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104TH CONGRESS
1st Session

HOUSE OF REPRESENTATIVES

REPT. 104–276
Part 1

MEDICARE PRESERVATION ACT OF 1995

R E P O R T

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

ON

H.R. 2425

together with

DISSENTING VIEWS

[Including cost estimate of the Congressional Budget Office]

OCTOBER 16, 1995.—Committed to the Committee of the Whole House
on the State of the Union and ordered to be printed

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104TH CONGRESS 1st Session } HOUSE OF REPRESENTATIVES { REPT. 104–276 Part 1

MEDICARE PRESERVATION ACT OF 1995

OCTOBER 16, 1995.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. ARCHER, from the Committee on Ways and Means, submitted the following

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 2425]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 2425) to amend title XVIII of the Social Security Act to preserve and reform the medicare program, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

The amendment is as follows:

Strike out all after the enacting clause and insert in lieu thereof the following:

SECTION 1. PURPOSE.

The purpose of this Act is to reform the medicare program, in order to preserve and protect the financial stability of the program.

TITLE XV—MEDICARE

SEC. 15000. SHORT TITLE OF TITLE; AMENDMENTS AND REFERENCES TO OBRA; TABLE OF CONTENTS OF TITLE.

(a) SHORT TITLE.—This title may be cited as the "Medicare Preservation Act of 1995".

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) REFERENCES TO OBRA.—In this title, the terms "OBRA–1986", "OBRA–1987", "OBRA–1989", "OBRA–1990", and "OBRA–1993" refer to the Omnibus Budget Rec-

onciliation Act of 1986 (Public Law 99–509), the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203), the Omnibus Budget Reconciliation Act of 1989 (Public Law 101–239), the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508), and the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66), respectively.

(d) TABLE OF CONTENTS OF TITLE.—The table of contents of this title is as follows:

Sec. 15000. Short title of title; amendments and references to OBRA; table of contents of title.

Subtitle A—MedicarePlus Program

PART 1—INCREASING CHOICE UNDER THE MEDICARE PROGRAM

Sec. 15001. Increasing choice under medicare.
Sec. 15002. MedicarePlus program.

"PART C—PROVISIONS RELATING TO MEDICAREPLUS

"Sec. 1851. Requirements for MedicarePlus organizations; high deductible/medisave products.
"Sec. 1852. Requirements relating to benefits, provision of services, enrollment, and premiums.
"Sec. 1853. Patient protection standards.
"Sec. 1854. Provider-sponsored organizations.
"Sec. 1855. Payments to MedicarePlus organizations.
"Sec. 1856. Establishment of standards for MedicarePlus organizations and products.
"Sec. 1857. MedicarePlus certification.
"Sec. 1858. Contracts with MedicarePlus organizations.
Sec. 15003. Duplication and coordination of medicare-related products.
Sec. 15004. Transitional rules for current medicare HMO program.

PART 2—SPECIAL RULES FOR MEDICAREPLUS MEDICAL SAVINGS ACCOUNTS

Sec. 15011. MedicarePlus MSA's.
Sec. 15012. Certain rebates excluded from gross income.

PART 3—SPECIAL ANTITRUST RULE FOR PROVIDER SERVICE NETWORKS

Sec. 15021. Application of antitrust rule of reason to provider service networks.

PART 4—COMMISSIONS

Sec. 15031. Medicare Payment Review Commission.
Sec. 15032. Commission on the Effect of the Baby Boom Generation on the Medicare Program.
Sec. 15033. Change in appointment of Administrator of HCFA.

PART 5—TREATMENT OF HOSPITALS WHICH PARTICIPATE IN PROVIDER-SPONSORED ORGANIZATIONS

Sec. 15041. Treatment of hospitals which participate in provider-sponsored organizations.

Subtitle B—Preventing Fraud and Abuse

Sec. 15101. Increasing awareness of fraud and abuse.
Sec. 15102. Beneficiary incentive programs.
Sec. 15103. Intermediate sanctions for medicare health maintenance organizations.
Sec. 15104. Voluntary disclosure program.
Sec. 15105. Revisions to current sanctions.
Sec. 15106. Direct spending for anti-fraud activities under medicare.
Sec. 15107. Permitting carriers to carry out prior authorization for certain items of durable medical equipment.
Sec. 15108. Establishment of Health Care Anti-Fraud Task Force.
Sec. 15109. Study of adequacy of private quality assurance programs.
Sec. 15110. Penalty for false certification for home health services.

Subtitle C—Regulatory Relief

PART 1—PHYSICIAN OWNERSHIP REFERRAL REFORM

Sec. 15201. Repeal of prohibitions based on compensation arrangements.
Sec. 15202. Revision of designated health services subject to prohibition.
Sec. 15203. Delay in implementation until promulgation of regulations.
Sec. 15204. Exceptions to prohibition.
Sec. 15205. Repeal of reporting requirements.
Sec. 15206. Preemption of State law.
Sec. 15207. Effective date.

PART 2—OTHER MEDICARE REGULATORY RELIEF

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Sec. 15212. Clarification of level of intent required for imposition of sanctions.
Sec. 15213. Additional exception to anti-kickback penalties for managed care arrangements.
Sec. 15214. Solicitation and publication of modifications to existing safe harbors and new safe harbors.
Sec. 15215. Issuance of advisory opinions under title XI.
Sec. 15216. Prior notice of changes in billing and claims processing requirements for physicians' services.

PART 3—PROMOTING PHYSICIAN SELF-POLICING

Sec. 15221. Exemption from antitrust laws for certain activities of medical self-regulatory entities.

Subtitle D—Medical Liability Reform

PART 1—GENERAL PROVISIONS

Sec. 15301. Federal reform of health care liability actions.
Sec. 15302. Definitions.
Sec. 15303. Effective date.

PART 2—UNIFORM STANDARDS FOR HEALTH CARE LIABILITY ACTIONS

Sec. 15311. Statute of limitations.
Sec. 15312. Calculation and payment of damages.
Sec. 15313. Alternative dispute resolution.

Subtitle E—Teaching Hospitals and Graduate Medical Education

PART 1—TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND

Sec. 15401. Establishment of Fund; payments to teaching hospitals.

"TITLE XXII—TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND

"PART A—ESTABLISHMENT OF FUND

"Sec. 2201. Establishment of Fund.

"PART B—PAYMENTS TO TEACHING HOSPITALS

"Subpart 1—Requirement of Payments

"Sec. 2211. Formula payments to teaching hospitals.

"Subpart 2—Amount Relating to Indirect Costs of Graduate Medical Education

"Sec. 2221. Determination of amount relating to indirect costs.
"Sec. 2222. Indirect costs; special rules regarding determination of hospital-specific percentage.
"Sec. 2223. Indirect costs; alternative payments regarding teaching hospitals in certain States.

"Subpart 3—Amount Relating to Direct Costs of Graduate Medical Education

"Sec. 2231. Determination of amount relating to direct costs.
"Sec. 2232. Direct costs; special rules regarding determination of hospital-specific percentage.
"Sec. 2233. Direct costs; authority for payments to consortia of providers.
"Sec. 2234. Direct costs; alternative payments regarding teaching hospitals in certain States.

"Subpart 4—General Provisions

"Sec. 2241. Adjustments in payment amounts.

PART 2—AMENDMENTS TO MEDICARE PROGRAM

Sec. 15411. Transfers to Teaching Hospital and Graduate Medical Education Trust Fund.
Sec. 15412. Modification in payment policies regarding graduate medical education.

PART 3—REFORM OF FEDERAL POLICIES REGARDING TEACHING HOSPITALS AND GRADUATE MEDICAL EDUCATION

Sec. 15421. Establishment of advisory panel for recommending policies.

"PART C—OTHER MATTERS

"Sec. 2251. Advisory Panel on Reform in Financing of Teaching Hospitals and Graduate Medical Education.

Subtitle F—Provisions Relating to Medicare Part A

PART 1—HOSPITALS

SUBPART A—GENERAL PROVISIONS RELATING TO HOSPITALS

Sec. 15501. Reductions in inflation updates for PPS hospitals.
Sec. 15502. Reductions in disproportionate share payment adjustments.
Sec. 15503. Payments for capital-related costs for inpatient hospital services.
Sec. 15504. Reduction in adjustment for indirect medical education.
Sec. 15505. Treatment of PPS-exempt hospitals.
Sec. 15506. Reduction in payments to hospitals for enrollees' bad debts.
Sec. 15507. Permanent extension of hemophilia pass-through.
Sec. 15508. Conforming amendment to certification of Christian Science providers.

SUBPART B—PROVISIONS RELATING TO RURAL HOSPITALS

Sec. 15511. Sole community hospitals.
Sec. 15512. Clarification of treatment of EAC and RPC hospitals.
Sec. 15513. Establishment of rural emergency access care hospitals.
Sec. 15514. Classification of rural referral centers.
Sec. 15515. Floor on area wage index.

PART 2—PAYMENTS TO SKILLED NURSING FACILITIES

Sec. 15521. Payments for routine service costs.
Sec. 15522. Incentives for cost effective management of covered non-routine services.
Sec. 15523. Payments for routine service costs.
Sec. 15524. Reductions in payment for capital-related costs.
Sec. 15525. Treatment of items and services paid for under part B.
Sec. 15526. Certification of facilities meeting revised nursing home reform standards.
Sec. 15527. Medical review process.
Sec. 15528. Report by Medicare Payment Review Commission.
Sec. 15529. Effective date.

Subtitle G—Provisions Relating to Medicare Part B

PART 1—PAYMENT REFORMS

Sec. 15601. Payments for physicians' services.
Sec. 15602. Elimination of formula-driven overpayments for certain outpatient hospital services.
Sec. 15603. Reduction in updates to payment amounts for durable medical equipment.

Sec. 15604. Reduction in updates to payment amounts for clinical diagnostic laboratory tests.
Sec. 15605. Extension of reductions in payments for costs of hospital outpatient services.
Sec. 15606. Freeze in payments for ambulatory surgical center services.
Sec. 15607. Rural emergency access care hospitals.

PART 2—PART B PREMIUM

Sec. 15611. Extension of part B premium.
Sec. 15612. Income-related reduction in medicare subsidy.

PART 3—ADMINISTRATIVE SIMPLIFICATION FOR LABORATORY SERVICES

Sec. 15621. Administrative simplification for laboratory services.

PART 4—COVERAGE OF CERTAIN ANTI-NAUSEA DRUGS

Sec. 15631. Coverage of oral anti-nausea drugs under chemotherapeutic regimen.
Sec. 15632. Effective date.

PART 5—COVERAGE OF CERTAIN SERVICES ORDERED OR REFERRED BY CHIROPRACTORS

Sec. 15641. Coverage of Certain Services Ordered or Referred by Chiropractors.

Subtitle H—Provisions Relating to Medicare Parts A and B

PART 1—PAYMENT FOR HOME HEALTH SERVICES

Sec. 15701. Payment for home health services.
Sec. 15702. Maintaining savings resulting from temporary freeze on payment increases for home health services.
Sec. 15703. Extension of waiver of presumption of lack of knowledge of exclusion from coverage for home health agencies.
Sec. 15704. Study of coverage of services of Christian Science providers.

PART 2—MEDICARE SECONDARY PAYER IMPROVEMENTS

Sec. 15711. Extension and expansion of existing requirements.
Sec. 15712. Improvements in recovery of payments.
Sec. 15713. Prohibiting retroactive application of policy regarding ESRD beneficiaries enrolled in primary plans.

PART 3—FAILSAFE

Sec. 15721. Failsafe budget mechanism.

PART 4—ADMINISTRATIVE SIMPLIFICATION

Sec. 15731. Standards for medicare information transactions and data elements.

PART 5—OTHER PROVISIONS RELATING TO PARTS A AND B

Sec. 15741. Clarification of medicare coverage of items and services associated with certain medical devices approved for investigational use.
Sec. 15742. Additional exclusion from coverage.

Subtitle I—Clinical Laboratories

Sec. 15801. Exemption of physician office laboratories.

Subtitle J—Lock-Box Provisions for Medicare Part B Savings from Growth Reductions

Sec. 15901. Establishment of Medicare Growth Reduction Trust Fund for Part B savings.

Subtitle A—MedicarePlus Program

PART 1—INCREASING CHOICE UNDER THE MEDICARE PROGRAM

SEC. 15001. INCREASING CHOICE UNDER MEDICARE.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1804 the following new section:

"PROVIDING FOR CHOICE OF COVERAGE

"SEC. 1805. (a) CHOICE OF COVERAGE.—

"(1) IN GENERAL.—Subject to the provisions of this section, every individual who is entitled to benefits under part A and enrolled under part B shall elect to receive benefits under this title through one of the following:

"(A) THROUGH FEE-FOR-SERVICE SYSTEM.—Through the provisions of parts A and B.

"(B) THROUGH A MEDICAREPLUS PRODUCT.—Through a MedicarePlus product (as defined in paragraph (2)), which may be—

"(i) a high deductible/medisave product (and a contribution into a MedicarePlus medical savings account (MSA)),

"(ii) a product offered by a provider-sponsored organization,

"(iii) a product offered by an organization that is a Taft-Hartley plan or association, or

"(iv) a product providing for benefits on a fee-for-service or other basis.

"(2) MEDICAREPLUS PRODUCT DEFINED.—For purposes this section and part C, the term 'MedicarePlus product' means health benefits coverage offered under a policy, contract, or plan by a MedicarePlus organization (as defined in section 1851(a)) pursuant to and in accordance with a contract under section 1857.

"(3) TERMINOLOGY RELATING TO OPTIONS.—For purposes of this section and part C—

"(A) NON-MEDICARE-PLUS OPTION.—An individual who has made the election described in paragraph (1)(A) is considered to have elected the 'Non-MedicarePlus option'.

"(B) MEDICAREPLUS OPTION.—An individual who has made the election described in paragraph (1)(B) to obtain coverage through a MedicarePlus product is considered to have elected the 'MedicarePlus option' for that product.

"(b) SPECIAL RULES.—

"(1) RESIDENCE REQUIREMENT.—Except as the Secretary may otherwise provide, an individual is eligible to elect a MedicarePlus product offered by a MedicarePlus organization only if the organization in relation to the product serves the geographic area in which the individual resides.

"(2) AFFILIATION REQUIREMENTS FOR CERTAIN PRODUCTS.—

"(A) IN GENERAL.—Subject to subparagraph (B), an individual is eligible to elect a MedicarePlus product offered by a limited enrollment MedicarePlus organization (as defined in section 1852(c)(4)(D)) only if—

"(i) the individual is eligible under section 1852(c)(4) to make such election, and

"(ii) in the case of a MedicarePlus organization that is a Taft-Hartley sponsor (as defined in section 1852(c)(4)), the individual elected under this section a MedicarePlus product offered by the sponsor during the first enrollment period in which the individual was eligible to make such election with respect to such sponsor.

"(B) NO REELECTION AFTER DISENROLLMENT FOR CERTAIN PRODUCTS.—An individual is not eligible to elect a MedicarePlus product offered by a MedicarePlus organization that is a Taft-Hartley sponsor if the individual previously had elected a MedicarePlus product offered by the organization and had subsequently discontinued to elect such a product offered by the organization.

"(3) SPECIAL RULE FOR CERTAIN ANNUITANTS.—An individual is not eligible to elect a high deductible/medisave product if the individual is entitled to benefits under chapter 89 of title 5, United States Code, as an annuitant or spouse of an annuitant.

"(c) PROCESS FOR EXERCISING CHOICE.—

"(1) IN GENERAL.—The Secretary shall establish a process through which elections described in subsection (a) are made and changed, including the form and manner in which such elections are made and changed. Such elections shall be made or changed only during coverage election periods specified under subsection (e) and shall become effective as provided in subsection (f).

"(2) EXPEDITED IMPLEMENTATION.—The Secretary shall establish the process of electing coverage under this section during the transition period (as defined in subsection (e)(1)(B)) in such an expedited manner as will permit such an election for MedicarePlus products in an area as soon as such products become available in that area.

"(3) COORDINATION THROUGH MEDICARE-PLUS ORGANIZATIONS.—

"(A) ENROLLMENT.—Such process shall permit an individual who wishes to elect a MedicarePlus product offered by a MedicarePlus organization to make such election through the filing of an appropriate election form with the organization.

"(B) DISENROLLMENT.—Such process shall permit an individual, who has elected a MedicarePlus product offered by a MedicarePlus organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

"(4) DEFAULT.—

"(A) INITIAL ELECTION.—

"(i) IN GENERAL.—Subject to clause (ii), an individual who fails to make an election during an initial election period under subsection (e)(1) is deemed to have chosen the Non-MedicarePlus option.

"(ii) SEAMLESS CONTINUATION OF COVERAGE.—The Secretary shall establish procedures under which individuals who are enrolled with a MedicarePlus organization at the time of the initial election period and who fail to elect to receive coverage other than through the organization are deemed to have elected an appropriate MedicarePlus product offered by the organization.

"(B) CONTINUING PERIODS.—An individual who has made (or deemed to have made) an election under this section is considered to have continued to make such election until such time as—

"(i) the individual changes the election under this section, or

"(ii) a MedicarePlus product is discontinued, if the individual had elected such product at the time of the discontinuation.

"(5) AGREEMENTS WITH COMMISSIONER OF SOCIAL SECURITY TO PROMOTE EFFICIENT ADMINISTRATION.—In order to promote the efficient administration of this section and the MedicarePlus program under part C, the Secretary may enter into an agreement with the Commissioner of Social Security under which the Commissioner performs administrative responsibilities relating to enrollment and disenrollment in MedicarePlus products under this section.

"(d) PROVISION OF BENEFICIARY INFORMATION TO PROMOTE INFORMED CHOICE.—

"(1) IN GENERAL.—The Secretary shall provide for activities under this subsection to disseminate broadly information to medicare beneficiaries (and prospective medicare beneficiaries) on the coverage options provided under this section in order to promote an active, informed selection among such options. Such information shall be made available on such a timely basis (such as 6 months before the date an individual would first attain eligibility for medicare on the basis of age) as to permit individuals to elect the MedicarePlus option during the initial election period described in subsection (e)(1).

"(2) USE OF NONFEDERAL ENTITIES.—The Secretary shall, to the maximum extent feasible, enter into contracts with appropriate non-Federal entities to carry out activities under this subsection.

"(3) SPECIFIC ACTIVITIES.—In carrying out this subsection, the Secretary shall provide for at least the following activities in all areas in which MedicarePlus products are offered:

"(A) INFORMATION BOOKLET.—

"(i) IN GENERAL.—The Secretary shall publish an information booklet and disseminate the booklet to all individuals eligible to elect the MedicarePlus option under this section during coverage election periods.

"(ii) INFORMATION INCLUDED.—The booklet shall include information presented in plain English and in a standardized format regarding—

"(I) the benefits (including cost-sharing) and premiums for the various MedicarePlus products in the areas involved;

"(II) the quality of such products, including consumer satisfaction information; and

"(III) rights and responsibilities of medicare beneficiaries under such products.

"(iii) PERIODIC UPDATING.—The booklet shall be updated on a regular basis (not less often than once every 12 months) to reflect changes in the availability of MedicarePlus products and the benefits and premiums for such products.

"(B) TOLL-FREE NUMBER.—The Secretary shall maintain a toll-free number for inquiries regarding MedicarePlus options and the operation of part C.

"(C) GENERAL INFORMATION IN MEDICARE HANDBOOK.—The Secretary shall include information about the MedicarePlus option provided under this section in the annual notice of medicare benefits under section 1804.

"(e) COVERAGE ELECTION PERIODS.—

"(1) INITIAL CHOICE UPON ELIGIBILITY TO MAKE ELECTION.—

"(A) IN GENERAL.—In the case of an individual who first becomes entitled to benefits under part A and enrolled under part B after the beginning of the transition period (as defined in subparagraph (B)), the individual shall make the election under this section during a period (of a duration and beginning at a time specified by the Secretary) at the first time the individual both is entitled to benefits under part A and enrolled under part B. Such period shall be specified in a manner so that, in the case of an individual

who elects a MedicarePlus product during the period, coverage under the product becomes effective as of the first date on which the individual may receive such coverage.

"(B) TRANSITION PERIOD DEFINED.—In this subsection, the term 'transition period' means, with respect to an individual in an area, the period beginning on the first day of the first month in which a MedicarePlus product is first made available to individuals in the area and ending with the month preceding the beginning of the first annual, coordinated election period under paragraph (3).

"(2) DURING TRANSITION PERIOD.—Subject to paragraph (6)—

"(A) CONTINUOUS OPEN ENROLLMENT INTO A MEDICARE-PLUS OPTION.—During the transition period, an individual who is eligible to make an election under this section and who has elected the non-MedicarePlus option may change such election to a MedicarePlus option at any time.

"(B) OPEN DISENROLLMENT BEFORE END OF TRANSITION PERIOD.—

"(i) IN GENERAL.—During the transition period, an individual who has elected a MedicarePlus option for a MedicarePlus product may change such election to another MedicarePlus product or to the non-MedicarePlus option.

"(ii) SPECIAL RULE.—During the transition period, an individual who has elected a high deductible/medisave product may not change such election to a MedicarePlus product that is not a high deductible/medisave product unless the individual has had such election in effect for 12 months.

"(3) ANNUAL, COORDINATED ELECTION PERIOD.—

"(A) IN GENERAL.—Subject to paragraph (5), each individual who is eligible to make an election under this section may change such election during annual, coordinated election periods.

"(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term 'annual, coordinated election period' means, with respect to a calendar year (beginning with 1998), the month of October before such year.

"(C) MEDICAREPLUS HEALTH FAIR DURING OCTOBER, 1996.—In the month of October, 1996, the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform individuals, who are eligible to elect MedicarePlus products, about such products and the election process provided under this section (including the annual, coordinated election periods that occur in subsequent years).

"(4) SPECIAL 90-DAY DISENROLLMENT OPTION.—

"(A) IN GENERAL.—In the case of the first time an individual elects a MedicarePlus option (other than a high deductible/medisave product) under this section, the individual may discontinue such election through the filing of an appropriate notice during the 90-day period beginning on the first day on which the individual's coverage under the MedicarePlus product under such option becomes effective.

"(B) EFFECT OF DISCONTINUATION OF ELECTION.—An individual who discontinues an election under this paragraph shall be deemed at the time of such discontinuation to have elected the Non-MedicarePlus option.

"(5) SPECIAL ELECTION PERIODS.—An individual may discontinue an election of a MedicarePlus product offered by a MedicarePlus organization other than during an annual, coordinated election period and make a new election under this section if—

"(A) the organization's or product's certification under part C has been terminated or the organization has terminated or otherwise discontinued providing the product;

"(B) in the case of an individual who has elected a MedicarePlus product offered by a MedicarePlus organization, the individual is no longer eligible to elect the product because of a change in the individual's place of residence or other change in circumstances (specified by the Secretary, but not including termination of membership in a qualified association in the case of a product offered by a qualified association or termination of the individual's enrollment on the basis described in clause (i) or (ii) section 1852(c)(3)(B));

"(C) the individual demonstrates (in accordance with guidelines established by the Secretary) that—

"(i) the organization offering the product substantially violated a material provision of the organization's contract under part C in relation to the individual and the product; or

"(ii) the organization (or an agent or other entity acting on the organization's behalf) materially misrepresented the product's provisions in marketing the product to the individual; or

"(D) the individual meets such other conditions as the Secretary may provide.

"(6) SPECIAL RULE FOR HIGH DEDUCTIBLE/MEDISAVE PRODUCTS.—Notwithstanding the previous provisions of this subsection, an individual may elect a high deductible/medisave product only during an annual, coordinated election period described in paragraph (3)(B) or during the month of October, 1996.

"(f) EFFECTIVENESS OF ELECTIONS.—

"(1) DURING INITIAL COVERAGE ELECTION PERIOD.—An election of coverage made during the initial coverage election period under subsection (e)(1)(A) shall take effect upon the date the individual becomes entitled to benefits under part A and enrolled under part B, except as the Secretary may provide (consistent with section 1838) in order to prevent retroactive coverage.

"(2) DURING TRANSITION; 90-DAY DISENROLLMENT OPTION.—An election of coverage made under subsection (e)(2) and an election to discontinue a MedicarePlus option under subsection (e)(4) at any time shall take effect with the first calendar month following the date on which the election is made.

"(3) ANNUAL, COORDINATED ELECTION PERIOD AND MEDISAVE ELECTION.—An election of coverage made during an annual, coordinated election period (as defined in subsection (e)(3)(B)) in a year or for a high deductible/medisave product shall take effect as of the first day of the following year.

"(4) OTHER PERIODS.—An election of coverage made during any other period under subsection (e)(5) shall take effect in such manner as the Secretary provides in a manner consistent (to the extent practicable) with protecting continuity of health benefit coverage.

"(g) EFFECT OF ELECTION OF MEDICAREPLUS OPTION.—Subject to the provisions of section 1855(f), payments under a contract with a MedicarePlus organization under section 1857(a) with respect to an individual electing a MedicarePlus product offered by the organization shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under parts A and B for items and services furnished to the individual.

"(h) ADMINISTRATION.—

"(1) IN GENERAL.—This part and sections 1805 and 1876 shall be administered through an operating division (A) that is established or identified by the Secretary in the Department of Health and Human Services, (B) that is separate from the Health Care Financing Administration, and (C) the primary function of which is the administration of this part and such sections. The director of such division shall be of equal pay and rank to that of the individual responsible for overall administration of parts A and B.

"(2) TRANSFER AUTHORITY.—The Secretary shall transfer such personnel, administrative support systems, assets, records, funds, and other resources in the Health Care Financing Administration to the operating division referred to in paragraph (1) as are used in the administration of section 1876 and as may be required to implement the provisions referred to in such paragraph promptly and efficiently.".

SEC. 15002. MEDICAREPLUS PROGRAM.

(a) IN GENERAL.—Title XVIII is amended by redesignating part C as part D and by inserting after part B the following new part:

"PART C—PROVISIONS RELATING TO MEDICAREPLUS

"REQUIREMENTS FOR MEDICAREPLUS ORGANIZATIONS; HIGH DEDUCTIBLE/MEDISAVE PRODUCTS

"SEC. 1851. (a) MEDICAREPLUS ORGANIZATION DEFINED.—In this part, subject to the succeeding provisions of this section, the term 'MedicarePlus organization' means a public or private entity that is certified under section 1857 as meeting the requirements and standards of this part for such an organization.

"(b) ORGANIZED AND LICENSED UNDER STATE LAW.—

"(1) IN GENERAL.—A MedicarePlus organization shall be organized and licensed under State law to offer health insurance or health benefits coverage in each State in which it offers a MedicarePlus product.

"(2) EXCEPTION FOR TAFT-HARTLEY SPONSORS.—Paragraph (1) shall not apply to an MedicarePlus organization that is a Taft-Hartley sponsor (as defined in section 1852(c)(4)).

"(3) EXCEPTION FOR PROVIDER-SPONSORED ORGANIZATIONS.—Paragraph (1) shall not apply to a MedicarePlus organization that is a provider-sponsored organization (as defined in section 1854(a)) except to the extent provided under section 1857(c).

"(4) EXCEPTION FOR QUALIFIED ASSOCIATIONS.—Paragraph (1) shall not apply to a MedicarePlus organization that is a qualified association (as defined in section 1852(c)(4)(B)).

"(c) PREPAID PAYMENT.—A MedicarePlus organization shall be compensated (except for deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided to a member.

"(d) ASSUMPTION OF FULL FINANCIAL RISK.—The MedicarePlus organization shall assume full financial risk on a prospective basis for the provision of the health care services (other than hospice care) for which benefits are required to be provided under section 1852(a)(1), except that the organization—

"(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which exceeds $5,000 in any year,

"(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization,

"(3) may obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and

"(4) may make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

In the case of a MedicarePlus organization that is a Taft-Hartley sponsor (as defined in section 1852(c)(4)(A)) or a qualified association (as defined in section 1852(c)(4)(B)), this subsection shall not apply with respect to MedicarePlus products offered by such organization and issued by an organization to which subsection (b)(1) applies or by a provider-sponsored organization (as defined in section 1854(a)).

"(e) PROVISION AGAINST RISK OF INSOLVENCY.—

"(1) IN GENERAL.—Each MedicarePlus organization shall meet standards under section 1856 relating to the financial solvency and capital adequacy of the organization. Such standards shall take into account the nature and type of MedicarePlus products offered by the organization.

"(2) TREATMENT OF TAFT-HARTLEY SPONSORS.—An entity that is a Taft-Hartley sponsor is deemed to meet the requirement of paragraph (1).

"(3) TREATMENT OF CERTAIN QUALIFIED ASSOCIATIONS.—An entity that is a qualified association is deemed to meet the requirement of paragraph (1) with respect to MedicarePlus products offered by such association and issued by an organization to which subsection (b)(1) applies or by a provider-sponsored organization.

"(f) HIGH DEDUCTIBLE/MEDISAVE PRODUCT DEFINED.—

"(1) IN GENERAL.—In this part, the term 'high deductible/medisave product' means a MedicarePlus product that—

"(A) provides reimbursement for at least the items and services described in section 1852(a)(1) in a year but only after the enrollee incurs countable expenses (as specified under the product) equal to the amount of a deductible (described in paragraph (2));

"(B) counts as such expenses (for purposes of such deductible) at least all amounts that would have been payable under parts A and B or by the enrollee if the enrollee had elected to receive benefits through the provisions of such parts; and

"(C) provides, after such deductible is met for a year and for all subsequent expenses for benefits referred to in subparagraph (A) in the year, for a level of reimbursement that is not less than—

"(i) 100 percent of such expenses, or

"(ii) 100 percent of the amounts that would have been paid (without regard to any deductibles or coinsurance) under parts A and B with respect to such expenses,

whichever is less. Such term does not include the MedicarePlus MSA itself or any contribution into such account.

"(2) DEDUCTIBLE.—The amount of deductible under a high deductible/medisave product—

"(A) for contract year 1997 shall be not more than $10,000; and

"(B) for a subsequent contract year shall be not more than the maximum amount of such deductible for the previous contract year under this paragraph increased by the national average per capita growth rate under section 1855(c)(3) for the year.

If the amount of the deductible under subparagraph (B) is not a multiple of $50, the amount shall be rounded to the nearest multiple of $50.

"(g) ORGANIZATIONS TREATED AS MEDICAREPLUS ORGANIZATIONS DURING TRANSITION.—Any of the following organizations shall be considered to qualify as a MedicarePlus organization for contract years beginning before January 1, 1998:

"(1) HEALTH MAINTENANCE ORGANIZATIONS.—An organization that is organized under the laws of any State and that is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act), an organization recognized under State law as a health maintenance organization, or a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

"(2) LICENSED INSURERS.—An organization that is organized under the laws of any State and—

"(A) is licensed by a State agency as an insurer for the offering of health benefit coverage, or

"(B) is licensed by a State agency as a service benefit plan,

but only for individuals residing in an area in which the organization is licensed to offer health insurance coverage.

"(3) CURRENT RISK-CONTRACTORS.—An organization that is an eligible organization (as defined in section 1876(b)) and that has a risk-sharing contract in effect under section 1876 as of the date of the enactment of this section.

"REQUIREMENTS RELATING TO BENEFITS, PROVISION OF SERVICES, ENROLLMENT, AND PREMIUMS

"SEC. 1852. (a) BENEFITS COVERED.—

"(1) IN GENERAL.—Except as provided in section 1851(f)(1) with respect to high deductible/medisave products, each MedicarePlus product offered under this part shall provide benefits for at least the items and services for which benefits are available under parts A and B consistent with the standards for coverage of such items and services applicable under this title.

"(2) ORGANIZATION AS SECONDARY PAYER.—Notwithstanding any other provision of law, a MedicarePlus organization may (in the case of the provision of items and services to an individual under this part under circumstances in which payment under this title is made secondary pursuant to section 1862(b)(2)) charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law or policy—

"(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

"(B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

"(3) SATISFACTION OF REQUIREMENT.—A MedicarePlus product (other than a high deductible/medisave product) offered by a MedicarePlus organization satisfies paragraph (1) with respect to benefits for items and services if the following requirements are met:

"(A) FEE FOR SERVICE PROVIDERS.—In the case of benefits furnished through a provider that does not have a contract with the organization, the product provides for at least the dollar amount of payment for such items and services as would otherwise be provided under parts A and B.

"(B) PARTICIPATING PROVIDERS.—In the case of benefits furnished through a provider that has such a contract, the individual's liability for payment for such items and services does not exceed (after taking into account any deductible, which does not exceed any deductible under parts A and B) the lesser of the following:

"(i) NON-MEDICAREPLUS LIABILITY.—The amount of the liability that the individual would have had (based on the provider being a participating provider) if the individual had elected the non-MedicarePlus option.

"(ii) MEDICARE COINSURANCE APPLIED TO PRODUCT PAYMENT RATES.—The applicable coinsurance or copayment rate (that would have applied

under the non-MedicarePlus option) of the payment rate provided under the contract.

"(b) ANTIDISCRIMINATION.—A MedicarePlus organization may not deny, limit, or condition the coverage or provision of benefits under this part based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual.

"(c) GUARANTEED ISSUE AND RENEWAL.—

"(1) IN GENERAL.—Except as provided in this subsection, a MedicarePlus organization shall provide that at any time during which elections are accepted under section 1805 with respect to a MedicarePlus product offered by the organization, the organization will accept without restrictions individuals who are eligible to make such election.

"(2) PRIORITY.—If the Secretary determines that a MedicarePlus organization, in relation to a MedicarePlus product it offers, has a capacity limit and the number of eligible individuals who elect the product under section 1805 exceeds the capacity limit, the organization may limit the election of individuals of the product under such section but only if priority in election is provided—

"(A) first to such individuals as have elected the product at the time of the determination, and

"(B) then to other such individuals in such a manner that does not discriminate among the individuals (who seek to elect the product) on a basis described in paragraph (1).

"(3) LIMITATION ON TERMINATION OF ELECTION.—

"(A) IN GENERAL.—Subject to subparagraph (B), a MedicarePlus organization may not for any reason terminate the election of any individual under section 1805 for a MedicarePlus product it offers.

"(B) BASIS FOR TERMINATION OF ELECTION.—A MedicarePlus organization may terminate an individual's election under section 1805 with respect to a MedicarePlus product it offers if—

"(i) any premiums required with respect to such product are not paid on a timely basis (consistent with standards under section 1856 that provide for a grace period for late payment of premiums),

"(ii) the individual has engaged in disruptive behavior (as specified in such standards), or

"(iii) the product is terminated with respect to all individuals under this part.

Any individual whose election is so terminated is deemed to have elected the Non-MedicarePlus option (as defined in section 1805(a)(3)(A)).

"(C) ORGANIZATION OBLIGATION WITH RESPECT TO ELECTION FORMS.—Pursuant to a contract under section 1858, each MedicarePlus organization receiving an election form under section 1805(c)(2) shall transmit to the Secretary (at such time and in such manner as the Secretary may specify) a copy of such form or such other information respecting the election as the Secretary may specify.

"(4) SPECIAL RULES FOR LIMITED ENROLLMENT MEDICAREPLUS ORGANIZATIONS.—

"(A) TAFT-HARTLEY SPONSORS.—

"(i) IN GENERAL.—Subject to subparagraph (C), a MedicarePlus organization that is a Taft-Hartley sponsor (as defined in clause (ii)) shall limit eligibility of enrollees under this part for MedicarePlus products it offers to individuals who are entitled to obtain benefits through such products under the terms of an applicable collective bargaining agreement.

"(ii) TAFT-HARTLEY SPONSOR.—In this part and section 1805, the term 'Taft-Hartley sponsor' means, in relation to a group health plan that is established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of parties who establish or maintain the plan.

"(B) QUALIFIED ASSOCIATIONS.—

"(i) IN GENERAL.—Subject to subparagraph (C), a MedicarePlus organization that is a qualified association (as defined in clause (iii)) shall limit eligibility of individuals under this part for products it offers to individuals who are members of the association (or who are spouses of such individuals).

"(ii) LIMITATION ON TERMINATION OF COVERAGE.—Such a qualifying association offering a MedicarePlus product to an individual may not terminate coverage of the individual on the basis that the individual is no longer a member of the association except pursuant to a change of

election during an open election period occurring on or after the date of the termination of membership.

"(iii) QUALIFIED ASSOCIATION.—In this part and section 1805, the term 'qualified association' means an association, religious fraternal organization, or other organization (which may be a trade, industry, or professional association, a chamber of commerce, or a public entity association) that the Secretary finds—

"(I) has been formed for purposes other than the sale of any health insurance and does not restrict membership based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual,

"(II) does not exist solely or principally for the purpose of selling insurance, and

"(III) has at least 1,000 individual members or 200 employer members.

Such term includes a subsidiary or corporation that is wholly owned by one or more qualified organizations.

"(C) LIMITATION.—Rules of eligibility to carry out the previous subparagraphs of this paragraph shall not have the effect of denying eligibility to individuals on the basis of health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability.

"(D) LIMITED ENROLLMENT MEDICAREPLUS ORGANIZATION.—In this part and section 1805, the term 'limited enrollment MedicarePlus organization' means a MedicarePlus organization that is a Taft-Hartley sponsor or a qualified association.

"(E) EMPLOYER, ETC.—In this paragraph, the terms 'employer', 'employee organization', and 'group health plan' have the meanings given such terms for purposes of part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

"(d) SUBMISSION AND CHARGING OF PREMIUMS.—

"(1) IN GENERAL.—Each MedicarePlus organization shall file with the Secretary each year, in a form and manner and at a time specified by the Secretary—

"(A) the amount of the monthly premiums for coverage under each MedicarePlus product it offers under this part in each payment area (as determined for purposes of section 1855) in which the product is being offered; and

"(B) the enrollment capacity in relation to the product in each such area.

"(2) AMOUNTS OF PREMIUMS CHARGED.—The amount of the monthly premium charged by a MedicarePlus organization for a MedicarePlus product offered in a payment area to an individual under this part shall be equal to the amount (if any) by which—

"(A) the amount of the monthly premium for the product for the period involved, as established under paragraph (3) and submitted under paragraph (1), exceeds

"(B)(i) 1/12 of the annual MedicarePlus capitation rate specified in section 1855(b)(2) for the area and period involved, or (ii) in the case of a high deductible/medisave product, the monthly adjusted MedicarePlus capitation rate specified in section 1855(b)(1) for the individual and period involved.

"(3) UNIFORM PREMIUM.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the premiums charged by a MedicarePlus organization under this part may not vary among individuals who reside in the same payment area.

"(B) EXCEPTION FOR HIGH DEDUCTIBLE/MEDISAVE PRODUCTS.—A MedicarePlus organization shall establish premiums for any high deductible/medisave product it offers in a payment area based on each of the risk adjustment categories established for purposes of determining the amount of the payment to MedicarePlus organizations under section 1855(b)(1) and using the identical demographic and other adjustments among such categories as are used for such purposes.

"(4) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each MedicarePlus organization shall permit the payment of monthly premiums on a monthly basis and may terminate election of individuals for a MedicarePlus product for failure to make premium payments only in accordance with subsection (c)(3)(B).

"(5) RELATION OF PREMIUMS AND COST-SHARING TO BENEFITS.—In no case may the portion of a MedicarePlus organization's premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (to the extent attributable to the minimum benefits described in subsection (a)(1) and not count

any amount attributable to balance billing) to individuals who are enrolled under this part with the organization exceed the actuarial value of the coinsurance and deductibles that would be applicable on the average to individuals enrolled under this part with the organization (or, if the Secretary finds that adequate data are not available to determine that actuarial value, the actuarial value of the coinsurance and deductibles applicable on the average to individuals in the area, in the State, or in the United States, eligible to enroll under this part with the organization, or other appropriate data) and entitled to benefits under part A and enrolled under part B if they were not members of a MedicarePlus organization.

"(e) REQUIREMENT FOR ADDITIONAL BENEFITS, PART B PREMIUM DISCOUNT REBATES, OR BOTH.—

"(1) REQUIREMENT.—

"(A) IN GENERAL.—Each MedicarePlus organization (in relation to a MedicarePlus product it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the product for a contract year, subject to the succeeding provisions of this subsection, the organization shall provide to individuals such additional benefits (as the organization may specify), a monetary rebate (paid on a monthly basis) of the part B monthly premium, or a combination thereof, in an total value which is at least equal to the adjusted excess amount (as defined in subparagraph (C)).

"(B) EXCESS AMOUNT.—For purposes of this paragraph, the 'excess amount', for an organization for a product, is the amount (if any) by which—

"(i) the average of the capitation payments made to the organization under this part for the product at the beginning of contract year, exceeds

"(ii) the actuarial value of the minimum benefits described in subsection (a)(1) under the product for individuals under this part, as determined based upon an adjusted community rate described in paragraph (5).

"(C) ADJUSTED EXCESS AMOUNT.—For purposes of this paragraph, the 'adjusted excess amount', for an organization for a product, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (3).

"(D) NO APPLICATION TO HIGH DEDUCTIBLE/MEDISAVE PRODUCT.—Subparagraph (A) shall not apply to a high deductible/medisave product.

"(E) UNIFORM APPLICATION.—This paragraph shall be applied uniformly for all enrollees for a product in a service area.

"(F) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a MedicarePlus organization from providing health care benefits that are in addition to the benefits otherwise required to be provided under this paragraph and from imposing a premium for such additional benefits.

"(2) LIMITATION ON AMOUNT OF PART B PREMIUM DISCOUNT REBATE.—In no case shall the amount of a part B premium discount rebate under paragraph (1)(A) exceed, with respect to a month, the amount of premiums imposed under part B (not taking into account section 1839(b) (relating to penalty for late enrollment) or 1839(h) (relating to affluence testing)), for the individual for the month. Except as provided in the previous sentence, a MedicarePlus organization is not authorized to provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

"(3) STABILIZATION FUND.—A MedicarePlus organization may provide that a part of the value of an excess actuarial amount described in paragraph (1) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits and rebates offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the MedicarePlus product in accordance with such paragraph prior to the end of such periods, shall revert for the use of such trust funds.

"(4) DETERMINATION BASED ON INSUFFICIENT DATA.—For purposes of this subsection, if the Secretary finds that there is insufficient enrollment experience (including no enrollment experience in the case of a provider-sponsored organization) to determine an average of the capitation payments to be made under this part at the beginning of a contract period, the Secretary may determine

such an average based on the enrollment experience of other contracts entered into under this part.

"(5) ADJUSTED COMMUNITY RATE.—

"(A) IN GENERAL.—For purposes of this subsection, subject to subparagraph (B), the term 'adjusted community rate' for a service or services means, at the election of a MedicarePlus organization, either—

"(i) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a MedicarePlus product under this part if the rate of payment were determined under a 'community rating system' (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)), or

"(ii) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to such an individual, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the individuals electing coverage under this part and the utilization characteristics of the other enrollees with the organization (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of individuals selecting other MedicarePlus coverage, or individuals in the area, in the State, or in the United States, eligible to elect MedicarePlus coverage under this part and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

"(B) SPECIAL RULE FOR PROVIDER-SPONSORED ORGANIZATIONS.—In the case of a MedicarePlus organization that is a provider-sponsored organization, the adjusted community rate under subparagraph (A) for a MedicarePlus product may be computed (in a manner specified by the Secretary) using data in the general commercial marketplace or (during a transition period) based on the costs incurred by the organization in providing such a product.

"(f) RULES REGARDING PHYSICIAN PARTICIPATION.—

"(1) PROCEDURES.—Each MedicarePlus organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under MedicarePlus products offered by the organization under this part. Such procedures shall include—

"(A) providing notice of the rules regarding participation,

"(B) providing written notice of participation decisions that are adverse to physicians, and

"(C) providing a process within the organization for appealing adverse decisions, including the presentation of information and views of the physician regarding such decision.

"(2) CONSULTATION IN MEDICAL POLICIES.—A MedicarePlus organization shall consult with physicians who have entered into participation agreements with the organization regarding the organization's medical policy, quality, and medical management procedures.

"(3) LIMITATIONS ON PHYSICIAN INCENTIVE PLANS.—

"(A) IN GENERAL.—Each MedicarePlus organization may not operate any physician incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

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

"(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization—

"(I) provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or the physician group, and

"(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

"(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to deter-

mine whether the plan is in compliance with the requirements of this subparagraph.

"(B) PHYSICIAN INCENTIVE PLAN DEFINED.—In this paragraph, the term 'physician incentive plan' means any compensation arrangement between a MedicarePlus organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization under this part.

"(4) EXCEPTION FOR CERTAIN FEE-FOR-SERVICE PLANS.—The previous provisions of this subsection shall not apply in the case of a MedicarePlus organization in relation to a MedicarePlus product if the organization does not have agreements between physicians and the organization for the provision of benefits under the product.

"(g) PROVISION OF INFORMATION.—A MedicarePlus organization shall provide the Secretary with such information on the organization and each MedicarePlus product it offers as may be required for the preparation of the information booklet described in section 1805(d)(3)(A).

"(h) COORDINATED ACUTE AND LONG-TERM CARE BENEFITS UNDER A MEDICAREPLUS PRODUCT.—Nothing in this part shall be construed as preventing a State from coordinating benefits under its MediGrant program under title XXI with those provided under a MedicarePlus product in a manner that assures continuity of a full-range of acute care and long-term care services to poor elderly or disabled individuals eligible for benefits under this title and under such program.

"(i) TRANSITIONAL FILE AND USE FOR CERTAIN REQUIREMENTS.—

"(1) IN GENERAL.—In the case of a MedicarePlus product proposed to be offered before the end of the transition period (as defined in section1805(e)(1)(B)), by a MedicarePlus organization described in section 1851(g)(3) or by a MedicarePlus organization with a contract in effect under section 1858, if the organization submits complete information to the Secretary regarding the product demonstrating that the product meets the requirements and standards under subsections (a), (d), and (e) (relating to benefits and premiums), the product shall be deemed as meeting such requirements and standards under such subsections unless the Secretary disapproves the product within 60 days after the date of submission of the complete information.

"(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as waiving the requirement of a contract under section 1858 or waiving requirements and standards not referred to in paragraph (1).

"PATIENT PROTECTION STANDARDS

"SEC. 1853. (a) DISCLOSURE TO ENROLLEES.—A MedicarePlus organization shall disclose in clear, accurate, and standardized form, information regarding all of the following for each MedicarePlus product it offers:

"(1) Benefits under the MedicarePlus product offered, including exclusions from coverage and, if it is a high deductible/medisave product, a comparison of benefits under such a product with benefits under other MedicarePlus products.

"(2) Rules regarding prior authorization or other review requirements that could result in nonpayment.

"(3) Potential liability for cost-sharing for out-of-network services.

"(4) The number, mix, and distribution of participating providers.

"(5) The financial obligations of the enrollee, including premiums, deductibles, co-payments, and maximum limits on out-of-pocket losses for items and services (both in and out of network).

"(6) Statistics on enrollee satisfaction with the product and organization, including rates of reenrollment.

"(7) Enrollee rights and responsibilities, including the grievance process provided under subsection (f).

"(8) A statement that the use of the 911 emergency telephone number is appropriate in emergency situations and an explanation of what constitutes an emergency situation.

"(9) A description of the organization's quality assurance program under subsection (d).

Such information shall be disclosed to each enrollee under this part at the time of enrollment and at least annually thereafter.

"(b) ACCESS TO SERVICES.—

"(1) IN GENERAL.—A MedicarePlus organization offering a MedicarePlus product may restrict the providers from whom the benefits under the product are provided so long as—

"(A) the organization makes such benefits available and accessible to each individual electing the product within the product service area with reasonable promptness and in a manner which assures continuity in the provision of benefits;

"(B) when medically necessary the organization makes such benefits available and accessible 24 hours a day and 7 days a week;

"(C) the product provides for reimbursement with respect to services which are covered under subparagraphs (A) and (B) and which are provided to such an individual other than through the organization, if—

"(i) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition, and

"(ii) it was not reasonable given the circumstances to obtain the services through the organization; and

"(D) coverage is provided for emergency services (as defined in paragraph (4)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization.

"(2) MINIMUM PAYMENT LEVELS WHERE PROVIDING POINT-OF-SERVICE COVERAGE.—If a MedicarePlus product provides benefits for items and services (not described in paragraph (1)(C)) through a network of providers and also permits payment to be made under the product for such items and services not provided through such a network, the payment level under the product with respect to such items and services furnished outside the network shall be at least 70 percent (or, if the effective cost-sharing rate is 50 percent, at least 35 percent) of the lesser of—

"(A) the payment basis (determined without regard to deductibles and cost-sharing) that would have applied for such items and services under parts A and B, or

"(B) the amount charged by the entity furnishing such items and services.

"(3) PROTECTION OF ENROLLEES FOR CERTAIN EMERGENCY SERVICES.—

"(A) PARTICIPATING PROVIDERS.—In the case of emergency services described in subparagraph (C) which are furnished by a participating physician or provider of services to an individual enrolled with a MedicarePlus organization under this section, the applicable participation agreement is deemed to provide that the physician or provider of services will accept as payment in full from the organization the amount that would be payable to the physician or provider of services under part B and from the individual under such part, if the individual were not enrolled with such an organization under this part.

"(B) NONPARTICIPATING PROVIDERS.—In the case of emergency services described in subparagraph (C) which are furnished by a nonparticipating physician, the limitations on actual charges for such services otherwise applicable under part B (to services furnished by individuals not enrolled with a MedicarePlus organization under this section) shall apply in the same manner as such limitations apply to services furnished to individuals not enrolled with such an organization.

"(C) EMERGENCY SERVICES DESCRIBED.—The emergency services described in this subparagraph are emergency services which are furnished to an enrollee of a MedicarePlus organization under this part by a physician or provider of services that is not under a contract with the organization.

"(4) DEFINITION OF EMERGENCY SERVICES.—In this subsection, the term 'emergency services' means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

"(A) are furnished by an appropriate source other than the organization,

"(B) are needed immediately because of an injury or sudden illness, and

"(C) are needed because the time required to reach the organization's providers or suppliers would have meant risk of serious damage to the patient's health.

"(c) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Each MedicarePlus organization shall establish procedures—

"(1) to safeguard the privacy of individually identifiable enrollee information, and

"(2) to maintain accurate and timely medical records for enrollees.

"(d) QUALITY ASSURANCE PROGRAM.—

"(1) IN GENERAL.—Each MedicarePlus organization must have arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for health care services it provides to such individuals.

"(2) ELEMENTS OF PROGRAM.—The quality assurance program shall—

"(A) stress health outcomes;

"(B) provide for the establishment of written protocols for utilization review, based on current standards of medical practice;

"(C) provide review by physicians and other health care professionals of the process followed in the provision of such health care services;

"(D) monitors and evaluates high volume and high risk services and the care of acute and chronic conditions;

"(E) evaluates the continuity and coordination of care that enrollees receive;

"(F) has mechanisms to detect both underutilization and overutilization of services;

"(G) after identifying areas for improvement, establishes or alters practice parameters;

"(H) takes action to improve quality and assesses the effectiveness of such action through systematic follow-up;

"(I) makes available information on quality and outcomes measures to facilitate beneficiary comparison and choice of health coverage options (in such form and on such quality and outcomes measures as the Secretary determines to be appropriate);

"(J) is evaluated on an ongoing basis as to its effectiveness; and

"(K) provide for external accreditation or review, by a utilization and quality control peer review organization under part B of title XI or other qualified independent review organization, of the quality of services furnished by the organization meets professionally recognized standards of health care (including providing adequate access of enrollees to services).

"(3) EXCEPTION FOR CERTAIN FEE-FOR-SERVICE PLANS.—Paragraph (1) and subsection (c)(2) shall not apply in the case of a MedicarePlus organization in relation to a MedicarePlus product to the extent the organization provides for coverage of benefits without restrictions relating to utilization and without regard to whether the provider has a contract or other arrangement with the plan for the provision of such benefits.

"(4) TREATMENT OF ACCREDITATION.—The Secretary shall provide that a MedicarePlus organization is deemed to meet the requirements of paragraphs (1) and (2) of this subsection and subsection (c) if the organization is accredited (and periodically reaccredited) by a private organization under a process that the Secretary has determined assures that the organization meets standards that are no less stringent than the standards established under section 1856 to carry out this subsection and subsection (c).

"(e) COVERAGE DETERMINATIONS.—

"(1) DECISIONS ON NONEMERGENCY CARE.—A MedicarePlus organization shall make determinations regarding authorization requests for nonemergency care on a timely basis, depending on the urgency of the situation.

"(2) APPEALS.—

"(A) IN GENERAL.—Appeals from a determination of an organization denying coverage shall be decided within 30 days of the date of receipt of medical information, but not later than 60 days after the date of the decision.

"(B) PHYSICIAN DECISION ON CERTAIN APPEALS.—Appeal decisions relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician.

"(C) EMERGENCY CASES.—Appeals from such a determination involving a life-threatening or emergency situation shall be decided on an expedited basis.

"(f) GRIEVANCES AND APPEALS.—

"(1) GRIEVANCE MECHANISM.—Each MedicarePlus organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and enrollees under this part.

"(2) APPEALS.—An enrollee with an organization under this part who is dissatisfied by reason of the enrollee's failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is $1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the organization shall be entitled to be parties to that judicial review. In applying sections 205(b) and 205(g) as provided in this subparagraph, and in applying section 205(l) thereto, any ref-

erence therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

"(3) COORDINATION WITH SECRETARY OF LABOR.—The Secretary shall consult with the Secretary of Labor so as to ensure that the requirements of this subsection, as they apply in the case of grievances referred to in paragraph (1) to which section 503 of the Employee Retirement Income Security Act of 1974 applies, are applied in a manner consistent with the requirements of such section 503.

"(g) INFORMATION ON ADVANCE DIRECTIVES.—Each MedicarePlus organization shall meet the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).

"(h) APPROVAL OF MARKETING MATERIALS.—

"(1) SUBMISSION.—Each MedicarePlus organization may not distribute marketing materials unless—

"(A) at least 45 days before the date of distribution the organization has submitted the material to the Secretary for review, and

"(B) the Secretary has not disapproved the distribution of such material.

"(2) REVIEW.—The standards established under section 1856 shall include guidelines for the review of all such material submitted and under such guidelines the Secretary shall disapprove such material if the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.

"(3) DEEMED APPROVAL (1-STOP SHOPPING).—In the case of material that is submitted under paragraph (1)(A) to the Secretary or a regional office of the Department of Health and Human Services and the Secretary or the office has not disapproved the distribution of marketing materials under paragraph (1)(B) with respect to a MedicarePlus product in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the product and organization.

"(4) PROHIBITION OF CERTAIN MARKETING PRACTICES.—Each MedicarePlus organization shall conform to fair marketing standards in relation to MedicarePlus products offered under this part, included in the standards established under section 1856. Such standards shall include a prohibition against an organization (or agent of such an organization) completing any portion of any election form under section 1805 on behalf of any individual.

"PROVIDER-SPONSORED ORGANIZATIONS

"SEC. 1854. (a) PROVIDER-SPONSORED ORGANIZATION DEFINED.—

"(1) IN GENERAL.—In this part, the term 'provider-sponsored organization' means a public or private entity that (in accordance with standards established under subsection (b)) is a provider, or group of affiliated providers, that provides a substantial proportion (as defined by the Secretary under such standards) of the health care items and services under the contract under this part directly through the provider or affiliated group of providers.

"(2) SUBSTANTIAL PROPORTION.—In defining what is a 'substantial proportion' for purposes of paragraph (1), the Secretary—

"(A) shall take into account the need for such an organization to assume responsibility for a substantial proportion of services in order to assure financial stability and the practical difficulties in such an organization integrating a very wide range of service providers; and

"(B) may vary such proportion based upon relevant differences among organizations, such as their location in an urban or rural area.

"(3) AFFILIATION.—For purposes of this subsection, a provider is 'affiliated' with another provider if, through contract, ownership, or otherwise—

"(A) one provider, directly or indirectly, controls, is controlled by, or is under common control with the other,

"(B) each provider is a participant in a lawful combination under which each provider shares, directly or indirectly, substantial financial risk in connection with their operations,

"(C) both providers are part of a controlled group of corporations under section 1563 of the Internal Revenue Code of 1986, or

"(D) both providers are part of an affiliated service group under section 414 of such Code.

"(4) CONTROL.—For purposes of paragraph (3), control is presumed to exist if one party, directly or indirectly, owns, controls, or holds the power to vote, or proxies for, not less than 51 percent of the voting rights or governance rights of another.

"(b) PROCESS FOR ESTABLISHING STANDARDS FOR PROVIDER-SPONSORED ORGANIZATIONS.—For process of establishing of standards for provider-sponsored organizations, see section 1856(c).

"(c) PROCESS FOR STATE CERTIFICATION OF PROVIDER-SPONSORED ORGANIZATIONS.—For process of State certification of provider-sponsored organizations, see section 1857(c).

"(d) PREEMPTION OF STATE INSURANCE LICENSING REQUIREMENTS.—

"(1) IN GENERAL.—This section supersedes any State law which—

"(A) requires that a provider-sponsored organization meet requirements for insurers of health services or health maintenance organizations doing business in the State with respect to initial capitalization and establishment of financial reserves against insolvency, or

"(B) imposes requirements that would have the effect of prohibiting the organization from complying with the applicable requirements of this part, insofar as such the law applies to individuals enrolled with the organization under this part.

"(2) EXCEPTION.—Paragraph (1) shall not apply with respect to any State law to the extent that such law provides standards or requirements, or provides for enforcement thereof, so as to meet the requirements of section 1857(c)(2) with respect to approval by the Secretary of State certification requirements thereunder.

"(3) CONSTRUCTION.—Nothing in this subsection shall be construed as affecting the operation of section 514 of the Employee Retirement Income Security Act of 1974.

"PAYMENTS TO MEDICAREPLUS ORGANIZATIONS

"SEC. 1855. (a) PAYMENTS.—

"(1) IN GENERAL.—Under a contract under section 1858 the Secretary shall pay to each MedicarePlus organization, with respect to coverage of an individual under this part in a payment area for a month, an amount equal to the monthly adjusted MedicarePlus capitation rate (as provided under subsection (b)) with respect to that individual for that area.

"(2) ANNUAL ANNOUNCEMENT.—The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than September 7 before the calendar year concerned—

"(A) the annual MedicarePlus capitation rate for each payment area for the year, and

"(B) the factors to be used in adjusting such rates under subsection (b) for payments for months in that year.

"(3) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under paragraph (2) for a year, the Secretary shall provide for notice to MedicarePlus organizations of proposed changes to be made in the methodology or benefit coverage assumptions from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

"(4) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (2) for a year, the Secretary shall include an explanation of the assumptions (including any benefit coverage assumptions) and changes in methodology used in the announcement in sufficient detail so that MedicarePlus organizations can compute monthly adjusted MedicarePlus capitation rates for classes of individuals located in each payment area which is in whole or in part within the service area of such an organization.

"(b) MONTHLY ADJUSTED MEDICAREPLUS CAPITATION RATE.—

"(1) IN GENERAL.—For purposes of this section, the 'monthly adjusted MedicarePlus capitation rate' under this subsection, for a month in a year for an individual in a payment area (specified under paragraph (3)) and in a class (established under paragraph (4)), is 1/12 of the annual MedicarePlus capitation rate specified in paragraph (2) for that area for the year, adjusted to reflect the actuarial value of benefits under this title with respect to individuals in such class compared to the national average for individuals in all classes.

"(2) ANNUAL MEDICAREPLUS CAPITATION RATES.—For purposes of this section, the annual MedicarePlus capitation rate for a payment area for a year is equal to the annual MedicarePlus capitation rate for the area for the previous year (or, in the case of 1996, the average annual per capita rate of payment described in section 1876(a)(1)(C) for the area for 1995) increased by the per capita growth rate for that area and year (as determined under subsection (c)).

"(3) PAYMENT AREA DEFINED.—In this section, the term 'payment area' means a county (or equivalent area specified by the Secretary), except that in the case of the population group described in paragraph (5)(C), the payment area shall be each State.

"(4) CLASSES.—

"(A) IN GENERAL.—For purposes of this section, the Secretary shall define appropriate classes of enrollees, consistent with paragraph (5), based on age, gender, welfare status, institutionalization, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence.

"(B) RESEARCH.—The Secretary shall conduct such research as may be necessary to provide for greater accuracy in the adjustment of capitation rates under this subsection. Such research may include research into the addition or modification of classes under subparagraph (A). The Secretary shall submit to Congress a report on such research by not later than January 1, 1997.

"(5) DIVISION OF MEDICARE POPULATION.—In carrying out paragraph (4) and this section, the Secretary shall recognize the following separate population groups:

"(A) AGED.—Individuals 65 years of age or older who are not described in subparagraph (C).

"(B) DISABLED.—Disabled individuals who are under 65 years of age and not described in subparagraph (C).

"(C) INDIVIDUALS WITH END STAGE RENAL DISEASE.—Individuals who are determined to have end stage renal disease.

"(c) PER CAPITA GROWTH RATES.—

"(1) FOR 1996.—

"(A) IN GENERAL.—For purposes of this section and subject to subparagraph (B), the per capita growth rates for 1996, for a payment area assigned to a service utilization cohort under subsection (d), shall be the following:

"(i) LOWEST SERVICE UTILIZATION COHORT.—For areas assigned to the lowest service utilization cohort, 9.7 percent.

"(ii) LOWER SERVICE UTILIZATION COHORT.—For areas assigned to the lower service utilization cohort, 8.0 percent.

"(iii) MEDIAN SERVICE UTILIZATION COHORT.—For areas assigned to the median service utilization cohort, 5.3 percent.

"(iv) HIGHER SERVICE UTILIZATION COHORT.—For areas assigned to the higher service utilization cohort, 4.7 percent.

"(v) HIGHEST SERVICE UTILIZATION COHORT.—For areas assigned to the highest service utilization cohort, 4.0 percent.

"(B) BUDGET NEUTRAL ADJUSTMENT.—The Secretary shall adjust the per capita growth rates specified in subparagraph (A) for all the areas by such uniform factor as may be necessary to assure that the total capitation payments under this section during 1996 are the same as the amount such payments would have been if the per capita growth rate for all such areas for 1996 were equal to the national average per capita growth rate, specified in paragraph (3) for 1996.

"(2) FOR SUBSEQUENT YEARS.—

"(A) IN GENERAL.—For purposes of this section and subject to subparagraph (B), the Secretary shall compute a per capita growth rate for each year after 1996, for each payment area as assigned to a service utilization cohort under subsection (d), consistent with the following rules:

"(i) MEDIAN SERVICE UTILIZATION COHORT SET AT NATIONAL AVERAGE PER CAPITA GROWTH RATE.—The per capita growth rate for areas assigned to the median service utilization cohort for the year shall be the national average per capita growth rate for the year (as specified under paragraph (3)).

"(ii) HIGHEST SERVICE UTILIZATION COHORT SET AT 75 PERCENT OF NATIONAL AVERAGE PER CAPITA GROWTH RATE.—The per capita growth rate for areas assigned to the highest service utilization cohort for the year shall be 75 percent of the national average per capita growth rate for the year.

"(iii) LOWEST SERVICE UTILIZATION COHORT SET AT 187.5 PERCENT OF NATIONAL AVERAGE PER CAPITA GROWTH RATE.—The per capita growth rate for areas assigned to the lowest service utilization cohort for the

year shall be 187.5 percent of the national average per capita growth rate for the year.

"(iv) LOWER SERVICE UTILIZATION COHORT SET AT 150 PERCENT OF NATIONAL AVERAGE PER CAPITA GROWTH RATE.—

"(I) IN GENERAL.—Subject to subclause (II), the per capita growth rate for areas assigned to the lower service utilization cohort for the year shall be 150 percent of the national average per capita growth rate for the year.

"(II) ADJUSTMENT.—If the Secretary has established under clause (v) the per capita growth rate for areas assigned to the higher service utilization cohort for the year at 75 percent of the national average per capita growth rate, the Secretary may provide for a reduced per capita growth rate under subclause (I) to the extent necessary to comply with subparagraph (B).

"(v) HIGHER SERVICE UTILIZATION COHORT.—The per capita growth rate for areas assigned to the higher service utilization cohort for the year shall be such percent (not less than 75 percent) of the national average per capita growth rate, as the Secretary may determine consistent with subparagraph (B).

"(B) AVERAGE PER CAPITA GROWTH RATE AT NATIONAL AVERAGE TO ASSURE BUDGET NEUTRALITY.—The Secretary shall compute per capita growth rates for a year under subparagraph (A) in a manner so that the weighted average per capita growth rate for all areas for the year (weighted to reflect the number of medicare beneficiaries in each area) is equal to the national average per capita growth rate under paragraph (3) for the year.

"(3) NATIONAL AVERAGE PER CAPITA GROWTH RATES.—In this subsection, the 'national average per capita growth rate' for—

"(A) 1996 is 5.3 percent,

"(B) 1997 is 3.8 percent,

"(C) 1998 is 4.6 percent,

"(D) 1999 is 4.3 percent,

"(E) 2000 is 3.8 percent,

"(F) 2001 is 5.5 percent,

"(G) 2002 is 5.6 percent, and

"(H) each subsequent year is 5.0 percent.

"(d) ASSIGNMENT OF PAYMENT AREAS TO SERVICE UTILIZATION COHORTS.—

"(1) IN GENERAL.—For purposes of determining per capita growth rates under subsection (c) for areas for a year, the Secretary shall assign each payment area to a service utilization cohort (based on the service utilization index value for that area determined under paragraph (2)) as follows:

"(A) LOWEST SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of less than .80 shall be assigned to the lowest service utilization cohort.

"(B) LOWER SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of at least .80 but less than .90 shall be assigned to the lower service utilization cohort.

"(C) MEDIAN SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of at least .90 but less than 1.10 shall be assigned to the median service utilization cohort.

"(D) HIGHER SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of at least 1.10 but less than 1.20 shall be assigned to the higher service utilization cohort.

"(E) HIGHEST SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of at least 1.20 shall be assigned to the highest service utilization cohort.

"(2) DETERMINATION OF SERVICE UTILIZATION INDEX VALUES.—In order to determine the per capita growth rate for a payment area for each year (beginning with 1996), the Secretary shall determine for such area and year a service utilization index value, which is equal to—

"(A) the annual MedicarePlus capitation rate under this section for the area for the year in which the determination is made (or, in the case of 1996, the average annual per capita rate of payment (described in section 1876(a)(1)(C)) for the area for 1995); divided by

"(B) the input-price-adjusted annual national MedicarePlus capitation rate (as determined under paragraph (3)) for that area for the year in which the determination is made.

"(3) DETERMINATION OF INPUT-PRICE-ADJUSTED RATES.—

"(A) IN GENERAL.—For purposes of paragraph (2), the 'input-price-adjusted annual national MedicarePlus capitation rate' for a payment area for a year is equal to the sum, for all the types of medicare services (as classified by the Secretary), of the product (for each such type) of—

"(i) the national standardized MedicarePlus capitation rate (determined under subparagraph (B)) for the year,

"(ii) the proportion of such rate for the year which is attributable to such type of services, and

"(iii) an index that reflects (for that year and that type of services) the relative input price of such services in the area compared to the national average input price of such services.

In applying clause (iii), the Secretary shall, subject to subparagraph (C), apply those indices under this title that are used in applying (or updating) national payment rates for specific areas and localities.

"(B) NATIONAL STANDARDIZED MEDICAREPLUS CAPITATION RATE.—In this paragraph, the 'national standardized MedicarePlus capitation rate' for a year is equal to—

"(i) the sum (for all payment areas) of the product of (I) the annual MedicarePlus capitation rate for that year for the area under subsection (b)(2), and (II) the average number of medicare beneficiaries residing in that area in the year; divided by

"(ii) the total average number of medicare beneficiaries residing in all the payment areas for that year.

"(C) SPECIAL RULES FOR 1996.—In applying this paragraph for 1996—

"(i) medicare services shall be divided into 2 types of services: part A services and part B services;

"(ii) the proportions described in subparagraph (A)(ii) for such types of services shall be—

"(I) for part A services, the ratio (expressed as a percentage) of the average annual per capita rate of payment for the area for part A for 1995 to the total average annual per capita rate of payment for the area for parts A and B for 1995, and

"(II) for part B services, 100 percent minus the ratio described in subclause (I);

"(iii) for the part A services, 70 percent of payments attributable to such services shall be adjusted by the index used under section 1886(d)(3)(E) to adjust payment rates for relative hospital wage levels for hospitals located in the payment area involved;

"(iv) for part B services—

"(I) 66 percent of payments attributable to such services shall be adjusted by the index of the geographic area factors under section 1848(e) used to adjust payment rates for physicians' services furnished in the payment area, and

"(II) of the remaining 34 percent of the amount of such payments, 70 percent shall be adjusted by the index described in clause (iii);

"(v) the index values shall be computed based only on the beneficiary population described in subsection (b)(5)(A).

The Secretary may continue to apply the rules described in this subparagraph (or similar rules) for 1997.

"(e) PAYMENT PROCESS.—

"(1) IN GENERAL.—Subject to subsection (f), the Secretary shall make monthly payments under this section in advance and in accordance with the rate determined under subsection (a) to the plan for each individual enrolled with a MedicarePlus organization under this part.

"(2) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—

"(A) IN GENERAL.—The amount of payment under this subsection may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled with an organization under this part and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

"(B) SPECIAL RULE FOR CERTAIN ENROLLEES.—

"(i) IN GENERAL.—Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a MedicarePlus organization under a product operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's

spouse) and ending on the date on which the individual is enrolled in the organization under this part, except that for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.

"(ii) EXCEPTION.—No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the disclosure statement described in section 1853(a) at the time the individual enrolled with the organization.

"(f) SPECIAL RULES FOR INDIVIDUALS ELECTING HIGH DEDUCTIBLE/MEDISAVE PRODUCT.—

"(1) IN GENERAL.—In the case of an individual who has elected a high deductible/medisave product, notwithstanding the preceding provisions of this section—

"(A) the amount of the payment to the MedicarePlus organization offering the high deductible/medisave product shall not exceed the premium for the product, and

"(B) subject to paragraph (2), the difference between the amount of payment that would otherwise be made and the amount of payment to such organization shall be made directly into a MedicarePlus MSA established (and, if applicable, designated) by the individual under paragraph (2).

"(2) ESTABLISHMENT AND DESIGNATION OF MEDICAREPLUS MEDICAL SAVINGS ACCOUNT AS REQUIREMENT FOR PAYMENT OF CONTRIBUTION.—In the case of an individual who has elected coverage under a high deductible/medisave product, no payment shall be made under paragraph (1)(B) on behalf of an individual for a month unless the individual—

"(A) has established before the beginning of the month (or by such other deadline as the Secretary may specify) a MedicarePlus MSA (as defined in section 137(b) of the Internal Revenue Code of 1986), and

"(B) if the individual has established more than one MedicarePlus MSA, has designated one of such accounts as the individual's MedicarePlus MSA for purposes of this part.

Under rules under this section, such an individual may change the designation of such account under subparagraph (B) for purposes of this part.

"(3) LUMP SUM DEPOSIT OF MEDICAL SAVINGS ACCOUNT CONTRIBUTION.—In the case of an individual electing a high deductible/medisave product effective beginning with a month in a year, the amount of the contribution to the MedicarePlus MSA on behalf of the individual for that month and all successive months in the year shall be deposited during that first month. In the case of a termination of such an election as of a month before the end of a year, the Secretary shall provide for a procedure for the recovery of deposits attributable to the remaining months in the year.

"(g) PAYMENTS FROM TRUST FUND.—The payment to a MedicarePlus organization under this section for individuals enrolled under this part with the organization, and payments to a MedicarePlus MSA under subsection (f)(1)(B), shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under part A and under part B represents of the actuarial value of the total benefits under this title.

"(h) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual's—

"(1) election under this part of a MedicarePlus product offered by a MedicarePlus organization—

"(A) payment for such services until the date of the individual's discharge shall be made under this title through the MedicarePlus product or Non-MedicarePlus option (as the case may be) elected before the election with such organization,

"(B) the elected organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

"(C) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this part; or

"(2) termination of election with respect to a MedicarePlus organization under this part—

"(A) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

"(B) payment for such services during the stay shall not be made under section 1886(d) or by any succeeding MedicarePlus organization, and

"(C) the terminated organization shall not receive any payment with respect to the individual under this part during the period the individual is not enrolled.

"ESTABLISHMENT OF STANDARDS FOR MEDICARE-PLUS ORGANIZATIONS AND PRODUCTS

"SEC. 1856. (a) STANDARDS APPLICABLE TO STATE-REGULATED ORGANIZATIONS AND PRODUCTS.—

"(1) RECOMMENDATIONS OF NAIC.—The Secretary shall request the National Association of Insurance Commissioners to develop and submit to the Secretary, not later than 12 months after the date of the enactment of the Medicare Preservation Act of 1995, proposed standards consistent with the requirements of this part for MedicarePlus organizations (other than Taft-Hartley sponsors and provider-sponsored organizations) and MedicarePlus products offered by such organizations, except that such proposed standards may relate to MedicarePlus organizations that are qualified associations only with respect to MedicarePlus products offered by them and only if such products are issued by organizations to which section 1851(b)(1) applies.

"(2) REVIEW.—If the Association submits such standards on a timely basis, the Secretary shall review such standards to determine if the standards meet the requirements of the part. The Secretary shall complete the review of the standards not later than 90 days after the date of their submission. The Secretary shall promulgate such proposed standards to apply to organizations and products described in paragraph (1) except to the extent that the Secretary modifies such proposed standards because they do not meet such requirements.

"(3) FAILURE TO SUBMIT.—If the Association does not submit such standards on a timely basis, the Secretary shall promulgate such standards by not later than the date the Secretary would otherwise have been required to promulgate standards under paragraph (2).

"(4) USE OF INTERIM RULES.—For the period in which this part is in effect and standards are being developed and established under the preceding provisions of this subsection, the Secretary shall provide by not later than June 1, 1996, for the application of such interim standards (without regard to any requirements for notice and public comment) as may be appropriate to provide for the expedited implementation of this part. Such interim standards shall not apply after the date standards are established under the preceding provisions of this subsection.

"(b) TAFT-HARTLEY SPONSORS, QUALIFIED ASSOCIATIONS, AND PRODUCTS.—

"(1) IN GENERAL.—The Secretary shall develop and promulgate by regulation standards consistent with the requirements of this part for Taft-Hartley sponsors, for qualified associations, and for MedicarePlus products offered by such organizations (other than MedicarePlus products offered by qualified associations that are issued by organizations to which section 1851(b)(1) applies).

"(2) CONSULTATION WITH LABOR.—The Secretary shall consult with the Secretary of Labor with respect to such standards for such sponsors and products.

"(3) TIMING.—Standards under this subsection shall be promulgated at or about the time standards are promulgated under subsection (a).

"(c) ESTABLISHMENT OF STANDARDS FOR PROVIDER-SPONSORED ORGANIZATIONS.—

"(1) IN GENERAL.—The Secretary shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter 3 of chapter 5 of title 5, United States Code, standards that entities must meet to qualify as provider-sponsored organizations under this part.

"(2) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under this subsection, the Secretary, after consultation with the National Association of Insurance Commissioners, the American Academy of Actuaries, organizations representative of medicare beneficiaries, and other interested parties, shall publish the notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of Medicare Preservation Act of 1995.

"(3) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under paragraph (2), and for purposes of this subsection, the 'target date for publication' (referred to in section 564(a)(5) of such title) shall be September 1, 1996.

"(4) ABBREVIATED PERIOD FOR SUBMISSION OF COMMENTS.—In applying section 564(c) of such title under this subsection, '15 days' shall be substituted for '30 days'.

"(5) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

"(A) the appointment of a negotiated rulemaking committee under section 565(a) of such title by not later than 30 days after the end of the comment period provided for under section 564(c) of such title (as shortened under paragraph (4)), and

"(B) the nomination of a facilitator under section 566(c) of such title by not later than 10 days after the date of appointment of the committee.

"(6) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under paragraph (5) shall report to the Secretary, by not later than June 1, 1996, regarding the committee's progress on achieving a concensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before one month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress towards such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this subsection through such other methods as the Secretary may provide.

"(7) FINAL COMMITTEE REPORT.—If the committee is not terminated under paragraph (6), the rulemaking committee shall submit a report containing a proposed rule by not later than one month before the target publication date.

"(8) INTERIM, FINAL EFFECT.—The Secretary shall publish a rule under this subsection in the Federal Register by not later than the target publication date. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 60 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications of entities to be certified as provider-sponsored organizations pursuant to such rules and consistent with this subsection.

"(9) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target publication date.

"(10) PROCESS FOR APPROVAL OF APPLICATIONS FOR CERTIFICATION.—

"(A) IN GENERAL.—The Secretary shall establish a process for the receipt and approval of applications of entities for certification as provider-sponsored organizations under this part. Under such process, the Secretary shall act upon a complete application submitted within 60 days after the date it is received.

"(B) CIRCULATION OF PROPOSED APPLICATION FORM.—By March 1, 1996, the Secretary, after consultation with the negotiated rulemaking committee, shall circulate a proposed application form that could be used by entities considering becoming certified as a provider-sponsored organization under this part.

"(d) COORDINATION AMONG FINAL STANDARDS.—In establishing standards (other than on an interim basis) under the previous provisions of this section, the Secretary shall seek to provide for consistency (as appropriate) across the different types of MedicarePlus organizations, in order to promote equitable treatment of different types of organizations and consistent protection for individuals who elect products offered by the different types of MedicarePlus organizations.

"(e) USE OF CURRENT STANDARDS FOR INTERIM STANDARDS.—To the extent practicable and consistent with the requirements of this part, standards established on an interim basis to carry out requirements of this part may be based on currently applicable standards, such as the rules established under section 1876 (as in effect as of the date of the enactment of this section) to carry out analogous provisions of such section or standards established or developed for application in the private health insurance market.

"(f) APPLICATION OF NEW STANDARDS TO ENTITIES WITH A CONTRACT.—In the case of a MedicarePlus organization with a contract in effect under this part at the time standards applicable to the organization under this section are changed, the organization may elect not to have such changes apply to the organization until the end of the current contract year (or, if there is less than 6 months remaining in the contract year, until 1 year after the end of the current contract year).

"(g) RELATION TO STATE LAWS.—The standards established under this section shall supersede any State law or regulation with respect to MedicarePlus products which are offered by MedicarePlus organizations and are issued by organizations to which section 1851(b)(1) applies, to the extent such law or regulation is inconsistent with such standards.

"MEDICARE-PLUS CERTIFICATION

"SEC. 1857. (a) STATE CERTIFICATION PROCESS FOR STATE-REGULATED ORGANIZATIONS.—

"(1) APPROVAL OF STATE PROCESS.—The Secretary shall approve a MedicarePlus certification and enforcement program established by a State for applying the standards established under section 1856 to MedicarePlus organizations (other than Taft-Hartley sponsors and provider-sponsored organizations) and MedicarePlus products offered by such organizations if the Secretary determines that the program effectively provides for the application and enforcement of such standards in the State with respect to such organizations and products. Such program shall provide for certification of compliance of MedicarePlus organizations and products with the applicable requirements of this part not less often than once every 3 years.

"(2) EFFECT OF CERTIFICATION UNDER STATE PROCESS.—A MedicarePlus organization and MedicarePlus product offered by such an organization that is certified under such program is considered to have been certified under this subsection with respect to the offering of the product to individuals residing in the State.

"(3) USER FEES.—The State may impose user fees on organizations seeking certification under this subsection in such amounts as the State deems sufficient to finance the costs of such certification. Nothing in this paragraph shall be construed as restricting a State's authority to impose premium taxes, other taxes, or other levies.

"(4) REVIEW.—The Secretary periodically shall review State programs approved under paragraph (1) to determine if they continue to provide for certification and enforcement described in such paragraph. If the Secretary finds that a State program no longer so provides, before making a final determination, the Secretary shall provide the State an opportunity to adopt such a plan of correction as would permit the State program to meet the requirements of paragraph (1). If the Secretary makes a final determination that the State program, after such an opportunity, fails to meet such requirements, the provisions of subsection (b) shall apply to MedicarePlus organizations and products in the State.

"(5) EFFECT OF NO STATE PROGRAM.—Beginning on the date standards are established under section 1856, in the case of organizations and products in States in which a certification program has not been approved and in operation under paragraph (1), the Secretary shall establish a process for the certification of MedicarePlus organizations (other than Taft-Hartley sponsors and provider-sponsored organizations) and products of such organizations as meeting such standards.

"(6) PUBLICATION OF LIST OF APPROVED STATE PROGRAMS.—The Secretary shall publish (and periodically update) a list of those State programs which are approved for purposes of this subsection.

"(b) FEDERAL CERTIFICATION PROCESS FOR TAFT-HARTLEY SPONSORS AND PROVIDER-SPONSORED ORGANIZATIONS.—

"(1) ESTABLISHMENT.—The Secretary shall establish a process for the certification of Taft-Hartley sponsors and provider-sponsored organizations and MedicarePlus products offered by such sponsors and organizations as meeting the applicable standards established under section 1856.

"(2) INVOLVEMENT OF SECRETARY OF LABOR.—Such process shall be established and operated in cooperation with the Secretary of Labor with respect to Taft-Hartley sponsors.

"(3) USE OF STATE LICENSING AND PRIVATE ACCREDITATION PROCESSES.—

"(A) IN GENERAL.—The process under this subsection shall, to the maximum extent practicable, provide that MedicarePlus organizations and products that are licensed or certified through a qualified private accreditation process that the Secretary finds applies standards that are no less stringent than the requirements of this part are deemed to meet the corresponding requirements of this part for such an organization or product.

"(B) PERIODIC ACCREDITATION.—The use of an accreditation under subparagraph (A) shall be valid only for such period as the Secretary specifies.

"(4) USER FEES.—The Secretary may impose user fees on entities seeking certification under this subsection in such amounts as the Secretary deems sufficient to finance the costs of such certification.

"(c) CERTIFICATION OF PROVIDER-SPONSORED ORGANIZATIONS BY STATES.—

"(1) IN GENERAL.—The Secretary shall establish a process under which a State may propose to provide for certification of entities as meeting the requirements of this part to be provider-sponsored organizations.

"(2) CONDITIONS FOR APPROVAL.—The Secretary may not approve a State program for certification under paragraph (1) unless the Secretary determines that the certification program applies standards and requirements that are identical to the standards and requirements of this part and the applicable provisions for enforcement of such standards and requirements do not result in a lower level or quality of enforcement than that which is otherwise applicable under this title.

"(d) NOTICE TO ENROLLEES IN CASE OF DECERTIFICATION.—If a MedicarePlus organization or product is decertified under this section, the organization shall notify each enrollee with the organization and product under this part of such decertification.

