The Medicare Preservation Act
"A BETTER MEDICARE"

I. Introduction of the Better Medicare Plan

On April 3rd, the Board of Trustees for the Medicare Hospital Insurance and Supplementary Medical Insurance trust funds urged the Congress to begin a careful examination of the Medicare program because both trust funds are facing significant financial problems in both the short-term and the long-term.

This document presents a comprehensive plan for a better Medicare program (hereinafter called "MedicarePlus") for improving beneficiary choices of health care coverage under the Medicare program. It provides a description of relevant provisions of current law and the major provisions of the plan. This proposal has been prepared after months of public hearings of the Ways and Means and Commerce Committees, testimony from scores of witnesses, countless meetings with seniors, providers, actuaries, health plan professionals, and town hall meetings across the country.

The proposal reflects careful listening and thoughtful consideration.

II. Reasons for Promoting New Approaches Within Medicare

a. The Medicare Hospital Insurance Trust Fund Is Severely Out of Financial Balance

According to the 1995 report of the Board of Trustees, the outlays of the Hospital Insurance (HI) trust fund will exceed income beginning in 1996 and the trust fund is projected to run out of reserves in 2002, using the intermediate set of assumptions. Moreover, under even the most optimistic set of assumptions, the trust fund is projected to be depleted in just 11 years, in 2006.

The long-range financial outlook is even more unfavorable. Over the 75-year projection period, the HI fund has an actuarial balance of -3.52%, using the intermediate set of assumptions. This actuarial balance indicates that the HI payroll tax rate of 1.45 percentage points (employers and employees each) would have to be more than doubled immediately to keep the fund solvent for the entire projection period. To keep the HI fund in actuarial balance for 25 years would require an immediate 0.65 percentage point increase in the payroll tax rate if spending is not slowed--a 44% tax rate increase.

In the report, the Board of Trustees urges Congress to act:

> "The HI trust fund continues to fail the short range test of financial adequacy and is projected to experience increasing annual deficits in future years, beginning in calendar year 1996....Trustees urge the Congress to take additional actions designed to control the HI program costs and to address the projected financial imbalance in both the short-range and the long-range through specific program legislation as part of broad-based health care reform. The Trustees believe that prompt, effective, and decisive action is necessary."

The two public members of the Board commented further:

> "The Medicare program is clearly unsustainable in its present form. We had hoped for several years that comprehensive health care reform would include meaningful Medicare reforms. However, with the results of the last Congress, it is now clear that Medicare reform needs to be addressed urgently as a distinct legislative initiative."

b. Medicare Spending Growth Is Unsustainable

Not only is the HI trust fund financially out of balance, but spending growth by the Supplementary Medical Insurance (SMI) trust fund is also a concern because the SMI rate of growth is unsustainable. SMI cost growth directly affects Medicare beneficiary Part B premiums as well as general revenues from which the largest share of SMI costs are financed.

In 1995, premiums paid by enrollees will finance only about 31.5% of annual costs, according to the 1995 trustees' report. Over the next decade, the contribution from general revenues to the SMI trust fund will increase from $46 billion in 1995 to $151 billion in 2004, for an average annual growth rate of over 14%.

As noted by the Board of Trustees in the 1995 report:

> "Although the SMI program is currently actuarially sound, the Trustees note with great concern the past and projected rapid growth in the cost of the program. In spite of evidence of somewhat slower growth rates in the recent past, overall, the past growth rates have been rapid, and the future growth rates are projected to increase above those of the recent past. Growth rates have been so rapid that outlays of the program have increased 53 percent in the aggregate and 40 percent

per enrollee in the last 5 years. For the same time period, the program grew 19 percent faster than the economy despite recent efforts to control the cost of the program. As a result, the incurred disbursements of the program are projected to increase from 0.93 percent of the Gross Domestic Product (GDP) in CY 1994 to 4.29 percent of GDP in 2069."

Overall Medicare spending is also growing much faster than nearly all other major federal programs. Between 1995 and 2005, the Congressional Budget Office projects Medicare spending will grow at an average annual rate of 10.4%. That compares to a 5.4% growth rate for the Social Security program and 3.6% for the rest of the federal budget, excluding net interest and Medicaid.

c. *Medicare Lags Behind Private Sector Coverage Changes*

Medicare insurance coverage remains largely as it was originally enacted in 1965: traditional fee-for-service indemnity insurance with beneficiary cost-sharing requirements to control utilization, and a small health maintenance organization program.

However, private health insurance has evolved substantially since that time. More and more privately insured Americans are enrolled in managed care plans, such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). According to the Group Health Association of America (GHAA), some 56 million Americans were enrolled in HMOs in 1994, up from 36 million in 1990, and 65% of people with employer-based health insurance plans were enrolled in some form of managed care arrangement, according to KPMG Peat Marwick's Health Benefits in 1994 (October 1994).

Moreover, managed care organizations have recently been successful in slowing the rate of growth of premiums. In 1995, on average, HMOs are expected to reduce their per person premiums by 1.2%, according to GHAA. Private health plan costs average $1,900 per person this year compared with Medicare costs of $4,800 per enrollee.

Some private employers have also begun to offer their employees medical savings accounts. Such accounts allow employees and their dependents to control their health care dollars, providing strong incentives for cost-conscious spending.

Medicare beneficiaries can enroll in HMOs under the risk contracting program and other managed care arrangements, but, due to certain features of the program, managed care remains a relatively small part of Medicare, with only 8 percent of the beneficiaries

enrolled in managed care plans as of December 1994. Medicare beneficiaries are also not currently able to enroll in any kind of medical savings account, point-of-service or other kinds of insurance arrangements now available to the under-65 population.

III. Mission Statement

For all of the above reasons, we are proceeding on the basis of a mission to preserve, protect and strengthen the Medicare program. For our purposes:

- *to preserve Medicare* is to make the program solvent and keep it affordable for the current and future generations;

- *to protect Medicare* is to assure the beneficiaries that the program as they know it will continue to be available; and

- *to strengthen Medicare* is to provide beneficiaries with private coverage options that empower them to choose the health plan that best fits their needs.

IV. Criteria for Reform

We adopted the following criteria to guide our reform efforts:

With the exception of the most affluent beneficiaries whose subsidy by the general taxpayer will be reduced and phased out, Medicare beneficiary cost sharing proportions shall not be increased over the next seven years.

Policy improvements to make Medicare solvent and affordable will ensure that Medicare continues to increase spending each year, but Medicare spending growth will be brought in line with the need to assure solvency in Part A and to make Part B affordable, rather than continuing at the uncontrolled and excessive rates experienced in the past.

Policy improvements will be designed to create opportunities for beneficiaries to choose more modern private coverage options, as well as for health care providers to reduce waste, eliminate abuse and increase efficiency.

V. Medicare Solvency Principles

We adopted the following principles with respect to meeting our objectives on assuring the solvency of the Part A Trust Fund and managing the future rate of growth in program spending:

For FY 1996 - 2002, Medicare spending will grow per beneficiary. In fact, under our plan. Medicare per enrollee spending will increase from $4,800 to $6,700 by the year 2002.

Spending for beneficiaries will grow, in aggregate, at the same rate whether enrolled in MedicarePlus plans or in the fee-for-service system.

Medicare spending policy will be managed to extend significantly the solvency of the Part A Trust Fund, and to moderate increases in both the beneficiary contributions to and the general taxpayers' subsidy of the Part B Trust Fund.

A Commission on the effect of the Baby-Boom Generation on the Medicare Program will be established to make recommendations to the Congress on the reforms necessary to ensure the preservation of the program, especially in light of anticipated demographic pressures on the program's financing.

Under this plan, Medicare spending will increase every year:

	1995	1996	1997	1998	1999	2000	2001	2002
Per Enrollee Spending	$4816	$5081	$5283	$5525	$5772	$6003	$6354	$6734

Between 1995 and 1996 alone under this plan, Medicare Part A spending will increase by almost 6 percent according to preliminary estimates. Preliminary figures also indicate that Medicare Part B spending will grow by 7.6 percent. The Medicare program will be preserved from bankruptcy even as spending increases at these rates.

VI. Background Descriptions of Current Law and Major Provisions of the MedicarePlus Program

SUBTITLE A - MEDICAREPLUS

I. MedicarePlus Overview

Currently, Medicare beneficiaries have two options: 1) enrollment in the standard Medicare benefit package delivered through a fee-for-service (FFS) system, which beneficiaries can

improve upon at personal expense through purchase of federally standardized Medigap policies: or 2) enrollment in the standard benefit package delivered through a health maintenance organization contract, which can be improved upon by the HMO, at either no or some expense to the beneficiary depending on certain rules.

Provision:

Under the MedicarePlus reform proposal, the law would be changed to permit a broader array of privately offered plans to be made available to beneficiaries, with the government making premium-type payments to plans on beneficiaries' behalf. These payments will purchase for beneficiaries private plans that will cover the complete Medicare Parts A and B benefits, and those plans may be enriched through the addition of supplemental benefits or reduced cost-sharing. The new plan choices could include coordinated care, fee-for-service or point-of-service products, and an option for a medical savings account paired with high-deductible insurance coverage. **Beneficiaries would continue to have the option of remaining in or returning to the program administered by the Health Care Financing Administration (HCFA).**

Any health plan that is offered to Medicare beneficiaries is accomplished through contracts with the government. This is necessary to transfer legal authority and public monies to private organizations on behalf of Medicare beneficiaries. So, in practical effect, the decision to expand plan choices under the Medicare law is a decision to legally expand the range of contracting options (both with respect to types of organizations and plan offerings) available for the government to enter into on beneficiaries' behalf. Plans will be required to meet standards in areas of consumer protection, quality assurance, and financial solvency. Following are the major types of contracting organizations that will be able to participate in the MedicarePlus program, and a description of the plans that may be offered to beneficiaries.

II. MedicarePlus Plans

(1) Medisave

Background:

Medisave refers to a MedicarePlus product that pairs purchase of a high-deductible insurance policy with a designated, Medicare medical savings account (MSA). The insurance policies are offered by traditional insurers, and the MSAs are managed by a financial trustee, similar to individual retirement accounts (IRAs).

One of the major advantages of the Medisave design is that Medicare beneficiaries will be permitted to gain direct, personal control over how part of their Medicare benefit is provided, and what it can be used for. For instance, beneficiaries could use funds deposited in the MSA to pay for prescription drugs or long-term care insurance premiums. Also, the higher deductible insurance coverage encourages beneficiaries to be

prudent purchasers of routine services, while granting beneficiaries the opportunity through the MSA deposits to accumulate savings to protect against the deductible or other expenses of an illness.

Provision:

Beneficiaries will be given the choice to select a Medisave product and gain direct control over some of the financial value of their Medicare benefit. If the beneficiary chooses a Medisave plan, the Medicare program would make monthly, risk-adjusted premium payments to the insurance carrier for the high-deductible insurance. Any residual difference between the cost of the insurance policy and the government's average contribution will be deposited into the MSA designated by the beneficiary as his or her Medicare account.

MSAs are grantor trusts for tax purposes, which means that there are no limits on maximum contributions, no tax advantage to contributions, and any earned interest or "inside build-up" is fully taxable. Beneficiaries will be able to spend MSA funds on any qualified medical expense as defined under the tax code, and to withdraw unspent funds from the account with certain stipulations. If funds are withdrawn and spent for a non-medical purpose, there will be assessed an excise tax penalty for such withdrawals if the fund balance drops below a minimum level.

The proposal provides that the minimum balance would be 60 percent of the deductible level. It would be a "soft" requirement to restrict the withdrawal of funds below the 60 percent level for non-medical purposes. Any withdrawal for qualified medical purposes, even down to a zero account balance, could occur without penalty. The purpose of the minimum balance threshold is to encourage, but not require, beneficiaries to build and maintain some level in the MSA against the contingency of a high cost illness.

In addition, a ceiling will be established on the maximum level of the deductible for the insurance policy. Insurance companies will be permitted to offer catastrophic plans, but the deductible level will not be permitted to exceed $10,000. This is to both protect beneficiaries from overly high out-of-pocket liability and prevent inappropriately high levels of cash deposits into the MSA. Regardless of the level of the deductible, insurers will not be permitted to sell "gap" coverage to beneficiaries to insure against the deductible.

