

While there is a clear open door to PSOs in the House bill, the Senate bill is unclear.

"Sec. 1895S. Regulations.

- The Secretary would promulgate interim, final regulations for Medicare Choice plans within 120 days of enactment.
- Medicare-eligible federal retirees under the Federal Employee Health Benefits Program would not be able to enroll in a high deductible/MCA plan until such time as it is determined that such an option would not increase FEHB expenditures.
- Within 90 days after enactment, the Secretary is required to submit to Congress a technical corrections bill for the provisions related to Medicare Choice Plans.

Issues: Given CBO's estimate of a multi-billion cost of the MSA provision, an MSA option for Medicare/FEHBP enrollees is not likely to be found to not increase expenditures.

Sec. 7002. Treatment of 1876 organizations.

- Section 1876 would not apply to risk-sharing contracts beginning in January 1997.
- Medicare Part-B only risk plan enrollees would be grandfathered. The Secretary would develop regulations for these enrollees by July 1996.
- Federally qualified HMOs would be allowed to offer high deductible/MCA plans.

Sec. 7003. Special rule for calculation of payment rates for 1996. (Also see sec. 1895M, described above.)

Within 30 days of enactment, the AAPCC for 1996 would be recalculated as a blended rate of the 1995 AAPCC updated by the revised increase in the USPCC (75 percent) and input-price adjusted USPCC (25 percent). No rate, however can be less than the rate for 1995.

SUBCHAPTER B -- TAX PROVISIONS RELATING TO MEDICARE CHOICE PLANS

Sec. 7006. Medicare Choice Accounts.

- Medicare Choice Accounts (MCAs) would be "exclusively for the payment of qualified medical expenses" and must meet certain requirements.
- Contributions to the MCA are limited to the difference between the Medicare payment amount and the premium for the accompanying high deductible policy and any "rollover" contributions.
- The trustee of the MCA could be a bank, insurance company, or other persons determined by the Secretary. MCA funds cannot be commingled with other property except in common trust or investment funds and cannot be invested in life insurance contracts. The MCA account is terminated if the individual engages in a prohibited transaction.
- Interest accrued on the MCA balance is taxable. Amounts withdrawn from the MCA for medical expenses are not taxable while amounts withdrawn for non-medical expenses are taxed as income.
- Trustees of MCAs must make reports to Secretary and the beneficiary according to regulations established by the Secretary or be subject to a $50 penalty for each failure to report.

Issue: Enforcement of limits on tax-preferred withdrawals from the MCA could be intrusive. It is unclear who decides if a withdrawal is for "qualified" expenses and whether there is an appeals process relative to these decisions.

Sec. 7007. Certain rebates included in gross income.

Rebates from Medicare Choice plans are treated as taxable income.

CHAPTER 2 -- PROVISIONS RELATING TO PART A

SUBCHAPTER A -- GENERAL PROVISIONS RELATING TO PART A

Sec. 7011. PPS hospital payment update.

[The House proposal is different from the Senate proposal. The Senate has a smaller update reduction, no minimum threshold.]

The prospective payment system (PPS) update factor is the amount that the PPS base payment rate is increased each year. Current law sets the PPS update factor at 2 percentage points lower than the hospital market basket index (MB-2.0) for FY 1996, MB-0.5 for FY 1997 and MB for FY 1998 and beyond. This proposal sets the update at MB-2.5 for FY 1996 through FY 2002. However, it sets a minimum threshold for the update, such that it cannot be below 1.3 percent in FY 96, 1.2 percent in FY 97, and 1.1 percent in FY 98-02.

Sec. 7012. PPS-exempt hospital payments.
[The House provision uses a different formula]

- The update factor for PPS-exempt hospitals is reduced to the market basket minus 2.5 percentage points for FY 1996 through FY 2002. The reduction of 2.5 percentage points is reduced by 0.25 percentage point for each percentage point the hospital's update adjustment percentage is less than 10 percentage points. A ceiling is applied to hospitals with costs 150 percent or more above TEFRA limits; they receive no inflation updates for FY 1996 through 2002. For hospitals receiving updates, the inflation update could not be less than 1.4 percent in FY 96, less than 1.3 percent in FY 97, and less than 1.1 percent in FY 98-2002.

- New rehabilitation and long-term care hospitals and units (established on or after October 1, 1995) will have TEFRA limits no greater than 130 percent of the mean of all similar hospitals and units. For those facilities and units established before October 1, 1995, a floor to the TEFRA limits is set at 50 percent of the mean of all such hospitals and units.

- The Secretary, in consultation with ProPAC, shall report to Congress by June 1996 on a prospective payment system for rehabilitation hospitals and units and other PPS-exempt hospitals.

Issues:

- Because the update factor is reduced and the current market basket minus 1 percent expires in 1997, this provision would save a significant amount of money. The reference to update factors less than 10 percentage points is unclear, since annual updates are tied to market basket increases, which are generally less than 10 percentage points. However, the 10 percentage point difference may refer to facilities below the new floor, whose limits are brought up to the floor. This

would reduce the amount of money that would otherwise go to hospitals whose limits were below the floor.

- Setting a uniform limit for all similar facilities simplifies the program. However, because this provision only relates to new hospitals and units, its impact may not be dramatic.

- It is very unlikely that HCFA will be able to develop a prospective payment system by June 1996. We will, however, be able to report on obstacles to implementing a new payment system.

Sec 7012(d). Capital payments for PPS-exempt hospitals.
[Identical to the House Ways and Means provision.]

Medicare currently pays the reasonable costs of capital to PPS-exempt hospitals. The proposal would reduce cost-based payment by 15 percent for fiscal years 1996-2002.

Sec. 7013(a). Capital payments for PPS hospitals.
[Identical to the House Ways and Means provision.]

- In FY 1992, Medicare began a ten-year transition toward prospective payment for hospital capital-related costs. Hospital payments are based on a gradually decreasing share of their own costs and a gradually increasing share of a national rate.

- During the first four years of the transition, a statutory budget neutrality provision required that aggregate payments equal 90 percent of what Medicare would have paid on a reasonable cost basis.

- The proposal would reduce the Federal capital rate by 7.47 percent, and the hospital specific rate by 8.27 percent.

- The proposal would also extend the budget neutrality provision at 85% (in place of the previous 90%) of what Medicare would have paid on a reasonable cost basis for fiscal years 1995-2002.

Issues:

- The proposal extends a link to reasonable cost at the level of aggregate payments for seven more years and undermines the prospective payment system.

- Because of the extension of budget neutrality, the proposed reductions to the rates will have no actual effect on the level of aggregate payments until FY 2002.

- By tying the aggregate level of payment to what Medicare would have paid on a reasonable cost basis, the provision would create a difficult technical problem. The provision could be read to require that aggregate payments equal 85 percent of what hospital costs would have been, if reasonable cost payment had continued. It is increasingly difficult to estimate what capital costs would have been under the behavioral patterns that prevailed under reasonable cost payment.

Sec 7013(c). Hospital-specific adjustment for capital-related tax costs.