"(e) QUALIFIED ASSOCIATIONS.—In the case of MedicarePlus products offered by a MedicarePlus organization that is a qualified association (as defined in section 1854(c)(4)(C)) and issued by an organization to which section 1851(b)(1) applies or by a provider-sponsored organization (as defined in section 1854(a)), nothing in this section shall be construed as limiting the authority of States to regulate such products.

"CONTRACTS WITH MEDICAREPLUS ORGANIZATIONS

"SEC. 1858. (a) IN GENERAL.—The Secretary shall not permit the election under section 1805 of a MedicarePlus product offered by a MedicarePlus organization under this part, and no payment shall be made under section 1856 to an organization, unless the Secretary has entered into a contract under this section with an organization with respect to the offering of such product. Such a contract with an organization may cover more than one MedicarePlus product. Such contract shall provide that the organization agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

"(b) MINIMUM ENROLLMENT REQUIREMENTS.—

"(1) IN GENERAL.—Subject to paragraphs (1) and (2), the Secretary may not enter into a contract under this section with a MedicarePlus organization (other than a Taft-Hartley sponsor) unless the organization has at least 5,000 individuals (or 1,500 individuals in the case of an organization that is a provider-sponsored organization) who are receiving health benefits through the organization, except that the standards under section 1856 may permit the organization to have a lesser number of beneficiaries (but not less than 500 in the case of an organization that is a provider-sponsored organization) if the organization primarily serves individuals residing outside of urbanized areas.

"(2) EXCEPTION FOR HIGH DEDUCTIBLE/MEDISAVE PRODUCT.—Paragraph (1) shall not apply with respect to a contract that relates only to a high deductible/medisave product.

"(3) ALLOWING TRANSITION.—The Secretary may waive the requirement of paragraph (1) during the first 3 contract years with respect to an organization.

"(c) CONTRACT PERIOD AND EFFECTIVENESS.—

"(1) PERIOD.—Each contract under this section shall be for a term of at least one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term.

"(2) TERMINATION AUTHORITY.—In accordance with procedures established under subsection (h), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in an applicable paragraph of subsection (g) on the MedicarePlus organization if the Secretary determines that the organization—

"(A) has failed substantially to carry out the contract;

"(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part;

"(C) is operating in a manner that is not in the best interests of the individuals covered under the contract; or

"(D) no longer substantially meets the applicable conditions of this part.

"(3) EFFECTIVE DATE OF CONTRACTS.—The effective date of any contract executed pursuant to this section shall be specified in the contract, except that in no case shall a contract under this section which provides for coverage under a high deductible/medisave account be effective before January 1997 with respect to such coverage.

"(4) PREVIOUS TERMINATIONS.—The Secretary may not enter into a contract with a MedicarePlus organization if a previous contract with that organization under this section was terminated at the request of the organization within the

preceding five-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

"(5) NO CONTRACTING AUTHORITY.—The authority vested in the Secretary by this part may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

"(d) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—

"(1) INSPECTION AND AUDIT.—Each contract under this section shall provide that the Secretary, or any person or organization designated by the Secretary—

"(A) shall have the right to inspect or otherwise evaluate (i) the quality, appropriateness, and timeliness of services performed under the contract and (ii) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

"(B) shall have the right to audit and inspect any books and records of the MedicarePlus organization that pertain (i) to the ability of the organization to bear the risk of potential financial losses, or (ii) to services performed or determinations of amounts payable under the contract.

"(2) ENROLLEE NOTICE AT TIME OF TERMINATION.—Each contract under this section shall require the organization to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled with the organization under this part.

"(3) DISCLOSURE.—

"(A) IN GENERAL.—Each MedicarePlus organization shall, in accordance with regulations of the Secretary, report to the Secretary financial information which shall include the following:

"(i) Such information as the Secretary may require demonstrating that the organization has a fiscally sound operation.

"(ii) A copy of the report, if any, filed with the Health Care Financing Administration containing the information required to be reported under section 1124 by disclosing entities.

"(iii) A description of transactions, as specified by the Secretary, between the organization and a party in interest. Such transactions shall include—

"(I) any sale or exchange, or leasing of any property between the organization and a party in interest;

"(II) any furnishing for consideration of goods, services (including management services), or facilities between the organization and a party in interest, but not including salaries paid to employees for services provided in the normal course of their employment and health services provided to members by hospitals and other providers and by staff, medical group (or groups), individual practice association (or associations), or any combination thereof; and

"(III) any lending of money or other extension of credit between an organization and a party in interest.

The Secretary may require that information reported respecting an organization which controls, is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

"(B) PARTY IN INTEREST DEFINED.—For the purposes of this paragraph, the term 'party in interest' means—

"(i) any director, officer, partner, or employee responsible for management or administration of a MedicarePlus organization, any person who is directly or indirectly the beneficial owner of more than 5 percent of the equity of the organization, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5 percent of the organization, and, in the case of a MedicarePlus organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

"(ii) any entity in which a person described in clause (i)—

"(I) is an officer or director;

"(II) is a partner (if such entity is organized as a partnership);

"(III) has directly or indirectly a beneficial interest of more than 5 percent of the equity; or

"(IV) has a mortgage, deed of trust, note, or other interest valuing more than 5 percent of the assets of such entity;

"(iii) any person directly or indirectly controlling, controlled by, or under common control with an organization; and

"(iv) any spouse, child, or parent of an individual described in clause (i).

"(C) ACCESS TO INFORMATION.—Each MedicarePlus organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

"(4) LOAN INFORMATION.—The contract shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties.

"(e) ADDITIONAL CONTRACT TERMS.—The contract shall contain such other terms and conditions not inconsistent with this part (including requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

"(f) INTERMEDIATE SANCTIONS.—

"(1) IN GENERAL.—If the Secretary determines that a MedicarePlus organization with a contract under this section—

"(A) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

"(B) imposes premiums on individuals enrolled under this part in excess of the premiums permitted;

"(C) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this part;

"(D) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this part) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

"(E) misrepresents or falsifies information that is furnished—

"(i) to the Secretary under this part, or

"(ii) to an individual or to any other entity under this part;

"(F) fails to comply with the requirements of section 1852(f)(3); or

"(G) employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly) through such an excluded individual or entity of such services;

the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2).

"(2) REMEDIES.—The remedies described in this paragraph are—

"(A) civil money penalties of not more than $25,000 for each determination under paragraph (1) or, with respect to a determination under subparagraph (D) or (E)(i) of such paragraph, of not more than $100,000 for each such determination, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(D), $15,000 for each individual not enrolled as a result of the practice involved,

"(B) suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

"(C) suspension of payment to the organization under this part for individuals enrolled after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

"(3) OTHER INTERMEDIATE SANCTIONS.—In the case of a MedicarePlus organization for which the Secretary makes a determination under subsection (c)(2) the basis of which is not described in paragraph (1), the Secretary may apply the following intermediate sanctions:

"(A) civil money penalties of not more than $25,000 for each determination under subsection (c)(2) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood

of adversely affecting) an individual covered under the organization's contract;

"(B) civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under subsection (h) during which the deficiency that is the basis of a determination under subsection (c)(2) exists; and

"(C) suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under subsection (c)(2) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.

"(4) PROCEDURES FOR IMPOSING SANCTIONS.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under paragraph (1) or (2) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

"(g) PROCEDURES FOR IMPOSING SANCTIONS.—The Secretary may terminate a contract with a MedicarePlus organization under this section or may impose the intermediate sanctions described in subsection (f) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

"(1) the Secretary provides the organization with the opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under subsection (c)(2);

"(2) the Secretary shall impose more severe sanctions on organizations that have a history of deficiencies or that have not taken steps to correct deficiencies the Secretary has brought to their attention;

"(3) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

"(4) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.".

(b) CONFORMING REFERENCES TO PREVIOUS PART C.—Any reference in law (in effect before the date of the enactment of this Act) to part C of title XVIII of the Social Security Act is deemed a reference to part D of such title (as in effect after such date).

(c) USE OF INTERIM, FINAL REGULATIONS.—In order to carry out the amendment made by subsection (a) in a timely manner, the Secretary of Health and Human Services may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

(d) ADVANCE DIRECTIVES.—Section 1866(f) (42 U.S.C. 1395cc(f)) is amended—

(1) in paragraph (1)—

(A) by inserting "1853(g)," after "1833(s),", and

(B) by inserting ", MedicarePlus organization," after "provider of services", and

(2) by adding at the end the following new paragraph:

"(4) Nothing in this subsection shall be construed to require the provision of information regarding assisted suicide, euthanasia, or mercy killing.".

(e) CONFORMING AMENDMENT.—Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended by inserting before the semicolon at the end the following: "and in the case of hospitals to accept as payment in full for inpatient hospital services that are emergency services (as defined in section 1853(b)(4)) that are covered under this title and are furnished to any individual enrolled under part C with a MedicarePlus organization which does not have a contract establishing payment amounts for services furnished to members of the organization the amounts that would be made as a payment in full under this title if the individuals were not so enrolled".

SEC. 15003. DUPLICATION AND COORDINATION OF MEDICARE-RELATED PRODUCTS.

(a) TREATMENT OF CERTAIN HEALTH INSURANCE POLICIES AS NONDUPLICATIVE.—

(1) IN GENERAL.—Effective as if included in the enactment of section 4354 of the Omnibus Budget Reconciliation Act of 1990, section 1882(d)(3)(A) (42 U.S.C. 1395ss(d)(3)(A)) is amended—

(A) by amending clause (i) to read as follows:

"(i) It is unlawful for a person to sell or issue to an individual entitled to benefits under part A or enrolled under part B of this title or electing a MedicarePlus product under section 1805—

"(I) a health insurance policy (other than a medicare supplemental policy) with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this title or title XIX,

"(II) in the case of an individual not electing a MedicarePlus product, a medicare supplemental policy with knowledge that the individual is entitled to benefits under another medicare supplemental policy, or

"(III) in the case of an individual electing a MedicarePlus product, a medicare supplemental policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this title or under another medicare supplemental policy.";

(B) in clause (iii), by striking "clause (i)" and inserting "clause (i)(II)"; and

(C) by adding at the end the following new clauses:

"(iv) For purposes of this subparagraph a health insurance policy shall be considered to 'duplicate' benefits under this title only when, under its terms, the policy provides specific reimbursement for identical items and services to the extent paid for under this title, and a health insurance policy providing for benefits which are payable to or on behalf of an individual without regard to other health benefit coverage of such individual is not considered to 'duplicate' any health benefits under this title.

"(v) For purposes of this subparagraph, a health insurance policy (or a rider to an insurance contract which is not a health insurance policy), including a policy (such as a long-term care insurance contract described in section 7702B(b) of the Internal Revenue Code of 1986, as added by the Contract with America Tax Relief Act of 1995 (H.R. 1215)) providing benefits for long-term care, nursing home care, home health care, or community-based care, that coordinates against or excludes items and services available or paid for under this title and (for policies sold or issued after January 1, 1996) that discloses such coordination or exclusion in the policy's outline of coverage, is not considered to 'duplicate' health benefits under this title. For purposes of this clause, the terms 'coordinates' and 'coordination' mean, with respect to a policy in relation to health benefits under this title, that the policy under its terms is secondary to, or excludes from payment, items and services to the extent available or paid for under this title.

"(vi) Notwithstanding any other provision of law, no criminal or civil penalty may be imposed at any time under this subparagraph and no legal action may be brought or continued at any time in any Federal or State court if the penalty or action is based on an act or omission that occurred after November 5, 1991, and before the date of the enactment of this clause, and relates to the sale, issuance, or renewal of any health insurance policy during such period, if such policy meets the requirements of clause (iv) or (v).

"(vii) A State may not impose, with respect to the sale or issuance of a policy (or rider) that meets the requirements of this title pursuant to clause (iv) or (v) to an individual entitled to benefits under part A or enrolled under part B or enrolled under a MedicarePlus product under part C, any requirement based on the premise that such a policy or rider duplicates health benefits to which the individual is otherwise entitled under this title.".

(2) CONFORMING AMENDMENTS.—Section 1882(d)(3) (42 U.S.C. 1395ss(d)(3)) is amended—

(A) in subparagraph (B), by inserting "(including any MedicarePlus product)" after "health insurance policies";

(B) in subparagraph (C)—

(i) by striking "with respect to (i)" and inserting "with respect to", and

(ii) by striking ", (ii) the sale" and all that follows up to the period at the end; and

(C) by striking subparagraph (D).

(3) MEDICAREPLUS PRODUCTS NOT TREATED AS MEDICARE SUPPLEMENTARY POLICIES.—Section 1882(g) (42 U.S.C. 1395ss(g)) is amended by inserting "a MedicarePlus product or" after "and does not include"

(4) REPORT ON DUPLICATION AND COORDINATION OF HEALTH INSURANCE POLICIES THAT ARE NOT MEDICARE SUPPLEMENTAL POLICIES.—Not later than 3 years after the date of the enactment of this Act, the Secretary of Health and Human Services shall prepare and submit to Congress a report on the advisability and feasibility of restricting the sale to medicare beneficiaries of health insurance policies that duplicate (within the meaning of section 1882(d)(3)(A) of the Social Security Act) other health insurance policies that such a beneficiary may have. In preparing such report, the Secretary shall seek the advice of the National Association of Insurance Commissioners and shall take into account the standards established under section 1807 of the Social Security Act for the electronic coordination of benefits.

(b) ADDITIONAL RULES RELATING TO INDIVIDUALS ENROLLED IN MEDICAREPLUS PRODUCTS.—Section 1882 (42 U.S.C. 1395ss) is further amended by adding at the end the following new subsection:

"(u)(1) Notwithstanding the previous provisions of this section, the following provisions shall not apply to a health insurance policy (other than a medicare supplemental policy) provided to an individual who has elected the MedicarePlus option under section 1805:

"(A) Subsections (o)(1), (o)(2), (p)(1)(A)(i), (p)(2), (p)(3), (p)(8), and (p)(9) (insofar as they relate to limitations on benefits or groups of benefits that may be offered).

"(B) Subsection (r) (relating to loss-ratios).

"(2)(A) It is unlawful for a person to sell or issue a policy described in subparagraph (B) to an individual with knowledge that the individual has in effect under section 1805 an election of a high deductible/medisave product.

"(B) A policy described in this subparagraph is a health insurance policy that provides for coverage of expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under the high deductible/medisave product.".

SEC. 15004. TRANSITIONAL RULES FOR CURRENT MEDICARE HMO PROGRAM.

(a) TRANSITION FROM CURRENT CONTRACTS.—

(1) LIMITATION ON NEW CONTRACTS.—

(A) NO NEW RISK-SHARING CONTRACTS AFTER NEW STANDARDS ESTABLISHED.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall not enter into any risk-sharing contract under section 1876 of the Social Security Act with an eligible organization for any contract year beginning on or after the date standards for MedicarePlus organizations and products are first established under section 1856(a) of such Act with respect to MedicarePlus organizations that are insurer or health maintenance organizations unless such a contract had been in effect under section 1876 of such Act for the organization for the previous contract year.

(B) NO NEW COST REIMBURSEMENT CONTRACTS.—The Secretary shall not enter into any cost reimbursement contract under section 1876 of the Social Security Act beginning for any contract year beginning on or after the date of the enactment of this Act.

(2) TERMINATION OF CURRENT CONTRACTS.—

(A) RISK-SHARING CONTRACTS.—Notwithstanding any other provision of law, the Secretary shall not extend or continue any risk-sharing contract with an eligible organization under section 1876 of the Social Security Act (for which a contract was entered into consistent with paragraph (1)(A)) for any contract year beginning on or after 1 year after the date standards described in paragraph (1)(A) are established.

(B) COST REIMBURSEMENT CONTRACTS.—The Secretary shall not extend or continue any reasonable cost reimbursement contract with an eligible organization under section 1876 of the Social Security Act for any contract year beginning on or after January 1, 1998.

(b) CONFORMING PAYMENT RATES.—

(1) RISK-SHARING CONTRACTS.—Notwithstanding any other provision of law, the Secretary shall provide that payment amounts under risk-sharing contracts under section 1876(a) of the Social Security Act for months in a year (beginning with January 1996) shall be computed—

(A) with respect to individuals both entitled to benefits under both parts A and B of title XVIII of such Act, by substituting payment rates under section 1855(a) of such Act for the payment rates otherwise established under section 1876(a) of such Act, and

(B) with respect to individuals only entitled to benefits under part B of such title, by substituting an appropriate proportion of such rates (reflecting the relative proportion of payments under such title attributable to such part) for the payment rates otherwise established under section 1876(a) of such Act.

For purposes of carrying out this paragraph for payment for months in 1996, the Secretary shall compute, announce, and apply the payment rates under section 1855(a) of such Act (notwithstanding any deadlines specified in such section) in as timely a manner as possible and may (to the extent necessary) provide for retroactive adjustment in payments made not in accordance with such rates.

(2) COST CONTRACTS.—Notwithstanding any other provision of law, the Secretary shall provide that payment amounts under cost reimbursement contracts under section 1876(a) of the Social Security Act shall take into account adjustments in payment amounts made in parts A and B of title XVIII of such Act pursuant to the amendments made by this title.

(c) ELIMINATION OF 50:50 RULE.—

(1) IN GENERAL.—Section 1876 (42 U.S.C. 1395mm) is amended by striking subsection (f).

(2) CONFORMING AMENDMENTS.—Section 1876 is further amended—

(A) in subsection (c)(3)(A)(i), by striking "would result in failure to meet the requirements of subsection (f) or", and

(B) in subsection (i)(1)(C), by striking "(e), and (f)" and inserting "and (e)".

(3) EFFECTIVE DATE.—The amendments made by this section shall apply to contract years beginning on or after January 1, 1996.

PART 2—SPECIAL RULES FOR MEDICAREPLUS MEDICAL SAVINGS ACCOUNTS

SEC. 15011. MEDICAREPLUS MSA'S.

(a) IN GENERAL.—Part III of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to amounts specifically excluded from gross income) is amended by redesignating section 137 as section 138 and by inserting after section 136 the following new section:

"SEC. 137. MEDICAREPLUS MSA'S.

"(a) EXCLUSION.—Gross income shall not include any payment to the MedicarePlus MSA of an individual by the Secretary of Health and Human Services under section 1855(f)(1)(B) of the Social Security Act.

"(b) MEDICAREPLUS MSA.—For purposes of this section—

"(1) MEDICAREPLUS MSA.—The term 'MedicarePlus MSA' means a trust created or organized in the United States exclusively for the purpose of paying the qualified medical expenses of the account holder, but only if the written governing instrument creating the trust meets the following requirements:

"(A) Except in the case of a trustee-to-trustee transfer described in subsection (d)(4), no contribution will be accepted unless it is made by the Secretary of Health and Human Services under section 1855(f)(1)(B) of the Social Security Act.

"(B) The trustee is a bank (as defined in section 408(n)), an insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

"(C) No part of the trust assets will be invested in life insurance contracts.

"(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

"(E) The interest of an individual in the balance in his account is nonforfeitable.

"(F) Trustee-to-trustee transfers described in subsection (d)(4) may be made to and from the trust.

"(2) QUALIFIED MEDICAL EXPENSES.—

"(A) IN GENERAL.—The term 'qualified medical expenses' means, with respect to an account holder, amounts paid by such holder—

"(i) for medical care (as defined in section 213(d)) for the account holder, but only to the extent such amounts are not compensated for by insurance or otherwise, or

"(ii) for long-term care insurance for the account holder.

"(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—Subparagraph (A)(i) shall not apply to any payment for insurance.

"(3) ACCOUNT HOLDER.—The term 'account holder' means the individual on whose behalf the MedicarePlus MSA is maintained.

"(4) CERTAIN RULES TO APPLY.—Rules similar to the rules of subsections (g) and (h) of section 408 shall apply for purposes of this section.

"(c) TAX TREATMENT OF ACCOUNTS.—

"(1) IN GENERAL.—A MedicarePlus MSA is exempt from taxation under this subtitle unless such MSA has ceased to be a MedicarePlus MSA by reason of paragraph (2). Notwithstanding the preceding sentence, any such MSA is sub-

ject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

"(2) ACCOUNT ASSETS TREATED AS DISTRIBUTED IN THE CASE OF PROHIBITED TRANSACTIONS OR ACCOUNT PLEDGED AS SECURITY FOR LOAN.—Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to MedicarePlus MSA's, and any amount treated as distributed under such rules shall be treated as not used to pay qualified medical expenses.

"(d) TAX TREATMENT OF DISTRIBUTIONS.—

"(1) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—No amount shall be included in the gross income of the account holder by reason of a payment or distribution from a MedicarePlus MSA which is used exclusively to pay the qualified medical expenses of the account holder. Any amount paid or distributed from a MedicarePlus MSA which is not so used shall be included in the gross income of such holder.

"(2) PENALTY FOR DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES IF MINIMUM BALANCE NOT MAINTAINED.—

"(A) IN GENERAL.—The tax imposed by this chapter for any taxable year in which there is a payment or distribution from a MedicarePlus MSA which is not used exclusively to pay the qualified medical expenses of the account holder shall be increased by 50 percent of the excess (if any) of—

"(i) the amount of such payment or distribution, over

"(ii) the excess (if any) of—

"(I) the fair market value of the assets in the MedicarePlus MSA as of the close of the calendar year preceding the calendar year in which the taxable year begins, over

"(II) an amount equal to 60 percent of the deductible under the high deductible/medisave product covering the account holder as of January 1 of the calendar year in which the taxable year begins.

"(B) EXCEPTIONS.—Subparagraph (A) shall not apply if the payment or distribution is made on or after the date the account holder—

"(i) becomes disabled within the meaning of section 72(m)(7), or

"(ii) dies.

"(C) SPECIAL RULES.—For purposes of subparagraph (A)—

"(i) all MedicarePlus MSA's of the account holder shall be treated as 1 account,

"(ii) all payments and distributions not used exclusively to pay the qualified medical expenses of the account holder during any taxable year shall be treated as 1 distribution, and

"(iii) any distribution of property shall be taken into account at its fair market value on the date of the distribution.

"(3) WITHDRAWAL OF ERRONEOUS CONTRIBUTIONS.—Paragraphs (1) and (2) shall not apply to any payment or distribution from a MedicarePlus MSA to the Secretary of Health and Human Services of an erroneous contribution to such MSA and of the net income attributable to such contribution.

"(4) TRUSTEE-TO-TRUSTEE TRANSFERS.—Paragraphs (1) and (2) shall not apply to any trustee-to-trustee transfer from a MedicarePlus MSA of an account holder to another MedicarePlus MSA of such account holder.

"(5) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of section 213, any payment or distribution out of a MedicarePlus MSA for qualified medical expenses shall not be treated as an expense paid for medical care.

"(e) TREATMENT OF ACCOUNT AFTER DEATH OF ACCOUNT HOLDER.—

"(1) TREATMENT IF DESIGNATED BENEFICIARY IS SPOUSE.—

"(A) IN GENERAL.—In the case of an account holder's interest in a MedicarePlus MSA which is payable to (or for the benefit of) such holder's spouse upon the death of such holder, such MedicarePlus MSA shall be treated as a MedicarePlus MSA of such spouse as of the date of such death.

"(B) SPECIAL RULES IF SPOUSE NOT MEDICARE ELIGIBLE.—If, as of the date of such death, such spouse is not entitled to benefits under title XVIII of the Social Security Act, then after the date of such death—

"(i) the Secretary of Health and Human Services may not make any payments to such MedicarePlus MSA, other than payments attributable to periods before such date,

"(ii) in applying subsection (b)(2) with respect to such MedicarePlus MSA, references to the account holder shall be treated as including references to any dependent (as defined in section 152) of such spouse and any subsequent spouse of such spouse, and

"(iii) in lieu of applying subsection (d)(2), the rules of section 220(f)(2) shall apply.

"(2) TREATMENT IF DESIGNATED BENEFICIARY IS NOT SPOUSE.—In the case of an account holder's interest in a MedicarePlus MSA which is payable to (or for the benefit of) any person other than such holder's spouse upon the death of such holder—

"(A) such account shall cease to be a MedicarePlus MSA as of the date of death, and

"(B) an amount equal to the fair market value of the assets in such account on such date shall be includible—

"(i) if such person is not the estate of such holder, in such person's gross income for the taxable year which includes such date, or

"(ii) if such person is the estate of such holder, in such holder's gross income for last taxable year of such holder.

"(f) REPORTS.—

"(1) IN GENERAL.—The trustee of a MedicarePlus MSA shall make such reports regarding such account to the Secretary and to the account holder with respect to—

"(A) the fair market value of the assets in such MedicarePlus MSA as of the close of each calendar year, and

"(B) contributions, distributions, and other matters,

as the Secretary may require by regulations.

"(2) TIME AND MANNER OF REPORTS.—The reports required by this subsection—

"(A) shall be filed at such time and in such manner as the Secretary prescribes in such regulations, and

"(B) shall be furnished to the account holder—

"(i) not later than January 31 of the calendar year following the calendar year to which such reports relate, and

"(ii) in such manner as the Secretary prescribes in such regulations."

(b) EXCLUSION OF MEDICAREPLUS MSA'S FROM ESTATE TAX.—Part IV of subchapter A of chapter 11 of such Code is amended by adding at the end the following new section:

"SEC. 2057. MEDICAREPLUS MSA'S.

"For purposes of the tax imposed by section 2001, the value of the taxable estate shall be determined by deducting from the value of the gross estate an amount equal to the value of any MedicarePlus MSA (as defined in section 137(b)) included in the gross estate."

(c) TAX ON PROHIBITED TRANSACTIONS.—

(1) Section 4975 of such Code (relating to tax on prohibited transactions) is amended by adding at the end of subsection (c) the following new paragraph:

"(4) SPECIAL RULE FOR MEDICAREPLUS MSA'S.—An individual for whose benefit a MedicarePlus MSA (within the meaning of section 137(b)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a MedicarePlus MSA by reason of the application of section 137(c)(2) to such account."

(2) Paragraph (1) of section 4975(e) of such Code is amended to read as follows:

"(1) PLAN.—For purposes of this section, the term 'plan' means—

"(A) a trust described in section 401(a) which forms a part of a plan, or a plan described in section 403(a), which trust or plan is exempt from tax under section 501(a),

"(B) an individual retirement account described in section 408(a),

"(C) an individual retirement annuity described in section 408(b),

"(D) a medical savings account described in section 220(d),

"(E) a MedicarePlus MSA described in section 137(b), or

"(F) a trust, plan, account, or annuity which, at any time, has been determined by the Secretary to be described in any preceding subparagraph of this paragraph."

(d) FAILURE TO PROVIDE REPORTS ON MEDICAREPLUS MSA'S.—

(1) Subsection (a) of section 6693 of such Code (relating to failure to provide reports on individual retirement accounts or annuities) is amended to read as follows:

"(a) REPORTS.—

"(1) IN GENERAL.—If a person required to file a report under a provision referred to in paragraph (2) fails to file such report at the time and in the manner

required by such provision, such person shall pay a penalty of $50 for each failure unless it is shown that such failure is due to reasonable cause.

"(2) PROVISIONS.—The provisions referred to in this paragraph are—

"(A) subsections (i) and (l) of section 408 (relating to individual retirement plans),

"(B) section 220(h) (relating to medical savings accounts), and

"(C) section 137(f) (relating to MedicarePlus MSA's)."

(2) The section heading for section 6693 of such Code is amended to read as follows:

"SEC. 6693. FAILURE TO FILE REPORTS ON INDIVIDUAL RETIREMENT PLANS AND CERTAIN OTHER TAX-FAVORED ACCOUNTS; PENALTIES RELATING TO DESIGNATED NONDEDUCTIBLE CONTRIBUTIONS."

(e) CLERICAL AMENDMENTS.—

(1) The table of sections for part III of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following:

"Sec. 137. MedicarePlus MSA's.
"Sec. 138. Cross references to other Acts."

(2) The table of sections for part 1 of subchapter B of chapter 68 of such Code is amended by striking the item relating to section 6693 and inserting the following new item:

"Sec. 6693. Failure to file reports on individual retirement plans and certain other tax-favored accounts; penalties relating to designated nondeductible contributions."

(3) The table of sections for part IV of subchapter A of chapter 11 of such Code is amended by adding at the end the following new item:

"Sec. 2057. MedicarePlus MSA's."

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 1996.

SEC. 15012. CERTAIN REBATES EXCLUDED FROM GROSS INCOME.

(a) IN GENERAL.—Section 105 of the Internal Revenue Code of 1986 (relating to amounts received under accident and health plans) is amended by adding at the end the following new subsection:

"(j) CERTAIN REBATES UNDER SOCIAL SECURITY ACT.—Gross income does not include any rebate received under section 1852(e)(1)(A) of the Social Security Act during the taxable year."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to amounts received after the date of the enactment of this Act.

PART 3—SPECIAL ANTITRUST RULE FOR PROVIDER SERVICE NETWORKS

SEC. 15021. APPLICATION OF ANTITRUST RULE OF REASON TO PROVIDER SERVICE NETWORKS.

(a) RULE OF REASON STANDARD.—In any action under the antitrust laws, or under any State law similar to the antitrust laws—

(1) the conduct of a provider service network in negotiating, making, or performing a contract (including the establishment and modification of a fee schedule and the development of a panel of physicians), to the extent such contract is for the purpose of providing health care services to individuals under the terms of a MedicarePlus PSO product, and

(2) the conduct of any member of such network for the purpose of providing such health care services under such contract to such extent,

shall not be deemed illegal per se. Such conduct shall be judged on the basis of its reasonableness, taking into account all relevant factors affecting competition, including the effects on competition in properly defined markets.

(b) DEFINITIONS.—For purposes of subsection (a):

(1) ANTITRUST LAWS.—The term "antitrust laws" has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that such section 5 applies to unfair methods of competition.

(2) HEALTH CARE PROVIDER.—The term "health care provider" means any individual or entity that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

(3) HEALTH CARE SERVICE.—The term "health care service" means any service for which payment may be made under a MedicarePlus PSO product including services related to the delivery or administration of such service.

(4) MEDICAREPLUS PROGRAM.—The term "MedicarePlus program" means the program under part C of title XVIII of the Social Security Act.

(5) MEDICAREPLUS PSO PRODUCT.—The term "MedicarePlus PSO product" means a MedicarePlus product offered by a provider-sponsored organization under part C of title XVIII of the Social Security Act.

(6) PROVIDER SERVICE NETWORK.—The term "provider service network" means an organization that—

(A) is organized by, operated by, and composed of members who are health care providers and for purposes that include providing health care services,

(B) is funded in part by capital contributions made by the members of such organization,

(C) with respect to each contract made by such organization for the purpose of providing a type of health care service to individuals under the terms of a MedicarePlus PSO product—

(i) requires all members of such organization who engage in providing such type of health care service to agree to provide health care services of such type under such contract,

(ii) receives the compensation paid for the health care services of such type provided under such contract by such members, and

(iii) provides for the distribution of such compensation,

(D) has established, consistent with the requirements of the MedicarePlus program for provider-sponsored organizations, a program to review, pursuant to written guidelines, the quality, efficiency, and appropriateness of treatment methods and setting of services for all health care providers and all patients participating in such product, along with internal procedures to correct identified deficiencies relating to such methods and such services,

(E) has established, consistent with the requirements of the MedicarePlus program for provider-sponsored organizations, a program to monitor and control utilization of health care services provided under such product, for the purpose of improving efficient, appropriate care and eliminating the provision of unnecessary health care services,

(F) has established a management program to coordinate the delivery of health care services for all health care providers and all patients participating in such product, for the purpose of achieving efficiencies and enhancing the quality of health care services provided, and

(G) has established, consistent with the requirements of the MedicarePlus program for provider-sponsored organizations, a grievance and appeal process for such organization designed to review and promptly resolve beneficiary or patient grievances and complaints.

Such term may include a provider-sponsored organization.

(7) PROVIDER-SPONSORED ORGANIZATION.—The term "provider-sponsored organization" means a MedicarePlus organization under the MedicarePlus program that is a provider-sponsored organization (as defined in section ____ of the Social Security Act).

(8) STATE.—The term "State" has the meaning given it in section 4G(2) of the Clayton Act (15 U.S.C. 15g(2)).

(c) ISSUANCE OF GUIDELINES.—Not later than 120 days after the date of the enactment of this Act, the Attorney General and the Federal Trade Commission shall issue jointly guidelines specifying the enforcement policies and analytical principles that will be applied by the Department of Justice and the Commission with respect to the operation of subsection (a).

PART 4—COMMISSIONS

SEC. 15031. MEDICARE PAYMENT REVIEW COMMISSION.

(a) IN GENERAL.—Title XVIII, as amended by section 15001(a), is amended by inserting after section 1805 the following new section:

"MEDICARE PAYMENT REVIEW COMMISSION

"SEC. 1806. (a) ESTABLISHMENT.—There is hereby established the Medicare Payment Review Commission (in this section referred to as the 'Commission').

"(b) DUTIES.—

"(1) GENERAL DUTIES AND REPORTS.—The Commission shall review, and make recommendations to Congress concerning, payment policies under this title. By not later than June 1 of each year, the Commission shall submit a report to Congress containing an examination of issues affecting the medicare program, including the implications of changes in health care delivery in the United States and in the market for health care services on the medicare program. The Commission may submit to Congress from time to time such other reports as the Commission deems appropriate. The Secretary shall respond to recommendations of the Commission in notices of rulemaking proceedings under this title.

"(2) SPECIFIC DUTIES RELATING TO MEDICAREPLUS PROGRAM.—Specifically, the Commission shall review, with respect to the MedicarePlus program under part C—

"(A) the appropriateness of the methodology for making payment to plans under such program, including the making of differential payments and the distribution of differential updates among different payment areas,

"(B) the appropriateness of the mechanisms used to adjust payments for risk and the need to adjust such mechanisms to take into account health status of beneficiaries,

"(C) the implications of risk selection both among MedicarePlus organizations and between the MedicarePlus option and the non-MedicarePlus option,

"(D) in relation to payment under part C, the development and implementation of mechanisms to assure the quality of care for those enrolled with MedicarePlus organizations,

"(F) the impact of the MedicarePlus program on access to care for medicare beneficiaries, and

"(G) other major issues in implementation and further development of the MedicarePlus program.

"(3) SPECIFIC DUTIES RELATING TO THE FAILSAFE BUDGET MECHANISM.—Specifically, the Commission shall review, with respect to the failsafe budget mechanism described in section 1895—

"(A) the appropriateness of the expenditure projections by the Secretary under section 1895(c) for each medicare sector;

"(B) the appropriateness of the growth factors for each sector and the ability to take into account substitution across sectors;

"(C) the appropriateness of the mechanisms for implementing reductions in payment amounts for different sectors, including any adjustments to reflect changes in volume or intensity resulting for any payment reductions;

"(D) the impact of the mechanism on provider participation in parts A and B and in the MedicarePlus program; and

"(E) the appropriateness of the medicare benefit budget (under section 1895(c)(2)(C) of the Social Security Act), particularly for fiscal years after fiscal year 2002.

"(4) SPECIFIC DUTIES RELATING TO THE FEE-FOR-SERVICE SYSTEM.—Specifically, the Commission shall review payment policies under parts A and B, including—

"(A) the factors affecting expenditures for services in different sectors, including the process for updating hospital, physician, and other fees,

"(B) payment methodologies; and

"(C) the impact of payment policies on access and quality of care for medicare beneficiaries.

"(5) SPECIFIC DUTIES RELATING TO INTERACTION OF PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—Specifically the Commission shall review the effect of payment policies under this title on the delivery of health care services under this title and assess the implications of changes in the health services market on the medicare program.

"(c) MEMBERSHIP.—

"(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members appointed by Comptroller General.

"(2) QUALIFICATIONS.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, physicians, and other providers of services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives, including physicians and other health professionals, employers, third party payors, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and

expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

"(3) CONSIDERATIONS IN INITIAL APPOINTMENT.—To the extent possible, in first appointing members to the Commission shall consider appointing individuals who (as of the date of the enactment of this section) were serving on the Prospective Payment Assessment Commission or the Physician Payment Review Commission.

"(4) TERMS.—

"(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

"(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

"(5) COMPENSATION.—While serving on the business of the Commission (including traveltime), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

"(6) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment.

"(7) MEETINGS.—The Commission shall meet at the call of the Chairman.

"(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General deems necessary to assure the efficient administration of the Commission, the Commission may—

"(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

"(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

"(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

"(4) make advance, progress, and other payments which relate to the work of the Commission;

"(5) provide transportation and subsistence for persons serving without compensation; and

"(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

"(e) POWERS.—

"(1) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Chairman, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

"(2) DATA COLLECTION.—In order to carry out its functions, the Commission shall collect and assess information—

"(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

"(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate, and

"(C) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

"(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and data of the Commission, immediately upon request.

"(4) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the General Accounting Office.

"(f) AUTHORIZATION OF APPROPRIATIONS.—

"(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

"(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. 60 percent of such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and 40 percent of such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund.".

(b) ABOLITION OF PROPAC AND PPRC.—

(1) PROPAC.—

(A) IN GENERAL.—Section 1886(e) (42 U.S.C. 1395ww(e)) is amended—

(i) by striking paragraphs (2) and (6); and

(ii) in paragraph (3), by striking "(A) The Commission" and all that follows through "(B)".

(B) CONFORMING AMENDMENT.—Section 1862 (42 U.S.C. 1395y) is amended by striking "Prospective Payment Assessment Commission" each place it appears in subsection (a)(1)(D) and subsection (i) and inserting "Medicare Payment Review Commission".

(2) PPRC.—

(A) IN GENERAL.—Title XVIII is amended by striking section 1845 (42 U.S.C. 1395w–1).

(B) CONFORMING AMENDMENTS.—

(i) Section 1834(b)(2) (42 U.S.C. 1395m(b)(2)) is amended by striking "Physician Payment Review Commission" and inserting "Medicare Payment Review Commission".

(ii) Section 1842(b) (42 U.S.C. 1395u(b)) is amended by striking "Physician Payment Review Commission" each place it appears in paragraphs (9)(D) and (14)(C)(i) and inserting "Medicare Payment Review Commission".

(iii) Section 1848 (42 U.S.C. 1395w–4) is amended by striking "Physician Payment Review Commission" and inserting "Medicare Payment Review Commission" each place it appears in paragraphs (2)(A)(ii), (2)(B)(iii), and (5) of subsection (c), subsection (d)(2)(F), paragraphs (1)(B), (3), and (4)(A) of subsection (f), and paragraphs (6)(C) and (7)(C) of subsection (g).

(c) EFFECTIVE DATE; TRANSITION.—

(1) IN GENERAL.—The Comptroller General shall first provide for appointment of members to the Medicare Payment Review Commission (in this subsection referred to as "MPRC") by not later than March 31, 1996.

(2) TRANSITION.—Effective on a date (not later than 30 days after the date a majority of members of the MPRC have first been appointed, the Prospective Payment Assessment Commission (in this subsection referred to as "ProPAC") and the Physician Payment Review Commission (in this subsection referred to as "PPRC"), and amendments made by subsection (b), are terminated. The Comptroller General, to the maximum extent feasible, shall provide for the transfer to the MPRC of assets and staff of ProPAC and PPRC, without any loss of benefits or seniority by virtue of such transfers. Fund balances available to the ProPAC or PPRC for any period shall be available to the MPRC for such period for like purposes.

(3) CONTINUING RESPONSIBILITY FOR REPORTS.—The MPRC shall be responsible for the preparation and submission of reports required by law to be submitted (and which have not been submitted by the date of establishment of the MPRC) by the ProPAC and PPRC, and, for this purpose, any reference in law to either such Commission is deemed, after the appointment of the MPRC, to refer to the MPRC.

SEC. 15032. COMMISSION ON THE EFFECT OF THE BABY BOOM GENERATION ON THE MEDICARE PROGRAM.

(a) ESTABLISHMENT.—There is established a commission to be known as the Commission on the Effect of the Baby Boom Generation on the Medicare Program (in this section referred to as the "Commission").

(b) DUTIES.—

(1) IN GENERAL.—The Commission shall—

(A) examine the financial impact on the medicare program of the significant increase in the number of medicare eligible individuals which will occur beginning approximately during 2010 and lasting for approximately 25 years, and

(B) make specific recommendations to the Congress respecting a comprehensive approach to preserve the medicare program for the period during which such individuals are eligible for medicare.

(2) CONSIDERATIONS IN MAKING RECOMMENDATIONS.—In making its recommendations, the Commission shall consider the following:

(A) The amount and sources of Federal funds to finance the medicare program, including the potential use of innovative financing methods.

(B) The most efficient and effective manner of administering the program, including the appropriateness of continuing the application of the failsafe budget mechanism under section 1895 of the Social Security Act for fiscal years after fiscal year 2002 and the appropriate long-term growth rates for contributions electing coverage under MedicarePlus under part C of title XVIII of such Act.

(C) Methods used by other nations to respond to comparable demographic patterns in eligibility for health care benefits for elderly and disabled individuals.

(D) Modifying age-based eligibility to correspond to changes in age-based eligibility under the OASDI program.

(E) Trends in employment-related health care for retirees, including the use of medical savings accounts and similar financing devices.

(c) MEMBERSHIP.—

(1) APPOINTMENT.—The Commission shall be composed of 15 members appointed as follows:

(A) The President shall appoint 3 members.

(B) The Majority Leader of the Senate shall appoint, after consultation with the minority leader of the Senate, 6 members, of whom not more than 4 may be of the same political party.

(C) The Speaker of the House of Representatives shall appoint, after consultation with the minority leader of the House of Representatives, 6 members, of whom not more than 4 may be of the same political party.

(2) CHAIRMAN AND VICE CHAIRMAN.—The Commission shall elect a Chairman and Vice Chairman from among its members.

(3) VACANCIES.—Any vacancy in the membership of the Commission shall be filled in the manner in which the original appointment was made and shall not affect the power of the remaining members to execute the duties of the Commission.

(4) QUORUM.—A quorum shall consist of 8 members of the Commission, except that 4 members may conduct a hearing under subsection (e).

(5) MEETINGS.—The Commission shall meet at the call of its Chairman or a majority of its members.

(6) COMPENSATION AND REIMBURSEMENT OF EXPENSES.—Members of the Commission are not entitled to receive compensation for service on the Commission. Members may be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Commission.

(d) STAFF AND CONSULTANTS.—

(1) STAFF.—The Commission may appoint and determine the compensation of such staff as may be necessary to carry out the duties of the Commission. Such appointments and compensation may be made without regard to the provisions of title 5, United States Code, that govern appointments in the competitive services, and the provisions of chapter 51 and subchapter III of chapter 53 of such title that relate to classifications and the General Schedule pay rates.

(2) CONSULTANTS.—The Commission may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code, as the Commission determines to be necessary to carry out the duties of the Commission.

(e) POWERS.—

(1) HEARINGS AND OTHER ACTIVITIES.—For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties.

(2) STUDIES BY GAO.—Upon the request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

(3) COST ESTIMATES BY CONGRESSIONAL BUDGET OFFICE.—

(A) Upon the request of the Commission, the Director of the Congressional Budget Office shall provide to the Commission such cost estimates as the Commission determines to be necessary to carry out its duties.

(B) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

(4) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

(5) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties.

(6) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(7) OBTAINING INFORMATION.—The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 5, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

(8) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

(9) ACCEPTANCE OF DONATIONS.—The Commission may accept, use, and dispose of gifts or donations of services or property.

(10) PRINTING.—For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of the Congress.

(f) REPORT.—Not later than May 1, 1997, the Commission shall submit to Congress a report containing its findings and recommendations regarding how to protect and preserve the medicare program in a financially solvent manner until 2030 (or, if later, throughout the period of projected solvency of the Federal Old-Age and Survivors Insurance Trust Fund). The report shall include detailed recommendations for appropriate legislative initiatives respecting how to accomplish this objective.

(g) TERMINATION.—The Commission shall terminate 60 days after the date of submission of the report required in subsection (f).

(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $1,500,000 to carry out this section. Amounts appropriated to carry out this section shall remain available until expended.

SEC. 15033. CHANGE IN APPOINTMENT OF ADMINISTRATOR OF HCFA.

(a) IN GENERAL.—Section 1117 (42 U.S.C. 1317) is amended by striking "President by and with the advice and consent of the Senate" and inserting "Secretary of Health and Human Services".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act and shall apply to Administrators appointed on or after the date of the enactment of this Act.

PART 5—TREATMENT OF HOSPITALS WHICH PARTICIPATE IN PROVIDER-SPONSORED ORGANIZATIONS

SEC. 15041. TREATMENT OF HOSPITALS WHICH PARTICIPATE IN PROVIDER-SPONSORED ORGANIZATIONS.

(a) IN GENERAL.—Section 501 of the Internal Revenue Code of 1986 (relating to exemption from tax on corporations, certain trusts, etc.) is amended by redesignat-

ing subsection (n) as subsection (o) and by inserting after subsection (m) the following new subsection:

"(n) TREATMENT OF HOSPITALS PARTICIPATING IN PROVIDER-SPONSORED ORGANIZATIONS.—An organization shall not fail to be treated as organized and operated exclusively for a charitable purpose for purposes of subsection (c)(3) solely because a hospital which is owned and operated by such organization participates in a provider-sponsored organization (as defined in section 1854(a)(1) of the Social Security Act), whether or not the provider-sponsored organization is exempt from tax. For purposes of subsection (c)(3), any person with a material financial interest in such a provider-sponsored organization shall be treated as a private shareholder or individual with respect to the hospital."

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

Subtitle B—Preventing Fraud and Abuse

SEC. 15101. INCREASING AWARENESS OF FRAUD AND ABUSE.

(a) BENEFICIARY OUTREACH EFFORTS.—The Secretary of Health and Human Services (acting through the Administrator of the Health Care Financing Administration and the Inspector General of the Department of Health and Human Services) shall make ongoing efforts (through public service announcements, publications, and other appropriate methods) to alert individuals entitled to benefits under the medicare program of the existence of fraud and abuse committed against the program and the costs to the program of such fraud and abuse, and of the existence of the toll-free telephone line operated by the Secretary to receive information on fraud and abuse committed against the program.

(b) CLARIFICATION OF REQUIREMENT TO PROVIDE EXPLANATION OF MEDICARE BENEFITS.—The Secretary shall provide an explanation of benefits under the medicare program with respect to each item or service for which payment may be made under the program which is furnished to an individual, without regard to whether or not a deductible or coinsurance may be imposed against the individual with respect to the item or service.

(c) PROVIDER OUTREACH EFFORTS; PUBLICATION OF FRAUD ALERTS.—

(1) SPECIAL FRAUD ALERTS.—

(A) IN GENERAL.—

(i) REQUEST FOR SPECIAL FRAUD ALERTS.—Any person may present, at any time, a request to the Secretary to issue and publish a special fraud alert.

(ii) SPECIAL FRAUD ALERT DEFINED.—In this section, a "special fraud alert" is a notice which informs the public of practices which the Secretary considers to be suspect or of particular concern under the medicare program or a State health care program (as defined in section 1128(h) of the Social Security Act).

(B) ISSUANCE AND PUBLICATION OF SPECIAL FRAUD ALERTS.—

(i) INVESTIGATION.—Upon receipt of a request for a special fraud alert under subparagraph (A), the Secretary shall investigate the subject matter of the request to determine whether a special fraud alert should be issued. If appropriate, the Secretary (in consultation with the Attorney General) shall issue a special fraud alert in response to the request. All special fraud alerts issued pursuant to this subparagraph shall be published in the Federal Register.

(ii) CRITERIA FOR ISSUANCE.—In determining whether to issue a special fraud alert upon a request under subparagraph (A), the Secretary may consider—

(I) whether and to what extent the practices that would be identified in the special fraud alert may result in any of the consequences described in 15214(b); and

(II) the extent and frequency of the conduct that would be identified in the special fraud alert.

(2) PUBLICATION OF ALL HCFA FRAUD ALERTS IN FEDERAL REGISTER.—Each notice issued by the Health Care Financing Administration which informs the public of practices which the Secretary considers to be suspect or of particular concern under the medicare program or a State health care program (as defined in section 1128(h) of the Social Security Act) shall be published in the Federal Register, without regard to whether or not the notice is issued by a regional office of the Health Care Financing Administration.

SEC. 15102. BENEFICIARY INCENTIVE PROGRAMS.

(a) PROGRAM TO COLLECT INFORMATION ON FRAUD AND ABUSE.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary of Health and Human Services (hereinafter in this subtitle referred to as the "Secretary") shall establish a program under which the Secretary shall encourage individuals to report to the Secretary information on individuals and entities who are engaging or who have engaged in acts or omissions which constitute grounds for the imposition of a sanction under section 1128, section 1128A, or section 1128B of the Social Security Act, or who have otherwise engaged in fraud and abuse against the medicare program for which there is a sanction provided under law. The program shall discourage provision of, and not consider, information which is frivolous or otherwise not relevant or material to the imposition of such a sanction.

(2) PAYMENT OF PORTION OF AMOUNTS COLLECTED.—If an individual reports information to the Secretary under the program established under paragraph (1) which serves as the basis for the collection by the Secretary or the Attorney General of any amount of at least $100 (other than any amount paid as a penalty under section 1128B of the Social Security Act), the Secretary may pay a portion of the amount collected to the individual (under procedures similar to those applicable under section 7623 of the Internal Revenue Code of 1986 to payments to individuals providing information on violations of such Code).

(b) PROGRAM TO COLLECT INFORMATION ON PROGRAM EFFICIENCY.—

(1) ESTABLISHMENT OF PROGRAM.—Not later than 3 months after the date of the enactment of this Act, the Secretary shall establish a program under which the Secretary shall encourage individuals to submit to the Secretary suggestions on methods to improve the efficiency of the medicare program.

(2) PAYMENT OF PORTION OF PROGRAM SAVINGS.—If an individual submits a suggestion to the Secretary under the program established under paragraph (1) which is adopted by the Secretary and which results in savings to the program, the Secretary may make a payment to the individual of such amount as the Secretary considers appropriate.

SEC. 15103. INTERMEDIATE SANCTIONS FOR MEDICARE HEALTH MAINTENANCE ORGANIZATIONS.

(a) APPLICATION OF INTERMEDIATE SANCTIONS FOR ANY PROGRAM VIOLATIONS.—

(1) IN GENERAL.—Section 1876(i)(1) (42 U.S.C. 1395mm(i)(1)) is amended by striking "the Secretary may terminate" and all that follows and inserting the following: "in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—

"(A) has failed substantially to carry out the contract;

"(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section;

"(C) is operating in a manner that is not in the best interests of the individuals covered under the contract; or

"(D) no longer substantially meets the applicable conditions of subsections (b), (c), and (e).".

(2) OTHER INTERMEDIATE SANCTIONS FOR MISCELLANEOUS PROGRAM VIOLATIONS.—Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is amended by adding at the end the following new subparagraph:

"(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1) the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

"(i) civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract;

"(ii) civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists; and

"(iii) suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.".

(3) PROCEDURES FOR IMPOSING SANCTIONS.—Section 1876(i) (42 U.S.C. 1395mm(i)) is amended by adding at the end the following new paragraph:

"(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

"(A) the Secretary provides the organization with the opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1);

"(B) the Secretary shall impose more severe sanctions on organizations that have a history of deficiencies or that have not taken steps to correct deficiencies the Secretary has brought to their attention;

"(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

"(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.".

(4) CONFORMING AMENDMENTS.—(A) Section 1876(i)(6)(B) (42 U.S.C. 1395mm(i)(6)(B)) is amended by striking the second sentence.

(B) Section 1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is further amended by adding at the end the following new subparagraph:

"(D) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (A) or (B) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contract years beginning on or after January 1, 1996.

SEC. 15104. VOLUNTARY DISCLOSURE PROGRAM.

Title XI (42 U.S.C. 1301 et seq.) is amended by inserting after section 1128B the following new section:

"VOLUNTARY DISCLOSURE OF ACTS OR OMISSIONS

"SEC. 1129. (a) ESTABLISHMENT OF VOLUNTARY DISCLOSURE PROGRAM.—Not later than 3 months after the date of the enactment of this section, the Secretary shall establish a program to encourage individuals and entities to voluntarily disclose to the Secretary information on acts or omissions of the individual or entity which constitute grounds for the imposition of a sanction described in section 1128, 1128A, or 1128B.

"(b) EFFECT OF VOLUNTARY DISCLOSURE.—If an individual or entity voluntarily discloses information with respect to an act or omission to the Secretary under subsection (a), the following rules shall apply:

"(1) The Secretary may waive, reduce, or otherwise mitigate any sanction which would otherwise be applicable to the individual or entity under section 1128, 1128A, or 1128B as a result of the act or omission involved.

"(2) No qui tam action may be brought pursuant to chapter 37 of title 31, United States Code, against the individual or entity with respect to the act or omission involved.".

SEC. 15105. REVISIONS TO CURRENT SANCTIONS.

(a) DOUBLING THE AMOUNT OF CIVIL MONETARY PENALTIES.—The maximum amount of civil monetary penalties specified in section 1128A of the Social Security Act or under title XVIII of such Act (as in effect on the day before the date of the enactment of this Act) shall, effective for violations occurring after the date of the enactment of this Act, be double the amount otherwise provided as of such date.

(b) ESTABLISHMENT OF MINIMUM PERIOD OF EXCLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUBJECT TO PERMISSIVE EXCLUSION.—Section 1128(c)(3) (42 U.S.C. 1320a–7(c)(3)) is amended by adding at the end the following new subparagraphs:

"(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

"(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

"(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to acts or omissions occurring on or after January 1, 1996.

SEC. 15106. DIRECT SPENDING FOR ANTI-FRAUD ACTIVITIES UNDER MEDICARE.

(a) ESTABLISHMENT OF MEDICARE INTEGRITY PROGRAM.—Title XVIII is amended by adding at the end the following new section:

"MEDICARE INTEGRITY PROGRAM

"SEC. 1893. (a) ESTABLISHMENT OF PROGRAM.—There is hereby established the Medicare Integrity Program (hereafter in this section referred to as the 'Program') under which the Secretary shall promote the integrity of the medicare program by entering into contracts in accordance with this section with eligible private entities to carry out the activities described in subsection (b).

"(b) ACTIVITIES DESCRIBED.—The activities described in this subsection are as follows:

"(1) Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review (employing similar standards, processes, and technologies used by private health plans, including equipment and software technologies which surpass the capability of the equipment and technologies used in the review of claims under this title as of the date of the enactment of this section).

"(2) Audit of cost reports.

"(3) Determinations as to whether payment should not be, or should not have been, made under this title by reason of section 1862(b), and recovery of payments that should not have been made.

"(4) Education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.

"(c) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract under the Program to carry out any of the activities described in subsection (b) if—

"(1) the entity has demonstrated capability to carry out such activities;

"(2) in carrying out such activities, the entity agrees to cooperate with the Inspector General of the Department of Health and Human Services, the Attorney General of the United States, and other law enforcement agencies, as appropriate, in the investigation and deterrence of fraud and abuse in relation to this title and in other cases arising out of such activities;

"(3) the entity's financial holdings, interests, or relationships will not interfere with its ability to perform the functions to be required by the contract in an effective and impartial manner; and

"(4) the entity meets such other requirements as the Secretary may impose.

"(d) PROCESS FOR ENTERING INTO CONTRACTS.—The Secretary shall enter into contracts under the Program in accordance with such procedures as the Secretary may by regulation establish, except that such procedures shall include the following:

"(1) The Secretary shall determine the appropriate number of separate contracts which are necessary to carry out the Program and the appropriate times at which the Secretary shall enter into such contracts.

"(2) The provisions of section 1153(e)(1) shall apply to contracts and contracting authority under this section, except that competitive procedures must be used when entering into new contracts under this section, or at any other time considered appropriate by the Secretary.

"(3) A contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

"(e) LIMITATION ON CONTRACTOR LIABILITY.—The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1157.

"(f) TRANSFER OF AMOUNTS TO MEDICARE ANTI-FRAUD AND ABUSE TRUST FUND.—For each fiscal year, the Secretary shall transfer from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to the Medicare Anti-Fraud and Abuse Trust Fund under subsection (g) such amounts as are necessary to carry out the activities described in subsection (b). Such transfer shall be in an allocation as reasonably reflects the proportion of such expenditures associated with part A and part B.

"(g) MEDICARE ANTI-FRAUD AND ABUSE TRUST FUND.—

"(1) ESTABLISHMENT.—

"(A) IN GENERAL.—There is hereby established in the Treasury of the United States the Anti-Fraud and Abuse Trust Fund (hereafter in this subsection referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in subparagraph (B) and such amounts as may be deposited in the Trust Fund as provided in subsection (f), paragraph (3), and title XI.

"(B) AUTHORIZATION TO ACCEPT GIFTS AND BEQUESTS.—The Trust Fund is authorized to accept on behalf of the United States money gifts and bequests made unconditionally to the Trust Fund, for the benefit of the Trust Fund or any activity financed through the Trust Fund.

"(2) INVESTMENT.—

"(A) IN GENERAL.—The Secretary of the Treasury shall invest such amounts of the Fund as such Secretary determines are not required to meet current withdrawals from the Fund in government account serial securities.

"(B) USE OF INCOME.—Any interest derived from investments under subparagraph (A) shall be credited to the Fund.

"(3) AMOUNTS DEPOSITED INTO TRUST FUND.—In addition to amounts transferred under subsection (f), there shall be deposited in the Trust Fund—

"(A) that portion of amounts recovered in relation to section 1128A arising out of a claim under title XVIII as remains after application of subsection (f)(2) (relating to repayment of the Federal Hospital Insurance Trust Fund or the Federal Supplementary Medical Insurance Trust Fund) of that section, as may be applicable,

"(B) fines imposed under section 1128B arising out of a claim under this title, and

"(C) penalties and damages imposed (other than funds awarded to a relator or for restitution) under sections 3729 through 3732 of title 31, United States Code (pertaining to false claims) in cases involving claims relating to programs under title XVIII, XIX, or XXI.

"(4) DIRECT APPROPRIATION OF FUNDS TO CARRY OUT PROGRAM.—

"(A) IN GENERAL.—There are appropriated from the Trust Fund for each fiscal year such amounts as are necessary to carry out the Medicare Integrity Program under this section, subject to subparagraph (B).

"(B) AMOUNTS SPECIFIED.—The amount appropriated under subparagraph (A) for a fiscal year is as follows:

"(i) For fiscal year 1996, such amount shall be not less than $430,000,000 and not more than $440,000,000.

"(ii) For fiscal year 1997, such amount shall be not less than $490,000,000 and not more than $500,000,000.

"(iii) For fiscal year 1998, such amount shall be not less than $550,000,000 and not more than $560,000,000.

"(iv) For fiscal year 1999, such amount shall be not less than $620,000,000 and not more than $630,000,000.

"(v) For fiscal year 2000, such amount shall be not less than $670,000,000 and not more than $680,000,000.

"(vi) For fiscal year 2001, such amount shall be not less than $690,000,000 and not more than $700,000,000.

"(vii) For fiscal year 2002, such amount shall be not less than $710,000,000 and not more than $720,000,000.

"(5) ANNUAL REPORT.—The Secretary shall submit an annual report to Congress on the amount of revenue which is generated and disbursed by the Trust Fund in each fiscal year.".

(b) ELIMINATION OF FI AND CARRIER RESPONSIBILITY FOR CARRYING OUT ACTIVITIES SUBJECT TO PROGRAM.—

(1) RESPONSIBILITIES OF FISCAL INTERMEDIARIES UNDER PART A.—Section 1816 (42 U.S.C. 1395h) is amended by adding at the end the following new subsection:

"(l) No agency or organization may carry out (or receive payment for carrying out) any activity pursuant to an agreement under this section to the extent that the activity is carried out pursuant to a contract under the Medicare Integrity Program under section 1893.".

(2) RESPONSIBILITIES OF CARRIERS UNDER PART B.—Section 1842(c) (42 U.S.C. 1395u(c)) is amended by adding at the end the following new paragraph:

"(6) No carrier may carry out (or receive payment for carrying out) any activity pursuant to a contract under this subsection to the extent that the activity is car-

ried out pursuant to a contract under the Medicare Integrity Program under section 1893.".

(c) CONFORMING AMENDMENT.—Section 1128A(f)(3) (42 U.S.C. 1320a–7a(f)(3)) is amended by striking "as miscellaneous receipts of the Treasury of the United States" and inserting "in the Anti-Fraud and Abuse Trust Fund established under section 1893(g)".

(d) DIRECT SPENDING FOR MEDICARE-RELATED ACTIVITIES OF INSPECTOR GENERAL.—Section 1893, as added by subsection (a), is amended by adding at the end the following new subsection:

"(h) DIRECT SPENDING FOR MEDICARE-RELATED ACTIVITIES OF INSPECTOR GENERAL.—

"(1) IN GENERAL.—There are appropriated from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to the Inspector General of the Department of Health and Human Services for each fiscal year such amounts as are necessary to enable the Inspector General to carry out activities relating to the medicare program (as described in paragraph (2)), subject to paragraph (3).

"(2) ACTIVITIES DESCRIBED.—The activities described in this paragraph are as follows:

"(A) Prosecuting medicare-related matters through criminal, civil, and administrative proceedings.

"(B) Conducting investigations relating to the medicare program.

"(C) Performing financial and performance audits of programs and operations relating to the medicare program.

"(D) Performing inspections and other evaluations relating to the medicare program.

"(E) Conducting provider and consumer education activities regarding the requirements of this title.

"(3) AMOUNTS SPECIFIED.—The amount appropriated under paragraph (1) for a fiscal year is as follows:

"(A) For fiscal year 1996, such amount shall be $130,000,000.

"(B) For fiscal year 1997, such amount shall be $181,000,000.

"(C) For fiscal year 1998, such amount shall be $204,000,000.

"(D) For each subsequent fiscal year, the amount appropriated for the previous fiscal year, increased by the percentage increase in aggregate expenditures under this title for the fiscal year involved over the previous fiscal year.

"(4) ALLOCATION OF PAYMENTS AMONG TRUST FUNDS.—The appropriations made under paragraph (1) shall be in an allocation as reasonably reflects the proportion of such expenditures associated with part A and part B.".

SEC. 15107. PERMITTING CARRIERS TO CARRY OUT PRIOR AUTHORIZATION FOR CERTAIN ITEMS OF DURABLE MEDICAL EQUIPMENT.

(a) IN GENERAL.—Section 1834(a)(15) (42 U.S.C. 1395m(a)(15)), as amended by section 135(b) of the Social Security Act Amendments of 1994, is amended by adding at the end the following new subparagraphs:

"(D) APPLICATION BY CARRIERS.—A carrier may develop (and periodically update) a list of items under subparagraph (A) and a list of suppliers under subparagraph (B) in the same manner as the Secretary may develop (and periodically update) such lists.

"(E) WAIVER OF PUBLICATION REQUIREMENT.—A carrier may make an advance determination under subparagraph (C) with respect to an item or supplier on a list developed by the Secretary or the carrier without regard to whether or not the Secretary has promulgated a regulation with respect to the list, except that the carrier may not make such an advance determination with respect to an item or supplier on a list until the expiration of the 30-day period beginning on the date the Secretary or the carrier places the item or supplier on the list.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the enactment of the Social Security Act Amendments of 1994.

SEC. 15108. ESTABLISHMENT OF HEALTH CARE ANTI-FRAUD TASK FORCE.

(a) IN GENERAL.—Not later than 120 days after the date of the enactment of this Act, the Attorney General shall establish (in consultation with the Advisory Group described in subsection (c)) within the Department of Justice a task force (similar to the Organized Crime Drug Enforcement Task Force) to be known as the "Health Care Anti-Fraud Task Force" (hereafter in this section referred to as the "Task Force") to prosecute health care fraud offenses. Nothing in this section may be construed as affecting the powers of the Attorney General or any other individual.

(b) OPERATIONS OF TASK FORCE.—The Attorney General shall establish and operate the Task Force in a manner such that—

(1) at least one fully staffed operational segment of the Task Force (including at least one Federal representative engaged in Task Force activities on a full-time basis) shall operate in each judicial district of the United States; and

(2) the Task Force maintains separate accounting of its finances, personnel, case load, and resolution of claims and actions.

(c) ADVISORY GROUP DESCRIBED.—The Advisory Group described in this subsection is a group consisting of the following individuals (or their designees):

(1) The Secretary of Health and Human Services.

(2) The Secretary of the Treasury.

(3) The Secretary of Veterans Affairs.

(4) The Chair of the Board of Governors of the United States Postal Service.

SEC. 15109. STUDY OF ADEQUACY OF PRIVATE QUALITY ASSURANCE PROGRAMS.

(a) IN GENERAL.—The Administrator of the Health Care Financing Administration (acting through the Director of the Office of Research and Development) shall enter into an agreement with a private entity to conduct a study during the 5-year period beginning on the date of the enactment of this Act of the adequacy of the quality assurance programs and consumer protections used by the MedicarePlus program under part C of title XVIII of the Social Security Act (as inserted by section 15002(a)), and shall include in the study an analysis of the effectiveness of such programs in protecting plan enrollees against the risk of insufficient provision of benefits which may result from utilization controls.

(b) REPORT.—Not later than 6 months after the conclusion of the 5-year period described in subsection (a), the Administrator shall submit a report to Congress on the study conducted under subsection (a).

SEC. 15110. PENALTY FOR FALSE CERTIFICATION FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1128A(b) (42 U.S.C. 1320a–7a(b)) is amended by adding at the end the following new paragraph:

"(3)(A) Any physician who executes a document described in subparagraph (B) with respect to an individual knowing that all of the requirements referred to in such subparagraph are not met with respect to the individual shall be subject to a civil monetary penalty of not more than the greater of—

"(i) $5,000, or

"(ii) three times the amount of the payments under title XVIII for home health services which are made pursuant to such certification.

"(B) A document described in this subparagraph is any document that certifies, for purposes of title XVIII, that an individual meets the requirements of section 1814(a)(2)(C) or 1835(a)(2)(A) in the case of home health services furnished to the individual.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to certifications made on or after the date of the enactment of this Act.

Subtitle C—Regulatory Relief

PART 1—PHYSICIAN OWNERSHIP REFERRAL REFORM

SEC. 15201. REPEAL OF PROHIBITIONS BASED ON COMPENSATION ARRANGEMENTS.

(a) IN GENERAL.—Section 1877(a)(2) (42 U.S.C. 1395nn(a)(2)) is amended by striking "is—" and all that follows through "equity," and inserting the following: "is (except as provided in subsection (c)) an ownership or investment interest in the entity through equity,".

(b) CONFORMING AMENDMENTS.—Section 1877 (42 U.S.C. 1395nn) is amended as follows:

(1) In subsection (b)—

(A) in the heading, by striking "TO BOTH OWNERSHIP AND COMPENSATION ARRANGEMENT PROHIBITIONS" and inserting "WHERE FINANCIAL RELATIONSHIP EXISTS"; and

(B) by redesignating paragraph (4) as paragraph (7).

(2) In subsection (c)—

(A) by amending the heading to read as follows: "EXCEPTION FOR OWNERSHIP OR INVESTMENT INTEREST IN PUBLICLY TRADED SECURITIES AND MUTUAL FUNDS"; and

(B) in the matter preceding paragraph (1), by striking "subsection (a)(2)(A)" and inserting "subsection (a)(2)".

(3) In subsection (d)—

(A) by striking the matter preceding paragraph (1);

(B) in paragraph (3), by striking "paragraph (1)" and inserting "paragraph (4)"; and

(C) by redesignating paragraphs (1), (2), and (3) as paragraphs (4), (5), and (6), and by transferring and inserting such paragraphs after paragraph (3) of subsection (b).

(4) By striking subsection (e).

(5) In subsection (f)(2)—

(A) in the matter preceding paragraph (1), by striking "ownership, investment, and compensation" and inserting "ownership and investment";

(B) in paragraph (2), by striking "subsection (a)(2)(A)" and all that follows through "subsection (a)(2)(B)),'' and inserting "subsection (a)(2),"; and

(C) in paragraph (2), by striking "or who have such a compensation relationship with the entity".

(6) In subsection (h)—

(A) by striking paragraphs (1), (2), and (3);

(B) in paragraph (4)(A), by striking clauses (iv) and (vi);

(C) in paragraph (4)(B), by striking "RULES.—" and all that follows through "(ii) FACULTY" and inserting "RULES FOR FACULTY"; and

(D) by adding at the end of paragraph (4) the following new subparagraph:

"(C) MEMBER OF A GROUP.—A physician is a 'member' of a group if the physician is an owner or a bona fide employee, or both, of the group.".

SEC. 15202. REVISION OF DESIGNATED HEALTH SERVICES SUBJECT TO PROHIBITION.

(a) IN GENERAL.—Section 1877(h)(6) (42 U.S.C. 1395nn(h)(6)) is amended by striking subparagraphs (B) through (K) and inserting the following:

"(B) Parenteral and enteral nutrients, equipment, and supplies.

"(C) Magnetic resonance imaging and computerized tomography services.

"(D) Outpatient physical or occupational therapy services.".

(b) CONFORMING AMENDMENTS.—

(1) Section 1877(b)(2) (42 U.S.C. 1395nn(b)(2)) is amended in the matter preceding subparagraph (A) by striking "services" and all that follows through "supplies)—" and inserting "services—".

(2) Section 1877(h)(5)(C) (42 U.S.C. 1395nn(h)(5)(C)) is amended—

(A) by striking ", a request by a radiologist for diagnostic radiology services, and a request by a radiation oncologist for radiation therapy," and inserting "and a request by a radiologist for magnetic resonance imaging or for computerized tomography", and

(B) by striking "radiologist, or radiation oncologist" and inserting "or radiologist".

SEC. 15203. DELAY IN IMPLEMENTATION UNTIL PROMULGATION OF REGULATIONS.

(a) IN GENERAL.—Section 13562(b) of OBRA–1993 (42 U.S.C. 1395nn note) is amended—

(1) in paragraph (1), by striking "paragraph (2)" and inserting "paragraphs (2) and (3)"; and

(2) by adding at the end the following new paragraph:

"(3) PROMULGATION OF REGULATIONS.—Notwithstanding paragraphs (1) and (2), the amendments made by this section shall not apply to any referrals made before the effective date of final regulations promulgated by the Secretary of Health and Human Services to carry out such amendments.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect as if included in the enactment of OBRA–1993.

SEC. 15204. EXCEPTIONS TO PROHIBITION.

(a) REVISIONS TO EXCEPTION FOR IN-OFFICE ANCILLARY SERVICES.—

(1) REPEAL OF SITE-OF-SERVICE REQUIREMENT.—Section 1877 (42 U.S.C. 1395nn) is amended—

(A) by amending subparagraph (A) of subsection (b)(2) to read as follows:

"(A) that are furnished personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individuals who are under the general supervision of the physician or of another physician in the group practice, and", and

(B) by adding at the end of subsection (h) the following new paragraph:

"(7) GENERAL SUPERVISION.—An individual is considered to be under the 'general supervision' of a physician if the physician (or group practice of which the

physician is a member) is legally responsible for the services performed by the individual and for ensuring that the individual meets licensure and certification requirements, if any, applicable under other provisions of law, regardless of whether or not the physician is physically present when the individual furnishes an item or service.".

(2) CLARIFICATION OF TREATMENT OF PHYSICIAN OWNERS OF GROUP PRACTICE.—Section 1877(b)(2)(B) (42 U.S.C. 1395nn(b)(2)(B)) is amended by striking "physician or such group practice" and inserting "physician, such group practice, or the physician owners of such group practice".

(3) CONFORMING AMENDMENT.—Section 1877(b)(2) (42 U.S.C. 1395nn(b)(2)) is amended by amending the heading to read as follows: "ANCILLARY SERVICES FURNISHED PERSONALLY OR THROUGH GROUP PRACTICE.—".

(b) CLARIFICATION OF EXCEPTION FOR SERVICES FURNISHED IN A RURAL AREA.—Paragraph (5) of section 1877(b) (42 U.S.C. 1395nn(b)), as transferred by section 15201(b)(3)(C), is amended by striking "substantially all" and inserting "not less than 75 percent".

(c) REVISION OF EXCEPTION FOR CERTAIN MANAGED CARE ARRANGEMENTS.—Section 1877(b)(3) (42 U.S.C. 1395nn(b)(3)) is amended—

(1) in the heading by inserting "MANAGED CARE ARRANGEMENTS" after "PREPAID PLANS";

(2) in the matter preceding subparagraph (A), by striking "organization—" and inserting "organization, directly or through contractual arrangements with other entities, to individuals enrolled with the organization—";

(3) in subparagraph (A), by inserting "or part C" after "section 1876";

(4) by striking "or" at the end of subparagraph (C);

(5) by striking the period at the end of subparagraph (D) and inserting a comma; and

(6) by adding at the end the following new subparagraphs:

"(E) with a contract with a State to provide services under the State plan under title XIX (in accordance with section 1903(m)) or a State MediGrant plan under title XXI; or

"(F) which is a MedicarePlus organization under part C or which provides or arranges for the provision of health care items or services pursuant to a written agreement between the organization and an individual or entity if the written agreement places the individual or entity at substantial financial risk for the cost or utilization of the items or services which the individual or entity is obligated to provide, whether through a withhold, capitation, incentive pool, per diem payment, or any other similar risk arrangement which places the individual or entity at substantial financial risk.".

(d) NEW EXCEPTION FOR SHARED FACILITY SERVICES.—

(1) IN GENERAL.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15201(b)(3)(C), is amended—

(A) by redesignating paragraphs (4) through (7) as paragraphs (5) through (8); and

(B) by inserting after paragraph (3) the following new paragraph:

"(4) SHARED FACILITY SERVICES.—In the case of a designated health service consisting of a shared facility service of a shared facility—

"(A) that is furnished—

"(i) personally by the referring physician who is a shared facility physician or personally by an individual directly employed or under the general supervision of such a physician,

"(ii) by a shared facility in a building in which the referring physician furnishes substantially all of the services of the physician that are unrelated to the furnishing of shared facility services, and

"(iii) to a patient of a shared facility physician; and

"(B) that is billed by the referring physician or a group practice of which the physician is a member.".

(2) DEFINITIONS.—Section 1877(h) (42 U.S.C. 1395nn(h)), as amended by section 15201(b)(6), is amended by inserting before paragraph (4) the following new paragraph:

"(1) SHARED FACILITY RELATED DEFINITIONS.—

"(A) SHARED FACILITY SERVICE.—The term 'shared facility service' means, with respect to a shared facility, a designated health service furnished by the facility to patients of shared facility physicians.

"(B) SHARED FACILITY.—The term 'shared facility' means an entity that furnishes shared facility services under a shared facility arrangement.

"(C) SHARED FACILITY PHYSICIAN.—The term 'shared facility physician' means, with respect to a shared facility, a physician (or a group practice

of which the physician is a member) who has a financial relationship under a shared facility arrangement with the facility.

"(D) SHARED FACILITY ARRANGEMENT.—The term 'shared facility arrangement' means, with respect to the provision of shared facility services in a building, a financial arrangement—

"(i) which is only between physicians who are providing services (unrelated to shared facility services) in the same building,

"(ii) in which the overhead expenses of the facility are shared, in accordance with methods previously determined by the physicians in the arrangement, among the physicians in the arrangement, and

"(iii) which, in the case of a corporation, is wholly owned and controlled by shared facility physicians.".

(e) NEW EXCEPTION FOR SERVICES FURNISHED IN COMMUNITIES WITH NO ALTERNATIVE PROVIDERS.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15201(b)(3)(C) and subsection (d)(1), is amended—

(1) by redesignating paragraphs (5) through (8) as paragraphs (6) through (9); and

(2) by inserting after paragraph (4) the following new paragraph:

"(5) NO ALTERNATIVE PROVIDERS IN AREA.—In the case of a designated health service furnished in any area with respect to which the Secretary determines that individuals residing in the area do not have reasonable access to such a designated health service for which subsection (a)(1) does not apply.".

(f) NEW EXCEPTION FOR SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15201(b)(3)(C), subsection (d)(1), and subsection (e)(1), is amended—

(1) by redesignating paragraphs (6) through (9) as paragraphs (7) through (10); and

(2) by inserting after paragraph (5) the following new paragraph:

"(6) SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.—In the case of a designated health service furnished in an ambulatory surgical center described in section 1832(a)(2)(F)(i).".

(g) NEW EXCEPTION FOR SERVICES FURNISHED IN RENAL DIALYSIS FACILITIES.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15201(b)(3)(C), subsection (d)(1), subsection (e)(1), and subsection (f), is amended—

(1) by redesignating paragraphs (7) through (10) as paragraphs (8) through (11); and

(2) by inserting after paragraph (6) the following new paragraph:

"(7) SERVICES FURNISHED IN RENAL DIALYSIS FACILITIES.—In the case of a designated health service furnished in a renal dialysis facility under section 1881.".

(h) NEW EXCEPTION FOR SERVICES FURNISHED IN A HOSPICE.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15201(b)(3)(C), subsection (d)(1), subsection (e)(1), subsection (f), and subsection (g), is amended—

(1) by redesignating paragraphs (8) through (11) as paragraphs (9) through (12); and

(2) by inserting after paragraph (7) the following new paragraph:

"(8) SERVICES FURNISHED BY A HOSPICE PROGRAM.—In the case of a designated health service furnished by a hospice program under section 1861(dd)(2).".

(i) NEW EXCEPTION FOR SERVICES FURNISHED IN A COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY.—Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by section 15201(b)(3)(C), subsection (d)(1), subsection (e)(1), subsection (f), subsection (g), and subsection (h), is amended—

(1) by redesignating paragraphs (9) through (12) as paragraphs (10) through (13); and

(2) by inserting after paragraph (8) the following new paragraph:

"(9) SERVICES FURNISHED IN A COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY.—In the case of a designated health service furnished in a comprehensive outpatient rehabilitation facility (as defined in section 1861(cc)(2)).".

(i) DEFINITION OF REFERRAL.—Section 1877(h)(5)(A) (42 U.S.C. 1395nn(h)(5)(A)) is amended—

(1) by striking "an item or service" and inserting "a designated health service", and

(2) by striking "the item or service" and inserting "the designated health service".

SEC. 15205. REPEAL OF REPORTING REQUIREMENTS.

Section 1877 (42 U.S.C. 1395nn) is amended—

(1) by striking subsection (f); and

(2) by striking subsection (g)(5).

SEC. 15206. PREEMPTION OF STATE LAW.

Section 1877 (42 U.S.C. 1395nn) is amended by adding at the end the following new subsection:

"(i) PREEMPTION OF STATE LAW.—This section preempts State law to the extent State law is inconsistent with this section.".

SEC. 15207. EFFECTIVE DATE.

Except as provided in section 15203(b), the amendments made by this part shall apply to referrals made on or after August 14, 1995, regardless of whether or not regulations are promulgated to carry out such amendments.

PART 2—OTHER MEDICARE REGULATORY RELIEF

SEC. 15211. REPEAL OF MEDICARE AND MEDICAID COVERAGE DATA BANK.

(a) IN GENERAL.—Section 1144 (42 U.S.C. 1320b–14) is repealed.

(b) CONFORMING AMENDMENTS.—

(1) MEDICARE.—Section 1862(b)(5) (42 U.S.C. 1395y(b)(5)) is amended—

(A) in subparagraph (B), by striking "under—" and all that follows through the end and inserting "subparagraph (A) for purposes of carrying out this subsection.", and

(B) in subparagraph (C)(i), by striking "subparagraph (B)(i)" and inserting "subparagraph (B)".

(2) MEDICAID.—Section 1902(a)(25)(A)(i) (42 U.S.C. 1396a(a)(25)(A)(i)) is amended by striking "including the use of" and all that follows through "any additional measures".

(3) ERISA.—Section 101(f) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1021(f)) is repealed.

(4) DATA MATCHES.—Section 552a(a)(8)(B) of title 5, United States Code, is amended—

(A) by adding "; or" at the end of clause (v),

(B) by striking "or" at the end of clause (vi), and

(C) by striking clause (vii).

SEC. 15212. CLARIFICATION OF LEVEL OF INTENT REQUIRED FOR IMPOSITION OF SANCTIONS.

(a) CLARIFICATION OF LEVEL OF KNOWLEDGE REQUIRED FOR IMPOSITION OF CIVIL MONETARY PENALTIES.—

(1) IN GENERAL.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)) is amended—

(1) in paragraphs (1) and (2), by inserting "knowingly" before "presents" each place it appears; and

(2) in paragraph (3), by striking "gives" and inserting "knowingly gives or causes to be given".

(2) DEFINITION OF STANDARD.—Section 1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by adding at the end the following new paragraph:

"(6) The term 'should know' means that a person, with respect to information—

"(A) acts in deliberate ignorance of the truth or falsity of the information; or

"(B) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.".

(b) CLARIFICATION OF EFFECT AND APPLICATION OF SAFE HARBOR EXCEPTIONS.—For purposes of section 1128B(b)(3) of the Social Security Act, the specification of any payment practice in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid Program and Patient Protection Act of 1987 is—

(1) solely for the purpose of adding additional exceptions to the types of conduct which are not subject to an anti-kickback penalty under such section and not for the purpose of limiting the scope of such exceptions; and

(2) for the purpose of prescribing criteria for qualifying for such an exception notwithstanding the intent of the party involved.

(c) LIMITING IMPOSITION OF ANTI-KICKBACK PENALTIES TO ACTIONS WITH SIGNIFICANT PURPOSE TO INDUCE REFERRALS.—Section 1128B(b)(2) (42 U.S.C. 1320a–7b(b)(2)) is amended in the matter preceding subparagraph (A) by striking "to induce" and inserting "for the significant purpose of inducing".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to acts or omissions occurring on or after January 1, 1996.

SEC. 15213. ADDITIONAL EXCEPTION TO ANTI-KICKBACK PENALTIES FOR MANAGED CARE ARRANGEMENTS.

(a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

(1) by striking "and" at the end of subparagraph (D);

(2) by striking the period at the end of subparagraph (E) and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(F) any remuneration between an organization and an individual or entity providing services pursuant to a written agreement between the organization and the individual or entity if the organization is a MedicarePlus organization under part C of title XVIII or if the written agreement places the individual or entity at substantial financial risk for the cost or utilization of the items or services which the individual or entity is obligated to provide, whether through a withhold, capitation, incentive pool, per diem payment, or any other similar risk arrangement which places the individual or entity at substantial financial risk.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to acts or omissions occurring on or after January 1, 1996.

SEC. 15214. SOLICITATION AND PUBLICATION OF MODIFICATIONS TO EXISTING SAFE HARBORS AND NEW SAFE HARBORS.

(a) IN GENERAL.—

(1) SOLICITATIONS.—Not later than January 1, 1996, and not less than annually thereafter, the Secretary of Health and Human Services shall publish a notice in the Federal Register soliciting proposals, which will be accepted during a 60-day period, for—

(A) modifications to existing safe harbors issued pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987;

(B) additional safe harbors specifying payment practices that shall not be treated as a criminal offense under section 1128B(b) of the Social Security Act and shall not serve as the basis for an exclusion under section 1128(b)(7) of such Act; and

(C) special fraud alerts to be issued pursuant to section 15101(c).