(2) Limited Enrollment Plans: Union or Association Sponsors

Background:

Limited enrollment plans are health plans offered by sponsoring organizations such as unions and membership associations. These sponsors, provided they meet certain federal

standards, would be permitted to contract with Medicare to provide coverage to beneficiaries who are members for the sponsoring organizations. Unions and associations, at their option, could provide plans as a service to members, enhancing plan choices for beneficiaries. These entities, to the extent they provide health benefits to non-Medicare populations, are currently regulated to varying degrees under other federal laws. For instance, some union plans are regulated as trusts under the Taft-Hartley Act. Employer associations and certain other types of associations are regulated by states under specific federal authority which otherwise preempts state regulation of employer plans.

Provision:

Health plans offered by sponsors such as unions and associations will be permitted to also offer coverage to their Medicare eligible members. These are referred to as "limited enrollment plans" because they are not offered to the general public, but are restricted to full-fledged members of either the union or the association. These plans are eligible to contract with Medicare and assume risk for providing health care coverage to Medicare beneficiaries who are members of such sponsoring organizations. These plans will be required to meet Medicare program standards in order to qualify as a MedicarePlus plan. Qualifying associations must be formed for purposes other than the marketing of a health insurance plan. Examples of potentially qualifying organizations might be the American Association of Retired Persons, the American Bar Association, National Federation of Independent Business, the Farm Bureau, the AFL-CIO or other similar organizations formed for broad fraternal or professional purposes.

(3) Provider-Sponsored Networks

Background:

Provider-sponsored networks (PSNs) are community-based delivery systems created through health care provider affiliations. These networks may be either physician- or hospital-based, or a collaboration between or in combination with insurance company partners. PSNs can range from loosely affiliated independent practice associations to tightly integrated ventures such as physician-hospital organizations. PSNs are a coordinated care option that could develop in any market, but especially in areas that have been largely unserved by HMOs or other managed care plans.

PSNs would be paid on the same basis as other types of MedicarePlus plans and would be subject to a full range of contracting standards (discussed in a later section). Special consideration would be given in developing those standards to address important differences between PSNs and insurance companies, especially with respect to financial solvency, definition of risk-based capital and issues of reinsurance. The objective is to

recognize legitimate differences between PSNs and insurance companies, while ensuring financial stability under PSN risk contracts.

Provision:

The proposal opens the Medicare market to provider-sponsored networks organized in local communities by permitting networks meeting certain standards to contract directly with Medicare as health plans. The PSNs most suited to direct contracting relationships with Medicare are those that are financially and clinically integrated to a degree which permits them to provide coverage for the complete Medicare benefit package and assume full financial risk for those services relative to a premium payment from the Medicare program. This means that a PSN will be a bona fide health plan which bears all risk for providing services to beneficiaries.

There are obstacles, however, to the formation of PSNs. One of the most serious is the application of the antitrust laws to such groups in a manner which does not allow the network to engage in joint pricing agreements.

Antitrust law prohibits agreements among competitors that fix prices or allocate markets. Such agreements are per se illegal. Where competitors economically integrate in a joint venture, however, agreements on prices or other terms of competition that are reasonably necessary to accomplish the procompetitive benefits of the integration are not necessarily unlawful. Price setting conduct by these joint ventures should be judged under the "rule of reason" -- that is, on the basis of its reasonableness, taking into account all relevant factors affecting competition.

Current Department of Justice/Federal Trade Commission (FTC) guidelines require that a physician group share "substantial financial risk" before being considered a joint venture, thus, being eligible for rule of reason analysis. The guidelines' definition of "substantial financial risk" is too rigid, thereby eliminating from the market physician groups which would provide an expanded set of consumer choice and increase competition for health care services.

The provisions overcome this barrier by mandating that the conduct of an organization meeting the criteria of a PSN be judged under the rule of reason. The result would be to permit a case by case determination as to whether the conduct of the PSN would be procompetitive, and thus permissible under the antitrust laws.

In order to provide guidance and certainty to entities wishing to form PSNs, the Department of Justice and the FTC are directed to promulgate guidelines implementing this policy within 180 days of enactment. Once these guidelines are in place, organizations wishing to qualify as PSNs would be able to obtain an opinion from the enforcement agencies as to whether their conduct would fall within the range of allowable

activities. If these guidelines are not issued in a timely manner, legislation will be offered to accomplish this objective.

The provisions establish a federal framework that fosters the development of provider-sponsored network plans capable of contracting for Medicare enrollees on a comprehensive benefit, full-risk assumption basis. Although this approach is quite different, there is precedent at the federal level for promoting an environment in which a desirable, emerging health care delivery system design can obtain a foothold and begin to compete in the market. For instance, this action is analogous to the objectives of the health maintenance organization provisions of the Public Health Service Act (enacted in 1973), which were designed to encourage the development and expansion of HMOs in the market.

The provisions would require PSNs contracting with Medicare to assume full financial liability for contractual services, in return for a fixed premium or contribution that does not vary with the actual provision of services.

During the start-up period, steps would be taken at the federal level to create national, uniform financial solvency, quality assurance and other key standards for PSNs on a fast-track basis. This would create the opportunity for PSNs to apply to become Medicare contractors and offer plans to beneficiaries within several months of enactment. PSN plans offered under MedicarePlus will be offered exclusively to Medicare beneficiaries.

III. MedicarePlus Design Features

There are several key elements to the design and operation of MedicarePlus plans. These relate to benefit packages, federal premium contributions to plans, the standards contractors must meet in order to offer MedicarePlus plans to beneficiaries, federal and state oversight responsibilities, and enrollment and disenrollment procedures for beneficiaries. These are discussed in the following sections.

(1) Medicare Standard Benefits

Background:

Under current law, the Medicare program's benefits are spelled out in statute in great detail, including what are commonly referred to as "inside limits." These inside limits refer to the determination of the general scope of the benefit package, ranging from cost-sharing levels, aggregate caps on covered hospital days, and prior hospital stay requirements for post-hospital benefits.

Following is a greatly abbreviated illustration of Medicare's benefits, plus an indication of certain benefits that are customary in commercial packages, but which Medicare does not

cover--most notably prescription drugs. Finally, there are detailed rules regarding how health care providers are paid, at what levels classes of services are reimbursed, and whether individual services are covered (for example, services judged to be experimental are not covered).

CURRENT MEDICARE COVERED SERVICES

BENEFITS	MEDICARE PAYS
Part A	
Inpatient Hospital & Inpatient Psychiatric First 60 days 61st to 90th day 91st to 150th day Beyond 150th day	 All but $716 All but $179/day All but $358/day No further payments
Post-Hospital Skilled Nursing	100% for the first 20 days $89.50 for days 21 to 100
Hospice	100%
Part B	
Surgical-Inpatient & Outpatient	80% after $100 deductible
Clinical Lab Services	100%
Prescription Drugs	Not covered
Dental Care	Not covered
Outpatient Home Health	80%

The Medicare standard benefit package is well-established and the insurance industry is experienced in using it as a reference plan for structuring supplemental benefits and other changes for HMO plans currently offered to beneficiaries. Today, Medicare HMO risk contractors' plans must approximate as closely as is feasible the scope of benefits specified in the law for the Medicare fee-for-service system. **A key advantage to retaining the standard benefit package is that future beneficiaries will be assured that their benefits will not somehow be reduced if they move to the new plans under MedicarePlus. No beneficiary enrolling in a MedicarePlus plan will receive fewer benefits than they now enjoy in traditional Medicare.** A second point is that standardization greatly facilitates competition during open enrollment because it allows

beneficiaries to make comparisons across plans, based on premiums and additional benefits.

Separately, current HMO risk-contractors would be required to provide the government with their determination of the actuarial value of their MedicarePlus plan. The risk-contractors would have to enrich their plan (by adding supplemental benefits or reducing cost-sharing) relative to the government's average contribution level in their local market when their estimated cost of providing the Medicare standard benefits is lower than the contribution. The process for reviewing HMOs' estimated costs, and their calculations for supplemental benefits and premiums, would be managed by the Health Care Financing Administration.

Provision:

All MedicarePlus plans would be required to provide beneficiaries the current Medicare benefits package. Further, these plans are required to continue the process established under current law that would require the filing and review of a MedicarePlus plan's estimated premium costs and its calculations for supplemental benefits and premiums. Plans may provide enrollees with cash rebates equivalent to the Medicare Part B premium. Medisave plans are required to provide Medicare benefits once the high deductible has been met.

(2) Medicare Premium Payments to Plans on Beneficiaries' Behalf

Background:

The Medicare program has a well-established approach to developing average per capita, market level payments. This system is used to pay HMOs that are marketing local plans to Medicare beneficiaries. Under these products, the HMOs have assumed full insurance risk for the cost of a Medicare enrollee's covered services, no matter how much those costs might vary relative to the program's average contribution. The program's payments to HMOs are designed to approximate per member/per month premium-type contributions which are based on average per capita spending in the fee-for-service program. These payments, known as adjusted average per capita costs (AAPCCs) are established for every county in the nation relative to the national average per capita spending level known as the United States per capita cost (USPCC). For illustration, the calendar year 1995 national average premium contributions to HMOs, for combined Parts A and B coverage, are:

$ 4,806.24 - Aged over 65, but not a disabled or end-stage renal disease (ESRD) beneficiary
$ 4,269.72 - Disabled, but not ESRD
$44,090.76 - ESRD beneficiary

The actual dollar level paid in each county is different because each AAPCC mirrors widely varying local differences in Medicare demographics, payment levels and utilization patterns. In order to actually pay an HMO for a specific enrollee, the AAPCC for the enrollee's area is adjusted by demographic factors relating to the enrollee's actual age, gender, institutional status and whether the person is receiving Medicaid. In effect, this is an insurance premium "rate-book" approach to creating proxy premiums for the Medicare population.

Provision:

The basic elements of the current HMO methodology for creating "proxy premiums" will be adapted for MedicarePlus payment rates. Improvements will be made to create fair market-oriented contribution levels across the country. This methodology, while highly technical, is extremely important because it creates the economic underpinnings for the future participation of health plans in the MedicarePlus program.

Local MedicarePlus premium contributions will be "decoupled" from the variable fee-for-service spending patterns and levels and converted to budgeted contributions for each market. These contributions, or premium payments, will grow each year under rates of growth that are consistent with our plan of growth through the year 2002. We will improve the definition of market areas by switching from counties to larger geographic areas (known as Metropolitan Statistical Areas and non-Metropolitan Statistical Areas) to provide more stability and consistency in payments to plans. Finally, contribution levels will be adjusted across markets in order to narrow variations in payment levels across urban and rural markets.

(3) Contracting Standards Applicable to MedicarePlus Plans: Federal and State Oversight

Background:

A health plan that is offered to Medicare beneficiaries is accomplished through execution of a contract with the government. Health plan contractors are typically expected to meet a range of standards in order to be eligible to contract with the Medicare program. These include:

- Financial solvency and capitalization standards
- Market conduct, including mode and content of advertising, sales techniques, and related matters
- Premium and rating rules
- Consumer protections
- Reporting and disclosure of plan benefits, coverage exclusions, and related rules
- Enrollment and disenrollment rules
- Processes for grievances and appeals

- Requirements for covering emergency and out-of-plan services
- Service area standards
- Quality assurance

Broad standards in these areas currently exist in federal law for HMOs that voluntarily choose to be federally qualified for purposes beyond Medicare contracting. For those HMOs that choose to contract with Medicare but are not federally qualified, HCFA has promulgated regulatory standards. Existing Medicare contracting standards do not address the different contractor types and plan offerings envisioned under the MedicarePlus system.

Provision:

MedicarePlus plans will be required to meet contracting and operational requirements relating to the areas listed above, and to new areas of provider and patient protections. MedicarePlus standards relate *exclusively* to the conditions that companies must meet in order to contract with the Medicare program. Standards under discussion here are not federally preemptive of state regulation of insurance or their licensure of companies. However, states will be requested to lend their expertise, through the National Association of Insurance Commissioners (NAIC), to develop standards for MedicarePlus plans through broad public consultation initiated immediately upon enactment of MedicarePlus. This is patterned after a process followed several years ago for standardizing Medigap policies.