[Identical to the House Ways and Means provision.]

The proposal would require that, effective for discharges occurring after September 30, 1995, eligible hospitals receive an adjustment to the portion of the payment based on the national rate for their capital-related tax costs.

- Public hospitals would not be eligible for the adjustment (presumably to prevent state and local governments from gaining revenues by taxing such hospitals in order to increase Medicare payments to public facilities).

- The provision prohibits hospitals that were not subject to taxation in the capital-PPS base year from receiving an adjustment until the fourth year after they become subject to taxation. (This is apparently to discourage state and local governments from extending taxation to previously tax exempt hospitals.)

- Tax-exempt hospitals that make "payments in lieu of taxes" would qualify for the adjustment.

The tax adjustment would be budget neutral. It would reduce payments to all other hospitals in order to assure that the tax adjustment would not increase total payments.

Issues:

- In attempting to remedy this possible inequity, the proposal creates a new inequity by reducing payments to all other hospitals (even beyond the level of the tax costs originally included in the rate calculation) in order to pay for the adjustment.

- The adjustment would almost exclusively benefit proprietary hospitals at the expense of hospitals that serve large numbers of uninsured patients.

- The proposal makes an open-ended commitment to reduce payments to non-tax-paying hospitals whenever state and local governments extend taxation to previously tax-exempt hospitals.

- The proposal requires complex and difficult comparisons with commercial properties and would be very difficult to administer.

- The proposal does not define what kinds of payments qualify as "payments in lieu of taxes."

Sec. 7013(d). Revision of exceptions process under prospective payment system for certain projects.

[Similar to the House Ways and Means provision.]

The proposal would modify the existing regulation establishing an exception process for major modernization projects by extending the class of eligible hospitals, raising the minimum payment level for certain hospitals, extending the deadline for project completion, and revising offsets provided in the regulation in determining the exception payment.

- The proposal would eliminate any consideration of DSH status in determining the eligibility of large urban hospitals.

- The proposal would waive the project completion deadline for hospitals that have obtained state or local certificate of need approval and expended $750,000 or 10 percent of estimated project costs by the September 1, 1995.

- Under the existing regulation, two offsets are applied in determining the amount of the exceptions payment: cumulative payments in excess of the minimum payment level for previous years, and any positive total PPS margin (excluding 75 percent of DSH payments) are offset against the additional exceptions payment. The proposal retains the cumulative payment offset, but replaces the offset of any positive total PPS margin with an offset of any positive capital-PPS margin (excluding 75 percent of capital-related disproportionate share payments).

- The proposal would establish a minimum payment level of 80 percent in place of the 70 percent provided under the current regulation.

- The proposal sets a limit for fiscal years 1996 through 2000 of $50,000,000 on the amount of additional payments, under the special exceptions provision, that result from the bill.

Issues:

- The proposed 80 percent minimum payment level for exceptions beyond the transition period is higher than the 70 percent minimum payment level that applies to most hospitals during the transition period.

- The existing extended exceptions provision is budget neutral: it reduces payments to all other hospitals in order to pay for exceptions to qualifying hospitals. By expanding the qualification requirements, and increasing the level of exceptions payments, the proposal would further reduce payments to all other hospitals.

- There is a drafting ambiguity in the provision that sets a limit on additional exceptions payments. It is not clear whether there is (a) a $50,000,000 limit on additional payments under the special exceptions provision that result from the reductions to the rates, or (b) a $50,000,000 limit on such payments that result from the amendment to the exceptions provision. (The latter interpretation is much more logical; the former interpretation tracks the actual text.) On either interpretation, the requirement would create difficult estimation problems and raise issues about the appropriateness of retroactive adjustments if initial estimates are inaccurate.

Sec. 7014. Disproportionate share hospital payments. [Specific reduction percentages differ in the similar House ways and Means provision.]

- The proposal phases down DSH payments by 5 percentage points each year from 1996 to 2000, so that payments in 2000 are 75 percent of the current law level. In 2001 and 2002, payments will continue at 75 percent of current law levels.

- The proposal mandates that DSH payments be adjusted so that total DSH payments during FY 1996 through 2002 should not exceed 5 percent of total estimated base PPS payments.

Issues:

- An across the board cut in DSH payments of this magnitude would especially affect hospitals that rely heavily on those payments, such as public hospitals. The proposal makes no provision to protect the most vulnerable DSH hospitals.

- The proposal mandates an adjustment to assure that DSH payments do not exceed 5 percent of estimated base PPS payments over a seven year period (1996 through 2002). It is not clear whether this adjustment should be determined in the aggregate or on a year-to-year basis.

- The proposed adjustment to limit DSH payments to 5 percent of base PPS payments raises the issue of whether retroactive adjustments would be necessary if initial estimates are inaccurate.

- Statutory language does not specify the continuation of the phase-down of DSH payments after 2002, thus implying that it rises to current levels after 2002.

Sec. 7015. Indirect medical education payments.
[The House proposal is very different from the Senate proposal, both with regards to IME, and GME in general.]

Medicare currently reimburses teaching hospitals for the indirect costs of teaching (i.e., lower efficiency and productivity, higher case mix) through indirect medical education payments (IME). The payment adjustment is currently based on a formula that increases the DRG payment by approximately 7.7 percent for each 10 percent increase in the ratio of interns and residents to beds. This proposal reduces the formula increase to 6.7 percent in FY 1996, 5.6 percent in FY 1997 and 4.5 for FY 1998-FY 2001. There is no provision for IME payments for FY 2002 and beyond.

Note: This was ProPAC's recommendation for an IME phase-down in its latest report.

Direct medical education payments

Medicare pays teaching hospitals for the direct costs of teaching (i.e., resident salaries, faculty salaries, administrative overhead) through direct medical education (DGME) payments. This proposal makes no changes to the current methodology.

Sec. 7016. Graduate medical education and disproportionate share payment adjustments for Medicare Choice.
[The House provision is significantly different.]

Phases in a policy that hospitals will receive the same GME (both direct and indirect) and DSH adjustments for patients that are covered under Medicare Choice plans as under the PPS system. This policy will begin in FY97, when hospitals will receive 50 percent of the PPS amount. For FY98 and thereafter, hospitals will receive exactly the same GME and DSH payments for risk-contract discharges as they do under PPS.

Issues:

Giving teaching and DSH hospitals the full GME and DSH payment adjustments on patients that are covered under risk contracts will likely have implications for the negotiations between hospitals and HMOs. Since HMOs would know that teaching and DSH hospitals are getting this additional funding, it is possible that HMOs would demand even lower rates than they currently do. Consequently, it is not clear that overall payments to teaching and DSH hospitals would increase. On the other hand, if HMOs pay lower rates to teaching and DSH hospitals and consequently send more patients to them than they otherwise would have, the amount of additional Medicare payments given to teaching and DSH hospitals could exceed the amount originally taken out of the AAPCC.

Sec. 7017 Payment for hospice services.