(2) PUBLICATION OF PROPOSED MODIFICATIONS AND PROPOSED ADDITIONAL SAFE HARBORS.—Not later than 120 days after receiving the proposals described in subparagraphs (A) and (B) of paragraph (1), the Secretary, after considering such proposals in consultation with the Attorney General, shall publish in the Federal Register proposed modifications to existing safe harbors and proposed additional safe harbors, if appropriate, with a 60-day comment period. After considering any public comments received during this period, the Secretary shall issue final rules modifying the existing safe harbors and establishing new safe harbors, as appropriate.

(3) REPORT.—The Inspector General shall, in an annual report to Congress or as part of the year-end semiannual report required by section 5 of the Inspector General Act of 1978, describe the proposals received under subparagraphs (A) and (B) of paragraph (1) and explain which proposals were included in the publication described in paragraph (2), which proposals were not included in that publication, and the reasons for the rejection of the proposals that were not included.

(b) CRITERIA FOR MODIFYING AND ESTABLISHING SAFE HARBORS.—In modifying and establishing safe harbors under subsection (a)(2), the Secretary may consider the extent to which providing a safe harbor for the specified payment practice may result in any of the following:

(1) An increase or decrease in access to health care services.

(2) An increase or decrease in the quality of health care services.

(3) An increase or decrease in patient freedom of choice among health care providers.

(4) An increase or decrease in competition among health care providers.

(5) An increase or decrease in the cost to health care programs of the Federal Government.

(6) An increase or decrease in the potential overutilization of health care services.

(8) Any other factors the Secretary deems appropriate in the interest of preventing fraud and abuse in health care programs of the Federal Government.

SEC. 15215. ISSUANCE OF ADVISORY OPINIONS UNDER TITLE XI.

(a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.), as amended by section 15104(a), is amended by inserting after section 1129 the following new section:

"ADVISORY OPINIONS

"SEC. 1130. (a) ISSUANCE OF ADVISORY OPINIONS.—The Secretary shall issue written advisory opinions as provided in this section.

"(b) MATTERS SUBJECT TO ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as to the following matters:

"(1) What constitutes prohibited remuneration within the meaning of section 1128B(b).

"(2) Whether an arrangement or proposed arrangement satisfies the criteria set forth in section 1128B(b)(3) for activities which do not result in prohibited remuneration.

"(3) Whether an arrangement or proposed arrangement satisfies the criteria which the Secretary has established, or shall establish by regulation for activities which do not result in prohibited remuneration.

"(4) What constitutes an inducement to reduce or limit services to individuals entitled to benefits under title XVIII or title XIX or title XXI within the meaning of section 1128B(b).

"(5) Whether any activity or proposed activity constitutes grounds for the imposition of a sanction under section 1128, 1128A, or 1128B.

"(c) MATTERS NOT SUBJECT TO ADVISORY OPINIONS.—Such advisory opinions shall not address the following matters:

"(1) Whether the fair market value shall be, or was paid or received for any goods, services or property.

"(2) Whether an individual is a bona fide employee within the requirements of section 3121(d)(2) of the Internal Revenue Code of 1986.

"(d) EFFECT OF ADVISORY OPINIONS.—

"(1) BINDING AS TO SECRETARY AND PARTIES INVOLVED.—Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

"(2) FAILURE TO SEEK OPINION.—The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of sections 1128, 1128A, or 1128B.

"(e) REGULATIONS.—

"(1) IN GENERAL.—Not later than 180 days after the date of the enactment of this section, the Secretary shall issue regulations to carry out this section. Such regulations shall provide for—

"(A) the procedure to be followed by a party applying for an advisory opinion;

"(B) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

"(C) the interval in which the Secretary shall respond;

"(D) the reasonable fee to be charged to the party requesting an advisory opinion; and

"(E) the manner in which advisory opinions will be made available to the public.

"(2) SPECIFIC CONTENTS.—Under the regulations promulgated pursuant to paragraph (1)—

"(A) the Secretary shall be required to respond to a party requesting an advisory opinion by not later than 30 days after the request is received; and

"(B) the fee charged to the party requesting an advisory opinion shall be equal to the costs incurred by the Secretary in responding to the request.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to requests for advisory opinions made on or after January 1, 1996.

SEC. 15216. PRIOR NOTICE OF CHANGES IN BILLING AND CLAIMS PROCESSING REQUIREMENTS FOR PHYSICIANS' SERVICES.

Except as may be specifically provided by Congress, the Secretary of Health and Human Services may not implement any change in the requirements imposed on the billing and processing of claims for payment for physicians' services under part B of the medicare program unless the Secretary notifies the individuals furnishing such services of the change not later than 120 days before the effective date of the change.

PART 3—PROMOTING PHYSICIAN SELF-POLICING

SEC. 15221. EXEMPTION FROM ANTITRUST LAWS FOR CERTAIN ACTIVITIES OF MEDICAL SELF-REGULATORY ENTITIES.

(a) EXEMPTION DESCRIBED.—An activity relating to the provision of health care services shall be exempt from the antitrust laws, and any State law similar to the antitrust laws, if the activity is within the safe harbor described in subsection (b).

(b) SAFE HARBOR FOR ACTIVITIES OF MEDICAL SELF-REGULATORY ENTITIES.—

(1) IN GENERAL.—Subject to paragraph (2), any activity of a medical self-regulatory entity relating to standard setting or standard enforcement activities that are designed to promote the quality of health care services provided to patients.

(2) EXCEPTION.—No activity of a medical self-regulatory entity may be deemed to fall under the safe harbor established under paragraph (1) if the activity—

(A) is conducted for purposes of financial gain, or

(B) interferes with the provision of health care services by any health care provider who is not a member of the specific profession which is subject to the authority of the medical self-regulatory entity.

(c) DEFINITIONS.—For purposes of this section:

(1) ANTITRUST LAWS.—The term "antitrust laws" has the meaning given it in subsection (a) of the first section of the Clayton Act (15 U.S.C. 12(a)), except that such term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent such section applies to unfair methods of competition.

(2) HEALTH BENEFIT PLAN.—The term "health benefit plan" means—

(A) a hospital or medical expense incurred policy or certificate,

(B) a hospital or medical service plan contract,

(C) a health maintenance subscriber contract,

(D) a multiple employer welfare arrangement or employee benefit plan (as defined under the Employee Retirement Income Security Act of 1974), or

(E) a MedicarePlus product (offered under part C of title XVIII of the Social Security Act),

that provides benefits with respect to health care services.

(3) HEALTH CARE SERVICE.—The term "health care service" means any service for which payment may be made under a health benefit plan including services related to the delivery or administration of such service.

(4) MEDICAL SELF-REGULATORY ENTITY.—The term "medical self-regulatory entity" means a medical society or association, a specialty board, a recognized accrediting agency, or a hospital medical staff, and includes the members, officers, employees, consultants, and volunteers or committees of such an entity.

(5) HEALTH CARE PROVIDER.—The term "health care provider" means any individual or entity that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

(6) STANDARD SETTING OR STANDARD ENFORCEMENT ACTIVITIES.—The term "standard setting or standard enforcement activities" means—

(A) accreditation of health care practitioners, health care providers, medical education institutions, or medical education programs,

(B) technology assessment and risk management activities,

(C) the development and implementation of practice guidelines or practice parameters, or

(D) official peer review proceedings undertaken by a hospital medical staff (or committee thereof) or a medical society or association for purposes of evaluating the professional conduct or quality of health care provided by a medical professional.

Subtitle D—Medical Liability Reform

PART 1—GENERAL PROVISIONS

SEC. 15301. FEDERAL REFORM OF HEALTH CARE LIABILITY ACTIONS.

(a) APPLICABILITY.—This subtitle shall apply with respect to any health care liability action brought in any State or Federal court, except that this subtitle shall not apply to an action for damages arising from a vaccine-related injury or death to the extent that title XXI of the Public Health Service Act applies to the action.

(b) PREEMPTION.—This subtitle shall preempt any State law to the extent such law is inconsistent with the limitations contained in this subtitle. This subtitle shall not preempt any State law that provides for defenses or places limitations on a person's liability in addition to those contained in this subtitle or otherwise imposes greater restrictions than those provided in this subtitle.

(c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE OF LAW OR VENUE.—Nothing in subsection (b) shall be construed to—

(1) waive or affect any defense of sovereign immunity asserted by any State under any provision of law;

(2) waive or affect any defense of sovereign immunity asserted by the United States;

(3) affect the applicability of any provision of the Foreign Sovereign Immunities Act of 1976;

(4) preempt State choice-of-law rules with respect to claims brought by a foreign nation or a citizen of a foreign nation; or

(5) affect the right of any court to transfer venue or to apply the law of a foreign nation or to dismiss a claim of a foreign nation or of a citizen of a foreign nation on the ground of inconvenient forum.

(d) AMOUNT IN CONTROVERSY.—In an action to which this subtitle applies and which is brought under section 1332 of title 28, United States Code, the amount of noneconomic damages or punitive damages, and attorneys' fees or costs, shall not be included in determining whether the matter in controversy exceeds the sum or value of $50,000.

(e) FEDERAL COURT JURISDICTION NOT ESTABLISHED ON FEDERAL QUESTION GROUNDS.—Nothing in this subtitle shall be construed to establish any jurisdiction in the district courts of the United States over health care liability actions on the basis of section 1331 or 1337 of title 28, United States Code.

SEC. 15302. DEFINITIONS.

As used in this subtitle:

(1) ACTUAL DAMAGES.—The term "actual damages" means damages awarded to pay for economic loss.

(2) ALTERNATIVE DISPUTE RESOLUTION SYSTEM; ADR.—The term "alternative dispute resolution system" or "ADR" means a system established under Federal or State law that provides for the resolution of health care liability claims in a manner other than through health care liability actions.

(3) CLAIMANT.—The term "claimant" means any person who brings a health care liability action and any person on whose behalf such an action is brought. If such action is brought through or on behalf of an estate, the term includes the claimant's decedent. If such action is brought through or on behalf of a minor or incompetent, the term includes the claimant's legal guardian.

(4) CLEAR AND CONVINCING EVIDENCE.—The term "clear and convincing evidence" is that measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established, except that such measure or degree of proof is more than that required under preponderance of the evidence but less than that required for proof beyond a reasonable doubt.

(5) COLLATERAL SOURCE PAYMENTS.—The term "collateral source payments" means any amount paid or reasonably likely to be paid in the future to or on behalf of a claimant, or any service, product, or other benefit provided or reasonably likely to be provided in the future to or on behalf of a claimant, as a result of an injury or wrongful death, pursuant to—

(A) any State or Federal health, sickness, income-disability, accident or workers' compensation Act;

(B) any health, sickness, income-disability, or accident insurance that provides health benefits or income-disability coverage;

(C) any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the cost of medical, hospital, dental, or income disability benefits; and

(D) any other publicly or privately funded program.

(6) ECONOMIC LOSS.—The term "economic loss" means any pecuniary loss resulting from harm (including the loss of earnings, medical expense loss, replacement services loss, loss due to death, and burial costs), to the extent recovery for such loss is allowed under applicable State law.

(7) HARM.—The term "harm" means any legally cognizable wrong or injury for which punitive damages may be imposed.

(8) HEALTH CARE LIABILITY ACTION.—The term "health care liability action" means a civil action brought in a State or Federal court against a health care

provider, an entity which is obligated to provide or pay for health benefits under any health plan (including any person or entity acting under a contract or arrangement to provide or administer any health benefit), or the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product, in which the claimant alleges a claim (including third party claims, cross claims, counter claims, or distribution claims) based upon the provision of (or the failure to provide or pay for) health care services or the use of a medical product, regardless of the theory of liability on which the claim is based or the number of plaintiffs, or defendants or causes of action.

(9) HEALTH CARE LIABILITY CLAIM.—The term "health care liability claim" means a claim in which the claimant alleges that injury was caused by the provision of (or the failure to provide) health care services.

(10) HEALTH CARE PROVIDER.—The term "health care provider" means any individual, organization, or institution that is engaged in the delivery of health care services in a State and that is required by the laws or regulations of the State to be licensed or certified by the State to engage in the delivery of such services in the State.

(11) NONECONOMIC DAMAGES.—The term "noneconomic damages" means damages paid to an individual for pain and suffering, inconvenience, emotional distress, mental anguish, loss of consortium, injury to reputation, humiliation, and other nonpecuniary losses.

(12) PERSON.—The term "person" means any individual, corporation, company, association, firm, partnership, society, joint stock company, or any other entity, including any governmental entity.

(13) PUNITIVE DAMAGES.—The term "punitive damages" means damages awarded against any person not to compensate for actual injury suffered, but to punish or deter such person or others from engaging in similar behavior in the future.

(14) STATE.—The term "State" means each of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, the Northern Mariana Islands, the Trust Territories of the Pacific Islands, and any other territory or possession of the United States.

SEC. 15303. EFFECTIVE DATE.

This subtitle will apply to any health care liability action brought in a Federal or State court and to any health care liability claim subject to an alternative dispute resolution system, that is initiated on or after the date of enactment of this subtitle, except that any health care liability claim or action arising from an injury occurring prior to the date of enactment of this subtitle shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

PART 2—UNIFORM STANDARDS FOR HEALTH CARE LIABILITY ACTIONS

SEC. 15311. STATUTE OF LIMITATIONS.

A health care liability action may not be brought after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject of the action was discovered or should reasonably have been discovered, but in no case after the expiration of the 5-year period that begins on the date the alleged injury occurred.

SEC. 15312. CALCULATION AND PAYMENT OF DAMAGES.

(a) TREATMENT OF NONECONOMIC DAMAGES.—

(1) LIMITATION ON NONECONOMIC DAMAGES.—The total amount of noneconomic damages that may be awarded to a claimant for losses resulting from the injury which is the subject of a health care liability action may not exceed $250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the injury.

(2) JOINT AND SEVERAL LIABILITY.—In any health care liability action brought in State or Federal court, a defendant shall be liable only for the amount of noneconomic damages attributable to such defendant in direct proportion to such defendant's share of fault or responsibility for the claimant's actual damages, as determined by the trier of fact. In all such cases, the liability of a defendant for noneconomic damages shall be several and not joint.

(b) TREATMENT OF PUNITIVE DAMAGES.—

(1) GENERAL RULE.—Punitive damages may, to the extent permitted by applicable State law, be awarded in any health care liability action for harm in any

Federal or State court against a defendant if the claimant establishes by clear and convincing evidence that the harm suffered was result of conduct—

(A) specifically intended to cause harm, or

(B) conduct manifesting a conscious, flagrant indifference to the rights or safety of others.

(2) PROPORTIONAL AWARDS.—The amount of punitive damages that may be awarded in any health care liability action subject to this subtitle shall not exceed 3 times the amount of damages awarded to the claimant for economic loss, or $250,000, whichever is greater. This section shall be applied by the court and shall not be disclosed to the jury.

(c) APPLICABILITY.—This section shall apply to any health care liability action brought in any Federal or State court on any theory where punitive damages are sought. This section does not create a cause of action for punitive damages. This section does not preempt or supersede any State or Federal law to the extent that such law would further limit the award of punitive damages.

(d) BIFURCATION.—At the request of any party, the trier of fact shall consider in a separate proceeding whether punitive damages are to be awarded and the amount of such award. If a separate proceeding is requested, evidence relevant only to the claim of punitive damages, as determined by applicable State law, shall be inadmissible in any proceeding to determine whether actual damages are to be awarded.

(e) DRUGS AND DEVICES.—

(1)(A) Punitive damages shall not be awarded against a manufacturer or product seller of a drug (as defined in section 201(g)(1) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(g)(1)) or medical device (as defined in section 201(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 321(h)) which caused the claimant's harm where—

(i) such drug or device was subject to premarket approval by the Food and Drug Administration with respect to the safety of the formulation or performance of the aspect of such drug or device which caused the claimant's harm or the adequacy of the packaging or labeling of such drug or device, and such drug was approved by the Food and Drug Administration; or

(ii) the drug is generally recognized as safe and effective pursuant to conditions established by the Food and Drug Administration and applicable regulations, including packaging and labeling regulations.

(B) Subparagraph (A) shall not apply in any case in which the defendant, before or after premarket approval of a drug or device—

(i) intentionally and wrongfully withheld from or misrepresented to the Food and Drug Administration information concerning such drug or device required to be submitted under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and relevant to the harm suffered by the claimant, or

(ii) made an illegal payment to an official or employee of the Food and Drug Administration for the purpose of securing or maintaining approval of such drug or device.

(2) PACKAGING.—In a health care liability action for harm which is alleged to relate to the adequacy of the packaging (or labeling relating to such packaging) of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer of the drug shall not be held liable for punitive damages unless the drug is found by the court by clear and convincing evidence to be substantially out of compliance with such regulations.

(f) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

(1) GENERAL RULE.—In any health care liability action in which the damages awarded for future economic and noneconomic loss exceeds $50,000, a person shall not be required to pay such damages in a single, lump-sum payment, but shall be permitted to make such payments periodically based on when the damages are found likely to occur, as such payments are determined by the court.

(2) FINALITY OF JUDGMENT.—The judgment of the court awarding periodic payments under this subsection may not, in the absence of fraud, be reopened at any time to contest, amend, or modify the schedule or amount of the payments.

(3) LUMP-SUM SETTLEMENTS.—This subsection shall not be construed to preclude a settlement providing for a single, lump-sum payment.

(g) TREATMENT OF COLLATERAL SOURCE PAYMENTS.—

(1) INTRODUCTION INTO EVIDENCE.—In any health care liability action, any defendant may introduce evidence of collateral source payments. If any defendant

elects to introduce such evidence, the claimant may introduce evidence of any amount paid or contributed or reasonably likely to be paid or contributed in the future by or on behalf of the claimant to secure the right to such collateral source payments.

(2) NO SUBROGATION.—No provider of collateral source payments shall recover any amount against the claimant or receive any lien or credit against the claimant's recovery or be equitably or legally subrogated the right of the claimant in a health care liability action. This subsection shall apply to an action that is settled as well as an action that is resolved by a fact finder.

SEC. 15313. ALTERNATIVE DISPUTE RESOLUTION.

Any ADR used to resolve a health care liability action or claim shall contain provisions relating to statute of limitations, non-economic damages, joint and several liability, punitive damages, collateral source rule, and periodic payments which are identical to the provisions relating to such matters in this subtitle.

Subtitle E—Teaching Hospitals and Graduate Medical Education

PART 1—TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND

SEC. 15401. ESTABLISHMENT OF FUND; PAYMENTS TO TEACHING HOSPITALS.

The Social Security Act (42 U.S.C. 300 et seq.) is amended by adding after title XXI the following title:

"TITLE XXII—TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND

"PART A—ESTABLISHMENT OF FUND

"SEC. 2201. ESTABLISHMENT OF FUND.

"(a) IN GENERAL.—There is established in the Treasury of the United States a fund to be known as the Teaching Hospital and Graduate Medical Education Trust Fund (in this title referred to as the 'Fund'), consisting of amounts appropriated to the Fund in subsection (d) and subsection (e)(3), amounts transferred to the Fund under section 1886(j), and such gifts and bequests as may be deposited in the Fund pursuant to subsection (f). Amounts in the Fund are available until expended.

"(b) EXPENDITURES FROM FUND.—Amounts in the Fund are available to the Secretary for making payments under section 2211.

"(c) ACCOUNTS IN FUND.—There are established within the Fund the following accounts:

"(1) The Indirect-Costs Medical Education Account.

"(2) The Medicare Direct-Costs Medical Education Account.

"(3) The General Direct-Costs Medical Education Account.

"(d) GENERAL TRANSFERS TO FUND.—

"(1) IN GENERAL.—For fiscal year 1997 and each subsequent fiscal year, there are appropriated to the Fund (effective on the applicable date under paragraph (2)), out of any money in the Treasury not otherwise appropriated, the following amounts (as applicable to the fiscal year involved):

"(A) For fiscal year 1997, $400,000,000.

"(B) For fiscal year 1998, $600,000,000.

"(C) For fiscal year 1999, $2,000,000,000.

"(D) For fiscal year 2000, $3,000,000,000.

"(E) For fiscal year 2001, $4,000,000,000.

"(F) For fiscal year 2002, $5,800,000,000.

"(G) For fiscal year 2003 and each subsequent fiscal year, the greater of the amount appropriated for the preceding fiscal year or an amount equal to the product of—

"(i) the amount appropriated for the preceding fiscal year; and

"(ii) 1 plus the percentage increase in the nominal gross domestic product for the one-year period ending upon July 1 of such preceding fiscal year.

"(2) EFFECTIVE DATE FOR ANNUAL APPROPRIATION.—For purposes of paragraph (1) (and for purposes of section 2221(a)(1), and subsections (b)(1)(A) and (c)(1)(A)

of section 2231)), the applicable date for a fiscal year is the first day of the fiscal year, exclusive of Saturdays, Sundays, and Federal holidays.

"(3) ALLOCATION AMONG CERTAIN ACCOUNTS.—Of the amount appropriated in paragraph (1) for a fiscal year—

"(A) there shall be allocated to the Indirect-Costs Medical Education Account the percentage determined under paragraph (4)(B); and

"(B) there shall be allocated to the General Direct-Costs Medical Education Account the percentage determined under paragraph (4)(C).

"(4) DETERMINATION OF PERCENTAGES.—The Secretary of Health and Human Services, acting through the Administrator of the Health Care Financing Administration, shall determine the following:

"(A) The total amount of payments that were made under subsections (d)(5)(B) and (h) of section 1886 for fiscal year 1994.

"(B) The percentage of such total that was constituted by payments under subsection (d)(5)(B) of such section.

"(C) The percentage of such total that was constituted by payments under subsection (h) of such section.

"(e) INVESTMENT.—

"(1) IN GENERAL.—The Secretary of the Treasury shall invest such amounts of the Fund as such Secretary determines are not required to meet current withdrawals from the Fund. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

"(2) SALE OF OBLIGATIONS.—Any obligation acquired by the Fund may be sold by the Secretary of the Treasury at the market price.

"(3) AVAILABILITY OF INCOME.—Any interest derived from obligations acquired by the Fund, and proceeds from any sale or redemption of such obligations, are hereby appropriated to the Fund.

"(f) ACCEPTANCE OF GIFTS AND BEQUESTS.—The Fund may accept on behalf of the United States money gifts and bequests made unconditionally to the Fund for the benefit of the Fund or any activity financed through the Fund.

"PART B—PAYMENTS TO TEACHING HOSPITALS

"Subpart 1—Requirement of Payments

"SEC. 2211. FORMULA PAYMENTS TO TEACHING HOSPITALS.

"(a) IN GENERAL.—Subject to subsection (d), in the case of each teaching hospital that in accordance with subsection (b) submits to the Secretary a payment document for fiscal year 1997 or any subsequent fiscal year, the Secretary shall make payments for the year to the teaching hospital for the costs of operating approved medical residency training programs. Such payments shall be made from the Fund, and the total of the payments to the hospital for the fiscal year shall equal the sum of the following:

"(1) An amount determined under section 2221 (relating to the indirect costs of graduate medical education).

"(2) An amount determined under section 2231 (relating to the direct costs of graduate medical education).

"(b) PAYMENT DOCUMENT.—For purposes of subsection (a), a payment document is a document containing such information as may be necessary for the Secretary to make payments under such subsection to a teaching hospital for a fiscal year. The document is submitted in accordance with this subsection if the document is submitted not later than the date specified by the Secretary, and the document is in such form and is made in such manner as the Secretary may require. The Secretary may require that information under this subsection be submitted to the Secretary in periodic reports.

"(c) ADMINISTRATOR OF PROGRAMS.—This part, and the subsequent parts of this title, shall be carried out by the Secretary acting through the Administrator of the Health Care Financing Administration.

"(d) SPECIAL RULES.—

"(1) AUTHORITY REGARDING PAYMENTS TO CONSORTIA OF PROVIDERS.—In the case of payments under subsection (a) that are determined under section 2231:

"(A) The requirement under such subsection to make the payments to teaching hospitals is subject to the authority of the Secretary under section 2233(a) to make payments to qualifying consortia.

"(B) If the Secretary authorizes such a consortium for purposes of section 2233(a), subsections (a) and (b) of this section apply to the consortium to

the same extent and in the same manner as the subsections apply to teaching hospitals.

"(2) CERTAIN HOSPITALS.—Paragraph (1) of subsection (a) is subject to sections 2222 and 2223 of subpart 2. Paragraph (2) of subsection (a) is subject to sections 2232 through 2234 of subpart 3.

"(e) APPROVED MEDICAL RESIDENCY TRAINING PROGRAM.—For purposes of this title, the term 'approved medical residency training program' has the meaning given such term in section 1886(h)(5)(A).

"Subpart 2—Amount Relating to Indirect Costs of Graduate Medical Education

"SEC. 2221. DETERMINATION OF AMOUNT RELATING TO INDIRECT COSTS.

"(a) IN GENERAL.—For purposes of section 2211(a)(1), the amount determined under this section for a teaching hospital for a fiscal year is the product of—

"(1) the amount in the Indirect-Costs Medical Education Account on the applicable date under section 2201(d) (once the appropriation under such section is made); and

"(2) the percentage determined for the hospital under subsection (b).

"(b) HOSPITAL-SPECIFIC PERCENTAGE.—

"(1) IN GENERAL.—For purposes of subsection (a)(2), the percentage determined under this subsection for a teaching hospital is the mean average of the respective percentages determined under paragraph (3) for each fiscal year of the applicable period (as defined in paragraph (2)), adjusted by the Secretary (upward or downward, as the case may be) on a pro rata basis to the extent necessary to ensure that the sum of the percentages determined under this paragraph for all teaching hospitals is equal to 100 percent. The preceding sentence is subject to sections 2222 and 2223.

"(2) APPLICABLE PERIOD REGARDING RELEVANT DATA; FISCAL YEARS 1992 THROUGH 1994.—For purposes of this part, the term 'applicable period' means the period beginning on the first day of fiscal year 1992 and continuing through the end of fiscal year 1994.

"(3) RESPECTIVE DETERMINATIONS FOR FISCAL YEARS OF APPLICABLE PERIOD.—For purposes of paragraph (1), the percentage determined under this paragraph for a teaching hospital for a fiscal year of the applicable period is the percentage constituted by the ratio of—

"(A) the total amount of payments received by the hospital under section 1886(d)(5)(B) for discharges occurring during the fiscal year involved; to

"(B) the sum of the respective amounts determined under subparagraph (A) for the fiscal year for all teaching hospitals.

"(c) AVAILABILITY OF DATA.—If a teaching hospital received the payments specified in subsection (b)(3)(A) during the applicable period but a complete set of the relevant data is not available to the Secretary for purposes of determining an amount under such subsection for the fiscal year involved, the Secretary shall for purposes of such subsection make an estimate on the basis of such data as are available to the Secretary for the applicable period.

"SEC. 2222. INDIRECT COSTS; SPECIAL RULES REGARDING DETERMINATION OF HOSPITAL-SPECIFIC PERCENTAGE.

"(a) SPECIAL RULE REGARDING FISCAL YEARS 1995 AND 1996.—

"(1) IN GENERAL.—In the case of a teaching hospital whose first payments under 1886(d)(5)(B) were for discharges occurring in fiscal year 1995 or in fiscal year 1996 (referred to in this subsection individually as a 'first payment year'), the percentage determined under paragraph (2) for the hospital is deemed to be the percentage applicable under section 2221(b) to the hospital, except that the percentage under paragraph (2) shall be adjusted in accordance with section 2221(b)(1) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent.

"(2) DETERMINATION OF PERCENTAGE.—For purposes of paragraph (1), the percentage determined under this paragraph for a teaching hospital is the percentage constituted by the ratio of the amount determined under subparagraph (A) to the amount determined under subparagraph (B), as follows:

"(A)(i) If the first payment year for the hospital is fiscal year 1995, the amount determined under this subparagraph is the total amount of payments received by the hospital under section 1886(d)(5)(B) for discharges occurring during fiscal year 1995.

"(ii) If the first payment year for the hospital is fiscal year 1996, the amount determined under this subparagraph is an amount equal to an estimate by the Secretary of the total amount of payments that would have

been paid to the hospital under section 1886(d)(5)(B) for discharges occurring during fiscal year 1995 if such section, as in effect for fiscal year 1996, had applied to the hospital for discharges occurring during fiscal year 1995.

"(B)(i) If the first payment year for the hospital is fiscal year 1995, the amount determined under this subparagraph is the aggregate total of the payments received by teaching hospitals under section 1886(d)(5)(B) for discharges occurring during fiscal year 1995.

"(ii) If the first payment year for the hospital is fiscal year 1996—

"(I) the Secretary shall make an estimate in accordance with subparagraph (A)(ii) for all teaching hospitals; and

"(II) the amount determined under this subparagraph is the sum of the estimates made by the Secretary under subclause (I).

"(b) NEW TEACHING HOSPITALS.—

"(1) IN GENERAL.—In the case of a teaching hospital that did not receive payments under section 1886(d)(5)(B) for any of the fiscal years 1992 through 1996, the percentage determined under paragraph (3) for the hospital is deemed to be the percentage applicable under section 2221(b) to the hospital, except that the percentage under paragraph (3) shall be adjusted in accordance with section 2221(b)(1) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent. This subsection does not apply to a teaching hospital described in the preceding sentence if the hospital is in a State for which a demonstration project under section 1814(b)(3) is in effect.

"(2) DESIGNATED FISCAL YEAR REGARDING DATA.—The determination under paragraph (3) of a percentage for a teaching hospital described in paragraph (1) shall be made for the most recent fiscal year for which the Secretary has sufficient data to make the determination (referred to in this subsection as the 'designated fiscal year').

"(3) DETERMINATION OF PERCENTAGE.—For purposes of paragraph (1), the percentage determined under this paragraph for the teaching hospital involved is the percentage constituted by the ratio of the amount determined under subparagraph (A) to the amount determined under subparagraph (B), as follows:

"(A) The amount determined under this subparagraph is an amount equal to an estimate by the Secretary of the total amount of payments that would have been paid to the hospital under section 1886(d)(5)(B) for the designated fiscal year if such section, as in effect for the first fiscal year for which payments pursuant to this subsection are to be made to the hospital, had applied to the hospital for the designated fiscal year.

"(B) The Secretary shall make an estimate in accordance with subparagraph (A) for all teaching hospitals. The amount determined under this subparagraph is the sum of the estimates made by the Secretary under the preceding sentence.

"(c) CONSOLIDATIONS AND MERGERS.—In the case of two or more teaching hospitals that have each received payments pursuant to section 2221 for one or more fiscal years and that undergo a consolidation or merger, the percentage applicable to the resulting teaching hospital for purposes of section 2221(b) is the sum of the respective percentages that would have applied pursuant to such section if the hospitals had not undergone the consolidation or merger.

"SEC. 2223. INDIRECT COSTS; ALTERNATIVE PAYMENTS REGARDING TEACHING HOSPITALS IN CERTAIN STATES.

"(a) IN GENERAL.—In the case of a teaching hospital in a State for which a demonstration project under section 1814(b)(3) is in effect, this section applies in lieu of section 2221. For purposes of section 2211(a)(1), the amount determined for a teaching hospital for a fiscal year is the product of—

"(1) the amount in the Indirect-Costs Medical Education Account for the fiscal year pursuant to the allocation under section 2201(d)(3)(A) for the year; and

"(2) the percentage determined under subsection (b) for the hospital.

"(b) DETERMINATION OF PERCENTAGE.—For purposes of subsection (a)(2):

"(1) The Secretary shall make an estimate of the total amount of payments that would have been received under section 1886(d)(5)(B) by the hospital involved with respect to each of the fiscal years of the applicable period if such section (as in effect for such fiscal years) had applied to the hospital for such years.

"(2) The percentage determined under this subsection for the hospital for a fiscal year is a mean average percentage determined for the hospital in accordance with the methodology of section 2221(b)(1), except that the estimate made by the Secretary under paragraph (1) of this subsection for a fiscal year of the

applicable period is deemed to be the amount that applies for purposes of section 2221(b)(3)(A) for such year.

"(c) RULE REGARDING PAYMENTS FROM CERTAIN AMOUNTS.—In the case of a teaching hospital in a State for which a demonstration project under section 1814(b)(3) is in effect, this section does not provide any payment to the hospital from amounts transferred to the Fund under section 1886(j).

"(d) ADJUSTMENT REGARDING PAYMENTS TO OTHER HOSPITALS.—In the case of a fiscal year for which payments pursuant to subsection (a) are made to one or more teaching hospitals, the following applies:

"(1) The Secretary shall determine a percentage equal to the sum of the respective percentages determined for the hospitals under subsection (b).

"(2) The Secretary shall determine an amount equal to the product of—

"(A) the percentage determined under paragraph (1); and

"(B) the amount in the Indirect-Costs Medical Education Account for the fiscal year pursuant to the transfer under section 1886(j)(1).

"(3) The Secretary shall, for each hospital (other than hospitals described in subsection (a)), make payments to the hospital whose sum is equal to the product of—

"(A) the amount determined under paragraph (2); and

"(B) the percentage that applies to the hospital for purposes of section 2221(b), except that such percentage shall be adjusted in accordance with the methodology of section 2221(b)(1) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent.

"Subpart 3—Amount Relating to Direct Costs of Graduate Medical Education

"SEC. 2231. DETERMINATION OF AMOUNT RELATING TO DIRECT COSTS.

"(a) IN GENERAL.—For purposes of section 2211(a)(2), the amount determined under this section for a teaching hospital for a fiscal year is the sum of—

"(1) the amount determined under subsection (b) (relating to the General Direct-Costs Medical Education Account); and

"(2) the amount determined under subsection (c) (relating to the Medicare Direct-Costs Medical Education Account).

"(b) PAYMENT FROM GENERAL ACCOUNT.—

"(1) IN GENERAL.—For purposes of subsection (a)(1), the amount determined under this subsection for a teaching hospital for a fiscal year is the product of—

"(A) the amount in the General Direct-Costs Medical Education Account on the applicable date under section 2201(d) (once the appropriation under such section is made); and

"(B) the percentage determined for the hospital under paragraph (2).

"(2) HOSPITAL-SPECIFIC PERCENTAGE.—

"(A) IN GENERAL.—For purposes of paragraph (1)(B), the percentage determined under this paragraph for a teaching hospital is the mean average of the respective percentages determined under subparagraph (B) for each fiscal year of the applicable period (as defined in section 2221(b)(2)), adjusted by the Secretary (upward or downward, as the case may be) on a pro rata basis to the extent necessary to ensure that the sum of the percentages determined under this subparagraph for all teaching hospitals is equal to 100 percent. The preceding sentence is subject to sections 2232 through 2234.

"(B) RESPECTIVE DETERMINATIONS FOR FISCAL YEARS OF APPLICABLE PERIOD.—For purposes of subparagraph (A), the percentage determined under this subparagraph for a teaching hospital for a fiscal year of the applicable period is the percentage constituted by the ratio of—

"(i) the total amount of payments received by the hospital under section 1886(h) for cost reporting periods beginning during the fiscal year involved; to

"(ii) the sum of the respective amounts determined under clause (i) for the fiscal year for all teaching hospitals.

"(3) AVAILABILITY OF DATA.—If a teaching hospital received the payments specified in paragraph (2)(B)(i) during the applicable period but a complete set of the relevant data is not available to the Secretary for purposes of determining an amount under such paragraph for the fiscal year involved, the Secretary shall for purposes of such paragraph make an estimate on the basis of such data as are available to the Secretary for the applicable period.

"(c) PAYMENT FROM MEDICARE ACCOUNT.—

"(1) IN GENERAL.—For purposes of subsection (a)(2), the amount determined under this subsection for a teaching hospital for a fiscal year is the product of—

"(A) the amount in the Medicare Direct-Costs Medical Education Account on the applicable date under section 2201(d) (once the appropriation under such section is made); and

"(B) the percentage determined for the hospital under paragraph (2).

"(2) HOSPITAL-SPECIFIC PERCENTAGE.—For purposes of paragraph (1)(B), the percentage determined under this subsection for a teaching hospital for a fiscal year is the percentage constituted by the ratio of—

"(A) the estimate made by the Secretary for the hospital for the fiscal year under section 1886(j)(2)(B); to

"(B) the sum of the respective estimates referred to in subparagraph (A) for all teaching hospitals.

"SEC. 2232. DIRECT COSTS; SPECIAL RULES REGARDING DETERMINATION OF HOSPITAL-SPECIFIC PERCENTAGE.

"(a) SPECIAL RULE REGARDING FISCAL YEARS 1995 AND 1996.—

"(1) IN GENERAL.—In the case of a teaching hospital whose first payments under 1886(h) were for cost reporting period beginning in fiscal year 1995 or in fiscal year 1996 (referred to in this subsection individually as a 'first payment year'), the percentage determined under paragraph (2) for the hospital is deemed to be the percentage applicable under section 2231(b)(2) to the hospital, except that the percentage under paragraph (2) shall be adjusted in accordance with section 2231(b)(2)(A) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent.

"(2) DETERMINATION OF PERCENTAGE.—For purposes of paragraph (1), the percentage determined under this paragraph for a teaching hospital is the percentage constituted by the ratio of the amount determined under subparagraph (A) to the amount determined under subparagraph (B), as follows:

"(A)(i) If the first payment year for the hospital is fiscal year 1995, the amount determined under this subparagraph is the total amount of payments received by the hospital under section 1886(h) for cost reporting periods beginning in fiscal year 1995.

"(ii) If the first payment year for the hospital is fiscal year 1996, the amount determined under this subparagraph is an amount equal to an estimate by the Secretary of the total amount of payments that would have been paid to the hospital under section 1886(h) for cost reporting periods beginning in fiscal year 1995 if such section, as in effect for fiscal year 1996, had applied to the hospital for fiscal year 1995.

"(B)(i) If the first payment year for the hospital is fiscal year 1995, the amount determined under this subparagraph is the aggregate total of the payments received by teaching hospitals under section 1886(h) for cost reporting periods beginning in fiscal year 1995.

"(ii) If the first payment year for the hospital is fiscal year 1996—

"(I) the Secretary shall make an estimate in accordance with subparagraph (A)(ii) for all teaching hospitals; and

"(II) the amount determined under this subparagraph is the sum of the estimates made by the Secretary under subclause (I).

"(b) NEW TEACHING HOSPITALS.—

"(1) IN GENERAL.—In the case of a teaching hospital that did not receive payments under section 1886(h) for any of the fiscal years 1992 through 1996, the percentage determined under paragraph (3) for the hospital is deemed to be the percentage applicable under section 2231(b)(2) to the hospital, except that the percentage under paragraph (3) shall be adjusted in accordance with section 2231(b)(2)(A) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent. This subsection does not apply to a teaching hospital described in the preceding sentence if the hospital is in a State for which a demonstration project under section 1814(b)(3) is in effect.

"(2) DESIGNATED FISCAL YEAR REGARDING DATA.—The determination under paragraph (3) of a percentage for a teaching hospital described in paragraph (1) shall be made for the most recent fiscal year for which the Secretary has sufficient data to make the determination (referred to in this subsection as the 'designated fiscal year').

"(3) DETERMINATION OF PERCENTAGE.—For purposes of paragraph (1), the percentage determined under this paragraph for the teaching hospital involved is the percentage constituted by the ratio of the amount determined under subparagraph (A) to the amount determined under subparagraph (B), as follows:

"(A) The amount determined under this subparagraph is an amount equal to an estimate by the Secretary of the total amount of payments that would have been paid to the hospital under section 1886(h) for the des-

ignated fiscal year if such section, as in effect for the first fiscal year for which payments pursuant to this subsection are to be made to the hospital, had applied to the hospital for cost reporting periods beginning in the designated fiscal year.

"(B) The Secretary shall make an estimate in accordance with subparagraph (A) for all teaching hospitals. The amount determined under this subparagraph is the sum of the estimates made by the Secretary under the preceding sentence.

"(c) CONSOLIDATIONS AND MERGERS.—In the case of two or more teaching hospitals that have each received payments pursuant to section 2231 for one or more fiscal years and that undergo a consolidation or merger, the percentage applicable to the resulting teaching hospital for purposes of section 2231(b) is the sum of the respective percentages that would have applied pursuant to such section if the hospitals had not undergone the consolidation or merger.

"SEC. 2233. DIRECT COSTS; AUTHORITY FOR PAYMENTS TO CONSORTIA OF PROVIDERS.

"(a) IN GENERAL.—In lieu of making payments to teaching hospitals pursuant to section 2231, the Secretary may make payments under this section to consortia that meet the requirements of subsection (b).

"(b) QUALIFYING CONSORTIUM.—For purposes of subsection (a), a consortium meets the requirements of this subsection if the consortium is in compliance with the following:

"(1) The consortium consists of an approved medical residency training program, a teaching hospital, and one or more of the following entities:

"(A) Schools of medicine or osteopathic medicine.

"(B) Other teaching hospitals (or the approved medical residency training programs of the hospitals).

"(C) Community health centers (under section 330 of the Public Health Service Act), migrant health centers (under section 329 of such Act), or facilities described in section 340 of such Act.

"(D) Medical group practices.

"(E) Managed care entities.

"(F) Entities furnishing outpatient services.

"(G) Such other entities as the Secretary determines to be appropriate.

"(2) The members of the consortium have agreed to participate in the programs of graduate medical education that are operated by the teaching hospitals in the consortium.

"(3) With respect to the receipt by the consortium of payments made pursuant to this section, the members of the consortium have agreed on a method for allocating the payments among the members.

"(4) The consortium meets such additional requirements as the Secretary may establish.

"(c) PAYMENTS FROM ACCOUNTS.—

"(1) IN GENERAL.—Subject to subsection (d), the total of payments to a qualifying consortium for a fiscal year pursuant to subsection (a) shall be the sum of—

"(1) the aggregate amount determined for the teaching hospitals of the consortium pursuant to paragraph (1) of section 2231(a); and

"(2) an amount determined in accordance with the methodology that applies pursuant to paragraph (2) of such section, except that the estimate used for purposes of subsection (c)(2)(A) of such section shall be the estimate made for the consortium under section 1886(j)(2)(C)(ii).

"(d) LIMITATION ON AGGREGATE TOTAL OF PAYMENTS TO CONSORTIA.—The aggregate total of the amounts paid under subsection (c)(2) to qualifying consortia for a fiscal year may not exceed the sum of—

"(1) the aggregate total of the amounts that would have been paid under section 2231(c) for the fiscal year to the teaching hospitals of the consortia if the hospitals had not been participants in the consortia; and

"(2) an amount equal to 1 percent of the amount that applies under paragraph (1)(A) of such section for the fiscal year (relating to the Medicare Direct-Costs Medical Education Account).

"(e) DEFINITION.—For purposes of this title, the term 'qualifying consortium' means a consortium that meets the requirements of subsection (b).

"SEC. 2234. DIRECT COSTS; ALTERNATIVE PAYMENTS REGARDING TEACHING HOSPITALS IN CERTAIN STATES.

"(a) IN GENERAL.—In the case of a teaching hospital in a State for which a demonstration project under section 1814(b)(3) is in effect, this section applies in lieu of section 2231. For purposes of section 2211(a)(2), the amount determined for a teaching hospital for a fiscal year is the product of—

"(1) the amount in the General Direct-Costs Medical Education Account on the applicable date under section 2201(d) (once the appropriation under such section is made); and

"(2) the percentage determined under subsection (b) for the hospital.

"(b) DETERMINATION OF PERCENTAGE.—For purposes of subsection (a)(2):

"(1) The Secretary shall make an estimate of the total amount of payments that would have been received under section 1886(h) by the hospital involved with respect to each of the fiscal years of the applicable period if such section (as in effect for such fiscal years) had applied to the hospital for such years.

"(2) The percentage determined under this subsection for the hospital for a fiscal year is a mean average percentage determined for the hospital in accordance with the methodology of section 2231(b)(2)(A), except that the estimate made by the Secretary under paragraph (1) of this subsection for a fiscal year of the applicable period is deemed to be the amount that applies for purposes of section 2231(b)(2)(B)(i) for such year.

"(c) RULE REGARDING PAYMENTS FROM CERTAIN AMOUNTS.—In the case of a teaching hospital in a State for which a demonstration project under section 1814(b)(3) is in effect, this section does not provide any payment to the hospital from amounts transferred to the Fund under section 1886(j).

"Subpart 4—General Provisions

"SEC. 2241. ADJUSTMENTS IN PAYMENT AMOUNTS.

"(a) COLLECTION OF DATA ON ACCURACY OF ESTIMATES.—The Secretary shall collect data on whether the estimates made by the Secretary under section 1886(j) for a fiscal year were substantially accurate.

"(b) ADJUSTMENTS.—If the Secretary determines under subsection (a) that an estimate for a fiscal year was not substantially accurate, the Secretary shall, for the first fiscal year beginning after the Secretary makes the determination—

"(1) make adjustments accordingly in transfers to the Fund under section 1886(j); and

"(2) make adjustments accordingly in the amount of payments to teaching hospitals pursuant to 2231(c) (or, as applicable, to qualifying consortia pursuant to section 2233(c)(2)).".

PART 2—AMENDMENTS TO MEDICARE PROGRAM

SEC. 15411. TRANSFERS TO TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND.

Section 1886 (42 U.S.C. 1395ww) is amended—

(1) in subsection (d)(5)(B), in the matter preceding clause (i), by striking "The Secretary shall provide" and inserting the following: "For discharges occurring on or before September 30, 1996, the Secretary shall provide";

(2) in subsection (h)—

(A) in paragraph (1), in the first sentence, by striking "the Secretary shall provide" and inserting "the Secretary shall, subject to paragraph (6), provide"; and

(B) by adding at the end the following paragraph:

"(6) LIMITATION.—

"(A) IN GENERAL.—The authority to make payments under this subsection applies only with respect to cost reporting periods ending on or before September 30, 1996, except as provided in subparagraph (B).

"(B) RULE REGARDING PORTION OF LAST COST REPORTING PERIOD.—In the case of a cost reporting period that extends beyond September 30, 1996, payments under this subsection shall be made with respect to such portion of the period as has lapsed as of such date.

"(C) RULE OF CONSTRUCTION.—This paragraph may not be construed as authorizing any payment under section 1861(v) with respect to graduate medical education."; and

(3) by adding at the end the following subsection:

"(j) TRANSFERS TO TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND.—

"(1) INDIRECT COSTS OF MEDICAL EDUCATION.—

"(A) IN GENERAL.—From the Federal Hospital Insurance Trust Fund, the Secretary shall, for fiscal year 1997 and each subsequent fiscal year, transfer to the Indirect-Costs Medical Education Account (under section 2201) an amount determined by the Secretary in accordance with subparagraph (B).

"(B) DETERMINATION OF AMOUNTS.—The Secretary shall make an estimate for the fiscal year involved of the nationwide total of the amounts that would have been paid under subsection (d)(5)(B) to hospitals during the fiscal year if such payments had not been terminated for discharges occurring after September 30, 1996. For purposes of subparagraph (A), the amount determined under this subparagraph for the fiscal year is the estimate made by the Secretary under the preceding sentence.

"(2) DIRECT COSTS OF MEDICAL EDUCATION.—

"(A) IN GENERAL.—From the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, the Secretary shall, for fiscal year 1997 and each subsequent fiscal year, transfer to the Medicare Direct-Costs Medical Education Account (under section 2201) the sum of—

"(i) an amount determined by the Secretary in accordance with subparagraph (B); and

"(ii) as applicable, an amount determined by the Secretary in accordance with subparagraph (C)(ii).

"(B) DETERMINATION OF AMOUNTS.—For each hospital (other than a hospital that is a member of a qualifying consortium referred to in subparagraph (C)), the Secretary shall make an estimate for the fiscal year involved of the amount that would have been paid under subsection (h) to the hospital during the fiscal year if such payments had not been terminated for cost reporting periods ending on or before September 30, 1996. For purposes of subparagraph (A)(i), the amount determined under this subparagraph for the fiscal year is the sum of all estimates made by the Secretary under the preceding sentence.

"(C) ESTIMATES REGARDING QUALIFYING CONSORTIA.—If the Secretary elects to authorize one or more qualifying consortia for purposes of section 2233(a), the Secretary shall carry out the following:

"(i) The Secretary shall establish a methodology for making payments to qualifying consortia with respect to the reasonable direct costs of such consortia in carrying out programs of graduate medical education. The methodology shall be the methodology established in subsection (h), modified to the extent necessary to take into account the participation in such programs of entities other than hospitals.

"(ii) For each qualifying consortium, the Secretary shall make an estimate for the fiscal year involved of the amount that would have been paid to the consortium during the fiscal year if, using the methodology under clause (i), payments had been made to the consortium for the fiscal year as reimbursements with respect to cost reporting periods. For purposes of subparagraph (A)(ii), the amount determined under this clause for the fiscal year is the sum of all estimates made by the Secretary under the preceding sentence.

"(D) ALLOCATION BETWEEN FUNDS.—In providing for a transfer under subparagraph (A) for a fiscal year, the Secretary shall provide for an allocation of the amounts involved between part A and part B (and the trust funds established under the respective parts) as reasonably reflects the proportion of direct graduate medical education costs of hospitals associated with the provision of services under each respective part.

"(3) APPLICABILITY OF CERTAIN AMENDMENTS.—Amendments made to subsection (d)(5)(B) and subsection (h) that are effective on or after October 1, 1996, apply only for purposes of estimates under paragraphs (1) and (2) and for purposes of determining the amount of payments under 2211. Such amendments do not require any adjustment to amounts paid under subsection (d)(5)(B) or (h) with respect to fiscal year 1996 or any prior fiscal year.

"(4) RELATIONSHIP TO CERTAIN DEMONSTRATION PROJECTS.—In the case of a State for which a demonstration project under section 1814(b)(3) is in effect, the Secretary, in making determinations of the rates of increase under such section, shall include all amounts transferred under this subsection. Such amounts shall be so included to the same extent and in the same manner as amounts determined under subsections (d)(5)(B) and (h) were included in such determination under the provisions of this title in effect on September 30, 1996.".

SEC. 15412. MODIFICATION IN PAYMENT POLICIES REGARDING GRADUATE MEDICAL EDUCATION.

(a) INDIRECT COSTS OF MEDICAL EDUCATION; APPLICABLE PERCENTAGE.—

(1) MODIFICATION REGARDING 5.6 PERCENT.—Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(A) by striking "on or after October 1, 1988," and inserting "on or after October 1, 1999,"; and

(B) by striking "1.89" and inserting "1.38".

(2) SPECIAL RULE REGARDING FISCAL YEARS 1996 THROUGH 1998; MODIFICATION REGARDING 6 PERCENT.—Section 1886(d)(5)(B)(ii), as amended by paragraph (1), is amended by adding at the end the following: "In the case of discharges occurring on or after October 1, 1995, and before October 1, 1999, the preceding sentence applies to the same extent and in the same manner as the sentence applies to discharges occurring on or after October 1, 1999, except that the term '1.38' is deemed to be '1.48'.".

(3) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNTS.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended by striking "1985" and inserting the following: "1985, but (for discharges occurring after September 30, 1995) not taking into account any reductions in such costs resulting from the amendments made by section 15412(a) of the Medicare Preservation Act of 1995".

(b) DIRECT COSTS OF MEDICAL EDUCATION.—

(1) LIMITATION ON NUMBER OF FULL-TIME-EQUIVALENT RESIDENTS.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended by adding at the end the following new subparagraph:

"(F) LIMITATION ON NUMBER OF RESIDENTS FOR CERTAIN FISCAL YEARS.—Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1995, and on or before September 30, 2002, the number of full-time-equivalent residents determined under this paragraph with respect to an approved medical residency training program may not exceed the number of full-time-equivalent residents with respect to the program as of August 1, 1995 (except that this subparagraph does not apply to any nonphysician teaching program that is approved for purposes of section 1861(b)(6) and that, under paragraph (5)(A), is an approved medical residency training program).".

(2) EXCLUSION OF RESIDENTS AFTER INITIAL RESIDENCY PERIOD.—Section 1886(h)(4)(C) (42 U.S.C. 1395ww(h)(4)(C)) is amended to read as follows:

"(C) WEIGHTING FACTORS FOR RESIDENTS.—Effective for cost reporting periods beginning on or after October 1, 1997, such rules shall provide that, in the calculation of the number of full-time-equivalent residents in an approved residency program, the weighting factor for a resident who is in the initial residency period (as defined in paragraph (5)(F)) is 1.0 and the weighting factor for a resident who has completed such period is 0.0. (In the case of cost reporting periods beginning before October 1, 1997, the weighting factors that apply in such calculation are the weighting factors that were applicable under this subparagraph on the day before the date of the enactment of the Medicare Preservation Act of 1995.)".

(3) REDUCTIONS IN PAYMENTS FOR ALIEN RESIDENTS.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)), as amended by paragraph (1), is amended by adding at the end the following new subparagraph:

"(G) SPECIAL RULES FOR ALIEN RESIDENTS.—In the case of individuals who are not citizens or nationals of the United States and who are not citizens of Canada, in the calculation of the number of full-time-equivalent residents in an approved medical residency program, the following rules shall apply with respect to such individuals who are residents in the program:

"(i) For a cost reporting period beginning during fiscal year 1996, for each such individual the Secretary shall apply a weighting factor of .75.

"(ii) For a cost reporting period beginning during fiscal year 1997, for each such individual the Secretary shall apply a weighting factor of .50.

"(iii) For a cost reporting period beginning during fiscal year 1998, for each such individual the Secretary shall apply a weighting factor of .25.

"(iv) For a cost reporting period beginning during fiscal year 1999 or any subsequent fiscal year, such individuals shall be excluded from the calculation of the number of full-time-equivalent residents in an approved medical residency program under this paragraph.".

(4) EFFECTIVE DATE.—Except as provided otherwise in this subsection (or in the amendments made by this subsection), the amendments made by this subsection apply to hospital cost reporting periods beginning on or after October 1, 1995.

PART 3—REFORM OF FEDERAL POLICIES REGARDING TEACHING HOSPITALS AND GRADUATE MEDICAL EDUCATION

SEC. 15421. ESTABLISHMENT OF ADVISORY PANEL FOR RECOMMENDING POLICIES.

Title XXII of the Social Security Act, as added by section 15401, is amended by adding at the end the following part:

"PART C—OTHER MATTERS

"SEC. 2251. ADVISORY PANEL ON REFORM IN FINANCING OF TEACHING HOSPITALS AND GRADUATE MEDICAL EDUCATION.

"(a) ESTABLISHMENT.—The Chair of the Medicare Payment Review Commission under section 1806 shall establish a temporary advisory panel to be known as the Advisory Panel on Financing for Teaching Hospitals and Graduate Medical Education (in this section referred to as the 'Panel').

"(b) DUTIES.—The Panel shall develop recommendations on whether and to what extent Federal policies regarding teaching hospitals and graduate medical education should be reformed, including recommendations regarding the following:

"(1) The financing of graduate medical education, including consideration of alternative broad-based sources of funding for such education.

"(2) The financing of teaching hospitals, including consideration of the difficulties encountered by such hospitals as competition among health care entities increases. Matters considered under this paragraph shall include consideration of the effects on teaching hospitals of the method of financing used for the MedicarePlus program under part C of title XVIII.

"(3) The methodology for making payments for graduate medical education, and the selection of entities to receive the payments. Matters considered under this paragraph shall include the following:

"(A) The methodology under part B for making payments from the Fund, including the use of data from the fiscal years 1992 through 1994, and including the methodology that applies with respect to consolidations and mergers of participants in the program under such part and with respect to the inclusion of additional participants in the program.

"(B) Issues regarding children's hospitals, and approved medical residency training programs in pediatrics.

"(C) Whether and to what extent payments are being made (or should be made) for graduate training in the various nonphysician health professions.

"(4) Federal policies regarding international medical graduates.

"(5) The dependence of schools of medicine on service-generated income.

"(6) The effects of the amendments made by section 15412 of the Medicare Preservation Act of 1995, including adverse effects on teaching hospitals that result from modifications in policies regarding international medical graduates.

"(7) Whether and to what extent the needs of the United States regarding the supply of physicians will change during the 10-year beginning on October 1, 1995, and whether and to what extent any such changes will have significant financial effects on teaching hospitals.

"(8) The appropriate number and mix of residents.

"(c) COMPOSITION.—Not later than three months after being designated as the initial chairman of the Medicare Payment Review Commission, the chairman of the Commission shall appoint to the Panel 19 individuals who are not members of the Commission, who are not officers or employees of the United States, and who possess expertise on matters on which the Panel is to make recommendations under subsection (b). Such individuals shall include the following:

"(1) Deans from allopathic and osteopathic schools of medicine.

"(2) Chief executive officers (or equivalent administrative heads) from academic health centers, integrated health care systems, and approved medical residency training programs.

"(3) Chairs of departments or divisions from allopathic and osteopathic schools of medicine, schools of dentistry, and approved medical residency training programs in oral surgery.

"(4) Individuals with leadership experience from each of the fields of advanced practice nursing, physician assistants, and podiatric medicine.

"(5) Individuals with substantial experience in the study of issues regarding the composition of the health care workforce of the United States.

"(6) Individuals with expertise on the financing of health care.

"(7) Representatives from health insurance organizations and health plan organizations.

"(d) RELATIONSHIP OF PANEL TO MEDICARE PAYMENT REVIEW COMMISSION.—From amounts appropriated under subsection (n), the Medicare Review Payment Commission shall provide for the Panel such staff and administrative support (including quarters for the Panel) as may be necessary for the Panel to carry out the duties under subsection (b).

"(e) CHAIR.—The Panel shall designate a member of the Panel to serve as the Chair of the Panel.

"(f) MEETINGS.—The Panel shall meet at the call of the Chair or a majority of the members, except that the first meeting of the Panel shall be held not later than three months after the date on which appointments under subsection (c) are completed.

"(g) TERMS.—The term of a member of the Panel is the duration of the Panel.

"(h) VACANCIES.—

"(1) IN GENERAL.—A vacancy in the membership of the Panel does not affect the power of the remaining members to carry out the duties under subsection (b). A vacancy in the membership of the Panel shall be filled in the manner in which the original appointment was made.

"(2) INCOMPLETE TERM.—If a member of the Panel does not serve the full term applicable to the member, the individual appointed to fill the resulting vacancy shall be appointed for the remainder of the term of the predecessor of the individual.

"(i) COMPENSATION; REIMBURSEMENT OF EXPENSES.—

"(1) COMPENSATION.—Members of the Panel shall receive compensation for each day (including traveltime) engaged in carrying out the duties of the Committee. Such compensation may not be in an amount in excess of the daily equivalent of the annual maximum rate of basic pay payable under the General Schedule (under title 5, United States Code) for positions above GS–15.

"(2) REIMBURSEMENT.—Members of the Panel may, in accordance with chapter 57 of title 5, United States Code, be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Panel.

"(j) CONSULTANTS.—The Panel may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code, as the Panel may determine to be useful in carrying out the duties under subsection (b). The Panel may not procure services under this subsection at any rate in excess of the daily equivalent of the maximum annual rate of basic pay payable under the General Schedule for positions above GS–15. Consultants under this subsection may, in accordance with chapter 57 of title 5, United States Code, be reimbursed for travel, subsistence, and other necessary expenses incurred for activities carried out on behalf of the Panel pursuant to subsection (b).

"(k) POWERS.—

"(1) IN GENERAL.—For the purpose of carrying out the duties of the Panel under subsection (b), the Panel may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Panel considers appropriate.

"(2) OBTAINING OFFICIAL INFORMATION.—Upon the request of the Panel, the heads of Federal agencies shall furnish directly to the Panel information necessary for the Panel to carry out the duties under subsection (b).±

"(3) USE OF MAILS.—The Panel may use the United States mails in the same manner and under the same conditions as Federal agencies.

"(l) REPORTS.—

"(1) FIRST INTERIM REPORT.—Not later than one year after the date of the enactment of the Medicare Preservation Act of 1995, the Panel shall submit to the Congress a report providing the recommendations of the Panel regarding the matters specified in paragraphs (1) through (4) of subsection (b).

"(2) SECOND INTERIM REPORT.—Not later than 2 years after the date of enactment specified in paragraph (1), the Panel shall submit to the Congress a report providing the recommendations of the Panel regarding the matters specified in paragraphs (5) and (6) of subsection (b).

"(3) FINAL REPORT.—Not later than 3 years after the date of enactment specified in paragraph (1), the Panel shall submit to the Congress a final report providing the recommendations of the Panel under subsection (b).

"(m) DURATION.—The Panel terminates upon the expiration of the 180-day period beginning on the date on which the final report under subsection (l)(3) is submitted to the Congress.

"(n) AUTHORIZATION OF APPROPRIATIONS.—

"(1) IN GENERAL.—Subject to paragraph (2), for the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 1996 through 2000.

"(2) LIMITATION.—The authorization of appropriations established in paragraph (1) is effective only with respect to appropriations made from allocations under section 302(b) of the Congressional Budget Act of 1974—

"(A) for the Subcommittee on Labor, Health and Human Services, and Education, Committee on Appropriations of the House of Representatives, in the case of any bill, resolution, or amendment considered in the House; and

"(B) for the Subcommittee on Labor, Health and Human Services, and Education, Committee on Appropriations of the Senate, in the case of any bill, resolution, or amendment considered in the Senate.".

Subtitle F—Provisions Relating to Medicare Part A

PART 1—HOSPITALS

Subpart A—General Provisions Relating to Hospitals

SEC. 15501. REDUCTIONS IN INFLATION UPDATES FOR PPS HOSPITALS.

Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended by striking subclauses (XI), (XII), and (XIII) and inserting the following:

"(XI) for fiscal year 1996, the market basket percentage increase minus 2.5 percentage points for hospitals in all areas,

"(XII) for each of the fiscal years 1997 through 2002, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas, and

"(XIII) for fiscal year 2003 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.".

SEC. 15502. REDUCTIONS IN DISPROPORTIONATE SHARE PAYMENT ADJUSTMENTS.

(a) IN GENERAL.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(1) in clause (ii), by striking "The amount" and inserting "Subject to clause (ix), the amount"; and

(2) by adding at the end the following new clause:

"(ix) In the case of discharges occurring on or after October 1, 1995, the additional payment amount otherwise determined under clause (ii) shall be reduced as follows:

"(I) For discharges occurring on or after October 1, 1995, and on or before September 30, 1996, by 20 percent.

"(II) For discharges occurring on or after October 1, 1996, and on or before September 30, 1997, by 25 percent.

"(III) For discharges occurring on or after October 1, 1997, by 30 percent.".

(b) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNTS.—Section 1886(d)(2)(C)(iv) (42 U.S.C. 1395ww(d)(2)(C)(iv)) is amended by striking the period at the end and inserting the following: ", and the Secretary shall not take into account any reductions in the amount of such additional payments resulting from the amendments made by section 15502(a) of the Medicare Preservation Act of 1995.".

SEC. 15503. PAYMENTS FOR CAPITAL-RELATED COSTS FOR INPATIENT HOSPITAL SERVICES.

(a) REDUCTION IN PAYMENTS FOR PPS HOSPITALS.—

(1) CONTINUATION OF CURRENT REDUCTIONS.—Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended in the second sentence—

(A) by striking "through 1995" and inserting "through 2002"; and

(B) by inserting after "10 percent reduction" the following: "(or a 15 percent reduction in the case of payments during fiscal years 1996 through 2002)".

(2) REDUCTION IN BASE PAYMENT RATES.—Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A)) is amended by adding at the end the following new sentence: "In addition to the reduction described in the preceding sentence, for discharges occurring after September 30, 1995, the Secretary shall reduce by 7.47 percent the unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on the date of the enactment of the Medicare Preservation Act of 1995) and shall reduce by 8.27 percent the unadjusted hospital-spe-

cific rate (as described in 42 CFR 412.328(e)(1), as in effect on such date of enactment).".

(b) REDUCTION IN PAYMENTS FOR PPS-EXEMPT HOSPITALS.—Section 1886(g) (42 U.S.C. 1395ww(g)) is amended by adding at the end the following new paragraph:

"(4)(A) Except as provided in subparagraph (B), in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of inpatient hospital services furnished during fiscal years 1996 through 2002 of a hospital which is not a subsection (d) hospital or a subsection (d) Puerto Rico hospital, the Secretary shall reduce the amounts of such payments otherwise determined under this title by 15 percent.

"(B) Subparagraph (A) shall not apply to payments with respect to the capital-related costs of any hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii) or a rural primary care hospital (as defined in section 1861(mm)(1)).".

(c) HOSPITAL-SPECIFIC ADJUSTMENT FOR CAPITAL-RELATED TAX COSTS.—Section 1886(g)(1) (42 U.S.C. 1395ww(g)(1)) is amended—

(1) by redesignating subparagraph (C) as subparagraph (D), and

(2) by inserting after subparagraph (B) the following:

"(C)(i) For discharges occurring after September 30, 1995, such system shall provide for an adjustment in an amount equal to the amount determined under clause (iv) for capital-related tax costs for each hospital that is eligible for such adjustment.

"(ii) Subject to clause (iii), a hospital is eligible for an adjustment under this subparagraph, with respect to discharges occurring in a fiscal year, if the hospital—

"(I) is a hospital that may otherwise receive payments under this subsection,

"(II) is not a public hospital, and

"(III) incurs capital-related tax costs for the fiscal year.

"(iii)(I) In the case of a hospital that first incurs capital-related tax costs in a fiscal year after fiscal year 1992 because of a change from nonproprietary to proprietary status or because the hospital commenced operation after such fiscal year, the first fiscal year for which the hospital shall be eligible for such adjustment is the second full fiscal year following the fiscal year in which the hospital first incurs such costs.

"(II) In the case of a hospital that first incurs capital-related tax costs in a fiscal year after fiscal year 1992 because of a change in State or local tax laws, the first fiscal year for which the hospital shall be eligible for such adjustment is the fourth full fiscal year following the fiscal year in which the hospital first incurs such costs.

"(iv) The per discharge adjustment under this clause shall be equal to the hospital-specific capital-related tax costs per discharge of a hospital for fiscal year 1992 (or, in the case of a hospital that first incurs capital-related tax costs for a fiscal year after fiscal year 1992, for the first full fiscal year for which such costs are incurred), updated to the fiscal year to which the adjustment applies. Such per discharge adjustment shall be added to the Federal capital rate, after such rate has been adjusted as described in 42 CFR 412.312 (as in effect on the date of the enactment of the Medicare Preservation Act of 1995), and before such rate is multiplied by the applicable Federal rate percentage.

"(v) For purposes of this subparagraph, capital-related tax costs include—

"(I) the costs of taxes on land and depreciable assets owned by a hospital (or related organization) and used for patient care,

"(II) payments in lieu of such taxes (made by hospitals that are exempt from taxation), and

"(III) the costs of taxes paid by a hospital (or related organization) as lessee of land, buildings, or fixed equipment from a lessor that is unrelated to the hospital (or related organization) under the terms of a lease that requires the lessee to pay all expenses (including mortgage, interest, and amortization) and leaves the lessor with an amount free of all claims (sometimes referred to as a 'net net net' or 'triple net' lease).

In determining the adjustment required under clause (i), the Secretary shall not take into account any capital-related tax costs of a hospital to the extent that such costs are based on tax rates and assessments that exceed those for similar commercial properties.

"(vi) The system shall provide that the Federal capital rate for any fiscal year after September 30, 1995, shall be reduced by a percentage sufficient to ensure that the adjustments required to be paid under clause (i) for a fiscal year neither increase nor decrease the total amount that would have been paid under this system but for the payment of such adjustments for such fiscal year.".

(d) REVISION OF EXCEPTIONS PROCESS UNDER PROSPECTIVE PAYMENT SYSTEM FOR CERTAIN PROJECTS.—

(1) IN GENERAL.—Section 1886(g)(1) (42 U.S.C. 1395ww(g)(1)), as amended by subsection (c), is amended—

(A) by redesignating subparagraph (D) as subparagraph (E), and

(B) by inserting after subparagraph (C) the following:

"(D) The exceptions under the system provided by the Secretary under subparagraph (B)(iii) shall include the provision of exception payments under the special exceptions process provided under 42 CFR 412.348(g) (as in effect on September 1, 1995), except that the Secretary shall revise such process as follows:

"(i) A hospital with at least 100 beds which is located in an urban area shall be eligible under such process without regard to its disproportionate patient percentage under subsection (d)(5)(F) or whether it qualifies for additional payment amounts under such subsection.

"(ii) The minimum payment level for qualifying hospitals shall be 85 percent.

"(iii) A hospital shall be considered to meet the requirement that it completes the project involved no later than the end of the hospital's last cost reporting period beginning after October 1, 2001, if—

"(I) the hospital has obtained a certificate of need for the project approved by the State or a local planning authority, and

"(II) by September 1, 1995, the hospital has expended on the project at least $750,000 or 10 percent of the estimated cost of the project.

"(iv) The amount of the exception payment made shall not be reduced by any offsetting amounts.".

(2) CONFORMING AMENDMENT.—Section 1886(g)(1)(B)(iii) (42 U.S.C. 1395ww(g)(1)(B)(iii)) is amended by striking "may provide" and inserting "shall provide (in accordance with subparagraph (D))".

SEC. 15504. REDUCTION IN ADJUSTMENT FOR INDIRECT MEDICAL EDUCATION.

For provisions modifying medicare payment policies regarding graduate medical education, see part 2 of subtitle E.

SEC. 15505. TREATMENT OF PPS-EXEMPT HOSPITALS.

(a) UPDATES.—Section 1886(b)(3)(B)(ii)(V) (42 U.S.C. 1395ww(b)(3)(B)(ii)(V)) is amended by striking "thorugh 1997" and inserting "through 2002".

(b) REBASING FOR CERTAIN LONG-TERM CARE HOSPITALS.—

(1) IN GENERAL.—Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)) is amended—

(A) in subparagraph (A), by striking "and (E)" and inserting "(E), and (F)";

(B) in subparagraph (B)(ii), by striking "(A) and (E)" and inserting "(A), (E), and (F)"; and

(C) by adding at the end the following new subparagraph:

"(F)(i) In the case of a qualified long-term care hospital (as defined in clause (ii)), the term 'target amount' means—

"(I) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital, the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period beginning during fiscal year 1991; or

"(II) with respect to a later cost reporting period, the target amount for the preceding cost reporting period, increase by the applicable percentage increase under subparagraph (B)(ii) for that later cost reporting period.

"(ii) In clause (i), a 'qualified long-term care hospital' means, with respect to a cost reporting period, a hospital described in clause (iv) of subsection (d)(1)(B) during fiscal year 1995 for which the hospital's allowable operating costs of inpatient hospital services recognized under this title for each of the two most recent previous 12-month cost reporting periods exceeded the hospital's target amount determined under this paragraph for such cost reporting periods, if the hospital—

"(I) has a disproportionate patient percentage during such cost reporting period (as determined by the Secretary under subsection (d)(5)(F)(vi) as if the hospital were a subsection (d) hospital) of at least 25 percent, or

"(II) is located in a State for which no payment is made under the State plan under title XIX for days of inpatient hospital services furnished to any individual in excess of the limit on the number of days of such services furnished to the individual for which payment may be made under this title.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to discharges occurring during cost reporting periods beginning on or after October 1, 1995.

(c) TREATMENT OF CERTAIN LONG-TERM CARE HOSPITALS LOCATED WITHIN OTHER HOSPITALS.—

(1) IN GENERAL.—Section 1886(d)(1)(B) (42 U.S.C. 1395ww(d)(1)(B)) is amended in the matter following clause (v) by striking the period and inserting the following: ", or a hospital classified by the Secretary as a long-term care hospital on or before September 30, 1995, and located in the same building as, or on the same campus as, another hospital.".

(2) STUDY BY REVIEW COMMISSION.—Not later than 12 months after the date a majority of the members of the Medicare Payment Review Commission are first appointed, the Commission shall submit a report to Congress containing recommendations for appropriate revisions in the treatment of long-term care hospitals located in the same building as or on the same campus as another hospital for purposes of section 1886 of the Social Security Act.

(3) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to discharges occurring on or after October 1, 1995.

(d) STUDY OF PROSPECTIVE PAYMENT SYSTEM FOR REHABILITATION HOSPITALS AND UNITS.—

(1) IN GENERAL.—After consultation with the Prospective Payment Assessment Commission, providers of rehabilitation services, and other appropriate parties, the Secretary of Health and Human Services shall submit to Congress, by not later than June 1, 1996, a report on the advisability and feasibility of providing for payment based on a prospective payment system for inpatient services of rehabilitation hospitals and units under the medicare program.

(2) ITEMS INCLUDED.—The report shall include the following:

(A) The available and preferred systems of classifying rehabilitation patients relative to duration and intensity of inpatient services, including the use of functional-related groups (FRGs).

(B) The means of calculating medicare program payments to reflect such patient requirements.

(C) Other appropriate adjustments which should be made, such as for geographic variations in wages and other costs and outliers.

(D) A timetable under which such a system might be introduced.

(E) Whether such a system should be applied to other types of providers of inpatient rehabilitation services.

SEC. 15506. REDUCTION IN PAYMENTS TO HOSPITALS FOR ENROLLEES' BAD DEBTS.

(a) IN GENERAL.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

"(T)(i) In determining such reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs which are attributable to the deductibles and coinsurance amounts under this title shall be reduced by—

"(I) 75 percent for cost reporting periods beginning during fiscal year 1996,

"(II) 60 percent for cost reporting periods beginning during fiscal year 1997, and

"(III) 50 percent for subsequent cost reporting periods.

"(ii) Clause (i) shall not apply with respect to bad debt of a hospital described in section 1886(d)(1)(B)(iv) if the debt is attributable to uncollectable deductible and coinsurance payments owed by individuals enrolled in a State plan under title XIX or under the MediGrant program under title XXI.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to hospital cost reporting periods beginning on or after October 1, 1995.

SEC. 15507. PERMANENT EXTENSION OF HEMOPHILIA PASS-THROUGH.

Effective as if included in the enactment of OBRA–1989, section 6011(d) of such Act (as amended by section 13505 of OBRA–1993) is amended by striking "and shall expire September 30, 1994".

SEC. 15508. CONFORMING AMENDMENT TO CERTIFICATION OF CHRISTIAN SCIENCE PROVIDERS.

(a) HOSPITALS.—Section 1861(e) (42 U.S.C. 1395x(e)) is amended in the sixth sentence by inserting after "Massachusetts," the following: "or by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.,".

(b) SKILLED NURSING FACILITIES.—Section 1861(y)(1) is amended by inserting after "Massachusetts," the following: "or by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.,".

Subpart B—Provisions Relating to Rural Hospitals

SEC. 15511. SOLE COMMUNITY HOSPITALS.

(a) UPDATE.—Section 1886(b)(3)(B)(iv) (42 U.S.C. 1395ww(b)(3)(B)(iv)) is amended—

(A) in subclause (III), by striking "and" at the end; and

(B) by striking subclause (IV) and inserting the following:

"(IV) for each of the fiscal years 1996 through 2000, the market basket percentage increase minus 1 percentage points, and

"(V) for fiscal year 2001 and each subsequent fiscal year, the applicable percentage increase under clause (i).".

(b) STUDY OF IMPACT OF SOLE COMMUNITY HOSPITAL DESIGNATIONS.—

(1) STUDY.—The Medicare Payment Review Commission shall conduct a study of the impact of the designation of hospitals as sole community hospitals under the medicare program on the delivery of health care services to individuals in rural areas, and shall include in the study an analysis of the characteristics of the hospitals designated as such sole community hospitals under the program.

(2) REPORT.—Not later than 12 months after the date a majority of the members of the Commission are first appointed, the Commission shall submit to Congress a report on the study conducted under paragraph (1).

SEC. 15512. CLARIFICATION OF TREATMENT OF EAC AND RPC HOSPITALS.

Paragraphs (1)(A)(i) and (2)(A)(i) of section 1820(i) (42 U.S.C. 1395i–4(i)) are each amended by striking the semicolon at the end and inserting the following: ", or in a State which the Secretary finds would receive a grant under such subsection during a fiscal year if funds were appropriated for grants under such subsection for the fiscal year;".

SEC. 15513. ESTABLISHMENT OF RURAL EMERGENCY ACCESS CARE HOSPITALS.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"Rural Emergency Access Care Hospital; Rural Emergency Access Care Hospital Services

"(oo)(1) The term 'rural emergency access care hospital' means, for a fiscal year, a facility with respect to which the Secretary finds the following:

"(A) The facility is located in a rural area (as defined in section 1886(d)(2)(D)).

"(B) The facility was a hospital under this title at any time during the 5-year period that ends on the date of the enactment of this subsection.

"(C) The facility is in danger of closing due to low inpatient utilization rates and operating losses, and the closure of the facility would limit the access to emergency services of individuals residing in the facility's service area.

"(D) The facility has entered into (or plans to enter into) an agreement with a hospital with a participation agreement in effect under section 1866(a), and under such agreement the hospital shall accept patients transferred to the hospital from the facility and receive data from and transmit data to the facility.

"(E) There is a practitioner who is qualified to provide advanced cardiac life support services (as determined by the State in which the facility is located) on-site at the facility on a 24-hour basis.

"(F) A physician is available on-call to provide emergency medical services on a 24-hour basis.

"(G) The facility meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

"(i) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open, except insofar as the facility is required to provide emergency care on a 24-hour basis under subparagraphs (E) and (F); and

"(ii) the facility may provide any services otherwise required to be provided by a full-time, on-site dietitian, pharmacist, laboratory technician, medical technologist, or radiological technologist on a part-time, off-site basis.

"(H) The facility meets the requirements applicable to clinics and facilities under subparagraphs (C) through (J) of paragraph (2) of section 1861(aa) and of clauses (ii) and (iv) of the second sentence of such paragraph (or, in the case of the requirements of subparagraph (E), (F), or (J) of such paragraph, would meet the requirements if any reference in such subparagraph to a 'nurse practitioner' or to 'nurse practitioners' were deemed to be a reference to a 'nurse prac-

titioner or nurse' or to 'nurse practitioners or nurses'); except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied as if any reference to a 'physician' is a reference to a physician as defined in section 1861(r)(1).

"(2) The term 'rural emergency access care hospital services' means the following services provided by a rural emergency access care hospital and furnished to an individual over a continuous period not to exceed 24 hours (except that such services may be furnished over a longer period in the case of an individual who is unable to leave the hospital because of inclement weather):

"(A) An appropriate medical screening examination (as described in section 1867(a)).

"(B) Necessary stabilizing examination and treatment services for an emergency medical condition and labor (as described in section 1867(b)).".

(b) REQUIRING RURAL EMERGENCY ACCESS CARE HOSPITALS TO MEET HOSPITAL ANTI-DUMPING REQUIREMENTS.—Section 1867(e)(5) (42 U.S.C. 1395dd(e)(5)) is amended by striking "1861(mm)(1))" and inserting "1861(mm)(1)) and a rural emergency access care hospital (as defined in section 1861(oo)(1))".

(c) REFERENCE TO PAYMENT PROVISIONS UNDER PART B.—For provisions relating to payment for rural emergency access care hospital services under part B, see section 15607.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to fiscal years beginning on or after October 1, 1995.

SEC. 15514. CLASSIFICATION OF RURAL REFERRAL CENTERS.

(a) PROHIBITING DENIAL OF REQUEST FOR RECLASSIFICATION ON BASIS OF COMPARABILITY OF WAGES.—

(1) IN GENERAL.—Section 1886(d)(10)(D) (42 U.S.C. 1395ww(d)(10)(D)) is amended—

(A) by redesignating clause (iii) as clause (iv); and

(B) by inserting after clause (ii) the following new clause:

"(iii) Under the guidelines published by the Secretary under clause (i), in the case of a hospital which is classified by the Secretary as a rural referral center under paragraph (5)(C), the Board may not reject the application of the hospital under this paragraph on the basis of any comparison between the average hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located.".

(2) EFFECTIVE DATE.—Notwithstanding section 1886(d)(10)(C)(ii) of the Social Security Act, a hospital may submit an application to the Medicare Geographic Classification Review Board during the 30-day period beginning on the date of the enactment of this Act requesting a change in its classification for purposes of determining the area wage index applicable to the hospital under section 1886(d)(3)(D) of such Act for fiscal year 1997, if the hospital would be eligible for such a change in its classification under the standards described in section 1886(d)(10)(D) (as amended by paragraph (1)) but for its failure to meet the deadline for applications under section 1886(d)(10)(C)(ii).

(b) CONTINUING TREATMENT OF PREVIOUSLY DESIGNATED CENTERS.—Any hospital classified as a rural referral center by the Secretary of Health and Human Services under section 1886(d)(5)(C) of the Social Security Act for fiscal year 1994 shall be classified as such a rural referral center for fiscal year 1996 and each subsequent fiscal year.

SEC. 15515. FLOOR ON AREA WAGE INDEX.

(a) IN GENERAL.—For purposes of section 1886(d)(3)(E) of the Social Security Act for discharges occurring on or after October 1, 1995, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act) may not be less than the average of the area wage indices applicable under such section to hospitals located in rural areas in the State in which the hospital is located.

(b) BUDGET-NEUTRALITY IN IMPLEMENTATION.—The Secretary of Health and Human Services shall adjust the area wage indices referred to in subsection (a) for hospitals not described in such subsection in a manner which assures that the aggregate payments made under section 1886(d) of the Social Security Act in a fiscal year for the operating costs of inpatient hospital services are not greater or less than those which would have been made in the year if this section did not apply.

PART 2—PAYMENTS TO SKILLED NURSING FACILITIES

SEC. 15521. PAYMENTS FOR ROUTINE SERVICE COSTS.

(a) CLARIFICATION OF DEFINITION OF ROUTINE SERVICE COSTS.—Section 1888 (42 U.S.C. 1395yy) is amended by adding at the end the following new subsection:

"(e) For purposes of this section, the 'routine service costs' of a skilled nursing facility are all costs which are attributable to nursing services, room and board, administrative costs, other overhead costs, and all other ancillary services (including supplies and equipment), excluding costs attributable to covered non-routine services subject to payment limits under section 1888A.".

(b) CONFORMING AMENDMENT.—Section 1888 (42 U.S.C. 1395yy) is amended in the heading by inserting "AND CERTAIN ANCILLARY" after "SERVICE".

SEC. 15522. INCENTIVES FOR COST EFFECTIVE MANAGEMENT OF COVERED NON-ROUTINE SERVICES.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1888 the following new section:

"INCENTIVES FOR COST-EFFECTIVE MANAGEMENT OF COVERED NON-ROUTINE SERVICES OF SKILLED NURSING FACILITIES

"SEC. 1888A. (a) DEFINITIONS.—For purposes of this section:

"(1) COVERED NON-ROUTINE SERVICES.—The term 'covered non-routine services' means post-hospital extended care services consisting of any of the following:

"(A) Physical or occupational therapy or speech-language pathology services, or respiratory therapy, including supplies and support services incident to such services and therapy.