Once MedicarePlus is up and running, expertise will be required to review plans for conformance with standards such as financial solvency, market conduct, patient protections, and other areas. Rather than increase bureaucracy at the federal level, the proposal utilizes existing state expertise in insurance regulation. The proposal includes processes under which states could assume responsibility for certifying plans and for overseeing their conduct in local markets. States would do this at their option and would be permitted to assess user fees or so-called "charge-backs" to any company for specific MedicarePlus plan certification costs. The latter is consistent with how states currently bill insurance companies for the costs of financial examinations and audits related to state licensure. Some federal capacity must exist to manage oversight of certain federal-only entities (union-sponsored plans and provider-sponsored networks), or to perform functions directly in any state that chooses not to undertake this responsibility.

(4) Transitioning to a "Better Medicare"

Provision:

As with any major reform effort, it is important to move quickly, but carefully. A reasonable balance must be struck between creating greatly enhanced opportunities

under Medicare for improved benefits and assuring that new contractors and plans meet the highest standards. Following is a chart depicting key elements and deadlines for making improvements in the Medicare program.

As indicated, the program will move to a model where each year, beneficiaries will be able during an annual open enrollment period to select from a menu of plans offered in their community. Emphasis will be placed on publicizing this program and on carefully educating beneficiaries about their choices and specific plans.

During a two-year transition, beneficiaries will be able to enroll and disenroll from plans on a monthly basis, as is the case under current law. At the end of the transition, it is expected that beneficiaries will begin to enroll in plans for 12-month periods. This is consistent with the private market today for workers and their families and contributes both to continuity of care and the overall financial stability of the program. Once the 12-month enrollment period begins in January 1998, a special protection for beneficiaries would permit them to disenroll from a plan of their choice within 90 days of enrollment. At all times, beneficiaries will be able to remain in, or under certain procedures, return to the current fee-for-service system.

Medisave plans would be an exception to these transition period enrollment and disenrollment rules. Medisave plans would always be a 12-month election for the beneficiary.

(5) Patient Protection

Background:

Under current law, there are a number of requirements that HMOs must meet under risk contracts in the Medicare program. For instance, an HMO must make all Medicare covered and other contracted services available and accessible within its service area. These must be available with reasonable promptness and in a manner that assures continuity of care. Urgent care must be available and accessible 24 hours a day, 7 days a week. HMOs must also pay for services provided by nonaffiliated providers when services are medically necessary and immediately required because of an unforeseen illness, injury, or condition and if it is not reasonable, given the circumstances, to obtain the services through the HMO.

HMO brochures, applications and other material may be distributed only after review and approval by the Secretary of HHS. HMOs may not disenroll or refuse to re-enroll a beneficiary because of health status or need for health care services. HMOs must provide enrollees, at the time of enrollment and annually thereafter, an explanation of rights to benefits, restrictions on services provided through nonaffiliated providers, out-of-area coverage, coverage of emergency and urgently needed services, and appeal rights. A

terminating HMO must arrange for supplementary coverage of Medicare enrollees for the duration of any preexisting condition exclusion under their successor coverage for the lesser of 6 months or the duration of the exclusion period. HMOs must have meaningful grievance procedures for the resolution of individual enrollee complaints concerning such problems as failure to receive covered services or unpaid bills. In addition, an enrollee who believes that an HMO has improperly denied a service or imposed an excessive charge has the right to a hearing before the Secretary if the amount involved is greater than $100. If the amount is greater than $1,000, either the enrollee or the HMO may seek judicial review.

In areas where Medicare has risk contracts with more than one HMO and an HMO's contract is not renewed or is terminated, the other HMOs serving the area must have an open enrollment period of 30 days for persons enrolled under the terminated contract. Penalties apply for violations of limits on the use of so-called "physician incentive plans," i.e., compensation arrangements between HMOs and physicians that might induce physicians to inappropriately withhold services. An HMO may not make a specific payment to a physician as an inducement to reduce or limit services to a specific enrollee. In addition, if physicians or physician groups are placed at substantial financial risk for services other than their own, the HMO must provide adequate stop-loss protection to limit the physicians' potential liability. Finally, HMOs must periodically survey enrollee-satisfaction.

Medicare contracts with HMOs are for a 12-month period and may be made automatically renewable. However, the contract may be terminated by the Secretary at any time (after reasonable notice and opportunity for a hearing) in the event that the organization fails substantially to carry out the contract; carries out the contract in a manner inconsistent with the efficient and effective administration of Medicare HMO law; or no longer meets the requirements specified for Medicare HMOs. The Secretary also has the authority to impose lesser sanctions, including suspension of enrollment or payment and imposition of civil monetary penalties. These sanctions may be applied for denial of medically necessary services, overcharging, enrollment violations, misrepresentation, failure to pay promptly for services, or employment of providers barred from Medicare participation.

Provision:

The provisions in current law relating to consumer protections are expanded. In addition, the Secretary is required to publish an information booklet for all Medicare eligible individuals every 12 months that will specify the benefits and premiums for MedicarePlus products and information about the quality of such products, including consumer satisfaction information and the rights and responsibilities of Medicare beneficiaries in MedicarePlus plans.

As applies under current law, MedicarePlus plans must disclose the following information to beneficiaries: plan benefit design including coverage exclusions; rules regarding prior authorization of services; liability for co-payments for out-of-network services; the number, mix and distribution of participating providers; any financial obligations of the enrollee, including co-payments, premiums, deductibles, and maximum out-of-pocket financial exposure.

MedicarePlus plans must provide patients with access to all medically necessary services for all Medicare covered benefits.

MedicarePlus plans would be required to safeguard the confidentiality of medical records.

Plans must have qualified utilization review programs which include: a set of written utilization review decision protocols that is based on current and appropriate medical practice; timely decisions regarding authorization requests for non-emergency care, depending on the urgency of the situation; and an expedited appeals process for life threatening situations.

Plans must provide coverage for emergency services without regard to whether the provider has a contractual relationship with the plan and without regard to prior authorization. Authorization for emergency services must be made in a timely manner depending on the urgency of the situation.

Health plans are required to include in their educational materials, a statement that the use of the 911 emergency system is appropriate in emergency situations, and include an explanation and examples of what constitutes an emergency service.

MedicarePlus plans must have written policies on notice and appeals process for terminated physicians.

SUBTITLE B - PROVISIONS RELATING TO FRAUD AND ABUSE IN THE TRADITIONAL MEDICARE PROGRAM

I. Increasing Beneficiary Awareness of Fraud and Abuse

Background:

Currently, Medicare provides little emphasis on educating beneficiaries to help them become better consumers. Efforts that the Department of Health and Human Services (HHS), the Health Care Financing Administration (HCFA), and the HHS Office of Inspector General (OIG) undertake to educate beneficiaries are sporadic, with little attention paid to matters such as targeting information to the appropriate audience.

Moreover, HCFA does not require its contractors to send beneficiaries explanations of all Medicare benefit payments made on their behalf. When beneficiaries do not receive such explanations, they are unable to check Medicare's payments.

Provision:

Beneficiaries will be given more information to detect and report instances of fraud and abuse by requiring that:

a) current outreach efforts be increased to alert beneficiaries to fraud and abuse problems in their areas;
b) beneficiaries receive explanations regarding all benefit payments that Medicare makes on their behalf;
c) the OIG routinely publish fraud alerts in the Federal Register; and
d) the Secretary will publish special Fraud Alerts, under certain circumstances.

II. Beneficiary Incentives to Report Fraud and Abuse

Background:

Medicare has no incentive program to encourage beneficiaries to identify fraud, abuse or waste, or provide suggestions to increase Medicare program efficiencies. While there is an available "whistle-blower statute" to encourage reporting evidence of fraud, it is geared toward providers or employees -- for example, salespersons of companies that sell medical supplies -- who could provide evidence to identify a pattern of criminal behavior.

Provision:

Beneficiaries will be given stronger incentives to detect and report opportunities to improve program efficiencies by giving HHS the authority to establish (1) financial incentives for program improvement suggestions, and (2) rewards for information on fraudulent or abusive practices or providers.

III. Revised Intermediate Sanctions for MedicarePlus Plans

Background:

Current law, section 1876(i) of the Social Security Act, allows the Secretary to impose intermediate sanctions on a Medicare risk-contract HMO for a specified list of contract violations, such as imposing premiums on enrollees that are higher than those approved.

To the extent that a specific violation of a contract provision is not listed under section 1876(I)(A), the Secretary can not use any of the intermediate sanctions available under existing law -- such as civil monetary penalties or suspension of new enrollments--to encourage prompt compliance.

Provision:

The Secretary will be provided with a more workable set of intermediate sanction authorities for MedicarePlus plans than currently exist for Medicare HMOs. The new authorities would allow the Secretary to take a sanction action -- such as stopping new enrollment in a plan until it corrects documented deficiencies -- for plans not meeting contract provisions.

IV. Voluntary Disclosure

Background:

Current law does not provide for a program permitting the Secretary to mitigate penalties for parties who voluntarily disclose acts or omissions. The statute directs the Secretary to impose mandatory exclusions from the Medicare program and State health care programs[1] for convictions of criminal offenses related to the delivery of an item or service under Medicare or State health care programs, as well as for convictions relating to patient abuse in connection with the delivery of a health care item or service. Current law also prescribes civil money penalties for a number of illegal activities relating to the submission of claims for reimbursement under the Medicare and Medicaid programs. Under current law, criminal penalties are set forth under Medicare and State health care programs for offenses such as false statements in benefit applications or in determining rights under such benefits, concealing information relating to benefits, submitting claims from non-licensed physicians, and soliciting and receiving kickbacks for referrals or soliciting or receiving remuneration for admitting a Medicaid patient.

Provision:

The Secretary is directed to establish a program encouraging individuals and entities to voluntarily disclose information on acts or omissions which constitute grounds for the imposition of a sanction under Title XI of the Social Security Act. The Secretary is authorized but is not required to reduce or mitigate applicable sanctions following a

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[1] "State health care programs" are defined as the Medicaid program and programs receiving funds under the Maternal and Child Health Service Block Grant, or the Social Services Block Grant. This definition applies to sections 1128, 1128A, and 1128B.

voluntary disclosure. This provision specifies that no *qui tam* lawsuit (private whistle blower lawsuit) could be brought under the False Claims Amendments Act of 1986 with respect to a voluntarily disclosed act or omission under this program.

V. Minimum Periods of Exclusion from Medicare

Background:

Under current law, Section 1128B authorizes the Secretary to impose permissive exclusions of individuals and entities from Medicare and Medicaid and several other federal programs. Permissive exclusions are authorized for a number of offenses relating to fraud, kickbacks, obstruction of an investigation, and misuse of controlled substances, and activities relating to license revocations or suspensions, claims for excessive charges or unnecessary services, and the like. There are currently no minimum exclusion periods specified for most of the prohibited activities under this subsection.

Provision:

Minimum periods of exclusion are stipulated under Section 1128A to authorize the Secretary to impose permissive exclusions of individuals and entities from Medicare. Specifically:

1) A three-year minimum exclusion (unless the Secretary finds mitigating circumstances) of individuals or entities convicted, under Federal or State law, of health care criminal offenses involving such matters as fraud, theft, or embezzlement.

2) A minimum exclusion period for persons who have had their medical licenses suspended or revoked that is no less than the period of suspension or revocation.

3) A one-year minimum exclusion period for individuals and entities to submit claims to Medicare or state health care programs for excess charges or for medically unnecessary services.

VI. Anti-Fraud and Abuse Trust Fund

Background:

Under current law, federal revenues generated from such sources as fines under Titles XI and XVIII of the Social Security Act revert to the Treasury and are not earmarked.

Funding for health care fraud and abuse prevention, detection, and enforcement actions is appropriated from discretionary revenues.

Provision:

An Anti-Fraud and Abuse Trust Fund is established to fund fraud and abuse prevention efforts and will be financed by fines from: convictions from Titles XI and XVIII of the Social Security Act, and from the False Claims Act.

VII. Medicare Integrity Program

Background:

Currently Medicare's program integrity functions are subsumed under Medicare's general administrative budget. These functions are performed, along with general claims processing functions, by insurance companies under contract with HCFA.

Provision:

Establish a new Medicare program component that focuses on anti-fraud and abuse activities. The provision also requires that HCFA use private sector companies, technologies, and software that are best suited to performing the activites.

VIII. Health Care Fraud and Abuse Task Force

Background:

Currently, there is no formal mechanism for coordinating health care fraud investigation and enforcement.