For FYs 1996-2002, payments for hospice services would be updated at the greater of the market basket minus 2.5 percentage points, or 1.1 percent (1.3 percent in FY 1996 and 1.2 percent in FY 1997). For each subsequent year, payments would be updated by the market basket. Currently, payment rates for hospice care services are increased annually by the hospital market basket index.

Sec. 7018 Extending Medicare Coverage of and application of hospital insurance tax to all State and local government employees.

The HI tax is extended to State and local government employees not otherwise covered under current law. The service of State and local government employees prior to January 1, 1996 would be considered covered employment for purposes of determining eligibility for Medicare coverage.

SUBCHAPTER B -- PAYMENTS TO SKILLED NURSING FACILITIES

Sec. 7031. Payments for routine service costs
[Identical to the House provision.]

The "routine service cost" portion of SNF payment, which is subject to routine cost limits, would be redefined to include ancillary services for cost reporting periods beginning in FY 1997. Routine service costs currently include nursing, room and board, administrative, and other overhead costs. Some ancillaries, outlined in the following section, would be deemed non-routine services and excepted from inclusion in the routine cost portion.

Issues: The definition of what is included as a routine cost is expanded to include ancillary services. This proposal has been recommended by the IG. Under this provision, there is no adjustment of the routine cost limits for this expanded definition of routine costs, which may place more complex patients at risk of inadequate services.

Sec. 7032. Incentives for cost effective management of covered non-routine services

[Almost identical to the House provision]

Non-routine services for beneficiaries receiving SNF care under Part A would be subject to new payment limits.

- Non-routine services are defined to include therapy services, prescription drugs, complex medical equipment, intravenous therapy and solutions, radiation therapy, and diagnostic services (laboratory, radiology, and pulmonary services).

Cost reporting periods ending in FY 1994 are to be used as the base year in setting the limits. Costs are updated using the greater of the SNF market basket minus 2.5 percentage points or 1.1 percent.

For each facility, the non-routine limit for a stay would be a blend of 50 percent of the national average amount paid for these services and 50 percent of the facility-specific amount paid for these services. The facility-specific amount would be calculated as the product of the average amount of Part A payments made for these services and the Secretary's best estimate for the average amount of payments made under Part B for these non-routine services.

As part of a new incentive system, each SNF would also be subject to cost limits applied to facilities in the aggregate. This limit would be calculated by multiplying the facility specific per stay limit and the number of stays for which payment to the SNF was made for the services. If actual costs were below this limit, the SNF could retain 50 percent of the difference though not more than 5 percent of the total. If costs were exceeded the limit, the Secretary would reduce payments for new stays.

- Separate limits would be established for hospital and freestanding SNFs.

- Exceptions to the limits would be allowed but could not exceed 5 percent of aggregate payments to all nursing facilities for non-routine services during the cost reporting period.

- For residents of SNFs who required intensive nursing or therapy services, a separate per stay limit would be established.

SNFs would be required to bill for all services that its Medicare patients receive.

Issues:

- The cost limit is established on a per discharge basis. The variation surrounding costs per discharge are so great that, in the absence of an adequate case-mix adjustor (which currently does not exist) there would be significant concerns about the advisability of this type of a payment limit.
- SNFs would have strong incentives to provide fewer ancillary services, due to the limits and incentive system, which may place more complex patients at risk of inadequate services.
- It is unclear how a separate payment limit for patients with "intensive nursing and therapy needs" would work as the payment limits apply on a facility, not individual, basis.

Sec. 7033. Payments for routine service costs
[Identical to the House provision.]

Extends the saving stream from the OBRA 93 freeze on SNF cost limits. (Note: This provision was in the President's FY 1996 Budget in February.)

The exceptions process would be altered by establishing an annual application period for adjustments to the limits and limiting the growth in aggregate payment for exceptions. The aggregate limit would be the payment made in the previous fiscal year increased by the SNF market basket.

Issues: More complex patients may be at risk of inadequate services as additional services are included in the routine costs, limits are placed on ancillary services, and exceptions are limited. Facilities, therefore, will likely avoid patients with greater resource needs. If admitted, there will be strong incentives to not provide these patients with needed services.

Sec. 7034. Reductions in payment for capital-related costs.
[Identical to the House provision.]

SNF capital payments would be reduced by 15 percent for cost reporting periods ending in FY 1996-2002.

Sec. 7035. Treatment of items and services paid for under Part B
[Identical to the House provision.]

For services or items in a SNF paid through part B, the amount currently considered reasonable would be reduced by 5.8 percent for cost reporting periods FY 1996-2002.

Sec. 7036. Medical review process.
[Identical to the House provision.]

The Secretary would establish and implement a medical review process to examine the effects of the amendments of this part on the quality of extended care services furnished to Medicare beneficiaries with particular emphasis on the quality of non-routine covered services.

Sec. 7037. Report by Prospective Payment Assessment Commission.

The Prospective Payment Assessment Commission would submit to Congress no later than October 1, 1997 a report including the following: (1) an analysis of the effect of the new SNF non-routine payment system on payment and quality, (2) an analysis of the advisability of paying for non-routine services on the basis of amounts paid for such services under part B, (3) an analysis of the desirability of maintaining separate limits for freestanding and hospital based SNFs, (4) an analysis of the quality of services furnished in SNFs, (5) an analysis of the adequacy of the process and standards used to provide exceptions to the limits.

Sec. 7038. Effective date
[Identical to the House provision.]

Unless otherwise specified, the amendments would apply to cost reporting periods beginning on or after October 1, 1996.

CHAPTER 3 -- PROVISIONS RELATING TO PART B

Sec. 7041. Payments for physicians' services.
[Similar to the House bill.]

This proposal would change the method used to update the Medicare physician fee schedule by a series of proposals recommended by the Physician Payment Review Commission. It ostensibly repeals the current Medicare Volume Performance Standard and replaces it with a very similar system, with:

(1) A single conversion factor, instead of the current three different factors,
(2) Specification of the single conversion factor for 1996 at $35.42 in statute (3.3 percent less than would occur under current law overall),
(3) Establishment of cumulative growth targets and basing them on real GDP per capita rather than historical physician volume/intensity, and increasing the maximum reduction in updates due to performance from 5 to 7 percentage points, and establishment of limits on annual bonuses at 3 percentage points.

Issues:

- There will be large differences between CBO and the Administration in pricing this provision.
  - CBO "scored" the provision as a big saver; the Administration is likely to score much lower savings.
- The Administration's savings from this provision come largely from the reduction in the conversion factor in 1996. In fact, the rest of the structure may be scored as a cost under the Administration baseline.
  - Differences between CBO and the Administration baselines account for this scoring difference.
  - It appears that the CBO baseline is higher (due to higher "projected" volume and intensity of services).
    - If the CBO baseline volume and intensity projections were similar to those of the Administration, it is believed that CBO would score much lower savings, if any, for the provision (apart from the 1996 conversion factor cut).
  - Thus, the "scorable" savings from this provision are highly contingent on assumptions about future volume and intensity of physician services.
  - If the actual volume and intensity of physician services turns out to be more like the projections made by the Administration (which are closer to historical figures), then there are no "real" savings here. Physicians will have obtained many legislative provisions (malpractice, CLIA exemption, physician service networks, referral relief) without paying any "real" price.