"(B) Prescription drugs.

"(C) Complex medical equipment.

"(D) Intravenous therapy and solutions (including enteral and parenteral nutrients, supplies, and equipment).

"(E) Radiation therapy.

"(F) Diagnostic services, including laboratory, radiology (including computerized tomography services and imaging services), and pulmonary services.

"(2) SNF MARKET BASKET PERCENTAGE INCREASE.—The term 'SNF market basket percentage increase' for a fiscal year means a percentage equal to the percentage increase in routine service cost limits for the year under section 1888(a).

"(3) STAY.—The term 'stay' means, with respect to an individual who is a resident of a skilled nursing facility, a period of continuous days during which the facility provides extended care services for which payment may be made under this title with respect to the individual during the individual's spell of illness.

"(b) NEW PAYMENT METHOD FOR COVERED NON-ROUTINE SERVICES.—

"(1) IN GENERAL.—Subject to subsection (c), a skilled nursing facility shall receive interim payments under this title for covered non-routine services furnished to an individual during a cost reporting period beginning during a fiscal year (after fiscal year 1996) in an amount equal to the reasonable cost of providing such services in accordance with section 1861(v). The Secretary may adjust such payments if the Secretary determines (on the basis of such estimated information as the Secretary considers appropriate) that payments to the facility under this paragraph for a cost reporting period would substantially exceed the cost reporting period limit determined under subsection (c)(1)(B).

"(2) RESPONSIBILITY OF SKILLED NURSING FACILITY TO MANAGE BILLINGS.—

"(A) CLARIFICATION RELATING TO PART A BILLING.—In the case of a covered non-routine service furnished to an individual who (at the time the service is furnished) is a resident of a skilled nursing facility who is entitled to coverage under section 1812(a)(2) for such service, the skilled nursing facility shall submit a claim for payment under this title for such service under part A (without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise).

"(B) PART B BILLING.—In the case of a covered non-routine service (other than a portable X-ray or portable electrocardiogram treated as a physician's service for purposes of section 1848(j)(3)) furnished to an individual who (at the time the service is furnished) is a resident of a skilled nursing facility

who is not entitled to coverage under section 1812(a)(2) for such service but is entitled to coverage under part B for such service, the skilled nursing facility shall submit a claim for payment under this title for such service under part B (without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise).

"(C) MAINTAINING RECORDS ON SERVICES FURNISHED TO RESIDENTS.—Each skilled nursing facility receiving payments for extended care services under this title shall document on the facility's cost report all covered non-routine services furnished to all residents of the facility to whom the facility provided extended care services for which payment was made under part A during a fiscal year (beginning with fiscal year 1996) (without regard to whether or not the services were furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise).

"(c) RECONCILIATION OF AMOUNTS.—

"(1) LIMIT BASED ON PER STAY LIMIT AND NUMBER OF STAYS.—

"(A) IN GENERAL.—If a skilled nursing facility has received aggregate payments under subsection (b) for covered non-routine services during a cost reporting period beginning during a fiscal year in excess of an amount equal to the cost reporting period limit determined under subparagraph (B), the Secretary shall reduce the payments made to the facility with respect to such services for cost reporting periods beginning during the following fiscal year in an amount equal to such excess. The Secretary shall reduce payments under this subparagraph at such times and in such manner during a fiscal year as the Secretary finds necessary to meet the requirement of this subparagraph.

"(B) COST REPORTING PERIOD LIMIT.—The cost reporting period limit determined under this subparagraph is an amount equal to the product of—

"(i) the per stay limit applicable to the facility under subsection (d) for the period; and

"(ii) the number of stays beginning during the period for which payment was made to the facility for such services.

"(C) PROSPECTIVE REDUCTION IN PAYMENTS.—In addition to the process for reducing payments described in subparagraph (A), the Secretary may reduce payments made to a facility under this section during a cost reporting period if the Secretary determines (on the basis of such estimated information as the Secretary considers appropriate) that payments to the facility under this section for the period will substantially exceed the cost reporting period limit for the period determined under this paragraph.

"(2) INCENTIVE PAYMENTS.—

"(A) IN GENERAL.—If a skilled nursing facility has received aggregate payments under subsection (b) for covered non-routine services during a cost reporting period beginning during a fiscal year in an amount that is less than the amount determined under paragraph (1)(B), the Secretary shall pay the skilled nursing facility in the following fiscal year an incentive payment equal to 50 percent of the difference between such amounts, except that the incentive payment may not exceed 5 percent of the aggregate payments made to the facility under subsection (b) for the previous fiscal year (without regard to subparagraph (B)).

"(B) INSTALLMENT INCENTIVE PAYMENTS.—The Secretary may make installment payments during a fiscal year to a skilled nursing facility based on the estimated incentive payment that the facility would be eligible to receive with respect to such fiscal year.

"(d) DETERMINATION OF FACILITY PER STAY LIMIT.—

"(1) LIMIT FOR FISCAL YEAR 1997.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), the Secretary shall establish separate per stay limits for hospital-based and freestanding skilled nursing facilities for the 12-month cost reporting period beginning during fiscal year 1997 that are equal to the sum of—

"(i) 50 percent of the facility-specific stay amount for the facility (as determined under subsection (e)) for the last 12-month cost reporting period ending on or before September 30, 1994, increased (in a compounded manner) by the SNF market basket percentage increase for fiscal years 1995 through 1997; and

"(ii) 50 percent of the average of all facility-specific stay amounts for all hospital-based facilities or all freestanding facilities (whichever is

applicable) during the cost reporting period described in clause (i), increased (in a compounded manner) by the SNF market basket percentage increase for fiscal years 1995 through 1997.

"(B) FACILITIES NOT HAVING 1994 COST REPORTING PERIOD.—In the case of a skilled nursing facility for which payments were not made under this title for covered non-routine services for the last 12-month cost reporting period ending on or before September 30, 1994, the per stay limit for the 12-month cost reporting period beginning during fiscal year 1997 shall be twice the amount determined under subparagraph (A)(ii).

"(2) LIMIT FOR SUBSEQUENT FISCAL YEARS.—The per stay limit for a skilled nursing facility for a 12-month cost reporting period beginning during a fiscal year after fiscal year 1997 is equal to the per stay limit established under this subsection for the 12-month cost reporting period beginning during the previous fiscal year, increased by the SNF market basket percentage increase for such subsequent fiscal year minus 2 percentage points.

"(3) REBASING OF AMOUNTS.—

"(A) IN GENERAL.—The Secretary shall provide for an update to the facility-specific amounts used to determine the per stay limits under this subsection for cost reporting periods beginning on or after October 1, 1999, and every 2 years thereafter.

"(B) TREATMENT OF FACILITIES NOT HAVING REBASED COST REPORTING PERIODS.—Paragraph (1)(B) shall apply with respect to a skilled nursing facility for which payments were not made under this title for covered non-routine services for the 12-month cost reporting period used by the Secretary to update facility-specific amounts under subparagraph (A) in the same manner as such paragraph applies with respect to a facility for which payments were not made under this title for covered non-routine services for the last 12-month cost reporting period ending on or before September 30, 1994.

"(e) DETERMINATION OF FACILITY-SPECIFIC STAY AMOUNTS.—The 'facility-specific stay amount' for a skilled nursing facility for a cost reporting period is the sum of—

"(1) the average amount of payments made to the facility under part A during the period which are attributable to covered non-routine services furnished during a stay; and

"(2) the Secretary's best estimate of the average amount of payments made under part B during the period for covered non-routine services furnished to all residents of the facility to whom the facility provided extended care services for which payment was made under part A during the period (without regard to whether or not the services were furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise), as estimated by the Secretary.

"(f) INTENSIVE NURSING OR THERAPY NEEDS.—

"(1) IN GENERAL.—In applying subsection (b) to covered non-routine services furnished during a stay beginning during a cost reporting period beginning during a fiscal year to a resident of a skilled nursing facility who requires intensive nursing or therapy services, the per stay limit determined for the fiscal year under the methodology for such resident shall be the per stay limit developed under paragraph (2) instead of the per stay limit determined under subsection (d)(1)(A).

"(2) PER STAY LIMIT FOR INTENSIVE NEED RESIDENTS.—Not later than June 30, 1996, the Secretary, after consultation with the Medicare Payment Review Commission and skilled nursing facility experts, shall develop and publish a methodology for determining on an annual basis a per stay limit for residents of a skilled nursing facility who require intensive nursing or therapy services.

"(3) BUDGET NEUTRALITY.—The Secretary shall adjust payments under subsection (b) in a manner that ensures that total payments for covered non-routine services under this section are not greater or less than total payments for such services would have been but for the application of paragraph (1).

"(g) SPECIAL TREATMENT FOR MEDICARE LOW VOLUME SKILLED NURSING FACILITIES.—This section shall not apply with respect to a skilled nursing facility for which payment is made for routine service costs during a cost reporting period on the basis of prospective payments under section 1888(d).

"(h) EXCEPTIONS AND ADJUSTMENTS TO LIMITS.—

"(1) IN GENERAL.—The Secretary may make exceptions and adjustments to the cost reporting limits applicable to a skilled nursing facility under subsection (c)(1)(B) for a cost reporting period, except that the total amount of any additional payments made under this section for covered non-routine services during the cost reporting period as a result of such exceptions and adjustments may

not exceed 5 percent of the aggregate payments made to all skilled nursing facilities for covered non-routine services during the cost reporting period (determined without regard to this paragraph).

"(2) BUDGET NEUTRALITY.—The Secretary shall adjust payments under subsection (b) in a manner that ensures that total payments for covered non-routine services under this section are not greater or less than total payments for such services would have been but for the application of paragraph (1).

"(i) SPECIAL RULE FOR X-RAY SERVICES.—Before furnishing a covered non-routine service consisting of an X-ray service for which payment may be made under part A or part B to a resident, a skilled nursing facility shall consider whether furnishing the service through a provider of portable X-ray services would be appropriate, taking into account the cost effectiveness of the service and the convenience to the resident.".

(b) CONFORMING AMENDMENT.—Section 1814(b) (42 U.S.C. 1395f(b)) is amended in the matter preceding paragraph (1) by striking "1813 and 1886" and inserting "1813, 1886, 1888, and 1888A".

SEC. 15523. PAYMENTS FOR ROUTINE SERVICE COSTS.

(a) MAINTAINING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES.—

(1) BASING UPDATES TO PER DIEM COST LIMITS ON LIMITS FOR FISCAL YEAR 1993.—

(A) IN GENERAL.—The last sentence of section 1888(a) (42 U.S.C. 1395yy(a)) is amended by inserting before the period at the end the following: "(except that such updates may not take into account any changes in the routine service costs of skilled nursing facilities occurring during cost reporting periods which began during fiscal year 1994 or fiscal year 1995)".

(B) NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.—The Secretary of Health and Human Services shall not consider the amendment made by subparagraph (A) in making any adjustments pursuant to section 1888(c) of the Social Security Act.

(2) PAYMENTS DETERMINED ON PROSPECTIVE BASIS.—Any change made by the Secretary of Health and Human Services in the amount of any prospective payment paid to a skilled nursing facility under section 1888(d) of the Social Security Act for cost reporting periods beginning on or after October 1, 1995, may not take into account any changes in the costs of services occurring during cost reporting periods which began during fiscal year 1994 or fiscal year 1995.

(b) ESTABLISHMENT OF SCHEDULE FOR MAKING ADJUSTMENTS TO LIMITS.—Section 1888(c) (42 U.S.C. 1395yy(c)) is amended by striking the period at the end of the second sentence and inserting ", and may only make adjustments under this subsection with respect to a facility which applies for an adjustment during an annual application period established by the Secretary.".

(c) LIMITATION ON AGGREGATE INCREASE IN PAYMENTS RESULTING FROM ADJUSTMENTS TO LIMITS.—Section 1888(c) (42 U.S.C. 1395yy(c)) is amended—

(1) by striking "(c) The Secretary" and inserting "(c)(1) Subject to paragraph (2), the Secretary"; and

(2) by adding at the end the following new paragraph:

"(2) The Secretary may not make any adjustments under this subsection in the limits set forth in subsection (a) for a cost reporting period beginning during a fiscal year to the extent that the total amount of the additional payments made under this title as a result of such adjustments is greater than an amount equal to—

"(A) for cost reporting periods beginning during fiscal year 1997, the total amount of the additional payments made under this title as a result of adjustments under this subsection for cost reporting periods beginning during fiscal year 1996 increased by the SNF market basket percentage increase (as defined in section 1888A(e)(3)) for fiscal year 1997; and

"(B) for cost reporting periods beginning during a subsequent fiscal year, the amount determined under this paragraph for the previous fiscal year increased by the SNF market basket percentage increase for such subsequent fiscal year.".

(d) IMPOSITION OF LIMITS FOR ALL COST REPORTING PERIODS.—Section 1888(a) (42 U.S.C. 1395yy(a)) is amended in the matter preceding paragraph (1) by inserting after "extended care services" the following: "(for any cost reporting period for which payment is made under this title to the skilled nursing facility for such services)".

SEC. 15524. REDUCTIONS IN PAYMENT FOR CAPITAL-RELATED COSTS.

Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)), as amended by section 15506, is amended by adding at the end the following new subparagraph:

"(U) Such regulations shall provide that, in determining the amount of the payments that may be made under this title with respect to all the capital-related costs

of skilled nursing facilities, the Secretary shall reduce the amounts of such payments otherwise established under this title by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1996 through 2002.".

SEC. 15525. TREATMENT OF ITEMS AND SERVICES PAID FOR UNDER PART B.

(a) REQUIRING PAYMENT FOR ALL ITEMS AND SERVICES TO BE MADE TO FACILITY.—

(1) IN GENERAL.—The first sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended—

(A) by striking "and (D)" and inserting "(D)"; and

(B) by striking the period at the end and inserting the following: ", and (E) in the case of an item or service (other than physicians' services and other than a portable X-ray or portable electrocardiogram treated as a physician's service for purposes of section 1848(j)(3)) furnished to an individual who (at the time the item or service is furnished) is a resident of a skilled nursing facility, payment shall be made to the facility (without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, or otherwise).".

(2) EXCLUSION FOR ITEMS AND SERVICES NOT BILLED BY FACILITY.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(A) by striking "or" at the end of paragraph (14);

(B) by striking the period at the end of paragraph (15) and inserting "; or"; and

(C) by inserting after paragraph (15) the following new paragraph:

"(16) where such expenses are for covered non-routine services (as defined in section 1888A(a)(1)) (other than a portable X-ray or portable electrocardiogram treated as a physician's service for purposes of section 1848(j)(3)) furnished to an individual who is a resident of a skilled nursing facility and for which the claim for payment under this title is not submitted by the facility.".

(3) CONFORMING AMENDMENT.—Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)) is amended by striking "(2);" and inserting "(2) and section 1842(b)(6)(E);".

(b) REDUCTION IN PAYMENTS FOR ITEMS AND SERVICES FURNISHED BY OR UNDER ARRANGEMENTS WITH FACILITIES.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)), as amended by sections 15506 and 15524, is amended by adding at the end the following new subparagraph:

"(V) In the case of an item or service furnished by a skilled nursing facility (or by others under arrangement with them made by a skilled nursing facility) for which payment is made under part B in an amount determined in accordance with section 1833(a)(2)(B), the Secretary shall reduce the reasonable cost for such item or service otherwise determined under clause (i)(I) of such section by 5.8 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1996 through 2002.".

SEC. 15526. CERTIFICATION OF FACILITIES MEETING REVISED NURSING HOME REFORM STANDARDS.

(a) IN GENERAL.—Section 1819(a)(3) (42 U.S.C. 1395i–3(a)(3)) is amended to read as follows:

"(3)(A) is certified by the Secretary as meeting the standards established under subsection (b), or (B) is a State-certified facility (as defined in subsection (d)).".

(b) REQUIREMENTS DESCRIBED.—Section 1819 (42 U.S.C. 1395i–3) is amended by striking subsections (b) through (i) and inserting the following:

"(b) STANDARDS FOR AND CERTIFICATION OF FACILITIES.—

"(1) STANDARDS FOR FACILITIES.—

"(A) IN GENERAL.—The Secretary shall provide for the establishment and maintenance of standards consistent with the contents described in subparagraph (B) for skilled nursing facilities which furnish services for which payment may be made under this title.

"(B) CONTENTS OF STANDARDS.—The standards established for facilities under this paragraph shall contain provisions relating to the following items:

"(i) The treatment of resident medical records.

"(ii) Policies, procedures, and bylaws for operation.

"(iii) Quality assurance systems.

"(iv) Resident assessment procedures, including care planning and outcome evaluation.

"(v) The assurance of a safe and adequate physical plant for the facility.

"(vi) Qualifications for staff sufficient to provide adequate care.

"(vii) Utilization review.

"(viii) The protection and enforcement of resident rights described in subparagraph (C).

"(C) RESIDENT RIGHTS DESCRIBED.—The resident rights described in this subparagraph are the rights of residents to the following:

"(i) To exercise the individual's rights as a resident of the facility and as a citizen or resident of the United States.

"(ii) To receive notice of rights and services.

"(iii) To be protected against the misuse of resident funds.

"(iv) To be provided privacy and confidentiality.

"(v) To voice grievances.

"(vi) To examine the results of inspections under the certification program.

"(vii) To refuse to perform services for the facility.

"(viii) To be provided privacy in communications and to receive mail.

"(ix) To have the facility provide immediate access to any resident by any representative of the certification program, the resident's individual physician, the State long term care ombudsman, and any person the resident has designated as a visitor.

"(x) To retain and use personal property.

"(xi) To be free from abuse, including verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion.

"(xii) To be provided with prior written notice of a pending transfer or discharge.

"(D) REQUIRING NOTICE AND COMMENT.—The standards established for facilities under this paragraph may only take effect after the Secretary has provided the public with notice and an opportunity for comment.

"(2) CERTIFICATION PROGRAM.—

"(A) IN GENERAL.—The Secretary shall provide for the establishment and operation of a program consistent with the requirements of subparagraph (B) for the certification of skilled nursing facilities which meet the standards established under paragraph (1) and the decertification of facilities which fail to meet such standards.

"(B) REQUIREMENTS FOR PROGRAM.—In addition to any other requirements the Secretary may impose, in establishing and operating the certification program under subparagraph (A), the Secretary shall ensure the following:

"(i) The Secretary shall ensure public access (as defined by the Secretary) to the certification program's evaluations of participating facilities, including compliance records and enforcement actions and other reports by the Secretary regarding the ownership, compliance histories, and services provided by certified facilities.

"(ii) Not less often than every 4 years, the Secretary shall audit its expenditures under the program, through an entity designated by the Secretary which is not affiliated with the program, as designated by the Secretary.

"(c) INTERMEDIATE SANCTION AUTHORITY.—

"(1) AUTHORITY.—In addition to any other authority, where the Secretary determines that a nursing facility which is certified for participation under this title (whether certified by the Secretary as meeting the standards established under subsection (b) or a State-ceritified facility) no longer or does not substantially meet the requirements for such a facility under this title as specified under subsection (b) and further determines that the facility's deficiencies—

"(A) immediately jeopardize the health and safety of its residents, the Secretary shall at least provide for the termination of the facility's certification for participation under this title, or

"(B) do not immediately jeopardize the health and safety of its residents, the Secretary may, in lieu of providing for terminating the facility's certification for participation under the plan, provide lesser sanctions including one that provides that no payment will be made under this title with respect to any individual admitted to such facility after a date specified by the Secretary.

"(2) NOTICE.—The Secretary shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer or does not substantially meet the requirements for such a facility under this title, to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

"(3) EFFECTIVENESS.—The Secretary's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the Secretary, and its effectiveness shall terminate (A) when the Secretary finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the requirements for such a facility under this title, or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the Secretary shall terminate such facility's certification for participation under this title effective with the first day of the first month following the month specified in such clause.

"(d) STATE-CERTIFIED FACILITY DEFINED.—In subsection (a), a 'State-certified facility' means a facility licensed or certified as a skilled nursing facility by the State in which it is located, or a facility which otherwise meets the requirements applicable to providers of nursing facility services under the State plan under title XIX or the MediGrant program under title XXI.".

(c) CONFORMING AMENDMENTS.—(1) Section 1861(v)(1)(E) (42 U.S.C. 1395x(v)(1)(E)) is amended by striking the second sentence.

(2) Section 1864 (42 U.S.C. 1395aa) is amended by striking subsection (d).

(3) Section 1866(f)(1) (42 U.S.C. 1395cc(f)(1)) is amended by striking "1819(c)(2)(E),".

(4) Section 1883(f) (42 U.S.C. 1395tt(f)) is amended—

(A) in the second sentence, by striking "such a hospital" and inserting "a hospital which enters into an agreement with the Secretary under this section"; and

(B) by striking the first sentence.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to cost reporting periods beginning on or after October 1, 1995.

SEC. 15527. MEDICAL REVIEW PROCESS.

In order to ensure that medicare beneficiaries are furnished appropriate extended care services, the Secretary of Health and Human Services shall establish and implement a thorough medical review process to examine the effects of the amendments made by this part on the quality of extended care services furnished to medicare beneficiaries. In developing such a medical review process, the Secretary shall place a particular emphasis on the quality of non-routine covered services for which payment is made under section 1888A of the Social Security Act.

SEC. 15528. REPORT BY MEDICARE PAYMENT REVIEW COMMISSION.

Not later than October 1, 1997, the Medicare Payment Review Commission shall submit to Congress a report on the system under which payment is made under the medicare program for extended care services furnished by skilled nursing facilities, and shall include in the report the following:

(1) An analysis of the effect of the methodology established under section 1888A of the Social Security Act (as added by section 15522) on the payments for, and the quality of, extended care services under the medicare program.

(2) An analysis of the advisability of determining the amount of payment for covered non-routine services of facilities (as described in such section) on the basis of the amounts paid for such services when furnished by suppliers under part B of the medicare program.

(3) An analysis of the desirability of maintaining separate limits for hospital-based and freestanding facilities in the costs of extended care services recognized as reasonable under the medicare program.

(4) An analysis of the quality of services furnished by skilled nursing facilities.

(5) An analysis of the adequacy of the process and standards used to provide exceptions to the limits described in paragraph (3).

SEC. 15529. EFFECTIVE DATE.

Except as otherwise provided in this part, the amendments made by this part shall apply to services furnished during cost reporting periods (or portions of cost reporting periods) beginning on or after October 1, 1996.

Subtitle G—Provisions Relating to Medicare Part B

PART 1—PAYMENT REFORMS

SEC. 15601. PAYMENTS FOR PHYSICIANS' SERVICES.

(a) REPLACEMENT OF VOLUME PERFORMANCE STANDARD WITH SUSTAINABLE GROWTH RATE.—Section 1848(f) (42 U.S.C. 1395w–4(f)) is amended to read as follows:

"(f) SUSTAINABLE GROWTH RATE.—

"(1) SPECIFICATION OF GROWTH RATE.—

"(A) FISCAL YEAR 1996.—The sustainable growth rate for all physicians' services for fiscal year 1996 shall be equal to the product of—

"(i) 1 plus the Secretary's estimate of the percentage change in the medicare economic index for 1996 (described in the fourth sentence of section 1842(b)(3)) (divided by 100),

"(ii) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than private plan enrollees) from fiscal year 1995 to fiscal year 1996,

"(iii) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from fiscal year 1995 to fiscal year 1996, plus 2 percentage points, and

"(iv) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in fiscal year 1996 (compared with fiscal year 1995) which will result from changes in law, determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians' services or changes in expenditures resulting from changes in the update to the conversion factor under subsection (d),

minus 1 and multiplied by 100.

"(B) SUBSEQUENT FISCAL YEARS.—The sustainable growth rate for all physicians' services for fiscal year 1997 and each subsequent fiscal year shall be equal to the product of—

"(i) 1 plus the Secretary's estimate of the percentage change in the medicare economic index for the fiscal year involved (described in the fourth sentence of section 1842(b)(3)) (divided by 100),

"(ii) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than private plan enrollees) from the previous fiscal year to the fiscal year involved,

"(iii) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from the previous fiscal year to the fiscal year involved, plus 2 percentage points, and

"(iv) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the fiscal year (compared with the previous fiscal year) which will result from changes in law (including changes made by the Secretary in response to section 1895), determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians' services or changes in expenditures resulting from changes in the update to the conversion factor under subsection (d)(3),

minus 1 and multiplied by 100.

"(2) EXCLUSION OF SERVICES FURNISHED TO PRIVATE PLAN ENROLLEES.—In this subsection, the term 'physicians' services' with respect to a fiscal year does not include services furnished to an individual enrolled under this part who has elected to receive benefits under this title for the fiscal year through a MedicarePlus product offered under part C or through enrollment with an eligible organization with a risk-sharing contract under section 1876.".

(b) ESTABLISHING UPDATE TO CONVERSION FACTOR TO MATCH SPENDING UNDER SUSTAINABLE GROWTH RATE.—

(1) IN GENERAL.—Section 1848(d) (42 U.S.C. 1395w–4(d)) is amended—

(A) by striking paragraph (2);

(B) by amending paragraph (3) to read as follows:

"(3) UPDATE.—

"(A) IN GENERAL.—Subject to subparagraph (E), for purposes of this section the update for a year (beginning with 1997) is equal to the product of—

"(i) 1 plus the Secretary's estimate of the percentage increase in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for the year (divided by 100), and

"(ii) 1 plus the Secretary's estimate of the update adjustment factor for the year (divided by 100),

minus 1 and multiplied by 100.

"(B) UPDATE ADJUSTMENT FACTOR.—The 'update adjustment factor' for a year is equal to the quotient of—

"(i) the difference between (I) the sum of the allowed expenditures for physicians' services furnished during each of the years 1995 through the year involved and (II) the sum of the amount of actual expenditures for physicians' services furnished during each of the years 1995 through the previous year; divided by

"(ii) the Secretary's estimate of allowed expenditures for physicians' services furnished during the year.

"(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of subparagraph (B), allowed expenditures for physicians' services shall be determined as follows (as estimated by the Secretary):

"(i) In the case of allowed expenditures for 1995, such expenditures shall be equal to actual expenditures for services furnished during the 12-month period ending with June of 1995.

"(ii) In the case of allowed expenditures for 1996 and each subsequent year, such expenditures shall be equal to allowed expenditures for the previous year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during the year.

"(D) DETERMINATION OF ACTUAL EXPENDITURES.—For purposes of subparagraph (B), the amount of actual expenditures for physicians' services furnished during a year shall be equal to the amount of expenditures for such services during the 12-month period ending with June of the previous year.

"(E) RESTRICTION ON VARIATION FROM MEDICARE ECONOMIC INDEX.—Notwithstanding the amount of the update adjustment factor determined under subparagraph (B) for a year, the update in the conversion factor under this paragraph for the year may not be—

"(i) greater than 103 percent of 1 plus the Secretary's estimate of the percentage increase in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for the year (divided by 100); or

"(ii) except as required to carry out section 1895, less than 93 percent of 1 plus the Secretary's estimate of the percentage increase in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for the year (divided by 100).."; and

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

"(4) REPORTING REQUIREMENTS.—

"(A) IN GENERAL.—Not later than November 1 of each year (beginning with 1996), the Secretary shall transmit to the Congress a report that describes the update in the conversion factor for physicians' services (as defined in subsection (f)(3)(A)) in the following year.

"(B) COMMISSION REVIEW.—The Medicare Payment Review Commission shall review the report submitted under subparagraph (A) for a year and shall submit to the Congress, by not later than December 1 of the year, a report containing its analysis of the conversion factor for the following year.".

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to physicians' services furnished on or after January 1, 1997.

(c) ESTABLISHMENT OF SINGLE CONVERSION FACTOR FOR 1996.—

(1) IN GENERAL.—Section 1848(d)(1) (42 U.S.C. 1395w–4(d)(1)) is amended—

(A) by redesignating subparagraph (C) as subparagraph (D); and

(B) by inserting after subparagraph (B) the following new subparagraph:

"(C) SPECIAL RULE FOR 1996.—For 1996, the conversion factor under this subsection shall be $34.60 for all physicians' services.".

(2) CONFORMING AMENDMENTS.—Section 1848 (42 U.S.C. 1395w–4), as amended by paragraph (1), is amended—

(A) by striking "(or factors)" each place it appears in subsection (d)(1)(A) and (d)(1)(D)(ii);

(B) in subsection (d)(1)(A), by striking "or updates";

(C) in subsection (d)(1)(D)(ii), by striking "(or updates)"; and

(D) in subsection (i)(1)(C), by striking "conversion factors" and inserting "the conversion factor".

SEC. 15602. ELIMINATION OF FORMULA-DRIVEN OVERPAYMENTS FOR CERTAIN OUTPATIENT HOSPITAL SERVICES.

(a) AMBULATORY SURGICAL CENTER PROCEDURES.—Section 1833(i)(3)(B)(i)(II) (42 U.S.C. 1395l(i)(3)(B)(i)(II)) is amended—

(1) by striking "of 80 percent"; and

(2) by striking the period at the end and inserting the following: ", less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).".

(b) RADIOLOGY SERVICES AND DIAGNOSTIC PROCEDURES.—Section 1833(n)(1)(B)(i)(II) (42 U.S.C. 1395l(n)(1)(B)(i)(II)) is amended—

(1) by striking "of 80 percent"; and

(2) by striking the period at the end and inserting the following: ", less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished during portions of cost reporting periods occurring on or after October 1, 1995.

SEC. 15603. REDUCTION IN UPDATES TO PAYMENT AMOUNTS FOR DURABLE MEDICAL EQUIPMENT.

(a) IN GENERAL.—

(1) FREEZE IN UPDATE FOR COVERED ITEMS.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended—

(A) by striking "and" at the end of subparagraph (A);

(B) in subparagraph (B)—

(i) by striking "a subsequent year" and inserting "1993, 1994, and 1995", and

(ii) by striking the period at the end and inserting a semicolon; and

(C) by adding at the end the following:

"(C) for each of the years 1996 through 2002, 0 percentage points; and

"(D) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.".

(2) UPDATE FOR ORTHOTICS AND PROSTHETICS.—Section 1834(h)(4)(A) (42 U.S.C. 1395m(h)(4)(A)) is amended—

(A) by striking "and" at the end of clause (iii);

(B) by redesignating clause (iv) as clause (v); and

(C) by inserting after clause (iii) the following new clause:

"(iv) for each of the years 1996 through 2002, 1 percent, and".

(b) OXYGEN AND OXYGEN EQUIPMENT.—Section 1834(a)(9)(C) (42 U.S.C. 1395m(a)(9)(C)) is amended—

(1) by striking "and" at the end of clause (iii);

(2) in clause (iv)—

(A) by striking "a subsequent year" and inserting "1993, 1994, and 1995", and

(B) by striking the period at the end and inserting a semicolon; and

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

"(v) in 1996, is 80 percent of the national limited monthly payment rate computed under subparagraph (B) for the item for the year; and

"(vi) in a subsequent year, is the national limited monthly payment rate computed under subparagraph (B) for the item for the year.".

SEC. 15604. REDUCTION IN UPDATES TO PAYMENT AMOUNTS FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) CHANGE IN UPDATE.—Section 1833(h)(2)(A)(ii)(IV) (42 U.S.C. 1395l(h)(2)(A)(ii)(IV)) is amended by striking "1994 and 1995" and inserting "1994 through 2002".

(b) LOWERING CAP ON PAYMENT AMOUNTS.—Section 1833(h)(4)(B) (42 U.S.C. 1395l(h)(4)(B)) is amended—

(1) in clause (vi), by striking "and" at the end;

(2) in clause (vii)—

(A) by inserting "and before January 1, 1997," after "1995,", and

(B) by striking the period at the end and inserting ", and"; and

(3) by adding at the end the following new clause:

"(viii) after December 31, 1996, is equal to 65 percent of such median.".

SEC. 15605. EXTENSION OF REDUCTIONS IN PAYMENTS FOR COSTS OF HOSPITAL OUTPATIENT SERVICES.

(a) REDUCTION IN PAYMENTS FOR CAPITAL-RELATED COSTS.—Section 1861(v)(1)(S)(ii)(I) (42 U.S.C. 1395x(v)(1)(S)(ii)(I)) is amended by striking "through 1998" and inserting "through 2002".

(b) REDUCTION IN PAYMENTS FOR OTHER COSTS.—Section 1861(v)(1)(S)(ii)(II) (42 U.S.C. 1395x(v)(1)(S)(ii)(II)) is amended by striking "through 1998" and inserting "through 2002".

SEC. 15606. FREEZE IN PAYMENTS FOR AMBULATORY SURGICAL CENTER SERVICES.

The Secretary of Health and Human Services shall not provide for any inflation update in the payment amounts under subparagraphs (A) and (B) of section 1833(i)(2) of the Social Security Act for any of the fiscal years 1996 through 2002.

SEC. 15607. RURAL EMERGENCY ACCESS CARE HOSPITALS.

(a) COVERAGE UNDER PART B.—Section 1832(a)(2) (42 U.S.C. 1395k(a)(2)) is amended—

(1) by striking "and" at the end of subparagraph (I);

(2) by striking the period at the end of subparagraph (J) and inserting "; and"; and

(3) by adding at the end the following new subparagraph:

"(K) rural emergency access care hospital services (as defined in section 1861(oo)(2)).".

(b) PAYMENT BASED ON PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—

(1) IN GENERAL.—Section 1833(a)(6) (42 U.S.C. 1395l(a)(6)) is amended by striking "services," and inserting "services and rural emergency access care hospital services,".

(2) PAYMENT METHODOLOGY DESCRIBED.—Section 1834(g) (42 U.S.C. 1395m(g)) is amended—

(A) in the heading, by striking "SERVICES" and inserting "SERVICES AND RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES"; and

(B) by adding at the end the following new sentence: "The amount of payment for rural emergency access care hospital services provided during a year shall be determined using the applicable method provided under this subsection for determining payment for outpatient rural primary care hospital services during the year.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after October 1, 1995.

PART 2—PART B PREMIUM

SEC. 15611. EXTENSION OF PART B PREMIUM.

(a) IN GENERAL.—Section 1839(e)(1) (42 U.S.C. 1395r(e)(1)) is amended—

(1) in subparagraph (A)—

(A) by striking "and prior to January 1999", and

(B) by inserting "(or, if higher, the percent described in subparagraph (C))" after "50 percent"; and

(2) by adding at the end the following new subparagraph:

"(C) For purposes of subparagraph (A), the percent described in this subparagraph is the ratio (expressed as a percentage) of the monthly premium established under this section for months in 1995 to the monthly actuarial rate for enrollees age 65 and over applicable to such months (as specified in the most recent report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund published prior to the date of the enactment of the Medicare Preservation Act of 1995).".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) apply to premiums for months beginning with January 1996.

SEC. 15612. INCOME-RELATED REDUCTION IN MEDICARE SUBSIDY.

(a) IN GENERAL.—Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following:

"(h)(1) Notwithstanding the previous subsections of this section, in the case of an individual whose modified adjusted gross income for a taxable year ending with or within a calendar year (as initially determined by the Secretary in accordance with paragraph (3)) exceeds the threshold amount described in paragraph (4), the Secretary shall increase the amount of the monthly premium for months in the calendar year by an amount equal to the difference between—

"(A) 200 percent of the monthly actuarial rate for enrollees age 65 and over as determined under subsection (a)(1) for that calendar year; and

"(B) the total of the monthly premiums paid by the individual under this section (determined without regard to subsection (b)) during such calendar year.

"(2) In the case of an individual described in paragraph (1) whose modified adjusted gross exceeds the threshold amount by less than $25,000, the amount of the increase in the monthly premium applicable under paragraph (1) shall be an amount which bears the same ratio to the amount of the increase described in paragraph (1) (determined without regard to this paragraph) as such excess bears to $25,000. In the case of a joint return filed under section 6013 of the Internal Revenue Code of 1986 by spouses both of whom are enrolled under this part, the previous sentence shall be applied by substituting '$50,000' for '$25,000'. The preceding provisions of this paragraph shall not apply to any individual whose threshold amount is zero.

"(3) The Secretary shall make an initial determination of the amount of an individual's adjusted gross income for a taxable year ending with or within a calendar year for purposes of this subsection as follows:

"(A) Not later than October 1 of the year preceding the year, the Secretary shall provide notice to each individual whom the Secretary finds (on the basis of the individual's actual adjusted gross income for the most recent taxable year for which such information is available or other information provided to the Secretary by the Secretary of the Treasury) will be subject to an increase under this subsection that the individual will be subject to such an increase, and shall include in such notice the Secretary's estimate of the individual's adjusted gross income for the year.

"(B) If, during the 30-day period beginning on the date notice is provided to an individual under subparagraph (A), the individual provides the Secretary with information on the individual's anticipated adjusted gross income for the year, the amount initially determined by the Secretary under this paragraph with respect to the individual shall be based on the information provided by the individual.

"(C) If an individual does not provide the Secretary with information under subparagraph (B), the amount initially determined by the Secretary under this paragraph with respect to the individual shall be the amount included in the notice provided to the individual under subparagraph (A).

"(4)(A) If the Secretary determines (on the basis of final information provided by the Secretary of the Treasury) that the amount of an individual's actual adjusted gross income for a taxable year ending with or within a calendar year is less than or greater than the amount initially determined by the Secretary under paragraph (3), the Secretary shall increase or decrease the amount of the individual's monthly premium under this section (as the case may be) for months during the following calendar year by an amount equal to 1/12 of the difference between—

"(i) the total amount of all monthly premiums paid by the individual under this section during the previous calendar year; and

"(ii) the total amount of all such premiums which would have been paid by the individual during the previous calendar year if the amount of the individual's adjusted gross income initially determined under paragraph (3) were equal to the actual amount of the individual's adjusted gross income determined under this paragraph.

"(B) In the case of an individual who is not enrolled under this part for any calendar year for which the individual's monthly premium under this section for months during the year would be increased pursuant to subparagraph (A) if the individual were enrolled under this part for the year, the Secretary may take such steps as the Secretary considers appropriate to recover from the individual the total amount by which the individual's monthly premium for months during the year would have been increased under subparagraph (A) if the individual were enrolled under this part for the year.

"(C) In the case of a deceased individual for whom the amount of the monthly premium under this section for months in a year would have been decreased pursuant to subparagraph (A) if the individual were not deceased, the Secretary shall make a payment to the individual's surviving spouse (or, in the case of an individual who does not have a surviving spouse, to the individual's estate) in an amount equal to the difference between—

"(i) the total amount by which the individual's premium would have been decreased for all months during the year pursuant to subparagraph (A); and

"(ii) the amount (if any) by which the individual's premium was decreased for months during the year pursuant to subparagraph (A).

"(5) In this subsection, the following definitions apply:

"(A) The term 'modified adjusted gross income' means, with respect to an individual for a taxable year, the individual's adjusted gross income under the Internal Revenue Code of 1986—

"(i) determined without regard to sections 135, 911, 931, and 933 of such Code, and

"(ii) increased by the amount of interest received or accrued by the individual during the taxable year which is exempt from tax under such Code.

"(B) The term 'threshold amount' means—

"(i) except as otherwise provided in this paragraph, $75,000,

"(ii) $125,000, in the case of a joint return, and

"(iii) zero in the case of a taxpayer who—

"(I) is married at the close of the taxable year but does not file a joint return for such year, and

"(II) does not live apart from his spouse at all times during the taxable year.".

(b) CONFORMING AMENDMENT.—Section 1839(f) (42 U.S.C. 1395r(f)) is amended by striking "if an individual" and inserting the following: "if an individual (other than an individual subject to an increase in the monthly premium under this section pursuant to subsection (h))".

(c) REPORTING REQUIREMENTS FOR SECRETARY OF THE TREASURY.—Notwithstanding section 6103 of the Internal Revenue Code of 1986, the Secretary of the Treasury shall provide, at the request of the Secretary of Health and Human Services, such information (at such times and in such form as the Secretary of Health and Human Services may require) as is necessary for the Secretary of Health and Human Services to carry out section 1839(h) of the Social Security Act (as added by subsection (a)).

(d) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to the monthly premium under section 1839 of the Social Security Act for months beginning with January 1997.

PART 3—ADMINISTRATIVE SIMPLIFICATION FOR LABORATORY SERVICES

SEC. 15621. ADMINISTRATIVE SIMPLIFICATION FOR LABORATORY SERVICES.

(a) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services (in accordance with the process described in subsection (b)) shall adopt uniform coverage, administration, and payment policies for clinical diagnostic laboratory tests under part B of the medicare program.

(b) PROCESS FOR ADOPTION OF POLICIES.—The Secretary shall adopt uniform policies under subsection (a) in accordance with the following process:

(1) The Secretary shall select from carriers with whom the Secretary has a contract under part B during 1995 15 medical directors, who will meet and develop recommendations for such uniform policies. The medical directors selected shall represent various geographic areas and have a varied range of experience in relevant medical fields, including pathology and clinical laboratory practice.

(2) The medical directors selected under paragraph (1) shall consult with independent experts in each major discipline of clinical laboratory medicine, including clinical laboratory personnel, bioanalysts, pathologists, and practicing physicians. The medical directors shall also solicit comments from other individuals and groups who wish to participate, including consumers and other affected parties. This process shall be conducted as a negotiated rulemaking under title 5, United States Code.

(3) Under the negotiated rulemaking, the recommendations for uniform policies shall be designed to simplify and reduce unnecessary administrative burdens in connection with the following:

(A) Beneficiary information required to be submitted with each claim.

(B) Physicians' obligations regarding documentation requirements and recordkeeping.

(C) Procedures for filing claims and for providing remittances by electronic media.

(D) The performance of post-payment review of test claims.

(E) The prohibition of the documentation of medical necessity except when determined to be appropriate after identification of aberrant utilization pattern through focused medical review.

(F) Beneficiary responsibility for payment.

(4) During the pendency of the adoption by the Secretary of the uniform policies, fiscal intermediaries and carriers under the medicare program may not implement any new requirement relating to the submission of a claim for clinical diagnostic laboratory tests retroactive to January 1, 1995, and carriers may not initiate any new coverage, administrative, or payment policy unless the policy promotes the goal of administrative simplification of requirements imposed on clinical laboratories in accordance with the Secretary's promulgation of the negotiated rulemaking.

(5) Not later than 6 months after the date of the enactment of this Act, the medical directors shall submit their recommendations to the Secretary, and the Secretary shall publish the recommendations and solicit public comment using negotiated rulemaking in accordance with title 5, United States Code. The Secretary shall publish final uniform policies for coverage, administration, and payment of claims for clinical diagnostic laboratory tests, effective after the expiration of the 180-day period which begins on the date of publication.

(6) After the publication of the final uniform policies, the Secretary shall implement identical uniform documentation and processing policies for all clinical diagnostic laboratory tests paid under the medicare program through fiscal intermediaries or carriers.

(c) OPTIONAL SELECTION OF SINGLE CARRIER.—Effective for claims submitted after the expiration of the 90-day period which begins on the date of the enactment of this Act, an independent laboratory may select a single carrier for the processing of all of its claims for payment under part B of the medicare program, without regard to the location where the laboratory or the patient or provider involved resides or conducts business. Such election of a single carrier shall be made by the clinical laboratory and an agreement made between the carrier and the laboratory shall be forwarded to the Secretary of Health and Human Services. Nothing in this subsection shall be construed to require a laboratory to select a single carrier under this subsection.

PART 4—COVERAGE OF CERTAIN ANTI-NAUSEA DRUGS

SEC. 15631. COVERAGE OF ORAL ANTI-NAUSEA DRUGS UNDER CHEMOTHERAPEUTIC REGIMEN.

Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(1) by striking "and" at the end of subparagraphs (N) and (O);

(2) in subparagraph (Q), by adding "and" at the end; and

(3) by adding at the end the following new subparagraph:

"(R) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an anti-emetic used as part of an anticancer chemotherapeutic regimen, if the drug is prescribed or dispensed—

"(i) for use not later than 12 hours after the administration of the anticancer chemotherapeutic agent; and

"(ii) as a substitute for any other anti-emetic therapy which would otherwise be administered intravenously.".

SEC. 15632. EFFECTIVE DATE.

The amendments made by this part shall apply to items and services furnished on or after January 1, 1996.

PART 5—COVERAGE OF CERTAIN SERVICES ORDERED OR REFERRED BY CHIROPRACTORS

SEC. 15641. COVERAGE OF CERTAIN SERVICES ORDERED OR REFERRED BY CHIROPRACTORS.

(a) CLARIFYING THAT CHIROPRACTORS MAY ORDER, AND REFER PATIENTS TO OTHER PRACTITIONERS FOR, X-RAYS.—Section 1861(r)(5) (42 U.S.C. 1395x(r)(5)) is amended by striking the period at the end and inserting the following: ", and for the ordering or referral of diagnostic X-ray tests under subsection (s)(3) which are not furnished by the chiropractor and for which payment may otherwise be made under this title.".

(b) BUDGET NEUTRALITY ADJUSTMENT.—Notwithstanding any other provision of law, for each year (beginning with 1996), the Secretary shall reduce the amount of payments under section 1833 of the Social Security Act with respect to services furnished by chiropractors by such uniform percentage as the Secretary determines to be required to assure that the amendment made by subsection (a) does not result in expenditures under title XVIII of such Act in the year that exceed the amount

of such expenditures that would have been made in such year if such amendment had not been made.

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to items and services furnished on or after January 1, 1996.

Subtitle H—Provisions Relating to Medicare Parts A and B

PART 1—PAYMENTS FOR HOME HEALTH SERVICES

SEC. 15701. PAYMENT FOR HOME HEALTH SERVICES.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 15106, is amended by adding at the end the following new section:

"PAYMENT FOR HOME HEALTH SERVICES

"SEC. 1894. (a) IN GENERAL.—

"(1) PER VISIT PAYMENTS.—Subject to subsection (c), the Secretary shall make per visit payments beginning with fiscal year 1997 to a home health agency in accordance with this section for each type of home health service described in paragraph (2) furnished to an individual who at the time the service is furnished is under a plan of care by the home health agency under this title (without regard to whether or not the item or service was furnished by the agency or by others under arrangement with them made by the agency, or otherwise).

"(2) TYPES OF SERVICES.—The types of home health services described in this paragraph are the following:

"(A) Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse.

"(B) Physical therapy.

"(C) Occupational therapy.

"(D) Speech-language pathology services.

"(E) Medical social services under the direction of a physician.

"(F) To the extent permitted in regulations, part-time or intermittent services of a home health aide who has successfully completed a training program approved by the Secretary.

"(b) ESTABLISHMENT OF PER VISIT RATE FOR EACH TYPE OF SERVICES.—

"(1) IN GENERAL.—The Secretary shall, subject to paragraph (3), establish a per visit payment rate for a home health agency in an area for each type of home health service described in subsection (a)(2). Such rate shall be equal to the national per visit payment rate determined under paragraph (2) for each such type, except that the labor-related portion of such rate shall be adjusted by the area wage index applicable under section 1886(d)(3)(E) for the area in which the agency is located (as determined without regard to any reclassification of the area under section 1886(d)(8)(B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under section 1886(d)(10) for cost reporting periods beginning after October 1, 1995).

"(2) NATIONAL PER VISIT PAYMENT RATE.—The national per visit payment rate for each type of service described in subsection (a)(2)—

"(A) for fiscal year 1997, is an amount equal to the national average amount paid per visit under this title to home health agencies for such type of service during the most recent 12-month cost reporting period ending on or before June 30, 1994, increased (in a compounded manner) by the home health market basket percentage increase for fiscal years 1995, 1996, and 1997; and

"(B) for each subsequent fiscal year, is an amount equal to the national per visit payment rate in effect for the preceding fiscal year, increased by the home health market basket percentage increase for such subsequent fiscal year minus 2 percentage points.

"(3) REBASING OF RATES.—The Secretary shall provide for an update to the national per visit payment rates under this subsection for cost reporting periods beginning not later than the first day of the fifth fiscal year which begins after fiscal year 1997, and not later than every 5 years thereafter, to reflect the most recent available data.

"(4) HOME HEALTH MARKET BASKET PERCENTAGE INCREASE.—For purposes of this subsection, the term 'home health market basket percentage increase' means, with respect to a fiscal year, a percentage (estimated by the Secretary

before the beginning of the fiscal year) determined and applied with respect to the types of home health services described in subsection (a)(2) in the same manner as the market basket percentage increase under section 1886(b)(3)(B)(iii) is determined and applied to inpatient hospital services for the fiscal year.

"(c) PER EPISODE LIMIT.—

"(1) AGGREGATE LIMIT.—

"(A) IN GENERAL.—Except as provided in paragraph (2), a home health agency may not receive aggregate per visit payments under subsection (a) for a fiscal year in excess of an amount equal to the sum of the following products determined for each case-mix category for which the agency receives payments:

"(i) The number of episodes of each case-mix category during the fiscal year; multiplied by

"(ii) the per episode limit determined for such case-mix category for such fiscal year.

"(B) ESTABLISHMENT OF PER EPISODE LIMITS.—

"(i) IN GENERAL.—The per episode limit for a fiscal year for any case-mix category for the area in which a home health agency is located is equal to—

"(I) the mean number of visits for each type of home health service described in subsection (a)(2) furnished during an episode of such case-mix category in such area during fiscal year 1994, adjusted by the case-mix adjustment factor determined in clause (ii) for the fiscal year involved; multiplied by

"(II) the per visit payment rate established under subsection (b) for such type of home health service for the fiscal year for which the determination is being made.

"(ii) CASE MIX ADJUSTMENT FACTOR.—For purposes of clause (i), the case-mix adjustment factor for a year is the factor determined by the Secretary to assure that aggregate payments for home health services under this section during the year will not exceed the payment for such services during the previous year as a result of changes in the number and type of home health visits within case-mix categories over the previous year.

"(iii) REBASING OF PER EPISODE AMOUNTS.—Beginning with fiscal year 1999 and every 2 years thereafter, the Secretary shall revise the mean number of home health visits determined under clause (i)(I) for each type of home health service visit described in subsection (a)(2) furnished during an episode in a case-mix category to reflect the most recently available data on the number of visits.

"(iv) DETERMINATION OF APPLICABLE AREA.—For purposes of determining per episode limits under this subparagraph, the area in which a home health agency is considered to be located shall be such area as the Secretary finds appropriate for purposes of this subparagraph.

"(C) CASE-MIX CATEGORY.—For purposes of this paragraph, the term 'case-mix category' means each of the 18 case-mix categories established under the Phase II Home Health Agency Prospective Payment Demonstration Project conducted by the Health Care Financing Administration. The Secretary may develop an alternate methodology for determining case-mix categories.

"(D) EPISODE.—

"(i) IN GENERAL.—For purposes of this paragraph, the term 'episode' means the continuous 120-day period that—

"(I) begins on the date of an individual's first visit for a type of home health service described in subsection (a)(2) for a case-mix category, and

"(II) is immediately preceded by a 60-day period in which the individual did not receive visits for a type of home health service described in subsection (a)(2).

"(ii) TREATMENT OF EPISODES SPANNING COST REPORTING PERIODS.—The Secretary shall provide for such rules as the Secretary considers appropriate regarding the treatment of episodes under this paragraph which begin during a cost reporting period and end in a subsequent cost reporting period.

"(E) EXEMPTIONS AND EXCEPTIONS.—The Secretary may provide for exemptions and exceptions to the limits established under this paragraph for a fiscal year as the Secretary deems appropriate, to the extent such exemp-

tions and exceptions do not result in greater payments under this section than the exemptions and exceptions provided under section 1861(v)(1)(L)(ii) in fiscal year 1994, increased by the home health market basket percentage increase for the fiscal year involved (as defined in subsection (b)(4)).

"(2) RECONCILIATION OF AMOUNTS.—

"(A) OVERPAYMENTS TO HOME HEALTH AGENCIES.—Subject to subparagraph (B), if a home health agency has received aggregate per visit payments under subsection (a) for a fiscal year in excess of the amount determined under paragraph (1) with respect to such home health agency for such fiscal year, the Secretary shall reduce payments under this section to the home health agency in the following fiscal year in such manner as the Secretary considers appropriate (including on an installment basis) to recapture the amount of such excess.

"(B) EXCEPTION FOR HOME HEALTH SERVICES FURNISHED OVER A PERIOD GREATER THAN 165 DAYS.—

"(i) IN GENERAL.—For purposes of subparagraph (A), the amount of aggregate per visit payments determined under subsection (a) shall not include payments for home health visits furnished to an individual on or after a continuous period of more than 165 days after an individual begins an episode described in subsection (c)(1)(D) (if such period is not interrupted by the beginning of a new episode).

"(ii) REQUIREMENT OF CERTIFICATION.—Clause (i) shall not apply if the agency has not obtained a physician's certification with respect to the individual requiring such visits that includes a statement that the individual requires such continued visits, the reason for the need for such visits, and a description of such services furnished during such visits.

"(C) SHARE OF SAVINGS.—

"(i) BONUS PAYMENTS.—If a home health agency has received aggregate per visit payments under subsection (a) for a fiscal year in an amount less than the amount determined under paragraph (1) with respect to such home health agency for such fiscal year, the Secretary shall pay such home health agency a bonus payment equal to 50 percent of the difference between such amounts in the following fiscal year, except that the bonus payment may not exceed 5 percent of the aggregate per visit payments made to the agency for the year.

"(ii) INSTALLMENT BONUS PAYMENTS.—The Secretary may make installment payments during a fiscal year to a home health agency based on the estimated bonus payment that the agency would be eligible to receive with respect to such fiscal year.

"(d) MEDICAL REVIEW PROCESS.—The Secretary shall implement a medical review process (with a particular emphasis on fiscal years 1997 and 1998) for the system of payments described in this section that shall provide an assessment of the pattern of care furnished to individuals receiving home health services for which payments are made under this section to ensure that such individuals receive appropriate home health services. Such review process shall focus on low-cost cases described in subsection (e)(3) and cases described in subsection (c)(2)(B) and shall require recertification by intermediaries at 30, 60, 90, 120, and 165 days into an episode described in subsection (c)(1)(D).

"(e) ADJUSTMENT OF PAYMENTS TO AVOID CIRCUMVENTION OF LIMITS.—

"(1) IN GENERAL.—The Secretary shall provide for appropriate adjustments to payments to home health agencies under this section to ensure that agencies do not circumvent the purpose of this section by—

"(A) discharging patients to another home health agency or similar provider;

"(B) altering corporate structure or name to avoid being subject to this section or for the purpose of increasing payments under this title; or

"(C) undertaking other actions considered unnecessary for effective patient care and intended to achieve maximum payments under this title.

"(2) TRACKING OF PATIENTS THAT SWITCH HOME HEALTH AGENCIES DURING EPISODE.—

"(A) DEVELOPMENT OF SYSTEM.—The Secretary shall develop a system that tracks home health patients that receive home health services described in subsection (a)(2) from more than 1 home health agency during an episode described in subsection (c)(1)(D).

"(B) ADJUSTMENT OF PAYMENTS.—The Secretary shall adjust payments under this section to each home health agency that furnishes an individual with a type of home health service described in subsection (a)(2) to ensure

that aggregate payments on behalf of such individual during such episode do not exceed the amount that would be paid under this section if the individual received such services from a single home health agency.

"(3) LOW-COST CASES.—The Secretary shall develop a system designed to adjust payments to a home health agency for a fiscal year to eliminate any increase in growth of the percentage of low-cost episodes for which home health services are furnished by the agency over such percentage determined for the agency for the 12-month cost reporting period ending on June 30, 1994. The Secretary shall define a low-cost episode in a manner that provides that a home health agency has an incentive to be cost efficient in delivering home health services and that the volume of such services does not increase as a result of factors other than patient needs.

"(f) REPORT BY MEDICARE PAYMENT REVIEW COMMISSION.—During the first 3 years in which payments are made under this section, the Medicare Payment Review Commission shall annually submit a report to Congress on the effectiveness of the payment methodology established under this section that shall include recommendations regarding the following:

"(1) Case-mix and volume increases.

"(2) Quality monitoring of home health agency practices.

"(3) Whether a capitated payment for home care patients receiving care during a continuous period exceeding 165 days is warranted.

"(4) Whether public providers of service are adequately reimbursed.

"(5) The adequacy of the exemptions and exceptions to the limits provided under subsection (c)(1)(E).

"(6) The appropriateness of the methods provided under this section to adjust the per episode limits and annual payment updates to reflect changes in the mix of services, number of visits, and assignment to case categories to reflect changing patterns of home health care.

"(7) The geographic areas used to determine the per episode limits.".

(b) PAYMENT FOR PROSTHETICS AND ORTHOTICS UNDER PART A.—Section 1814(k) (42 U.S.C. 1395f(k)) is amended—

(1) by inserting "and prosthetics and orthotics" after "durable medical equipment"; and

(2) by inserting "and 1834(h), respectively" after "1834(a)(1)".

(c) CONFORMING AMENDMENTS.—

(1) PAYMENTS UNDER PART A.—Section 1814(b) (42 U.S.C. 1395f(b)), as amended by section 15522(b), is amended in the matter preceding paragraph (1) by striking "1888 and 1888A" and inserting "1888, 1888A, and 1894".

(2) TREATMENT OF ITEMS AND SERVICES PAID UNDER PART B.—

(A) PAYMENTS UNDER PART B.—Section 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amended—

(i) by amending subparagraph (A) to read as follows:

"(A) with respect to home health services—

"(i) that are a type of home health service described in section 1894(a)(2), and which are furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home health agency, the amount determined under section 1894; or

"(ii) that are not described in clause (i) (other than a covered osteoporosis drug) (as defined in section 1861(kk)), the lesser of—

"(I) the reasonable cost of such services, as determined under section 1861(v), or

"(II) the customary charges with respect to such services;".

(ii) by striking "and" at the end of subparagraph (E);

(iii) by adding "and" at the end of subparagraph (F); and

(iv) by adding at the end the following new subparagraph:

"(G) with respect to items and services described in section 1861(s)(10)(A), the lesser of—

"(i) the reasonable cost of such services, as determined under section 1861(v), or

"(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);".

(B) REQUIRING PAYMENT FOR ALL ITEMS AND SERVICES TO BE MADE TO AGENCY.—

(i) IN GENERAL.—The first sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)), as amended by section 15525(a)(1), is amended—

(I) by striking "and (E)" and inserting "(E)"; and

(II) by striking the period at the end and inserting the following: ", and (F) in the case of types of home health services described in section 1894(a)(2) furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home health agency, payment shall be made to the agency (without regard to whether or not the item or service was furnished by the agency, by others under arrangement with them made by the agency, or otherwise).".

(ii) CONFORMING AMENDMENT.—Section 1832(a)(1) (42 U.S.C. 1395k(a)(1)), as amended by section 15525(a)(3), is amended by striking "section 1842(b)(6)(E);" and inserting "subparagraphs (E) and (F) of section 1842(b)(6);".

(C) EXCLUSIONS FROM COVERAGE.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 15525(a)(2), is amended—

(i) by striking "or" at the end of paragraph (15);

(ii) by striking the period at the end of paragraph (16) and inserting "; or"; and

(iii) by adding at the end the following new paragraph:

"(17) where such expenses are for home health services furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency.".

(3) SUNSET OF REASONABLE COST LIMITATIONS.—Section 1861(v)(1)(L) (42 U.S.C. 1395x(v)(1)(L)) is amended by adding at the end the following new clause:

"(iv) This subparagraph shall apply only to services furnished by home health agencies during cost reporting periods ending on or before September 30, 1996.".

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 1996.

SEC. 15702. MAINTAINING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES FOR HOME HEALTH SERVICES.

(a) BASING UPDATES TO PER VISIT COST LIMITS ON LIMITS FOR FISCAL YEAR 1993.—Section 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is amended by adding at the end the following sentence: "In establishing limits under this subparagraph, the Secretary may not take into account any changes in the costs of the provision of services furnished by home health agencies with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996.".

(b) NO EXCEPTIONS PERMITTED BASED ON AMENDMENT.—The Secretary of Health and Human Services shall not consider the amendment made by subsection (a) in making any exemptions and exceptions pursuant to section 1861(v)(1)(L)(ii) of the Social Security Act.

SEC. 15703. EXTENSION OF WAIVER OF PRESUMPTION OF LACK OF KNOWLEDGE OF EXCLUSION FROM COVERAGE FOR HOME HEALTH AGENCIES.

Section 9305(g)(3) of OBRA–1986, as amended by section 426(d) of the Medicare Catastrophic Coverage Act of 1988 and section 4207(b)(3) of OBRA–1990 (as renumbered by section 160(d)(4) of the Social Security Act Amendments of 1994), is amended by striking "December 31, 1995" and inserting "September 30, 1996".

SEC. 15704. STUDY OF COVERAGE OF SERVICES OF CHRISTIAN SCIENCE PROVIDERS.

(a) STUDY.—The Secretary of Health and Human Services shall conduct a study of the feasibility and desirability of providing for coverage under the medicare program of home health services furnished by Christian Science providers who meet applicable requirements of the First Church of Christ, Scientist, Boston, Massachusetts.

(b) REPORT.—Not later than July 1, 1996, the Secretary shall submit a report to Congress on the study conducted under subsection (a), and (to the extent the report includes recommendations for coverage under the medicare program of home health services furnished by Christian Science providers) shall include in the report recommendations regarding appropriate criteria for the certification of such providers and an appropriate methodology for making payments under the medicare program for such services.

PART 2—MEDICARE SECONDARY PAYER IMPROVEMENTS

SEC. 15711. EXTENSION AND EXPANSION OF EXISTING REQUIREMENTS.

(a) DATA MATCH.—

(1) Section 1862(b)(5)(C) (42 U.S.C. 1395y(b)(5)(C)) is amended by striking clause (iii).

(2) Section 6103(l)(12) of the Internal Revenue Code of 1986 is amended by striking subparagraph (F).

(b) APPLICATION TO DISABLED INDIVIDUALS IN LARGE GROUP HEALTH PLANS.—

(1) IN GENERAL.—Section 1862(b)(1)(B) (42 U.S.C. 1395y(b)(1)(B)) is amended—

(A) in clause (i), by striking "clause (iv)" and inserting "clause (iii)",

(B) by striking clause (iii), and

(C) by redesignating clause (iv) as clause (iii).

(2) CONFORMING AMENDMENTS.—Paragraphs (1) through (3) of section 1837(i) (42 U.S.C. 1395p(i)) and the second sentence of section 1839(b) (42 U.S.C. 1395r(b)) are each amended by striking "1862(b)(1)(B)(iv)" each place it appears and inserting "1862(b)(1)(B)(iii)".

(c) EXPANSION OF PERIOD OF APPLICATION TO INDIVIDUALS WITH END STAGE RENAL DISEASE.—Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the first sentence, by striking "12-month" each place it appears and inserting "24-month", and

(2) by striking the second sentence.

SEC. 15712. IMPROVEMENTS IN RECOVERY OF PAYMENTS.

(a) PERMITTING RECOVERY AGAINST THIRD PARTY ADMINISTRATORS OF PRIMARY PLANS.—Section 1862(b)(2)(B)(ii) (42 U.S.C. 1395y(b)(2)(B)(ii)) is amended—

(1) by striking "under this subsection to pay" and inserting "(directly, as a third-party administrator, or otherwise) to make payment", and

(2) by adding at the end the following: "The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.".

(b) EXTENSION OF CLAIMS FILING PERIOD.—Section 1862(b)(2)(B) (42 U.S.C. 1395y(b)(2)(B)) is amended by adding at the end the following new clause:

"(v) CLAIMS-FILING PERIOD.—Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after the date of the enactment of this Act.

SEC. 15713. PROHIBITING RETROACTIVE APPLICATION OF POLICY REGARDING ESRD BENEFICIARIES ENROLLED IN PRIMARY PLANS.

For purposes of carrying out section 1862(b)(1)(C) of the Social Security Act, the Secretary of Health and Human Services shall apply the policy directive issued by the Administrator of the Health Care Financing Administration on April 24, 1995, only with respect to items and services furnished on or after such date.

PART 3—FAILSAFE

SEC. 15721. FAILSAFE BUDGET MECHANISM.

(a) IN GENERAL.—Title XVIII, as amended by sections 15106(a) and 15701(a), is amended by adding at the end the following new section:

"FAILSAFE BUDGET MECHANISM

"SEC. 1895. (a) REQUIREMENT OF PAYMENT ADJUSTMENTS TO ACHIEVE MEDICARE BUDGET TARGETS.—If the Secretary determines under subsection (e)(3)(C) before a fiscal year (beginning with fiscal year 1998) that—

"(1) the fee-for-service expenditures (as defined in subsection (f)) for a sector of medicare services (as defined in subsection (b)) for the fiscal year, will exceed

"(2) the allotment specified under subsection (c)(2) for such fiscal year (taking into account any adjustment in the allotment under subsection (h) for that fiscal year),

then, notwithstanding any other provision of this title, there shall be an adjustment (consistent with subsection (d)) in applicable payment rates or payments for items and services included in the sector in the fiscal year so that such expenditures for the sector for the year will be reduced by 133⅓ percent of the amount of such excess.

"(b) SECTORS OF MEDICARE SERVICES DESCRIBED.—

"(1) IN GENERAL.—For purposes of this section, items and services included under each of the following subparagraphs shall be considered to be a separate 'sector' of medicare services:

"(A) Inpatient hospital services.

"(B) Home health services.

"(C) Extended care services (for inpatients of skilled nursing facilities).

"(D) Hospice care.

"(E) Physicians' services (including services and supplies described in section 1861(s)(2)(A)) and services of other health care professionals (including certified registered nurse anesthetists, nurse practitioners, physician assistants, and clinical psychologists) for which separate payment is made under this title.

"(F) Outpatient hospital services and ambulatory facility services.

"(G) Durable medical equipment and supplies, including prosthetic devices and orthotics.

"(H) Diagnostic tests (including clinical laboratory services and x-ray services).

"(I) Other items and services.

"(2) CLASSIFICATION OF ITEMS AND SERVICES.—The Secretary shall classify each type of items and services covered and paid for separately under this title into one of the sectors specified in paragraph (1). After publication of such classification under subsection (e)(1), the Secretary is not authorized to make substantive changes in such classification.

"(c) ALLOTMENT.—

"(1) ALLOTMENTS FOR EACH SECTOR.—For purposes of this section, subject to subsection (h)(1), the allotment for a sector of medicare services for a fiscal year is equal to the product of—

"(A) the total allotment for the fiscal year established under paragraph (2), and

"(B) the allotment proportion (specified under paragraph (3)) for the sector and fiscal year involved.

"(2) TOTAL ALLOTMENT.—

"(A) IN GENERAL.—For purposes of this section, the total allotment for a fiscal year is equal to—

"(i) the medicare benefit budget for the fiscal year (as specified under subparagraph (B)), reduced by

"(ii) the amount of payments the Secretary estimates will be made in the fiscal year under the MedicarePlus program under part C.

In making the estimate under clause (ii), the Secretary shall take into account estimated enrollment and demographic profile of individuals electing MedicarePlus products.

"(B) MEDICARE BENEFIT BUDGET.—For purposes of this subsection, subject to subparagraph (C), the 'medicare benefit budget'—

"(i) for fiscal year 1997 is $203.1 billion;

"(ii) for fiscal year 1998 is $214.3 billion;

"(iii) for fiscal year 1999 is $227.2 billion;

"(iv) for fiscal year 2000 is $241.0 billion;

"(v) for fiscal year 2001 is $259.1 billion;

"(vi) for fiscal year 2002 is $280.0 billion; and

"(vii) for a subsequent fiscal year is equal to the medicare benefit budget under this subparagraph for the preceding fiscal year increased by the sum of (I) 5 percentage points, and (II) product of (I) 1.05, and (II) 1 plus the annual percentage increase in the average number of medicare beneficiaries from the previous fiscal year to the fiscal year involved.

"(3) MEDICARE ALLOTMENT PROPORTION DEFINED.—

"(A) IN GENERAL.—For purposes of this section and with respect to a sector of medicare services for a fiscal year, the term 'medicare allotment proportion' means the ratio of—

"(i) the baseline-projected medicare expenditures (as determined under subparagraph (B)) for the sector for the fiscal year, to

"(ii) the sum of such baseline expenditures for all such sectors for the fiscal year.

"(B) BASELINE-PROJECTED MEDICARE EXPENDITURES.—In this paragraph, the 'baseline, projected medicare expenditures' for a sector of medicare services—

"(i) for fiscal year 1996 is equal to fee-for-service expenditures for such sector during fiscal year 1995, increased by the baseline annual growth rate for such sector of medicare services for fiscal year 1996 (as specified in table in subparagraph (C)); and

"(ii) for a subsequent fiscal year is equal to the baseline-projected medicare expenditures under this subparagraph for the sector for the previous fiscal year increased by the baseline annual growth rate for such sector for the fiscal year involved (as specified in such table).

"(C) BASELINE ANNUAL GROWTH RATES.—The following table specifies the baseline annual growth rates for each of the sectors for different fiscal years:

"For the following sector—	Baseline annual growth rates for fiscal year—						
	1996	1997	1998	1999	2000	2001	2002 and thereafter
(A) Inpatient hospital services	5.7%	5.6%	6.0%	6.1%	5.7%	5.5%	5.2%
(B) Home health services	17.2%	15.1%	11.7%	9.1%	8.4%	8.1%	7.9%
(C) Extended care services	19.7%	12.3%	9.3%	8.7%	8.6%	8.4%	8.0%
(D) Hospice care	32.0%	24.0%	18.0%	15.0%	12.0%	10.0%	9.0%
(E) Physicians' services	12.4%	9.7%	8.7%	9.0%	9.3%	9.6%	10.1%
(F) Outpatient hospital services	14.7%	13.9%	14.5%	15.0%	14.1%	13.9%	14.0%
(G) Durable medical equipment and supplies	16.1%	15.5%	13.7%	12.4%	13.2%	13.9%	14.5%
(H) Diagnostic tests	13.1%	11.3%	11.0%	11.4%	11.4%	11.5%	11.9%
(I) Other items and services	11.2%	10.2%	10.9%	12.0%	11.6%	11.6%	11.8%

"(d) MANNER OF PAYMENT ADJUSTMENT.—

"(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall apply a payment reduction for a sector for a fiscal year in such a manner as to—

"(A) make a change in payment rates (to the maximum extent practicable) at the time payment rates are otherwise changed or subject to change for that fiscal year; and

"(B) provide for the full appropriate adjustment so that the fee-for-service expenditures for the sector for the fiscal year will approximate (and not exceed) the allotment for the sector for the fiscal year.

"(2) TAKING INTO ACCOUNT VOLUME AND CASH FLOW.—In providing for an adjustment in payments under this subsection for a sector for a fiscal year, the Secretary shall take into account (in a manner consistent with actuarial projections)—

"(A) the impact of such an adjustment on the volume or type of services provided in such sector (and other sectors), and

"(B) the fact that an adjustment may apply to items and services furnished in a fiscal year (payment for which may occur in a subsequent fiscal year),

in a manner that is consistent with assuring that total fee-for-services expenditures for each sector for the fiscal year will not exceed the allotment under subsection (c)(1) for such sector for such year.

"(3) PROPORTIONALITY OF REDUCTIONS WITHIN A SECTOR.—In making adjustments under this subsection in payment for items and services included within a sector of medicare services for a fiscal year, the Secretary shall provide for such an adjustment that results (to the maximum extent feasible) in the same

percentage reductions in aggregate Federal payments under parts A and B for the different classes of items and services included within the sector for the fiscal year.

"(4) APPLICATION TO PAYMENTS MADE BASED ON PROSPECTIVE PAYMENT RATES DETERMINED ON A FISCAL YEAR BASIS.—

"(A) IN GENERAL.—In applying subsection (a) with respect to items and services for which payment is made under part A or B on the basis of rates that are established on a prospective basis for (and in advance of) a fiscal year, the Secretary shall provide for the payment adjustment under such subsection through an appropriate reduction in such rates established for items and services furnished (or, in the case of payment for operating costs of inpatient hospital services of subsection (d) hospitals and subsection (d) Puerto Rico hospitals (as defined in paragraphs (1)(B) and (9)(A) of section 1886(d)), discharges occurring) during such year.

"(B) DESCRIPTION OF APPLICATION TO SPECIFIC SERVICES.—The payment adjustment described in subparagraph (A) applies for a fiscal year to at least the following:

"(i) UPDATE FACTOR FOR PAYMENT FOR OPERATING COSTS OF INPATIENT HOSPITAL SERVICES OF PPS HOSPITALS.—To the computation of the applicable percentage increase specified in section 1886(d)(3)(B)(i) for discharges occurring in the fiscal year.

"(ii) HOME HEALTH SERVICES.—To the extent payment amounts for home health services are based on per visit payment rates under section 1894, to the computation of the increase in the national per visit payment rates established for the year under section 1894(b)(2)(B).

"(iii) HOSPICE CARE.—To the update of payment rates for hospice care under section 1814(i) for services furnished during the fiscal year.

"(iv) UPDATE FACTOR FOR PAYMENT OF OPERATING COSTS OF INPATIENT HOSPITAL SERVICES OF PPS-EXEMPT HOSPITALS.—To the computation of the target amount under section 1886(b)(3) for discharges occurring during the fiscal year.

"(v) COVERED NON-ROUTINE SERVICES OF SKILLED NURSING FACILITIES.—To the computation of the facility per stay limits for the year under section 1888A(d) for covered non-routine services of a skilled nursing facility (as described in such section).

"(5) APPLICATION TO PAYMENTS MADE BASED ON PROSPECTIVE PAYMENT RATES DETERMINED ON A CALENDAR YEAR BASIS.—

"(A) IN GENERAL.—In applying subsection (a) for a fiscal year with respect to items and services for which payment is made under part A or B on the basis of rates that are established on a prospective basis for (and in advance of) a calendar year, the Secretary shall provide for the payment adjustment under such subsection through an appropriate reduction in such rates established for items and services furnished at any time during such calendar year as follows:

"(i) For fiscal year 1997, the reduction shall be made for payment rates during calendar year 1997 in a manner so as to achieve the necessary payment reductions for such fiscal year for items and services furnished during the first 3 quarters of calendar year 1997.

"(ii) For a subsequent fiscal year, the reduction shall be made for payment rates during the calendar year in which the fiscal year ends in a manner so as to achieve the necessary payment reductions for such fiscal year for items and services furnished during the first 3 quarters of the calendar year, but also taking into account the payment reductions made in the first quarter of the fiscal year resulting from payment reductions made under this paragraph for the previous calendar year.

"(iii) Payment rate reductions effected under this subparagraph for a calendar year and applicable to the last 3 quarters of the fiscal year in which the calendar year ends shall continue to apply during the first quarter of the succeeding fiscal year.

"(B) APPLICATION IN SPECIFIC CASES.—The payment adjustment described in subparagraph (A) applies for a fiscal year to at least the following:

"(i) UPDATE IN CONVERSION FACTOR FOR PHYSICIANS' SERVICES.—To the computation of the conversion factor under subsection (d) of section 1848 used in the fee schedule established under subsection (b) of such section, for items and services furnished during the calendar year in which the fiscal year ends.

"(ii) PAYMENT RATES FOR OTHER HEALTH CARE PROFESSIONALS.—To the computation of payments for professional services of certified registered nurse anesthetists under section 1833(l), nurse midwives, physician assistants, nurse practitioners and clinical nurse specialists under section 1833(r), clinical psychologists, clinical social workers, physical or occupational therapists, and any other health professionals for which payment rates are based (in whole or in part) on payments for physicians' services, for services furnished during the calendar year in which the fiscal year ends.

"(iii) UPDATE IN LAB FEE SCHEDULE.—To the computation of the fee schedule amount under section 1833(h)(2) for clinical diagnostic laboratory services furnished during the calendar year in which the fiscal year ends.

"(iv) UPDATE IN REASONABLE CHARGES FOR VACCINES.—To the computation of the reasonable charge for vaccines described in section 1861(s)(10) for vaccines furnished during the calendar year in which the fiscal year ends.

"(v) DURABLE MEDICAL EQUIPMENT-RELATED ITEMS.—To the computation of the payment basis under section 1834(a)(1)(B) for covered items described in section 1834(a)(13), for items furnished during the calendar year in which the fiscal year ends.

"(vi) RADIOLOGIST SERVICES.—To the computation of conversion factors for radiologist services under section 1834(b), for services furnished during the calendar year in which the fiscal year ends.

"(vii) SCREENING MAMMOGRAPHY.—To the computation of payment rates for screening mammography under section 1834(c)(1)(C)(ii), for screening mammography performed during the calendar year in which the fiscal year ends.

"(viii) PROSTHETICS AND ORTHOTICS.—To the computation of the amount to be recognized under section 1834(h) for payment for prosthetic devices and orthotics and prosthetics, for items furnished during the calendar year in which the fiscal year ends.

"(ix) SURGICAL DRESSINGS.—To the computation of the payment amount referred to in section 1834(i)(1)(B) for surgical dressings, for items furnished during the calendar year in which the fiscal year ends.

"(x) PARENTERAL AND ENTERAL NUTRITION.—To the computation of reasonable charge screens for payment for parenteral and enteral nutrition under section 1834(h), for nutrients furnished during the calendar year in which the fiscal year ends.

"(xi) AMBULANCE SERVICES.—To the computation of limits on reasonable charges for ambulance services, for services furnished during the calendar year in which the fiscal year ends.

"(6) APPLICATION TO PAYMENTS MADE BASED ON COSTS DURING A COST REPORTING PERIOD.—

"(A) IN GENERAL.—In applying subsection (a) for a fiscal year with respect to items and services for which payment is made under part A or B on the basis of costs incurred for items and services in a cost reporting period, the Secretary shall provide for the payment adjustment under such subsection for a fiscal year through an appropriate proportional reduction in the payment for costs for such items and services incurred at any time during each cost reporting period any part of which occurs during the fiscal year involved, but only (for each such cost reporting period) in the same proportion as the fraction of the cost reporting period that occurs during the fiscal year involved.

"(B) APPLICATION IN SPECIFIC CASES.—The payment adjustment described in subparagraph (A) applies for a fiscal year to at least the following:

"(i) CAPITAL-RELATED COSTS OF HOSPITAL SERVICES.—To the computation of payment amounts for inpatient and outpatient hospital services under sections 1886(g) and 1861(v) for portions of cost reporting periods occurring during the fiscal year.

"(ii) OPERATING COSTS FOR PPS-EXEMPT HOSPITALS.—To the computation of payment amounts under section 1886(b) for operating costs of inpatient hospital services of PPS-exempt hospitals for portions of cost reporting periods occurring during the fiscal year.

"(iii) DIRECT GRADUATE MEDICAL EDUCATION.—To the computation of payment amounts under section 1886(h) for reasonable costs of direct graduate medical education costs for portions of cost reporting periods occurring during the fiscal year.

"(iv) INPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—To the computation of payment amounts under section 1814(j) for inpatient rural primary care hospital services for portions of cost reporting periods occurring during the fiscal year.

"(v) EXTENDED CARE SERVICES OF A SKILLED NURSING FACILITY.—To the computation of payment amounts under section 1861(v) for post-hospital extended care services of a skilled nursing facility (other than covered non-routine services subject to section 1888A) for portions of cost reporting periods occurring during the fiscal year.

"(vi) REASONABLE COST CONTRACTS.—To the computation of payment amounts under section 1833(a)(1)(A) for organizations for portions of cost reporting periods occurring during the fiscal year.

"(vii) HOME HEALTH SERVICES.—Subject to paragraph (4)(B)(ii), for payment amounts for home health services, for portions of cost reporting periods occurring during such fiscal year.

"(7) OTHER.—In applying subsection (a) for a fiscal year with respect to items and services for which payment is made under part A or B on a basis not described in a previous paragraph of this subsection, the Secretary shall provide for the payment adjustment under such subsection through an appropriate proportional reduction in the payments (or payment bases for items and services furnished) during the fiscal year.

"(8) ADJUSTMENT OF PAYMENT LIMITS.—The Secretary shall provide for such proportional adjustment in any limits on payment established under part A or B for payment for items and services within a sector as may be appropriate based on (and in order to properly carry out) the adjustment on the amount of payment under this subsection in the sector.

"(9) REFERENCES TO PAYMENT RATES.—Except as the Secretary may provide, any reference in this title (other than this section) to a payment rate is deemed a reference to such a rate as adjusted under this subsection.

"(e) PUBLICATION OF DETERMINATIONS; JUDICIAL REVIEW.—

"(1) ONE-TIME PUBLICATION OF SECTORS AND GENERAL PAYMENT ADJUSTMENT METHODOLOGY.—Not later than October 1, 1996, the Secretary shall publish in the Federal Register the classification of medicare items and services into the sectors of medicare services under subsection (b) and the general methodology to be used in applying payment adjustments to the different classes of items and services within the sectors.

"(2) INCLUSION OF INFORMATION IN PRESIDENT'S BUDGET.—

"(A) IN GENERAL.—With respect to fiscal years beginning with fiscal year 1999, the President shall include in the budget submitted under section 1105 of title 31, United States Code, information on—

"(i) the fee-for-service expenditures, within each sector, for the second previous fiscal year, and how such expenditures compare to the adjusted sector allotment for that sector for that fiscal year; and

"(ii) actual annual growth rates for fee-for-service expenditures in the different sectors in the second previous fiscal year.

"(B) RECOMMENDATIONS REGARDING GROWTH FACTORS.—The President may include in such budget for a fiscal year (beginning with fiscal year 1998) recommendations regarding percentages that should be applied (for one or more fiscal years beginning with that fiscal year) instead of the baseline annual growth rates under subsection (c)(3)(C). Such recommendations shall take into account medically appropriate practice patterns.

"(3) DETERMINATIONS CONCERNING PAYMENT ADJUSTMENTS.—

"(A) RECOMMENDATIONS OF COMMISSION.—By not later than March 1 of each year (beginning with 1997), the Medicare Payment Review Commission shall submit to the Secretary and the Congress a report that analyzes the previous operation (if any) of this section and that includes recommendations concerning the manner in which this section should be applied for the following fiscal year.

"(B) PRELIMINARY NOTICE BY SECRETARY.—Not later than May 15 preceding the beginning of each fiscal year (beginning with fiscal year 1998), the Secretary shall publish in the Federal Register a notice containing the Secretary's preliminary determination, for each sector of medicare services, concerning the following:

"(i) The projected allotment under subsection (c) for such sector for the fiscal year.

"(ii) Whether there will be a payment adjustment for items and services included in such sector for the fiscal year under subsection (a).

"(iii) If there will be such an adjustment, the size of such adjustment and the methodology to be used in making such a payment adjustment for classes of items and services included in such sector.

"(iv) Beginning with fiscal year 1999, the fee-for-service expenditures for such sector for the second preceding fiscal year.

Such notice shall include an explanation of the basis for such determination. Determinations under this subparagraph and subparagraph (C) shall be based on the best data available at the time of such determinations.