Provision:

The proposal would require the Department of Justice within 120 days of enactment to establish a nation-wide Health Care Fraud and Abuse Task Force in cooperation and coordination with the Inspector General of the Department of Health and Human Services, State Attorneys General, and representatives from other relevant governmental entities, as determined by the Attorney General.

IX. Allowing Prior Authorization for Abused Supplied Items

Background:

Medicare's current prior approval authority for durable medical equipment (DME), orthotics, and medical supplies is national in scope and is an inefficient way of targeting the limited resources Medicare has to review questionable claims for these items. If there is a problem with a particular item or supplier in one geographic area, prior authorization can not be limited to that area. Moreover, for HCFA to use its national prior approval authority requires a long and costly administrative process not conducive to good management in today's health care market.

Provision:

The proposal gives Medicare contractors greater capability to respond quickly to DME, orthotics, or medical supply item scams by permitting contractors to require prior authorization for individual items that are being abused (either nationwide or in selected locations), or for individual providers who are abusive.

X. HCFA Outside Contracts

Background:

Quality assurance systems are likely to be a subject of great interest as Medicare beneficiaries migrate from traditional Medicare to private sector alternatives.

Provision:

The plan directs HCFA through its Office of Research to contract for a study of the adequacy of quality assurance systems currently used by health plans to protect enrollees against the potential risks of under-service that can result from utilization control features.

XI. CIVIL MONEY PENALTIES

Background:

Titles XI and XVIII of the Social Security Act include a broad range of civil monetary penalties for fraudulent and abusive practices.

Provision:

The proposal increases civil monetary penalties in Titles XI and XVIII.

SUBTITLE C--PROVISIONS RELATING TO REGULATORY RELIEF AND PHYSICIAN SELF-REFERRAL

I. Financial Arrangements

Background:

The law establishes a ban on certain financial arrangements between a referring physician and an entity. Specifically, if a physician (or immediate family member) has an ownership or investment interest in or a compensation arrangement with an entity, the physician is prohibited from making a referral to the entity for services for which Medicare would otherwise pay. Further, the entity may not bill for such services. For purposes of the ban, an ownership or investment interest may be through equity or debt or other means and includes an interest in an entity that holds an ownership or investment interest in any entity providing designated health services.

The law includes general exceptions to the ban. Some are general exceptions to both the ownership and compensation arrangement prohibitions, while others relate only to ownership or only to compensation arrangements.

Hearing testimony indicates that this provision is a barrier to appropriate development in the health care market place in arrangements between and among providers and health care plans. It particularly presents a problem for managed care arrangements where the referral issue is not relevant. Testimony indicates that for many of these services, there is little or no evidence that increased volume is due to inappropriate incentives for referrals, and that existing law is a barrier to the efficient delivery of necessary medical services.

Provision:

Referrals based on compensation arrangements, generally defined as any arrangement involving any remuneration between a physician (or immediate family member) and an entity, will no longer be prohibited. Compensation arrangements would continue to be subject to the anti-kickback statute.

II. Designated Health Services

Background:

The ban applies to referrals for clinical laboratory services and the following designated health services: (i) physical therapy services; (ii) occupational therapy services; (iii) radiology, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services; (iv) radiation therapy services and supplies; (v) durable medical equipment and supplies; (vi) parenteral and enteral nutrients, equipment and supplies; (vii) prosthetics, orthotics, and prosthetic devices; (viii) home health services and supplies; (ix) outpatient prescription drugs; and (x) inpatient and outpatient hospital services. Testimony has been received that several of these result in a significant barrier to the efficient delivery of health care.

Provision:

The list of designated health services will be revised to include:

1) clinical laboratory services;
2) items and services furnished by a community pharmacy;
3) magnetic resonance imaging and computerized tomography services; and
4) physical therapy services.

A community pharmacy would be defined as any entity licensed or certified to dispense outpatient prescription drugs by the State in which the entity is located (including an entity which dispenses such drugs by mail order). The term would not include an entity which is owned and operated by a hospital, an ambulatory surgical center, or a prepaid health plan.

III. Implementation of the Statute

Background:

The self-referral provisions included in OBRA 89 applied to Medicare referrals for clinical laboratory services made on or after January 1, 1992. On August 14, 1995, DHHS issued final regulations implementing the OBRA 89 requirements. DHHS noted that these regulations relate only to referrals for clinical laboratory services and address only those provisions that had an effective date, including a retroactive effective date, of January 1, 1992.

OBRA 93 expanded the referral ban to a list of "designated health services" and extended the prohibition to Medicaid. OBRA 93 also included significant revisions to the

OBRA 89 provisions. The amendments made by OBRA 93 (as amended by P.L. 103-432) apply with respect to referrals made on or after January 1, 1995; however some provisions had a retroactive effective date of January 1, 1992.

Thus far the Secretary has not issued final regulations, and there is a great deal of confusion concerning the enforcement of these requirements. It is clearly unfair to expect providers to meet standards which have not been articulated in final regulation.

Provision:

The Secretary would not be permitted to take enforcement actions, based on OBRA 93 provisions, against providers until regulations are promulgated.

IV. Three Types of Exceptions for Prohibition

Background:

The law includes general exceptions to the self-referral ban. Some are general exceptions to both the ownership and compensation arrangement prohibitions, while others relate only to ownership or only to compensation arrangements.

A general exception applies to in-office ancillary services which are defined as furnished by the referring physician, another physician in the same group practice, or personally by individuals directly supervised by the physician or another physician in the same group practice. The services must be furnished in: (i) a building in which the referring physician or other member of the group practice provides services unrelated to the furnishing of designated health services; or (ii) in a building used for the centralized provision of the group's designated health services. OBRA 93 specified that for clinical laboratory services only, the exception only applies if the services are provided in a centralized location.

Provision:

This exception is modified by repealing the site of service requirement and the requirement that non-physician personnel must be directly supervised by the referring physician or another physician in the group practice.

Background:

The law includes an exception, related only to the ownership and investment prohibition, for rural providers. The entity must be in a rural area (using the same criteria as are used

under the PPS system for hospitals). Further, the exception only applies if substantially all of the designated health services furnished by the entity are furnished to individuals residing in rural areas.

Provision:

This exception is modified to specify that substantially all of the services must be either furnished to individuals residing in rural areas or to individuals furnished services by state Medicaid plans or state regulated plans.

Background:

The law includes a general exception for services provided by a prepaid health plan to enrollees. The definition of prepaid plans includes those either meeting Medicare requirements, operating as prepaid plans under a Medicare demonstration project, or meeting the requirements of a federally-qualified health maintenance organization.

Provision:

The definition of prepaid health plans is modified to include other types of entities which: (1) are HMOs which have a contract with the State to provide Medicaid services; (2) provide designated health services directly or through contractual arrangements with providers; (3) assume financial risk for the provision of services or provide services on behalf of another entity that assumes risk; and (4) provide for utilization review of services. Moreover, the definition of prepaid plans is also modified to include services which are provided by a physician or physician group as part of a capitated arrangement.

A new exception is added for shared facility services where a shared facility arrangement is one: (1) which is only between physicians who are providing services in the same building; (2) in which the overhead expenses are shared; and (3) which, in the case of a corporation, is wholly owned and controlled by shared facility physicians.

An exception is added for services furnished in communities which the Secretary determines lacks access to alternative providers.

An exception is added for services furnished in ambulatory surgical centers.

V. Clarification of Level of Intent Required for Imposition of Sanctions

Background:

Civil money penalties may be imposed for each fraudulent claim for reimbursement under the Medicare and Medicaid programs. The violations which are subject to civil money penalties under the Medicare and Medicaid programs include submitting claims for items or services not provided, or which were false or fraudulent; and submitting claims for services by someone who was not a licensed physician, whose license was obtained through misrepresentation, or who misrepresented his or her qualification as a specialist.

Provision:

The current "knows or should know" standard in Sec. 1128(a) is clarified to convey the intent of Congress that the standard required for recovery under this section is consistent with the standard required under the Civil False Claims Act. This provision clarifies that the term "should know" be applied to persons, who with respect to information, act in deliberate ignorance of the truth or falsity of the information; or act in reckless disregard of the truth or falsity of the information. Thus, an assessment under this provision would not be made when a person (including an organization or entity, but excluding a beneficiary) made an honest mistake.

VI. No Intent Required to Meet Safe Harbor Exceptions

Background:

Currently, the Medicare and Medicaid anti-kickback provisions generally prohibit anyone from providing or offering to provide remuneration in cash or in kind in return for a patient referral whose treatment is paid for in whole or in part by Medicaid or Medicare. Also prohibited are the solicitation or receipt of such remuneration and arranging or recommending a referral for remuneration. Violations are felonies and are subject to a fine of up to $25,000 or imprisonment for up to five years, or both.

Certain business practices are exempted from the application of these provisions, and the HHS Office of Inspector General is directed to issue safe harbor regulations for additional payment practices that would not be subject to criminal prosecution or provide a basis for exclusion from participation in Medicare and Medicaid. If an individual or entity engages in a business arrangement which is the subject of a safe harbor provision and complies with all of the applicable requirements of the provision, then the individual or entity will be assured that he or she will not be prosecuted.

Provision:

The Secretary may not, in making a determination of whether a business practice meets the safe harbor exceptions, look behind the safe harbor to question the intent behind its establishment.

VII. Limiting Imposition of Anti-Kickback Penalties to Actions With Significant Purpose to Induce Referrals

Background:

Section 1128B(b) contains the general anti-kickback prohibition against "knowingly and willingly" offering or paying any remuneration directly or indirectly, to any person to induce patient referrals whose treatment is paid for in whole or in part by Medicare or Medicaid, or for purchases, leases, or order of any goods, facilities, services or items for which payment may be made under Medicare or Medicaid.

Provision:

The phrase "to induce" in current law is modified to read "for the significant purpose of inducing." Thus, a person or entity would be prohibited from offering or paying remuneration to any person if the significant purpose was to induce patient referrals.

VIII. Exemption From Anti-Kickback Penalties for Certain Managed Care Arrangements

Background:

The anti-kickback provisions in Section 1128B(b), which generally prescribe criminal penalties for individuals or entities that knowingly and willfully offer or receive remuneration to induce business reimbursed under Medicare or State health care programs, list several exceptions to the application of this section. These exceptions include discounts or other reductions in price obtained by a provider if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under Medicare or a State health care program. Exceptions also include any amount paid by an employer to an employee for employment in the provision of covered items or services; any amount paid by a vendor for goods or services to a person authorized to act as a purchasing agent for a group of individuals or entities under specified conditions; a waiver of any coinsurance under Part B of Medicare by a Federally qualified health care center with respect to an individual who qualified for

subsidized services under a provision of the Public Health Service Act; and any payment practice specified by the Secretary as a safe harbor exception.

Provisions:

a) An exception is added to the anti-kickback provisions that would allow any reduction in cost sharing or increased benefits given to an individual, or any amounts paid to a provider for an item or service to such an individual, or any discount or reduction in price given by the provider for an item or service if the item or service is provided by a prepaid plan or health maintenance organization (as described in section 1877(b)(3) of the Social Security Act), or if the item or service is provided through such a prepaid plan or health maintenance organization on behalf of another entity, such as self-insured employer or indemnity plan, that assumes financial risk for the provision of the item or services.

b) The discount exception is clarified to include reductions in price applied to combinations of items and services, and reductions made available as part of capitation, risk sharing, disease management, or similar programs provided there is adequate disclosure of the discount so that the Medicare and state health care programs are able to ascertain cost data for purposes of revising payment rates and otherwise evaluating the impact of these arrangements.

c) The discount exception is clarified to include de minimis remuneration (such as pens, textbooks, and the like to practitioners as long as the gifts primarily benefit patient care and are not of substantial value) and drug samples (if in compliance with section 503(d) of the Federal Food, Drug, and Cosmetic Act).

IX. New Safe Harbor Rules

Background:

The health care market has changed dramatically since the fraud and abuse law was first enacted in the mid-1970's. There is interest in a procedure that would enable the IG to obtain information about ever evolving health care delivery arrangements that may not technically meet the current safe harbors, but are legitimate business practices. A new procedure would be required to help to alleviate much of the confusion about the current safe harbors.

Provision:

A procedure would be established whereby the Office of Inspector General would be required to solicit proposals for new safe harbors and modifications to safe harbors and, if appropriate, promulgate modified and new safe harbors.