Sec. 7042. Elimination of formula-driven overpayments for certain outpatient hospital services.

[Same provision as in the House bill.]

Under current law, there is an anomaly in Medicare's payment for certain hospital outpatient department services which are paid on the basis of a blend of hospital costs and fee schedules. As a result of the anomaly, beneficiaries' coinsurance payments do not reduce Medicare payments on a dollar-for-dollar basis. This provision would correct this anomaly in the current payment formula. It would be effective for services furnished during portions of cost reporting periods occurring on or after October 1, 1995.

Issues: The formula would be fixed without addressing the issue of beneficiary coinsurance.

Sec. 7043. Payment for clinical laboratory diagnostic services. [Same update policy and limit reductions in the House bill.]

Payments for clinical lab services are based on local fee schedules, which are updated annually based on changes in the CPI. There is a cap on payment amounts, which for 1996 and subsequent years is set at 76 percent of the national median. The provision would (1) eliminate CPI updates from 1996 through 2002 (no updates were provided in 1994 or 1995); (2) reduce the payment cap to 65 percent of the national median fee beginning 1997; and (3) direct the Secretary to compare rates paid by Medicare with other volume purchasers and recommend changes in the fee schedule methodology.

Sec. 7044. Durable medical equipment.
[Similar provision in the House bill, except the House has a 20 percent reduction on the total oxygen rate.]

- The fee schedules for DME would be maintained at 1995 levels through 2002 rather than increased annually by the CPI-U as required by current law.

- Under current law, Medicare makes a single monthly payment for oxygen and oxygen equipment (excluding portable equipment). Effective 1/1/96, this provision would split this monthly payment such that separate monthly payments would be made for oxygen and oxygen equipment. The payment for oxygen equipment and for portable oxygen equipment would then be reduced by 40 percent.

- Upgraded DME - If a beneficiary purchases an upgraded item of DME, Medicare payment shall be made as if it were a standard item, and the beneficiary shall pay the supplier an amount equal to the difference between the supplier's charge and the Medicare payment amount for the standard item. A supplier's charge, however, may not exceed the applicable fee schedule amount (if there is one) for such upgraded item.

  The Secretary is required to issue regulations providing for consumer protection standards for furnishing upgraded equipment. These regulations must provide for:

  - determination of fair market prices for upgraded items.

  - full disclosure of the availability and price of standard items and proof of receipt of such information by the beneficiary.

- conditions of participation for suppliers in the simplified billing arrangement.
- sanctions for suppliers who engage in coercive or abusive practices, including exclusion.
- other safeguards determined to be necessary.

The provision is effective at such time as the Secretary issues the consumer protection safeguards.

Issues:

- In general, since there are no extra-billing requirements for DME, reductions of this magnitude increase the risk that costs could be passed along to beneficiaries.
- HCFA is currently in the process of determining whether Medicare's payments for home oxygen are grossly excessive through the inherent reasonableness process. Preliminary analysis could justify payment reductions in the current payment for oxygen and oxygen equipment in the range of 7 to 43 percent.
- Upgraded Items of DME - There is potential for abuse of this provision. There would be an incentive for suppliers to routinely try to persuade beneficiaries to purchase items that are above the standard version. Under current law, when a supplier or physician accepts assignment, the beneficiary's liability is limited to the coinsurance amount. This provision undermines the concept of assignment, since suppliers could bill beneficiaries for more than coinsurance amounts. It would establish a precedent for other areas such as physician services.

Sec. 7045. Updates for orthotics and prosthetics.
[The House bill provides a one percent update per year through 2002.]

The fee schedules for prosthetics and orthotics would be maintained at 1993 levels through 2002 rather than increased annually by the CPI-U as required by law (no updates were provided in 1994 or 1995).

Issues: Since there are no extra-billing requirements for orthotics and prosthetics, reductions in this area could be passed along to beneficiaries.

Sec. 7046. Payments for capital-related costs of outpatient hospital services.
[Similar to the House bill, which retains a 10 percent reduction.]

Payments for outpatient capital have been reduced since FY 1991 as a result of OBRA 90 and OBRA 93. Under current law, payments are reduced by 10 percent through 1998. The proposal would reduce hospital outpatient capital-related costs an additional 5 percent in FYs 1996-1998. (The total reduction in these years would be 15 percent.) This 15 percent reduction would also be maintained through 2002.

Sec. 7047. Payments for non-capital costs of outpatient hospital services.
[Same as in the House bill.]
A 5.8 percent reduction for hospital OPD services paid on a cost basis (and the cost portion of blended payments) has been in place since 1991 and is authorized through FY 1998. This proposal would extend this policy through 2002.

Sec. 7048. Updates for ambulatory surgical services.
[Same as in the House bill.]

The annual updates would be eliminated for ambulatory surgical center payments from 1996 through 2002 (rates have not been updated since 1993).

Sec. 7049. Payment for ambulance services.
[The House bill provides for a budget neutral fee schedule with updates.]

Medicare covers ambulance services when other forms of transportation would endanger the patient's health. Payments are based on "reasonable charges," which are updated annually. The provision would eliminate payment updates from 1996 through 2002.

Issues: Since there are no extra-billing protections for ambulance services, reductions in this area could be passed along to beneficiaries.

Sec. 7050. Physician supervision of nurse anesthetists.
[No provision in the House bill.]

Effective January 1, 1996, requires the Secretary to revise regulations to allow payment for certified registered nurse anesthetists (CRNAs) without supervision by the physician performing the operation or the anesthesiologist if allowed by State law.

Sec. 7051. Part B deductible.
[No provision in the House bill.]

The annual Part B deductible would be increased from $100 to $150 in 1996. In subsequent years, it will be increased by $10.00 each year.

Note: In the mark-up document, the deductible would have been increased only through 2002

Sec. 7052. Part B premium.
[Reflects the same policy as in the House bill, but the House bill would have the Secretary determine the premium.]

Premium amounts would be set in statute as follows: 1996 - $53; 1997 - $57; 1998 - $61; 1999 - $66; 2000 - $74; 2001 - $80; 2002 - $89. Beginning in 2003, premium would revert to 25% methodology.

Sec. 7053. Increase in Medicare Part B premium for high income individuals.
[Similar to the House bill, which has higher thresholds.]

Effective January 1, 1997, individuals with adjusted gross incomes plus tax-exempt interest in excess of $50,000, couples with incomes in excess of $75,000 would be responsible for an additional Part B premium (there would be no threshold for a married beneficiary who does not file a joint return). Thresholds are not indexed. The individuals would assume an increased percentage of the premium, with the premium subsidy being completely phased out at $100,000 for individuals and $150,000 for couples. That is -- between the 31.5 percent base premium and the income-related premium, these individuals would pay 100 percent of program costs.