"(C) FINAL DETERMINATION.—Not later than September 1 preceding the beginning of each fiscal year (beginning with fiscal year 1998), the Secretary shall publish in the Federal Register a final determination, for each sector of medicare services, concerning the matters described in subparagraph (B) and an explanation of the reasons for any differences between such determination and the preliminary determination for such fiscal year published under subparagraph (B).

"(4) LIMITATION ON ADMINISTRATIVE OR JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1878 or otherwise of—

"(A) the classification of items and services among the sectors of medicare services under subsection (b),

"(B) the determination of the amounts of allotments for the different sectors of medicare services under subsection (c),

"(C) the determination of the amount (or method of application) of any payment adjustment under subsection (d), or

"(D) any adjustment in an allotment effected under subsection (h).

"(f) FEE-FOR-SERVICE EXPENDITURES DEFINED.—In this section, the term 'fee-for-service expenditures', for items and services within a sector of medicare services in a fiscal year, means amounts payable for such items and services which are furnished during the fiscal year, and—

"(1) includes types of expenses otherwise reimbursable under parts A and B (including administrative costs incurred by organizations described in sections 1816 and 1842) with respect to such items and services, and

"(2) does not include amounts paid under part C.

"(g) EXPEDITED PROCESS FOR ADJUSTMENT OF SECTOR GROWTH RATES.—

"(1) OPTIONAL INCLUSION OF LEGISLATIVE PROPOSAL.—The President may include in recommendations under subsection (e)(2)(B) submitted with respect to a fiscal year a specific legislative proposal that provides only for the substitution of percentages specified in the proposal for one or more of the baseline annual growth rates (specified in the table in subsection (c)(3)(C) or in a previous legislative proposal under this subsection) for that fiscal year or any subsequent fiscal year.

"(2) CONGRESSIONAL CONSIDERATION.—

"(A) IN GENERAL.—The percentages contained in a legislative proposal submitted under paragraph (1) shall apply under this section if a joint resolution (described in subparagraph (B)) approving such proposal is enacted, in accordance with the provisions of subparagraph (C), before the end of the 60-day period beginning on the date on which such proposal was submitted. For purposes of applying the preceding sentence and subparagraphs (B) and (C), the days on which either House of Congress is not in session because of an adjournment of more than three days to a day certain shall be excluded in the computation of a period.

"(B) JOINT RESOLUTION OF APPROVAL.—A joint resolution described in this subparagraph means only a joint resolution which is introduced within the 10-day period beginning on the date on which the President submits a proposal under paragraph (1) and—

"(i) which does not have a preamble;

"(ii) the matter after the resolving clause of which is as follows: 'That Congress approves the proposal of the President providing for substitution of percentages for certain baseline annual growth rates under section 1895 of the Social Security Act, as submitted by the President on _____.', the blank space being filled in with the appropriate date; and

"(iii) the title of which is as follows: 'Joint resolution approving Presidential proposal to substitute certain specified percentages for baseline annual growth rates under section 1895 of the Social Security Act, as submitted by the President on _____.', the blank space being filled in with the appropriate date.

"(C) PROCEDURES FOR CONSIDERATION OF RESOLUTION OF APPROVAL.—Subject to subparagraph (D), the provisions of section 2908 (other than sub-

section (a)) of the Defense Base Closure and Realignment Act of 1990 shall apply to the consideration of a joint resolution described in subparagraph (B) in the same manner as such provisions apply to a joint resolution described in section 2908(a) of such Act.

"(D) SPECIAL RULES.—For purposes of applying subparagraph (C) with respect to such provisions—

"(i) any reference to the Committee on Armed Services of the House of Representatives shall be deemed a reference to an appropriate Committee of the House of Representatives (specified by the Speaker of the House of Representatives at the time of submission of a legislative proposal under paragraph (1)) and any reference to the Committee on Armed Services of the Senate shall be deemed a reference to the Committee on Finance of the Senate; and

"(ii) any reference to the date on which the President transmits a report shall be deemed a reference to the date on which the President submits the legislative proposal under paragraph (1).

"(h) LOOK-BACK ADJUSTMENT IN ALLOTMENTS TO REFLECT ACTUAL EXPENDITURES.—

"(1) IN GENERAL.—If the Secretary determines under subsection (e)(3)(B) with respect to a particular fiscal year (beginning with fiscal year 1999) that the fee-for-service expenditures for a sector of medicare services for the second preceding fiscal year—

"(A) exceeded the adjusted allotment for such sector for such year (as defined in paragraph (2)), then the allotment for the sector for the particular fiscal year shall be reduced by 133⅓ percent of the amount of such excess, or

"(B) was less than the adjusted allotment for such sector for such year, then the allotment for the sector for the particular fiscal year shall be increased by the amount of such deficit.

"(2) ADJUSTED ALLOTMENT.—The adjusted allotment under this paragraph for a sector for a fiscal year is—

"(A) the amount that would be computed as the allotment under subsection (c) for the sector for the fiscal year if the actual amount of payments made in the fiscal year under the MedicarePlus program under part C in the fiscal year were substituted for the amount described in subsection (c)(2)(A)(ii) for that fiscal year,

"(B) adjusted to take into account the amount of any adjustment under paragraph (1) for that fiscal year (based on expenditures in the second previous fiscal year).

"(i) PROSPECTIVE APPLICATION OF CERTAIN NATIONAL COVERAGE DETERMINATIONS.—In the case of a national coverage determination that the Secretary projects will result in significant additional expenditures under this title (taking into account any substitution for existing procedures or technologies), such determination shall not become effective before the beginning of the fiscal year that begins after the date of such determination and shall apply to contracts under part C entered into (or renewed) after the date of such determination.".

(b) REPORT OF TRUSTEES ON GROWTH RATE IN PART A EXPENDITURES.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

"(k) Each annual report provided in subsection (b)(2) shall include information regarding the annual rate of growth in program expenditures that would be required to maintain the financial solvency of the Trust Fund and the extent to which the provisions of section 1895 restrain the rate of growth of expenditures under this part in order to achieve such solvency.".

PART 4—ADMINISTRATIVE SIMPLIFICATION

SEC. 15731. STANDARDS FOR MEDICARE INFORMATION TRANSACTIONS AND DATA ELEMENTS.

Title XVIII, as amended by section 15031, is amended by inserting after section 1806 the following new section:

"STANDARDS FOR MEDICARE INFORMATION TRANSACTIONS AND DATA ELEMENTS

"SEC. 1807. (a) ADOPTION OF STANDARDS FOR DATA ELEMENTS.—

"(1) IN GENERAL.—Pursuant to subsection (b), the Secretary shall adopt standards for information transactions and data elements of medicare information and modifications to the standards under this section that are—

"(A) consistent with the objective of reducing the administrative costs of providing and paying for health care; and

"(B) developed or modified by a standard setting organization (as defined in subsection (h)(8)).

"(2) SPECIAL RULE RELATING TO DATA ELEMENTS.—The Secretary may adopt or modify a standard relating to data elements that is different from the standard developed by a standard setting organization, if—

"(A) the different standard or modification will substantially reduce administrative costs to health care providers and health plans compared to the alternative; and

"(B) the standard or modification is promulgated in accordance with the rulemaking procedures of subchapter III of chapter 5 of title 5, United States Code.

"(3) SECURITY STANDARDS FOR HEALTH INFORMATION NETWORK.—

"(A) IN GENERAL.—Each person, who maintains or transmits medicare information or data elements of medicare information and is subject to this section, shall maintain reasonable and appropriate administrative, technical, and physical safeguards—

"(i) to ensure the integrity and confidentiality of the information;

"(ii) to protect against any reasonably anticipated—

"(I) threats or hazards to the security or integrity of the information; and

"(II) unauthorized uses or disclosures of the information; and

"(iii) to otherwise ensure compliance with this section by the officers and employees of such person.

"(B) SECURITY STANDARDS.—The Secretary shall establish security standards and modifications to such standards with respect to medicare information network services, health plans, and health care providers that—

"(i) take into account—

"(I) the technical capabilities of record systems used to maintain medicare information;

"(II) the costs of security measures;

"(III) the need for training persons who have access to medicare information; and

"(IV) the value of audit trails in computerized record systems; and

"(ii) ensure that a medicare information network service, if it is part of a larger organization, has policies and security procedures which isolate the activities of such service with respect to processing information in a manner that prevents unauthorized access to such information by such larger organization.

The security standards established by the Secretary shall be based on the standards developed or modified by standard setting organizations. If such standards do not exist, the Secretary shall rely on the recommendations of the Medicare Information Advisory Committee (established under subsection (g)) and shall consult with appropriate government agencies and private organizations in accordance with paragraph (5).

"(4) IMPLEMENTATION SPECIFICATIONS.—The Secretary shall establish specifications for implementing each of the standards and the modifications to the standards adopted pursuant to paragraph (1) or (3).

"(5) ASSISTANCE TO THE SECRETARY.—In complying with the requirements of this section, the Secretary shall rely on recommendations of the Medicare Information Advisory Committee established under subsection (g) and shall consult with appropriate Federal and State agencies and private organizations. The Secretary shall publish in the Federal Register the recommendations of the Medicare Information Advisory Committee regarding the adoption of a standard under this section.

"(b) STANDARDS FOR INFORMATION TRANSACTIONS AND DATA ELEMENTS.—

"(1) IN GENERAL.—The Secretary shall adopt standards for transactions and data elements to make medicare information uniformly available to be exchanged electronically, that is—

"(A) appropriate for the following financial and administrative transactions: claims (including coordination of benefits) or equivalent encounter information, enrollment and disenrollment, eligibility, premium payments, and referral certification and authorization; and

"(B) related to other financial and administrative transactions determined appropriate by the Secretary consistent with the goals of improving the operation of the health care system and reducing administrative costs.

"(2) UNIQUE HEALTH IDENTIFIERS.—

"(A) ADOPTION OF STANDARDS.—The Secretary shall adopt standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the medicare information system. In developing unique health identifiers for each health plan and health care provider, the Secretary shall take into account multiple uses for identifiers and multiple locations and specialty classifications for health care providers.

"(B) PENALTY FOR IMPROPER DISCLOSURE.—A person who knowingly uses or causes to be used a unique health identifier under subparagraph (A) for a purpose that is not authorized by the Secretary shall—

"(i) be fined not more than $50,000, imprisoned not more than 1 year, or both; or

"(ii) if the offense is committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both.

"(3) CODE SETS.—

"(A) IN GENERAL.—The Secretary, in consultation with the Medicare Information Advisory Committee, experts from the private sector, and Federal and State agencies, shall—

"(i) select code sets for appropriate data elements from among the code sets that have been developed by private and public entities; or

"(ii) establish code sets for such data elements if no code sets for the data elements have been developed.

"(B) DISTRIBUTION.—The Secretary shall establish efficient and low-cost procedures for distribution (including electronic distribution) of code sets and modifications made to such code sets under subsection (c)(2).

"(4) ELECTRONIC SIGNATURE.—

"(A) IN GENERAL.—The Secretary, after consultation with the Medicare Information Advisory Committee, shall promulgate regulations specifying procedures for the electronic transmission and authentication of signatures, compliance with which will be deemed to satisfy Federal and State statutory requirements for written signatures with respect to information transactions required by this section and written signatures on enrollment and disenrollment forms.

"(B) PAYMENTS FOR SERVICES AND PREMIUMS.—Nothing in this section shall be construed to prohibit the payment of health care services or health plan premiums by debit, credit, payment card or numbers, or other electronic means.

"(5) TRANSFER OF INFORMATION BETWEEN HEALTH PLANS.—The Secretary shall develop rules and procedures—

"(A) for determining the financial liability of health plans when health care benefits are payable under two or more health plans; and

"(B) for transferring among health plans appropriate standard data elements needed for the coordination of benefits, the sequential processing of claims, and other data elements for individuals who have more than one health plan.

"(6) COORDINATION OF BENEFITS.—If, at the end of the 5-year period beginning on the date of the enactment of this section, the Secretary determines that additional transaction standards for coordinating benefits are necessary to reduce administrative costs or duplicative (or inappropriate) payment of claims, the Secretary shall establish further transaction standards for the coordination of benefits between health plans.

"(7) PROTECTION OF TRADE SECRETS.—Except as otherwise required by law, the standards adopted under this section shall not require disclosure of trade secrets or confidential commercial information by an entity operating a medicare information network.

"(c) TIMETABLES FOR ADOPTION OF STANDARDS.—

"(1) INITIAL STANDARDS.—Not later than 18 months after the date of the enactment of this section, the Secretary shall adopt standards relating to the information transactions, data elements of medicare information and security described in subsections (a) and (b).

"(2) ADDITIONS AND MODIFICATIONS TO STANDARDS.—

"(A) IN GENERAL.—The Secretary shall review the standards adopted under this section and shall adopt additional or modified standards, that have been developed or modified by a standard setting organization, as determined appropriate, but not more frequently than once every 12 months. Any addition or modification to such standards shall be completed in a manner which minimizes the disruption and cost of compliance.

"(B) ADDITIONS AND MODIFICATIONS TO CODE SETS.—

"(i) IN GENERAL.—The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets.

"(ii) ADDITIONAL RULES.—If a code set is modified under this paragraph, the modified code set shall include instructions on how data elements of medicare information that were encoded prior to the modification may be converted or translated so as to preserve the informational value of the data elements that existed before the modification. Any modification to a code set under this paragraph shall be implemented in a manner that minimizes the disruption and cost of complying with such modification.

"(d) REQUIREMENTS FOR HEALTH PLANS.—

"(1) IN GENERAL.—If a person desires to conduct any of the information transactions described in subsection (b)(1) with a health plan as a standard transaction, the health plan shall conduct such standard transaction in a timely manner and the information transmitted or received in connection with such transaction shall be in the form of standard data elements of medicare information.

"(2) SATISFACTION OF REQUIREMENTS.—A health plan may satisfy the requirement imposed on such plan under paragraph (1) by directly transmitting standard data elements of medicare information or submitting nonstandard data elements to a medicare information network service for processing into standard data elements and transmission.

"(3) TIMETABLES FOR COMPLIANCE WITH REQUIREMENTS.—Not later than 24 months after the date on which standards are adopted under subsections (a) and (b) with respect to any type of information transaction or data element of medicare information or with respect to security, a health plan shall comply with the requirements of this section with respect to such transaction or data element.

"(4) COMPLIANCE WITH MODIFIED STANDARDS.—If the Secretary adopts a modified standard under subsection (a) or (b), a health plan shall be required to comply with the modified standard at such time as the Secretary determines appropriate taking into account the time needed to comply due to the nature and extent of the modification. However, the time determined appropriate under the preceding sentence shall be not earlier than the last day of the 180-day period beginning on the date such modified standard is adopted. The Secretary may extend the time for compliance for small health plans, if the Secretary determines such extension is appropriate.

"(e) GENERAL PENALTY FOR FAILURE TO COMPLY WITH REQUIREMENTS AND STANDARDS.—

"(1) GENERAL PENALTY.—

"(A) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall impose on any person that violates a requirement or standard—

"(i) with respect to medicare information transactions, data elements of medicare information, or security imposed under subsection (a) or (b); or

"(ii) with respect to health plans imposed under subsection (d);

a penalty of not more than $100 for each such violation of a specific standard or requirement, but the total amount imposed for all such violations of a specific standard or requirement during the calendar year shall not exceed $25,000.

"(B) PROCEDURES.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil money penalty under this paragraph in the same manner as such provisions apply to the imposition of a penalty under such section 1128A.

"(C) DENIAL OF PAYMENT.—Except as provided in paragraph (2), the Secretary may deny payment under this title for an item or service furnished by a person if the person fails to comply with an applicable requirement or standard for medicare information relating to that item or service.

"(2) LIMITATIONS.—

"(A) NONCOMPLIANCE NOT DISCOVERED.—A penalty may not be imposed under paragraph (1) if it is established to the satisfaction of the Secretary that the person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person failed to comply with the requirement or standard described in paragraph (1).

"(B) FAILURES DUE TO REASONABLE CAUSE.—

"(i) IN GENERAL.—Except as provided in clause (ii), a penalty may not be imposed under paragraph (1) if—

"(I) the failure to comply was due to reasonable cause and not to willful neglect; and

"(II) the failure to comply is corrected during the 30-day period beginning on the first date the person liable for the penalty knew, or by exercising reasonable diligence would have known, that the failure to comply occurred.

"(ii) EXTENSION OF PERIOD.—

"(I) NO PENALTY.—The period referred to in clause (i)(II) may be extended as determined appropriate by the Secretary based on the nature and extent of the failure to comply.

"(II) ASSISTANCE.—If the Secretary determines that a health plan failed to comply because such plan was unable to comply, the Secretary may provide technical assistance to such plan during the period described in clause (i)(II). Such assistance shall be provided in any manner determined appropriate by the Secretary.

"(C) REDUCTION.—In the case of a failure to comply which is due to reasonable cause and not to willful neglect, any penalty under paragraph (1) that is not entirely waived under subparagraph (B) may be waived to the extent that the payment of such penalty would be excessive relative to the compliance failure involved.

"(f) EFFECT ON STATE LAW.—

"(1) GENERAL EFFECT.—

"(A) GENERAL RULE.—Except as provided in subparagraph (B), a provision, requirement, or standard under this section shall supersede any contrary provision of State law, including a provision of State law that requires medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form.

"(B) EXCEPTIONS.—A provision, requirement, or standard under this section shall not supersede a contrary provision of State law if the Secretary determines that the provision of State law should be continued for any reason, including for reasons relating to prevention of fraud and abuse or regulation of controlled substances.

"(2) PUBLIC HEALTH REPORTING.—Nothing in this section shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.

"(g) MEDICARE INFORMATION ADVISORY COMMITTEE.—

"(1) ESTABLISHMENT.—There is established a committee to be known as the Medicare Information Advisory Committee (in this subsection referred to as the 'committee').

"(2) DUTIES.—The committee shall—

"(A) advise the Secretary in the development of standards under this section; and

"(B) be generally responsible for advising the Secretary and the Congress on the status and the future of the medicare information network.

"(3) MEMBERSHIP.—

"(A) IN GENERAL.—The committee shall consist of 9 members of whom—

"(i) 3 shall be appointed by the President;

"(ii) 3 shall be appointed by the Speaker of the House of Representatives after consultation with the minority leader of the House of Representatives; and

"(iii) 3 shall be appointed by the President pro tempore of the Senate after consultation with the minority leader of the Senate.

The appointments of the members shall be made not later than 60 days after the date of the enactment of this section. The President shall designate 1 member as the Chair.

"(B) EXPERTISE.—The membership of the committee shall consist of individuals who are of recognized standing and distinction in the areas of information systems, information networking and integration, consumer health, or health care financial management, and who possess the demonstrated capacity to discharge the duties imposed on the committee.

"(C) TERMS.—Each member of the committee shall be appointed for a term of 5 years, except that the members first appointed shall serve staggered terms such that the terms of not more than 3 members expire at one time.

"(D) INITIAL MEETING.—Not later than 30 days after the date on which a majority of the members have been appointed, the committee shall hold its first meeting.

"(4) REPORTS.—Not later than 1 year after the date of the enactment of this section, and annually thereafter, the committee shall submit to Congress and the Secretary a report regarding—

"(A) the extent to which entities using the medicare information network are meeting the standards adopted under this section and working together to form an integrated network that meets the needs of its users;

"(B) the extent to which such entities are meeting the security standards established pursuant to this section and the types of penalties assessed for noncompliance with such standards;

"(C) any problems that exist with respect to implementation of the medicare information network; and

"(D) the extent to which timetables under this section are being met.

Reports made under this subsection shall be made available to health care providers, health plans, and other entities that use the medicare information network to exchange medicare information.

"(h) DEFINITIONS.—For purposes of this section:

"(1) CODE SET.—The term 'code set' means any set of codes used for encoding data elements, such as tables of terms, enrollment information, and encounter data.

"(2) COORDINATION OF BENEFITS.—The term 'coordination of benefits' means determining and coordinating the financial obligations of health plans when health care benefits are payable under such a plan and under this title (including under a MedicarePlus product).

"(3) MEDICARE INFORMATION.—The term 'medicare information' means any information that relates to the enrollment of individuals under this title (including information relating to elections of MedicarePlus products under section 1805) and the provision of health benefits (including benefits provided under such products) under this title.

"(4) MEDICARE INFORMATION NETWORK.—The term 'medicare information network' means the medicare information system that is formed through the application of the requirements and standards established under this section.

"(5) MEDICARE INFORMATION NETWORK SERVICE.—The term 'medicare information network service' means a public or private entity that—

"(A) processes or facilitates the processing of nonstandard data elements of medicare information into standard data elements;

"(B) provides the means by which persons may meet the requirements of this section; or

"(C) provides specific information processing services.

"(6) HEALTH PLAN.—The term 'health plan' means a plan which provides, or pays the cost of, health benefits. Such term includes the following, or any combination thereof:

"(A) Part A or part B of this title, and includes a MedicarePlus product.

"(B) The medicaid program under title XIX and the MediGrant program under title XXI.

"(C) A medicare supplemental policy (as defined in section 1882(g)(1)).

"(D) Worker's compensation or similar insurance.

"(E) Automobile or automobile medical-payment insurance.

"(F) A long-term care policy, other than a fixed indemnity policy.

"(G) The Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code.

"(H) An employee welfare benefit plan, as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(1)), but only to the extent the plan is established or maintained for the purpose of providing health benefits.

"(7) INDIVIDUALLY IDENTIFIABLE MEDICARE INFORMATION.—The term 'individually identifiable medicare information' means medicare enrollment information, including demographic information collected from an individual, that—

"(A) is created or received by a health care provider, health plan, employer, or medicare information network service, and

"(B) identifies an individual.

"(8) STANDARD SETTING ORGANIZATION.—The term 'standard setting organization' means a standard setting organization accredited by the American National Standards Institute.

"(9) STANDARD TRANSACTION.—The term 'standard transaction' means, when referring to an information transaction or to data elements of medicare informa-

tion, any transaction that meets the requirements and implementation specifications adopted by the Secretary under subsections (a) and (b).''.

PART 5—OTHER PROVISIONS RELATING TO PARTS A AND B

SEC. 15741. CLARIFICATION OF MEDICARE COVERAGE OF ITEMS AND SERVICES ASSOCIATED WITH CERTAIN MEDICAL DEVICES APPROVED FOR INVESTIGATIONAL USE.

(a) COVERAGE.—Nothing in title XVIII of the Social Security Act may be construed to prohibit coverage under part A or part B of the medicare program of items and services associated with the use of a medical device in the furnishing of inpatient or outpatient hospital services (including outpatient diagnostic imaging services) for which payment may be made under the program solely 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 either an approved device or a covered procedure.

(b) CLARIFICATION OF PAYMENT AMOUNT.—Notwithstanding any other provision of title XVIII of the Social Security Act, the amount of payment made under the medicare program for any item or service associated with the use of an investigational device in the furnishing of inpatient or outpatient hospital services (including outpatient diagnostic imaging services) for which payment may be made under the program may not exceed the amount of the payment which would have been made under the program for the item or service if the item or service were associated with the use of an approved device or a covered procedure.

(c) DEFINITIONS.—In this section—

(1) the term ''approved device'' means a medical device (or devices) which has been approved for marketing under pre-market approval under the Federal Food, Drug, and Cosmetic Act or cleared for marketing under a 510(k) notice under such Act; and

(2) the term ''investigational device'' means—

(A) a medical device or devices (other than a device described in paragraph (1)) approved for investigational use under section 520(g) of the Federal Food, Drug, and Cosmetic Act, or

(B) a product authorized for use under section 505(i) of the Federal Food, Drug, and Cosmetic Act which includes the use of a medical device (or devices) or an investigational combination product under section 503(g) of such Act which includes a device (or devices) authorized for use under section 505(i) of such Act.

SEC. 15742. ADDITIONAL EXCLUSION FROM COVERAGE.

(a) IN GENERAL.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 15525(a)(2) and section 15701(c)(2)(C), is amended—

(1) by striking ''or'' at the end of paragraph (16),

(2) by striking the period at the end of paragraph (17) and inserting ''; or'', and

(3) by inserting after paragraph (17) the following new paragraph:

''(18) where such expenses are for items or services, or to assist in the purchase, in whole or in part, of health benefit coverage that includes items or services, for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to payment for items and services furnished on or after the date of the enactment of this Act.

Subtitle I—Clinical Laboratories

SEC. 15801. EXEMPTION OF PHYSICIAN OFFICE LABORATORIES.

Section 353(d) of the Public Health Service Act (42 U.S.C. 263a(d)) is amended—

(1) by redesignating paragraphs (2), (3), and (4) as paragraphs (3), (4), and (5) and by adding after paragraph (1) the following:

''(2) EXEMPTION OF PHYSICIAN OFFICE LABORATORIES.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), a clinical laboratory in a physician's office (including an office of a group of physicians) which is directed by a physician and in which examinations and procedures are either performed by a physician or by individuals supervised by a physi-

cian solely as an adjunct to other services provided by the physician's office is exempt from this section.

"(B) EXCEPTION.—A clinical laboratory described in subparagraph (A) is not exempt from this section when it performs a pap smear (Papanicolaou Smear) analysis.

"(C) DEFINITION.—For purposes of subparagraph (A), the term 'physician' has the same meaning as is prescribed for such term by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).";

(2) in paragraph (3) (as so redesignated) by striking "(3)" and inserting "(4)"; and

(3) in paragraphs (4) and (5) (as so redesignated) by striking "(2)" and inserting "(3)".

Subtitle J—Lock-Box Provisions for Medicare Part B Savings from Growth Reductions

SEC. 15901. ESTABLISHMENT OF MEDICARE GROWTH REDUCTION TRUST FUND FOR PART B SAVINGS.

Part B of title XVIII is amended by inserting after section 1841 the following new section:

"MEDICARE GROWTH REDUCTION TRUST FUND

"SEC. 1841A. (a)(1) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Medicare Growth Reduction Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1) and amounts appropriated under paragraph (2).

"(2) There are hereby appropriated to the Trust Fund amounts equivalent to 100 percent of the Secretary's estimate of the reductions in expenditures under this part that are attributable to the Medicare Preservation Act of 1995. The amounts appropriated by the preceding sentence shall be transferred from time to time (not less frequently than monthly) from the general fund in the Treasury to the Trust Fund.

"(3)(A) Subject to subparagraph (B), with respect to monies transferred to the Trust Fund, no transfers, authorizations of appropriations, or appropriations are permitted.

"(B) Beginning with fiscal year 2003, the Secretary may expend funds in the Trust Fund to carry out this title, but only to the extent provided by Congress in advance through a specific amendment to this section.

"(b) The provisions of subsections (b) through (e) of section 1841 shall apply to the Trust Fund in the same manner as they apply to the Federal Supplementary Medical Insurance Trust Fund, except that the Board of Trustees and Managing Trustee of the Trust Fund shall be composed of the members of the Board of Trustees and the Managing Trustee, respectively, of the Federal Supplementary Medical Insurance Trust Fund.".

I. INTRODUCTION

A. PURPOSE AND SUMMARY

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 were facing significant financial imbalance in both the short-term and the long-term.

In response to the concerns raised by the Trustees and their recommendation for "prompt, effective, and decisive action," the Committee on Ways and Means set as its mission to preserve, protect, and strengthen Medicare for the program's current beneficiaries as well as those generations of working Americans who are paying much of the cost of Medicare now and will become entitled to Medicare coverage in the future.

The Committee set as its goals to bring the Hospital Insurance (HI) trust fund into balance up to the retirement of the baby boom generation, curb unsustainable growth in the Supplementary Medical Insurance (SMI) trust fund, develop new choices for Medicare beneficiaries that would enhance coverage and moderate cost growth, and finally to establish a commission to make recommendations to Congress to secure Medicare through the baby boom retirement years beginning after 2010.

H.R. 2425 provides a comprehensive program to meet these goals. The bill meets its objectives and brings Medicare into financial balance and initiates new Medicare options (hereinafter called "MedicarePlus") which will improve beneficiary choices of health care coverage.

H.R. 2425 was developed after months of public hearings before the Committee on Ways and Means and its Health Subcommittee, with testimony from scores of witnesses, including seniors, medical providers, actuaries, health economists, health plan professionals, and other experts in health care and Medicare policy.

B. Background and Need for Legislation

According to the 1995 report of the Board of Trustees, the outlays of the 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.

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 without adequate spending reductions the HI payroll tax rate of 1.45 percentage points (paid by both employers and employees) 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 44% increase in the payroll tax rate if spending is not slowed.

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.

Not only is the HI trust fund financially out of balance, but spending growth within the 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.

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 the enactment of the Medicare program. 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 not only slowing the rate of growth of premiums, but in many instances recognizing actual reductions in 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.

To address these pressing concerns and developments in the private health care market, the Committee has set as its mission to preserve, protect and strengthen the Medicare program. The Committee defines its mission as follows:

> to preserve Medicare to bring the program into financial balance and keep it affordable for the current and future generations;
>
> to protect Medicare to assure beneficiaries that the program as they know it will continue to be available; and
>
> to strengthen Medicare to provide beneficiaries with private coverage options that empower them to choose the health plan that best fits their needs.

The Committee used the following criteria to guide its efforts to secure Medicare:

> Medicare beneficiary cost sharing proportions *would not be increased* over the next seven years, with the sole exception of the most affluent beneficiaries whose subsidy by the general taxpayer will be reduced and phased out at higher levels of income.
>
> Policies to bring Medicare into financial balance and affordable would ensure that *Medicare continues to increase spending each year, but Medicare spending growth would be made consistent with the objective to assure solvency in Part A and to make Part B affordable,* rather than continuing at the unsustainable and excessive rates experienced in the past.
>
> The Committee's improvements in Medicare policy would 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.

The Committee adhered to the following principles in meeting its objectives on ensuring the solvency of the Part A Trust Fund and managing the future rate of growth in the cost of Medicare:

> For FY 1996–2002, Medicare spending will grow per beneficiary. In fact, under H.R. 2425, Medicare per enrollee spending will increase from $4,800 in 1995 to $6,700 by the year 2002.
>
> Spending for beneficiaries will grow, in aggregate, at the same rate whether enrolled in MedicarePlus organizations or in the current fee-for-service alternative.

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 through the retirement of the baby boom generation, anticipating the demographic pressures this generation will place on the program's financing.

Under H.R. 2425, Medicare spending will increase annually:

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

Between 1995 and 1996, under this plan, Medicare Part A spending will increase by almost 6 percent. CBO projections also indicate that Medicare Part B spending will grow by 7.6 percent. As a result of the reforms included in H.R. 2425, the Medicare program will be preserved from bankruptcy even as spending continues to grow.

C. Legislative History

Committee bill

H.R. 2425 was introduced on September 29, 1995, by Mr. Archer, et al., and referred to the Committee on Ways and Means, and in addition, to the Committees on Commerce, the Judiciary, and Rules. The bill as introduced includes nine subtitles. Subtitle A defines the MedicarePlus program which will provide beneficiaries with more choices of health plan design. Subtitle B establishes new initiatives for preventing fraud and abuse under the Medicare program. Subtitle C provides regulatory relief which will reduce the inefficiencies in the program created by years of redundant bureaucratic controls. Subtitle D provides for reform of the medical malpractice system. Subtitle E reforms the graduate medical education program and provides for a new trust fund to ensure a continuing supply of high quality medical professionals. Subtitle F contains provisions to slow the rate of growth of the HI program and extend the solvency of the HI trust fund. Subtitle G provides reforms to slow the rate of growth in the SMI program and to reduce the federal subsidy for affluent seniors. Subtitle H provides for reform of the way in which the Medicare program pays for home health services and reduces the rate of growth of many services that have implications under both Part A and Part B of the Medicare program. Subtitle I reforms the oversight of the Clinical Laboratories. Subtitle J guarantees that the savings that result from slowing the rate of growth in the SMI portion of the program will be kept in the SMI trust fund.

The Committee on Ways and Means began consideration of H.R. 2425 on October 9, 1995, continued consideration on October 10, 1995, completed consideration of H.R. 2425 on October 11, 1995, and ordered the bill to be favorably reported as amended by a roll call vote of 22 ayes and 14 nays.

Legislative hearings

The Subcommittee on Health of the Committee on Ways and Means held 14 public hearings on reform of the Medicare program. The full Ways and Means Committee held an additional three hearings. The first subcommittee hearing took place on February 6, 1995 and focused on areas of extraordinary growth in certain Medicare costs. On February 7, 1995, the subcommittee reviewed issues involved in income relating the Part B premium. The subcommittee reviewed the existing Medicare managed-care programs, including Medicare Select, and issues related to expanding managed-care under Medicare. On February 23, 1995 the subcommittee heard testimony regarding the Medicare proposals contained in the President's fiscal year 1996 budget and the status of the Hospital Insurance Trust Fund.

On March 21, 1995, the subcommittee held a hearing on the innovative quality measurement, assurance, and improvement systems that can be applied to the Medicare program, and the effectiveness of existing quality assurance programs for Medicare fee-for-service and HMO beneficiaries. On March 23, 1995, the subcommittee conducted a hearing on graduate medical education which focused on alternative policy directions regarding the training of future health professionals, medical manpower needs of the evolving health care system, and the financing of teaching hospitals under Medicare. The subcommittee held an additional hearing on March 30, 1995 to review the formal recommendations of the Physician Payment Review Commission (PPRC) regarding physician payment under the Medicare program.

On April 3, 1995, the subcommittee held a hearing on the Medicare end-stage renal disease (ESRD) program, examining trends in costs, beneficiaries, and the number and organization of providers under the ESRD program.

On May 3, 1995 the subcommittee reviewed problems with compliance with the existing self-referral provision of the Social Security Act, focusing on the obstacles the law in its current form may present to physicians, hospitals, and health plans which are forming legitimate managed care plans. The subcommittee hearing schedule continued on May 16, 1995 with a review of the experience employer-based plans have had in controlling health care costs and improving the quality of care. The hearing focused on the issues and problems encountered as new approaches were implemented, the effectiveness of different approaches, and the lessons the Federal Government can learn from these private-sector experiences. On May 24, 1995, the subcommittee investigated the reasons for increasing beneficiary enrollment in Medicare risk contracting HMOs, and current and alternative HMO payment methodologies. On May 25, 1995, the subcommittee explored issues involved in enabling employers and associations to offer Medicare coverage to former employees and members respectively, and the potential role Medical Savings Accounts can play in the Medicare program.

The subcommittee held a continuing hearing on July 19, 20, and 25, 1995, reviewing issues involved in saving Medicare. On July 27, 1995, the subcommittee held a joint hearing with the Subcommittee on Health and the Environment, Committee on Commerce. The hearing reviewed standards for health plans providing coverage

under the Medicare program. The subcommittees heard testimony on the full range of standards currently applied in the health care system, both public and private, with an emphasis on the needs and unique requirements of the Medicare program. The testimony included information on how best to discharge this responsibility and the appropriate roles for private sector entities, the states, and the federal government.

In addition, the full Ways and Means Committee held a hearing regarding the Medicare program on February 8, 1995 which reviewed the Medicare provisions contained in the President's 1996 budget. The full Committee held a second hearing on May 2, 1995 which focused on the Trustees report on the Medicare Hospital Insurance Trust Fund. The full committee held an additional hearing on September 22, 1995 on the issues involved in saving Medicare, focusing specifically on the Medicare proposal which formed the basis for H.R. 2425.

II. EXPLANATION OF BILL

SUBTITLE A—MEDICAREPLUS PROGRAM

PART 1. INCREASING CHOICE UNDER THE MEDICARE PROGRAM

Sec. 15001. Increasing choice under medicare

Present law

Persons enrolling in Medicare have two basic coverage options. They may elect to obtain services through the traditional fee-for-service system under which program payments are made for each service rendered. Under section 1876 of the Social Security Act, they may also elect to enroll with a managed care organization which has entered into a payment agreement with Medicare. Three types of managed care organizations are authorized to contract with Medicare: an entity that has a risk contract with Medicare, an entity that has a cost contract with Medicare, or a health care prepayment plan (HCPP) that has a cost contract to provide Medicare Part B services. Risk-contracts are frequently referred to as TEFRA risk contracts and cost contracts are frequently referred to as TEFRA cost contracts. TEFRA refers to the 1982 legislation, the Tax Equity and Fiscal Responsibility Act of 1982, which established the rules governing these types of contracts.

A beneficiary in an area served by a health maintenance organization (HMO) or competitive medical plan (CMP) with a Medicare risk contract may voluntarily choose to enroll in the organization. Medicare makes a single monthly capitation payment for each of its enrollees. In return, the entity agrees to provide or arrange for the full range of Medicare services through an organized system of affiliated physicians, hospitals and other providers. The beneficiary must obtain all covered services through the HMO or CMP, except in emergencies. The beneficiary may be charged the usual cost-sharing charges or pay the equivalent in the form of a monthly premium to the organization. Beneficiaries are expected to share in the projected savings through the provision of benefits in addition to that included in Medicare's benefit package.

Beneficiaries may also enroll in organizations with TEFRA cost contracts. These entities must meet essentially the same conditions of participation as risk contractors; however they may have as few as 1,500 enrollees (rather than 5,000) to qualify. Under a cost contract, Medicare pays the actual cost the entity incurs in furnishing covered services (less the estimated value of beneficiary cost-sharing). Enrollees obtain supplemental benefits by paying a monthly premium. The entity must offer a basic package (which covers all or a portion of Medicare cost-sharing charges); any additional benefits must be priced separately. (Conversely, a risk-contractor may offer just one package.) Enrollees in TEFRA cost-contract entities may obtain services outside the entity's network; however, the entity has no obligation to cover the beneficiary's cost-sharing in this case.

A third type of managed care arrangement is the HCPP. An HCPP arrangement is similar to a TEFRA cost-contract except that it provides only Part B services. Further, there are no specific statutory conditions to qualify for a HCPP contract. Some HCPPs are private market HMOs, while others are union or employer plans. HCPPs have no minimum enrollment requirements, no requirement that the plan have non-Medicare enrollees, or a requirement for an open enrollment period. Unlike TEFRA cost contractors (but like risk contractors), HCPPs may offer a single supplemental package that includes both Part B cost-sharing and other benefits; cost-sharing benefits need not be priced separately.

Any Medicare beneficiary residing in the area served by an HMO/CMP may enroll, with two exceptions. The first exception applies to beneficiaries not enrolled in Part B. The second exception applies to persons qualifying for Medicare on the basis of end-stage renal disease (ESRD); however, persons already enrolled who later develop ESRD may remain enrolled in the entity.

The HMO/CMP must have an annual open enrollment period of at least 30 days duration. During this period, it must accept beneficiaries in the order in which they apply up to the limits of its capacity, unless to do so would lead to violation of the 50 percent Medicare-Medicaid maximum or to an enrolled population unrepresentative of the population in the area served by the HMO.

TEFRA risk contractors are required to hold an additional open enrollment period if any other risk-based entity serving part of the same geographic area does not renew its Medicare contract, has its contract terminated, or has reduced its service area to exclude any portion of the service area previously served by both contractors. In such cases, the Secretary must establish a single coordinated open enrollment period for the remaining contractors. These remaining HMOs/CMPs must then accept its enrollees during an enrollment period of 30 days.

An enrollee may request termination of his or her enrollment at any time. An individual may file disenrollment requests directly with the HMO or at the local social security office. Disenrollment takes effect on the first day of the month following the month during which the request is filed. The HMO may not disenroll or refuse to re-enroll a beneficiary on the basis of health status or need for health services.

The requirement for an open enrollment period does not apply to HCPPs. These entities may deny enrollment or terminate enrollment on medical or other grounds, if in doing so they use the same criteria for Medicare and non-Medicare enrollees. As a result, employer or union plans may restrict enrollment to covered retirees.

The Secretary is authorized to prescribe procedures and conditions under which eligible organizations contracting with Medicare may inform beneficiaries about the organization. Brochures, applications forms, or other promotional or informational 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 for 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.

Explanation of provision

The principal change is the creation of the MedicarePlus program to permit a wider array of private insurance and other organizations to offer health care plans to Medicare beneficiaries. MedicarePlus plans could be offered by licensed insurers and health maintenance organizations, new entities known as provider-sponsored organizations or PSOs, and limited enrollment plans such as are offered by Taft-Hartley or association sponsors. The array of products can include fee-for-service, HMO, point-of-service and high-deductible/medical savings account plans. As will be noted in later sections, MedicarePlus plans must at a minimum cover the traditional Parts A and B benefits, and may add supplemental benefits or reduce beneficiaries' premium and cost-sharing obligations otherwise applicable under the traditional program. As will also be discussed in later sections, MedicarePlus plans will be actively supervised by the federal government, with the assistance of state governments, and will be required to meet rigorous quality, patient protection, financial viability and other standards enforced through federal contracts.

The processes under which beneficiaries would be apprised of and exercise their plan choices is designed to maximize the ease and efficiency with which beneficiaries can enroll into the plans of their choice. The reason for the transition period is to provide a reasonable timeframe for the Secretary to develop standards where needed, to minimize disruption to current HMO contractors, and to permit additional health care companies to design new MedicarePlus products, contract with the Secretary, and begin to market their products to beneficiaries.

Great emphasis in the provisions is placed on the Secretary's development of clear, effective and timely informational materials to assist beneficiaries in making well-informed choices. The MedicarePlus Health Fair scheduled for October, 1996 will be a major opportunity for the Secretary to "field-test" a national aware-

ness effort in preparation for the beginning of annual, open and coordinated enrollment periods to be held every subsequent October. These annual open enrollment periods will be crucial to promoting competition among plans for enrollment of beneficiaries because all plans will be competing during a specified period and beneficiaries will be able to compare the plans' benefits and costs against each other and relative to the traditional program.

It is the Committee's intent that the MedicarePlus program be implemented through an office in the Department of Health and Human Services that is separate from the Health Care Financing Administration (HCFA), but led by a Director of equal pay and rank to that of the HCFA Administrator. This provision reflects the Committee's concern that the MedicarePlus program be developed and administered in a manner that will foster its advancement, rather than placing it in competition for resources and attention with an organization principally concerned with the ongoing management of the traditional fee-for-service program.

Successful implementation of MedicarePlus will require 1) innovative executive management, 2) an understanding of private insurance markets and skill in creating effective public-private partnerships, 3) accelerated rulemaking processes, 4) strengthened contracting operations, and 5) careful attention to customer service, principally Medicare beneficiaries. The provisions grant the Secretary the authority to make the transfers of funds, personnel, systems and records necessary to retool and organize within the Department of Health and Human Services to support the MedicarePlus effort.

The Social Security Act would be amended by establishing a MedicarePlus program. Every individual entitled to Medicare Part A and enrolled under Part B could elect to receive benefits through two options: (1) the existing fee-for-service system ("the non-MedicarePlus option") or (2) through a MedicarePlus product ("the MedicarePlus option"). A MedicarePlus product could be a product offered by a provider-sponsored organization; a high deductible policy which would be coupled with a Medisave account; or a product operating on a fee-for-service, or any other basis. It also could be offered by an organization that is a Taft-Hartley or association sponsor.

Special Rules. In general, an individual would be eligible to elect a MedicarePlus product offered by a MedicarePlus organization only if the organization served the geographic area in which in the individual lived. To enroll in a product offered by a limited-enrollment MedicarePlus organization, an individual would have to be affiliated with it. In the case of a product offered by a Taft-Hartley sponsor, the individual would have to elect the MedicarePlus product offered by the sponsor during the first enrollment period in which the individual was eligible to make such an election. An individual would not be eligible to elect a product offered by a Taft-Hartley sponsor if the individual previously had elected a MedicarePlus product offered by the organization and had subsequently discontinued to elect the product. An individual eligible for an annuity under the Federal Employee Health Benefit Program would not be eligible for a high-deductible/medisave product.

Process For Exercising Choice. The Secretary would be required to establish a process for electing non-MedicarePlus or MedicarePlus coverage in an expedited manner to permit election of MedicarePlus products in an area as soon as they became available. Elections would be made (or changed) only during specified coverage election periods. An individual who wished to elect a MedicarePlus product would do so by filing an appropriate election form with the organization. Disenrollment would be accomplished the same way. An individual failing to make an election during the initial election period would be deemed to have chosen the non-MedicarePlus option. An election would continue until the individual changed elections or the MedicarePlus product was discontinued. The Secretary could enter into an agreement with the Commissioner of Social Security under which the Commissioner would be responsible for the administration of enrollment and disenrollment in MedicarePlus products.

Provision of Beneficiary Information to Promote Informed Choice. The Secretary would provide for activities to disseminate broadly information to current and prospective Medicare beneficiaries on the coverage options available in order to promote an active, informed selection among such options. The information would have to be provided so as to permit individuals to elect the MedicarePlus option during an initial election period. The Secretary would be required to contract with appropriate public and private entities to carry out such activities.

The Secretary would be required to provide for at least the following in all areas in which MedicarePlus products were offered: (1) publish and disseminate an information booklet during coverage election periods, including information in standardized format and in plain English on benefits and premiums, quality (including consumer satisfaction); and beneficiary rights and responsibilities; (2) maintain a toll-free number for inquiries regarding MedicarePlus options; and (3) include information in the Medicare Handbook on the MedicarePlus option. The information booklet would have to be updated regularly.

Coverage Election Periods. For individuals newly eligible for Medicare after the transition period, elections would occur at the first time the individual both was entitled to benefits under Part A and enrolled under Part B. The transition period would be the period beginning when a MedicarePlus product first became available in an individual's area and ending with the close of the annual, coordinated election period occurring in October 1997.

During the transition period, an individual who elected to enroll in the non-MedicarePlus option could change election to a MedicarePlus option at any time. An individual in a MedicarePlus product could change election to another MedicarePlus product or the non-MedicarePlus option.

In October, 1996, the Secretary would be required to conduct a MedicarePlus Health Fair which would provide for a nationally coordinated educational and publicity program to inform MedicarePlus eligible persons about MedicarePlus products and the election process, including the upcoming annual, coordinated election periods that would begin in 1997.

After the transition period, there would be an annual, coordinated election period during October of each year (beginning 1997) in which individuals could change elections. An individual who elected the MedicarePlus product option (other than the high-deductible/medisave option) for the first time could discontinue such election through the filing of an appropriate notice for up to 90 days from the enrollment's effective date. An individual who discontinued an election would be deemed to have elected the Non-MedicarePlus option.

A person who had elected a high-deductible/medisave product could not change to a MedicarePlus option that was not a high-deductible/medisave product unless the individual made such change during an annual, coordinated election period, or the individual had had such election in effect for 12 months. The high-deductible/medisave option would become first available, effective January 1, 1997. Elections for 1997 would occur during the October 1996 election period.

Special election periods would be provided in which an individual could discontinue an election of a MedicarePlus product and make a new election if: (1) the organization's or product's certification was terminated or the organization terminated or otherwise discontinued providing the product; (2) the person who elected a MedicarePlus product was no longer eligible because of a change in residence or certain other changes in circumstances; (3) the individual demonstrated that the organization offering the product violated its contract with Medicare or misrepresented the product in its marketing; or (4) the individual met other conditions specified by the Secretary.

Effectiveness of Elections. An election made during the initial election period would become effective when the individual became entitled to benefits, except as the Secretary might provide in order to prevent retroactive coverage through a MedicarePlus product. In general, after the transition, elections made during an annual election period would take effect as of the first day of the following year. Elections during other periods would take effect in the manner specified by the Secretary to protect continuity of coverage.

Administration. These provisions would be administered through an office in the DHHS that was separate from the HCFA, and whose primary function would be administration of the MedicarePlus and Medicare managed care programs. The director of this Division would be of equal pay and rank to that of the HCFA Administrator.

Reason for change

The Medicare program, except for the addition of HMOs, modest changes in benefits, and episodic reforms in provider payment methods, has remained essentially unaltered in its fundamental design and operation since the program's inception in 1965. This contrasts starkly with the health benefit design, delivery, and cost containment innovations that have occurred in the private sector, especially in employer plans, including the Federal Employee's Health Benefit Plan. The creation of MedicarePlus permits the introduction of comparable innovations and opportunities for improvement into the Medicare program, while keeping the existing

Medicare program available for those beneficiaries who prefer to remain in it. However, over time as MedicarePlus plans enter local communities, many beneficiaries should find that they can improve their overall benefits and reduce their out-of-pocket costs by enrolling in these privately designed and administered products.

Effective date

These provisions are effective upon enactment. The transition period effectively ends with the first annual open enrollment period of October 1997. The MedicarePlus Health Fair is to be conducted in October 1996. The high-deductible/medisave option would first become effective on January 1, 1997, although marketing and applications for enrollment will occur in 1996.

Sec. 15002. Provisions relating to MedicarePlus requirements for MedicarePlus organizations; high-deductible/Medisave products (Part C of Medicare)

Present law

Under section 1876 of the Social Security Act, Medicare specifies requirements to be met by an organization seeking to become a managed care contractor with Medicare. In general, these include the following: (1) the entity must be organized under the laws of the State and be a Federally qualified HMO or meet specified requirements (provide physician, inpatient, laboratory, and other services, and provide out-of-area coverage); (2) the organization is paid a predetermined amount without regard to the frequency, extent, or kind of services actually delivered to a member; (3) the entity provides physicians' services primarily through physicians who are either employees or partners of the organization or through contracts with individual physicians or physician groups; (4) the entity assumes full financial risk on a prospective basis for the provision of covered services, except that it may obtain stop loss coverage and other insurance for catastrophic and other specified costs; and (5) the entity has made adequate protection against the risk of insolvency.

There is no provision under current law for high-deductible/medisave products.

Explanation of provision

The Social Security Act would be amended to create a new Part C: Provisions Relating to MedicarePlus Organizations; High-Deductible/Medisave Products. Similar to current law, a MedicarePlus organization would be defined as a public or private entity certified (as described below) as meeting the requirements described in the following provisions.

Overview. The provisions are designed to emphasize the central importance of new types of MedicarePlus organizations assuming full financial liability for the costs of providing MedicarePlus benefits to enrollees. The provisions further emphasize the related and equal importance of each organization meeting federal solvency standards, and where applicable, traditional state insurance licensing standards which address fundamental rules regarding solvency. Taft-Hartley plans are treated differently because they are already

separately regulated under federal law and must meet stringent standards of fiduciary conduct.

In general, the provisions specified in greater detail below provide that the Medicare program will make a premium payment to MedicarePlus organizations for each Medicare beneficiary that is enrolled in a plan. It is the Committee's intent that the Medicare program contribute the principal financing to enroll beneficiaries in approved, privately administered plans. Although these premium amounts will vary for actuarial reasons as specified in later sections, they will not vary by the type of plan in which a beneficiary chooses to enroll.

This section of the bill contains provisions for a major new product that can be made available to Medicare beneficiaries known as the high deductible/medisave product (to be referred to simply as Medisave). Medisave pairs a high deductible insurance policy with a medical savings account. It is the Committee's intent to make available to beneficiaries a product designed to grant them greater control over how they spend at least a portion of the annual actuarial value of their Medicare benefit, while also encouraging the prudent use of more routine types of health services. The annual deductible may not initially exceed $10,000, but it is the Committee's expectation that most Medisave products will come onto the market with deductibles lower than that amount. It is the higher annual deductible that evidence suggests will encourage careful use of routine services, while amounts deposited in the medical savings account portion can either accrue as savings against the high deductible, or be used by beneficiaries for other health expenses not currently covered by Medicare, such as prescription drugs or long-term care insurance premiums.

Organized and Licensed under State Law. In general, a MedicarePlus organization would have to be organized and licensed under State law to offer health insurance or health benefits coverage in each State in which it offered a MedicarePlus product. This would not apply to Taft-Hartley sponsors or provider-sponsored organizations.

Prepaid Payment. A MedicarePlus organization would have to be compensated (except for deductibles, coinsurance, and copayments) by a fixed payment paid on a periodic basis and without regard to the frequency, extent, or kind of health care services actually provided to an enrollee.

Assumption of Full Financial Risk. The organization would have to assume full financial risk on a prospective basis for the provision of health services (other than hospice care) except the organization could obtain insurance or make other arrangements for: stop-loss coverage for aggregate costs in excess of $5,000; services needing to be provided other than through the organization; and for no more than 90 percent of the amount by which its costs for any of its fiscal years exceeded 115 percent of its income for such year. It could also make arrangements with providers or health institutions to assume all or part of the risk on a prospective basis for the provision of basic services.

Provision Against Risk of Insolvency. Each MedicarePlus organization would have to meet standards relating to financial solvency

and capital adequacy, as specified below. Taft-Hartley plans would be deemed to meet this requirement.

High Deductible/Medisave Products. The bill authorizes a Medisave option within MedicarePlus. A Medisave plan combines high deductible insurance with a medical savings account. High deductible insurance would provide reimbursement for Medicare benefits and others the plan may elect to provide only after the enrollee incurred annual expenses equal to a deductible of not greater than $10,000. These thresholds would be increased yearly (and rounded to the nearest $50) by the percentage increase in the national average per capita growth rate (described below). For purposes of the deductible, the insurance would have to at a minimum count all expenses that would have been payable by Medicare and the enrollee under Parts A and B. After the deductible was met, the insurance would have to reimburse all expenses that would have been paid without regard to deductibles or coinsurance under Parts A and B.

Organizations Treated as MedicarePlus Organizations During Transition. Certain organizations would be considered qualified as MedicarePlus organizations for contract years beginning before January 1, 1998. These include:

HMOs organized under State law that are qualified under the Public Health Service Act; an organization that is recognized under State law as an HMO; or a similar organization regulated for solvency in the same manner and extent as an HMO.

Organizations that are organized under State laws and are licensed by a State agency as a health insurer or as a service benefit plan, but only for individuals residing in an area in which the organization is licensed to offer health insurance coverage; and

Organizations with Medicare risk contracts as of the date of enactment.

Reason for change

It is the Committee's view that the introduction of significant innovations from the private sector, coupled with the full transfer of risk for each enrollee to participating private sector plans, will effectively temper the growth in spending in the Medicare program while providing opportunities for beneficiaries to improve upon the traditional Medicare benefit package.

Effective date

These provisions are effective upon enactment, except as noted earlier, Medisave products are effective January 1, 1997.

Requirements relating to benefits, provision of services, enrollment, and premiums

Present law

Section 1876 provides for requirements relating to benefits, payment to the plans by Medicare, and payments to the plans by beneficiaries. In addition, it specifies standards for patient protection, quality assurance, and general contractor requirements.

A Medicare beneficiary enrolled in an HMO/CMP is entitled to receive all services and supplies covered under Medicare Parts A and B (or Part B only, if only enrolled in Part B). These services must be provided directly by the organization or under arrangements with the organization. Enrollees in risk-based organizations are required to receive all services from the HMO/CMP except in emergencies.

In general, HMOs/CMPs offer benefits in addition to those provided under Medicare's benefit package. In certain cases, the beneficiary has the option of selecting the additional benefits, while in other cases some or all of the supplementary benefits are mandatory.

Some entities may require members to accept additional benefits (and pay extra for them in some cases). These required additional services may be approved by the Secretary if it is determined that the provision of such additional services will not discourage enrollment in the organization by other Medicare beneficiaries.

The amount an HMO/CMP may charge for additional benefits is based on a comparison of the entity's adjusted community rate (ACR, essentially the estimated market price) for the Medicare package and the average of the Medicare per capita payment rate. A risk-based organization is required to offer "additional benefits" at no additional charge if the organization achieves a savings from Medicare. This "savings" occurs if the ACR for the Medicare package is less than the average of the per capita Medicare payment rates. The difference between the two is the amount available to pay additional benefits to enrollees. These may include types of services not covered, such as outpatient prescription drugs, or waivers of coverage limits, such as Medicare's lifetime limit on inpatient hospital care. The organization might also waive some or all of the Medicare's cost-sharing requirements.

The entity may elect to have a portion of its "savings" placed in a benefit stabilization fund. The purpose of this fund is to permit the entity to continue to offer the same set of benefits in future years even if the revenues available to finance those benefits diminish. Any amounts not provided as additional benefits or placed in a stabilization fund would be offset by a reduction in Medicare's payment rate.

If the difference between the average Medicare payment rate and the adjusted ACR is insufficient to cover the cost of additional benefits, the HMO/CMP may charge a supplemental premium or impose additional cost-sharing charges. If, on the other hand, the HMO does not offer additional benefits equal in value to the difference between the ACR and the average Medicare payment, the Medicare payments are reduced until the average payment is equal to the sum of the ACR and the value of the additional benefits.

For the basic Medicare covered services, premiums and the projected average amount of any other cost-sharing may not exceed what would have been paid by the average enrollee under Medicare rules if she or he had not joined the HMO. For supplementary services, premiums and projected average cost-sharing may not exceed what the HMO would have charged for the same set of services in the private market.

HMOs/CMPs contracting with Medicare can pay second to workers' compensation, automobile liability or other specified sources of insurance.

Current law also provides for Medicare managed care contracts with Health care Prepayment Plans (HCPPs). A HCPP arrangement is similar to a TEFRA cost-contract except that it provides only Part B services. There are no specific statutory conditions to qualify for a HCPP contract.

Collectively bargained health plans and those sponsored by private multiemployer health plans (most of which are Taft-Hartley plans) are regulated under the Employee Retirement Income Security Act (ERISA). Under ERISA, the States are authorized to regulate multiple employer welfare arrangements (MEWAs) to the extent that such regulation does not conflict with ERISA. Association plans may or may not be regulated as MEWAs and are generally regulated by the States.

Penalties apply for violations of limits on the use of "physician incentive plans," i.e., compensation arrangements between HMOs and physicians that might induce physicians to 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 and must periodically survey enrollee satisfaction.

There are no provisions in current law for provider protections, or for the Department of Labor to play a role in establishing and enforcing Medicare contractor standards for employer-sponsored health plans. In addition, there is no provision in current law for high-deductible/medisave products.

Explanation of provision

Overview. With a few key exceptions to be noted, most of the provisions in this section derive from current law as applied to risk contractors. The following discussion highlights key new provisions.

As noted earlier, MedicarePlus organizations must provide at a minimum all benefits currently available under Parts A and B. In recognition of the new types of products that can be offered, the Committee thought it important to introduce basic payment protections tailored to reflect different product designs. In the payment provisions, a beneficiary's liability is generally limited to what the liability would have been on average had the beneficiary chosen to remain in the traditional program. The exception to these rules applies to fee-for-service plans, where balance billing is permitted.

It is the Committee's intent that Christian Science nursing facility services that are currently covered under Part A of Medicare must also be made available by MedicarePlus plans to enrollees who choose to use such services.

Special rules apply to limited enrollment plans in order to define what is intended by the term limited enrollment and to make clear that such plans can only enroll beneficiaries who have a connection to the sponsoring organization such as union or association membership.

A broad non-discrimination rule has been adopted to prevent plans from discriminating against beneficiaries by reason of health status and other factors. This is coupled with guaranteed issue requirements and other rules in other sections that work in tandem to reflect the Committee's intent that beneficiaries have a true and open choice of plans and that MedicarePlus organizations not evade their obligation to fully assume risk for and provide all medically necessary health care services, even for costly cases.

Insurance carriers offering high deductible coverage under Medisave plans must structure their premiums using the same demographic and other factors by which the Secretary adjusts the actuarial value of the MedicarePlus contribution paid on behalf of individual enrollees. This is necessary to maintain appropriate financial relationships between the MedicarePlus program's premium contribution and the residual amount paid into the beneficiary's medical savings account.

MedicarePlus plans will be permitted to offer, as one form of additional benefits, rebates to beneficiaries not to exceed the level of the Medicare Part B premium. It is the Committee's view that although enrollment in Part B of Medicare is voluntary, the vast majority of seniors do enroll and face a premium expense for doing so. The Committee viewed this as an out-of-pocket expense to beneficiaries that plans should be able to reduce in a manner similar to the way in which they may reduce other out-of-pocket expenses associated with the Medicare program, such as deductibles and copayments. However, in order to safeguard against inappropriate uses of rebate authority, plans may not offer rebates in excess of the level of the basic Part B premium, nor may they use such rebates as inappropriate inducements to enrollment.

The provisions establish basic procedures governing the relationship between MedicarePlus plans and providers participating in those plans. It is the Committee's belief that MedicarePlus plans must be able to freely organize provider networks and enter into various arrangements with different providers as needed to effectively and efficiently support their product. This also means that plans must be able to modify those arrangements under the same premise. However, it is the Committee's intent that MedicarePlus plans follow basic procedures so that providers are given information regarding the plans' participation requirements, and so that providers are apprised of and can respond to adverse decisions regarding their arrangements with MedicarePlus organizations.

Benefits Covered. Each MedicarePlus product would be required to provide benefits for at least the items and services for which benefits are available under parts A and B consistent with the standards for coverage of such items and services. A MedicarePlus product would meet the general benefit requirements if in the case of benefits furnished through fee-for-service providers, the product provided for at least the dollar amount of payment for such items and services as would otherwise have been provided under Medicare Parts A and B. In the case of benefits furnished through providers with a contract with the organization, the individual's liability for payment for services could not exceed (after taking into account any deductible which does not exceed any deductible under Parts A and B) the lesser of:

(a) the amount of liability that the individual would have had (based on the provider being a participating provider) if the individual had elected the non-MedicarePlus option, or

(b) the applicable coinsurance or copayment amounts (that would have applied under the non-MedicarePlus option) provided under the contract.

As under current law, the MedicarePlus organization could pay second in specified cases.

Guaranteed Issue and Renewal. Generally, a MedicarePlus organization would be required to provide that at any time during which elections were accepted, it would have to accept without restrictions individuals eligible to make such an election. If the Secretary determined that the organization had a capacity limit and the number of individuals who elected the product exceeded that limit, the organization could limit the election of individuals, but only if priority was given first to those individuals who had already elected the product, and then to others in a manner which did not discriminate. A MedicarePlus organization could not terminate or refuse to accept an individual's election except in the event of nonpayment of premiums, disruptive behavior, or the product was terminated with respect to all eligible Medicare individuals. (Those terminated would be deemed to have elected the non-MedicarePlus option).

Special Rules for Limited Enrollment MedicarePlus Organizations. MedicarePlus sponsors would have to limit enrollment for MedicarePlus products to specific individuals. A Taft-Hartley sponsor would have to limit eligibility to individuals who were entitled to obtain benefits under the terms of an applicable collective bargaining agreement.

A qualified association would be defined as an individual-membership association, religious fraternal organization, or other organization (a trade, industry, or professional association, a chamber of commerce, or a public entity association) that the Secretary found (1) was formed for purposes other than the sale of health insurance and did not restrict membership based on the health status, claims experience, receipt of health care, medical history, or lack of insurability, of an individual; (2) did not exist solely or principally for the purposes of selling insurance; and had at least 1,000 individual members, or 200 company members. Association sponsors would have to limit eligibility to individuals who were members of the association (or their spouses). Associations could not terminate coverage of an individual because the individual was no longer an association member except pursuant to a change of election during an open election period occurring on or after the date of termination of membership.

These eligibility rules could not have the effect of denying eligibility to individuals on the basis of health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability.

Submission and Charging of Premiums. Similar to current law, each MedicarePlus organization would be required annually to file the amount of the monthly premium for coverage under each of its products it would be offering in each payment area, and the enrollment capacity in relation to the product in each such area. The pre-

mium charged for a product offered in a payment area would equal 1/12 of the amount (if any) by which the premium exceeded the MedicarePlus capitation rate (see below). Premiums could not vary among individuals who resided in the same payment area. An exception would apply to high-deductible/Medisave products which would be experience-rated based on specified risk factors. (These factors are the same as those used for setting the MedicarePlus contribution level.) Each MedicarePlus organization would have to permit monthly payment of premiums. An organization could terminate election of individuals for a MedicarePlus product for failure to make premium payments but only under specified conditions. A MedicarePlus organization's premium rate and the actuarial value of its deductibles and coinsurance, attributable to the basic Parts A and B benefits and excluding permissable balance billing, could not exceed the actuarial value of the deductibles and coinsurance otherwise applicable under the Medicare program.

Requirement for Additional Benefits, Part B Premium Discount Rebates, or Both. If the actuarial value of the benefits under the MedicarePlus product (as determined based upon the adjusted community rate (ACR)—see below) for individuals was less than the average of the capitation payments made to the organization for the product at the beginning of an annual contract period, the organization could provide additional benefits, a monetary rebate (paid on a monthly basis) of the Part B monthly premium, or a combination of both. The value of these benefits, rebates or combination thereof would have to be at least as much as the amount by which the capitation payment exceeded the ACR, and would have to be applied uniformly for all enrollees in a product area. The rebate could not exceed the amount of the Part B premium (not taking into account penalties for late enrollment or the amount incurred as a result of affluence testing). The organization could provide that a part of the excess be withheld for the organization's stabilization fund. A MedicarePlus organization could provide additional benefits (over and above those required to be added as a result of the excess payment), and could impose a premium for such additional benefits. Cash or other types of rebates to induce enrollment or otherwise would be prohibited.

A MedicarePlus organization could provide that a part of the value of the excess actuarial amount be withheld and reserved in the HI and SMI trust funds (in such proportions as the Secretary determined to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits and rebates offered in those subsequent periods. Leftover amounts not provided as additional benefits would revert to the trust funds.

Adjusted Community Rate (ACR). Similar to current law, the ACR would mean, at the election of the MedicarePlus organization, either the rate of payment services which the Secretary annually determined would apply to the individuals electing a MedicarePlus product if the payment were determined under a community rating system, or the portion of the weighted aggregate premium which the Secretary annually estimated would apply to the individual but adjusted for differences between the utilization of individuals under Medicare and the utilization of other enrollees (or through another

specified manner). For PSOs, the ACR could be computed using data in the general commercial marketplace or (during the transition period) based on the costs incurred by the organization in providing such a product.

Protections for Providers. Each MedicarePlus organization would be required to establish reasonable procedures relating to the participation of physicians by providing: (a) notice of rules of participation, (b) written notice of participation decisions that are adverse to providers, and (c) a process within the organization for appealing adverse decisions, including the presentation of information and views of the provider regarding such decision. The organization would be required to consult with physicians who have entered into participation agreements with the organization regarding the organization's medical policy, quality and credentialing criteria, and medical management procedures.

Similar to current law, each MedicarePlus organization would be prohibited from operating any physician incentive plan (i.e., any compensation arrangement between a MedicarePlus organization and a physician or physician group that directly or indirectly has the effect of reducing or limiting services provided to enrollees) unless certain requirements were met: (1) no specific payment could be made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific enrollee; (2) if a plan placed a physician or physician group at substantial financial risk for services not provided by the physician or group, the organization provided adequate and appropriate stop-loss protection and conducted periodic surveys of both individuals enrolled and previously enrolled to determine their degree of access to services and satisfaction with the quality of those services; and (3) the organization provided to the Secretary descriptive information sufficient to determine the plan's compliance.

Provision of Information. Each MedicarePlus organization would be required to provide the Secretary with the information needed to prepare the information booklet described above.

Coordinated Acute and Long-Term Care Benefits under a MedicarePlus Product. States would be able to coordinate benefits under their MediGrant programs with those provided under a MedicarePlus product to assure continuity of a full range of acute and long-term care services to eligible poor elderly or disabled individuals.

Reason for change

It is the Committee's view that beneficiaries are interested in health insurance coverage options under Medicare which improve their coverage, and would welcome the opportunity to take advantage of additional choices made available under a carefully designed and administered MedicarePlus program. In addition, the Committee felt it was important to improve the conditions under which health care providers and MedicarePlus organizations relate to each other under MedicarePlus contracts in order to encourage providers to participate in organizations.

Effective date

These provisions are effective upon enactment.

Patient protection standards

Present law

Medicare HMOs/CMPs 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.

Medicare HMOs/CMPs must make all Medicare covered services and all other services contracted for available and accessible within its service area, with reasonable promptness and in a manner that assures continuity of care. Urgent care must be available and accessible 24 hours a day and 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 it is not reasonable, given the circumstances, to obtain the services through the HMO.

Medicare HMOs/CMPs must enroll individuals and provide covered services to enrollees who live within the geographic area served by the organization. Regulations provide that geographic area means the area found by HCFA to be that within which the HMO furnishes, or arranges for furnishing, the full range of services it offers to its Medicare enrollees.

HMOs/CMPs are required to have arrangements for an ongoing quality assurance program that stresses health outcomes and provides review by physicians and other health care professionals of the process followed in the provision of health services. External review is conducted by a peer review organization (PRO), one of the groups that has contracted with the Secretary for review of the quality and appropriateness of hospital services. PRO reviews of HMOs/CMPs covers both inpatient and outpatient care. The Secretary also has the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided and the facilities of the organization when there is reasonable evidence of some need for inspection.

In up to 25 States, the Secretary is authorized to designate another external agency, known as a quality review organization or QRO to perform reviews. QROs must meet many of the same standards as PROs, but have not contracted with the Department of HHS for the review of services other than those provided by an HMO/CMP.

HMOs/CMPs must have meaningful grievance procedures for the resolution of individual enrollee complaints, about such problems as failure to receive covered services or unpaid bills. In addition, an enrollee who believes that the 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.

Explanation of provision

Overview. Many of the provisions in this section of the bill derive from current law. However, reflecting the new types of products that can be offered, the Committee thought it was especially important to emphasize clear, accurate and prominent disclosure of benefits and of any financial liabilities for beneficiaries associated with specific products. In addition, the provisions establish organizations' minimum responsibilities under point-of-service features, where beneficiaries are authorized to go out of plan for services, but may face higher cost sharing as a result. The additional provisions limiting provider payment levels and beneficiary liability for emergency services provided out of plan are a protection for organizations and for beneficiary enrollees, facing the need for services on an emergency basis. This is, however, a change from current law which imposes payment limits even for non-emergency services provided out of plan. It is the Committee's view that plans should assume responsibility for securing and setting payment levels for authorized services provided out of plan, including for example, renal dialysis services. Plans are not responsible for unauthorized, non-emergency services that a beneficiary may obtain out of plan.

The provisions on external quality review organizations expand current law because it was the Committee's view that all MedicarePlus plans should be able to meet the quality standards of approved, independent external review organizations and that more organizations should be eligible to function in that role without limitations on the numbers of organizations competing to perform these functions.

With respect to marketing and enrollment, it is the Committee's intent to allow independent agents acting on behalf of MedicarePlus organizations to explain the plan's benefits and limitations and to accept enrollment forms from individuals electing the product. However, it is counter to the Committee's view that such agents be permitted to complete enrollment forms for individuals. At all permissable election periods, beneficiaries may enroll directly with the MedicarePlus organization of their choice.

Disclosure to Enrollees. Each MedicarePlus organization would be required to disclose in clear, accurate, and standardized forms certain information including: (1) benefits, including coverage exclusions and, for a high-deductible/medisave product, a comparison of its benefits with those under other MedicarePlus products; (2) rules relating to prior authorization or other review requirements that could result in nonpayment; (3) liability for cost-sharing for out-of-network services; (4) the number, mix, and distribution of providers; (5) financial obligations of the enrollee; (7) enrollee satisfaction data; (8) enrollee rights and responsibilities; and (8) a statement that use of the 911 number is appropriate in emergency situations.

Access to Services. A MedicarePlus organization offering a MedicarePlus product could restrict the providers from whom benefits were to be provided so long as: (1) the organization made the benefits available to each individual electing the product within the service area with reasonable promptness and in a manner which assured continuity in the provision of benefits, (2) when medically necessary, the organization made benefits available and accessible 24 hours a day and 7 days a week, and (3) the product provided

for reimbursement to other organizations if the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition and it was not reasonable given the circumstances to obtain the services through the organization. Emergency services are given a specific definition in the bill.

If the MedicarePlus product provided out-of-network coverage, the payment level for services furnished outside the network would have to be at least 70 percent (or, if the cost-sharing was 50 percent, at least 35 percent) of the lesser of the payment basis (determined without regard to deductibles and cost-sharing) that would have applied under Medicare Parts A and B, or the amount charged by the entity furnishing such items and services.

In the case of emergency services provided out of plan to an enrollee, participating providers would be required to accept as payment in full from the MedicarePlus organization the amount that would have been payable under Part B and from the individual, if the individual had not enrolled with the organization. In the case of nonparticipating physicians, the limitations on actual charges for such services otherwise applicable under Part B would apply.

Confidentiality and Accuracy of Enrollee Records. Each MedicarePlus organization would have to establish procedures to safeguard the privacy of individually identifiable enrollee information, and maintain accurate and timely medical records.

Quality Assurance. Each MedicarePlus organization would be required to arrange (in accordance with regulations of the Secretary) for an ongoing quality assurance program meeting certain requirements such as: (1) stressing health outcomes; (2) providing the establishment of written protocols for utilization review, (3) providing review by physicians and other health care professionals of the process followed in the provision of services; (4) monitoring and evaluating high volume and high risk services and the care of acute and chronic conditions; (5) evaluating the continuity and coordination of care; (6) establishing mechanisms to detect underutilization and overutilization; (6) making information available on quality and outcomes to facilitate beneficiary comparison and choice; (7) evaluating on an ongoing basis the plan's effectiveness, and (8) providing for external accreditation and review by a Medicare peer review organization or other qualified independent review organization that the quality of services meets professionally recognized standards of care.

Coverage Determinations. Each MedicarePlus organization would have to make determinations regarding authorization requests for nonemergency care on a timely basis. Medical necessity decisions could only be made by a physician. Appeals of a determination would have to be decided within 30 days of receiving medical information and no later than 60 days after the date of the decision. Appeals relating to a life-threatening or emergency situation would have to be decided on an expedited basis.

Grievance and Appeals. Each MedicarePlus organization would have to provide for meaningful procedures for hearing and resolving grievances between the organization (and entities and individuals through which it provides services) and enrollees. An enrollee dissatisfied by reason of the enrollee's failure to receive health services would be entitled, if the amount in controversy was $100

or more, to a hearing before the Secretary. If the amount in controversy was $1,000 or more, the individual or organization, upon notifying the other party, would be entitled to judicial review.

Information on Advance Directives. Each MedicarePlus organization would be required to maintain written policies and procedures respecting advance directives (as specified elsewhere in the Medicare statute).

Approval of Marketing Materials. Each MedicarePlus organization could not distribute marketing material unless (1) at least 45 days before distribution, the organization submitted the material to the Secretary for review, and the Secretary did not disapprove the material. Standards established below would include guidelines for the review of such materials. Under these guidelines, the Secretary would be required to disapprove marketing material if it was materially inaccurate or misleading or otherwise made a material misrepresentation. To facilitate "one stop shopping," materials submitted to the Secretary by an organization for a MedicarePlus product in an area that were not disapproved would be considered as approved for all other areas covered by the product and organization. Each organization would be required to conform to fair marketing standards included in the MedicarePlus standards. Such standards would include a prohibition against a plan (or agent of such a plan) completing any portion of any election form on behalf of any individual.

Reason for change

Medicare beneficiaries participating in MedicarePlus must have the information necessary to make informed decisions concerning enrollment in organization products. Beneficiaries should be assured that disclosure concerning products will enable them to clearly understand the opportunities and constraints of specific products offered by MedicarePlus organizations. Additionally, HMO and coordinated care type organization products must ensure that beneficiaries will have ready access to quality providers and any medically necessary emergency services.

Effective date

These provisions are effective upon enactment.

Provider-sponsored organizations (PSOs)

Present law

PSOs do not qualify as eligible organizations for Medicare managed care contracts.

Explanation of Provision

Overview. The Committee viewed the PSO concept as a means by which the Medicare program can enter directly into contracts with financially and clinically integrated provider-based organizations. However, it is the Committee's intent that in order to qualify as a MedicarePlus contractor, a PSO must be a substantial and sufficiently financially integrated network as to be able to assume full risk and provide the complete minimum Medicare benefit package, as must other MedicarePlus contractors. It is the Committee's ex-

pectation that PSOs will both enhance competition in larger markets and provide a viable managed care option in smaller and rural markets which have not been adequately served by other types of organized delivery systems or health insurance products.

As defined in these provisions, PSOs will be direct contractors for MedicarePlus only contracts. In that context, the Committee thought it was important to provide for development of uniform federal MedicarePlus standards and in so doing, to preempt state regulation of PSOs except where states demonstrate that their regulatory model is identical to the federal model.

Provider-Sponsored Organization (PSO) Defined. A PSO means a public or private entity that (in accordance with standards established under this bill) is a provider or group of affiliated providers that provides a substantial portion of health care under the contract directly through the provider or affiliated group of providers. In defining substantial proportion, the Secretary would be required to consider the need for such an organization to assume responsibility for a substantial portion of services in order to assure financial stability and other factors. Affiliation is specifically defined.

Process for Establishing Standards and Process for State Certification of PSOs. These requirements are specified in other sections of the bill.

Conditions for Preemption from State Insurance Licensing Requirements. In general, State laws that would prevent a PSO from complying with the applicable requirements of the bill would be preempted, including laws which would require a PSO to meet requirements for insurers or HMOs doing business in the state. This preemption would not apply to individuals who are participants or beneficiaries of an employee welfare benefit plan to which section 514(a) of ERISA applies and who receive services from a PSO. (Section 514(a) of ERISA preempts State laws from regulating employee welfare benefit plans, including health plans.) Federal preemption of PSO regulation would also not apply in those States with approved certification programs.

Reason for change

In today's employer health benefit market, many companies contract directly with hospitals and other providers in networks to provide services under employee welfare benefit plans. In many of these private market arrangements, the providers assume partial or full financial risk under the terms of their contracts for the cost of the health care services they provide. Because these are direct contracting arrangements that have primarily been developed under the umbrella of the federal preemption that employee welfare benefit plans enjoy under ERISA, these provider-based organizations to date are largely unregulated by states.

Effective date

These provisions are effective upon enactment.

Payments to MedicarePlus plans

Present law

Under a Medicare risk contract, an HMO agrees to provide or arrange the full scope of covered Medicare services in return for a single monthly capitation payment issued by Medicare for each enrolled beneficiary. One of the numbers used to determine this payment is the adjusted average per capita cost, or AAPCC. The other, the adjusted community rate or ACR, is discussed above.

The AAPCC is Medicare's estimate of the average per capita amount it would spend for a given beneficiary (classified by certain demographic characteristics and county of residence) who was not enrolled in an HMO and who obtained services on the usual fee-for-service basis. Separate AAPCCs are established for enrollees on the basis of age, sex, whether they are in a nursing home or other institution, and whether they are also eligible for Medicaid, and the county of their residence. These AAPCC values are calculated in four basic steps:

Medicare national average calendar year per capita costs are projected for the future year under consideration. These numbers are known as the U.S. per capita costs (USPCCs) and are estimated average incurred benefit costs per Medicare enrollee and adjusted to include program administration costs. USPCCs are developed separately for Parts A and B of Medicare, and for costs incurred by the aged, disabled, and those with ESRD in those two parts of the program.

Geographic adjustment factors that reflect the historical relationships between the county's and the Nation's per capita costs are used to convert the national average per capita costs to the county level.

Expected Medicare per capita costs for the county are adjusted to a fee-for-service basis by removing both reimbursement and enrollment attributable to Medicare beneficiaries in prepaid plans.

The recalculated county per capita cost is converted into rates that vary according to the demographic variables enumerated above: age, sex, institutional status, Medicaid status.

For each Medicare beneficiary enrolled under a risk contract, Medicare will pay the HMO 95 percent of the rate corresponding to the demographic class to which the beneficiary is assigned.

Explanation of provision

The principal change outlined below is the new methodology for establishing contribution levels to plans across markets. This is done to correct serious flaws and inequities that have developed over time under the current law. It is the Committee's view that the system for setting contribution levels to MedicarePlus plans is a crucial and intrinsic part of the foundation on which the MedicarePlus program is to be built and requires serious attention.

In general, a MedicarePlus organization under a contract with the Secretary would be paid, with respect to coverage of an individual in a payment area for a month, an amount equal to the monthly adjusted MedicarePlus capitation rate with respect to that individual for that area. Each year, the Secretary would be required to

determine and announce no later than September 7 the annual MedicarePlus capitation rate for each payment area for the year, and the factors to be used in adjusting monthly payment rates. An explanation of the assumptions and changes in methodology would have to be included in sufficient detail so that organizations could compute monthly adjusted MedicarePlus capitation rates. The Secretary would be required to provide advance notice (at least 45 days prior to the announcement) of the proposed changes in the methodology and assumptions used to develop the rates, and give organizations an opportunity to comment.

Monthly Adjusted MedicarePlus Capitation rate. Each month, the MedicarePlus organization would be paid for an individual in a payment area, and in a class (as described below), 1/12 of that year's annual MedicarePlus capitation rate. This amount would be adjusted to reflect the relative actuarial value of Medicare benefits with respect to individuals in a class compared to the national average for individuals in all classes. A payment area is a county (or equivalent area specified by the Secretary) except for the end stage renal disease (ESRD) population, in which case the area is the State.

For purposes of calculating rates, the Medicare population would be divided into three separate groups: the aged, the disabled, and those who have been determined to have ESRD. The Secretary would be required to define appropriate classes of enrollees, based on age, gender, welfare status, institutionalization, and such other factors as the Secretary determined to be appropriate so as to ensure actuarial equivalence. The Secretary could add, modify, or substitute for such classes to improve determination of actuarial equivalence. The Secretary would be required to conduct the research needed to provide for greater accuracy in the adjustment of capitation rates. This could include research into the addition or modification of classes. The Secretary would have to report to Congress on this research by January 1, 1997.

Per Capita Growth Rates. In general, payment rates for each area would be calculated so as to improve contribution levels in rural and low service utilization markets. Payments to health plans from 1996 onward would be "decoupled" from local fee-for-service expenditures and paid instead on a budgeted system. Rates would be established so that over time, payments to areas with higher-than-average utilization of services would be increased more slowly than payments to areas with lower-than-average utilization. In addition, payments would be calculated so as to ensure that legitimate costs of doing business in different areas (based on certain input prices) would be recognized in the contribution levels.

To establish the payment rates for 1996, areas would be classified according to their average per capita utilization of services (see below). Those areas experiencing the lowest utilization in services would be assigned a per capita growth rate of 9.7 percent, the next lower, 8.0 percent, the median, 5.3 percent, the next higher, 4.7 percent, and those with the highest utilization, being assigned a per capita growth rate of 4.0 percent. A further adjustment might be necessary to ensure that the total capitation payments made in 1996 are the same as would have otherwise been made if the per

capita growth rate for all areas were equal to the national average per capita growth rate of 5.3 percent.

To establish the payment rates for years after 1996, the Secretary would be required to compute a per capita growth rate for each year for each of the five service utilization cohorts. This computation of payments for each cohort is pegged to the national average per capita growth rate which is as follows:

1996 = 5.3%
1997 = 3.8%
1998 = 4.6%
1999 = 4.3%
2000 = 3.8%
2001 = 5.5%
2002 = 5.6%
Subsequent years = 5.0%

The median service utilization cohort would receive the national average per capita growth rate for the year. Those areas assigned to the lowest service utilization cohort would get 187.5 percent of the national average growth rate, and those in the highest would get 75 percent. The Secretary would calculate intermediate growth rates for the second and fourth cohorts at an amount that would assure budget neutrality relative to the national average per capita growth rates. Specifically, the growth rates for each cohort are as follows:

lowest = 187.5% of the national average per capita growth rate (NAGR)
lower = 150% of the NAGR or lower if needed to meet budget neutrality
median = the average NAGR
higher = gets a rate calculated to achieve budget neutrality, but not less than 75% of the NAGR.
highest = 75% of the NAGR.