X. Advisory Opinions

Background:

There is interest in a procedure whereby providers can seek guidance from the Secretary of HHS on the application of the safe harbor rules and physician ownership and referral arrangements.

Provision:

A procedure shall be established whereby providers can seek guidance from the Secretary of HHS on the application of the safe harbor rules and physician ownership and referral arrangements.

XI. Antitrust Relief for Medical Self-Regulatory Entities

Background:

Physicians and other medical providers set standards in such areas as medical education, professional ethics, and specialty certification. These standard-setting activities have been challenged in recent years under the antitrust laws. The Congress attempted to address this problem with the Health Care Quality Improvement Act of 1986, which provided antitrust protection for peer review actions conducted in "good faith." While beneficial, this law shifted the debate in antitrust litigation to whether the participants acted in "good faith." The result is that the stream of antitrust suits has continued.

Provision:

The plan bars antitrust suits against medical self-regulatory entities, including suits against individual members of the groups which undertake these activities, and the organizational entity on whose behalf they act. Activities conducted for purposes of financial gain or which interfere with providers who are not members of the profession setting the standards would not be covered or exempted by this legislation.

SUBTITLE D - MEDICAL LIABILITY

Background:

Our health care system is clearly being burdened by a number of cost-based pressures. One of these "costs" is the threat of liability suits facing medical practitioners and health care providers. The average physician has a 40% chance of being sued at some time in

his or her career. This increases to 52% for surgeons and to 78% for obstetricians. The estimate is that medical malpractice premiums now total $10 billion annually. For a doctor specializing in obstetrics in an urban or suburban area in New York State, the average annual medical malpractice premium now exceeds $100.000.

High premiums for malpractice coverage represent only a part of this problem. The estimates are that the costs of "defensive medicine" run from $20 to $25 billion a year. Numerous other entities, such as pharmaceutical manufacturers and those that manufacture medical devices or provide blood or tissue services, are also impacted by the same liability concerns.

Provisions:

The provisions would:

-- limit the time period for filing claims to no more than two years after the injury is discovered but in no event more than 5 years after the initial injury occurred;

-- limit non-economic damages to $250,000;

-- limit a defendants' liability for non-economic damages to his or her proportionate share of the fault;

-- limit punitive damages to no more than three times the amount of damages to a claimant for economic loss, or $250,000, whichever is greater;

-- exclude from punitive damages cases where a drug or device received pre-market approval by the Food and Drug Administration, unless there was misrepresentation or fraud;

-- permit defendants to introduce evidence of the amounts paid or likely to be paid to the claimant through insurance; and

-- allow non-economic damages in excess of $50,000 to a claimant be paid periodically rather than in a lump sum.

SUBTITLE E - REFORM OF PAYMENT FOR GRADUATE MEDICAL EDUCATION AND TEACHING HOSPITAL PAYMENT

I. Graduate Medical Education and Teaching Hospital Payment

Background:

Since its inception. Medicare has recognized the costs of graduate medical education (GME) in teaching hospitals and the higher costs of providing services in those institutuions. Under current law, Medicare makes two separate payments to teaching hospitals for providing graduate medical education and to cover the higher costs of services provided in these institutions (one for direct costs and one for indirect costs to teaching hospitals for medical education). The direct costs of approved GME programs (such as the salaries of residents and faculty, and other education costs for residents) are excluded from PPS and are paid on the basis of a formula that reflects each hospital's per resident costs. Costs for certain training programs for nurses and allied health professionals are also funded through the reimbursement for direct costs.

Medicare's GME payment for direct costs of medical education to each hospital equals the hospital's costs per full-time equivalent (FTE) resident, times the average number of FTE residents. times the percentage of inpatient days attributable to Medicare Part A beneficiaries. Each hospital's per FTE resident amount is calculated using data from the hospital's costs reporting period that began in FY 1984, increased one percent for hospital cost reporting periods beginning July 1, 1985, and updated in subsequent cost reporting periods by the change in the CPI. OBRA 93 provided that the per resident amount would not be updated by the CPI for cost reporting periods during FY 1994 and FY 1995. except for primary care residents in obstetrics and gynecology. The number of FTE residents is paid at 100 percent for residents in their initial residency period (i.e., the number of years of formal training necessary to satisfy speciality requirements for board eligibility). Residents in preventive care or geriatrics are allowed a period of up to 2 additional years that is not counted as part of the initial residency training period. For residents not in their initial residency period. only 50 percent of costs are allowable. On or after July 1986. residents who are foreign medical graduates can be only counted as FTE residents if they have passed designated examinations.

Medicare makes payment for indirect medical education costs (IME) to teaching hospitals under PPS for the indirect costs attributable to approved medical education programs. These indirect costs may be due to a variety of factors, including the extra demands placed on the hospital staff as a result of the teaching activity or additional tests and procedures that may be ordered by residents. Congressional reports on the PPS authorizing legislation indicate that the indirect education payments are also to account for factors not necessarily related to medical education which may increase costs to

teaching hospitals, such as higher numbers of severely ill patients, increased use of diagnostic testing, and higher staff-to-patient ratios.

IME payment to a hospital is based on a formula that provides an increase of approximately 7.7 percent in the federal portion of the DRG payment for each 10 percent increase in the hospital's intern and resident-to-bed ratio on a curvilinear basis (i.e., the increase in the payment is less than proportional to the increase in the ratio of interns and residents to beds). The Prospective Payment Assessment Commission has consistently over the years recommended that the indirect medical education adjustment for teaching hospitals be reduced.

Provision:

The proposal creates a new Graduate Medical Education and Teaching Hospital Trust Fund to make annual distributions to teaching hospitals. It also authorizes the Secretary to pay direct costs of graduate medical education to qualified consortia and establishes a new federal commission to address issues facing the financing of graduate medical education and teaching hospitals.

Contributions to the Trust Fund. Funds for the Trust Fund would come annually from the Medicare Part A and Part B Trust Funds and a specific appropriated amount from general revenues. Three Trust Fund accounts are established: (1) the Indirect-Costs Medical Education Account, (2) The Medicare Direct-Costs Medical Education Account, and (3) the General Direct-Costs Medical Education Account.

The Medicare contributions to the new Trust Fund will come from funds currently distributed to teaching hospitals through the indirect medical education (IME) adjustment and direct medical education (GME) payments. The Secretary would annually determine a Medicare contribution to the Indirect-Costs ME Account of the new Trust Fund and a Medicare contribution to the Medicare Direct-Costs ME Account of the Fund. The amounts are based on what the Secretary estimates Medicare would have spent for payments under the previous payment methodologies, modified as follows:

The IME component is the amount that Medicare would have spent if the current discharge payment method were in place, and the level of the adjustment were based on 6.5 percent in 1996 and 6.0 percent thereafter for every 10 percent increase in the hospital's interns and residents-to-bed ratio, and the number of discharges expected under the Medicare prospective payment system.

The GME component is the amount that Medicare would have spent for each teaching hospital if the current payment method were in place subject to several limitations. The total number of full-time-equivalent residents cannot exceed that hospital's total as of July 1, 1995. The number of full-time-equivalent residents may not include a resident

not in an initial residency period, who is certified in any speciality or subspeciality, or for whom payments have been made for more than 5 consecutive cost reporting periods. An exception for up to 3 years additional time is provided for specialists in geriatrics. The cost reporting for non-U.S. citizen medical residents would be reduced to 0.75 in FY 96, 0.50 in FY 97, 0.25 in FY 98, and zero thereafter, thus eliminating any amount for non-U.S. citizen medical graduates.

A "look-back" provision would require the Secretary to determine whether the estimates made by the Secretary for a fiscal year were substantially accurate. If not, corrective adjustments would be made to subsequent transfers to the Fund and accordingly, adjustments made to teaching hospitals.

The annual specific appropriated amount is established by law. The annual specific appropriated amount will be split between the Indirect-Costs ME Account and the General Direct Cost ME account based upon the ratio that such payments constituted the total of such payments made in the base period. The Secretary of the Treasury is allowed to invest the Trust funds not required to meet current withdrawals, and the Fund may accept gifts and bequests.

Payments to Hospitals from the Trust Fund. Each year the Secretary will disburse to teaching hospitals the contributions paid into the Trust Fund. Each teaching hospital that submits a payment request to the Secretary is to receive an amount for the indirect costs of graduate medical education and an amount for direct costs of graduate medical education. Each teaching hospital will receive a certain percentage of the amount in the Indirect-Costs ME Account. The percentage is based on the ratio of amounts received by the hospital to the sum of IME for all hospitals for discharges occurring during a base year.

Each teaching hospital's amount for direct costs for a fiscal year is the sum of the amount determined for the hospital's General Direct-Costs ME Account and the amount for the hospital's Medicare Direct-Costs ME Account. A hospital's payment for a fiscal year from the General Direct-Costs ME Account is a percentage of the total Account based upon the ratio of the amount the hospital received for direct medical education (DME) for discharges occurring during the base period to the sum for all hospitals for DME discharges occurring during the base period. A hospital's payment for a fiscal year from the Medicare Direct-Costs ME Account is a percentage of the total Account based upon the ratio of the estimate made by the Secretary for the hospital under section 1886(h) and the sum of all such estimates for all teaching hospitals.

Paying Consortia. The Secretary is given discretion to pay from the Direct Costs ME Account a limited amount per year to consortia in lieu of funds which would have been paid for these purposes to certain teaching hospitals. A qualified consortium is a network

consisting of one of more of the following: teaching hospitals, medical group practices, entities furnishing outpatient services, and medical residency training programs.

Commission on Reform in Financing of Graduate Medical Education. A legislative commission is directed to study and make recommendations on: (1) the financing of GME, including consideration of alternative broad based sources of funding and the treatment of GME under Medicare payments for Medicare physicians; (2) the financing of teaching hospitals, including consideration of the difficulties encountered by such hospitals as competition among health care entities increases; (3) the methodology for making payments for graduate medical education, and the selection of entities to receive the payments; (4) the dependence of schools of medicine on service generated income; (5) federal policies regarding international medical graduates; (6) the effects of these amendments; and (7) the feasibility and desirability of reducing payments for certain graduate medical education for high-cost resident programs under the Social Security Act.

SUBTITLE F - PROVISIONS RELATING TO MEDICARE PART A

I. Disproportionate Share Adjustment

Background:

Under PPS, an adjustment is made to the payment to hospitals that serve a disproportionate share (DSH) of low-income patients. The DSH adjustment is intended to compensate hospitals that treat large proportions of low-income patients. The factors considered in determining whether a hospital qualifies for a DSH payment adjustment include the number of beds, the number of patient days, and the hospital's location. A hospital's disproportionate patient percentage is the sum of (1) the total number of inpatient days attributable to Federal SSI beneficiaries divided by the total number of Medicare patient days, and (2) the number of Medicaid patient days divided by total patient days, expressed as a percentage. A hospital is classified as a disproportionate share hospital under any of the following circumstances:

(1) If its disproportionate patient percentage equals or exceeds:

- (a) 15 percent for an urban hospital with 100 or more beds, or a rural hospital with 500 or more beds (the latter is set by regulation);
- (b) 30 percent for a rural hospital with more than 100 beds and fewer than 500 beds or is classified as a sole community hospital;
- (c) 40 percent for an urban hospital with fewer than 100 beds;
- (d) 45 percent for a rural hospital with 100 or fewer beds; or

(2) If it is located in an urban area, has 100 or more beds, and can demonstrate that, during its cost reporting period, more than 30 percent of its net inpatient care

revenues are derived from State and local government payments for care furnished to indigent payments. (This provision is intended to help hospitals in States that fund care for low-income patients through direct grants rather than expanded Medicaid programs.)

Provision:

This provision reduces the adjustment for hospitals that treat large proportions of low-income patients by 25% on average over the next 7 years.

II. PPS Hospital Inpatient Capital Related Costs

Background:

In FY 1992. Medicare began phasing in prospectively-determined per case rates for capital-related costs. During the 10-year transition to a single capital rate, payments will reflect both hospital-specific costs and a single Federal capital payment rate. During the transition. hospitals are paid according to either a fully prospective method or a "hold harmless" method of payment.