Medicare enrollees will declare during open enrollment whether their incomes will exceed the thresholds for the coming year. The premium will be deducted from their Social Security checks. HHS will determine the correct premium deduction and notify SSA. HHS will reconcile the amount of the premium deduction through verification of the individuals declared income with the actual income reported to IRS.

Issues:

- In order to avoid this new "premium" being classified as a tax by CBO, the plan would collect the premium through HHS and SSA rather than through the IRS. Under the Medicare Catastrophic Coverage Act and the Health Security Act, the income-related premium would have been administered through the IRS. Implementation through HHS/SSA would require the creation a new bureaucracy and duplicative reporting system. Under the House proposal, the estimated administrative cost burden for implementation of such system for income thresholds of $75,000 and $125,000 (joint) totals $171 million ($17.8 million for FY 96, million, $16.9 million for FY 97, $12.7 million for FY 98 and $30.9 million for each year from FY 99 to 2002). The Senate proposal would be more costly to administer because the income threshold is lower and would affect 1.6 million more

beneficiaries. The comparable figures for Treasury administration are [negligible].

- Lack of indexing would mean that an increasing number of beneficiaries would be subject to the premium over time.

CHAPTER 4 -- PROVISIONS RELATING TO PARTS A AND B

SUBCHAPTER A -- GENERAL PROVISIONS RELATING TO PARTS A AND B

Sec. 7055 Secondary payor provisions.

- Makes permanent the provision that makes Medicare the secondary payer for disabled employees with employer-based health insurance.
  [Identical to House bill]

  Note: This provision was included in the President's FY 1996 budget in February.

- Mandates that for 30 months after entitlement, Medicare would be the secondary, rather than the primary payer for beneficiaries with ESRD who have health coverage through an employer group health plan.
  [House bill makes permanent the 18 month ESRD coordination period]

  Issues: This proposal would result in savings, but would increase by 12 months the time during which employers would be exposed to the high health care costs of covering ESRD beneficiaries. Concern has been raised in the past about the possibility that such an extension might lead insurers and employers to drop ESRD coverage. The President's FY96 budget in February proposed to make permanent a provision that, for 18 months after entitlement, Medicare would be the secondary, rather than the primary payer for beneficiaries with ESRD who have health coverage through an employer group health plan.

- Makes permanent HCFA's current authority to match data among HCFA, IRS, and SSA in order to identify the primary payers for Medicare beneficiaries with health coverage in addition to Medicare.
  [Identical to House bill]

  Note: This provision is included in the President's FY 1996 budget in February.

- Makes permanent the court injunction of April 1995 prohibiting HCFA from deeming group health plans the primary payer (and attempting to collect from them) for current retired or disabled beneficiaries who developed ESRD between August 1993 and April 1995.

[Similar to House bill]

Sec. 7056. Treatment of assisted suicide.
[Similar provision in the House bill.]

Stipulates that Medicare may not pay for items and services or may not assist in the purchase of health benefit coverage that includes items or services with the purpose of causing (or assisting in causing) the death, suicide, euthanasia, or mercy killing of a person.

Further stipulates that no health care provider or employee be required to inform or counsel a patient regarding assisted suicide, euthanasia, or mercy killing.

Sec. 7057. Administrative provisions.

- Maintains the Medicare status quo for Indian health providers. Clarifies that nothing in the Reconciliation Act can be interpreted as changing current law provisions that allow Indian Health Service hospitals and skilled nursing facilities (whether operated by IHS or by a tribe or tribal organization) and certain FQHCs (operated by a tribe, tribal organization, or urban Indian organization) to be eligible for Medicare reimbursement. [The House bill has no provision.]

- Effective 1/1/97, the certifying authority for Christian Science health facilities, for the purposes of Medicare payment, is changed from "the First Church of Christ, Scientist" to "the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc." [There is a similar provision in the House bill.]

Issues: Medicare law never has been brought up to date to fully recognize the changing circumstances of Indian health programs resulting from the Indian Self-Determination Act and the Indian Health Care Improvement Act. These two laws started a process of shifting both responsibilities for providing health care services and the funds to support them from IHS to tribal and urban Indian organizations who request it, under any of several different arrangements. IHS continues to provide some or all of the services directly, to the extent that tribal and urban providers do not opt to do so. The Senate bill preserves Medicare reimbursement eligibility for IHS but does not extend eligibility for Medicare reimbursement to these newer provider types.

SUBCHAPTER B -- PAYMENTS FOR HOME HEALTH SERVICES

Sec. 7061 Payment for home health services.
[Most of the provisions are similar to the House bill, except that H.R. 2485 would limit Part A financing of home health

services to 165 days of care. Part B financing would then be invoked (with no deductible, co-payment, or Part B premium increase) for services rendered after 165 days.]

- Effective for cost reporting periods beginning on or after 10/1/96, home health agencies (HHAs) would be paid on a national average per visit prospective rate for each of the 6 disciplines (skilled nursing, home health aide, PT, OT, speech pathology, and medical social services).

- The base year national average per visit rates would be established to equal the national average amount paid per visit to HHAs for the most recent cost reporting periods ending before 6/30/94. Per visit rates would be updated annually by the greater of the market basket minus 2.5 percentage points, or 1.1 percent (1.2 percent in FY 1997). [In the House bill, the base year national average per visit rates would be updated each year by the market basket minus 2 percentage points.]

- The per visit rates would be subject to one of 18 per episode limits, which are effectively dollar caps. (These 18 categories, based on HCFA's HHA PPS demo, serve as crude substitutes to a true case mix system.) The per episode limit for a category would cover all care provided to a beneficiary during a period of 120 days.

- No new episode of care would be recognized for reimbursement purposes until after a beneficiary has been discharged for a period of 60 days.

- The per episode limit is calculated to approximate all covered services delivered to a beneficiary during a period of 120 days, multiplied by the number of beneficiaries served by the HHA per year. Calculation of per episode limits would be done on a regional basis using areas that the Secretary finds most appropriate.

- HCFA would rebase the episode cap every 2 years to adjust for case mix changes.

- Each HHA would be paid per visit payments throughout the year. At the end of the year, an agency's aggregate limit would be calculated by first multiplying the Secretary's regional target per episode limit for each of the 18 case categories times the number of episodes admitted by an agency to each of the 18 categories. The sum of these products becomes the agency aggregate payment limit. For purposes of calculating agency-specific per episode limits, 165 days of care per episode would be counted.

- New HHAs not receiving payments in the base year period of FY 1994 would be subject to the regional per episode limits immediately.

- Total per visit payments to an agency would be compared with the aggregate payment limit. HHAs that keep total payments for the year below the annual cap would be allowed to retain 50 percent of the savings; shared savings could not exceed 5 percent of an agency's aggregate Medicare payments in a year.

- Separate Part B billings would be prohibited for any services covered under the per episode limit while the beneficiary is receiving home health services. Agencies would bill furnished prosthetics and orthotics under the Part B fee schedule.