Assignment of Payment Areas to Service Utilization Cohorts. Each year the Secretary would assign each payment area to a utilization cohort based on a service utilization index value:

lowest—less than .80
lower—.80–.89
median—.90–1.09
higher—1.10–1.19
highest—1.20 or more

The service utilization index value would be equal to the annual MedicarePlus capitation rate for each payment area divided by the input-price adjusted national capitation rate for that area for the year. (The utilization index for one year would be used to set cohorts for the update for the next year). The input-price adjusted capitation rate would be calculated by multiplying the weighted average capitation rate by an input price index (separate indices would be applied for different types of services). For 1996, the Secretary would apply an input price adjustment specified in the legislation; for 1997, the Secretary could continue to use the special rules for 1996. The Secretary would develop refined input price adjustments to be used in later years.

Payment Process. The Secretary would be required to make monthly payments in advance to the plan for each individual en-

rolled with a MedicarePlus organization. The payment would be retroactively adjusted to take into account any differences between the actual number of individuals enrolled with an organization and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

Special Rules for Individuals Electing High-Deductible/Medisave Products. In the case of an individual who elected a high-deductible/medisave product, the payment to the MedicarePlus organization could not exceed the premium for the high-deductible product and the difference between the amount that would have otherwise been paid. Anything in addition to that amount would be paid directly into the individual's medisave account on a monthly basis.

Payments from Trust Fund. Payments to the MedicarePlus organizations would be made from the HI and SMI trust funds in such proportion as the Secretary determined reflected the relative weights that benefits under Parts A and B represented of Medicare's actuarial value.

Reason for change

The current system for calculating capitation payments for HMOs under the Medicare program has led to highly variable payment levels even in areas of close geographic proximity, and has generated volatile changes in payment levels in particular markets from year to year. In addition, contribution levels are suppressed in rural areas and are excessive in selected urban areas, relative to what is necessary to encourage or induce private plans to participate in these markets. The Committee examined the extent to which the real cost of providing health care services varies across markets and compared those costs to actual current law contribution levels. The Committee found that objectively measured input costs varied by only about 55%, while current law contribution levels varied by about 284%. The principal explanation for the difference in contribution levels across markets is in average, per beneficiary service use across markets.

While a good portion of this variation in service use is explainable and justifiable, much is not and the Committee decided to take steps to narrow these differences insofar as they are reflected in MedicarePlus contribution levels. In so doing, over a several year transition period, contribution levels for each area would be calculated so as to improve contribution levels in low average service utilization markets and to moderate the growth in contribution levels in high average service utilization markets.

Effective date

These provisions are effective upon enactment and would be applied for contracting periods beginning on or after January 1, 1996.

Establishment of MedicarePlus Standards

Present law

Under section 1876 of the Social Security Act, Medicare specifies requirements to be met by an organization seeking to become a managed care contractor with Medicare. There is no provision for

NAIC to play a role in developing or establishing these requirements. There is no provision for PSOs.

Explanation of provision

Overview. The key provisions relate to obtaining the external assistance of the NAIC in developing longer-term standards for certain categories of MedicarePlus organizations, and the use of a special negotiated rulemaking process for developing standards for PSOs. With respect to the first, the Committee felt that the NAIC is uniquely qualified to provide assistance and advice on contracting standards for selected categories of MedicarePlus organizations due to the expertise of state officials in regulating the insurance markets and certain insuring organizations at the state level. Second, the process followed by the NAIC in developing standards fosters broad public input in areas which are highly specialized and require broad-based expertise. Therefore, the Committee felt that the Secretary could be greatly assisted by NAIC if the Association would agree to undertake this assistance. If the NAIC chose not to undertake this effort, the Secretary would proceed under usual rulemaking procedures.

The Committee notes, however, that usual rulemaking procedures often are prolonged, and therefore has specified an accelerated rulemaking procedure under which to establish standards for PSOs. The Committee also felt that since PSOs are a new type of contractor, presenting unique regulatory standard questions in the areas of solvency and premium setting, the Secretary would benefit from the formation of a negotiated rulemaking committee that would bring affected parties and appropriate experts to the table rapidly to assist in developing satisfactory initial standards. Although the process for setting initial standards is accelerated, the Committee expects that refinements would be made over time as the Secretary gains experience in direct contracting with PSOs and final standards are developed.

The Secretary would be required to request the NAIC to develop and submit within 12 months after enactment proposed standards consistent with the bill requirements for MedicarePlus organizations (other than Taft-Hartley plans and PSOs) and products. If the Association's submission was timely, the Secretary would review the proposed standards within 90 days and promulgate them with modifications to the extent they did not meet the requirements. If the Association's submission was not timely, the Secretary would be required to promulgate proposed standards no later than otherwise required. Until such standards were established, the Secretary would provide interim standards as might be appropriate.

The Secretary would also develop and promulgate MedicarePlus standards for limited enrollment organizations and products. With respect to Taft-Hartley sponsors, the Secretary would be required to consult with the Secretary of Labor and the standards would be promulgated about the same time as the general MedicarePlus standards. With respect to provider-sponsored organizations, the Secretary would establish standards on an expedited basis using the negotiated rule-making process under title 5 United States Code.

The target publication date for the rule would be September 1, 1996.

Within 45 days after enactment, the Secretary, after consulting with the NAIC, the American Academy of Actuaries, organizations representing Medicare beneficiaries, and other interested parties, would publish the notice required by section 564(a) of title 5.

The period for submitting comments would be shortened to 15 days, and within 30 days thereafter the Secretary would be required to provide for the appointment of a negotiated rulemaking committee. The Secretary would be required to provide for a facilitator no later than 10 days after the establishment of the committee.

The negotiated rulemaking committee would be required to report to the Secretary no later than June 1, 1996, regarding its progress towards reaching consensus and whether that was likely to occur before one month prior to the target publication date. If the committee reported it had failed to make significant progress towards reaching consensus, or if it was unlikely to reach consensus by the target date, the Secretary could terminate the process and provide for the publication of the rule through other methods. Otherwise, the committee would be required to submit a report containing the proposed rule no later than one month before the target publication date.

The Secretary would publish the rule in the Federal Register by the target publication date. The rule would be effective and final immediately on an interim basis, but subject to revision after public notice and opportunity for comment of not less than 60 days. The Secretary would be required to provide for consideration of such comments and republication of the rule not later than one year after the target publication date.

With the initial publication of the final rule, the Secretary would be required to specify a process for timely review and approval of entities to be certified as provider-sponsored organizations. Completed applications would be acted upon within 60 days of receipt.

After consulting with the negotiated rulemaking committee, the Secretary by March 1, 1996, would be required to circulate a proposed application form.

In establishing MedicarePlus standards other than on an interim basis, the Secretary would be required to try to be consistent where appropriate in order to promote the equitable treatment of different types of MedicarePlus organizations and the consistent protection for individuals who chose their products. Standards established on an interim basis could be based on currently applicable standards, such as those established for analogous provisions of section 1876 or the private health insurance market. At the time MedicarePlus standards change, an organization with a contract in effect could elect not to have the changes apply until the end of the contract year (or, if there is less than 6 months remaining in the contract year, until one year after its end). Standards under this section would supersede any State law or regulation with respect to MedicarePlus products to the extent it was inconsistent with the standards.

Reason for change

The Committee's view is that the and usual rulemaking procedures are somewhat cumbersome and unsuited to it's objectives in implementing the MedicarePlus program as efficiently and quickly as is feasible.

Separately, it is the Committee's intent that standards promulgated for qualified associations recognize and distinguish the open contract and assessment features whereby the governing authority of certain religious fraternal benefit societies, such as the Mennonite Mutual Aid, protect their members from insolvency. The standards should also recognize the extent to which state insurance laws exempt religious fraternal benefit societies from the guaranty funds required for commercial health insurance companies.

Effective date

These provisions are effective upon enactment. The deadline for general interim standards is June 1, 1996. The deadline for initial PSO standards is September 1, 1996. The deadline for NAIC's recommendations, if any, is December 31, 1996.

Process for certification of MedicarePlus organizations and products

Present law

Eligibility to be a Medicare managed care contractor is determined by the DHHS. States do not play a role in certifying organizations as eligible to become Medicare managed care contractors.

Explanation of provision

State Certification Process. The Secretary would be required to approve a MedicarePlus certification and enforcement program established by a State for applying MedicarePlus standards to MedicarePlus organizations and products if the Secretary determined that the program effectively provided for the application and enforcement of the MedicarePlus standards. State certification would not apply to Taft-Hartley sponsors or, except as follows, provider-sponsored organizations. The Secretary would be required to establish a process under which States could propose to certify provider-sponsored organizations, but State proposals would not be approved unless the Secretary determined that they were identical to the standards of this part and would not result in a lower level or quality of enforcement. State certification programs would have to provide for certification of compliance of MedicarePlus organizations and products not less often than once every three years. A State could impose user fees on organizations seeking certification to finance its cost. A MedicarePlus organization or product with State certification would be considered to be certified with respect to offerings of the product to individuals residing in the State.

In the Committee's view, these arrangements for oversight of the MedicarePlus organizations and products have the advantage of maximizing the use of the traditional State role of insurance regulation and minimizing the necessity of expanding significantly the Federal bureaucracy to oversee MedicarePlus.

The Secretary would be required to periodically review approved State certification programs to determine if they continued to pro-

vide for certification and enforcement. States found to be out of compliance would be allowed an opportunity to adopt a plan of correction. If the failure continued, the Federal certification process described below would be applied. The Secretary would be required to publish and periodically update a list of approved State programs.

Federal Certification Processes. Beginning on the date MedicarePlus standards were established, for States for which certification programs were not approved and operating, the Secretary would be required to establish a process for certifying that such organizations and products met the standards.

The Secretary would also be required to establish a process for certifying that sponsoring organizations and their respective MedicarePlus products met MedicarePlus standards. With respect to Taft-Hartley sponsors, the process would be established in consultation with the Secretary of Labor. To the maximum extent practicable, the Federal process would use private accreditation processes that the Secretary finds apply standards no less stringent than the requirements of this part. The use of private accreditation processes would be valid only for periods specified by the Secretary. The Secretary could impose user fees on organizations seeking certification to finance the cost.

Notice to Enrollees in Case of Decertification. In the event that a MedicarePlus organization or product was decertified, the plan would have to notify each enrollee.

Qualified Associations. The certification provisions of this section would not limit the authority of States to regulate products offered by MedicarePlus organizations that are qualified associations.

Reason for change

The Committee, as noted earlier, values the expertise of states in regulating insurance and believes it would be advantageous to the Secretary if states entered into agreements to manage some of the administrative oversight functions required under the MedicarePlus program. The Committee notes that with the exception of Taft-Hartley plans and, at least initially, PSOs, the states already license and oversee the solvency and market conduct of the other types of companies that will participate as MedicarePlus contractors.

Effective date

These provisions are effective upon enactment.

Contracts with MedicarePlus organizations

Present law

Contracts with HMOs are for 1 year, 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, or 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 authority to impose cer-

tain 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.

To be eligible to be a risk contractor, HMOs/CMPs must have at least 5,000 members; if, however, they primarily serve members outside urbanized areas, they may have fewer enrollees (defined in regulation as at least 1,500). Organizations eligible for Medicare cost contracts may have fewer members than 5,000 (specified in regulation as at least 1,500).

No more than 50 percent of the organization's enrollees may be Medicare or Medicaid beneficiaries. This rule may be waived, however, for an organization that serves a geographic area where Medicare and Medicaid beneficiaries make up more than 50 percent of the population or (for 3 years) for an HMO that is owned and operated by a governmental entity.

During its annual open enrollment period of at least 30 days duration, HMOs must accept beneficiaries in the order in which they apply, up to the limits of its capacity, unless to do so would lead to violation of the 50 percent Medicare-Medicaid maximum or to an enrolled population unrepresentative of the population in the area served by the HMO. If an HMO chooses to limit enrollment because of its capacity, regulation provides that it must notify HCFA at least 90 days before the beginning of its open enrollment period and, at that time, provide HCFA with its reasons for limiting enrollment.

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.

Explanation of provision

In General. In order to be paid by Medicare, the MedicarePlus organization would have to enter into a contract with the Secretary providing that the organization agreed to the specific terms and conditions of payment as provided under the bill. A contract could cover more than one MedicarePlus product. In addition, elections of a Medicare Plus product would not be permitted unless these conditions were met.

Enrollment Requirements. The Secretary would be prohibited from entering a contract with a MedicarePlus organization other than a Taft-Hartley sponsor unless the organization had at least 5,000 individuals (or 1,500 individuals in the case of a PSO) who were receiving health benefits through the organization. An exception would apply if the MedicarePlus standards permitted the organization to have a lesser number of beneficiaries (but not less than 500 for a PSO) if the organization primarily served individuals residing outside of urbanized areas. The Secretary could waive this requirement during an organization's first 3 contract years. (The enrollment requirements would not apply to a high-deductible/medisave product.)

Contract Period and Effectiveness. The contract would be for at least one year, and could be made automatically renewable. The Secretary could terminate any contract or impose intermediate sanctions (as specified in the bill) on the organization if the Secretary found that the organization: (a) failed substantially to carry out the contract; (b) was carrying it out in a manner inconsistent with efficient and effective administration; or (c) was operating in a manner that was not in the best interests of the individuals covered under the contract; or (d) no longer substantially met MedicarePlus standards. The Secretary would not have to contract with an organization that had voluntarily terminated its contract with Medicare in the previous 5 years. Contracts for coverage under a high-deductible/medisave account could not take effect before January 1997.

Protections Against Fraud and Beneficiary Protections. Each contract would provide that the Secretary or his or her designee would have the right to inspect or otherwise evaluate the quality, appropriateness and timeliness of services, and the organization's facilities if there was reasonable evidence of need for such inspection, and would have the right to audit and inspect the books and records. The contract would require the organization to provide and pay for written notice in advance of a termination, and a description of alternatives for obtaining benefits, to each enrollee. In addition, the contract would require the organization to comply with certain financial disclosure and liability requirements; to provide specified information; notify the Secretary of loans or other financial arrangements made between the organization, subcontractors and affiliates; and contain other provisions as the Secretary found appropriate. Each MedicarePlus organization would be required to make specified information available to enrollees.

Intermediate Sanctions. The Secretary would be authorized to carry out specific remedies in the event that a contractor organization: (1) failed substantially to provide medically necessary items and services required to be provided, if the failure adversely affected (or had the substantial likelihood of adversely affecting) the individual; (2) imposed premiums on individuals that were in excess of the premiums permitted; (3) expelled or refused to re-enroll an individual; (4) engaged in any practice that would reasonably be expected to have the effect of denying or discouraging enrolling by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services; (5) misrepresented or falsified information; (6) failed to comply with other specified requirements; or (7) employed or contracted with any individual or entity that was excluded from Medicare or Medicaid participation for the provision of health care, utilization review, medical social work, or administrative services, or employed or contracted with any entity for the provision through such an excluded individual or entity.

The remedies would include civil money penalties of not more than $25,000 for each determination of a failure (as described above) or with respect to certain failures (such as denying enrollment to persons with a preexisting medical condition or misrepresenting information furnished to the Secretary), of not more than $100,000. In cases of the latter, the Secretary could also levy a

$15,000 fine for each individual not enrolled. In the case of an organization determined to have charged excess premiums, the Secretary could also recover twice the excess amount (and return the excess amount to the affected individual). In addition, the Secretary could suspend enrollment of individuals and payment to the organization after notifying the organization of an adverse determination and until the Secretary was satisfied that the failure had been corrected or would not reoccur.

If, under his or her authority to terminate contracts, the Secretary determined that an organization failure had occurred other than those described above, other intermediate sanctions could be imposed. These include: (1) civil money penalties up to $25,000 if the deficiency directly adversely affected (or had the likelihood of adversely affecting) an individual under the organization's contract; (2) penalties of not more $10,000 for each week after the Secretary initiated procedures for imposing sanctions; and (3) suspension of enrollment until the deficiency had been corrected and the Secretary determined was unlikely to recur.

Procedures for Imposing Sanctions. The Secretary could terminate a contract or impose the intermediate sanctions described above in accordance with formal investigation and compliance procedures established by the Secretary which follow certain specifications (e.g., the organization is given a chance to implement a corrective action plan).

Use of Interim, Final Regulations. To carry out the MedicarePlus contracting responsibilities, the Secretary would be authorized to promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

Reason for change

These provisions are derived mainly from current law, but the Committee wants to emphasize that no MedicarePlus product can be sold, nor payment be made to a MedicarePlus organization, until or unless the organization has entered into a contract with the Secretary.

Effective date

These provisions are effective upon enactment.

Sec. 15003. Duplication and coordination of Medicare-related products

Present law

Many Medicare beneficiaries purchase private health insurance to supplement their Medicare coverage. These individually purchased policies are commonly known as Medigap policies. OBRA 90, P.L. 101–508 provided for a standardization of Medigap policies. OBRA 90 also substantially modified the antiduplication provision contained in law. The intent of the OBRA 90 anti-duplication provision was to prohibit sales of duplicative Medigap policies. However, the statutory language applied, with very limited exceptions, to all "health insurance policies" sold to Medicare beneficiaries. Observers noted that this provision could thus apply to a

broad range of policies including hospital indemnity plans, dread disease policies, and long-term care insurance policies.

The Social Security Amendments of 1994 (P.L.103–432) included a number of technical modifications to the Medigap statute, including modifications to the anti-duplication provisions. Under the revised language, it is illegal to sell or issue the following policies to Medicare beneficiaries: (i) a health insurance policy with knowledge that it duplicates Medicare or Medicaid benefits to which a beneficiary is otherwise entitled; (ii) a Medigap policy, with knowledge that the beneficiary already has a Medigap policy, or (iii) a health insurance policy (other than Medigap) with knowledge that it duplicates private health benefits to which the beneficiary is already entitled. A number of exceptions to these prohibitions are established. The sale of a medigap policy is not in violation of the provisions relating to duplication of Medicaid coverage if: (i) the State Medicaid program pays the premiums for the policy; (ii) in the case of qualified Medicare beneficiaries (QMBs), the policy includes prescription drug coverage; or (iii) the only Medicaid assistance the individual is entitled to is payment of Medicare Part B premiums.

The sale of a health insurance policy (other than a Medigap policy) that duplicates private coverage is not prohibited if the policy pays benefits directly to the individual without regard to other coverage. Further, the sale of a health insurance policy (other than a Medigap policy to an individual entitled to Medicaid) is not in violation of the prohibition relating to selling of a policy duplicating Medicare or Medicaid, if the benefits are paid without regard to the duplication in coverage. This exception is conditional on the prominent disclosure of the extent of the duplication, as part of or together with, the application statement.

P.L.103–432 provided for the development by the NAIC of disclosure statements describing the extent of duplication for each of the types of private health insurance policies. Statements were to be developed, at a minimum, for policies paying fixed cash benefits directly to the beneficiary and policies limiting benefits to specific diseases. The NAIC identified 10 types of health insurance policies requiring disclosure statements and developed statements for them. These were approved by the Secretary and published in the *Federal Register* on June 12, 1995.

Explanation of provision

Duplication and Coordination of Medicare-Related Products. The provision would modify the anti-duplication provisions. It would be unlawful to sell to a Medicare beneficiary (including a person under MedicarePlus) a health insurance policy (other than a Medigap policy) with knowledge that it duplicated benefits under Medicare or Medicaid. It would be unlawful to sell, to persons not electing MedicarePlus, a Medigap policy with knowledge that the person is entitled to benefits under another Medigap policy. It would be unlawful to sell to a person electing MedicarePlus a Medigap policy duplicating benefits to which the individual is otherwise eligible under Medicare or another Medigap policy. A policy would be considered duplicative if the policy provided specific reimbursement for identical items and services to the extent paid for under Medicare.

A policy would be considered to coordinate if it provided for payment of benefits without regard to other health benefits coverage of the individual. The provision would change the disclosure requirements contained in P.L.103–432 to require plans to disclose the extent to which they may coordinate benefits with Medicare as part of their outline of coverage.

A health insurance policy (or a rider to an insurance contract which is not a health insurance policy) that coordinates against or excludes items and services covered under Medicare, and for policies sold after January 1, 1996, discloses such coordination or exclusion in the policy's outline of coverage would not be considered duplicative. For this purpose, health insurance policies would include policies providing benefits for long-term care, nursing home care, home health care, or community-based care.

The provision would prohibit the imposition of criminal or civil penalties or the bringing or continuing of legal action relating to selling duplicative policies if the penalty or action was based on actions occurring after November 1, 1991 and before enactment of OBRA of 1995 and if the policy was not duplicative under the revised language. The provision would also prohibit a State from imposing any requirement related to the sale or issuance of a policy (or rider) to a Medicare beneficiary based on the premise that the policy or rider was duplicative. The provision would require the Secretary to report within 3 years of enactment on the advisability of restricting the sale to Medicare beneficiaries of health insurance policies that duplicate other insurance policies the individual may have.

The provision would specifically exclude MedicarePlus products from the definition of Medigap policies. It would also exempt health insurance products sold to persons electing MedicarePlus from requirements relating to sale of standardized benefits packages and minimum loss ratios.

The provision would make it unlawful to sell or issue a health insurance policy covering expenses which would otherwise be counted toward meeting the annual deductible amount under a high deductible/medisave product.

Reason for change

The enactment of H.R. 5252, the Social Security Act Amendments of 1994 (P.L. 103–432) has created confusion in the insurance market regarding the sale of Medigap polices and other health insurance policies to individuals on Medicare. This has resulted because that law is ambiguous and imposes unreasonable requirements that are not necessarily helpful to the beneficiaries it is intended to protect.

First, the statute does not define the term "duplication" and, as a result the NAIC has declared that all policies are duplicative of Medicare without findings of any factual duplication. Second, a factual determination cannot be reached except on a case by case basis after application of Medicare's coverage requirements, exclusions, and other limitations. The disclosure statements developed by the NAIC do not help beneficiaries by declaring all policies as duplicative.

With respect to long-term care policies, the NAIC has recommended a disclosure statement which declares that long-term care policies duplicate some Medicare benefits. Significant issues are raised with respect to long-term care policies that coordinate with Medicare. The Secretary's approval and publication of the NAICs disclosure statements in the *Federal Register* on June 12, 1995, has resulted in the adoption of a position which is adverse to long-term care policies that coordinate with Medicare. The Secretary has essentially taken the position that such policies are technically illegal as of October 31, 1994. However, the Secretary has not issued a written legal explanation or promulgated a rule stating its position. The Secretary's position on long-term care policies assumes that duplication exists and, therefore, policies must pay benefits regardless of other coverage.

Concerns have been expressed to the Committee that the current lack of clarity regarding duplication is causing a significant chilling effect on the marketing of long-term care insurance.

Coordination of benefits with Medicare of long-term care policies is consistent with current public policy. Both State and Congressional policy is supportive of long-term care policies being coordinated with Medicare. The Robert Wood Johnson state Medicaid and private long-term care policy partnership program requires coordination with Medicare. Importantly, current federal legislative proposals establishing standards for long-term care policies specify that long-term care policies must provide coordination with Medicare.

Finally, the developed statements do not meet the intent of Congress which has been to allow coordination with long-term care policies and provide clear, understandable information to Medicare beneficiaries regarding the choice of health insurance coverage to meet their personal needs. During Senate consideration of H.R. 5252, Senator Dodd and Senator Moynihan engaged in a colloquy that clearly stated it was not the intent of H.R. 5252 to halt the sale of public private long-term care term insurance partnership programs involving policies that coordinate with Medicare. In December of 1994, in a letter to the NAIC, Senator Packwood and Congressman Archer stated that the objectives for duplication statements were for them to be, "straight forward, simple, and required only for policies where there is unquestionable duplication."

Effective date

The provisions of this section are effective as if they were included in the enactment of section 4354 of the Omnibus Budget Reconciliation Act of 1990.

Sec. 15004. Transitional rules for current Medicare HMO program

Present law

There is no provision for transition rules under current law.

Explanation of provision

The Secretary would be prohibited from entering into any new risk sharing contract under section 1876 with an eligible organization for any contract year beginning on or after the date

MedicarePlus standards are first established with respect to MedicarePlus organizations that are insurers or health maintenance organizations unless a contract with the organization had been in effect under section 1876 for the previous contract year. The Secretary could not extend or continue any risk-sharing contract for any contract year beginning on or after one year after the MedicarePlus standards are established.

The Secretary would also be prohibited from entering into any cost reimbursement contract under section 1876 beginning in any contract year starting on or after the enactment of this legislation. The Secretary could not extend or continue any cost reimbursement contract for any contract year beginning on or after January 1, 1998.

For individuals entitled to benefits under both part A and part B, payments for risk-sharing contracts for months beginning with January 1996 would be computed by substituting the payment rates specified in this bill in as timely a manner as possible. For individuals entitled to benefits only under part B, the substitution would be based upon the proportion of those rates that reflects the proportion of payments under title XVIII attributable to part B.

Payments under cost reimbursement contracts under section 1876(a) would take into account the adjustments to part A and part B payments made by this legislation.

The 50:50 rule under section 1876(f) would not apply to contract years beginning on or after January 1, 1996.

Reason for change

It is the Committee's view that the 50:50 rule has become an unnecessary and outdated proxy for quality in health plans. The Committee believes that the various safeguards and provisions governing matters ranging from solvency, patient protections, quality assurance programs and other contracting standards provide the necessary substance that the 50:50 rule only attempted to provide indirectly.

Effective date

These provisions are effective upon enactment, except that the 50:50 rule would not apply to contract years beginning on or after January 1, 1996.

PART 2. SPECIAL RULES FOR MEDICAREPLUS MEDICAL SAVINGS ACCOUNTS

Sec. 15011. MedicarePlus MSAs

Present law

Under present law, the value of Medicare coverage and benefits is not includible in taxable income.

Individuals who itemize deductions may deduct amounts paid during the taxable year (if not reimbursed by insurance or otherwise) for medical expenses of the taxpayer and the taxpayer's spouse and dependents, to the extent that the total of such expenses exceeds 7.5 percent of the taxpayer's adjusted gross income. Medical expenses for this purpose include amounts paid for medical

insurance, including Medicare Part B premiums paid by the taxpayer.

Under present law, there are no specific tax provisions for MedicarePlus medical savings accounts ("MedicarePlus MSAs").

Explanation of provision

Under the proposal, individuals who are eligible for Medicare would be permitted to choose either the traditional Medicare program or a plan with a high deductible insurance policy and a MedicarePlus MSA. To the extent an individual chooses such a plan, the Secretary of Health and Human Services would make a specified contribution directly into a MedicarePlus MSA designated by such individual. Only contributions by the Secretary of Health and Human Services could be made to a MedicarePlus MSA and such contributions would not be included in the taxable income of the MedicarePlus MSA holder.[1] Income earned on amounts held in a MedicarePlus MSA would not be currently includible in taxable income. Withdrawals from a MedicarePlus MSA would be excludable from taxable income if used for the qualified medical expenses of the MedicarePlus MSA holder.

Definition of MedicarePlus MSAs. In general, a MedicarePlus MSA would be a tax-exempt trust (or a custodial account) created exclusively for the purpose of paying the qualified medical expenses of the account holder that meets requirements similar to those applicable to individual retirement arrangements ("IRAs").[2] The trustee of a MedicarePlus MSA could be a bank, insurance company, or other person that demonstrates to the satisfaction of the Secretary of the Treasury that the manner in which such person would administer the trust would be consistent with applicable requirements.

A MedicarePlus MSA trustee would be required to make such reports as may be required by the Secretary of the Treasury. A $50 penalty would be imposed for each failure to file without reasonable cause.

Taxation of distributions from a MedicarePlus MSA. Distributions from a MedicarePlus MSA that are used to pay the qualified medical expenses of the account holder would be excludable from taxable income regardless of whether the account holder is enrolled in a Medisave plan at the time of the distribution.[3] Qualified medical expenses generally would be defined as under the rules relating to the itemized deduction for medical expenses (sec. 213). However, for this purpose, qualified medical expenses would not include any insurance premiums other than premiums for long-term care insur-

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[1] An individual would not have taxable income merely because the individual can choose among various Medicare Plus options and the traditional Medicare program.

[2] For example, no MedicarePlus MSA assets could be invested in life insurance contracts. MedicarePlus MSA assets could not be commingled with other property except in a common trust fund or common investment fund, and an account holder's interest in a MedicarePlus MSA would be nonforfeitable. In addition, if an account holder engages in a prohibited transaction with respect to a MedicarePlus MSA or pledges assets in a MedicarePlus MSA, rules similar to those for IRAs would apply, and any amounts treated as distributed to the account holder under such rules would be treated as not used for qualified medical expenses.

[3] Under the proposal, medical expenses of the account holder's spouse or dependents would not be treated as qualified medical expenses.

ance.[4] Distributions from a MedicarePlus MSA that are excludable from gross income under the proposal could not be taken into account for purposes of the itemized deduction for medical expenses.

Distributions for purposes other than qualified medical expenses would be includible in taxable income. An additional tax of 50 percent of the amount includible in taxable income would apply to the extent the total distributions for purposes other than qualified medical expenses in a taxable year exceed the amount by which the value of the MedicarePlus MSA as of December 31, of the preceding taxable year exceeds 60 percent of the deductible of the plan under which the individual is covered. The additional tax would not apply to distributions on account of the disability or death of the account holder.

Direct trustee-to-trustee transfers could be made from one MedicarePlus MSA to another MedicarePlus MSA without income inclusion.

The proposal includes a correction mechanism so that if contributions for a year are erroneously made by the Secretary of Health and Human Services, such erroneous contributions could be returned to the Secretary of Health and Human Services (along with any attributable earnings) from the MedicarePlus MSA without tax consequence to the account holder.

Treatment of MedicarePlus MSA at death. The proposal includes rules that would apply on the death of the MedicarePlus MSA owner. If the beneficiary of the MedicarePlus MSA is the account holder's surviving spouse and the spouse is eligible for Medicare, the spouse could treat the inherited MedicarePlus MSA as his or her own MedicarePlus MSA. If the spouse is not eligible for Medicare, the spouse could continue the MedicarePlus MSA and make withdrawals from the MedicarePlus MSA under the rules applicable to a medical savings account for individuals not eligible for Medicare under the medical savings account provisions of the Revenue Reconciliation Act of 1995 as approved by the Committee. Thus, distributions from the account for the qualified medical expenses of the spouse or the spouse's dependents (or subsequent spouse) would not be includible in income. Distributions not for such medical expenses would be includible in income, and would be subject to a 10-percent excise tax unless the distribution is made after the surviving spouse attains age 59, dies, or becomes disabled. However, no new contributions could be made to the account and earnings would not be currently includible in income.

If the beneficiary of an inherited MedicarePlus MSA is not the account holder's spouse, the MedicarePlus MSA would no longer be treated as a MedicarePlus MSA and the value of the MedicarePlus MSA on the account holder's date of death would be included in the taxable income of the beneficiary for the taxable year in which the death occurred. If the account holder fails to name a beneficiary, the value of the MedicarePlus MSA on the account holder's date of death would be included in the taxable income of the account holder's final income tax return. In all cases, the value of the

[4] Under the Tax Fairness and Deficit Reduction Act of 1995, as passed by the House, long-term care expenses would be treated as medical expenses for purposes of section 213. Under present law, the treatment of such expenses is unclear.

MedicarePlus MSA would not be included in the account holder's gross estate for estate tax purposes.

Reason for change

The Committee believes the cornerstone to providing America's senior citizens with greater power over their health care is to bring private sector ideas and improvements into the Medicare system. MedicarePlus MSAs will provide seniors with choices other than the traditional Medicare program and give them control over their own health care expenses.

Effective date

The proposal would be effective with respect to taxable years beginning after December 31, 1996.

Sec. 15012. Certain rebates excluded from gross income

Present law

Tax Treatment of Rebates. Present law does not provide for cash payments to individuals under Medicare.

Explanation of provision

Tax Treatment of Rebates. Under the proposal, certain individuals would be entitled to cash rebates under the MedicarePlus program. These rebates would not be includible in income.

Reason for change

MedicarePlus is a cornerstone to providing seniors with greater control over their health care expenses. MedicarePlus gives seniors choices over their health care program, and rewards those who choose a lower cost health insurance option.

Effective date

The provision would apply to rebates received after the date of enactment.

PART 3. SPECIAL ANTITRUST RULES FOR PROVIDER SPONSORED ORGANIZATIONS

(This Part is under the jurisdiction of the Committee on the Judiciary.)

Sec. 15021. Application of antitrust rule of reason to provider service Networks

Present law

Under Federal antitrust law, agreements among competitors that fix prices or allocate markets are per se (automatically) illegal. Some joint activities, however, if deemed to create an entity separate from and in addition to the competitors who create them (*i.e.*, true joint ventures), are judged under the rule of reason. The Department of Justice and the Federal Trade Commission have issued Statements of Enforcement Policy Relating to Health Care and Antitrust, which indicate the limited circumstances under which they will consider "physician network joint ventures" not violations of Federal antitrust law.

Explanation of provision

Rule of Reason Standard. This provision states that the conduct of a provider service network in negotiating, making, or performing a contract (including the establishment and modification of a fee schedule and the development of a panel of physicians), to the extent such contract is for the purpose of providing health care services to individuals under the terms of a MedicarePlus PSO product, would not be a per se violation of Federal or State antitrust laws. In addition, the conduct of any member of such a provider service network for the purpose of providing health care services under a MedicarePlus contract would not be deemed illegal per se under Federal or State antitrust laws. Such conduct shall be judged on the basis of its reasonableness, taking into account all relevant factors affecting competition in properly defined markets.

Definitions. This section defines "antitrust laws" to include those set out in the first section of the Clayton Act, 15 U.S.C. § 12, as well as § 5 of the Federal Trade Commission Act, 15 U.S.C. § 45, to the extent that § 5 applies to unfair methods of competition. MedicarePlus is defined elsewhere under these provisions. "Health care provider" is defined as any individual or entity engaged in the delivery of health care services that must be licensed or certified by State law or regulation to deliver such services. "Health care service" is defined as any service for which payment may be made under a MedicarePlus PSO product, including services related to the delivery or administration of such service. "MedicarePlus PSO Product" is defined as a MedicarePlus product offered by a provider-sponsored organization under Part C of title XVIII of the Social Security Act. "Provider services network" is defined as an organization that meets the following requirements: It is organized by, operated by, and composed of members who are health care providers and for purposes that include health care services. It is funded in part by capital contributions made by the members of such organization.

With respect to each contract made by such organization for the purpose of providing a type of health care service to individuals under the terms of a MedicarePlus PSO product, the organization requires all members of the organization to agree to provide health care services of such type under such contract, receives the compensation paid for the provision of such health care services, and provides for the distribution of such compensation. It has established, consistent with the requirements of the MedicarePlus program for provider-sponsored organizations, programs based on written guidelines to review the quality, efficiency, and appropriateness of treatment methods and health care services. It coordinates the delivery of health care services by all health care providers to all patients participating in the health care plan so as to enhance the quality of health care services provided and, it has established a grievance and appeal process to review and promptly resolve patient or beneficiary grievances or complaints. "State" is defined as the States, the District of Columbia, the Commonwealth of Puerto Rico, and any other territory or possession of the United States.

Issuance of Guidelines. This provision requires the Attorney General and the Federal Trade Commission, within 120 days after en-

actment of this bill, to issue joint guidelines specifying the enforcement policies and analytical principles they will apply with respect to the operation of the rule of reason standard.

Reason for change

The provisions is under the jurisdiction of the House Judiciary Committee.

Effective date

The provision is effective upon enactment.

PART 4. COMMISSIONS

Sec. 15031. Medicare Payment Review Commission.

Present law

The Prospective Payment Assessment Commission (PROPAC) was established by Congress through the Social Security Act Amendments of 1983 (P.L. 98-21). The Commission is charged with reporting each year its recommendation of an update factor for PPS payment rates and for other changes in reimbursement policy. It is also required each year to submit a report to Congress which provides background information on trends in health care delivery and financing. The Physician Payment Review Commission (PPRC) was established by the Congress through the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272). It was charged with advising and making recommendations to the Congress on methods to reform payment to physicians under the Medicare program. In subsequent laws, Congress mandated additional responsibilities relating to the Medicare and Medicaid programs as well as the health care system more generally. Both Commissions are appointed by the Director of the Office of Technology Assessment and are funded through appropriations from the Medicare trust funds.

Explanation of provision

The provision would establish the Medicare Payment Review Commission (hereafter referred to as "the Commission") to review and make recommendations to Congress concerning payment policies under this title. The Commission would be required to submit a report to Congress by June 1 of each year containing an examination of issues affecting the Medicare program, including implications of changes in health care delivery and in the market for health care services on the Medicare program. The Commission would be authorized to submit from time to time other reports as it deemed appropriate. The Secretary would be required to respond to recommendations of the Commission in notices of rulemaking proceedings.

The Commission would be charged with the following specific responsibilities, including reviewing: (1) the appropriateness of the methodology for making payments to the health plans; (2) the appropriateness of the risk adjustment mechanisms and the need to adjust such mechanisms to take into account health status; (3) implications of risk selection; (4) the development and implementation of quality assurance mechanisms with respect to MedicarePlus or-

ganizations; and (5) the impact of the MedicarePlus program on beneficiary access to care.

The Commission would also be required to review specific aspects of the failsafe budget mechanism established under the bill, including: (1) the appropriateness of the expenditure projections by the Secretary and growth factors for each Medicare sector; (2) the appropriateness of the mechanism for implementing reductions in payment amounts for different sectors; (3) the impact of the failsafe mechanism on provider participation; and (4) the appropriateness of the Medicare benefit budget, especially for fiscal years after 2002.

In addition, the Commission would be required to review payments policies under Medicare parts A and B (fee-for-service), including: (1) factors affecting expenditures in different sectors; (2) payment methodologies; and (3) the impact of payment policies on access and quality of care. It would also look at the effect of Medicare payment policies on the delivery of Medicare services and assess the implications of changes in the health services market on Medicare.

The Commission would be composed of 15 members appointed by the Comptroller General, with the first appointments being made by March 31, 1996. These members would have to meet specific qualifications, (such as national recognition for their expertise in health finance), including representatives of consumers and the elderly. Consideration in the initial appointment would be given to individuals who were already serving on the PPRC or the PROPAC. Commissioners would serve for 3-year terms. The bill provides for a mechanism for filling vacancies, compensating commissioners, appointing a chair and vice chair; convening meetings; and providing for staff, experts, and consultants. The Commission would be authorized to secure directly from any department or agency information to carry out these provisions. It would be required to collect and assess information (which would be available on an unrestricted basis to GAO). The Commission would be subject to periodic audit by GAO.

The provision authorizes such sums as may be necessary to be appropriated from the Medicare trust funds (60 percent part A and 40 percent from part B). The Comptroller General would be required to provide for appointment of members to the Commission by March 31, 1996. The PROPAC and PPRC would be abolished within 30 days after a majority of the Medicare Payment Review Commission were appointed. To the extent possible, the Comptroller General would be required to provide for the transfer from the former to the new commission assets and staff without any loss of benefits or seniority by virtue of such transfers. The Commission would be responsible for the preparation and submission of reports required by law to be submitted (and which had not been submitted by the time it was established) by the former commissions.

Reason for change

Both the PROPAC, which is responsible for hospital and health facilities payment policy, and the PPRC, which is responsible for physician payment policy and other Part B issues, have assumed critically important roles in assisting Congress with oversight and

policy making for the Medicare program. However, with fee-for-service payment policy becoming relatively mature after years of refinement, Congress will require guidance in the future primarily in the areas of MedicarePlus and the new failsafe budget mechanism. These two areas will require evaluation and oversight best suited for a single commission which can view the Medicare program in terms of an integrated totality between Parts A and B.

Effective date

The provision is effective upon enactment.

Sec. 15032. Commission on the effect of the baby boom generation on the Medicare Program

Present law

No provision.

Explanation of provision

The provision would establish a commission to be known as the Commission on the Effect of the Baby Boom Generation on the Medicare Program, hereafter referred to as "the Commission." It would be required to: (1) examine the financial impact on the Medicare program of the significant increase in the number of Medicare eligible individuals which will occur approximately during 2010 and lasting for approximately 25 years, and (2) make specific recommendations to Congress with respect to a comprehensive approach to preserve the Medicare program for the period during which such individuals are eligible for Medicare. In making its recommendations, the Commission would be required to consider: (1) the amount and sources of Federal funds to finance Medicare, including innovative financing methods; (2) the most efficient and effective manner of administering the program, including the appropriateness of continuing the failsafe mechanism after 2002; (3) methods used by other nations to respond to comparable demographics; (4) modifying age-based eligibility to correspond to that under the OASDI program; and (5) trends in employment-related health care for retirees, including the use of medical savings accounts and similar financing devices.

The Commission would be composed of 15 members, 3 appointed by the President, 6 by the Majority Leader of the Senate in consultation with the Minority Leader, of whom no more than 4 are of the same party; and 6 by the Speaker of the House, after consultation with the Minority Leader, of whom no more than 4 are in the same party. The provision spells out the appointment of a chair and vice chair, appointment of staff and consultants, compensation, the procedure for filling vacancies, and requirements relating to meetings and quorums. Upon request of the Commission, the Comptroller General would be required to conduct such studies or investigations as the Commission determined were needed to carry out its duties. The Director of CBO would be required to provide the commission with cost estimates, for which CBO would be compensated. The Commission would be authorized to detail to it employees of Federal agencies, and to obtain technical assistance and information from Federal agencies.

The Commission would be required to submit to Congress a report, no later than May 1, 1997, containing its findings and recommendations regarding how to protect and preserve the Medicare program in a financially solvent manner until 2030 (or, if later, throughout a period of projected solvency of the Federal Old-Age and Survivors Insurance Trust Fund). The report would be required to include detailed recommendations for appropriate legislative initiatives respecting how to accomplish this objective. The Commission would terminate 60 days after the date of submission of the mandated report. An amount of $1.5 million would be authorized to be appropriated.

Reason for change

H.R. 2425 brings Medicare into fiscal balance through the first decade of the next century, and provides more choices for Medicare beneficiaries through MedicarePlus. These changes strengthen the Medicare program and prepare it for its next great challenge, the retirement of the baby-boom generation. The significant demographic shift occurring with the retirement of that generation will require further Congressional action to preserve Medicare for the long-term.

Effective date

The provision is effective upon enactment.

Sec. 15033. Change in appointment of administrator of HCFA

Present law

The Administrator of HCFA is appointed by the President with the advise and consent of the Senate.

Explanation of provision

Under the bill, the Administrator of HCFA would be appointed by the Secretary of Health and Human Services. The amendment would become effective on the date of enactment and would apply to Administrators appointed on or after the date of enactment.

Reason for change

The Committee believes that with the emphasis on the MedicarePlus program, the person responsible for the MedicarePlus program should be of equal standing with the Administrator of HCFA. Additionally, the Committee believes that it would be inappropriate to add another Presidential appointee to the Department of Health and Human Services.

Effective date

The provision is effective upon enactment.

PART 5. TREATMENT OF HOSPITALS WHICH PARTICIPATE IN PROVIDER-SPONSORED ORGANIZATIONS

Sec. 15041. Treatment of Hospitals Which Participate in Provider-Sponsored Organizations.

Present law

No provision.

Explanation of provision

The amendment would provide that an organization shall not fail to be treated as organized and operated exclusively for a charitable purpose for purposes of Internal Revenue Code (IRC) section 501(c)(3) solely because a hospital which is owned and operated by such organization participates in a PSO (as defined in section 1845(a)(1) of the Social Security Act), whether or not such PSO is exempt from tax. Thus participation by a hospital in a PSO would be deemed to be an activity in furtherance of a charitable purpose (assuming the hospital itself qualifies for tax-exempt status under the present-law community benefit standard).

The amendment also would provide that any person with a material financial interest in such PSO shall be treated as a private shareholder or individual with respect to the hospital for purposes of applying the private inurement prohibition in IRC section 501(c)(3). Accordingly, the facts and circumstances of each PSO arrangement would be evaluated to determine whether the arrangement entails impermissible private inurement or more than incidental private benefit (e.g., where there is a disproportionate allocation of profits and losses to the non-exempt partners, the tax-exempt partner makes loans to the joint venture that are commercially unreasonable, the tax-exempt partner provides property or services to the joint venture at less than market value, or a non-exempt partner receives more than reasonable compensation for the sale of property or services to the joint venture).

The amendment would not change present-law restrictions on lobbying and political activities. In addition, the restrictions of IRC section 501(m) on the provision of commercial-type insurance would continue to apply.

Reason for change

The Committee believes non-profit hospitals should be permitted to participate in joint venture arrangements or other arrangements that qualify as PSOs, provided that there is no private inurement of non-profit hospital assets.

Effective date

The provision would be effective upon enactment.

SUBTITLE B—PREVENTING FRAUD AND ABUSE

Sec. 15101. Increasing Awareness of Fraud and Abuse

Present law

No provision.

Explanation of provision

This provision would require the Secretary to make ongoing efforts to alert individuals entitled to Medicare benefits of the existence of fraud and abuse committed against the program, of the costs of such fraud and abuse, and of a toll-free telephone line operated by the Secretary to receive information about such fraud and abuse.

The Secretary would be required to provide an explanation of Medicare benefits with respect to each item or service for which payment may be made, without regard to whether a deductible or coinsurance may be imposed with respect to the item or service.

Any person may, at any time, request the Secretary to publish a "special fraud alert," which is defined as a notice that informs the public of practices the Secretary considers to be suspect or of particular concern under the Medicare program or a State health care program. Upon receipt of a request for a special fraud alert, the Secretary would be required to investigate to determine whether to issue a special fraud alert. If he determines issuance of a special fraud alert appropriate, he would be required, in consultation with the Attorney General, to publish a special fraud alert in the Federal Register. In determining whether to issue a special fraud alert, the Secretary could consider whether and to what extent the practices in question may result in the consequences described in section 15214(b) relating to the criteria used to modify and establish safe harbors, and the extent and frequency of the conduct in question. Each notice issued by the HCFA that informs the public of practices the Secretary considers to be suspect or of particular concern under the Medicare program or a State health care program would be required to be published in the Federal Register, without regard to whether it was issued by a regional office of HCFA.

Reason for change

Medicare beneficiaries are frequently in the best position to identify fraud and abuse committed against the Medicare program and commonly, fraud and abuse investigations result from beneficiaries reporting problems regarding claims. Nevertheless, beneficiaries are not always notified when Medicare pays for services on their behalf.

Effective date

The provision would be effective upon enactment.

Sec. 15102. Beneficiary incentive programs

Present law

No provision.

Explanation of provision

This provision would require the Secretary, within three months after enactment of this bill, to establish a program to encourage individuals to report to the Secretary information on individuals and entities who are engaging or who have engaged in acts or omissions that constitute grounds for sanctions under sections 1128, 1128A, or 1128B of the Social Security Act, or who have otherwise engaged

in fraud and abuse against the Medicare program. If an individual reports information to the Secretary under this program that serves as a basis for the collection by the Secretary or the Attorney General of any amount of at least $100 (other amount collected to the individual, under procedures similar to those applicable under section 7623 of the Internal Revenue Code of 1986.

The Secretary would be required, within three months after enactment of this bill, to establish a program to encourage individuals to submit to the Secretary suggestions on methods to improve the efficiency of the Medicare program. If the Secretary adopts such a suggestion and savings to the program result, the Secretary could make a payment to the individual of an amount the Secretary considers appropriate.

Reason for change

Medicare beneficiaries are typically in the best position to identify potentially fraudulent or abusive practices or excessive charging. Moreover, the Medicare beneficiaries and the medical providers and suppliers who serve them are often in the best position to identify opportunities to improve the efficiency of the Medicare program and reduce fraud and abuse.

Effective date

The provision would be effective upon enactment.

Sec. 15103. Intermediate sanctions for MedicarePlus plans

Present law

A contract between the Secretary and a Medicare HMO is generally for a one year term, with an option for automatic renewal. However, the Secretary may terminate any such contract at any time, after reasonable notice and an opportunity for a hearing, if the Medicare HMO has failed substantially to carry out the contract, or is carrying out the contract in a manner inconsistent with the efficient and effective administration of the requirements of section 1876 of the Social Security Act, or if the Medicare HMO no longer substantially meets the statutory requirements contained in Section 1876(b),(c),(e) and (f).

Explanation of provision

This provision would add one more ground for termination of a Medicare HMO contract by the Secretary, specifying that the Secretary may terminate such a contract if the organization is operating in a manner that is not in the best interests of the individuals covered under the contract. In addition, the Secretary would have the discretion to either terminate the contract or to impose certain intermediate sanctions on the eligible organization. The sanctions available to the Secretary under section 1876(I)(6)(B) include civil money penalties up to $25,000 for each determination of non-compliance, with an assessment of up to $100,000 if the basis for non-compliance was that the eligible organization engaged in a practice which denied or discouraged enrollment by eligible individuals with a need for substantial future medical services, or if the eligible organization falsified information given to the Secretary under this

section; suspension by the Secretary of enrollment of individuals, until the Secretary is satisfied that the basis for the determination has been corrected and is not likely to recur; or suspension of payment to the organization for individuals enrolled after the date of a determination of non-compliance, until the Secretary is satisfied that the basis for the determination has been corrected and is not likely to recur.

If the basis for the determination by the Secretary that an intermediate sanction should be imposed on an eligible organization is other than that the organization has failed substantially to carry out its contract with the Secretary, then the Secretary may apply intermediate sanctions as follows: civil money penalties of not more than $25,000 for each determination if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract; civil money penalties of not more than $10,000 for each week of a continuing violation; and suspension of enrollment of individuals until the Secretary is satisfied that the deficiency has been corrected and is not likely to recur.

Whenever the Secretary seeks to either terminate a Medicare HMO contract or impose intermediate sanctions on such an organization, the Secretary must do so pursuant to a formal investigation and under compliance procedures which provide the organization with an opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's adverse determination. The Secretary would impose more severe sanctions on organizations that have a history of deficiencies or that have not corrected deficiencies brought to their attention. The Secretary's compliance procedures must also include reasonable notice and opportunity for a hearing (including the right to appeal an initial decision) before the Secretary imposes any sanction or terminates the contract of a Medicare HMO, and there must not be any unreasonable or unnecessary delay between the finding of a deficiency and the imposition of sanctions.

Effective Date. The amendments made by this section would apply to contract years of eligible organizations beginning on or after January 1, 1996.

Reason for change

The Secretary currently lacks sufficient authority to effectively oversee the Medicare HMO provisions. This section provides the Secretary with the discretion she needs to terminate the contract with a Medicare Plus organization or apply intermediate sanctions if the organization is operating in a manner that is not in the best interests of the beneficiaries covered under the contract. Under current law, the Secretary may only impose intermediate sanctions against a Medicare risk-contract HMO for a specified list of contract violations.

Effective date

The provision would be effective upon enactment.

Sec. 15104. Voluntary disclosure program

Present law

Current law does not provide for a program permitting the Secretary to mitigate penalties for parties who voluntarily disclose acts or omissions under Section 1128, 1128A, or 1128B. Section 1128 directs the Secretary to impose mandatory exclusions from the Medicare program and State health care programs[5] 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. The Secretary has permissive exclusion authority for a number of criminal offenses relating to health care-related fraud, theft, embezzlement, financial misconduct, kickbacks, misuse of controlled substances, and activities relating to license revocations or suspensions, claims for excessive charges or unnecessary services, and the like. Section 1128A prescribes civil money penalties for a number of illegal activities relating to the submission of claims for reimbursement under the Medicare and Medicaid programs. Violations which are subject to civil money penalties include submitting claims for items or services not provided or which were false or fraudulent, providing services when not a properly licensed physician, and providing items or services by an excluded practitioner. Civil money penalties may also be imposed on a hospital which knowingly makes a payment to a physician, or a physician who knowingly accepts payment from a hospital, as inducement to limit or reduce care to a Medicare or Medicaid patient. Section 1128B sets forth criminal penalties 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.

Explanation of provision

Under this section a new provision would be added to Title XI of the Social Security Act directing the Secretary of Health and Human Services to establish a program encouraging individuals and entities to voluntarily disclose to the Secretary information on acts or omissions which constitute grounds for the imposition of a sanction under Section 1128, 1128A, or 1128B of the Social Security Act.

Under this program the Secretary would have the authority to mitigate any applicable sanction which the Secretary might otherwise have imposed under Section 1128, 1128A or 1128B. The Secretary would not be required to reduce or mitigate applicable sanctions, but may do so, following a voluntary disclosure. This section would specify that no qui tam lawsuit could be brought under the False Claims Amendments Act of 1986, by private parties against

[5] "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.

the individual or entity with respect to a voluntarily disclosed act or omission under sections 1128, 1128A or 1128B.

Reason for change

A voluntary disclosure program has been used effectively by the Department of Defense, and development of a voluntary disclosure program for Medicare has been recommended and is supported by the Office of the Inspector General in the DHHS.

Effective date

The provision would be effective upon enactment.

Sec. 15105. Revisions to current sanctions

Present law

Civil money penalties may be imposed under section 1128A for false or fraudulent claims for reimbursement under the Medicare and Medicaid programs. In addition, twice the amount claimed may be assessed against the fraudulent party for false or fraudulent claims.

Section 1128B provides that whoever knowingly and willfully makes a false statement or representation in connection with the furnishing of items or services for which payment is or may be made by Medicare shall, upon conviction of a program related felony, be fined not more than $25,000 or imprisoned for not more than five years, or both. Section 1128(b) authorizes the Secretary to impose permissive exclusions of individuals and entities from Medicare program, Medicaid program and programs receiving funds under the Maternal and Child Health Block Grant, or the Social Services Block Grant. 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. There is, however, a minimum period of exclusion of not less than five years for mandatory exclusions imposed by the Secretary under section 1128(a).

Explanation of provision

This section would provide that civil monetary penalties under Section 1128A be doubled for violations occurring after the date of enactment of this Act.

This section would also establish a minimum period of exclusion of three years for permissive exclusions of individuals or entities convicted, under Federal or State law, of health care criminal offenses relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct, as well as for convictions relating to obstruction of an investigation, or of a criminal offense involving misuse of controlled substances. The Secretary may determine that a shorter period than three years is appropriate in cases of mitigating circumstances, or that a longer period is appropriate because of aggravating circumstances.

Permissive exclusions in cases relating to license revocations or suspensions for reasons bearing on an individual's or entity's professional competence or financial integrity, and permissive exclusions following the suspension, exclusion or sanction of an individual or entity from any Federal or State health care program for reasons bearing on professional competence or financial integrity, shall be not less than the period during which the individual's or entity's license to provide health care has been revoked or suspended, or the individual or entity has been excluded or suspended from a Federal or State health care program.

In cases where the Secretary has permissive authority to exclude an individual or entity from Medicare or State health care programs due to submission of claims for excessive charges or for medically unnecessary services, the period of exclusion shall be not less than one year.

Reason for change

The Committee felt that greater deterrence was needed against fraud and abuse in the Medicare program.

Effective date

The amendments made by this section would apply to acts or omissions occurring on or after January 1, 1996.

Sec. 15106. Consolidated funding for anti-fraud and abuse activities under Medicare integrity program

Present law

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 the Health Care Financing Administration.

Explanation of provision

This provision establishes a Medicare Integrity Program under which the Secretary would promote the integrity of the Medicare program by entering into contracts with eligible private entities to carry out certain activities. These activities would include the following: (1) review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under the Medicare program, including medical and utilization review and fraud review, (2) audit of cost reports, (3) determinations as to whether payment should not be, or should not have been, made by reason of the Medicare as secondary payor provisions, and recovery of payments that should not have been made, and (4) education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.

Eligibility of Entities. There are four eligibility requirements for an entity to enter into a contract to carry out any of the activities described in subsection (b). They are the following: (1) the entity has demonstrated capability to carry out such activities; (2) in carrying out such activities, the entity agrees to cooperate with the In-

spector General of the Department of Health and Human Services, the Attorney General, and other law enforcement agencies, in the investigation and deterrence of Medicare fraud and abuse; (3) the entity's financial holdings, interests, or relationships will not interfere with its ability to perform the functions required by the contract in an effective and impartial manner; and (4) the entity meets such other requirements as the Secretary may impose.

Process for Entering into Contracts. The Secretary is authorized to establish, by regulation, procedures for entering into contracts; such procedures would be required to include at least the following three components: (1) the Secretary would be required to determine the appropriate number of separate contracts necessary to carry out the Program and the appropriate times at which the Secretary shall enter into such contracts; (2) the provisions of section 1153(e)(1), regarding the authority of the Secretary to contract, would apply to contract and contracting authority under this section, except that competitive procedures would have to be used when entering into new contracts or at any other time the Secretary considers appropriate; and (3) a contract could be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

Limitation on Contractor Liability. The Secretary is required to provide, by regulation, for the limitation of a contractor's liability under the Program. The Secretary would employ, to the extent he finds appropriate, the same or comparable standards and other substantive and procedural provisions as are contained in section 1157.

Transfer of Amounts to Medicare Anti-Fraud and Abuse Trust Fund. The Secretary is required to transfer, for each fiscal year, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, to the Medicare Anti-Fraud and Abuse Trust Fund under subsection (g), amounts necessary to carry out the activities of subsection (b). The allocation shall reasonably reflect the proportion of expenditures from part A and part B.

Medicare Anti-Fraud and Abuse Trust Fund. There is established in the Treasury of the United States the Anti-Fraud and Abuse Trust Fund, which would consist of gifts and bequests as may be made unconditionally to the Trust Fund and such amounts as may be deposited in the Trust Fund as provided in subsection (f), paragraph (3) of this subsection, and title XI.

The Secretary of the Treasury would be required to invest such amounts of the Fund as he determines are not required to meet current withdrawals from the Fund in government account serial securities. Any interest derived from investments would be credited to the Fund.

The following moneys would be required to be deposited in the Trust Fund: that portion of amounts recovered in relation to section 1128A arising out of Medicare claims as remains after application of subsection (f)(2) relating to repayment of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund; fines imposed under section 1128B arising out of a claim under this title; and, penalties and damages

(other than those funds awarded to a relator or for restitution under the False Claims Act) in cases involving claims relating to programs under Medicare or Medicaid.

There would be appropriated from the Trust Fund for each fiscal year such amounts as are necessary to carry out the Medicare Integrity Program, subject to the appropriation amount limits specified in the section for fiscal years 1996 through 2002.

The Secretary would be required to submit an annual report to Congress on the amount of revenue generated and disbursed by the Trust in each fiscal year.

Elimination of FI and Carrier Responsibility for Carrying Out Activities Subject to Program. This provision prohibits any agency, organization, or carrier, from carrying out (or receiving payment for carrying out) any activity pursuant to an agreement under this section to the extent that the activity is carried out pursuant to a contract under the Medical Integrity Program.

Direct Spending for Medicare-Related Activities of the Inspector General. This provision appropriates from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund such amounts as are necessary to carry out Medicare-related activities, subject to the appropriation amount limits specified in the section for fiscal years 1996 through 1998 and subsequent years. The Medicare-related activities described in this section are: (1) prosecuting Medicare-related matters through criminal, civil, and administrative proceedings; (2) conducting investigations relating to the Medicare program; (3) performing financial and performance audits of programs and operations relating to the Medicare program; (4) performing inspections and other evaluations relating to the Medicare program; and (5) conducting provider and consumer education activities regarding Medicare fraud and abuse.

Reason for change

Currently, funding for health care fraud and abuse prevention, detection, and enforcement actions are considered discretionary spending, and thus subject to limits. Despite evidence of substantial net savings to the government by investing more in these activities, spending has not kept pace with the growth in program expenditures. As a result, today Medicare spends over 30 percent less per claim on fraud and abuse activities than it spent in 1989—despite strong evidence that fraud and abuse problems are on the rise. These provisions provide a mandatory funding stream to modernize Medicare's fraud and abuse detection and prevention capabilities and give Medicare greater flexibility to contract with companies having demonstrated expertise in the area of claims review and fraud and abuse detection and prevention. Similarly, the DHHS Office of Inspector General has had significant decreases in its budget for investigating Medicare-related fraud and abuse. Under current law its funding for these activities is likewise considered discretionary and subject to limits regardless of the potential net savings to Medicare.

Effective date

The provision would be effective upon enactment.

Sec. 15107. Permitting carriers to carry out prior authorization for certain items of durable medical equipment (DME)

Present law

The Secretary is authorized to develop and periodically update a list of DME items that are subject to unnecessary utilization throughout a carrier's entire service area or a portion of such area. The Secretary may also develop and update a list of DME suppliers with a substantial number of denied claims or a pattern of over utilization resulting from the business practices of suppliers. Carriers are required to make advance coverage determinations for items on the lists developed by the Secretary.

Explanation of provision

Carriers would be authorized to develop the same lists of DME items and suppliers that the Secretary is authorized to develop. Carriers would also be authorized to make advance coverage determinations, regardless of whether or not the Secretary has promulgated a regulation for the list, except for items and suppliers on the lists that a carrier could not make advance determinations until the expiration of the 30-day period beginning on the date the Secretary or carrier places the item on the list.

Reason for change

Schemes to defraud the Medicare program in the area of durable medical equipment and supply items have been particularly problematic to Medicare over the past decade. Medicare contractors do not have sufficient flexibility to require prior authorization for individual medical supply or equipment items that are being billed to the program excessively, or for individual suppliers that are submitting unwarranted claims.

Effective date

The provision would be effective upon enactment.

Sec. 15108. Establishment of health care anti-fraud task force

(This section is under the jurisdiction of the Committee on the Judiciary.)

Present law

No provision.

Explanation of provision

Within 120 days of enactment the Attorney General would be required to establish, within the Department of Justice, a nationwide "Health Care Anti-Fraud Task Force" to prosecute health care fraud offenses. This Task Force would be set up in consultation with the Secretary of Health and Human Services, the Secretary of the Treasury, the Secretary of Veterans' Affairs, and the Chair of the Board of Governors of the United States Postal Service. There would be at least one fully staffed operational segment of the Task Force in each judicial district of the United States, with at least one Federal representative from each entity engaged on a full-time basis in the activities of the Task Force. The Task Force

would maintain separate accounting of its finances, personnel, case load, and resolution of claims and actions.

Reason for change

There is concern over a lack of coordination between the federal and state law enforcement efforts to combat health care fraud and abuse. The task force approach has been used successfully in other areas of law enforcement.

Effective date

The provision would be effective upon enactment.

Sec. 15109. Study of adequacy of private quality assurance programs

Present law

No provision.

Explanation of provision

The Administrator of HCFA, through the Office of Research, would be required to contract for a study of the adequacy of quality assurance programs and consumer protections used by plans enrolling Medicare beneficiaries under part C of title XVIII of the Social Security Act, including an analysis of the effectiveness of such programs in protecting plan enrollees against the risk of insufficient provision of benefits which may result from utilization controls. A report would be submitted to Congress on the study not later than 6 months after the conclusion of the 5-year period for the study.

Reason for change

With the growing participation of Medicare beneficiaries in HMOs and other types of coordinated care, additional vigilance is necessary concerning the potential for the under-provision of medically necessary services.

Effective date

The provision would be effective upon enactment.

Sec. 15110. Penalty for False Certification for Home Health Services

Present law

No provision.

Explanation of provision

This provision would add an additional civil monetary penalty of not more than three times the amount of the payments, or $5,000, whichever is greater, for a physician who certifies that an individual meets all of Medicare's requirements to receive home health care while knowing that the individual does not meet all such requirements.

Reason for change

Expert testimony has indicated that physicians sometimes do not adequately review statements certifying patients' eligibility for home health care.

Effective date

The provision would be effective upon enactment.

SUBTITLE C—REGULATORY RELIEF

PART 1. PHYSICIAN OWNERSHIP AND REFERRAL REFORM

Sec. 15201. Repeal of prohibitions based on compensation arrangements

Present law

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. A compensation arrangement is generally defined as any arrangement involving any remuneration between a physician (or immediate family member) and an entity.

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.

Explanation of provision

The provision would repeal the prohibitions based on compensation arrangements.

Reason for change

Current law places Medicare in a position of micro-managing compensation arrangements whether or not there is any evidence or research that these arrangements are inappropriate or would result in fraudulent or abusive referral patterns. Current law also would require Medicare to review literally hundreds of thousands of contracts and other arrangements to determine whether or not particular physicians are paying the appropriate rent on office space, a lab is paying a lawful amount for a medical director's services, or a clinic is paying appropriately for physician salaries. The anti-kickback provisions in current law will still apply to any appropriate compensation arrangements.

Effective date

The provision would be effective upon enactment.

Sec. 15202. Revision of designated health services subject to the prohibition

Present law

OBRA 89, which established the initial self-referral ban applied the ban to referrals for clinical laboratory services only. OBRA 93

(as modified by P.L. 103–432) extended the ban to additional "designated health services", effective January 1, 1995. These designated health services are: (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.

Explanation of provision

This provision revises the list of "designated health services". Under the provision, the referral ban would apply only to: (i) physical therapy services; (ii) occupational therapy services; (iii) magnetic resonance imaging and computerized axial tomography scans; and (iv) parenteral and enteral nutrients, equipment and supplies.

Reason for change

There are many services covered under current law for which there has been no demonstrable record of abuse related to physician ownership or there is lacking even a presumption that physician ownership and referral may lead to abusive practices. There are other areas where there is not even a significant potential problem or which may have the unattended consequence of producing the opposite effect—the under utilization of service. Included in this category are radiation therapy services, and prosthetic and orthotic devices.

Effective date

The provision would be effective upon enactment.

Sec. 15203. Delay in implementation until promulgation of regulations

Present law

The self-referral provisions included in OBRA 89 applied to Medicare referrals for clinical laboratory services made on or after 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. In general, 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.

On August 14, 1995, DHHS issued final regulations implementing the OBRA 89 requirements. These regulations are effective September 13, 1995. 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.

Explanation of provision

The proposal specifies that the amendments made by OBRA 93 would not apply to any referrals made before the effective date of the final implementing regulations promulgated by the Secretary of Health and Human Services.

Reason for change

The OBRA 93 expansion of designated services and other self-referral legislative amendments created ambiguity over what constitutes an acceptable ownership or investment arrangement. Because of the ambiguous nature of these provisions, there is confusion over compliance issues which are particularly problematic for medical providers because of severe penalties for noncompliance.

Effective date

The provision would be effective upon enactment.

Sec. 15204. Exception to prohibitions

Present law

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 physician making the referral, 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 in-office ancillary services exception contains a site-of-service requirement. To meet the exception, 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.

The law includes an exception, related only to the ownership and investment prohibition, for rural providers. To be eligible for an exception, the entity must be in a rural area. 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.

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.

Explanation of provision

The provision would modify the exception for in-office ancillary services. It would repeal the site-of-service requirement. It would also provide that non-physician personnel must be under the gen-

eral supervision (rather than the direct supervision) of a physician. An individual would be under the general supervision of a physician (or a group practice of which the physician is a member) if the physician is legally responsible for the services performed by the individual and for ensuring the individual meets licensure requirements and certification standards regardless of whether or not the physician is physically present when the services are delivered.

The provision would modify the provision relating to rural providers. To qualify for an exception, not less than 75 percent of the designated health services must be furnished to individuals residing in rural areas.

The provision would modify the definition of prepaid plans to refer to managed care plans. It would add an exception for entities which are MedicarePlus organization or other entities under the following conditions. The entity must provide or arrange for the provision of services pursuant to a written agreement between the organization and an individual or entity. The agreement must place the individual or entity at substantial financial risk for the cost or utilization of services which the individual or entity is obligated to provide. This obligation may be through withhold, capitation, incentive pool, per diem payment, or any other similar risk arrangement which places the individual or entity at substantial financial risk.

The provision would add a new exception for shared facility services. The services must be furnished by the facility to patients of shared facility physicians; the physicians must have a financial relationship under a shared facility arrangement with the facility. A shared facility arrangement is one: (i) which is only between physicians who are providing services (unrelated to shared facility services) in the same building; (ii) in which the overhead expenses are shared among the physicians in accordance with previously determined methods; and (iii) which, in the case of a corporation, is wholly owned and controlled by shared facility physicians.

The provision would add a new exception for services furnished in communities which the Secretary of Health and Human Services determines do not have access to alternative providers.

The provision would add an exception for services furnished in ambulatory surgical centers, renal dialysis facilities, comprehensive rehabilitation facilities, and hospice programs.

Reason for change

Current law would prohibit a number of long standing arrangements, including arrangements for physicians to use non-physician practitioners without being physically present in the office suite, or arrangements for physicians practicing in the same building to share clinical laboratory, x-ray and other designated services when treating their own patients, where there is no indication that fraudulent or abusive referral arrangements have been experienced. In addition, there is clearly no incentive in managed care arrangements for fraudulent or abusive referrals. The current law treatment of managed care entities places a potential chilling effect on arrangements designed to encourage efficient use of medical services.

Effective date

The provision would be effective upon enactment

Sec. 15205. Repeal of reporting requirements

Present law

The law establishes a reporting requirement for entities providing services under Medicare. Reports are to include information on the entity's ownership, investment and compensation arrangements.

Explanation of provision

The provision would delete the reporting requirements.

Reason for change

Current law places the undue administrative burden on providers and suppliers of providing separate reports to the Health Care Financing Administration for the self-referral provisions.

Effective date

The provision would be effective upon enactment.

Sec. 15206. Preemption of state law

Present law

No provision.

Explanation of provision

The provision would specify that the self-referral provisions preempt State law to the extent State law was inconsistent.

Reason for change

The current self-referral law was designed to deter fraudulent or abusive referral patterns. The reforms in this bill concentrate the self referral law on the areas where it is most appropriate. State and federal law, however, may be inconsistent regarding requirements limiting physician ownership of health services and other compensation arrangements.

Effective date

The provision would be effective upon enactment.

Sec. 15207. Effective date

Present law

No provision.

Explanation of provision

The provisions in this part apply to referrals made on or after August 14, 1995, regardless of whether or not regulations are promulgated to carry out such amendments.

Reason for change

Under current law there is ambiguity over the potential liability of persons who would be in violation of the Medicare self-referral

regulations issued on August 14, 1995 if the provisions discussed in this part remain in place without publication of regulations.

Effective date

The provision would be effective upon enactment.

PART 2. OTHER MEDICARE REGULATORY RELIEF

Sec. 15211. Repeal of Medicare and Medicaid coverage data bank

Present law

Under the Medicare secondary payer (MSP) program, the individual's employer-based group health insurance, liability insurance, or no-fault insurance may be the primary payer in certain cases. The OBRA 93 provided for the establishment of a Medicare and Medicaid Coverage Data Bank by the Secretary of Health and Human Services. OBRA 93 required employers having or contributing to a group health insurance plan to submit employee health insurance information to the Secretary, on an annual basis, for calendar years 1994–1997. The 1994 submission was due by February 1995. The information was intended to facilitate the identification of both Medicare secondary payer cases and those circumstances in which employer-based insurance, rather than Medicaid, should be the primary payer.

A number of employers voiced strong opposition to the Data Bank requirements. One of the principal concerns was that employers would be required to report information which they did not routinely collect. In response to these concerns, the Conference agreement accompanying the FY 1995 Labor, DHHS, and Education appropriations bill (P.L. 103–333) contained specific language relating to the Data Bank. It directed that no DHHS funds should be used for the implementation of or planning for implementation of the Bank.

Explanation of provision

The provision would repeal the Data Bank requirement.

Reason for change

The General Accounting Office (GAO) has testified that the "enormous administrative burden the data bank would place on HCFA and the nation's employers . . . likely would do little or nothing to enhance current efforts to identify those beneficiaries who have other health insurance coverage." The basis for GAO's conclusion is discussed in detail in their report "Medicare/Medicaid Data Bank Unlikely to Increase Collections From Other Insurers" released on May 6, 1994.

In addition, the administrative simplification provisions contained in this bill will provide the basis for prospectively identifying instances where an individual has other health insurance coverage which should be primary to Medicare coverage.

Effective date

This provision will be effective upon enactment.

Sec. 15212. Clarification of level of intent required for imposition of sanctions

Clarification of Level of Knowledge Required for Imposition of Civil Monetary Penalties.

Present law

Civil money penalties may be imposed for seeking reimbursement under the Medicare and Medicaid programs for items or services not provided or for services provided by someone who was not a licensed physician, whose license was obtained through misrepresentation, or who misrepresented his or her qualification as a specialist, or where the claim is otherwise fraudulent. Civil penalties may also be sought for presenting a claim for payments which are in violation of: 1) contracts limiting payment due to assignment of a patient, 2) agreements with state agencies limiting permitted charges, 3) agreement with participating physicians or suppliers, and 4) agreements with providers of service. Civil penalties may also be sought against persons who provide false or misleading information that could reasonably be expected to influence a decision to discharge a person from a hospital. A person is subject to these provisions if they presented a claim and he or she "knows or should have known" that the claim fell into one of the categories listed above. Further, the person presenting the claim may be assessed twice the amount fraudulently claimed.

Explanation of provision

This section adds a requirement that a person is subject to this provision when they "knowingly" present a claim that the person "knows or should know" fell into one of the above categories. Thus, an assessment under this provision would only be made where a person had actual knowledge that they had submitted a claim or had provided false or misleading information, and where they had actual knowledge of the fraudulent nature of the claim, act in deliberate ignorance, or acted in reckless disregard. The requirement that a person "knowingly" presents a claim or "knowingly" makes a false or misleading statement which influences discharge would prevent charging persons who inadvertently perform these acts.

Reason for change

The current standard is inconsistent with the Civil False Claims Act which applies to all other federal programs. Additionally, concerns have been raised that the standard currently applied by the Health and Human Services Department Office of the Inspector General is less specific and can result in pursuit of allegations based on simple mistakes.

Effective date

The provision would be effective upon enactment.

Clarification of Effect and Application of Safe Harbor Exceptions.

Present law

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 Medicare or Medicaid. The provisions in section 1128B(b) of the Social Security Act also prohibit 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 DHHS Office of Inspector General (OIG) 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 that individual or entity will be assured that he or she will not be prosecuted.

Explanation of provision

This section provides that the specification of any payment practice by the Secretary under this provision are to be solely for the purpose of adding additional exceptions to the types of conduct, and are not for the purpose of limiting the scope of such exceptions. In addition, such a specification of an acceptable payment practice shall apply notwithstanding whether the party engaging in that practice actually does intend to induce Medicaid or Medicare referrals.

Reason for change

The safe harbor regulations have been rendered meaningless by the DHHS OIG decision to deny the protection of the regulations whenever the OIG believes that an arrangement that meets the regulatory requirements is nevertheless a "sham". Looking behind the safe-harbor, defeats its purpose, and renders a chilling effect on the very safe harbors which are meant to protect legitimate financial arrangements.

Effective date

The provision would be effective upon enactment.

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

Present law

The anti-kickback provisions in Section 1128B(b) prescribe criminal penalties for individuals or entities that knowingly and willfully offer or pay remuneration to induce business reimbursed under Medicare or State health care programs.

Explanation of provision

This section would amend Section 1128B(b)(2) to provide that a person was subject to the anti-kickback provisions only if the remuneration which is offered is done so "for the significant purpose of inducing" business which would be reimbursed under Medicare or State health care programs. This will narrow the application of the anti-kickback provisions to only those situations where inducement was a significant purpose of remuneration.

Reason for change

Although financial arrangements between a provider or supplier and an entity that is capable of referring business might be motivated by many factors, a desire to increase referrals or purchases can almost always be inferred. The fact that the motivations behind a financial arrangement are not entirely free of profit considerations should not be grounds to impose criminal penalties, as is currently possible under the "one-purpose" rule. Under current law, virtually every provider or supplier that enters into a financial arrangement with an entity that has the potential to refer Medicare or Medicaid business is at risk of an anti-kickback investigation.

Effective date

The provision would be effective upon enactment.

Sec. 15213. Clarification of and additions to exceptions to anti-kickback penalties

Present law

The anti-kickback provisions in Section 1128B(b) contain several exceptions. These exceptions include discounts or other reductions in price obtained by a provider of services or other entity under Medicare or a State health care program 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; 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 of 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 qualifies 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.

Explanation of provision

The provision would add a new exception for remuneration between an organization and an individual or entity providing services pursuant to a written agreement between the organization and the entity. The organization must be either a MedicarePlus entity or its written agreement must place the individual at substantial financial risk for the cost or utilization of services which the individual or entity is obligated to provide. This obligation may be through withhold, capitation, incentive pool, per diem payment, or any other similar risk arrangement which places the individual or entity at substantial financial risk.

Reason for change

Absent an exemption, nearly all managed care arrangements (except those that comply with the current safe harbors for HMOs that contract with Medicare or Medicaid) could potentially be deemed unlawful. This is because an essential feature of managed care is the offer by providers of remuneration (in the form of dis-

counting or risk sharing) in exchange for a stream of patients. Another common feature is the offer by managed care organizations to providers of incentives to encourage adherence to cost-saving measures and protocols. There is no assurance that either of these (as well as other arrangements inherent in managed care) are permissible under the anti-kickback law.

Effective date

The provision would be effective upon enactment.

Sec. 15214. Solicitation and publication of modifications to existing safe harbors and new safe harbors

Present law

The 1987 Medicare and Medicaid Patient and Program Protection Act specified various payment practices which, although potentially capable of inducing referrals of business under Medicare or State health care programs, will be protected from criminal prosecution or civil sanction under the anti-kickback provisions of the law. The 1987 law also established authority for the Secretary to promulgate regulations specifying additional payment practices, known as "safe harbors", that will not be subject to sanctions under the fraud and abuse provisions.

Explanation of provision

The Secretary shall publish an annual notice in the Federal Register soliciting proposals for modifications to existing safe harbors, new safe harbors, interpretive rulings and special fraud alerts. After considering such proposals the Secretary, in consultation with the Attorney General, shall, after notice and comment, issue final rules modifying existing safe harbors and establishing new safe harbors, as appropriate. The Secretary, in considering these proposals, may consider the extent to which such a proposal would affect access to health care service, quality of health care services, patient freedom of choice among health care providers, competition among health care providers, cost of health care programs to Government, over-utilization of health care services, and any other factors appropriate to prevent fraud and abuse in health care programs of the Federal Government. The Inspector General shall annually issue a report on the proposals received by the Secretary, the proposal issued by the Secretary, and an explanation of the reason for rejection of any of the proposals received.

Reason for change

Greater public involvement in the processes for identifying changes or additions to safe harbors, interpretive rulings, and fraud alerts could stimulate more timely and responsive information for assisting providers and suppliers in understanding Medicare requirements.

Effective date

The provision would be effective upon enactment.

Sec. 15215. Issuance of advisory opinions under title XI

Present law

No provision.

Explanation of provision

The Secretary shall issue regulations to provide for a procedure by which a party may seek an advisory opinion. These opinions are binding, and may include: (1) what constitutes prohibited enumeration, (2) what arrangements are excluded from these prohibitions, (3) whether an arrangement satisfies the criteria established by the Secretary, (4) what constitutes an inducement to reduce or limit services, (5) whether an activity constitutes grounds for imposition of penalties. Such opinions shall not address whether the fair market value was received for goods and whether an individual is a bona fide employee for tax purposes. The Secretary shall respond to advisory opinions within 30 days after the request is made, and a fee equal to the costs incurred shall be charged. This section will be effective January 1, 1996.

Reason for change

Providers who want to comply with the fraud and abuse statutes should be able to receive guidance from the government regarding financial arrangements. Without this ability, a chilling effect is placed on legitimate arrangements, particularly when providers are attempting to structure new and innovative health care delivery systems to help bring health care costs under control.

Effective date

The provision would be effective upon enactment.

Sec. 15216. Prior notice of changes in billing and claims processing requirements for physicians' services

Present law

Currently, changes in Medicare policy are effective 30 days after their dissemination by notices in carrier newsletters or bulletins. In addition to these newsletters and bulletins, many carriers offer educational programs to notify physicians and their staff of changes in Medicare regulations and requirements.

Explanation of provision

The provision would require the Secretary to give at least 120 days notice before making changes in billing and processing requirements for physician's claims.

Reason for change

Concerns have been raised that this 30 day period does not allow enough time for physicians and their staffs to modify their systems in order to be in compliance.

Effective date

The provision is effective upon enactment.

PART 3. PROMOTING PHYSICIAN SELF-POLICING

(This Part is under the jurisdiction of the Committee on the Judiciary.)

Sec. 15221. Exemption from antitrust laws for certain activities of medical self-regulatory entities

Present law

No provision.

Explanation of provision

This section would provide an exemption from Federal and State antitrust laws for health care service activities which are considered safe harbors under this section. A safe harbor is generally described as any activity of a medical self-regulatory entity relating to standard setting or standard enforcement activities that are designed to promote the quality of health care services provided to patients. However, no activity of a medical self-regulatory entity may be deemed to be a safe harbor under this section if the activity is conducted for purposes of financial gain, or the activity interferes with the provision of health care services by any health care provider who is not a member of the specific profession which is subject to the authority of the medical self-regulatory entity.

For purposes of this section the term "antitrust laws" has the meaning given it in subsection (a) of the first section of the Clayton Act, except that the term includes section 5 of the Federal Trade Commission Act to the extent that section applies to unfair methods of competition. A "medical self-regulating entity" is defined as a medical society or association, a specialty board, a recognized accrediting agency, or a hospital medical staff, and includes the members, officers, employees, consultants, and volunteers or committees of such an entity. "Standard setting or standard enforcement activities" mean accreditation of health care practitioners, health care providers, medical education institutions, or medical education programs, as well as technology assessment and risk management activities, the development and implementation of practice guidelines or practice parameters, or official peer review proceedings undertaken by a hospital medical staff or a medical society for purposes of evaluating the professional conduct or quality of health care provided by a medical professional. This section also defines "health care service", "health care provider" and "health benefit plan".

Reason for change

Self-regulatory entities 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. The purpose of the medical self-regulatory entity exemption included in this proposal is to bar antitrust suits against medical

self-regulatory entities that develop or enforce medical standards. This would include activities such as accreditation of health care providers and medical education programs and institutions, technology assessment and risk management, development and implementation of practice guidelines and parameters, and official peer review proceedings. The exemption would cover suits against individual members of the groups which undertake these activities as well as the organizational entity on whose behalf they act. This section is under the jurisdiction of the Judiciary Committee.

Effective date

The provision would be effective upon enactment.

SUBTITLE D—MEDICAL LIABILITY REFORM

(The provisions of this Subtitle are under the jurisdiction of the Committee on the Judiciary.)