Capital payment rates are updated annually. For the first 5 years of the transition to prospectively determined per-case rates, historical cost increases were used to increase the Federal and hospital-specific rates. Under a budget neutrality requirement, per case capital rates were adjusted in the first 5 years of the transition so that total payments equalled 90 percent of estimated Medicare-allowed capital costs. In fiscal year 1996, the budget neutrality requirement will be lifted. In addition. the cost-based updates will be replaced by an "update framework" (developed by HCFA and proposed in the June 2, 1995 Federal Register), which will determine payment rate growth. This analytical framework is to take into account changes in the price of capital and appropriate changes in capital requirements resulting from development of new technologies and other factors. Capital costs for PPS exempt hospitals are reimbursed on a reasonable cost basis.

Provision:

Medicare payment of the cost of hospital capital was set at 90 cents on the dollar over the last 5 years. Under current law, this policy terminates in 1996 and would return payment levels to 100% of the allowed amount. The base upon which capital cost to hospitals are paid is to be updated to account for lower capital costs in recent years. Under this proposal. Medicare payments for capital costs will be set at 85% of the allowed amount.

III. Prospective Payment System (PPS) Update

Background:

Hospitals are paid on the basis of a prospectively fixed payment rate for costs associated with each discharge. Each hospital's basic payment rate is based on a national standardized payment amount. which is higher for hospitals in large urban areas than for other hospitals. Each standardized payment amount is adjusted by a wage index. Payment also depends on the relative costliness of the case, based on the diagnosis related group (DRG) to which the discharge is assigned. Additional payments are made for: extraordinary costs (outliers); indirect costs of medical education; and for hospitals serving a disproportionate share of low-income patients. Other exceptions and adjustments are made.

PPS payment rates are annually updated using an "update factor." The annual update factor applied to increase the Federal base payment amounts is determined, in part, by the projected increase in the hospital market basket index, which measures the costs of goods and services purchased by hospitals. Under the Omnibus Budget Reconciliation Act of 1993 (OBRA 93), the PPS update factor for all PPS hospitals is equal to the percentage increase in the market basket minus 2 percentage points. Hospitals have received an average PPS rate update of market basket minus 2 for the last decade.

Provision:

PPS hospitals will receive an update in their payment rates of market basket minus 2.5% in FY 1996, market basket minus 2.0% in FY 1997 - 2000, and the full market basket thereafter.

IV. Non-PPS Hospitals -- Sole Community Hospitals

Background:

Sole Community Hospitals (SCHs) are facilities located in geographically isolated areas and are the sole provider of inpatient, acute care hospital services in a geographic area based on distance, travel time, severe weather conditions, and/or market share. SCHs are paid the greater of what would be payable under PPS or a target amount comparable to that for PPS-exempt hospitals. Target amounts for SCHs are updated by an "applicable percentage increase" which is specified by statute and is generally pegged to the hospital market basket index. For FY 1996 and thereafter, the update for SCHs is the same as for all PPS hospitals.

Provision:

The differential increase sole community hospitals have received is extended based on a methodology comparable to that used in the past.

V. Non-PPS Hospitals (Rehabilitation and Long-Term Care Hospitals)

Background:

Five types of specialty hospitals (psychiatric, rehabilitation, long-term care, children's, and cancer) and two types of distinct-part units in general hospitals (psychiatric and rehabilitation) are exempt from PPS. Long-term care hospitals have an average length of inpatient days greater than 25 days and meet and other requirements. Rehabilitation facilities must provide intensive rehabilitative services for specified conditions (e.g. stroke and spinal chord injuries) and meet other requirements.

Each excluded provider is paid on the basis of its current Medicare allowable inpatient operating costs or a target amount. The target amount is based on the provider's costs per discharge in a base year, updated to the current year by an annual update factor. The update factor is established by statute and is generally pegged to the market basket index. Facilities with Medicare allowable inpatient operating costs less than their target amount per discharge receive their costs plus an additional payment (known as an incentive payment) that is the lesser of 50 percent of the difference between their costs and the target amount, or 5 percent of the target amount. Providers whose costs exceed the target amount receive this amount plus 50 percent of additional costs, subject to a ceiling of 110 percent of the target amount. Medicare allowable capital costs are paid in their entirety.

Provision:

The five types of specialty hospitals under this category, psychiatric, rehabilitation, long-term care, Children's, and cancer and the distinct parts for psychiatric and rehabilitation hospitals will continue to receive an update of market basket minus 1% through the year 2002.

VI. Hospital Bad Debt

Background:

Certain hospital and other provider bad debts are reimbursed by Medicare on an allowable cost basis. To be qualified for reimbursement, the debt must be related to covered services and derived from deductible and coinsurance amounts left unpaid by Medicare beneficiaries. The provider must be able to establish that reasonable collection efforts were made and that sound business judgment established that there was no likelihood of recovery at any time in the future.

Provision:

Certain hospitals and other providers will continue to receive reimbursement from Medicare for beneficiary bad debt, but reimbursement will be phased down to 75% in FY 1996, 60% in FY 1997, and 50% in FY 1998 in order to provide a further incentive for eligible providers to collect the payments due from beneficiaries.

VII. Skilled Nursing Facility (SNF) Care

Background:

SNFs are generally reimbursed on the basis of reasonable costs, subject to limits that are applied to per diem routine service costs (nursing, room and board, administrative, and other overhead). Ancillary services (such as therapy and certain equipment) and capital-related costs are excluded from the cost limits and are generally paid on the basis of reasonable costs.

Separate per diem limits are established for freestanding and hospital-based SNFs by urban or rural area. Freestanding SNF cost limits are set at 112 percent of the average per diem labor-related and non labor-related costs. Hospital-based SNF limits are set at the limit for freestanding SNFs, plus 50 percent of the difference between the freestanding limits and 112 percent of the average per diem routine services costs of hospital-based SNFs. The limits are adjusted by the hospital wage index to reflect differences in wage levels. The law authorizes the Secretary to allow for exceptions to the limits, based on case mix or circumstances beyond the control of the facility. The Secretary is required to rebase cost limits every 2 years, i.e. to develop cost limits using the latest available SNF cost report data every 2 years. In the interim the Secretary applies a SNF market basket developed by the Health Care Financing Administration (HCFA) to reflect changes in the price of goods and services purchased by SNFs.

SNFs providing less than 1,500 days of care per year to Medicare patients in the preceding year have the option of being paid a prospective payment rate set at 105 percent of the regional mean for all SNFs in the region. The rate covers routine and capital-related costs (and not ancillary services) and is calculated separately for urban and rural areas, adjusted to reflect differences in wage levels. Prospective rates can not exceed the routine service cost limit that would be applicable to the facility, adjusted to take into account average capital-related costs with respect to the type and location of the facility. For low-volume SNFs, the Secretary is required to establish on an annual basis, prospective payments that reflect current SNF costs using the most recent data available from SNF cost reports. For SNFs receiving prospectively determined payment rates, the Secretary may pay for ancillary services on a reasonable charge basis, rather than on a cost basis, if the Secretary determines that a reasonable charge basis provides an equitable level of payment and eases the SNF's reporting burden.

OBRA 93 required that there be no changes in SNF cost limits (including no adjustments for changes in the wage index or updates of data) for cost reporting periods beginning in FY 1994 and FY 1995, or in prospective payment amounts for low-volume SNFs during these cost reporting periods. The Secretary was also required, when granting or extending exceptions to cost limits, to limit any exception to the amount that would have been granted if there were no restriction on changes in cost limits. OBRA 93 also repealed the requirement that additional payments be made to hospital-based SNFs for costs attributable to excess overhead allocations, effective for cost reporting periods

beginning on or after October 1, 1993. Payments to proprietary SNFs for return on equity were also eliminated, effective for cost reporting periods beginning on or after October 1, 1993.

Provisions:

a) The OBRA 93 freeze savings are extended through FY 2002.

b) Nursing homes frequently charge Medicare for surgical dressings and diaper kits and other routine ancillary items or services separate from the room rate for nursing, room and board. Under these provisions, the costs for these services will be included in the room rate and subject to routine cost limits.

c) Much of the growth in SNF costs has come in the area of therapy services. These and other non-routine services are not subject to limits and currently comprise half of all SNF costs. Current nursing home payment policies lack an incentive for the prudent management of the non-routine ancillary services such as therapies, diagnostics, drugs and certain supplies and equipment. Under these provisions, payment for these services will be subject to limits based on a blended rate of facility specific and national costs for these services, and then reconciled at the end of the year with an aggregate limit calculated for each SNF. The SNF in this approach would have the incentive to stay below the limit, because those SNF's below the limit could retain 50% of the difference. SNFs above the limit would either have to return the excess in a lump sum or receive lower payments in the future.

d) Under current law, payment for the capital costs of SNFs is not subject to any limits or constraints comparable to those that exist for hospitals and outpatient hospital departments. Under these provisions, capital related costs will be reduced by 15%.

VIII. Medicare Payment for Hemophilia Clotting Factor

Background:

In 1989, Congress changed the way Medicare paid for inpatient costs of clotting factor by providing an add on payment to the DRG for the cost of clotting factor. This change was initially limited to a 18 month period to allow for the collection of better data and it was then extended through fiscal year 1994 as part of the Omnibus Budget Reconciliation Act of 1993.

Provision:

The Medicare payment for hemophilia clotting factor is extended permanently.

IX. Long-term Care (LTC) - Hospital Within a Hospital

Background:

Recent regulations issued by the Secretary place significant restrictions on long-term care hospitals located within or on the same campus as the "acute care PPS-related" hospital. Most LTC hospital units will not be able to meet these additional regulations either because of financial or physical plant barriers.

Provision:

The existing LTC hospitals within hospitals are grandfathered and will not be subject to these regulations.

X. Disproportionate Share LTC Hospitals

Background:

LTC hospitals are paid reasonable costs subject to limits. A small number of long-term care hospitals (generally older hospitals serving a higher number of poor) reached their cost limits several years ago as they began to take sicker and more complex patients who required more intensive services. For several of these hospitals, the Medicare program payment is significantly less than costs.

Provision:

Rebasing of LTC hospitals is required if hospitals meet a new financial loss test and a low-income patient load test as follows: 25% of the patients they serve are disproportionate share and they have shown losses on their cost reports for the past two years.

XI. Essential Access Community Hosptital (EACH)/Rural Primary Care Hospital (RPCH) Demonstration Project

Background:

The EACH/RPCH demonstration program allows about 20 small rural hospitals to

continue to receive Medicare payments as hospitals (even though they do not meet all the qualifications for a full service hospitals). The two conditions that RPCH hospitals must meet are: 1) they are a recipients of an EACH/RPCH grant, and 2) they have an arrangement with a full service hospital (EACH) for services that they cannot deliver. Funds were not appropriated for the EACH/RPCH program for this year and thus no grants will be issued.

Provision:

The RPCHs continue to receive Medicare hospital payments for their services and EACHs continue to be paid on the basis of reasonable costs

XII. Rural Essential Access Community Hospitals (REACH) Program

Background:

Many very small rural and frontier hospitals have struggled to remain open as full service hospitals. Achieving any sort of economies of scale is nearly impossible. Further, most of these hospitals are completely dependent on the Federal government for payment.

Provision:

A mechanism will be established for very small rural and frontier facilities to remain open as emergency facility/ stabilization units and continue to receive Medicare payment.

SUBTITLE G - PROVISIONS RELATING TO MEDICARE PART B

I. General Overview

Part B, the Supplementary Medical Insurance (SMI) program covers a broad range of medical services including physicians services, laboratory services, durable medical equipment, and outpatient hospital services. Payment for physician services, clinical laboratory services, and durable medical equipment are made on the basis of fee schedules. Certain other services are paid on the basis of reasonable costs or reasonable charges. The program provides for annual updates of the payment amounts to reflect inflation and other factors.

II. Process for Updating Physician Fees

Background:

Payments for physician services are currently made on the basis of a fee schedule. The fee schedule assigns relative values to services based on several factors. This is referred

to as the Resource-Based Relative Value Scale (RBRVS). These relative values are adjusted for geographic variations in the costs of practicing medicine and then converted into a dollar payment amount by a conversion factor. There are three separate conversion factors: one for surgical services, one for primary care services, and one for other non-surgical services. These conversion factors are updated each year by a default formula. The default formula combines inflation, measured by the Medicare Economic Index (MEI), plus or minus the difference between actual spending for services in a base period compared to the Medicare Volume Performance Standard (MVPS) for the period. A separate MVPS is determined for each category of service. The MVPS is a goal for the rate of expenditure growth for each category of service. It is calculated based on several factors: changes in fees, enrollment, volume, intensity, and laws and regulations. The MVPS is then subject to a 4% reduction.