- If a beneficiary continues to need home health visits after a period of 165 days, then an agency may request that additional payments be made on a per visit basis. These payments would not be subject to the aggregate limit.

- The cap would be adjusted by case mix categories based on HCFA's PPS demo. To combat case mix creep in FYs 1997-2000, the Secretary will adjust case mix to assure budget neutrality. For each subsequent year, the Secretary could remove the effects of case mix increase due to reporting improvements, but not "real changes in patients" resource usage. [In the House bill, to combat case mix creep, the Secretary would be required to adjust per episode limits to assure that aggregate case mix, at the regional level, remains budget neutral.]

- Recertification for home health eligibility would be made at 30, 60, 120, and 165 days of home health care, as opposed to the current law 60-day interval.

- HCFA would be required to revise its medical review process to assess patterns of care to assure that beneficiaries receive appropriate services per episode. Medical reviews would be required to focus on short-stay cases and cases over 165 days.

- The Secretary would be required to make adjustments in payments to home health care agencies to account for such irregularities intended to circumvent the system (prematurely discharging patients to another home health agency or similar provider; altering corporate structure or name to avoid being subject to payment limits or for purposes of increasing Medicare payments; and any other actions that are unnecessary for effective patient care and that are intended to maximize Medicare payments).

- The Secretary would be required to develop a system to track home health patients who receive care from more than one

agency during an episode. The Secretary would be required to adjust payments to assure that total amounts paid to these agencies are no greater than the payment that would otherwise have been made if the patient had completed the episode in a single agency.

- The Secretary would also be required to develop a system to adjust payments to eliminate any increase in growth in the percentage of low-cost episodes over the percentage of such cases occurring at the agency for the 12-month cost reporting period ending 6/30/94.

Issues:

- The proposal envisions implementation almost immediately. However, implementation would require a substantial 2-3 year lead time to collect case-mix data and updated cost report data, and to ensure their validly and reliability. Implementation requires reliable data, systems to collect them, and a tested working model.

- The proposal relies on an untested new payment methodology. Especially problematic is the case-mix adjuster. The case-mix adjustment methodology is inappropriately based on a simplified model that explains only 10% of the variation in costs. The model was designed only for use in HCFA's demo and was not intended for use in establishing episodic payment rates for a national system. The demo was intended to analyze the severity of a particular agency's case load; therefore, the 18 case categories are not the best way to establish to set payment rates for each type of patient across regions. The application of this case-mix adjuster would invite case mix creep ("upcoding") and could result in costs, rather than savings, to the program.

- The episode cap is designed to control volume, but it is nothing more than a budget ceiling that creates strong incentives to HHAs to avoid heavy/long-care patients and serve large numbers of low cost cases. The requirement that HHAs provide care up to 165 days (but get paid for only 120 days worth of service) for patients who need extended care could hurt access to and continuity of care for the sickest patients with the greatest needs.

- In spite of the shared-savings provision, the cap provides an incentive to maximize utilization up to the cap since HHAs may be able to generate more revenues by providing low cost/low skilled visits than by sharing 50 percent of the savings. As a result, this could erode anticipated savings significantly.

- The proposal allows outliers (cases exceeding 165 days) that would be paid a per visit rate -- not subject to the aggregate cap -- with no constraint on utilization.

- Recertification for home health eligibility at 30, 60, 120, and 165 days could be expensive and administratively burdensome.

- HCFA would be required to investigate, and make payment adjustments for, irregularities intended to circumvent the system (premature discharges, transferring patients between HHAs, creating mini-episodes, etc.) There is absolutely no mechanism by which HCFA could learn of these irregularities while they are happening.

Sec. 7062 Maintaining savings resulting from temporary freeze on payment increases for home health services.
[Identical to the House bill.]

OBRA-93 required that there be no changes in home health cost limits (including no adjustments nor changes in the wage index or other updates of data) for cost reporting periods beginning on or after 7/1/94, and before 7/1/96. Under this proposal, for cost reporting periods beginning on or after 7/1/96, the savings generated by the OBRA-93 "freeze" on cost limit adjustments, but not the freeze itself, would be extended indefinitely in setting future home health limits by not allowing for the inflation that occurred during the two freeze years. In addition, the Secretary would not be allowed to account for the effects of this restriction on cost limit changes when granting exemptions or exceptions to the cost limits. This provision was included in the President's FY96 Budget proposal in proposal.

Sec. 7063. Extension of waiver of presumption of lack of knowledge of exclusion from coverage for HHAs.
[Identical to the House bill.]

Extends the "favorable presumption" toward the limitation on liability for HHAs (due to expire 12/31/95) to 9/30/96.

Issues: HHAs now have more explicit coverage regulations and guidelines; thus, there this is sufficient information available to them to hold them responsible for all coverage decisions. Extension of the favorable presumption will cost money.

CHAPTER 5 -- RURAL AREAS

Sec. 7071. Medicare-dependent, small, rural hospital payment extension.

The Medicare-dependent hospital program is re-instituted effective for cost reporting periods on or after September 1, 1995. This program was terminated September 30, 1994. Criteria for inclusion in this program remain unchanged (100 or fewer beds and at least 60% Medicare patient days or discharges.) These hospitals are paid as if they were sole community hospitals.

Issues: There are a relatively few hospitals which meet these criteria, and therefore the reinstitution of this program will probably result in a minor cost impact.

Sec. 7072. Medicare rural hospital flexibility program.
[House continues EACH/RPCH program, does not mention MAF.]

A new program, the Rural Hospital Flexibility Program, (similar to the Rural Primary Care Hospital [RPCH] program) is established in all states with an unspecified grant program. The State must have at least one rural health network and one critical access hospital. These limited service hospitals must be located at least 35 miles from another hospital, be a "necessary provider" of services in the area, provide 24 hour ER services, have no more than 6 acute care inpatient beds providing inpatient care for no more than 72 hours (with emergency time provisions), and not be fully staffed unless there are inpatients present. Physician assistants, nurse practitioners, or clinical nurse specialists may provide care under the supervision of a physician who does not have to be present. Hospitals participating in the swing bed program may use 12 beds. These hospitals are paid on a reasonable cost basis. The Secretary may award grants to states for rural planning, network development, and designation of critical access hospitals, ($25 million is authorized for each FY 1996 through 2000.) HCFA must submit a report to Congress by January 1996 on the 72-hour limitation.

The Medical Assistance Facility (MAF) Program in Montana is continued for all qualified facilities in that state until December 31, 2002.

Issues: This institutes a program similar to the RPCH program prior to the changes announced in the September 1, 1995, regulation, based on a strict interpretation of the 1994 Social Security Amendments. (The major change in the current rule is the elimination of the swing bed option for new RPCHs.) Under this program additional states could participate (currently there are seven that participate in the RPCH program), and the grant program for statewide planning and development is expanded (no grant funds were expended in FY 1995.) It is unlikely that HCFA will be able to meet the January 1996 deadline for the report to Congress on the 72-hour limitation.

Sec. 7073. Establishment of rural emergency access care hospitals.