PART 1. GENERAL PROVISIONS

Sec. 15301. Federal reform of health care liability actions

Present law

There are no uniform Federal standards governing health care liability actions.

Explanation of provision

The provision would provide for Federal reform of health care liability actions. It would apply to any health care liability action brought in any State or Federal court. The provisions would not apply to any action for damages arising from a vaccine-related injury or death or to the extent that the provisions of the National Vaccine Injury Compensation Program apply. The provisions would preempt State law to the extent State law provisions were inconsistent with the new requirements. However, it would not preempt State law to the extent State law provisions were more stringent.

Sec. 15302. Definitions

Present law

No provision.

Explanation of provision

The provision would define the following terms for purposes of the Federal reforms: actual damages; alternative dispute resolution system; claimant; clear and convincing evidence; collateral source payments; economic loss; harm; health care liability action; health care liability claim; health care provider; noneconomic damages; person; punitive damages; and State.

Sec. 15303. Effective date

Present law

No provision.

Explanation of provision

The provision would specify that Federal reforms apply to any health care liability action brought in any State or Federal court that is initiated after the date of enactment. The provision would also apply to any health care liability claim subject to an alternative dispute resolution system. Any health care liability claim or action arising from an injury occurring prior to enactment would be governed by the statute of limitations in effect at the time the injury occurred.

PART 2. UNIFORM STANDARDS FOR HEALTH CARE LIABILITY ACTIONS

Sec. 15311. Statute of limitations

Present law

To date reforms of the malpractice system have occurred primarily at the State level and have generally involved changes in the rules governing tort cases.

Explanation of provision

The provision would establish uniform standards for health care liability claims. It would establish a uniform statute of limitations. Actions could not be brought more than two years after the injury was discovered or reasonably should have been discovered. In no event could the action be brought more than five years after the date of the alleged injury.

Sec. 15312. Calculation and payment of damages

Present law

No provision.

Explanation of provision

The provision would limit noneconomic damages to $250,000 in a particular case. The limit would apply regardless of the number of persons against whom the action was brought or the number of actions brought.

The provision would specify that a defendant would only be liable for the amount of noneconomic damages attributable to that defendant's proportionate share of the fault or responsibility for that claimant's injury.

The provision would permit the award of punitive damages (to the extent allowed under State law) only if the claimant established by clear and convincing evidence either that the harm was the result of conduct that specifically intended to cause harm or the conduct manifested a conscious flagrant indifference to the rights or safety of others. The amount of punitive damages awarded could not exceed $250,000 or three times the amount of economic damages, whichever was greater. The determination on punitive damages would be made by the court and not be disclosed to the jury The provision would not create a cause of action for punitive damages. Further, it would not preempt or supersede any State or Federal law to the extent that such law would further limit punitive damage awards.

The provision would permit either party to request a separate proceeding (bifurcation) on the issue of whether punitive damages should be awarded and in what amount. If a separate proceeding was requested, evidence related only to the claim of punitive damages would be inadmissible in any proceeding to determine whether actual damages should be awarded.

The provision would prohibit the award of punitive damages in a case where the drug or device was subject to premarket approval by the Food and Drug Administration (FDA), unless there was misrepresentation or fraud.

The provision would permit the periodic (rather than lump sum) payment of future losses in excess of $50,000. The judgment of a court awarding periodic payments could not, in the absence of fraud, be reopened at any time to contest, amend, or modify the schedule or amount of payments. The provision would not preclude a lump sum settlement.

The provision would permit a defendant to introduce evidence of collateral source payments. Such payments are those which have been paid or are reasonably likely to be paid by health or accident insurance, disability coverage, workers compensation, or other third party sources. If such evidence was introduced, the claimant could introduce evidence of any amount paid or reasonably likely to be paid to secure the right to such collateral source payments. No provider of collateral source payments would be permitted to recover any amount against the claimant or against the claimant's recovery.

Sec. 15313. Alternative dispute resolution

Present law

No comparable provision.

Explanation of provision

The provision would further require that any alternative dispute resolution system used to resolve health care liability actions or claims must include provisions identical to those specified in the bill.

SUBTITLE E—TEACHING HOSPITALS; GRADUATE MEDICAL EDUCATION

PART 1. TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND

Sec. 15401. Establishment of fund; payments to teaching hospitals

Present law

Medicare recognizes the costs of graduate medical education in teaching hospitals and the higher costs of providing services in those institutions. Medicare reimburses the costs of graduate medical education under two mechanisms: direct graduate medical education (GME) payments and an indirect medical education (IME) adjustment. The IME is designed to reimburse hospitals for indirect costs due to a variety of factors, including the extra demands placed on the hospital staff as a result of the teaching activity,

greater severity of patient illness, or additional tests and procedures that may be ordered by residents. The direct costs of approved GME programs include the salaries of residents and faculty, and other education costs for residents, nurses, and allied health professionals trained in provider-operated programs and are paid on the basis of a formula that reflects each hospital's per resident costs.

Explanation of provision

The proposal would add a new title XXII to the Social Security Act (SSA) creating a trust fund in the Treasury known as the Teaching Hospital and Graduate Medical Education Trust Fund, which would make annual payment distributions to teaching hospitals. The Fund would consist of three accounts: the Indirect-Costs Medical Education Account, the Medicare Direct-Costs Medical Education Account, and the General Direct-Costs Medical Education Account.

Beginning in FY1997 and each subsequent year thereafter, the bill would appropriate amounts from the Treasury and allocations would be made from Medicare 's Part A and Part B trust funds, and would be transferred into the Trust Fund for allocation to accounts within the Trust Fund. Appropriations from the Treasury would be: $400 million in FY1997; $600 million in FY1998; $2.0 billion in FY1999; $3.0 billion in FY2000; $4.0 billion in FY2001; and $5.8 billion in FY2002. For FY2003 and each subsequent fiscal year, the appropriation amount would be the greater of the amount appropriated for the preceding fiscal year, or the product of the amount appropriated for the preceding fiscal year and an amount equal to 1 plus the percentage increase in the nominal gross domestic product for the one-year period ending upon July 1 of the preceding fiscal year. The appropriated amounts would be allocated to the accounts by the Secretary based on the total amount of payments made under Medicare for indirect medical education (IME) and direct graduate medical education (GME) payments for FY1994, and the percentage of the total amount of payments for IME and GME.

The proposal would require that teaching hospitals submit a payment document for FY1997 and any subsequent fiscal year to the Secretary to receive a payment from the Fund equal to the sum of amounts related to IME and direct GME. The payment document would contain such information as necessary for the Secretary to make payments, and the Secretary would be permitted to require that the information be submitted by the teaching hospitals in periodic reports. The proposal would also authorize the Secretary to make payments to authorized consortia of providers.

For a teaching hospital's indirect costs, the proposal would determine an amount for a fiscal year as the product of: (1) the amount in the Indirect-Costs Medical Education Account for the applicable date, and (2) the hospital-specific percentage determined for the hospital. Once determined, the hospital-specific percentage would remain in effect for all subsequent fiscal years. The hospital-specific percentage would be the mean average of the respective percentages for the applicable period, adjusted by the Secretary on a pro rata basis to ensure that the sum of the percentages for all

teaching hospitals would be equal to 100 percent. Generally, the applicable period would be fiscal years 1992–1994. The percentage determined for a teaching hospital for a fiscal year of the applicable period would be constituted by the ratio of: (1) the total amount of IME payments received by the hospital for the fiscal year involved, to (2) the sum of the respective amounts of IME payments for all teaching hospitals.

To determine the direct costs of graduate medical education for a teaching hospital for a fiscal year, the proposal would determine an amount equal to the sum of the amount determined under the General Direct-Cost Medical Education Account, and the amount determined under the Medicare Direct-Costs Medical Education Account. A teaching hospital's payment amount from the General Account would be equal to the product of: (1) the amount in the General Direct-Costs Medical Education Account, and (2) the hospital-specific percentage. A teaching hospital's hospital-specific percentage for each fiscal year of the applicable period (1992–1994), would be determined in the same manner as for IME payments, except using data on GME payments received by the hospitals.

Payment from the Medicare Direct-Costs Medical Education Account for a teaching hospital for a fiscal year would be the product of (1) the amount in the Medicare Direct-Costs Medical Education Account, and (2) the hospital-specific percentage determined for the teaching hospital. Unlike the other accounts, the hospital-specific percentage for Medicare Direct-Costs would be determined annually based on the Secretary's estimate of what the hospital would have received for the year if the Medicare rules for GME were applicable. The hospital-specific percentage would be the ratio of: (1) the estimate made by the Secretary of the GME payment amount for a teaching hospital in a fiscal year under Medicare's GME if the payments had not been discontinued; to (2) the sum of the respective estimates of GME payments for all teaching hospitals. This subsection would not apply to a teaching hospital if the hospital is in a State for which a demonstration project under section 1814(b)(3), relating to a State hospital rate-setting system, is in effect.

Special rules would be applied to teaching hospitals that consolidated or merged and to new teaching hospitals. In the case of two or more teaching hospitals consolidating or merging that had received IME and GME payments under Medicare, the applicable percentage would be the sum of the percentage that would have been determined if the consolidation or merger had not occurred. For new teaching hospitals that had not received IME and GME payments under Medicare, the Secretary would be required to estimate the appropriate hospital-specific percentage based on the amount of IME and GME payments the teaching hospital would have received under Medicare. Special rules would also be applied to teaching hospitals that first received IME or GME payments under Medicare in FY1995 and FY1996, with the hospital-specific percentages being estimated by the Secretary based on the most recent data available.

The proposal would make payments to qualifying consortium for the costs of graduate medical education. Qualifying consortium would consist of a medical residency training program of a teaching

hospital and one or more of the following entities: schools of medicine or osteopathic medicine; other teaching hospitals; community health centers; medical group practices; managed care entities; entities furnishing outpatient services; and other such entities the Secretary determines to be appropriate. Payments from the accounts in the Trust Fund for consortium would equal the sum of: (1) the aggregate amount determined for the teaching hospitals of the consortium under the proposal; and (2) an amount determined using the methodology provided under the Medicare Direct-Costs Medical Education Account for consortia payments. Aggregate total payments to qualifying consortia could not exceed the sum of the aggregate total amount that would have been paid to the teaching hospitals of the consortia, and an amount equal to 1 percent of the amount in the Medicare Direct-Costs Medical Education Account.

The Secretary would be required to collect data to determine whether the estimates of Medicare's payments for the costs of IME and GME in each fiscal year were substantially accurate, and make corrective adjustments in subsequent transfers to the Trust Fund and payments to teaching hospitals.

Reason for change

Teaching hospitals have to meet multiple missions including patient service (tertiary and specialty services and services for the low income persons who may be more expensive to treat due to special needs), medical training, and research. Changes occurring in health care delivery and financing both in Medicare and the private sector have raised serious questions concerning the ability of many major teaching hospitals to survive financially while meeting these multiple missions. In the communities where teaching hospitals are located and in the health care market more broadly, the survival of these institutions is in question because the institutions face competition from other hospitals or providers and health care systems that do not share the same multiple missions of teaching hospitals. There is a significant public interest in maintaining the many contributions that teaching hospitals make to the communities in which they are located and the nation as a whole. These institutions, however, have often not been operated efficiently in the past, and Medicare has in recent years carried a disproportionate share of the costs of these hospitals considering Medicare's share of overall patient service costs.

Effective date

The provision would be effective upon enactment.

PART 2. AMENDMENTS TO MEDICARE PROGRAM

Sec. 15411. Transfers to teaching hospital and graduate medical education fund

Present law

No provision.

Explanation of the provision

The proposal would amend Medicare law by adding a new subsection (j) at the end of section 1886 of the SSA, under which the

Secretary would, beginning in FY1997 transfer amounts to the Teaching Hospital and Graduate Medical Education Trust Fund. Amounts transferred to the Indirect-Costs Medical Education Account would be from the Medicare Part A trust fund on the basis of an estimate of the nationwide total of the amount that would have been paid to hospitals under Medicare's IME payment. The Secretary would also be required to transfer from Medicare Part A and B Trust Funds into the Medicare Direct-Costs Medical Education Account the amount estimated to be spent for teaching hospitals and consortium under Medicare's direct GME payment.

Reason for change

The formation of the new trust fund for teaching hospitals and graduate medical education requires the transfer of funds from Medicare trust funds.

Effective date

The provision would be effective upon enactment.

Sec. 15412. Modification in payment policies regarding graduate medical education

Present law

Medicare makes additional payments 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 indicated that the indirect medical education payments are also to account for factors not necessarily related to medical education which may increase costs in teaching hospitals, such as more severely ill patients, increased use of diagnostic testing, and higher staff-to-patient ratios.

The additional 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 0.1 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 direct costs of approved graduate medical education (GME) programs (such as the salaries of residents and faculty, and other education costs for residents, nurses, and allied health professionals trained in provider-operated programs) are excluded from PPS and are paid on the basis of a formula that reflects Medicare's share of each hospital's per resident costs. Medicare's payment to each hospital equals the hospital's costs per full-time-equivalent (FTE) resident, times the weighted 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 cost reporting period that began in FY1984, increased by 1 percent for hospital cost reporting periods beginning July 1, 1995, 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 costs reporting periods during FY1994 and FY1995, except for primary care residents in obstetrics and gynecology. The number of FTE residents is weighted at 100 percent for residents in their initial residency period (i.e., the number of years of formal training necessary to satisfy specialty 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, the weighing factor is 50 percent. On or after July 1, 1996, residents who are foreign medical graduates can only be counted as FTE residents if they have passed designated examinations.

Explanation of the provision

The proposal would reduce the IME payment amount under Medicare by changing the current formula multiplier to 1.48, resulting in a 6.0 percent aggregate payment adjustment for FY1996–FY1998. A further reduction in the multiplier would begin in FY1999 and for each subsequent fiscal year, for a 5.6 percent aggregate payment adjustment, for every 10 percent increase in teaching intensity measured by the ratio of interns and residents per bed, and the number of discharges expected under PPS.

The GME formula would be modified to limit the number of residents that could be counted by a teaching hospital. The total number of full-time-equivalent (FTE) residents in an approved residency program would be limited to the total number of residents at a hospital as of August 1, 1995, for cost reporting periods beginning on or after October 1, 1995, and on or before September 30, 2002. For hospital cost reporting periods beginning on or after October 1, 1997, the weighing factor for a resident in the initial residency period would be 1.0 FTEs, and the weighing factor for a resident who had completed the initial residency period would be 0.0 FTEs. For cost reporting periods beginning during FY1996, the FTE amount paid for medical residents who are not citizens or nationals of the United States (or citizens of Canada) would be reduced and ultimately eliminated by lowering the FTE weight that a hospital would be allowed to count for GME payments to: 0.75 in FY1996; 0.50 in FY1997; 0.25 in FY1998; and for cost reporting periods beginning during FY1999 or any subsequent fiscal year, zero.

Reason for change

The PROPAC in its March 1, 1995 report recommended "the indirect medical education adjustment should be reduced." PROPAC recommended immediate reductions in the Medicare IME adjustment, and said it should ultimately be reduced by 40% from current levels. However, PROPAC also recommended that "changes in the IME adjustment should be considered in the context of its interactions and its effects on PPS payments, as well as hospitals' overall financial status."

The number of graduates of U.S. medical schools filling residency positions in teaching hospitals has remained approximately constant, while the total number of residencies have grown in recent

years. Since 1988 most of this growth in filled residencies is attributable to foreign medical school graduates filling hospital residency positions in this country. Over 60 percent of the growth in the number of residents can be attributed to increases in the number of foreign medical graduates. As a result, between 1988 and 1993, the number of foreign medical school graduates grew from 14 percent of the total number of residents to 23 percent. The number of residency positions is now nearly 40 percent greater than the number of slots filled by graduates from American medical schools. Expert testimony has questioned the need for the current number of residency positions, and raised concerns about the recent and rapid growth in residency slots primarily filled by graduates of foreign medical schools. Expert testimony has also raised concerns regarding Medicare funding of residency positions in excess of first board certification or five years of training.

Effective date

The effective date for these provisions, unless otherwise specified would apply to hospital cost reporting periods beginning on or after October 1, 1995.

PART 3. REFORM OF FEDERAL POLICIES REGARDING TEACHING HOSPITALS AND GRADUATE MEDICAL EDUCATION

Sec. 15421. Establishment of advisory panel for recommending policies regarding teaching hospitals and graduate medical education

Present law

No provision.

Explanation of the provision

The bill would require the Chair of the Medicare Payment Review Commission to establish an advisory panel on reform in the financing of teaching hospitals and graduate medical education. The advisory panel would be required to study and make recommendations on reforming Federal policies regarding teaching hospitals and the financing of graduate medical education. The recommendations of the panel would include the following: (1) the financing of graduate medical education, including consideration of alternative broad-based sources of funding; (2) the financing of teaching hospitals, including consideration of the competitive difficulties such hospitals face; (3) the methodology for making payments and the selection of entities to receive the payments; (4) Federal policies regarding international medical graduates; (5) the dependence of schools of medicine on service generated income; (6) the effects of the amendments made by the Omnibus Budget Reconciliation Act of 1995; (7) the feasibility and desirability of reducing payments for graduate medical education for high-cost residency programs under Medicare; and (8) whether and to what extent the needs of the U.S. regarding the supply of physicians would change during the 10-year period beginning on October 1, 1995, and whether and to what extent any such changes would have significant financial effects on teaching hospitals.

The Committee emphasizes that the panel should particularly address the effects of this legislation on hospitals that serve significant numbers of low income patients.

The advisory panel would be composed of 19 members with expertise on matters related to graduate medical education. The advisory panel would be required to provide Congress with a first interim report (not later than one year after enactment), a second interim report (not later than 2 years after enactment), and final report (not later than 3 years after enactment). The advisory panel would terminate 180 days after the date on which the final report was submitted to Congress. The bill would authorize appropriations of such sums as may be necessary for each of the fiscal years 1996 through 2000.

Reason for change

The Committee recognizes that the measures undertaken to reform the methods used to reimburse teaching hospitals and graduate medical education are only initial steps. The Advisory Panel is necessary to assess the effect of this legislation and to develop recommendations for longer term solutions to financing of the missions of teaching hospitals and graduate medical education.

Effective date

The provision would be effective upon enactment.

SUBTITLE F—PROVISIONS RELATING TO MEDICARE PART A

PART 1. HOSPITALS

Sec. 15501. Reductions in inflation updates for PPS hospitals

Present law

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 cost of the case, based on the 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.

Explanation of provision

The proposal sets the update factor for FY1996 the market basket index (MBI) minus 2.5 percentage points for all hospitals in all

areas, for FY1997–FY2002 at MBI minus 2.0 percentage points for all hospitals in all areas, and for FY2003 and each subsequent fiscal year equal to the MBI for all hospitals in all areas.

Reason for change

In the past two years, competition in the private sector, together with continuing payment constraints by the Medicare and Medicaid programs, have led to a large decline in hospital cost growth. In the past year, hospital costs per adjusted admission have increased almost 2 percentage points less than inflation. Because of previous actions by the Congress, the increase in payments under the Medicare prospective payment system in the last four years has been greater than the increase in hospital costs. Consequently, hospitals on average now have a positive margin on Medicare patients. Given these trends in cost growth, the updates stipulated in this provision should allow hospitals to continue earning positive margins, on average, for Medicare patients through 2002.

Effective date

The provision would be effective upon enactment.

Sec. 15502. Reductions in disproportionate share payment adjustments

Present law

Under PPS, an adjustment is made to the payment to hospitals that serve a disproportionate share 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 Supplemental Security Income 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 DSH 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; or

(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 fur-

nished 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.)

For a hospital qualifying on the basis of (1)(a) above, if its disproportionate patient percentage is greater than 20.2 percent, the applicable PPS payment adjustment factor is 5.88 percent plus .825 percent of the difference between 20.2 percent and the hospital's disproportionate patient percentage. If the hospital's disproportionate patient percentage is less than 20.2 percent, the applicable payment adjustment factor is equal to: 2.5 percent plus 65 percent of the difference between 15 percent and the hospital's disproportionate patient percentage. If the hospital qualifies as a DSH on the basis of (1)(b), the payment adjustment factor is determined as follows:

(a) if the hospital is classified as a rural referral center, the payment adjustment factor is 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent;

(b) if the hospital is a SCH, the adjustment factor is 10 percent;

(c) if the hospital is classified as both a rural referral center and a SCH, the adjustment factor is the greater of 10 percent or 4 percent plus 60 percent of the difference between the hospital's disproportionate patient percentage and 30 percent; and

(d) if the hospital is not classified as either a SCH or a rural referral center, the payment adjustment factor is 4 percent.

If the hospital qualifies on the basis of (1)(c), the adjustment factor is equal to 5 percent. If the hospital qualifies on the basis of (1)(d), the adjustment factor is 4 percent. If the hospital qualifies on the basis of (2) above, the payment adjustment factor is 35 percent.

Explanation of provision

The proposal would reduce the DSH payment by 20 percent for discharges occurring on or after October 1, 1995, and on or before September 30, 1996; 25 percent for discharges occurring on or after October 1, 1996, and on or before September 30, 1997; and 30 percent for discharges occurring on or after October 1, 1997.

Reason for change

Current levels of disproportionate share payment adjustments are based on a significant increase in these payments made in 1989 and 1990 legislation. The payment reductions included here bring payments to the same percentage of total prospective payment system payments that were in place in the early 1990s. It is expected that hospitals receiving disproportionate share payments will, on average, continue to receive prospective payment system margins that are well above overall hospital averages for those institutions that do not receive the adjustment, even with reduced payment levels.

Effective date

The provision would be effective upon enactment.

Sec. 15503. Payments for capital-related costs for inpatient hospital services

Present law

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.

Medicare's capital-related costs include local property taxes and property "fees" paid by nonprofit hospitals. The hospital-specific component of capital payments is based on a hospital's spending in a base year (generally 1990). Hospitals that have changed from nonprofit or public to proprietary may become subject to property taxes not included in their base. This may also occur as a result of changes in State or local law.

Explanation of provision

The proposal would reduce aggregate payments for PPS and PPS-exempt capital payments by 15 percent of the allowable amount for FY1996 through FY2002. The capital payment reduction would not apply to payments for sole community hospitals or rural primary care hospitals (defined in the bill).

The proposal would provide an adjustment for the amount of capital-related tax costs for eligible hospitals for discharges occurring after September 30, 1995. Eligible hospitals would be facilities that may otherwise receive capital payments, are not public hospitals, and incur capital-related tax costs for the fiscal year.

The proposal would also amend the exceptions process under PPS for certain capital projects as follows: (1) urban hospitals with 100 beds would be eligible without regard to its DSH patient percentage or whether it qualifies for capital additional payments amounts; (2) the minimum payment level for qualifying hospitals would be 85 percent; (3) hospitals would be considered to meet the requirement that it completed a project involved no later than the end of the hospital's last cost reporting period beginning after October 1, 2001, if (i) the hospital obtained a certificate of need for the

project approved by the State or a local planning authority, and (ii) by September 1, 1995, the hospital had expended on the project at least $750,000 or 10 percent of the estimated cost of the project; and (4) the amount of the exception payment made would not be reduced by any offsetting amounts.

Reason for change

Payments for capital costs were over estimated in setting the capital payment rates in 1992. 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. The 90 percent provision ends in 1996, so despite the overestimates, current law would go back to 100 percent payment of what would have been paid under cost-based reimbursement.

Effective date

The provision would be effective upon enactment.

Sec. 15504. Reduction in adjustment for indirect medical education

See Subtitle E above.

Sec. 15505. Treatment of PPS-exempt hospitals

Present law

Under Medicare, 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. They are subject to the payment limitations and incentives established in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). Each provider is paid on the basis of reasonable cost subject to a rate of increase ceiling on inpatient operating costs. The ceiling is based on a target amount per discharge. The target amount for a cost reporting period is equal to the hospital's allowable inpatient operating costs (excluding capital and medical education costs) per discharge in a base year increased by applicable update factors for subsequent years. This amount is then multiplied by Medicare discharges, to yield the ceiling or upper limit on operating costs.

OBRA 93 provided that the applicable rate of increase percentage, or update, would be equal to the MBI minus 1.0 percent for FY1994–1997.

Explanation of the provision

The proposal would extend the target amount updates through FY2002.

The proposal would also provide for rebasing the target amount for certain long-term care hospitals for discharges occurring on or after October 1, 1995.

The proposal would also apply to long-term care units of hospitals not treated as PPS hospitals for discharges occurring on or after September 30, 1995. The provision is intended to prevent the Secretary from applying the amendments to 42 CFR Section 412.23(c)(3) adopted by the Secretary on September 1, 1995 to a

hospital which was classified as a long term care hospital for the cost reporting period ending on or before September 30, 1995. Nothing contained in this provision shall affect the applicability of 42 U.S.C. Section 1886(d)(1)(B)(iv) which requires that long term care hospitals must maintain an average length of stay of greater than twenty-five days, to a hospital which was classified as a long term care hospital for cost reporting period ending on or before September 30, 1995. To determine how to best treat such distinct units of hospitals for purposes of Medicare's prospective payment system, the Committee asked the Medicare Payment Review Commission to make recommendations for any necessary revisions to current payment methods.

The proposal would also require that the Secretary submit to Congress, by not later than June 1, 1996, a report on the advisability and feasibility of providing for payment based on a prospective payment system for inpatient services of rehabilitation hospitals and units under Medicare.

Reason for change

Under current law, concerns have been raised about the adequacy of Medicare payments for these hospitals, so the Committee required the Secretary and Medicare Payment Review Commission to review these methods and make recommendations.

Effective date

The provision would be effective upon enactment.

Sec. 15506. Reduction in payments to hospitals for Enrollees' bad debts

Present law

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 judgement established that there was no likelihood of recovery at any time in the future.

Explanation of provision

The proposal would reduce bad debt payments to providers by 75 percent for cost reporting periods beginning during FY1996; 60 percent for cost reporting periods beginning during FY1997; and 50 percent for subsequent cost reporting periods. The reductions in bad debt payments would not apply if the debt is attributable to uncollectible deductible and coinsurance payments owed by individuals enrolled in a State plan under Medicaid or under the new MediGrant program. To avoid any unintended consequences from this provision, the Committee intends that the Medicare Payment Review Commission will conduct a study of payments under the Medicare program for hospital bad debt. The study will analyze historic trends in such payments and identify hospitals that incur bad debt at significantly higher levels than other similar hospitals.

Not later than one year after the date of the enactment of this Act, the Commission will submit to Congress a report that includes recommendations for methods to reduce payment under the Medicare program for hospital bad debt and to improve debt collection by hospitals. The manner in which reductions in reimbursement are implemented, beyond those specified in this Act for fiscal year 1996, will be based on recommendations of the Commission.

Reason for change

The payment of hospitals' Medicare-related bad debt is a legacy of hospital cost-based reimbursement. Under the current prospective payment system, bad debts should be considered a cost of doing business.

Effective date

The provision would be effective upon enactment.

Sec. 15507. Permanent extension of hemophilia pass-through

Present law

Medicare makes additional payments for the costs of administering blood clotting factor to Medicare beneficiaries with hemophilia admitted for hospital stays where the clotting factor was furnished between June 19,1990 and September 30,1994.

Explanation of provision

The proposal would make the payment permanent.

Reason for change

Due to increases in the cost of clotting factor resulting from the increase in AIDs, in 1989, the Congress changed the way Medicare paid for inpatient costs of clotting factor by providing an add-on to the PPS payment rates. This change was initially limited to 18 months and then subsequently extended through fiscal year 1994. Information collected throughout this period justifies the separate payment for clotting factor.

Effective date

The provision would be effective upon enactment.

Sec. 15508. Conforming amendment to certification of Christian Science providers

Present law

Certain services furnished in a Christian Science sanatorium are covered under Medicare Part A if the institution is operated or listed and certified by the First Church of Christ, Scientists, Boston, Mass. Such a sanatorium qualifies as both a hospital and as a skilled nursing facility.

Explanation of provision

The proposal would expand coverage of Christian Science sanatorium to include facilities (both hospitals and skilled nursing facilities) certified by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.

Reason for change

Currently, the First Church of Christ, Scientists cannot use its new non-profit organization to certify its sanatoriums for Medicare coverage.

Effective date

The provision would be effective upon enactment.

Sec. 15511. Sole Community Hospitals

Present law

Sole Community Hospitals (SCHs) are facilities located in geographically isolated areas and are the sole provider of inpatient, acute cure 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. OBRA 93 provided separate SCH updates of MBI minus 2.2 percent for FY1995 and MBI minus 2.0 percent for FY1996. For FY1997 and thereafter, the update for SCHs is the same as for all PPS hospitals.

Explanation of provision

The proposal would provide a target amount update of MBI minus 1 percentage point for fiscal years 1996–2000; and for FY2001 and each subsequent fiscal year, the applicable update would be applied.

The bill would require the Medicare Payment Review Commission to conduct a study of the impact of the designation of hospitals as SCHs on the delivery of health care services to individuals in rural areas, and include an analysis of the characteristics of the hospitals so designated. The Commission would be required to submit the report to Congress within 12 months after a majority of Commission members are first appointed.

Reason for change

Medicare's hospital payment policy has historically recognized payment problems related to the unique role of sole community hospitals and the Committee requested the Medicare Payment Review Commission to study the impact of the designation of hospitals as sole community providers on the delivery of health care to rural communities.

Effective date

The provision would be effective upon enactment.

Sec. 15512. Clarification of Treatment of Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH)

Present law

Under the EACH demonstration program up to 7 States may be designated by the Secretary to receive grants to develop rural

health networks consisting of essential access community hospitals (EACHs) and rural primary care hospitals (RPCHs). Individual hospitals may be designated as EACHs and RPCHs. In order to receive designation by a State as an RPCH, a facility must meet certain criteria, including a requirement that inpatient stays not exceed 72 hours.

Explanation of provision

The bill would allow EACHs to continue to receive payments under Medicare equal to their reasonable costs, and RPCHs to continue to receive Medicare payments for their services, even in fiscal years in which the program did not receive appropriations.

Reason for change

The funding for the EACH/RPCH demonstrations was included as part of the recision package. Recognizing the merits of the EACH and RPCH programs in providing services to their rural communities, the Committee provided authorization for continued Medicare reimbursement of the services they provide.

Effective date

The provision would be effective upon enactment.

Sec. 15513. Rural emergency access care hospitals (REACHs)

Present law

No provision.

Explanation of provision

The bill would provide for the establishment of a new category of hospitals under Medicare to provide for medical screening examinations and treatment for emergency medical conditions and active labor for rural facilities that are in danger of closing due to low inpatient utilization rates and operating losses and whose closing would reduce access to emergency services. Such facilities would have to meet specific requirements including those relating to appropriate medical staffing, referral arrangements, and diagnostic and laboratory services. Payment for outpatient services provided by rural emergency access care hospitals would be determined according to the same method used for rural primary care hospitals. Services provided to individuals in REACHs would be provided over a continuous period not to exceed 24 hours, except in cases where the individual is unable to leave because of inclement weather.

Reason for change

Rural communities in danger of losing their hospitals because they lack the population base to maintain sufficient use rates to operate profitably can also be in danger of losing their only source of accessible emergency health care. These hospitals can be downsized and still provide essential urgent and emergency services to local communities.

Effective date

The provision would be effective upon enactment.

Sec. 15514. Classification of rural referral centers

Present law

Referral centers are paid prospective payments based on the applicable urban payment amount rather than the rural payment amount, as adjusted by the hospital's area wage index. The applicable amount is the "other urban" rate (i.e., the rate for urban areas with 1 million or fewer people) for all referral centers except those (if any) located in MSAs greater than 1 million. These centers are defined as:

(1) rural hospitals having 275 or more beds;

(2) hospitals having at least 50 percent of their Medicare patients referred from other hospitals or from physicians not on the hospital's staff, at least 60 percent of their Medicare patients residing more than 25 miles from the hospital, and at least 60 percent of the services furnished to Medicare beneficiaries are furnished to those who live 25 miles or more from the hospital; or

(3) rural hospitals meeting the following criteria for hospital cost reporting periods beginning on or after October 1, 1985: (a) a case mix index equal to or greater than the median case mix for all urban hospital (the national standard), or the median case mix for urban hospitals located in the same census region, excluding hospitals with approved teaching programs; (b) a minimum of 5,000 discharges, the national discharge criterion (3,000 in the case of osteopathic hospitals), or the median number of discharges in urban hospitals for the region in which the hospital is located; and (c) at least one of the following three criteria: more than 50 percent of the hospital's medical staff are specialists, at least 60 percent of discharges are for inpatients who reside more than 25 miles from the hospital, or at least 40 percent of inpatients treated at the hospital have been referred either from physicians not on the hospital's staff or from other hospitals.

OBRA 93 extended the classification through FY1994 for those referral centers classified as of September 30, 1992.

Explanation of provision

The bill would prohibit the Medicare Geographic Classification Review Board from denying a referral center's request for reclassification on the basis of any comparison between the average hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located. Hospitals would be allowed to submit applications to the Board during the 30-day period beginning on the date of enactment requesting a change in classification for purposes of determining the area wage index applicable to the hospital for FY1997, if the hospital would be eligible for such change except for its failure to meet the deadline for applications.

The bill would, beginning in FY1996, extend the referral center classification for any hospital classified as a referral center for

FY1994, and such hospitals would continue to be classified as a referral center for each subsequent fiscal year.

Reason for change

Rural referral centers have difficulty meeting the hospital wage ratio that the Medicare Geographic Classification Review Board requires to qualify for reclassifying their wage adjustments. Moreover, because of changes in Medicare administrative policies, some rural referral centers have lost their opportunity to apply for reclassification. Lastly, some rural referral centers lost their designation because they no longer satisfied the original referral center criteria, though the new criteria has never been validated as requested by the Congress.

Effective date

The provision would be effective upon enactment.

Sec. 15515. Floor on area wage index

Present law

As part of the methodology for determining prospective payments to hospitals under PPS, the Secretary is required to adjust a portion of the standardized amounts for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

Explanation of provision

For discharges occurring on or after October 1, 1995, the area wage index applicable for any hospital which was not located in a rural area could not be less than the average of the area wage indices applicable to hospitals located in rural areas in the State in which the hospital was located. The Secretary would be required to make any adjustments in the wage index in a budget neutral manner.

Reason for change

An anomaly that exists with the way area wage indexes are applied has resulted in some urban hospitals being paid less than the average rural hospital in their states.

Effective date

The provision would be effective upon enactment.

PART 2. PAYMENTS TO SKILLED NURSING FACILITIES (SNFS)

Sec. 15521. Payments for routine service costs

Present law

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). Non-routine, or 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 for routine service costs 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 nonlabor-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 an SNF market basket developed by the 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 cannot 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.

Explanation of provision

For cost reporting periods beginning in FY 1997, the Secretary would be required to redefine routine service costs that would be subject to the routine cost limits. These would include all items used in the current definition—nursing, room and board, administrative, and other overhead—and, in addition, all ancillary services (including supplies and equipment), with the exception of non-routine services listed below.

Reason for change

Frequently used items such as surgical dressings and incontinence supplies are not included in the room rates, as they are with hospitals, and these items have sometimes been overbilled or oversupplied.

Effective date

The provision would be effective beginning in FY 1997.

Sec. 15522. Incentives for cost effective management of covered non-routine services

Present law

Currently non-routine ancillary services are generally paid on the basis of reasonable costs and are not subject to limits.

Explanation of provision

For cost reporting periods beginning in FY 1997, new payment limits would be established for non-routine services provided to beneficiaries eligible for and receiving SNF care under Part A. For these purposes, non-routine services would be defined to include therapy services (physical and occupational therapy, speech language pathology, and respiratory therapy); prescription drugs; complex medical equipment; intravenous therapy and solutions (including enteral and parenteral nutrients, supplies, and equipment); radiation therapy; and diagnostic services, including laboratory, pulmonary, and radiology services (including tomography and imaging services).

The non-routine limit for a stay would be the sum of the following two amounts: 50 percent would be the facility-specific amount for these services; and 50 percent would represent the national average amount paid for these services for all SNF stays. The facility-specific amount would be calculated by summing (1) the average amount of payments made to a facility under Part A for non-routine services during a stay and (2) the Secretary's best estimate of the average amount of payments made under Part B for non-routine services furnished to all residents provided SNF care under Part A.

In establishing base year payments for the new limits, the Secretary would be required to use cost reporting periods ending September 30, 1994. These base year payments would be updated to FY 1997 by the SNF market basket. In subsequent years, per stay limits would be updated by the SNF market basket minus 2 percentage points. National average payments used for determining a facility's per stay limit would be calculated separately for free-standing and hospital-based SNFs.

Separate per stay limits would apply to residents of SNFs who require intensive nursing or therapy services. The Secretary, after consulting with the Medicare Payment Review Commission and SNF experts, would be required to develop and publish this separate limit by June 30, 1996, and would be required to ensure its budget neutrality. In developing the high acuity per stay limit required in this legislation, the Secretary shall consider the use of performance measures, such as length of stay and discharge rates, to assure the delivery of medically necessary high intensity services to patients.

The Secretary would also be required to rebase facility-specific amounts for cost reporting periods beginning October 1, 1999, and every 2 years thereafter. An SNF stay would be defined by the number of continuous days a beneficiary spent in the facility during a covered spell of illness.

An aggregate payment limit for non-routine services would also be determined annually for each SNF. This would be calculated by

multiplying the number of SNF stays for which payments for these services were made times the blended payment limit. This amount would be compared to actual interim payments made to the SNF for these services; these payments would be based on the facility's reasonable costs of providing these services. If total payments for the year were below the SNF's payment limit, then the SNF would be allowed to retain 50 percent of the difference, up to 5 percent of the total amount paid to the facility for covered non-routine services. In the event that total payments exceeded the SNF's payment limit, the Secretary would be required to reduce payments for new stays in the next fiscal year at such times and in a manner the Secretary considers appropriate.

SNFs would be required to bill Medicare for all services provided to beneficiaries eligible for SNF care, regardless of whether the service was provided by the facility, by others under arrangements with the facility, or under any other contracting or consulting arrangement. For beneficiaries residing in SNFs but not eligible for Part A SNF benefits, the SNF would again be required to bill for covered Part B services. SNFs would be required to maintain records of all covered non-routine services furnished beneficiaries.

Currently, obtaining information from Medicare or a nursing home on the services provided to a nursing home resident and the costs of that resident's care can be a difficult, sometimes nearly impossible task. There is no way for a beneficiary, a beneficiary's legal representative, or the executor of a beneficiary's estate to routinely access such information. The Committee expects that by collecting consolidated data on services provided to nursing home residents, Medicare can improve the information it provides to beneficiaries, or their representatives, on the services provided and prices paid during a nursing home stay. It is expected that the Health Care Financing Administration will develop a system that will routinely provide such information as part of the explanation of Medicare benefits (EOMBs) or on the request of persons with a right to such information. Moreover, the routine use of such information by Medicare contractors should help the contractors prevent billing abuses—such as billing excessively for rehabilitation therapy services—that have been a recurring problem in nursing homes.

The Secretary could provide for exceptions to the per stay limits, so long as additional payments were budget neutral and did not exceed 5 percent of aggregate payments to all SNFs for covered non-routine services. New SNFs not receiving payments for non-routine services in the base year period of FY 1994 would be subject to the national mean payment limit described above. Low-volume SNFs receiving prospective payments would not be subject to the new non-routine limits. Before furnishing a covered x-ray service to a SNF beneficiary, SNFs would be required to consider the appropriateness of portable x-ray services, taking into account the cost effectiveness of the service and the convenience to the resident.

Reason for change

Nursing home expenditures have increased over 35 percent per year in recent years and non-routine services—which historically have not been subject to cost limits—have been the major source

of this growth. Moreover, skilled nursing homes have not always monitored the services their patients are being provided. Because skilled nursing home services can be reimbursed through either Medicare part A or part B (depending on circumstances) and the skilled nursing home or separate providers or suppliers can bill Medicare for reimbursement, not even Medicare is in a position to understand the services individual nursing home residents are receiving. To encourage nursing homes to better monitor their residents' services and also to provide Medicare better data on nursing home residents' costs to assist the agency in setting future nursing home payment rates, the Committee has required skilled nursing homes to consolidate and submit bills for all services provided to their residents.

Effective date

The provision would be effective upon enactment.

Sec. 15523. Payments for routine service costs

Present law

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.

Explanation of provision

Beginning in FY 1996, the proposal would permanently extend the savings stream, but not the OBRA 93 freeze on SNF cost limits, by not allowing for the inflation that occurred during the freeze years. The Secretary would accomplish this by collecting new historical cost data that would be used for rebasing SNF limits, and for the period of the freeze, not applying the SNF market basket that is used for inflating the cost limits. Low-volume SNFs receiving prospective payments would be subject to the permanent extension of the savings stream of the freeze.

Reimbursements for exceptions to routine cost limits in FY 1997 would be limited to aggregate payments made in FY 1996, adjusted for increases in the SNF market basket. In future fiscal years, increases in aggregate payments for exceptions to the limits would be limited by percentage increases in the SNF market basket. The Secretary would be required to provide exceptions only to those facilities that make annual applications for adjustments.

Reason for change

The provision would otherwise expire.

Effective date

The provision would be effective upon enactment.

Sec. 15524. Reductions in payment for capital-related costs

Present law

Capital-related costs of SNFs are excluded from cost limits.

Explanation of provision

SNF capital costs would be reduced by 15 percent.

Reason for change

The treatment of SNFs is currently not consistent with hospitals.

Effective date

The provision would be effective upon enactment.

Sec. 15525. Treatment of items and services paid for under part B

Present law

Certain covered Part B services provided in SNFs are paid the lesser of reasonable costs or charges.

Explanation of provision

For services billed at the lesser of costs or charges, reasonable costs would be reduced by 5.8 percent from amounts currently recognized as reasonable for cost reporting periods occurring during fiscal years 1996 through 2002.

Reason for change

The treatment of SNFs is not consistent with the treatment of outpatient hospital services.

Effective date

The provision would be effective upon enactment.

Sec. 15526. Certification of facilities meeting revised nursing home reform standards

Present law

OBRA 87 comprehensively revised Medicare and Medicaid requirements for nursing homes participating in the programs. These provisions, collectively referred to as nursing home reform law, are virtually identical in Medicare and Medicaid statutes. They have three major parts: (1) requirements that nursing homes must meet in order to be certified to participate in Medicare and/or Medicaid, including requirements about assessments of residents, available services, nurse staffing, nurse aide training, and resident rights; (2) provisions revising the survey and certification process that State survey agencies must use for determining whether nursing homes comply with the requirements for participation; and (3) provisions that expand the range of sanctions and penalties that States and

the Secretary of HHS may impose against nursing homes found to be out of compliance with the requirements for participation.

The Committee on Commerce has reported legislation transforming the Medicaid program into a new MediGrant program authorized under Title XXI of the SSA program. The new program would replace the OBRA 87 nursing home reform provisions with more general requirements for assuring quality care in nursing homes.

Explanation of provision

The proposal would require that SNFs participating in Medicare either be State-certified or meet new federal requirements that would replace OBRA 87 reforms. State-certified facilities would include facilities licensed or certified as a SNF by the State in which it is located, or a facility which otherwise meets the requirements for nursing facilities specified under the Medicaid or new MediGrant authorities.

The Secretary would be required to establish and maintain standards in the following areas for SNFs providing Medicare covered services: the treatment of resident medical records; policies, procedures, and bylaws for operation; quality assurance systems; resident assessment procedures, including care planning and outcome evaluation; the assurance of a safe and adequate physical plant for the facility; qualifications for staff sufficient to provide adequate care; and utilization review.

Standards for SNFs would also be required to provide for the protection and enforcement of resident rights, including rights to exercise the individual's rights as a resident of the facility and as a citizen or resident of the U.S.; to receive notice of rights and services; to be protected against the misuse of resident funds; to be provided privacy and confidentiality; to voice grievances; to examine the results of State certification program inspections; to refuse to perform services for the facility; to be provided privacy in communications and to receive mail; to have the facility provide immediate access to any resident by any representative of the State's certification program, the resident's individual physician, the State long-term care ombudsman, and any person the resident has designated as a visitor; to retain and use personal property; to be free from abuse, including verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion; and to be provided with prior written notice of a pending transfer or discharge.

Standards established by the Secretary for SNFs could take effect only after public notice and an opportunity for comment.

The Secretary would also be required to provide for the establishment and operation of a program for the certification of SNFs that meet specified standards as well as the decertification of those facilities that fail to meet the standards. The Secretary would be required to ensure public access (as defined by the Secretary) to the certification program's evaluations of participating facilities, including compliance records and enforcement actions and other reports regarding ownership, compliance histories, and services provided by certified facilities. The Secretary would be required to audit expenditures under the program, not less often than every 4 years, through an entity designated by the Secretary and not affiliated with the program.

The Secretary would be required to impose certain sanctions against SNFs not meeting minimum federal requirements regardless of state certification. If the Secretary determines that a certified facility no longer substantially meets the requirements for participation and further determines that the facility's deficiencies immediately jeopardize the health and safety of residents, then the Secretary would be required, at a minimum, to terminate the facility's certification for participation. If the facility's deficiencies do not immediately jeopardize the health and safety of residents, the Secretary could, in lieu of termination, provide lesser sanctions, including denial of payment for persons admitted after a specified date.

The Secretary could not impose sanctions until a facility has had a reasonable opportunity to correct its deficiencies, following the initial determination that it no longer substantially meets the requirements for certification, and, has been given reasonable notice and opportunity for a hearing. The Secretary's decision to deny payment for new admissions would be effective only after notice to the public and the facility, as may be provided for by the Secretary. Denial of payment for new admissions would end when the Secretary finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance). Facilities would, however, be required to be in compliance by the end of the eleventh month following the month when the decision to deny payments becomes effective. If facilities did not substantially meet the requirements by that time, the Secretary would be required to terminate their certification for participation.

Reason for change

The MediGrant program will transfer to the states principal responsibility for establishing and enforcing nursing home standards.

Effective date

The provision would be effective upon enactment.

Sec. 15527. Medical review process

Present law

No Provision.

Explanation of provision

The Secretary would be required to implement a medical review process to examine the effects of the amendments of this part on the quality of care received by Medicare beneficiaries, placing a particular emphasis on the quality of non-routine covered services.

Reason for change

The changes adopted to the SNF reimbursement system can create perverse incentives to under provide non-routine services. For this reason, the Committee requires the Secretary to implement a medical review process to assure that beneficiaries continue to receive appropriate levels of service.

Effective date

The provision would be effective upon enactment.

Sec. 15528. Report by medicare payment review commission

Present law

The Prospective Payment Assessment Commission has been authorized to review and make recommendations on prospective payment for SNF care.

Explanation of provision

The Medicare Payment Review Commission would be required to report on Medicare's method for paying for SNF care and would be required to include in the report: (1) an analysis of the effect of the new payment limits for non-routine services on payments for and the quality of SNF services (2) an analysis of the advisability of determining the amount of payment for covered non-routine services on the basis of amounts paid for such services under Part B of the program; (3) an analysis of the desirability of maintaining separate limits for hospital-based and freestanding SNFs; (4) an analysis of the quality of services furnished by SNFs; and (5) an analysis of the adequacy of the process and standards used for exceptions to routine cost limits.

Reason for change

The reforms in the SNF payment method under this legislation represent a first step toward broader based reform, so further analysis is essential to assure the Committee's objectives are met.

Effective date

The provision would be effective upon enactment.

Sec. 15529. Effective date

Explanation of provision

The provisions would be effective for services furnished during cost reporting periods beginning on or after October 1, 1996.

SUBTITLE G—PROVISIONS RELATING TO MEDICARE PART B

PART 1. PAYMENT REFORMS

Sec. 15601. Payments for physicians services

Present law

Payments for physicians' services are made on the basis of a fee schedule. The fee schedule assigns relative values to services based on the time, skill, and intensity it takes physicians to provide them. The relative values are adjusted for geographic variations in the costs of practicing medicine. The adjusted relative values are converted into a dollar payment amount by a conversion factor. There are three conversion factors: one for surgical services, one for primary care services, and one for all other services. The 1995 conversion factors are $39.45 for surgical services, $36.38 for primary care services, and $34.62 for other services.

Conversion factors are updated each year by a *default formula*. The update equals inflation as measured by the Medicare Economic Index (MEI), plus or minus the difference between actual physician spending for the category of services in a base period compared to the *Medicare Volume Performance Standard (MVPS)* for that category for the period. (If spending was below the MVPS, the update is larger than the MEI; if spending exceeded the MVPS, the update is less than the MEI).

The MVPS is a goal for the rate of expenditure growth from one fiscal year to the next. The calculation of the MVPS for a year is based on estimates of several factors (changes in fees, enrollment, volume and intensity, and laws and regulations). The MVPS derived from the calculation is subject to a reduction which is known as the *performance standard factor*. The performance standard factor is four percentage points for FY 1995 and subsequent years.

Explanation of provision

The provision would replace the MVPS with a sustainable growth rate beginning for FY 1996. The provision would establish the sustainable growth rate for FY 1996 based on: (i) changes in the MEI, (ii) changes in Medicare enrollment (excluding Medicare Plus and HMO enrollees), (iii) growth in the real gross domestic product from FY 95 to FY 96 plus 2 percentage points; and (iv) changes resulting from changes in law (determined without taking into account changes in volume or intensity or changes resulting from changes in the calculation of the conversion factor update). For each subsequent fiscal year beginning in 1997, the sustainable growth rate would equal the previous year's rate, updated by the same factors used to set the FY 96 rate.

The provision would provide for the establishment of a single conversion factor, rather than three conversion factors, effective January 1, 1996. It would set the factor for 1996 at $34.60 and modify the calculation of the update beginning in 1997. The provision would specify that the update for a year would equal the MEI, subject to an adjustment to match the cumulative sustainable growth rate. Specifically, the update for a year would equal the MEI, plus or minus the difference between the percentage increase in actual physician spending for the 12-month period ending the previous June compared to the allowable growth rate for the year. The allowable growth rate would be based on the cumulative sustainable growth rate from the base year 1995. If spending was below the cumulative sustainable growth rate, the update would be larger than the MEI; if spending exceeded the cumulative sustainable growth rate, the update would be less than the MEI. However, the adjustment to the update would be limited to no more than three percentage points larger than the MEI, and no more than seven percentage points lower than the MEI.

The provision would require the Secretary to submit to Congress by November 1 of each year, beginning in 1996, a report describing the update in the conversion factor for the following year. The Medicare Review Commission would review the report and submit to Congress by December 1 a report containing an analysis of the conversion factor.

Reason for change

The PPRC has raised serious concerns with the current system for updating physicians' fees. It has continually warned that flaws in the default formulas prevent the MVPS process from working as intended and in the 1995 Annual Report to Congress, the PPRC also provided an overview of the potential negative consequences of not changing the MVPS system.

Since 1990, the PPRC has recommended that the performance standard formula be linked to projected growth of real gross domestic product (GDP) per capita instead of a five-year historical trend less an arbitrary deduction. Projected GDP growth is suggested because it represents the economy's capacity to grow. This recommendation provides a more realistic and affordable goal that links the budget targets to the economy as a whole. The PPRC has also recommended that estimates of GDP growth be increased by an additional 2 percentage points to allow for higher rates of growth due to advancements in medical technologies.

In addition, the PPRC has strongly recommended moving to a single performance standard and update. Currently, separate updates and performance standards are set for each of the three categories of physicians' services: primary care, surgical, and other nonsurgical services. Because different updates are determined for each of the separate categories, relative value units in different categories are not paid the same amount. As a result, relative value units have become seriously distorted. This distortion violates the basic principle underlying the resource-based relative value scale (RBRVS), namely that each relative value unit should be worth the same amount regardless of the patient or service to which it is attached. Continuing to set three updates under the current default formulas for 1996 would exacerbate the distortion of relative payments and penalize primary care services.

In addition to the PPRC recommendations, the Committee received testimony from many physician groups supporting reform of the process for updating physicians fees. Each of these groups support the move to a single conversion factor and a more predictable rate of growth in payment for physicians' services. Adoption of these policies will eliminate the distortions that have resulted from the use of three separate performance standards and place a greater emphasis on the use of primary care verses surgical services.

The reforms will provide for more sustainable and reasonable growth which is not tied to past performance, but rather to more predictable changes in the economy and the advancement in medical technologies. The reforms will also remove the current distortions to the fee schedule by setting a single limit and update for all services applied to a single conversion factor.

Effective date

The provision would establish a single conversion factor effective January 1, 1996 and modify the calculation of the update beginning in 1997.

Sec. 15602. Elimination of formula-driven overpayment for certain outpatient hospital services

Present law

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 or 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 percent 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 amount a beneficiary pays in coinsurance does not equal 20 percent of the program's payment and does not result in a dollar-for-dollar decrease in Medicare program payments.

Explanation of provision

The provision would require that beneficiary coinsurance amounts be deducted later in the reimbursement calculation for hospital outpatient services, so that Medicare payments for covered services would be lower. Medicare's payment for hospital outpatient services would equal the blended amount less any amount the hospital may charge the beneficiary as coinsurance for services furnished during portions of cost reporting periods occurring on or after October 1, 1995.

Reason for change

Because of the anomaly in the formula for determining Medicare payments for services provided in hospital outpatient departments, the program does not recognize the reduction in payment associated with the actual amount of a beneficiary's copayment.

Effective date

The amendments made by this section shall apply to services furnished during portions of cost reporting periods occurring on or after October 1, 1995.

Sec. 15603. Reduction in updates to payment amounts for durable medical equipment (DME)

Present law

DME is reimbursed on the basis of a fee schedule. Items are classified into five groups for purposes of determining the fee schedules and making payments: (1) inexpensive or other routinely purchased equipment (defined as items costing less than $150 or which is purchased at least 75 percent of the time); (2) items requiring frequent and substantial servicing; (3) customized items; (4) oxygen and oxy-

gen equipment; and (5) other items referred to as capped rental items. In general, the fee schedules establish national payment limits for DME. The national limits have floors and ceilings. The floor is equal to 85 percent of the weighted median of local payment amounts and the ceiling is equal to 100 percent of the weighted median of local payment amounts. Fee schedule amounts are updated annually by the consumer price index for all urban consumers, CPI–U. OBRA 93 changed the basis for the floors and ceiling for the DME fee schedules from the weighted average to the weighted median, effective January 1, 1994.

Prosthetics and orthotics are reimbursed on the basis of a fee schedule. Items covered by this 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. The regional limits have floors and ceilings. The floor is equal to 90 percent of the weighted average of local payment amounts and the ceiling is equal to 120 percent of the weighted average of local payment amounts. Fee schedule amounts are updated annually by CPI–U. OBRA 93 eliminated updates for prosthetics and orthotics for 1994 and 1995.

Explanation of provision

The provision would eliminate updates to the DME fee schedules for the period 1996 through 2002. The provision would also reduce in 1996 the national payment limit for oxygen and oxygen equipment by 20 percent.

The update for prosthetics and orthotics would be limited to 1 percent for each of years 1996 through 2002.

The Committee directs the Secretary to conduct a study on the extent to which telemarketing or other types of unsolicited approaches are used for the sale of durable medical equipment and supplies. The Secretary is to determine whether these types of marketing activities lead to increased instances of fraud and abuse.

Reason for change

In August 1995, the GAO released a report finding that despite improvements in the payment for DME, unwarranted expenditures persist.

Effective date

The amendments are effective upon enactment.

Sec. 15604. Reduction in updates to payment amounts for clinical laboratory services

Present law

Medicare pays for clinical laboratory services on the basis of area wide fee schedules which are periodically updated. There is no update for 1994 and 1995. In addition, the law establishes a ceiling on payment amounts. In 1995, this ceiling is set at 80 percent of the median of all fee schedules for the test; in 1996 and subsequent years the ceiling is set at 76 percent of the national median. No beneficiary cost-sharing is required.

Explanation of provision

The provision would provide for no update in the fee schedules through 2002. In addition, the provision would lower the ceiling on payment amounts to 65 percent of the median, effective January 1, 1997.

Reason for change

The provision would contribute toward slowing the rate of growth in the Part B program.

Effective date

The amendment is effective upon enactment.

Sec. 15605. Extension of reductions in payments for costs of hospital outpatient services

Present law

Hospitals receive payments for Medicare's share of capital costs associated with outpatient departments. OBRA 93 extended a 10 percent reduction in payments for the capital costs of outpatient departments through FY 1998.

Certain hospital outpatient services are paid on the basis of reasonable costs. OBRA 93 extended a 5.8 percent reduction for those services paid on a cost-related basis through FY 1998.

Explanation of provision

The proposal would extend the 10 percent reduction in payments for outpatient capital through FY 2002. The 5.8 percent reduction for outpatient services paid on a cost basis would be extended through FY 2002.

Reason for change

The provision would otherwise expire.

Effective date

The provision is effective upon enactment.

Sec. 15606. Freeze in payments for ambulatory surgical center services

Present law

Medicare pays for ambulatory surgical center (ASC) services on the basis of prospectively determined rates. These rates are updated annually by CPI–U. OBRA 93 eliminated updates for ASCs for FY 1994 and FY 1995.

Explanation of provision

The proposal would eliminate the inflation update for ASCs for each of the fiscal years 1996 through 2002.

Reason for change

The provision would otherwise expire.

Effective date

The provision is effective upon enactment.

Sec. 15607. Rural emergency access care hospitals.

Present law

See Subtitle F, Sec. 15513 above.

Explanation of provision

The provision would make conforming amendments to Part B.

Reason for change

See Subtitle F, Sec. 15513 above

Effective date

The provision is effective upon enactment.

PART 2. PART B PREMIUM

Sec. 15611. Extension of part B premium

Present law

When Medicare was established in 1965, the Part B monthly premium was set at a level to finance one-half of Part B program costs. Beginning in 1974, however, Congress limited the percentage increase in the premium to the same percentage by which Social Security cash benefits were adjusted for changes in cost of living (i.e. cost-of-living adjustments or COLAs). Under this formula, revenues from premiums soon dropped from 50 percent to below 25 percent of program costs. This was because Part B program costs increased much faster than inflation as measured by the Consumer Price Index on which the Social Security COLA is based.

Since the early 1980s, Congress has regularly voted to set Part B premiums at a level to cover 25 percent of program costs, in effect overriding the COLA limitation. The 25 percent provision first became effective January 1, 1984. General revenues cover the remaining 75 percent of Part B program costs. Congress took this general approach again in the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), but instead of leaving the calculations to the Secretary, the law set specific premium amounts for each year, 1991–1995, based on estimates of the program's costs. For 1995, the Part B premium is set at $46.10 per month. Part B program cost estimates have since proven to be too large, and the 1995 premium is now projected to cover approximately 31.5 percent of program costs. Most recently, OBRA 93 extended the policy of setting the Part B premium at a level to cover 25 percent of program costs through 1998, leaving the calculations to the Secretary. Under current law, the provision limiting the annual percentage increase to the percentage increase in the social security COLA would again apply, beginning in 1999.

Explanation of provision

The provision would permanently set the Part B premium at 31.5 percent of program costs, beginning in 1996.

Reason for change

The Committee was committed to not changing Part B premiums, or coinsurance levels from those in place in 1995. The Part B premium would remain at the 1995 level. Over the last 15 years the Congress has acted on numerous occasions to set the Part B premium at a given level of program costs without allowing it to return to annual increases in the premium based on the Social Security cost of living adjustment.

Effective date

The provision is effective upon enactment.

Sec. 15612. Income-related reduction in Medicare subsidy

Present law

Under current law, all beneficiaries, regardless of income pay the same Part B premium which covers a portion of the costs for providing Part B benefits. Participation by eligible individuals in Part B is voluntary, and individuals can elect not to enroll in the program. Those who elect to enroll must pay the premium. The Part B premium is not currently adjusted based on beneficiary affluence. The primary method of collection for the premium is a direct deduction from beneficiaries' social security benefits, railroad retirement benefits, and civil service annuities. The premium constitutes about 31.5% of Part B program costs, with the balance of the actuarial value of a given beneficiaries benefits being subsidized by general revenues. All Part B premiums are dedicated to the SMI trust fund.

Explanation of provision

Under the provision, individuals with incomes over $75,000 and couples with incomes over $125,000 would be responsible for increases in the Part B premium. The Federal subsidy would be gradually phased out. Individuals with incomes at $100,000, couples (with one spouse enrolled in Part B) with incomes at $150,000, and couples (with both spouses enrolled in Part B) with incomes at $175,000 would be required to pay a premium equal to 100 percent of Part B program costs. The provision would apply to monthly Part B premiums beginning in 1996, which as under current law is still voluntary on the part of the elderly.

The Secretary of Health and Human Services would be required to make an initial determination of the amount of an individual's actual adjusted gross income (AGI) for a year. The determination would be based on information supplied by the Secretary of the Treasury. Not later than October 1 of the preceding year, the Secretary would be required to notify each individual subject to an increased premium. The notice would include the Secretary's estimate of the individual's AGI for the year. The individual would have a 30-day period (beginning with the date on which the notice is provided) to provide information on the individual's anticipated AGI for the forthcoming year.

The Secretary would be required to make a premium adjustment if he or she determined (based on information provided by the Secretary of the Treasury) that actual AGI was different from the

amount initially determined. The adjustment would be made to the subsequent year's premium to adjust for any overpayment or underpayment in the previous year. The Secretary would be authorized to make appropriate recovery efforts in the case of an individual who owed an additional amount, but was not enrolled in Part B in such subsequent year. The Secretary is also authorized, in the case of a deceased individual, to make a payment to the surviving spouse, or an individual's estate, in the case of overpayment to the program.

Reason for change

Concerns have been raised regarding the level of subsidy that affluent Medicare beneficiaries are receiving under the current, voluntary Part B program, and the fact that young, less well-to-do Americans are significantly subsidizing the Medicare costs for the affluent.

Effective date

The provision would apply to monthly Part B premiums beginning in 1996.

PART 3. ADMINISTRATION OF LABORATORY SERVICES

Sec. 15621. Administrative simplification

Present law

No provision.

Explanation of provision

The section would require the Secretary to adopt uniform coverage, administration and payment policies for clinical diagnostic laboratory tests within one year of enactment. The Secretary would be required to select 15 carrier medical directors to develop recommendations to the Secretary for uniform coverage, administration, and payment policies. The directors would be representative of geographic areas and have a varied range of interest in relevant fields, including pathology and clinical laboratory practice. The directors would be required to consult with independent experts in each major discipline of clinical laboratory medicine (including clinical laboratory personnel, bioanalysts, pathologists, and practicing physicians). The medical directors would also solicit comments from others wishing to participate. The provision would provide that the process would be conducted as negotiated rule-making as provided under the Administrative Procedures Act.

The section would provide that the negotiated rule-making would result in recommendations for uniform policies in the following areas: (i) beneficiary information required to be submitted with each claim; (ii) physicians' obligations regarding documentation and record keeping; (iii) procedures for filing claims and providing remittances by electronic media; (iv) performance of post-payment review of test claims; (v) documentation of medical necessity limited to instances where determined appropriate after identification of aberrant utilization pattern through focused medical review; and (vi) beneficiary responsibility for payment.

The section would prohibit carriers and intermediaries from implementing any new requirements for submission of claims retroactive to January 1, 1995, during the period when the Secretary is adopting uniform policies. Further, carriers would be prohibited from issuing new coverage, administration, or payment policies unless they promote the goal of administrative simplification.

The provision would require medical directors to forward their recommendations to the Secretary within six months of enactment. The Secretary would provide for publication of recommendations for public comment using negotiated rule-making. The Secretary would publish final uniform policies which would become effective 180 days following publication. Following publication, the Secretary would implement uniform documentation and processing policies.

The provision would permit any independent laboratory to select one carrier for processing all of its claims for payment regardless of where the laboratory, patient, or provider resides or conducts business. The election would be made by the laboratory, and an agreement between the carrier and the laboratory would be forwarded to the Secretary. No laboratory would be required to select a single carrier.

Reason for change

Concerns have been raised about the widely varying documentation required by Medicare carriers regarding claims for clinical laboratory tests, and the resulting significant administrative costs associated with this documentation, particularly for laboratories which send claims to multiple carriers.

Effective date

The provision is effective upon enactment.

PART 4. COVERAGE OF ANTI-NAUSEA DRUGS

Sec. 15631. Coverage of certain anti-nausea drugs under chemotherapeutic regimen

Present law

Medicare Part B covers oral anti-cancer drugs that are prescribed as anti-cancer chemotherapeutic agents providing they have the same active ingredients and are used for the same indications as anti-cancer chemotherapeutic agents which would be covered if they were not self-administered and they were furnished incident to a physician's service as drugs and biologicals. In addition, unlabeled uses for FDA approved drugs and biologicals used in an anti-cancer chemotherapeutic regimen for a medically accepted indication are also covered. These provisions apply only to the coverage of anti-cancer chemotherapeutic agents used in the treatment of cancer. It does not apply to oral drugs or biologicals used to treat indications other than cancer, toxicity, or side effects such as nausea or bone marrow depression.

Explanation of provision

The section would clarify Medicare coverage of oral anti-cancer drugs to specify that coverage is also provided for oral-anti-emetic

drugs given at the time that chemotherapy treatments are administered.

Reason for change

In certain cases, HCFA does not adopt new FDA approved pharmaceuticals for coverage even when they meet all of the criteria necessary under current law.

Effective date

The provision is effective upon enactment.

PART 5. COVERAGE OF CHIROPRACTIC SERVICES

Sec. 15641. Coverage of chiropractic services

Present law

Medicare recognizes chiropractors under the term physician if the chiropractor is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meet uniform minimum standards promulgated by the Secretary, but only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by X-ray to exist) which he is legally authorized to perform in the State or jurisdiction in which the treatment is provided.

Explanation of provision

The section would clarify that chiropractors may order and refer patients to other practitioners for the purpose of providing X-rays.

Reason for change

Under current law concerns have been raised regarding access to chiropractic services because chiropractors have been unable to directly refer patients for X-rays. As a result chiropractors are severely limited in their ability to treat patients because they have no direct role in obtaining the x-ray which is required for the beneficiary to qualify for certain chiropractic services.

Effective date

The provision is effective upon enactment.

SUBTITLE H—PROVISIONS RELATING TO MEDICARE PARTS A AND B

PART 1. HOME HEALTH SERVICES

Sec. 15701. Payment for home health services

Present law

In provisions contained in the Orphan Drug Act of 1993, OBRA 87 and OBRA 90, Congress required the Secretary to develop alternative methods for paying for home health care on a prospective basis. In 1994, the Office of Research and Demonstration in the HCFA completed a demonstration project that tested prospective payment on a per visit basis. Preliminary analysis indicates that the per visit prospective payment methodology had no effect on cost

per visit or volume of visits. HCFA has just begun a second project, referred to as Phase II, to test prospective payment on a per episode basis.

Explanation of provision

The proposal would establish a prospective payment system for home health services. This system would be based on prospectively determined per visit rates that are subject to per episode limits applied in the aggregate. The proposal would have the following specific components.

Beginning in FY 1997, 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 based on amounts paid during cost reporting periods ending June 30, 1994, updated by the home health market basket for fiscal years 1995 through 1997. The home health market basket is currently used to update cost limits. 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. These adjusted per visit rates would be the amounts that home health care agencies would receive throughout the year 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 (or an alternative methodology developed by the Secretary), 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.

The per episode limit would be calculated as follows. For each of the 18 case categories, the Secretary would determine the mean number of visits of each type of home health services furnished during a period of 120 days following the initial admission of the beneficiary to the case during the base year FY 1994. The Secretary would then multiply the results by the per visit payment rates for services. This would become the target per episode limit for a case. Calculation of per episode limits would be done on an area-wide basis; for these purposes the area in which an agency is located would be that area the Secretary finds most appropriate.

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

Total per visit payments to an agency would be compared with the aggregate payment limit, i.e. the mix of an agency's episodes times the per episode limits. 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, up to 5 percent of an agency's aggregate Medicare payments in a year. For agencies with aggregate payments over the limit, the Secretary would be required to reduce payments to agencies in the following fiscal year in a manner the Secretary considers appropriate (including on an installment basis).

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

Beginning in FY 1998, per visit payment rates would be updated annually by the home health market basket. The Secretary would be required to rebase the market basket update at least once every 5 years with the most recent available data. Beginning in FY 1999, the Secretary would also be required to rebase the per episode limits every 2 years to adjust for changes in the number and mix of visits per episode. 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 area-wide level, remains budget neutral.

The Secretary would be required to implement a medical review process for the new payment system, giving particular attention to fiscal years 1997 and 1998. The purpose of the medical review process would be to assess patterns of care to assure that beneficiaries receive appropriate services per episode. Medical reviews would be required to focus on short stay cases and cases over 165 days. Recertification of the need for care would have to done at 30, 60, 120, and 165 days of home health care.

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

The Secretary would be required to develop a system to track home health patients who receive care from more than one agency during an episode. For such situations, the Secretary would be required to adjust payments to assure that total amounts paid to these agencies do not exceed the payment that would otherwise have been made if the patient had completed the episode in a single agency.

The Secretary would also be required to develop a system to adjust payments to agencies to eliminate any increase in growth in the percentage of low-cost episodes over the percentage of such cases occurring at the agency for the 12-month cost reporting pe-

riod ending June 30, 1994. The Secretary would be required to define low-cost episode in a manner to assure that a home health agency has an incentive to be cost efficient in delivering services and that the volume of services does not increase as a result of factors other than patient needs.

Reimbursements for exceptions to the home health services cost limits would be limited to aggregate payments made in FY 1994 adjusted for increases in the home health market basket.

Separate Part B billings would be prohibited for any services covered under the per episode limit while the beneficiary is receiving home health services. Agencies would be required to bill prosthetics and orthotics furnished as part of a home health visit under Part B's prosthetics and orthotics fee schedule, just as DME furnished by an agency as part of home health must now be billed under the fee schedules for DME.

The Medicare Review Commission would be required to report on the effectiveness of the new payment system for each of the first three years of its operation. The Commission would also be required to make recommendations to Congress on (1) case-mix and volume increases, (2) quality monitoring of home health agency practices, (3) whether a capitated payment system for home health care patients using over 165 days of service is warranted; (4) whether public providers of service are adequately reimbursed; (5) the adequacy of the exemptions and exceptions to the limits; (6) the appropriateness of methods used to adjust the per episode limits and annual payment updates to reflect changes in the mix of services, number of visits, and assignment to case categories to reflect changing patterns of home health care; and (7) the geographic areas used to determine per episode limits.

Reason for change

Over the past five years Medicare spending for home health services has grown an average of almost 40 percent a year. Medicare's current cost based reimbursement approach encourages agencies to increase the number of visits. It also fails to reward agencies for improving their efficiency.

Effective date

The provision would be effective October 1, 1986.

Sec. 15702. Maintaining savings resulting from temporary freeze on payment increase for home health services

Present law

Home health care agencies are currently reimbursed on the basis of reasonable costs, up to specified limits. Cost limits are determined separately for each type of covered home health service (skilled nursing care, physical therapy, speech pathology, occupational therapy, medical social services, and home health aide), and according to whether an agency is located in an urban or rural area. Costs limits, however, are applied to aggregate agency expenditures; that is, an aggregate cost limit is set for each agency that equals the limit for each type of service multiplied by the number of visits of each type provided by the agency. Limits for the

individual services are set at 112 percent of the mean labor-related and nonlabor per visit costs for freestanding agencies. Cost limits are updated annually by applying a market basket index to base year data derived from home health agency cost reports. The labor-related portion of a service limit is adjusted by the current hospital wage index.

OBRA 93 required that there be no changes in home health cost limits (including no adjustments for changes in the wage index or other updates of data) for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996. 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 the cost limits. OBRA 93 also repealed the requirement that additional payments be made to hospital-based home health agencies for costs attributable to excess overhead allocations, effective for cost reporting periods beginning on or after October 1, 1993.

Explanation of provision

The provision would permanently extend the savings stream, but not the freeze, in setting future home health limits, by not allowing for the inflation that occurred during the freeze years.

Reason for change

The provision would otherwise expire.

Effective date

The provision would be effective upon enactment.

Sec. 15703. Extension of waiver of presumption of lack of knowledge of exclusion from coverage for home health agencies

Present law

When a provider furnishes services that are not covered under Medicare, the provider is not normally entitled to Medicare payment for those services. The program, however, has recognized that circumstances may exist where providers of services or beneficiaries could not have reasonably known that services would not be covered. Medicare has paid for a limited number of services which are not covered services, so long as it is determined that the provider or beneficiary did not know and could not reasonably have been expected to know that services would be uncovered. The provider is presumed not to know that coverage for certain services would be denied—it qualifies for a "favorable presumption"—when its denial rate is below a certain level. With this favorable presumption, its liability for denied claims below the threshold is waived and it is paid for these claims. The provider receives waiver of liability protection for denied claims below the threshold.

For home health agencies, waiver of liability protection is available for two separate categories of denials. One waiver applies to medical denials, i.e., to claims that are denied because the care was not medically necessary or was determined to be custodial in nature. Another waiver applies to services determined to be non-covered because the beneficiary was not homebound or did not require

intermittent skilled nursing care. These are referred to as technical denials.

For both categories, the principal criterion for meeting the favorable presumption test is a denial rate of 2.5 percent or less. Waiver of liability protection for both medical and technical denials expires December 31, 1995.

Explanation of provision

Waiver of liability for home health agencies would be extended through September 30, 1996.

Reason for change

Current waiver of liability protections are a legacy of the current cost-based home health care reimbursement system, and they were extended only until the new home health agency prospective payment becomes effective in fiscal year 1997.

Effective date

The provision would be effective upon enactment.

Sec. 15704. Study of coverage of services of Christian Science providers

Present law

No provision.

Explanation of provision

The section would require the Secretary of Health and Human Services to conduct a study of the feasibility and desirability of providing Medicare coverage for home health services furnished by Christian Science providers which meet applicable requirements of the First Church of Christ, Scientist, Boston. The Secretary would be required to submit a report on the study by July 1, 1996, and to include recommendations on criteria for certifying providers and an appropriate payment methodology for reimbursing covered services.

Reason for change

Though Christian Scientists are eligible for Part A benefits, Christian Science home health agencies are not certified to provide Medicare covered services.

Effective date

This provision would be effective upon enactment.

PART 2. MEDICARE SECONDARY PAYER IMPROVEMENTS

Sec. 15711. Extension and expansion of existing requirements

Present law

Generally Medicare is the "primary payer," that is, it pays health claims first, with an individual's private or other public insurance filling in some or all of Medicare's coverage gaps. However, in certain instances, the individual's other coverage pays first, while Medicare is the secondary payer. This phenomenon is referred to

as the MSP program. A group health plan offered by an employer (with 20 or more employees is required to offer workers age 65 or over (and workers spouses age 65 or over) the same group health insurance coverage as is offered to younger workers. If the worker accepts the coverage, the employer is the primary payer, with Medicare becoming the secondary payer.

Similarly, a group health plan offered by a large employer (100 or more employees) is the primary payer for employees or their dependents who are on the Medicare disability program. The provision applies only to persons covered under the group plan because the employee is in "current employment status" (i.e. is an employee or is treated as an employee by the employer). The MSP provision for the disabled population expires October 1, 1998.

The MSP provisions apply to ESRD beneficiaries with employer group health plans, regardless of employer size. The group health plan is the primary payer for 18 months for persons who become eligible for Medicare ESRD benefits. The employer's role as primary payer is limited to a maximum of 21 months (18 months plus the usual 3-month waiting period for Medicare ESRD coverage). The MSP provisions for the ESRD population expire October 1, 1998.

The law authorizes a data match program which is intended to identify potential secondary payer situations. Medicare beneficiaries are matched against data contained in the SSA and Internal Revenue Service (IRS) files to identify cases in which a working beneficiary (or working spouse) may have employer-based health insurance coverage. Cases of previous incorrect Medicare payments are identified and recoveries are attempted. The authority for the program extends through Sept. 30, 1998.

Explanation of provision

The provision would make permanent the MSP provisions for the disabled and the ESRD population. It would extend the period during which the employer group health plan is primary payer for an ESRD beneficiary from 18 to 24 months. The provision would also make permanent the data match requirement.

Reason for change

The provisions would otherwise expire.

Effective date

The provision is effective upon enactment.

Sec. 15712. Improvements in recovery of payments

Present law

Recent court action may lessen the effectiveness of the data match program. In many cases where recoveries are sought, claims have never been filed with the primary payer. Identification of potential recoveries under the data match process usually takes in excess of the time period most health plans allow for claims filing. Two May 1994 decisions by the U.S. Court of Appeals for the District of Columbia held certain portions of the MSP overpayment recovery procedures invalid. In particular, it held invalid provisions

authorizing payment recoveries without regard to a health plan's timeliness requirements. The U.S. Supreme Court denied a HCFA petition to review the 1994 decisions.

Explanation of provision

The provision would specifically permit MSP recoveries from third party administrators of health plans, except in cases of insolvency or bankruptcy of the employer or plan.. It would also permit recovery actions up to three years from the date the item or service was furnished to the beneficiary.

Reason for change

The recent court decisions have reduced the effectiveness of the MSP recovery efforts.

Effective date

The amendment is effective upon enactment.

Sec. 15713. Prohibiting retroactive application of policy regarding ESRD beneficiaries enrolled in primary plans

Present law

Medicare remains the primary payer if a group health plan was already secondary for an individual entitled on the basis of age or disability when the individual becomes entitled on the basis of ESRD. Following enactment of OBRA 93, HCFA stated that the private plan would become primary in such cases. On April 24, 1995, HCFA corrected its construction of the statute; it issued guidelines stating that Medicare remains the primary payer in these cases.

Explanation of provision

The provision would specify that the policy change specified in the April 24, 1995 HCFA guidelines would only apply with respect to items and services furnished on or after such date.

Reason for change

The administrative costs associated with HCFA's reversal of it's policy interpretation have created a significant burden on ESRD providers.

Effective date

The provision is effective upon enactment.

PART 3. FAILSAFE

Sec. 15714. Failsafe budget mechanism

Present law

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 OBRA of 1990, 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.

Limitation created by trust fund reserves. Part A claims for hospitalization are paid from the HI Trust Fund. Part B claims for physicians' services are paid from the 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, however, since general fund transfers are credited each year in amounts sufficient to maintain the fund's solvency.

Limitation created by OBRA of 1990. A provision in OBRA of 1990 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 of 1990 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.

Explanation of provision

A new section 1895 would be added to Title XVIII of the SSA to provide a mechanism by which certain Medicare spending would be reduced automatically if it were anticipated that spending would exceed budget targets during the next fiscal year. This "failsafe budget mechanism" would be in effect for fiscal years beginning with 1998.

The failsafe budget mechanism would apply to both Parts A and B of Medicare, but only to fee-for-service expenditures. 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. The Secretary of Health and Human Services would classify each item and service paid for separately by Medicare into one of these sectors. No substantive reclassifications would be permitted after the classification was published.

If the Secretary 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 be reduced by 133⅓ percent of the amount of the excess. The Secretary would be required to publish the size of any necessary adjustments and the methodology to be used by May 15 preceding the fiscal year in question. A final determination on adjustments would have to be published by September 1 prior to that fiscal year.

The budget allotment for a sector for a fiscal year would be determined by multiplying the total fee-for-service allotment for that year by an 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 (a new Part C of Medicare). The Medicare benefit budget would be set forth in law as follows:

[In billions of dollars]	*Benefit budget*
Fiscal year:	
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 product of: (1) 1.05; and (2) 1.0 plus the annual percentage increase in the average number of Medicare beneficiaries in the subsequent 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 expenditure for a sector. For example, the baseline expenditure projection for inpatient hospital services would be determined by applying to the prior-year expenditure the following growth rates: 5.7 percent for FY 1996; 5.6 percent for FY 1997; 6.0 percent for FY 1998; 6.1 percent for FY 1999; 5.7 percent for FY 2000; 5.5 percent for FY 2001; and 5.2 percent for FY 2002 and thereafter. 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 pro-

vided 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 1999, 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 a sector were to exceed the total allotments for the second preceding year, then the sector's allotment would be reduced for the next fiscal year by 133⅓ percent the excess amount. Should spending in the second preceding year fall below a sector's allotment for that year, the excess allotment could be added to the allotment for the next fiscal year. These adjustments would be made after adjusting the prior-year allotments to reflect actual Part C expenditures for the second preceding year.

If the President submits 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.

Beginning in 1997, the Medicare Payment Review Commission would be required to submit by March 1 of each year a report analyzing the past operation of the failsafe mechanism and making recommendations with respect to its application to the following fiscal year.

The Committee directs the Commission, in evaluating the appropriateness of the implementation of the fail safe, to separately look at the effect of such reductions, if necessary, on urban critical access hospitals.

Reason for change

The Committee is confident that a significant proportion of Medicare beneficiaries will choose MedicarePlus, and produce the growth levels in program costs necessary to preserve Medicare. However, if the combination of the expansion of MedicarePlus and the specific payment policies set forth in H.R. 2425 are not sufficient to bring Medicare into fiscal balance, then further adjustments in payment policy would be necessary to ensure that Medicare spending will not exceed the sustainable levels set by the Committee.

Effective date

The provision is effective upon enactment.

PART 4. ADMINISTRATIVE SIMPLIFICATION

Sec. 15731. Standards for Medicare information transactions and data elements

Present law

No provision.

Explanation of provision

The provision would provide for the adoption of standards for Medicare information transactions and data elements. The Secretary would be required to adopt standards which were consistent with reducing administrative costs and which were developed or modified by a standard setting organization accredited by the American National Standards Institute. The Secretary could adopt or modify a standard relating to data elements that was different from such standard if, compared to the alternative, it would substantially reduce administrative costs to providers and health plans and it was promulgated in accordance with Federal rule making procedures.

The provision would require each person who maintains or transmits Medicare information or data elements to maintain reasonable and appropriate administrative, technical, and physical safeguards to: (i) ensure integrity and confidentiality of information; and (ii) protect against any reasonably anticipated threats or hazards to security or unauthorized uses or disclosures.

The Secretary would be required to establish security standards and modifications to those standards that take into account technical capability of record systems, costs of security measures, need for training personnel who have access to information, and the value of audit trails. The standards would assure that a medicare information network service that was part of a larger organization had policies which isolated its activities. Security standards would be based on those developed by standard setting organizations or, if such standards do not exist, by the Medicare Information Advisory Committee.

The Secretary would be required to adopt standards for transactions and data elements to make Medicare information uniformly available to be exchanged electronically. The standards would provide for unique health identifiers for each individual, plan, employer, and provider. Penalties would be imposed for improper disclosure of this number. In addition, the Secretary would: (i) provide for the establishment of code sets in consultation with the Medicare Information Advisory Committee and other experts; (ii) promulgate regulations specifying procedures for the electronic transmission and authentication of signatures; (iii) develop rules for transfer of information between health plans needed for coordination of benefits; and (iv) develop further transaction standards if, after 5 years, they were deemed necessary for coordination of benefits. The provision would provide for protection of trade secrets.