Several problems have developed during the evolution of this system. Instead of a single conversion factor, as originally proposed, three separate conversion factors are now used. These separate conversion factors require three separate volume performance standards. These combined mechanisms have recreated the very distortions the RBRVS was intended to correct, that is, greater value being placed on specialty care rather than primary care. In addition, changes included in OBRA '93 have created a structural flaw in the default formula which results in negative updates regardless of how successful physicians are in meeting their MVPS.

Provision:

The Medicare Volume Performance Standard (MVPS) system would be repealed. It would be replaced with the system recommended by the Physician Payment Review Commission (PPRC) based on a single conversion factor (CF) in which a sustainable growth rate would be set each year allowing for inflation, changes in enrollment, GDP + 2 percentage points, and changes in law. The conversion factor would be updated each year so that total actual spending accrued through the following year falls within the sustainable growth rate limits. Upper and lower limits would be placed on the annual adjustment to ensure reasonable updates and to reduce volatility.

III. Hospital Outpatient Formula-Driven Overpayment

Background:

Medicare payments for hospital outpatient ambulatory surgery, radiology, and other diagnostic services equals the lesser of: (1) the lower of a hospital's reasonable costs or

its customary charges, net of deductible and coinsurance amounts, or (2) a blended amount comprised of a cost portion and a charge portion, net of beneficiary cost-sharing. The cost portion of the blend is based on the lower of the hospital's costs of charges, net of beneficiary cost sharing, and the charge portion is based, in part, on ambulatory surgery center payment rates, net of beneficiary coinsurance.

A hospital may bill a beneficiary for the coinsurance amount owed for the outpatient service provided. The beneficiary coinsurance is based on 20% of the hospital's submitted charges for the outpatient service, whereas Medicare usually pays based on the blend of the hospital's costs and the amount paid to ambulatory surgery centers for the same service. This results in an anomaly whereby the program's payment does not result in a dollar-for-dollar decrease in Medicare program payments.

Provision:

The anomaly in the current payment formula is corrected to allow Medicare to benefit dollar-for-dollar for beneficiary co-payments.

IV. Durable Medical Equipment

Background:

Durable medical equipment (DME) is reimbursed on the basis of a fee schedule. Items are classified into five groups for the purposes of determining the fee schedule and making payments. The fee schedules establish national payment limits for DME. The national limits have a floor and ceiling. The floor is equal to 85% of the weighted median of local payment amounts, and the ceiling is equal to 100% of the weighted median of local payment amounts. The fee schedule is updated each year by the consumer price index for all urban consumers, CPI-U.

Provisions:

a) The fee schedule is frozen through FY 2002.

b) Oxygen services payment amounts will be reduced.

V. Reduction in update for Orthotics and Prosthetics

Background:

Orthotics and prosthetics are reimbursed on the basis of a fee schedule. Items covered by the fee schedule include leg, arm, and neck braces, artificial limbs and eyes, and items that replace all or part of an internal body organ. The fee schedule establishes regional payment limits for covered items, with a floor of 90% of the weighted average of local payment amounts and a ceiling equal to 120%. The fee schedule is updated annually by the consumer price index for all urban consumers (CPI-U).

Provision:

Updates for orthotics and prosthetics would be limited to a 1% CPI-U update annually for the period 1996 through 2002.

VI. Clinical Laboratory Services

Background:

Clinical lab services are paid on the basis of area-wide fee schedules. The fee schedule amounts are updated annually. There is also a ceiling on payment amounts which is being phased down to 76 percent of the national median in 1996. The Secretary is required to adjust payment amounts annually by the percentage change in the CPI, together with any additional adjustments the Secretary deems appropriate.

Provisions:

a) The fee schedule is frozen through FY 2002.

b) The ceiling is reduced.

VII. Outpatient Capital

Background:

Outpatient capital is paid on the basis of hospital-specific reasonable costs. Payment for outpatient capital were reduced by 15% for portions of cost reporting periods in FY 1991 and by 10% for FY 1992-1995. Sole community hospitals and rural primary care hospitals were exempt for all years. OBRA 93 extended the 10% reduction for capital related costs through FY 1998.

Provision:

The savings stream under current law is extended. The exemption for sole community

hospitals and certain other rural hospitals is continued.

VIII. Extension of 5.8% Reasonable Cost Reduction

Background:

Many services provided in hospital outpatient clinics and facilities are reimbursed on a hospital-specific cost basis. These services include, clinic visits; physical, occupational, respiratory, and speech therapy services; surgical procedures that are not ASC-approved; chemotherapy; drugs; and allergy tests.

A 5.8% reduction for hospital outpatient operating payment for services paid on a cost basis (and the cost portion of blended payments) has been in effect since fiscal year 1991 and is scheduled to continue through fiscal year 1998. In addition, the 5.8% operating cost reduction is applied to the aggregated hospital-specific cost portion of the blended payment amount for ASC-approved surgery, radiology, and other diagnostic procedures.

Provision:

The provision in current law is extended. The exemption for sole community hospitals and certain other rural hospitals is continued.

IX. Extension of Part B premium

Background:

Benefits under Medicare's Supplementary Medical Insurance (SMI) program are partially funded by monthly premiums paid by enrollees, and the remainder are paid from general revenues. Although the SMI premium was initially set to cover 50% of the cost of benefits, between 1975 and 1983 premiums covered a declining share of SMI costs, falling from 50 percent to less than 25 percent. In 1990, the Part B premium rates were set by statute through 1995 based on estimates of the amount necessary to cover 25 percent of program costs. For 1995, the monthly premium is $46.10, which is 31.5% of program costs.

Provision:

The current Part B premium set at 31.5% of program costs as specified in the 1995 SMI

Board of Trustees report would be made permanent.

X. Affluence Testing for Part B premium

Background:

Coverage under Part B of Medicare is voluntary. Individuals entitled to Medicare Part A benefits must actively choose not to enroll in Part B. All persons age 65 or older and certain other persons may elect to enroll in Part B by paying the monthly premium.

Provision:

Individuals enrolled in Medicare Part B with adjusted gross incomes (AGI) in excess of $75,000 per individual and $125,000 per couple would be responsible for an additional Part B premium. These individuals would assume an increased percentage of the premium, with the Medicare premium subsidy being completely phased out at $100,000 for individuals and $150,000 for couples. The additional premium will be paid through a deduction in an affected individual's Social Security, or other applicable, check. An individual's AGI will be determined from the most recent information available to the Secretary of HHS from the Department of Treasury. Beneficiaries impacted by this proposal will be notified of their increased premium obligation and will have an opportunity to provide more current information regarding their estimated income before premium deductions begin.

SUBTITLE H - PROVISIONS RELATING TO PARTS A AND B

I. Policy Overview

Parts A/B involve programs that contain or affect both Part A and Part B services and benefits. Examples include: home health benefits and services, payment and operation of health maintenance organizations, the end-stage renal disease (ESRD) program, and the Medicare Secondary Payer (MSP) provisions.

II. Extensions of Medicare Secondary Payer (MSP) Requirements

Background:

Under the MSP program an individual's employer-based group health insurance, liability

insurance, or no-fault insurance may be the primary payer. The following MSP payer provisions will expire at the end of 1998: (1) the data match requirements among HCFA, IRS, and SSA to identify the primary payers for Medicare enrollees with health coverage in addition to Medicare; (2) the provisions making Medicare the secondary payer for disabled employees with employer-based health insurance; (3) the provision requiring non-Medicare insurers to be the primary payers for ESRD patients for 18 months before Medicare becomes the primary payer.

Provisions:

The following MSP provisions in current law are extended: (1) the data match requirement among HCFA, IRS, and SSA to identify the primary payers for Medicare enrollees with health coverage in addition to Medicare; (2) the provisions making Medicare the secondary payer for disabled employees with employer-based health insurance; (3) the provision requiring non-Medicare insurers to be the primary payer for ESRD patients for 18 months before Medicare becomes the primary payer.

III. MSP End-Stage Renal Disease Expansion

Background:

Currently, employer-based group health plans are the primary payers of individuals who become eligible for Medicare because of their ESRD condition for a period of 18 months.

Provision:

The period in which employer-based group health plans are the primary payers under the ESRD program is expanded to 24 months.

IV. Improvements to MSP Program

Background:

The main purpose of the MSP provision is to avoid Medicare payment when private insurance is available to cover the cost of medical expenses incurred by Medicare. Section 6202 of the Omnibus Reconciliation Act of 1989 permits HCFA to match data contained in Internal Revenue and Social Security files to identify beneficiaries with private insurance and require employers in such cases to verify coverage for Medicare. To date, the data match program has been cost effective, recovering hundreds of millions of dollars in payments from insurers.

However, the courts have recently invalidated MSP regulations needed to effectively continue the data match recovery procedure. Medicare is now subject to the same timely filing requirements as other claimants. Since the data match information by nature is at least two years old, this renders the data match useless for recovery purposes. The court's ruling prevents Medicare from collecting claims directly from third party administrators (TPAs). TPAs typically adjudicate claims and write benefit checks for employers who self-insure.

Provisions:

a) The MSP regulations are codified with a three year time limit for HCFA to file a request for recovery from primary insurers; i.e., three years from the date on which the service was rendered is the minimum time it would take HCFA to identify the claim and notify the responsible insurer. This provision would apply prospectively for plans which have settlements with HCFA, and retroactively for all other plans.

b) Medicare is authorized to recover from TPAs in all cases except in instances where a TPA has no way to recover these costs from employers because of insolvency or bankruptcy proceedings.

V. Home Health Services Extension of Cost Limits and Establishment of a Prospective Payment Methodology

Background:

Both Parts A and B of Medicare cover home health visits for persons who need skilled nursing care on an intermittent basis, physical therapy, or speech therapy. Persons must also be homebound and under the care of a physician. Medicare pays for covered home health services on a reasonable cost basis, subject to cost limits that are updated annually. These limits are set at 112 percent of the mean labor-related and non-labor-related per visit costs for freestanding home health care agencies. OBRA 93 eliminated the update for home health cost limits for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996. Beginning July 1, 1996, new cost limits would be established that do not reflect the effects of the freeze.

Provisions:

a) Future payments will be based on current payment levels by not allowing for the inflation that occurred during the freeze years.

b) A prospective payment methodology for home health services will be established.

The system will be based on prospectively determined per visit rates that are subject to an overall limit. This limit would be applied when actual payments are reconciled at year's end with payments allowed based on the number of episodes of care actually provided by each home health agency.

The proposal would have the following specific components:

From the most recent home health cost report data available, the Secretary would be required to establish *national average* per visit rates for each of the home health service disciplines covered under Medicare--skilled nursing care, physical therapy, speech pathology, occupational therapy, medical social services, and home health aide services. The per visit rates would be set to assure budget neutrality with respect to the OBRA 93 freeze on limits in effect for cost reporting periods ending June 30, 1996. To reflect regional differences in the costs of providing services, the labor-related portion of the per visit rates would be adjusted by the hospital wage index. This wage index is currently used to adjust home health cost limits. The adjusted per visit rates would be the amounts that home health care agencies would receive for each of the particular mix of visits provided to a given home health care beneficiary.

Per visit rates would be subject to a per episode limit. The Secretary would calculate separate per episode limits for each of 18 different case categories of home health care. These 18 categories would be the same as those being used in HCFA's Phase II demonstration, and would serve as a substitute for a true case-mix adjustment not yet available. 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. Agencies would have a strong incentive to keep their costs below this rate to make a profit.

The per episode limit would be calculated as follows. For a base year, using the most recent home health agency cost report data, the Secretary would calculate for each of the 18 categories the *mean* costs incurred by agencies for care delivered during a period of 120 days following the initial admission of the beneficiary to home health. This would become the target per episode limit. Total per visit payments to an agency for each episode of care would be compared with the target limit. Calculation of per episode limits would be done on a regional basis; for these purposes region would be defined by

the same metropolitan statistical area (MSA)/rural classification system used for the hospital wage index.

If a beneficiary continues to need home health visits after 120 days, the home health agency is responsible for providing the care through the 165th day. After a period of 165 days, then an agency may request that additional payments be made on a per visit basis.