[The House provision is similar]

A new rural emergency access care hospital (REACH) program is established for rural hospitals to serve patients who stay only 24 hours. Medicare payments are based on reasonable costs. There are limiting criteria for allowing hospitals to participate in this program (e.g., hospital financial status and staffing available.)

Issues: This program is similar to the RPCH program on a more restrictive scale, i.e., shorter length of stay and no overnight beds. It also applies financial criteria to hospitals participating in this program.

Sec. 7074. Additional payments for physicians' services furnished in shortage areas.

[No provision in the House bill.]

- Increases the bonus payment for primary care services furnished in rural health professional shortage areas (HPSAs) from 10 percent to 20 percent effective 10/1/95. Maintains for three years the bonus payments for areas that are removed from the HPSA list, effective 1/1/96.

- Requires carriers to provide periodic information to the Secretary on the types of providers to whom the carrier makes the bonus payments, together with a description of the services furnished by such providers.

- Requires the Physician Payment Review Commission (PPRC) to conduct a study analyzing the effectiveness of the provision of increased bonus payments in recruiting physicians to provide services in HPSAs. Requires the Secretary to submit to Congress the report conducted by PPRC, including recommendations the Secretary considers appropriate, by 1 year from enactment.

Issues:

- Places unnecessary burden on carriers. This report could alternatively be done from a national claims file.

- Requiring the Secretary to submit a report prepared by a congressional commission is odd.

Sec. 7075. Payments to physician assistants and nurse practitioners for services furnished in outpatient or home settings.

Currently, Medicare makes direct payments to nurse practitioners (NPs) in rural areas and in nursing facilities. Payment is 75 percent of the physician fee schedule for services furnished in

inpatient settings and 85 percent for all other services. Medicare also makes direct payments to physician assistants (PAs) (payments go to the employer) in hospitals, nursing facilities, and in rural health professional shortage areas. Payment is 75 percent of the physician fee schedule for services in inpatient settings, 65 percent for assistant-at-surgery services, and 85 percent for nursing facility and outpatient settings.

Effective 10/1/95, this proposal would allow physician assistants and nurse practitioners to be paid directly in all outpatient and home settings, as defined by the Secretary. In these settings, payments could be made directly to the NP or PA, and payment would be 85 percent of the physician fee schedule. Payment for assistant-at-surgery services would also be 85 percent of the fee schedule for physicians who are assistants-at-surgery.

Sec. 7076. Demonstration projects to promote telemedicine.
[No provision in the House bill.]

An additional telemedicine grant program will be available through the PHS Office of Rural Health.

Sec. 7077. ProPAC recommendations on urban medicare dependent hospitals.
[No provision in the House bill.]

Requires ProPAC to submit a report to Congress in early 1996 with recommendations for an appropriate update for urban hospitals with a high proportion of Medicare patient days.

CHAPTER 6 -- HEALTH CARE FRAUD AND ABUSE PREVENTION

SUBCHAPTER A -- FRAUD AND ABUSE CONTROL PROGRAM

Sec. 7101. Fraud and abuse control program.
[Similar to House bill]

- The Secretary, acting through the OIG, and the Attorney General would jointly establish a program to: coordinate Federal, State, and local law enforcement efforts to combat fraud and abuse in the delivery of, and payment for, health care; conduct investigations, audits, evaluations, and inspections relating to the delivery and payment of health care; facilitate the enforcement of statutes applicable to health care fraud and abuse; and to provide for the modifications to existing safe harbors, new safe harbors, interpretive rulings, and special fraud alerts.

  Issue: HCFA, OIG, and DOJ are currently coordinating such activities under Operation Restore Trust.

- The Secretary and the Attorney General shall arrange for the sharing of data with health plans. Guidelines would be issued that relate to the furnishing of information by health plans, providers and others to enable the Secretary and the Attorney General to carry out the fraud and abuse control program, including coordination with health plans.

- **Health care fraud and abuse account.** Establishes an account to receive all monies (up to a ceiling of $200 million in FY 1996, with 15 percent annual increases thereafter) from all civil money penalties, fines, forfeitures, and damages assessed in criminal, civil, or administrative health care cases, along with any gifts. The account will be used for the costs of administration and operation of the coordinated fraud and abuse control program for HHS-OIG and DoJ, and for additional activities of the State Medicaid Fraud Control Units.

- **Annual report.** The Secretary and the Attorney General shall annually report to Congress the amount of revenue which is generated and disbursed by the Health Care Fraud and Abuse Account.

Sec. 7102. Application of certain health anti-fraud and abuse sanctions to fraud and abuse against federal health programs.

Extends criminal penalties for acts involving Medicare or State health care programs to all Federal and State health care programs. The Secretary in consultation with State and local health care officials may identify community service obligations that a court may impose upon the conviction of a criminal health care offense.

Sec. 7103. Health care fraud and abuse guidance.
[Similar to House bill]

The Secretary shall publish an annual notice in the Federal Register soliciting proposals for modifications to existing safe harbors, new safe harbors, interpretive rulings, and special fraud alerts. Proposed rules with comment period and final rules modifying existing safe harbors and establishing new safe harbors will be published. The public can at any time request interpretive rulings related to anti-fraud and abuse laws applicable to Federal and State health care programs. Ninety days after receipt of a request, the HHS-OIG in consultation with DoJ, must publish in the Federal Register interpretive rulings that will not have the force of law. The public can request the OIG to investigate and issue a special fraud alert informing the public of practices which could relate to fraud and abuse against Federal and State health care programs.

Issues:

- Initiating a new rulemaking on safe harbors whenever the public requests would be burdensome and probably unnecessary since current safeharbors are sufficiently broad.

- If interpretive rulings were mandated for the anti-fraud and abuse laws applicable to Federal and State health care programs, HHS would be inundated with requests.

SUBCHAPTER B -- REVISIONS TO CURRENT SANCTIONS FOR FRAUD AND ABUSE

Sec. 7111. Mandatory exclusion from participation in Medicare and State health care programs.

[No provision in House bill]

The Secretary must exclude providers from Medicare and Medicaid if they have been convicted of a felony relating to health care fraud or controlled substance.

Sec. 7112. Establishment of minimum period of exclusion for certain individuals and entities subject to permissive exclusion from Medicare and State health care programs.

[No provision in House bill]

The Secretary may exclude persons convicted of a criminal misdemeanor related to health care fraud. The proposal sets a minimum three-year period of exclusion.

Sec. 7113. Permissive exclusion of individuals with ownership or control interest in sanctioned entities.

[No provision in House bill]

The Secretary may exclude individuals with a direct or indirect ownership or control interest of 5 percent or more in an entity or is an officer or managing employee if the entity is already excluded from Medicare or a State health care program or has been convicted of a criminal offense relating to health care fraud.

Sec. 7114. Sanctions against practitioners and persons for failure to comply with statutory obligations.

[No provision in House bill]

(a) The Secretary may exclude practitioners and persons failing to meet statutory obligations for a minimum of one year.

(b) The "unwilling or unable" condition for the imposition of sanctions is repealed.

Sec. 7115. Intermediate sanctions for Medicare health maintenance organizations.
[Similar provisions in the House bill]

- Provides for termination of contract, civil money penalties, or suspension of enrollment or payments as intermediate sanctions against HMOs.
- HMOs will be permitted to develop and implement corrective action plans before penalties are imposed.
- Each HMO must have an agreement with a peer review organization (PRO) or similar organization to perform quality review.

Sec. 7116. Clarification of and additions to exceptions to anti-kickback penalties.
[Similar provision in the House bill.]

The anti-kickback law specifies exceptions including discounts to providers, if properly disclosed and reflected in costs claimed under Medicare or Medicaid. The provision would:

- Add an exception allowing payments to providers, discounts given by providers, or other remuneration in connection with services furnished through a Medicare Choice plan.
- Require the Secretary to study the benefits of discounts to the Medicare program, including those offered as part of "capitation, risk sharing, decrease management or similar programs." Based on the study's findings, the Secretary would develop budget neutral regulations on the acceptability of discounts.

Issues:

- The new exception is broad and poorly defined, and could create a loophole in the law. It would appear to permit a wide, undefined range of "remuneration" in Medicare Choice plans that would likely violate the anti-kickback law applicable in other contexts.
- The exception does not require disclosure of payments or discounts, which is a key element of the existing discount exception.

SUBCHAPTER C -- ADMINISTRATIVE AND MISCELLANEOUS PROVISIONS

Sec. 7121. Establishment of the health care fraud and abuse data collection program.
[No provision in House bill]

Establishes a national health care fraud and abuse data collection program for reporting final adverse actions against health care providers, suppliers, or practitioners. The tax identification number (TIN) of those subjected to a final adverse action would be also reported.

Issue: Including TINs in a final adverse action data base would provide this information after the fact, and it would be ineffective in preventing "bad actors" from entering the program. To permit verification that suppliers and providers were not previously involved in fraudulent or abusive behavior, submission of TINs and social security numbers of all entities that request a supplier or provider number would be necessary at time of application.

SUBCHAPTER D -- CIVIL MONETARY PENALTIES

Sec. 7131. Social security act civil monetary penalties.
[No provision in House bill]

(a) Civil money penalties and assessments will be used to pay back Medicare and Medicaid. Remaining dollars will go to the health care fraud and abuse account.

(b) If an individual is excluded from Medicare or a State health care program and maintains a direct or indirect ownership or control interest of 5 percent or more in an entity or is an officer or managing employee of a Medicare or State health care program entity shall be subject to civil money penalties.

(c) Civil money penalties are increased to $10,000 for many current law fraud and abuse activities.
[Similar provision in House bill]

(d) Allows civil money penalties to be assessed for (1) incorrect coding; (2) medically unnecessary services; and (3) persons offering remuneration (including waiving coinsurance and deductible amounts) to induce the individual to order from a particular provider or supplier receiving Medicare or State health care funds.

Issues:

- There should be an abnormal pattern of ordering medically unnecessary services before a civil money penalty is levied.
- The Secretary can impose intermediate civil money penalties of not more than $10,000 per violation for criminal anti-kickback violations.

SUBCHAPTER E -- AMENDMENTS TO CRIMINAL LAW

A health care fraud section is added to the criminal code.

SUBCHAPTER F -- STATE HEALTH CARE FRAUD CONTROL UNITS

Sec. 7151. State health care fraud control units.
[No provision in House bill.]

Extends the authority of the units by allowing the units to investigate other federal fraud abuses and allowing investigation and prosecution in the case of patient abuse in non-Medicaid board and care facilities.

CHAPTER 7 -- OTHER PROVISIONS FOR TRUST FUND SOLVENCY

SUBCHAPTER A -- GENERAL PROVISIONS

Sec. 7171. Conforming age for eligibility under Medicare to retirement age for social security benefits.

Raises the age of eligibility for Medicare benefits from age 65 to age 67 over the years 2003 to 2027 in the same steps as for Social Security old-age pensions.

The eligibility age for Supplemental Security Income (SSI) is raised in tandem with that for Medicare.

Issues:

- It is not clear that an insurance market exists for persons age 65 and over. The proposal could thus have a harmful impact on individuals who would otherwise be eligible for Medicare.
- Raising the eligibility age for SSI would mean that those who would otherwise have qualified for Medicaid through SSI could not do so until later.

Sec. 7172. Nondischargeability of certain Medicare debts.
[No provision in the House bill.]

Under Federal bankruptcy law, debtors are discharged in certain statutorily-defined cases (for example, liquidation and reorganization). This provision states that any discharge under Federal bankruptcy law would not discharge an individual debtor from any debt for an overpayment to a Medicare provider or supplier.

Sec. 7173 Transfers of certain Part B savings to hospital insurance trust fund.

[The House has a "lockbox" that puts all Part B savings in a trust fund from which funds cannot be expended without amending the law.]

All savings resulting from changes in Part B premium and Part B deductible shall be transferred from the general fund of the Treasury to the Hospital Insurance Trust Fund.

SUBCHAPTER B -- BUDGET EXPENDITURE LIMITING TOOL

Sec. 7175. Budget expenditure limiting tool.

[The House has a "failsafe" mechanism.]

- The Medicare BELT proposal sets mandatory Medicare outlay targets at: $193.3 billion in FY 1996, $206.5 billion in FY 1997, $219.7 billion in FY 1998, $233.5 in FY 1999, $249.6 in FY 2000, $266.9 in FY 2001, and $285.6 in FY 2002.

- Beginning for FY 1996, based upon CBO and OMB estimates of Medicare outlays for the fiscal year in comparison to baseline Medicare outlays (as defined by the FY 1995 Budget Act) for the fiscal year, a presidential order to bring spending within the annual target for the fiscal year will be issued by October 15. This order will specify the reduction in payment amounts to meet the annual spending target.

- The Secretary may adjust the percentage changes to payment rates to reflect the variation in rates of growth in per capita spending across medicare payment areas.

- Based on a final OMB report on Medicare spending, a Presidential order will be issued specifying reductions in provider service payments. Each payment amount for covered services would be reduced by a specified percentage which, when applied proportionately to all payments, will equal the amount of reductions needed to bring spending within BELT targets.

- Congress retains the ability, through an expedited process similar to reconciliation, to alter the way across-the-board cuts are applied to the various Medicare payments for services. Three-fifths of the Senate and House are needed to approve such changes.

- The payment adjustments will also affect the coinsurance, deductible, or premium amounts payable by Medicare beneficiaries.

Issues:

- The average annual rate of growth allowed under the BELT is 6.7 percent, considerably lower than the average annual rates of growth projected in either the CBO or Administration's baseline estimates (9.6 percent and 9.1 percent respectively).

- Although CBO does not estimate that the BELT would go into effect, if it did the across-the-board cuts could be quite large, and could potentially result in negative payment increases from one year to the next.

- The rate reductions under the BELT are limited to fee-for-service Medicare.

Prepared by HHS.