In order for fiscal intermediaries to approve such requests, agencies would be required to submit a physician's certification of the continuing need for skilled care as well as information about utilization of services in the previous period and expected use of services in the upcoming period.

A single case-mix adjusted *aggregate* payment limit would also be determined annually for each agency. This would be calculated by multiplying the number of episodes admitted by an agency to each of the 18 case categories times the per episode limit for the appropriate category, and then summing the products. This amount would be compared to actual payments made to the home health care agency for all of its cases. If total payments for the year are below the agency's aggregate payment limit, then agencies would be allowed to retain 50 percent of the difference. Agencies would not be allowed to keep aggregate payments that are over the limit.

Per visit and per episode limits would be adjusted annually by the home health market basket currently used to update cost limits. To deal with case-mix "creep," the Secretary would also be required to adjust per episode limits to assure that aggregate case-mix, at the regional level, remains budget neutral during the first 3 years of the new payment system.

VI. Denial of Retroactivity under ESRD

Background:

HCFA interprets current law to require Medicare to remain primary pay for retirees who develop ESRD after they are already subject to the working aged and disabled provisions under Medicare. This position reflects a significant change in HCFA's interpretation of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93).

Provision:

HCFA's August 1994 policy determination shall only apply prospectively.

VII. Coverage and Payment for Certain Medical Devices Approved for Investigational Use

Background:

Medicare law does not provide an all-inclusive list of specific items, services, treatments, procedures, or technologies covered by the program. The law, however, provides that no payment may be made for any expenses which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. While HCFA has not explicitly defined "reasonable" and "necessary" for purposes of making decisions about the appropriateness of Medicare's coverage for specific services and items, it has applied a general policy that services be safe and effective and not experimental or investigational. In 1994, HCFA clarified its coverage policy to prohibit coverage and payment of services associated with the use of investigational devices.

Provision:

Current law is clarified to specify that nothing under current Medicare law may be construed as prohibiting coverage of items and services associated with the use of a medical device in the furnishing of inpatient hospital services on the grounds that the device is not an approved device if: (1) the device is an investigational device; and (2) the device is used instead of an approved device. In addition, payment for items and services associated with the use of investigational devices in inpatient hospital settings is limited to the amount that Medicare would have paid if the item or service were associated with an approved device.

VIII. Medicare Commission

Background:

Currently, the Congress is advised on Medicare policy matters by the Prospective Payment Assessment Commission (PROPAC) and the Physician Payment Review Commission (PPRC). PROPAC provides guidance primarily on hospital and health facility related issues. PPRC provides guidance primarily on physician related issues.

Provision:

The functions of PROPAC and PPRC are combined into a new advisory body to advise Congress on Medicare policy regarding fee-for-service payment policy and issues related to the operation of MedicarePlus. The new Commission is required to report to the Congress on Medicare benefits in both fee for service and MedicarePlus, the geographic distribution issues regarding Medicare contributions, and the development of additional risk adjustment for health status for the Medicare contribution under MedicarePlus.

IX. Commission on the Effect of the Baby Boom Generation on the Medicare Program.

Background:

This bill is designed to address the need to modernize the Medicare Program and to assure the short-term solvency of the Program. However, the Trustees Reports examine the long-term future of the Program as a result of impending demographic changes.

In the long run. the Report describes the demographic changes we can expect as a result of the baby boom and its implications for the Program:

> "Currently about four covered workers support each HI enrollee. This ratio will begin to decline rapidly early in the next century. By the middle of that century, only about two covered workers will support each enrollee. Not only are the anticipated reserves and financing of the HI program inadequate to offset this demographic change, but under all the sets of assumptions, the trust fund is projected to become exhausted even before the major demographic shift begins to occur."
>
> "The long range financial outlook is even more unfavorable. Over the 75 year projection period, the HI trust fund has an actuarial balance of -3.52 percentage points. using the intermediate set of assumptions. This actuarial balance indicates that the HI payroll tax rate of 1.45% (employers and employees each) would have

to be more than doubled immediately to keep the fund solvent for the entire projection period. To keep the HI fund in actuarial balance for 25 years would require an immediate increase in the payroll tax rate if spending is not slowed. That would be a 44% tax rate increase."

Provision:

A Commission on the Effect of the Baby Boom Generation on the Medicare Program is established. The Commission's mission is to examine the effect of the baby boom on the financing of the Medicare Program. The Commission is charged with making recommendations to the Congress on how to preserve the Medicare Federal Hospital Trust Fund and to assure that growth in spending by the Supplementary Medical Insurance Trust Fund is affordable. In addition, the Commission will report on the demographic and economic changes that will affect the financing of the Trust Fund, and the developments in the health care marketplace.

X. Medicare Medigap Issues

Background:

Although Medicare pays a significant amount of health care costs, several expenses are the responsibility of seniors. To offset these expenses, many people purchase private supplemental insurance. These policies are often referred to as Medigap insurance policies and are designed to pay for deductibles, coinsurance, and some health services not covered by Medicare under the fee-for-service program. In addition, many people purchase additional protection in the form of supplemental insurance and/or long-term care insurance.

Current law regarding Medicare non-duplication has created confusion in the supplemental insurance market. On June 12, 1995, HCFA issued an interpretation of current law that deemed all private insurance policies duplicative to Medicare. It also prohibited long-term care and home health insurance policies from coordinating benefits with Medicare.

Provisions:

a) The current risk contract exemption from Medicare non-duplication provisions will be maintained for MedicarePlus plans.

b) The definitions on duplication and coordination are clarified.

XI. Medicare Fail Safe Adjustment

Background:

A new adjustment will be applied to Medicare to keep fee-for-service spending in line with the objective of reaching and maintaining solvency for the HI Trust Fund and sustainable growth for the SMI Trust Fund. Although the Federal Government is required by law to pay Medicare claims on behalf of eligible participants, total Medicare spending is limited in two ways: (1) by availability of reserves in the Medicare trust funds; and (2) by provisions of the Omnibus Budget Reconciliation Act of 1990 (OBRA), P.L. 101-508. These limitations are intended to set ongoing aggregate limits on spending, not to regulate the annual rate of growth in Medicare.

(1) Limitation created by trust fund reserves. Part A claims for hospitalization are paid from the Hospital Insurance (HI) Trust Fund. Part B claims for physicians' services are paid from the Supplementary Medical Insurance (SMI) Trust Fund. These two trust funds are accounting devices by which the Government determines the extent to which spending on Medicare claims is authorized without new legislation or appropriations. Trust fund balances represent spending authority. An insolvency in either fund would force a stoppage in Government reimbursement for Medicare claims until the fund had accrued new credits.

The sources of trust fund credits are: (1) payroll tax revenue; (2) enrollee premiums; (3) Government general fund contributions; and (4) interest on Government debt held by the funds. The earmarked revenue for the HI fund comes from a payroll tax of 1.45 percent applicable to both employees and employers. The SMI fund is credited with monthly premium payments made by Part B enrollees (currently $46.10 a month) and transfers of general Government funds. The HI fund is projected to be depleted in FY 2002. The SMI fund will not be depleted as the HI Fund will, since general fund transfers are credited each year in amounts sufficient to maintain the fund's solvency. However, the Trustees for the SMI Fund report that its expenditure growth is unsustainable, and if this growth continues unabated, it will make it more difficult to maintain HI Fund solvency.

(2) Limitation created by OBRA. A provision in OBRA requires that legislated increases in entitlement spending and decreases in revenue be offset by entitlement decreases and/or revenue increases on a pay-as-you-go (PAYGO) basis. A violation of PAYGO rules can trigger sequestration, a process by which all budget accounts subject to sequestration are reduced by the percentage necessary to make up any spending overrun or revenue shortfall. However, the law limits the sequestration percentage that can be applied to Medicare benefits to 4.0 percent or less. These budget rules apply through FY 1998.

Sequestration has not occurred because of a PAYGO violation, but OBRA restricted increases in certain Medicare payment rates beginning in FY 1991 as part of the budget agreement set forth by that law. Sequestration did occur in FY 1988 under an earlier law, the Balanced Budget and Emergency Deficit Control Reaffirmation Act of 1987 (P.L. 100-119). The sequestration percentage applied to Medicare spending was 2.0 percent, the maximum allowed for Medicare under that law. It was achieved by reducing payment rates for covered services.

Provision:

A new section will be added to Title XVIII of the Social Security Act to provide a mechanism by which certain Medicare spending would be reduced automatically if it were anticipated that spending would exceed the budget resolution and threaten the HI Trust Fund solvency during the next fiscal year. This "failsafe budget mechanism" would be in effect for fiscal years 1998 through 2002. The mechanism would continue beyond FY 2002, but would be the subject of recommendations by the Commission on the Effect of the Baby Boom Generation on the Medicare Program to be established in this Act.

The failsafe budget mechanism would apply to both Parts A and B of Medicare, but only to fee-for-service expenditures. Constraint on the growth of per beneficiary spending under MedicarePlus is described elsewhere. Distinct limits would be specified for the following fee-for-service sectors: inpatient hospital services; home health services; extended care services; hospice care; physicians' services; outpatient hospital services and ambulatory facility services; durable medical equipment and supplies; diagnostic tests; and other items and services.

If the Secretary of Health and Human Services determines that expenditures for a sector for a fiscal year would exceed the sector's budget allotment for that year, then Medicare payment rates applicable to that sector would be adjusted so that expenditures would not exceed the budget allotment. The Medicare payments to be adjusted in each fee-for-service sector would be specified in the law.

The sector specific budget allotment for a fiscal year would be determined by multiplying the total fee-for-service allotment for that year by a sector specific allotment proportion specified by sector and year in the new law. The total allotment for a year would equal the Medicare benefit budget less the payments the Secretary estimates would be made

under MedicarePlus (the new Part C of Medicare). The Medicare benefit budget would be set forth in law as follows:

Fiscal Year	Benefit Budget ($bil.)
1997	203.1
1998	214.3
1999	227.2
2000	241.0
2001	259.1
2002	280.0

The benefit budget for a subsequent fiscal year would equal the benefit budget for the preceding fiscal year increased by the sum of: (1) the annual percentage increase in the CPI-U for the 12-month period ending with June of the prior year; and (2) the annual percentage increase in the average number of Medicare beneficiaries in the current fiscal year compared to the preceding fiscal year.

A sector's allotment of the benefit budget would equal the ratio of the baseline projection of expenditures for the sector in a year to the sum of all such baseline expenditures for all sectors in that year. Baseline projections would be determined by applying annual growth rates for each sector, as specified in the new law, to the prior year's baseline projection for a sector. If a sector's expenditures were to fall below the baseline allotment, the unspent balance available within that allotment would be reallocated proportionately to the allotments for the other sectors.

In providing for adjustments to Medicare payments for a particular sector, the Secretary would be required to take into account the impact of the adjustment on the volume or type of services provided in that sector and any delays in payments from one year to the next that might be expected in that sector.

Beginning with the budget documents for FY 1998, the President's Budget would be required to include information on actual Medicare fee-for-service expenditures by sector for the second preceding year, with a comparison to the corresponding Medicare benefit budget and sector allotments. Data on actual annual growth rates for each fee-for-service sector would also be required. If the actual fee-for-service expenditures for all sectors were to exceed the total allotments for the second preceding year, then the allotments for each sector with excess spending would be reduced for the next fiscal year in proportion to the sector's contribution to the second preceding year's expenditure overrun.

If the President were to submit a legislative proposal to revise the baseline annual growth rates specified for fee-for-service sectors, Congress would be required to consider the proposal under an expedited procedure. Passage of a joint resolution of approval would

be required within 60 days of submittal for the changes to become law. Procedure for consideration of a joint resolution would be the same as that used under the Defense Base Closure and Realignment Act of 1990.

Annual reports of the Trustees on Part A of Medicare would be required to include information on the annual rate of program expenditures that would maintain the solvency of the trust fund and the extent to which the failsafe budget mechanism restrained the expenditure growth rate.

SUBTITLE I - CLINICAL LABORATORY IMPROVEMENTS ACT REFORM

Background:

The law requires clinical laboratories to have a license issued by the Secretary. In order to receive a license a laboratory must meet standards relating to facilities, equipment, and personnel. A laboratory also must participate in proficiency testing and must pass onsight inspection. The law is considered overly regulatory, burdensome, and costly.

Provision:

Modify current law to relieve the burden of physician office clinical laboratories.