The provision would require the development of the standards within 18 months of enactment. Additional or modified standards could be adopted not more than once every 12 months. Additions or modifications would be completed in a manner that minimized

disruption and cost of compliance. Health plans would be required to conduct standard transactions in a timely manner and comply with transaction and data element standards within 24 months of adoption. Compliance with any modified standards would be required within an appropriate period but not less than 180 days after adoption of the modified standard. Penalties would be established for failure to comply with requirements and standards.

The provision would supersede any contrary provision of state law unless: (i) the state law provision is more stringent with respect to privacy guarantees; or (ii) it is a provision the Secretary deems necessary to prevent fraud and abuse.

The provision would establish a Medicare Information Advisory Committee to advise the Secretary in development of standards and to advise the Secretary and the Congress on the status and future of the Medicare information network. The Committee would be composed of 9 members—three appointed by the President, three appointed by the Speaker of the House, and three by the President pro tempore of the Senate. The Committee would be required to submit an annual report to the Congress which would include information on the extent to which entities using the Medicare information network were meeting the standards, forming an integrated network, and meeting security standards.

Reason for change

The MedicarePlus program will significantly expand the role of private insurance under the Medicare program. As this expansion occurs the need for information on beneficiary eligibility, enrollment, disenrollment, plan design, and coordination of benefits will increase dramatically. This provision provides a process through which the determination of information needs and the standards to be used in transmitting this information will be developed to ensure uniformity.

Effective date

The provision is effective upon enactment.

PART 5. OTHER PROVISION RELATING TO PARTS A AND B

Sec. 15741. Clarification of Medicare coverage of items and services associated with certain medical devices approved for investigational use

Present law

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. 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.

Explanation of provision

The proposal specifies that nothing in Medicare law could be construed as prohibiting coverage of items and services associated with the use of a medical device in the furnishing of inpatient or outpatient hospital services (including outpatient diagnostic imaging 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 or a covered procedure. The amount of payment for items and services associated with the use of investigational devices in inpatient or outpatient hospital services could not exceed the amount that Medicare would have paid if the item or service were associated with an approved device. The provision would define approved device as a medical device which has been approved for marketing under pre-market approval or cleared for marketing under the Federal Food, Drug, and Cosmetic Act. An investigational device would be defined as a device approved for investigational use under the Food, Drug, and Cosmetic Act, or an investigational combination product under the Food, Drug, and Cosmetic Act.

The Committee is aware of the strong interest in requiring Medicare reimbursement of patient care provided in peer reviewed clinical trials approved by the National Institutes of Health (NIH), the FDA, or non-governmental entities meeting NIH guidelines. The Committee is further aware that clinical trials provide the best medical treatment for people suffering from cancer, AIDS, or other life threatening disease, for whom standard therapies offer limited chance for survival or enhanced quality of life.

The Committee directs the Medicare Payment Review Commission to assess whether or not there would be additional cost to the Medicare program if reimbursement was made for the services beneficiaries receive when participating in approved clinical trials.

Reason for change

Until recently, it had been HCFA's practice to pay for services including investigational devices.

Effective date

The provision is effective upon enactment.

Sec. 15742. Additional exclusion from coverage

Present law

Medicare excludes coverage for certain defined items and services.

Explanation of provision

The provision would exclude Medicare coverage for items or services used for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.

Reason for change

Concerns have been raised that Medicare funds will be used for purposes of assisting in causing the death, suicide, euthanasia, or mercy killing of a person.

Effective date

The provision is effective upon enactment.

SUBTITLE I—CLINICAL LABORATORIES

(The provisions under this subtitle are under the jurisdiction of the Committee on Commerce.)

Sec. 15801. Exemption of physicians office laboratories

Present law

The Clinical Laboratory Improvement Amendments of 1988 (CLIA 88) significantly strengthened Federal regulation of laboratories and expanded Federal oversight to virtually all laboratories in the country, including physicians office laboratories. All laboratories are required to register with DHHS. Laboratories performing only simple tests receive a certificate of waiver. Other laboratories (performing moderate complexity and/or high complexity testing) must meet performance standards issued by the Secretary.

A special category of tests, physician performed microscopy procedures, was established in 1993. This category was expanded and renamed provider-performed microscopy procedures earlier this year. These are specified procedures which are personally performed by physicians, dentists, and certain mid-level personnel; the procedures must be performed on specimens derived from their patients as part of a physical examination and evaluation. The tests are labelled moderate complexity; however physicians (or other personnel) performing only these tests and waivered tests are not subject to routine inspections, though most other moderate complexity requirements continue to apply.

Explanation of provision

The provision would exempt a clinical laboratory in a physician's office from the CLIA requirements. Exempted laboratories would be those in the office of a physician (including an office of a group of physicians) which is directed by a physician. The examinations and procedures must be performed by a physician or by individuals supervised by a physician solely as an adjunct to other services provided by the physician's office.

A clinical office laboratory would not be exempt from CLIA when it performed Papanicolaou (PAP) Smears.

Reason for change

This provision is under the jurisdiction of the Committee on Commerce.

SUBTITLE J—LOCK-BOX PROVISIONS FOR MEDICARE PART B SAVINGS FROM GROWTH REDUCTIONS

Sec. 15901. Establishment of Medicare growth reduction trust fund for part B savings.

Present law

There is no provision under current law.

Explanation of provision

The section establishes a Medicare Preservation Trust Fund. All Part B savings attributable to the Medicare Preservation Act of 1995 would be appropriated to this fund. No transfer would be permitted from the fund for the purpose of offsetting any change to the Internal Revenue Code. Beginning with FY 2003, the Secretary could use this fund for the Medicare program, but only to the extent provided by Congress in advance through specific amendment.

Reason for change

Creation of a separate Medicare Preservation Trust Fund would ensure that, as a matter of law, none of the savings from the reductions in the rate of growth of Medicare Part B can be used for any other purpose. This insures that Medicare savings are not to be divided among other parts of the budget; it preserves the integrity of Medicare by keeping the reforms of the Medicare program within Medicare Part B.

The SMI trust fund is not a closed trust fund as is the Hospital Insurance Trust Fund. SMI receives a significant in-flow of general revenue. This new provision would create a separate trust fund to prevent any out-flow of savings into the general fund.

Effective date

The provision is effective upon enactment.

III. VOTES OF THE COMMITTEE

In compliance with clause 2(1)(2)(B) of rule XI of the Rules of the House of Representatives, the following statements are made concerning the votes of the Committee on Ways and Means in its consideration of the bill H.R. 2425.

MOTION TO REPORT THE BILL

The bill, H.R. 2425, as amended, was ordered favorably reported by a roll call vote of 22 yeas and 14 nays (with a quorum being present). The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer	X			Mr. Gibbons		X	
Mr. Crane	X			Mr. Rangel		X	
Mr. Thomas	X			Mr. Stark		X	
Mr. Shaw	X			Mr. Jacobs		X	
Mrs. Johnson	X			Mr. Ford		X	
Mr. Bunning	X			Mr. Matsui		X	
Mr. Houghton	X			Mrs. Kennelly			
Mr. Herger	X			Mr. Coyne		X	
Mr. McCrery	X			Mr. Levin		X	
Mr. Hancock	X			Mr. Cardin		X	
Mr. Camp	X			Mr. McDermott		X	
Mr. Ramstad	X			Mr. Kleczka		X	
Mr. Zimmer	X			Mr. Lewis		X	
Mr. Nussle	X			Mr. Payne		X	
Mr. Johnson	X			Mr. Neal		X	
Ms. Dunn	X						
Mr. Collins	X						
Mr. Portman	X						
Mr. Laughlin	X						
Mr. English	X						

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Ensign	X						
Mr. Christensen	X						

MOTION ON CHAIRMAN'S AMENDMENT

The Committee approved Chairman Archer's amendment, as amended, in the nature of a substitute to H.R. 2425 by a roll call vote of 22 yeas and 14 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer	X			Mr. Gibbons		X	
Mr. Crane	X			Mr. Rangel		X	
Mr. Thomas	X			Mr. Stark		X	
Mr. Shaw	X			Mr. Jacobs		X	
Mrs. Johnson	X			Mr. Ford		X	
Mr. Bunning	X			Mr. Matsui		X	
Mr. Houghton	X			Mrs. Kennelly			
Mr. Herger	X			Mr. Coyne		X	
Mr. McCrery	X			Mr. Levin		X	
Mr. Hancock	X			Mr. Cardin		X	
Mr. Camp	X			Mr. McDermott		X	
Mr. Ramstad	X			Mr. Kleczka		X	
Mr. Zimmer	X			Mr. Lewis		X	
Mr. Nussle	X			Mr. Payne		X	
Mr. Johnson	X			Mr. Neal		X	
Ms. Dunn	X						
Mr. Collins	X						
Mr. Portman	X						
Mr. Laughlin	X						
Mr. English	X						
Mr. Ensign	X						
Mr. Christensen	X						

VOTES ON AMENDMENTS

Roll call votes were conducted on the following amendments to the Chairman's substitute markup amendment.

An amendment by Mr. Cardin to Subtitle G to replace the proposed seven-year freeze on updates in lab services and the reduction in the payment cap with a one-year freeze on the update was defeated by a roll call vote of 9 yeas to 22 nays, with one Member voting present. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		
Mr. Crane		X		Mr. Rangel	X		
Mr. Thomas		X		Mr. Stark			
Mr. Shaw		X		Mr. Jacobs		X	
Mrs. Johnson		X		Mr. Ford			
Mr. Bunning		X		Mr. Matsui			
Mr. Houghton			X	Mrs. Kennelly			
Mr. Herger		X		Mr. Coyne			
Mr. McCrery		X		Mr. Levin	X		
Mr. Hancock		X		Mr. Cardin	X		
Mr. Camp		X		Mr. McDermott	X		
Mr. Ramstad		X		Mr. Kleczka	X		
Mr. Zimmer		X		Mr. Lewis	X		
Mr. Nussle		X		Mr. Payne	X		
Mr. Johnson		X		Mr. Neal	X		
Ms. Dunn		X					
Mr. Collins		X					

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Portman		X					
Mr. Laughlin		X					
Mr. English		X					
Mr. Ensign		X					
Mr. Christensen		X					

An amendment by Mr. Levin to Subtitle G to replace the seven-year freeze on payments for durable medical equipment with a one-year freeze was defeated by a roll call vote of 9 yeas to 23 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		
Mr. Crane		X		Mr. Rangel	X		
Mr. Thomas		X		Mr. Stark			
Mr. Shaw		X		Mr. Jacobs		X	
Mrs. Johnson		X		Mr. Ford			
Mr. Bunning		X		Mr. Matsui			
Mr. Houghton		X		Mrs. Kennelly			
Mr. Herger		X		Mr. Coyne			
Mr. McCrery		X		Mr. Levin	X		
Mr. Hancock		X		Mr. Cardin	X		
Mr. Camp		X		Mr. McDermott	X		
Mr. Ramstad		X		Mr. Kleczka	X		
Mr. Zimmer		X		Mr. Lewis	X		
Mr. Nussle		X		Mr. Payne	X		
Mr. Johnson		X		Mr. Neal	X		
Ms. Dunn		X					
Mr. Collins		X					
Mr. Portman		X					
Mr. Laughlin		X					
Mr. English		X					
Mr. Ensign		X					
Mr. Christensen		X					

An amendment by Mr. McDermott to Subtitle H to begin payments on a per diem basis for home health care after a 120-day period of continuous care, as apposed to a 165-day period was defeated by a roll call vote of 11 yeas to 21 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		
Mr. Crane		X		Mr. Rangel	X		
Mr. Thomas		X		Mr. Stark			
Mr. Shaw		X		Mr. Jacobs	X		
Mrs. Johnson	X			Mr. Ford			
Mr. Bunning		X		Mr. Matsui			
Mr. Houghton		X		Mrs. Kennelly			
Mr. Herger		X		Mr. Coyne			
Mr. McCrery		X		Mr. Levin	X		
Mr. Hancock		X		Mr. Cardin	X		
Mr. Camp		X		Mr. McDermott	X		
Mr. Ramstad		X		Mr. Kleczka	X		
Mr. Zimmer		X		Mr. Lewis	X		
Mr. Nussle		X		Mr. Payne	X		
Mr. Johnson		X		Mr. Neal	X		
Ms. Dunn		X		.			
Mr. Collins		X		.			
Mr. Portman		X		.			
Mr. Laughlin		X		.			
Mr. English		X		.			

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Ensign		X					
Mr. Christensen		X					

An amendment by Mr. Stark to Subtitle A to provide for a series of beneficiary protections in plans which contract with Medicare, in Medicare-Select plans, and in MediGap plans was defeated by a roll call vote of 13 yeas to 22 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		
Mr. Crane		X		Mr. Rangel	X		
Mr. Thomas		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Jacobs	X		
Mrs. Johnson		X		Mr. Ford	X		
Mr. Bunning		X		Mr. Matsui			
Mr. Houghton		X		Mrs. Kennelly			
Mr. Herger		X		Mr. Coyne	X		
Mr. McCrery		X		Mr. Levin.	X		
Mr. Hancock		X		Mr. Cardin	X		
Mr. Camp		X		Mr. McDermott	X		
Mr. Ramstad		X		Mr. Kleczka	X		
Mr. Zimmer		X		Mr. Lewis	X		
Mr. Nussle		X		Mr. Payne	X		
Mr. Johnson		X		Mr. Neal	X		
Ms. Dunn		X					
Mr. Collins		X					
Mr. Portman		X					
Mr. Laughlin		X					
Mr. English		X					
Mr. Ensign		X					
Mr. Christensen		X					

An amendment by Mr. Levin, on behalf of Mrs. Kennelly, to Subtitle A to remove the top-down national budget proposal for paying Medicare-contracting plans and replace it with current law payment policies was defeated by a role call vote of 13 yeas to 22 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		
Mr. Crane		X		Mr. Rangel	X		
Mr. Thomas		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Jacobs	X		
Mrs. Johnson		X		Mr. Ford	X		
Mr. Bunning		X		Mr. Matsui	X		
Mr. Houghton		X		Mrs. Kennelly	X		
Mr. Herger		X		Mr. Coyne	X		
Mr. McCrery		X		Mr. Levin	X		
Mr. Hancock		X		Mr. Cardin	X		
Mr. Camp		X		Mr. McDermott	X		
Mr. Ramstad		X		Mr. Kleczka	X		
Mr. Zimmer		X		Mr. Lewis	X		
Mr. Nussle		X		Mr. Payne	X		
Mr. Johnson		X		Mr. Neal	X		
Ms. Dunn		X					
Mr. Collins		X					
Mr. Portman		X					
Mr. Laughlin		X					
Mr. English		X					
Mr. Ensign		X					
Mr. Christensen		X					

An amendment by Mr. Rangel to Subtitle A to add access to centers of excellence was defeated by a roll call vote of 13 yeas to 21 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		
Mr. Crane		X		Mr. Rangel	X		
Mr. Thomas		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Jacobs	X		
Mrs. Johnson		X		Mr. Ford	X		
Mr. Bunning		X		Mr. Matsui	X		
Mr. Houghton		X		Mrs. Kennelly			
Mr. Herger		X		Mr. Coyne	X		
Mr. McCrery		X		Mr. Levin	X		
Mr. Hancock		X		Mr. Cardin	X		
Mr. Camp		X		Mr. McDermott	X		
Mr. Ramstad		X		Mr. Kleczka	X		
Mr. Zimmer		X		Mr. Lewis	X		
Mr. Nussle		X		Mr. Payne	X		
Mr. Johnson		X		Mr. Neal	X		
Ms. Dunn		X					
Mr. Collins							
Mr. Portman		X					
Mr. Laughlin		X					
Mr. English		X					
Mr. Ensign		X					
Mr. Christensen		X					

An amendment by Mr. Kleczka to Subtitle A to allow States to require provider-sponsored networks to meet State licensure requirements for such networks, if any, was defeated by a roll call vote of 7 yeas to 28 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		
Mr. Crane		X		Mr. Rangel	X		
Mr. Thomas		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Jacobs		X	
Mrs. Johnson		X		Mr. Ford		X	
Mr. Bunning		X		Mr. Matsui			
Mr. Houghton		X		Mrs. Kennelly			
Mr. Herger		X		Mr. Coyne	X		
Mr. McCrery		X		Mr. Levin		X	
Mr. Hancock		X		Mr. Cardin	X		
Mr. Camp		X		Mr. McDermott	X		
Mr. Ramstad		X		Mr. Kleczka	X		
Mr. Zimmer		X		Mr. Lewis		X	
Mr. Nussle		X		Mr. Payne		X	
Mr. Johnson		X		Mr. Neal		X	
Ms. Dunn		X					
Mr. Collins		X					
Mr. Portman		X					
Mr. Laughlin		X					
Mr. English		X					
Mr. Ensign		X					
Mr. Christensen		X					

An amendment by Mr. Neal, on behalf of Mrs. Kennelly, to Subtitle A to require the Medisave provisions be limited to demonstration projects which would test the cost-effectiveness of offering Medicare beneficiaries the option of selecting high-deductible coverage coupled with a Medical Savings Account in lieu of their tradi-

tional Medicare benefits was defeated by a roll call vote of 13 yeas to 22 nays The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		
Mr. Crane		X		Mr. Rangel	X		
Mr. Thomas		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Jacobs	X		
Mrs. Johnson		X		Mr. Ford	X		
Mr. Bunning		X		Mr. Matsui			
Mr. Houghton		X		Mrs. Kennelly	X		
Mr. Herger		X		Mr. Coyne	X		
Mr. McCrery		X		Mr. Levin	X		
Mr. Hancock		X		Mr. Cardin	X		
Mr. Camp		X		Mr. McDermott	X		
Mr. Ramstad		X		Mr. Kleczka	X		
Mr. Zimmer		X		Mr. Lewis	X		
Mr. Nussle		X		Mr. Payne	X		
Mr. Johnson		X		Mr. Neal	X		
Ms. Dunn		X					
Mr. Collins		X					
Mr. Portman		X					
Mr. Laughlin		X					
Mr. English		X					
Mr. Ensign		X					
Mr. Christensen		X					

An amendment by Mr. Kleczka to Subtitle A to require beneficiaries who choose high-deductible, medical savings account coverage to stay in that coverage for five years was defeated by a roll call vote of 13 yeas to 22 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		
Mr. Crane		X		Mr. Rangel	X		
Mr. Thomas		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Jacobs	X		
Mrs. Johnson		X		Mr. Ford	X		
Mr. Bunning		X		Mr. Matsui			
Mr. Houghton		X		Mrs. Kennelly			
Mr. Herger		X		Mr. Coyne	X		
Mr. McCrery		X		Mr. Levin	X		
Mr. Hancock		X		Mr. Cardin	X		
Mr. Camp		X		Mr. McDermott	X		
Mr. Ramstad		X		Mr. Kleczka	X		
Mr. Zimmer		X		Mr. Lewis	X		
Mr. Nussle		X		Mr. Payne	X		
Mr. Johnson		X		Mr. Neal	X		
Ms. Dunn		X					
Mr. Collins		X					
Mr. Portman		X					
Mr. Laughlin		X					
Mr. English		X					
Mr. Ensign		X					
Mr. Christensen		X					

An amendment by Mr. Cardin to Subtitle A regarding the membership of the Commission on the Effect of the Baby Boom Generation on the Medicare program was defeated by a roll call vote of 16 yeas to 18 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Crane		X		Mr. Rangel	X		
Mr. Thomas		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Jacobs	X		
Mrs. Johnson		X		Mr. Ford	X		
Mr. Bunning		X		Mr. Matsui			
Mr. Houghton	X			Mrs. Kennelly			
Mr. Herger		X		Mr. Coyne	X		
Mr. McCrery		X		Mr. Levin	X		
Mr. Hancock		X		Mr. Cardin	X		
Mr. Camp		X		Mr. McDermott	X		
Mr. Ramstad		X		Mr. Kleczka	X		
Mr. Zimmer				Mr. Lewis	X		
Mr. Nussle		X		Mr. Payne	X		
Mr. Johnson		X		Mr. Neal	X		
Ms. Dunn		X					
Mr. Collins		X					
Mr. Portman		X					
Mr. Laughlin	X						
Mr. English		X					
Mr. Ensign	X						
Mr. Christensen		X					

An amendment by Messrs. Stark and Levin to Subtitle B to substitute the anti-fraud and abuse provisions to assure sufficient funding to the Office of the Inspector General, increase current civil monetary penalties, and add new civil monetary penalties was defeated by a roll call vote of 12 yeas to 22 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		
Mr. Crane		X		Mr. Rangel	X		
Mr. Thomas		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Jacobs			
Mrs. Johnson		X		Mr. Ford	X		
Mr. Bunning		X		Mr. Matsui			
Mr. Houghton		X		Mrs. Kennelly			
Mr. Herger		X		Mr. Coyne	X		
Mr. McCrery		X		Mr. Levin	X		
Mr. Hancock		X		Mr. Cardin	X		
Mr. Camp		X		Mr. McDermott	X		
Mr. Ramstad		X		Mr. Kleczka	X		
Mr. Zimmer		X		Mr. Lewis	X		
Mr. Nussle		X		Mr. Payne	X		
Mr. Johnson		X		Mr. Neal	X		
Ms. Dunn		X					
Mr. Collins		X					
Mr. Portman		X					
Mr. Laughlin		X					
Mr. English		X					
Mr. Ensign		X					
Mr. Christensen		X					

An amendment by Mr. Kleczka to Subtitle A to clarify that in cases where a beneficiary chooses a MedicarePlus plan in which providers may bill beneficiaries directly, the providers are subject to same balance-billing limits as under the traditional Medicare program was defeated by a roll call vote of 13 yeas to 22 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Crane		X		Mr. Rangel	X		
Mr. Thomas		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Jacobs	X		
Mrs. Johnson		X		Mr. Ford	X		
Mr. Bunning		X		Mr. Matsui			
Mr. Houghton		X		Mrs. Kennelly			
Mr. Herger		X		Mr. Coyne	X		
Mr. McCrery		X		Mr. Levin	X		
Mr. Hancock		X		Mr. Cardin	X		
Mr. Camp		X		Mr. McDermott	X		
Mr. Ramstad		X		Mr. Kleczka	X		
Mr. Zimmer		X		Mr. Lewis	X		
Mr. Nussle		X		Mr. Payne	X		
Mr. Johnson		X		Mr. Neal	X		
Ms. Dunn		X					
Mr. Collins		X					
Mr. Portman		X					
Mr. Laughlin		X					
Mr. English		X					
Mr. Ensign		X					
Mr. Christensen		X					

An amendment by Mr. Rangel to add a new Subtitle K to allow a tax credit for primary health service providers was defeated by a roll call vote of 16 yeas to 19 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		
Mr. Crane		X		Mr. Rangel	X		
Mr. Thomas		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Jacobs	X		
Mrs. Johnson		X		Mr. Ford	X		
Mr. Bunning	X			Mr. Matsui			
Mr. Houghton	X			Mrs. Kennelly			
Mr. Herger		X		Mr. Coyne	X		
Mr. McCrery	X			Mr. Levin	X		
Mr. Hancock		X		Mr. Cardin	X		
Mr. Camp		X		Mr. McDermott	X		
Mr. Ramstad		X		Mr. Kleczka	X		
Mr. Zimmer		X		Mr. Lewis	X		
Mr. Nussle		X		Mr. Payne	X		
Mr. Johnson		X		Mr. Neal	X		
Ms. Dunn		X					
Mr. Collins		X					
Mr. Portman		X					
Mr. Laughlin		X					
Mr. English		X					
Mr. Ensign		X					
Mr. Christensen		X					

An amendment by Messrs. Matsui, Neal, and Cardin to Subtitle A to retarget funding for teaching programs and disproportionate share hospitals was defeated by a roll call vote of 11 yeas to 21 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		
Mr. Crane		X		Mr. Rangel			
Mr. Thomas		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Jacobs	X		
Mrs. Johnson		X		Mr. Ford	X		
Mr. Bunning		X		Mr. Matsui	X		
Mr. Houghton				Mrs. Kennelly			

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Herger		X		Mr. Coyne	X		
Mr. McCrery		X		Mr. Levin	X		
Mr. Hancock		X		Mr. Cardin	X		
Mr. Camp		X		Mr. McDermott	X		
Mr. Ramstad		X		Mr. Kleczka	X		
Mr. Zimmer		X		Mr. Lewis	X		
Mr. Nussle		X		Mr. Payne			
Mr. Johnson		X		Mr. Neal			
Ms. Dunn		X					
Mr. Collins		X					
Mr. Portman		X					
Mr. Laughlin		X					
Mr. English		X					
Mr. Ensign		X					
Mr. Christensen		X					

An amendment by Messrs. Stark and Matsui to require open enrollment for Medicare Supplemental Insurance (MediGap) policies during the annual, coordinated election period was defeated by a roll call vote of 12 yeas to 21 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		
Mr. Crane		X		Mr. Rangel			
Mr. Thomas		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Jacobs	X		
Mrs. Johnson		X		Mr. Ford	X		
Mr. Bunning		X		Mr. Matsui	X		
Mr. Houghton				Mrs. Kennelly			
Mr. Herger		X		Mr. Coyne	X		
Mr. McCrery		X		Mr. Levin	X		
Mr. Hancock		X		Mr. Cardin	X		
Mr. Camp		X		Mr. McDermott	X		
Mr. Ramstad		X		Mr. Kleczka	X		
Mr. Zimmer		X		Mr. Lewis	X		
Mr. Nussle		X		Mr. Payne	X		
Mr. Johnson		X		Mr. Neal	X		
Ms. Dunn		X					
Mr. Collins		X					
Mr. Portman		X					
Mr. Laughlin		X					
Mr. English		X					
Mr. Ensign		X					
Mr. Christensen		X					

An amendment by Mr. Cardin to Subtitle G to provide payment for colorectal screening was defeated by a roll call vote of 13 yeas to 21 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		
Mr. Crane		X		Mr. Rangel	X		
Mr. Thomas		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Jacobs	X		
Mrs. Johnson		X		Mr. Ford			
Mr. Bunning	X			Mr. Matsui	X		
Mr. Houghton		X		Mrs. Kennelly			
Mr. Herger		X		Mr. Coyne	X		
Mr. McCrery		X		Mr. Levin	X		
Mr. Hancock		X		Mr. Cardin	X		
Mr. Camp		X		Mr. McDermott	X		
Mr. Ramstad		X		Mr. Kleczka	X		
Mr. Zimmer		X		Mr. Lewis	X		

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Nussle		X		Mr. Payne	X		
Mr. Johnson		X		Mr. Neal			
Ms. Dunn		X					
Mr. Collins		X					
Mr. Portman		X					
Mr. Laughlin		X					
Mr. English		X					
Mr. Ensign		X					
Mr. Christensen		X					

An amendment by Mr. Cardin, on behalf of Mrs. Kennelly, to Subtitle G to make available an annual screening mammogram to Medicare-eligible women over age 49 without payment of a twenty percent co-payment was defeated by a roll call vote of 15 yeas to 21 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		
Mr. Crane		X		Mr. Rangel	X		
Mr. Thomas		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Jacobs	X		
Mrs. Johnson		X		Mr. Ford	X		
Mr. Bunning	X			Mr. Matsui	X		
Mr. Houghton		X		Mrs. Kennelly			
Mr. Herger		X		Mr. Coyne	X		
Mr. McCrery		X		Mr. Levin	X		
Mr. Hancock		X		Mr. Cardin	X		
Mr. Camp		X		Mr. McDermott	X		
Mr. Ramstad		X		Mr. Kleczka	X		
Mr. Zimmer		X		Mr. Lewis	X		
Mr. Nussle		X		Mr. Payne	X		
Mr. Johnson		X		Mr. Neal	X		
Ms. Dunn		X					
Mr. Collins		X					
Mr. Portman		X					
Mr. Laughlin		X					
Mr. English		X					
Mr. Ensign		X					
Mr. Christensen		X					

An amendment by Mr. Payne to Subtitle G to provide payment for diabetes self-management training services and authorization for payment for blood-testing strips for individuals with diabetes was defeated by a roll call vote of 15 yeas to 21 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		
Mr. Crane		X		Mr. Rangel	X		
Mr. Thomas		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Jacobs	X		
Mrs. Johnson		X		Mr. Ford	X		
Mr. Bunning		X		Mr. Matsui	X		
Mr. Houghton		X		Mrs. Kennelly			
Mr. Herger		X		Mr. Coyne	X		
Mr. McCrery		X		Mr. Levin	X		
Mr. Hancock		X		Mr. Cardin	X		
Mr. Camp		X		Mr. McDermott	X		
Mr. Ramstad		X		Mr. Kleczka	X		
Mr. Zimmer		X		Mr. Lewis	X		
Mr. Nussle		X		Mr. Payne	X		
Mr. Johnson		X		Mr. Neal	X		

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Ms. Dunn	.....	X					
Mr. Collins	.....	X					
Mr. Portman	.....	X					
Mr. Laughlin	.....	X					
Mr. English	.....	X					
Mr. Ensign	X	.....					
Mr. Christensen	.....	X					

An amendment by Mr. Matsui, on behalf of Mrs. Kennelly, to Subtitle H to allow growth in Medicare spending to equal private sector growth was defeated by a roll call vote of 13 yeas to 22 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer	.....	X	.....	Mr. Gibbons	X	.....	.....
Mr. Crane	.....	X	.....	Mr. Rangel	X	.....	.....
Mr. Thomas	.....	X	.....	Mr. Stark	.....	.....	.....
Mr. Shaw	.....	X	.....	Mr. Jacobs	X	.....	.....
Mrs. Johnson	.....	X	.....	Mr. Ford	X	.....	.....
Mr. Bunning	.....	X	.....	Mr. Matsui	X	.....	.....
Mr. Houghton	.....	X	.....	Mrs. Kennelly	.....	.....	.....
Mr. Herger	.....	X	.....	Mr. Coyne	X	.....	.....
Mr. McCrery	.....	X	.....	Mr. Levin	X	.....	.....
Mr. Hancock	.....	X	.....	Mr. Cardin	X	.....	.....
Mr. Camp	.....	X	.....	Mr. McDermott	X	.....	.....
Mr. Ramstad	.....	X	.....	Mr. Kleczka	X	.....	.....
Mr. Zimmer	.....	X	.....	Mr. Lewis	X	.....	.....
Mr. Nussle	.....	X	.....	Mr. Payne	X	.....	.....
Mr. Johnson	.....	X	.....	Mr. Neal	X	.....	.....
Ms. Dunn	.....	X	.....				
Mr. Collins	.....	X	.....				
Mr. Portman	.....	X	.....				
Mr. Laughlin	.....	X	.....				
Mr. English	.....	X	.....				
Mr. Ensign	.....	X	.....				
Mr. Christensen	.....	X	.....				

An amendment by Mr. Rangel to Subtitle F to strike the provision eliminating the nursing home reform standards was defeated by a roll call vote of 15 yeas to 21 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer	.....	X	.....	Mr. Gibbons	X	.....	.....
Mr. Crane	.....	X	.....	Mr. Rangel	X	.....	.....
Mr. Thomas	.....	X	.....	Mr. Stark	X	.....	.....
Mr. Shaw	.....	X	.....	Mr. Jacobs	X	.....	.....
Mrs. Johnson	.....	X	.....	Mr. Ford	X	.....	.....
Mr. Bunning	.....	X	.....	Mr. Matsui	X	.....	.....
Mr. Houghton	.....	X	.....	Mrs. Kennelly	.....	.....	.....
Mr. Herger	.....	X	.....	Mr. Coyne	X	.....	.....
Mr. McCrery	.....	X	.....	Mr. Levin	X	.....	.....
Mr. Hancock	.....	X	.....	Mr. Cardin	X	.....	.....
Mr. Camp	.....	X	.....	Mr. McDermott	X	.....	.....
Mr. Ramstad	.....	X	.....	Mr. Kleczka	X	.....	.....
Mr. Zimmer	.....	X	.....	Mr. Lewis	X	.....	.....
Mr. Nussle	.....	X	.....	Mr. Payne	X	.....	.....
Mr. Johnson	.....	X	.....	Mr. Neal	X	.....	.....
Ms. Dunn	.....	X	.....				
Mr. Collins	.....	X	.....				
Mr. Portman	.....	X	.....				
Mr. Laughlin	.....	X	.....				
Mr. English	X	.....	.....				

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Ensign		X					
Mr. Christensen		X					

An amendment by Mr. Rangel to Subtitle F to delete the reduction in disproportionate share payments was defeated by a roll call vote of 14 yeas to 22 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		
Mr. Crane		X		Mr. Rangel	X		
Mr. Thomas		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Jacobs	X		
Mrs. Johnson		X		Mr. Ford	X		
Mr. Bunning		X		Mr. Matsui	X		
Mr. Houghton		X		Mrs. Kennelly			
Mr. Herger		X		Mr. Coyne	X		
Mr. McCrery		X		Mr. Levin	X		
Mr. Hancock		X		Mr. Cardin	X		
Mr. Camp		X		Mr. McDermott	X		
Mr. Ramstad		X		Mr. Kleczka	X		
Mr. Zimmer		X		Mr. Lewis	X		
Mr. Nussle		X		Mr. Payne	X		
Mr. Johnson		X		Mr. Neal	X		
Ms. Dunn		X					
Mr. Collins		X					
Mr. Portman		X					
Mr. Laughlin		X					
Mr. English		X					
Mr. Ensign		X					
Mr. Christensen		X					

An amendment by Mr. Rangel to Subtitle E to allow an exemption from the proposed elimination of Medicare payments for residency positions filled by non-U.S. citizens for hospitals that the Secretary finds to have a high dependency on public dollars (Medicare and Medicaid) was defeated by a roll call vote of 16 yeas to 19 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		
Mr. Crane		X		Mr. Rangel	X		
Mr. Thomas		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Jacobs	X		
Mrs. Johnson		X		Mr. Ford	X		
Mr. Bunning		X		Mr. Matsui	X		
Mr. Houghton	X			Mrs. Kennelly			
Mr. Herger		X		Mr. Coyne	X		
Mr. McCrery		X		Mr. Levin	X		
Mr. Hancock		X		Mr. Cardin	X		
Mr. Camp		X		Mr. McDermott	X		
Mr. Ramstad		X		Mr. Kleczka	X		
Mr. Zimmer	X			Mr. Lewis	X		
Mr. Nussle		X		Mr. Payne	X		
Mr. Johnson		X		Mr. Neal	X		
Ms. Dunn		X					
Mr. Collins		X					
Mr. Portman		X					
Mr. Laughlin		X					
Mr. English		X					
Mr. Ensign		X					
Mr. Christensen		X					

An amendment, in the nature of a substitute, by Mr. McDermott was defeated by a roll call vote 10 yeas to 25 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		
Mr. Crane		X		Mr. Rangel	X		
Mr. Thomas		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Jacobs			
Mrs. Johnson		X		Mr. Ford	X		
Mr. Bunning		X		Mr. Matsui	X		
Mr. Houghton		X		Mrs. Kennelly			
Mr. Herger		X		Mr. Coyne	X		
Mr. McCrery		X		Mr. Levin	X		
Mr. Hancock		X		Mr. Cardin		X	
Mr. Camp		X		Mr. McDermott	X		
Mr. Ramstad		X		Mr. Kleczka	X		
Mr. Zimmer		X		Mr. Lewis	X		
Mr. Nussle		X		Mr. Payne		X	
Mr. Johnson		X		Mr. Neal		X	
Ms. Dunn		X					
Mr. Collins		X					
Mr. Portman		X					
Mr. Laughlin		X					
Mr. English		X					
Mr. Ensign		X					
Mr. Christensen		X					

An amendment, in the nature of a substitute, by Mr. Gibbons was defeated by a roll call vote of 14 yeas to 22 nays.The vote was as follows:

Representatives	Yea	Nay	Present	Representatives	Yea	Nay	Present
Mr. Archer		X		Mr. Gibbons	X		
Mr. Crane		X		Mr. Rangel	X		
Mr. Thomas		X		Mr. Stark	X		
Mr. Shaw		X		Mr. Jacobs	X		
Mrs. Johnson		X		Mr. Ford	X		
Mr. Bunning		X		Mr. Matsui	X		
Mr. Houghton		X		Mrs. Kennelly			
Mr. Herger		X		Mr. Coyne	X		
Mr. McCrery		X		Mr. Levin	X		
Mr. Hancock		X		Mr. Cardin	X		
Mr. Camp		X		Mr. McDermott	X		
Mr. Ramstad		X		Mr. Kleczka	X		
Mr. Zimmer		X		Mr. Lewis	X		
Mr. Nussle		X		Mr. Payne	X		
Mr. Johnson		X		Mr. Neal	X		
Ms. Dunn		X					
Mr. Collins		X					
Mr. Portman		X					
Mr. Laughlin		X					
Mr. English		X					
Mr. Ensign		X					
Mr. Christensen		X					

IV. BUDGET EFFECTS OF THE BILL

A. Committee Estimate of Budgetary Effects

In compliance with clause 7(a) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of this bill, H.R. 2425, as reported:

The Committee accepts the estimate prepared by CBO, which is included below. However, the Committee has several concerns with the CBO estimates. The first concern regards the CBO assumption used regarding the number of Medicare beneficiaries which will enroll with MedicarePlus organizations. Given the new opportunities and better information Medicare beneficiaries will have regarding these options the Committee expects a higher number of individuals to elect coverage under MedicarePlus plans than is assumed under the CBO estimate. The second area of concern is the CBO position that the MedicarePlus, Medical Savings Accounts will lead to adverse selection. The third area of concern involves the use of an extreme behavioral offset for benefits or services in which the supplier of the service is not directly responsible for ordering the services provided.

The bill is estimated to have the following effects on budget receipts for fiscal years 1996–2002.

ESTIMATED REVENUE EFFECTS OF H.R. 2425, THE ''MEDICARE PRESERVATION ACT OF 1995'' AS PASSED BY THE COMMITTEE ON WAYS AND MEANS ON OCTOBER 11, 1995—FISCAL YEARS 1996–2002

[Millions of dollars]

Provision	Effective	1996	1997	1998	1999	2000	2001	2002	1996–00	1996–02
1. Tax treatment of hospitals which participate in provider-sponsored organization	DOE				Negligible revenue effect					
2. Tax treatment of Medicare Plus provisions	1/1/97				Negligible revenue effect					
Net totals					Negligible revenue effect					

Joint Committee on Taxation.

Note.—Details may not add to totals due to rounding.

B. Statement Regarding New Budget Authority and Tax Expenditures

In compliance with clause 2(l)(3)(B) of rule XI of the Rules of the House of Representatives, the Committee states that the Committee bill results in net decreased budget authority for direct spending programs relative to current law and no new or increased tax expenditures or revenues.

C. Cost Estimate Prepared by the Congressional Budget Office

In compliance with subdivision (C) of clause 2(l)(3) of rule XI of the Rules of the House of Representative, requiring a cost estimate prepared by the Congressional Budget Office, the following report prepared by CBO is provided.

U.S. Congress,
Congressional Budget Office,
Washington, DC, October 16, 1995.

Hon. Bill Archer,
Chairman, Committee on Ways and Means,
House of Representatives, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 2425, the Medicare Preservation Act of 1995, as ordered reported by the Committee on Ways and Means on October 11, 1995.

The table shows the budgetary effects of the bill over the 1996–2002 period. CBO understands that the Committee on the Budget will be responsible for interpreting how savings contained in this proposal measure against the budget resolution reconciliation instructions. The estimate assumes that the bill will be enacted by November 15 and could change if the bill is enacted later.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

June E. O'Neill.

H.R. 2425 AS REPORTED BY THE COMMITTEE ON WAYS AND MEANS—BY FISCAL YEAR

[In billions of dollars]

	1996	1997	1998	1999	2000	2001	2002	Total
Change in Direct Spending:								
Subtitle A—MedicarePlus Program [1]	−0.5	−1.0	−2.1	−3.7	−6.3	−8.9	−12.1	−34.6
Subtitle B—Preventing Fraud and Abuse:								
Payment Safeguards and Enforcement	0.4	−0.1	−0.3	−0.5	−0.6	−0.6	−0.6	−2.3
Double Civil Monetary Penalties	−0.0	−0.0	−0.0	−0.0	−0.0	−0.0	−0.1	−0.3
Other Provisions	−0.0	−0.0	−0.0	−0.0	−0.0	−0.0	−0.0	−0.1

H.R. 2425 AS REPORTED BY THE COMMITTEE ON WAYS AND MEANS—BY FISCAL YEAR—Continued

[In billions of dollars]

	1996	1997	1998	1999	2000	2001	2002	Total
Subtotal, Subtitle B	−0.4	−0.1	−0.4	−0.6	−0.7	−0.7	−0.7	−2.7
Subtitle C—Regulatory Relief:								
Physician Ownership Referral	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.4
Other Regulatory Relief	0.0	0.1	0.2	0.2	0.2	0.2	0.2	1.1
Physician Self Policing [2]	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Subtotal, Subtitle C	0.1	0.2	0.2	0.3	0.3	0.3	0.3	1.6
Subtitle D—Medical Liability Reform	0.0	−0.0	−0.0	−0.0	−0.0	−0.0	−0.1	−0.2
Subtitle F—Medicare								
Part A:								
Part 1—Hospitals:								
Reduce PPS update [3]	−0.2	−1.1	−2.4	−3.8	−5.4	−7.1	−9.0	−29.0
Reduce disproportionate share payments	−0.6	−0.8	−1.0	−1.1	−1.1	−1.2	−1.2	−7.1
Reduce PPS capital by 15%	−1.0	−1.2	−1.3	−1.3	−1.4	−1.4	−1.5	−9.0
Rebase Capital rates	−0.3	−0.4	−0.4	−0.4	−0.4	−0.4	−0.4	−2.7
Reduce nonPPS capital by 15%	−0.1	−0.2	−0.2	−0.2	−0.2	−0.3	−0.3	−1.5
Adjustment for capital-related tax costs	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Capital exceptions revisions	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Reduce indirect medical education [4]	−0.7	−0.8	−0.8	−0.9	−1.1	−1.1	−1.2	−6.6
Reduce direct medical education [4]	−0.1	−0.2	−0.4	−0.7	−0.8	−0.9	−0.9	−3.9
Reduce nonPPS update	0.0	0.0	0.0	0.0	0.1	0.1	0.2	0.4
Rebase LTC hospitals [5]	0.0	0.1	0.1	0.1	0.1	0.2	0.2	0.7
LTC hospitals within other hospitals [6]	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2

H.R. 2425 AS REPORTED BY THE COMMITTEE ON WAYS AND MEANS—BY FISCAL YEAR—Continued

[In billions of dollars]

	1996	1997	1998	1999	2000	2001	2002	Total
Reduce payments for hospital bad debt	−0.1	−0.1	−0.2	−0.2	−0.2	−0.2	−0.2	−1.1
Extent hemophilia pass through [7]	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Christian Science practitioners	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
EAC/RPC Hospitals [8]	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Rural referral centers	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.7
Floor on area wage index	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Part 2—Skilled Nursing Facilities:								
Skilled Nursing Facilities	−0.2	−0.6	−1.0	−1.4	−1.8	−2.2	−2.8	−10.0
Subtotal, Subtitle F	−3.1	−5.1	−7.4	−9.7	−12.2	−14.6	−17.2	−69.5
Subtitle G—Medicare								
Part B:								
Part 1—Payment Reforms:								
Reduce payments for physicians' services	−0.7	−1.8	−2.9	−3.8	−4.7	−5.7	−6.8	−26.4
Eliminate formula driven overpayment	−0.9	−1.2	−1.5	−2.0	−2.5	−3.3	−4.5	−15.9
Reduce updates for durable medical equipment [9]	−0.1	−0.3	−0.4	−0.5	−0.7	−0.8	−1.0	−3.8
Reduce updates for clinical labs	−0.1	−0.4	−0.7	−0.9	−1.1	−1.3	−1.6	−6.0
Extend outpatient capital reduction	0.0	0.0	0.0	0.1	0.1	0.2	0.2	−0.6
Extend outpatient payment reduction	0.0	0.0	0.0	0.3	0.3	0.4	0.4	−1.4

H.R. 2425 AS REPORTED BY THE COMMITTEE ON WAYS AND MEANS—BY FISCAL YEAR—Continued

[In billions of dollars]

	1996	1997	1998	1999	2000	2001	2002	Total
Freeze payments for ASC services	−0.0	−0.1	−0.1	−0.2	−0.2	−0.3	−0.4	−1.3
Establish REACH program [10]	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2
Allow chiropractors to make referrals	0.1	0.2	0.2	0.2	0.3	0.4	0.4	1.7
Allow payments for certain oral cancer medication	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.5
Interactions	−0.1	−0.1	−0.2	−0.2	−0.3	−0.3	−0.3	−1.4
Part 2—Part B Premium:								
Extension of Part B premium at 31.5%	−3.2	−4.1	−3.9	−5.1	−7.6	−10.2	−13.4	−47.5
Income-related reduction in medicare subsidy	0.0	−0.4	−0.7	−1.2	−1.5	−1.7	−2.0	−7.5
Subtotal, Subtitle G	−4.9	−8.1	−10.0	−13.9	−18.7	−23.8	−30.1	−109.5
Subtitle H—Medicare Parts A and B:								
Payment for home health services	0.0	−1.4	−2.3	−2.8	−3.2	−3.6	−4.1	−17.3
Medicare second payer improvements	0.0	0.0	0.0	−1.3	−1.5	−1.6	−1.8	−6.2
Subtotal, Subtitle H	0.0	−1.4	−2.3	−4.0	−4.6	−5.2	−5.9	−23.5
Change in Net Mandatory Medicare Outlays before Failsafe	−8.1	−15.6	−22.1	−31.7	−42.3	−53.0	−65.7	−238.4
Additional Outlays Reduction Required by Failsafe, Net of Premiums [11]	0.0	0.0	−4.6	−7.7	−6.9	−7.0	−5.5	−31.8
Total, Medicare	−8.1	−15.6	−26.7	−39.4	−49.2	−59.9	−71.3	−270.2
Subtitle E—Teaching Hospitals and Graduate Medical Education Trust Fund	0.0	0.4	0.6	2.0	3.0	4.0	5.8	15.8
Total, H.R. 2425	−8.1	−15.2	−26.1	−37.4	−46.2	−55.9	−65.5	−254.4

H.R. 2425 AS REPORTED BY THE COMMITTEE ON WAYS AND MEANS—BY FISCAL YEAR—Continued

[In billions of dollars]

	1996	1997	1998	1999	2000	2001	2002	Total
Memorandum: Monthly Part B Premium (By calendar year):								
Estimated premium before failsafe	53.40	57.40	61.80	67.10	75.10	81.90	90.90	.....
Estimated premium after failsafe	53.40	56.70	59.50	64.20	72.40	79.40	88.20	.....

FOOTNOTES:

[1] Estimate includes medical savings accounts provision.

[2] This provision would increase spending by about $40 million over the period 1996 through 2002.

[3] Includes provision for sole community hospitals.

[4] These provisions are described in Subtitle E and included by reference in Subtitle F.

[5] This estimate assumes that the provision will only be applied to existing LTC facilities.

[6] This estimate assumes that grandfathering would apply only to existing long term care hospitals that are located in the same building as, or on the same campus as, another hospital.

[7] This provision would cost approximately $5 million per year.

[8] This provision is budget neutral if EACH/RPCH designation is limited to those hospitals currently so designated, hospitals/facilities can be designated as such.

[9] This line includes a 1% annual update for prosthetics and orthotics

[10] This estimate assumes that policy is to provide cost-based reimbursement for specified Part B services only, as specified in subtitle. The provision would cost approximately $20–$30 million per year.

[11] For this estimate, CBO assumes that the target levels of benefits would be consistent with the mandatory spending levels specified in the budget resolution. Reductions in outlays for benefits would be larger than the amounts shown here because of interactions with the Part B premium.

NOTES:

Details may not sum to total because of rounding.

These estimates assume an enactment date of November 15, 1995. The estimates would change if the proposal was enacted at a later date.

To the extent that health care providers are able to offset lower reimbursements by shifting costs to other payers, federal revenues could fall.

These estimates do not incorporate changes in discretionary spending for administration.

H.R. 2425 AS REPORTED BY THE COMMITTEE ON WAYS AND MEANS—BY FISCAL YEAR

[In billions of dollars]

	1995	1996	1997	1998	1999	2000	2001	2002	Total
Comparison of Mandatory Medicare Spending Under H.R. 2425 With Current Law:									
Gross Outlays for Medicare Benefits before Failsafe:									
Current Law	177.8	198.6	219.1	240.1	263.0	287.7	314.8	344.8	.....
H.R. 2425	.....	193.7	208.0	222.6	237.6	254.6	273.7	294.5	.....
Change	.....	−4.9	−11.1	−17.5	−25.5	−33.1	−41.1	−50.3	−183.5
Less: Part A and Flat Part B Premiums before Failsafe:									
Current Law	−20.1	−20.3	−21.9	−24.4	−26.0	−27.2	−28.5	−29.9	.....
H.R. 2425	.....	−23.4	−26.0	−28.3	−31.0	−34.9	−38.7	−43.3	.....
Change	.....	−3.2	−4.1	−3.9	−5.1	−7.6	−10.2	−13.4	−47.5
Less: Income-Related Part B Premiums before Failsafe:									
Current Law	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	.....
H.R. 2425	.....	0.0	−0.4	−0.7	−1.2	−1.5	−1.7	−2.0	.....
Change	.....	0.0	−0.4	−0.7	−1.2	−1.5	−1.7	−2.0	−7.5
Net Outlays for Medicare Benefits before Failsafe:									
Current Law	157.7	178.4	197.2	215.7	237.1	260.5	286.3	314.9	.....
H.R. 2425	.....	170.3	181.6	193.6	205.3	218.2	233.3	249.2	.....
Change	.....	−8.1	−15.6	−22.1	−31.7	−42.3	−53.0	−65.7	−238.4
Additional Outlay Reductions Required by Failsafe, Net of Premiums	.....	0.0	0.0	−4.6	−7.7	−6.9	−7.0	−5.5	−31.8
Change in Net Outlays with Failsafe	.....	−8.1	−15.6	−26.7	−39.4	−49.2	−59.9	−71.3	−270.2
Net Outlays for Medicare Benefits Under H.R. 2425	.....	170.3	181.6	189.0	197.6	211.3	226.4	243.7	.....
Net Medicare Outlays Including Mandatory Administration Under H.R. 2425	.....	170.7	181.9	189.3	198.0	211.6	226.7	244.0	.....

V. OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

A. Committee Oversight Findings and Recommendations

With respect to subdivision (A) of clause 2(l)(3) of rule XI of the Rules of the House of Representatives (relating to oversight findings), the Committee advises that it was as a result of the Committee's oversight activities concerning the financial problems facing both the Hospital Insurance and Supplementary Medical Insurance Trust Funds that the Committee concluded that it is appropriate to enact the provisions contained in the bill.

B. Summary of Findings and Recommendations of the Committee on Government Reform and Oversight

With respect to subdivision (D) of clause 2(l)(3) of rule XI of the Rules of the House of Representatives (relating to oversight findings), the Committee advises that no oversight findings or recommendations have been submitted to this Committee by the Committee on Government Reform and Oversight with respect to the provisions contained in this bill.

C. Inflationary Impact Statement

In compliance with clause 2(l)(4) of rule XI of the Rules of the House of Representatives, the Committee states that the provisions of the bill are not expected to have an overall inflationary impact on prices and costs in the operation of the national economy. As is indicated above (in part IV of this report), the bill is projected to be deficit neutral over fiscal years 1996–2002.

VI. APPLICABILITY OF HOUSE RULE XXI5(C)

Rule XXI5(c) of the Rules of the House of Representatives provides that "No bill or joint resolution, amendment, or conference report carrying a Federal income tax rate increase shall be considered as passed or agreed to unless so determined by a vote of not less than three-fifths of the Members voting." The Committee has carefully reviewed the provisions of H.R. 2425 approved by the Committee to determine whether any of these provisions constitute a Federal income tax rate increase within the meaning of the House Rules. It is the opinion of the Committee that there is no provision of H.R. 2425 that constitutes a Federal income tax rate increase within the meaning of House Rule XXI5(c) or (d).

VII. APPLICABILITY OF FEDERAL ADVISORY COMMITTEE ACT

Pursuant to the Federal Advisory Committee Act (5 U.S.C., App., section 5(b)), the Committee states that any advisory bodies created by the bill, such as the Medicare Payment Review Commission in section 15031 and the Commission on the Effect of the Baby Boom Generation in section 15031, are consciously created, and are deemed appropriate and necessary to carry out the purposes of the bill. It is the view of the Committee that the functions of any such advisory bodies are not being and could not be performed by one

or more agencies or by an advisory committee already in existence, or by enlarging the mandate of an existing advisory committee.

VIII. CHANGES IN EXISTING LAW MADE BY THE BILL AS REPORTED

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XI—GENERAL PROVISIONS AND PEER REVIEW

* * * * * * *

PART A—GENERAL PROVISIONS

* * * * * * *

APPOINTMENT OF THE ADMINISTRATOR OF THE HEALTH CARE FINANCING ADMINISTRATION

SEC. 1117. The Administrator of the Health Care Financing Administration shall be appointed by the [President by and with the advice and consent of the Senate] *Secretary of Health and Human Services*.

* * * * * * *

EXCLUSION OF CERTAIN INDIVIDUALS AND ENTITIES FROM PARTICIPATION IN MEDICARE AND STATE HEALTH CARE PROGRAMS

SEC. 1128. (a) * * *

* * * * * * *

(c) NOTICE, EFFECTIVE DATE, AND PERIOD OF EXCLUSION.—(1) * * *

* * * * * * *

(3)(A) * * *

* * * * * * *

(D) In the case of an exclusion of an individual or entity under paragraph (1), (2), or (3) of subsection (b), the period of the exclusion shall be 3 years, unless the Secretary determines in accordance with regulations that a shorter period is appropriate because of mitigating circumstances or that a longer period is appropriate because of aggravating circumstances.

(E) In the case of an exclusion of an individual or entity under subsection (b)(4) or (b)(5), the period of the exclusion shall not be less than the period during which the individual's or entity's license

to provide health care is revoked, suspended, or surrendered, or the individual or the entity is excluded or suspended from a Federal or State health care program.

(F) In the case of an exclusion of an individual or entity under subsection (b)(6)(B), the period of the exclusion shall be not less than 1 year.

* * * * * * *

CIVIL MONETARY PENALTIES

SEC. 1128A. (a) Any person (including an organization, agency, or other entity, but excluding a beneficiary, as defined in subsection (i)(5)) that—

(1) *knowingly* presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (i)(1)), a claim (as defined in subsection (i)(2)) that the Secretary determines—

(A) * * *

* * * * * * *

(2) *knowingly* presents or causes to be presented to any person a request for payment which is in violation of the terms of (A) an assignment under section 1842(b)(3)(B)(ii), or (B) an agreement with a State agency (or other requirement of a State plan under title XIX) not to charge a person for an item or service in excess of the amount permitted to be charged, or (C) an agreement to be a participating physician or supplier under section 1842(h)(1), or (D) an agreement pursuant to section 1866(a)(1)(G), or

(3) [gives] *knowingly gives or causes to be given* to any person, with respect to coverage under title XVIII of inpatient hospital services subject to the provisions of section 1886, information that he knows or should know is false or misleading, and that could reasonably be expected to influence the decision when to discharge such person or another individual from the hospital;

* * * * * * *

(b)(1) * * *

* * * * * * *

(3)(A) Any physician who executes a document described in subparagraph (B) with respect to an individual knowing that all of the requirements referred to in such subparagraph are not met with respect to the individual shall be subject to a civil monetary penalty of not more than the greater of—

(i) $5,000, or

(ii) three times the amount of the payments under title XVIII for home health services which are made pursuant to such certification,.

(B) A document described in this subparagraph is any document that certifies, for purposes of title XVIII, that an individual meets

the requirements of section 1814(a)(2)(C) or 1835(a)(2)(A) in the case of home health services furnished to the individual.

* * * * * * *

(f) Civil money penalties and assessments imposed under this section may be compromised by the Secretary and may be recovered in a civil action in the name of the United States brought in United States district court for the district where the claim was presented, or where the claimant resides, as determined by the Secretary. Amounts recovered under this section shall be paid to the Secretary and disposed of as follows:

(1) * * *

* * * * * * *

(3) The remainder of the amounts recovered shall be deposited [as miscellaneous receipts of the Treasury of the United States] *in the Anti-Fraud and Abuse Trust Fund established under section 1893(g).*

The amount of such penalty or assessment, when finally determined, or the amount agreed upon in compromise, may be deducted from any sum then or later owing by the United States or a State agency to the person against whom the penalty or assessment has been assessed.

* * * * * * *

(i) For the purposes of this section:

(1) * * *

* * * * * * *

(6) The term "should know" means that a person, with respect to information—

(A) acts in deliberate ignorance of the truth or falsity of the information; or

(B) acts in reckless disregard of the truth or falsity of the information,

and no proof of specific intent to defraud is required.

* * * * * * *

CRIMINAL PENALTIES FOR ACTS INVOLVING MEDICARE OR STATE HEALTH CARE PROGRAMS

SEC. 1128B. (a) * * *

(b)(1) * * *

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person [to induce] *for the significant purpose of inducing* such person—

(A) * * *

* * * * * * *

(3) Paragraphs (1) and (2) shall not apply to—

(A) * * *

* * * * * * *

(D) a waiver of any coinsurance under part B of title XVIII by a Federally qualified health care center with respect to an

individual who qualifies for subsidized services under a provision of the Public Health Service Act; [and]

(E) any payment practice specified by the Secretary in regulations promulgated pursuant to section 14(a) of the Medicare and Medicaid Patient and Program Protection Act of 1987[.] *; and*

(F) any remuneration between an organization and an individual or entity providing services pursuant to a written agreement between the organization and the individual or entity if the organization is a MedicarePlus organization under part C of title XVIII or if the written agreement places the individual or entity at substantial financial risk for the cost or utilization of the items or services which the individual or entity is obligated to provide, whether through a withhold, capitation, incentive pool, per diem payment, or any other similar risk arrangement which places the individual or entity at substantial financial risk.

* * * * * * *

VOLUNTARY DISCLOSURE OF ACTS OR OMISSIONS

SEC. 1129. (a) ESTABLISHMENT OF VOLUNTARY DISCLOSURE PROGRAM.—Not later than 3 months after the date of the enactment of this section, the Secretary shall establish a program to encourage individuals and entities to voluntarily disclose to the Secretary information on acts or omissions of the individual or entity which constitute grounds for the imposition of a sanction described in section 1128, 1128A, or 1128B.

(b) EFFECT OF VOLUNTARY DISCLOSURE.—If an individual or entity voluntarily discloses information with respect to an act or omission to the Secretary under subsection (a), the following rules shall apply:

(1) The Secretary may waive, reduce, or otherwise mitigate any sanction which would otherwise be applicable to the individual or entity under section 1128, 1128A, or 1128B as a result of the act or omission involved.

(2) No qui tam action may be brought pursuant to chapter 37 of title 31, United States Code, against the individual or entity with respect to the act or omission involved.

ADVISORY OPINIONS

SEC. 1130. (a) ISSUANCE OF ADVISORY OPINIONS.—The Secretary shall issue written advisory opinions as provided in this section.

(b) MATTERS SUBJECT TO ADVISORY OPINIONS.—The Secretary shall issue advisory opinions as to the following matters:

(1) What constitutes prohibited remuneration within the meaning of section 1128B(b).

(2) Whether an arrangement or proposed arrangement satisfies the criteria set forth in section 1128B(b)(3) for activities which do not result in prohibited remuneration.

(2) Whether an arrangement or proposed arrangement satisfies the criteria which the Secretary has established, or shall establish by regulation for activities which do not result in prohibited remuneration.

(4) What constitutes an inducement to reduce or limit services to individuals entitled to benefits under title XVIII or title XIX or title XXI within the meaning of section 1128B(b).

(5) Whether any activity or proposed activity constitutes grounds for the imposition of a sanction under section 1128, 1128A, or 1128B.

(c) MATTERS NOT SUBJECT TO ADVISORY OPINIONS.—Such advisory opinions shall not address the following matters:

(1) Whether the fair market value shall be, or was paid or received for any goods, services or property.

(2) Whether an individual is a bona fide employee within the requirements of section 3121(d)(2) of the Internal Revenue Code of 1986.

(d) EFFECT OF ADVISORY OPINIONS.—

(1) BINDING AS TO SECRETARY AND PARTIES INVOLVED.—Each advisory opinion issued by the Secretary shall be binding as to the Secretary and the party or parties requesting the opinion.

(2) FAILURE TO SEEK OPINION.—The failure of a party to seek an advisory opinion may not be introduced into evidence to prove that the party intended to violate the provisions of sections 1128, 1128A, or 1128B.

(e) REGULATIONS.—

(1) IN GENERAL.—Not later than 180 days after the date of the enactment of this section, the Secretary shall issue regulations of this section, the Secretary shall issue regulations to carry out this section. Such regulations shall provide for—

(A) the procedure to be followed by a party applying for an advisory opinion;

(B) the procedure to be followed by the Secretary in responding to a request for an advisory opinion;

(C) the interval in which the Secretary shall respond;

(D) the reasonable fee to be charged to the party requested an advisory opinion; and

(E) the manner in which advisory opinions will be made available to the public.

(2) SPECIFIC CONTENTS.—Under the regulations promulgated pursuant to paragraph (1)—

(A) the Secretary shall be required to respond to a party requesting an advisory opinion by not later than 30 days after the request is received; and

(B) the fee charged to the party requesting an advisory opinion shall be equal to the costs incurred by the Secretary in responding to the request.

* * * * * * *

[MEDICARE AND MEDICAID COVERAGE DATA BANK

[SEC. 1144. (a) ESTABLISHMENT OF DATA BANK.—The Secretary shall establish a Medicare and Medicaid Coverage Data Bank (hereafter in this section referred to as the "Data Bank") to—

[(1) further the purposes of section 1862(b) in the identification of, and collection from, third parties responsible for payment for health care items and services furnished to medicare beneficiaries, and

[(2) assist in the identification of, and the collect from, third parties responsible for the reimbursement of costs incurred by any State plan under title XIX with respect of medicaid beneficiaries, upon request by the State agency described in section 1902(a)(5) administering such plan.

[(b) INFORMATION IN DATA BANK.—

[(1) IN GENERAL.—The Data Bank shall contain information obtained pursuant to section 6103(1)(12) of the Internal Revenue Code of 1986 and subsection (c).

[(2) DISCLOSURE OF INFORMATION IN DATA BANK.—The Secretary is authorized until September 30, 1998—

[(A) (subject to the restriction in subparagraph (D)(i) of section 6103(l)(12) of the Internal Revenue Code of 1986) to disclose any information in the Data Bank obtained pursuant to such section solely for the purposes of such section, and

[(B) (subject to the restriction in subsection (c)(7)) to disclose any other information in the Data Bank to any State agency described in section 1902(a)(5), employer, or group health plan solely for the purposes described in subsection (a).

[(c) REQUIREMENT THAT EMPLOYERS REPORT INFORMATION.—

[(1) REPORTING REQUIREMENT.—

[(A) IN GENERAL.—Any employer described in paragraph (2) shall report to the Secretary (in such form and manner as the Secretary determines will minimize the burden of such reporting) with respect to each electing individual the information required under paragraph (5) for each calendar year beginning on or after January 1, 1994, and before January 1, 1998.

[(B) SPECIAL RULE.—To the extent a group health plan provides information required under paragraph (5) in a form and manner specified by the Secretary (in consultation with the Secretary of Labor) on behalf of an employer in accordance with section 101(f) of the Employee Retirement Income Security Act of 1974, the employer has complied with the reporting requirement under subparagraph (A) with respect to the reporting of such information.

[(2) EMPLOYER DESCRIBED.—An employer is described in this paragraph if such employer has, or contributes to, a group health plan, with respect to which at least 1 employee of such employer is an electing individual.

[(3) ELECTING INDIVIDUAL.—For purposes of this subsection, the term "electing individual" means an individual associated or formerly associated with the employer in a business relationship who elects coverage under the employer's group health plan.

[(4) CERTAIN INDIVIDUALS EXCLUDED.—For purposes of this subsection, an individual providing service referred to in section 3121(a)(7)(B) of the Internal Revenue Code of 1986 shall not be considered an employee or electing individual with respect to an employer.

[(5) INFORMATION REQUIRED.—For purposes of paragraph (1), each employer shall provide the following information:

[(A) The name and TIN of the electing individual.

[(B) The type of group health plan coverage (single or family) elected by the electing individual.

[(C) The name, address, and identifying number of the group health plan elected by such electing individual.

[(D) The name and TIN of each other individual covered under the group health plan pursuant to such election.

[(E) The period during which such coverage is elected.

[(F) The name, address, and TIN of the employer.

[(6) TIME OF FILING.—For purposes of determining the date for filing the report under paragraph (1), such report shall be treated as a statement described in section 6051(d) of the Internal Revenue Code of 1986.

[(7) LIMITS ON DISCLOSURE OF INFORMATION REPORTED.—

[(A) IN GENERAL.—The disclosure of the information reported under paragraph (1) shall be restricted by the Secretary under rules similar to the rules of subsections(a) and (p) of section 6103 of the Internal Revenue Code of 1986.

[(B) PENALTY FOR UNAUTHORIZED WILLFUL DISCLOSURE OF INFORMATION.—The unauthorized disclosure of any information reported under paragraph (1) shall be subject to the penalty described in paragraph (1), (2), (3), or (4) of section 7213(a) of such Code.

[(9) PENALTY FOR FAILURE TO REPORT.—In the case of the failure of an employer (other than a Federal or other governmental entity) to report under paragraph (1)(A) with respect to each electing individual, the Secretary shall impose a penalty as described in part II of subchapter B of chapter 68 of the Internal Revenue Code of 1986.

[(d) FEES FOR DATA BANK SERVICES.—The Secretary shall establish fees for services provided under this section which shall remain available, without fiscal year limitation, to the Secretary to cover the administrative costs to the Data Bank of providing such services.

[(f) DEFINITIONS.—In this section:

[(1) MEDICARE BENEFICIARY.—The term "medicare beneficiary" means an individual entitled to benefits under part A, or enrolled under part B, of title XVIII, but does not include such an individual enrolled in part A under section 1818.

[(2) MEDICAID BENEFICIARY.—The term "medicaid beneficiary" means an individual entitled to benefits under a State plan for medical assistance under title XIX (including a State plan operating under a statewide waiver under section 1115).

[(3) GROUP HEALTH PLAN.—The term "group health plan" shall have the meaning given to such term by section 5000(b)(1) of the Internal Revenue Code of 1986.

[(4) TIN.—The term "TIN" shall have the meaning given to such term by section 7701(a)(41) of such Code.]

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

PROVIDING FOR CHOICE OF COVERAGE

SEC. 1805. (a) CHOICE OF COVERAGE.—

(1) IN GENERAL.—Subject to the provisions of this section, every individual who is entitled to benefits under part A and enrolled under part B shall elect to receive benefits under this title through one of the following:

(A) THROUGH FEE-FOR-SERVICE SYSTEM.—Through the provisions of parts A and B.

(B) THROUGH A MEDICAREPLUS PRODUCT.—Through a MedicarePlus product (as defined in paragraph (2)), which may be—

(i) a high deductible/medisave product (and a contribution into a MedicarePlus medical savings account (MSA)),

(ii) a product offered by a provider-sponsored organization,

(iii) a product offered by an organization that is a Taft-Hartley plan or association, or

(iv) a product providing for benefits on a fee-for-service or other basis.

(2) MEDICAREPLUS PRODUCT DEFINED.—For purposes this section and part C, the term "MedicarePlus product" means health benefits coverage offered under a policy, contract, or plan by a MedicarePlus organization (as defined in section 1851(a)) pursuant to and in accordance with a contract under section 1857.

(3) TERMINOLOGY RELATING TO OPTIONS.—For purposes of this section and part C—

(A) NON-MEDICARE-PLUS OPTION.—An individual who has made the election described in paragraph (1)(A) is considered to have elected the "Non-MedicarePlus option".

(B) MEDICAREPLUS OPTION.—An individual who has made the election described in paragraph (1)(B) to obtain coverage through a MedicarePlus product is considered to have elected the "MedicarePlus option" for that product.

(b) SPECIAL RULES.—

(1) RESIDENCE REQUIREMENT.—Except as the Secretary may otherwise provide, an individual is eligible to elect a MedicarePlus product offered by a MedicarePlus organization only if the organization in relation to the product serves the geographic area in which the individual resides.

(2) AFFILIATION REQUIREMENTS FOR CERTAIN PRODUCTS.—

(A) IN GENERAL.—Subject to subparagraph (B), an individual is eligible to elect a MedicarePlus product offered by a limited enrollment MedicarePlus organization (as defined in section 1852(c)(4)(D)) only if—

(i) the individual is eligible under section 1852(c)(4) to make such election, and

(ii) in the case of a MedicarePlus organization that is a Taft-Hartley sponsor (as defined in section

1852(c)(4)), the individual elected under this section a MedicarePlus product offered by the sponsor during the first enrollment period in which the individual was eligible to make such election with respect to such sponsor.

(B) NO REELECTION AFTER DISENROLLMENT FOR CERTAIN PRODUCTS.—An individual is not eligible to elect a MedicarePlus product offered by a MedicarePlus organization that is a Taft-Hartley sponsor if the individual previously had elected a MedicarePlus product offered by the organization and had subsequently discontinued to elect such a product offered by the organization.

(3) SPECIAL RULE FOR CERTAIN ANNUITANTS.—An individual is not eligible to elect a high deductible/medisave product if the individual is entitled to benefits under chapter 89 of title 5, United States Code, as an annuitant or spouse of an annuitant.

(c) PROCESS FOR EXERCISING CHOICE.—

(1) IN GENERAL.—The Secretary shall establish a process through which elections described in subsection (a) are made and changed, including the form and manner in which such elections are made and changed. Such elections shall be made or changed only during coverage election periods specified under subsection (e) and shall become effective as provided in subsection (f).

(2) EXPEDITED IMPLEMENTATION.—The Secretary shall establish the process of electing coverage under this section during the transition period (as defined in subsection (e)(1)(B)) in such an expedited manner as will permit such an election for MedicarePlus products in an area as soon as such products become available in that area.

(3) COORDINATION THROUGH MEDICARE-PLUS ORGANIZATIONS.—

(A) ENROLLMENT.—Such process shall permit an individual who wishes to elect a MedicarePlus product offered by a MedicarePlus organization to make such election through the filing of an appropriate election form with the organization.

(B) DISENROLLMENT.—Such process shall permit an individual, who has elected a MedicarePlus product offered by a MedicarePlus organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

(4) DEFAULT.—

(A) INITIAL ELECTION.—

(i) IN GENERAL.—Subject to clause (ii), an individual who fails to make an election during an initial election period under subsection (e)(1) is deemed to have chosen the Non-MedicarePlus option.

(ii) SEAMLESS CONTINUATION OF COVERAGE.—The Secretary shall establish procedures under which individuals who are enrolled with a MedicarePlus organization at the time of the initial election period and who fail to elect to receive coverage other than through the

organization are deemed to have elected an appropriate MedicarePlus product offered by the organization.

(B) CONTINUING PERIODS.—An individual who has made (or deemed to have made) an election under this section is considered to have continued to make such election until such time as—

(i) the individual changes the election under this section, or

(ii) a MedicarePlus product is discontinued, if the individual had elected such product at the time of the discontinuation.

(5) AGREEMENTS WITH COMMISSIONER OF SOCIAL SECURITY TO PROMOTE EFFICIENT ADMINISTRATION.—In order to promote the efficient administration of this section and the MedicarePlus program under part C, the Secretary may enter into an agreement with the Commissioner of Social Security under which the Commissioner performs administrative responsibilities relating to enrollment and disenrollment in MedicarePlus products under this section.

(d) PROVISION OF BENEFICIARY INFORMATION TO PROMOTE INFORMED CHOICE.—

(1) IN GENERAL.—The Secretary shall provide for activities under this subsection to disseminate broadly information to medicare beneficiaries (and prospective medicare beneficiaries) on the coverage options provided under this section in order to promote an active, informed selection among such options. Such information shall be made available on such a timely basis (such as 6 months before the date an individual would first attain eligibility for medicare on the basis of age) as to permit individuals to elect the MedicarePlus option during the initial election period described in subsection (e)(1).

(2) USE OF NONFEDERAL ENTITIES.—The Secretary shall, to the maximum extent feasible, enter into contracts with appropriate non-Federal entities to carry out activities under this subsection.

(3) SPECIFIC ACTIVITIES.—In carrying out this subsection, the Secretary shall provide for at least the following activities in all areas in which MedicarePlus products are offered:

(A) INFORMATION BOOKLET.—

(i) IN GENERAL.—The Secretary shall publish an information booklet and disseminate the booklet to all individuals eligible to elect the MedicarePlus option under this section during coverage election periods.

(ii) INFORMATION INCLUDED.—The booklet shall include information presented in plain English and in a standardized format regarding—

(I) the benefits (including cost-sharing) and premiums for the various MedicarePlus products in the areas involved;

(II) the quality of such products, including consumer satisfaction information; and

(III) rights and responsibilities of medicare beneficiaries under such products.

(iii) PERIODIC UPDATING.—The booklet shall be updated on a regular basis (not less often than once every 12 months) to reflect changes in the availability of MedicarePlus products and the benefits and premiums for such products.

(B) TOLL-FREE NUMBER.—The Secretary shall maintain a toll-free number for inquiries regarding MedicarePlus options and the operation of part C.

(C) GENERAL INFORMATION IN MEDICARE HANDBOOK.—The Secretary shall include information about the MedicarePlus option provided under this section in the annual notice of medicare benefits under section 1804.

(e) COVERAGE ELECTION PERIODS.—

(1) INITIAL CHOICE UPON ELIGIBILITY TO MAKE ELECTION.—

(A) IN GENERAL.—In the case of an individual who first becomes entitled to benefits under part A and enrolled under part B after the beginning of the transition period (as defined in subparagraph (B)), the individual shall make the election under this section during a period (of a duration and beginning at a time specified by the Secretary) at the first time the individual both is entitled to benefits under part A and enrolled under part B. Such period shall be specified in a manner so that, in the case of an individual who elects a MedicarePlus product during the period, coverage under the product becomes effective as of the first date on which the individual may receive such coverage.

(B) TRANSITION PERIOD DEFINED.—In this subsection, the term "transition period" means, with respect to an individual in an area, the period beginning on the first day of the first month in which a MedicarePlus product is first made available to individuals in the area and ending with the month preceding the beginning of the first annual, coordinated election period under paragraph (3).

(2) DURING TRANSITION PERIOD.—Subject to paragraph (6)—

(A) CONTINUOUS OPEN ENROLLMENT INTO A MEDICAREPLUS OPTION.—During the transition period, an individual who is eligible to make an election under this section and who has elected the non-MedicarePlus option may change such election to a MedicarePlus option at any time.

(B) OPEN DISENROLLMENT BEFORE END OF TRANSITION PERIOD.—

(i) IN GENERAL.—During the transition period, an individual who has elected a MedicarePlus option for a MedicarePlus product may change such election to another MedicarePlus product or to the non-MedicarePlus option.

(ii) SPECIAL RULE.—During the transition period, an individual who has elected a high deductible/medisave product may not change such election to a MedicarePlus product that is not a high deductible/medisave product unless the individual has had such election in effect for 12 months.

(3) ANNUAL, COORDINATED ELECTION PERIOD.—

(A) IN GENERAL.—Subject to paragraph (5), each individual who is eligible to make an election under this section may change such election during annual, coordinated election periods.

(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term "annual, coordinated election period" means, with respect to a calendar year (beginning with 1998), the month of October before such year.

(C) MEDICAREPLUS HEALTH FAIR DURING OCTOBER, 1996.—In the month of October, 1996, the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform individuals, who are eligible to elect MedicarePlus products, about such products and the election process provided under this section (including the annual, coordinated election periods that occur in subsequent years).

(4) SPECIAL 90-DAY DISENROLLMENT OPTION.—

(A) IN GENERAL.—In the case of the first time an individual elects a MedicarePlus option (other than a high deductible/medisave product) under this section, the individual may discontinue such election through the filing of an appropriate notice during the 90-day period beginning on the first day on which the individual's coverage under the MedicarePlus product under such option becomes effective.

(B) EFFECT OF DISCONTINUATION OF ELECTION.—An individual who discontinues an election under this paragraph shall be deemed at the time of such discontinuation to have elected the Non-MedicarePlus option.

(5) SPECIAL ELECTION PERIODS.—An individual may discontinue an election of a MedicarePlus product offered by a MedicarePlus organization other than during an annual, coordinated election period and make a new election under this section if—

(A) the organization's or product's certification under part C has been terminated or the organization has terminated or otherwise discontinued providing the product;

(B) in the case of an individual who has elected a MedicarePlus product offered by a MedicarePlus organization, the individual is no longer eligible to elect the product because of a change in the individual's place of residence or other change in circumstances (specified by the Secretary, but not including termination of membership in a qualified association in the case of a product offered by a qualified association or termination of the individual's enrollment on the basis described in clause (i) or (ii) section 1852(c)(3)(B));

(C) the individual demonstrates (in accordance with guidelines established by the Secretary) that—

(i) the organization offering the product substantially violated a material provision of the organization's contract under part C in relation to the individual and the product; or

(ii) the organization (or an agent or other entity acting on the organization's behalf) materially misrepre-

sented the product's provisions in marketing the product to the individual; or

(D) the individual meets such other conditions as the Secretary may provide.

(6) SPECIAL RULE FOR HIGH DEDUCTIBLE/MEDISAVE PRODUCTS.—Notwithstanding the previous provisions of this subsection, an individual may elect a high deductible/medisave product only during an annual, coordinated election period described in paragraph (3)(B) or during the month of October, 1996.

(f) EFFECTIVENESS OF ELECTIONS.—

(1) DURING INITIAL COVERAGE ELECTION PERIOD.—An election of coverage made during the initial coverage election period under subsection (e)(1)(A) shall take effect upon the date the individual becomes entitled to benefits under part A and enrolled under part B, except as the Secretary may provide (consistent with section 1838) in order to prevent retroactive coverage.

(2) DURING TRANSITION; 90-DAY DISENROLLMENT OPTION.—An election of coverage made under subsection (e)(2) and an election to discontinue a MedicarePlus option under subsection (e)(4) at any time shall take effect with the first calendar month following the date on which the election is made.

(3) ANNUAL, COORDINATED ELECTION PERIOD AND MEDISAVE ELECTION.—An election of coverage made during an annual, coordinated election period (as defined in subsection (e)(3)(B)) in a year or for a high deductible/medisave product shall take effect as of the first day of the following year.

(4) OTHER PERIODS.—An election of coverage made during any other period under subsection (e)(5) shall take effect in such manner as the Secretary provides in a manner consistent (to the extent practicable) with protecting continuity of health benefit coverage.

(g) EFFECT OF ELECTION OF MEDICAREPLUS OPTION.—Subject to the provisions of section 1855(f), payments under a contract with a MedicarePlus organization under section 1857(a) with respect to an individual electing a MedicarePlus product offered by the organization shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under parts A and B for items and services furnished to the individual.

(h) ADMINISTRATION.—

(1) IN GENERAL.—This part and sections 1805 and 1876 shall be administered through an operating division (A) that is established or identified by the Secretary in the Department of Health and Human Services, (B) that is separate from the Health Care Financing Administration, and (C) the primary function of which is the administration of this part and such sections. The director of such division shall be of equal pay and rank to that of the individual responsible for overall administration of parts A and B.

(2) TRANSFER AUTHORITY.—The Secretary shall transfer such personnel, administrative support systems, assets, records, funds, and other resources in the Health Care Financing Administration to the operating division referred to in paragraph (1) as are used in the administration of section 1876 and as

may be required to implement the provisions referred to in such paragraph promptly and efficiently.

MEDICARE PAYMENT REVIEW COMMISSION

SEC. 1806. (a) ESTABLISHMENT.—There is hereby established the Medicare Payment Review Commission (in this section referred to as the "Commission").

(b) DUTIES.—

(1) GENERAL DUTIES AND REPORTS.—The Commission shall review, and make recommendations to Congress concerning, payment policies under this title. By not later than June 1 of each year, the Commission shall submit a report to Congress containing an examination of issues affecting the medicare program, including the implications of changes in health care delivery in the United States and in the market for health care services on the medicare program. The Commission may submit to Congress from time to time such other reports as the Commission deems appropriate. The Secretary shall respond to recommendations of the Commission in notices of rulemaking proceedings under this title.

(2) SPECIFIC DUTIES RELATING TO MEDICAREPLUS PROGRAM.—Specifically, the Commission shall review, with respect to the MedicarePlus program under part C—

(A) the appropriateness of the methodology for making payment to plans under such program, including the making of differential payments and the distribution of differential updates among different payment areas,

(B) the appropriateness of the mechanisms used to adjust payments for risk and the need to adjust such mechanisms to take into account health status of beneficiaries,

(C) the implications of risk selection both among MedicarePlus organizations and between the MedicarePlus option and the non-MedicarePlus option,

(D) in relation to payment under part C, the development and implementation of mechanisms to assure the quality of care for those enrolled with MedicarePlus organizations,

(F) the impact of the MedicarePlus program on access to care for medicare beneficiaries, and

(G) other major issues in implementation and further development of the MedicarePlus program.

(3) SPECIFIC DUTIES RELATING TO THE FAILSAFE BUDGET MECHANISM.—Specifically, the Commission shall review, with respect to the failsafe budget mechanism described in section 1895—

(A) the appropriateness of the expenditure projections by the Secretary under section 1895(c) for each medicare sector;

(B) the appropriateness of the growth factors for each sector and the ability to take into account substitution across sectors;

(C) the appropriateness of the mechanisms for implementing reductions in payment amounts for different sectors, including any adjustments to reflect changes in volume or intensity resulting for any payment reductions;

(D) the impact of the mechanism on provider participation in parts A and B and in the MedicarePlus program; and

(E) the appropriateness of the medicare benefit budget (under section 1895(c)(2)(C) of the Social Security Act), particularly for fiscal years after fiscal year 2002.

(4) SPECIFIC DUTIES RELATING TO THE FEE-FOR-SERVICE SYSTEM.—Specifically, the Commission shall review payment policies under parts A and B, including—

(A) the factors affecting expenditures for services in different sectors, including the process for updating hospital, physician, and other fees,

(B) payment methodologies; and

(C) the impact of payment policies on access and quality of care for medicare beneficiaries.

(5) SPECIFIC DUTIES RELATING TO INTERACTION OF PAYMENT POLICIES WITH HEALTH CARE DELIVERY GENERALLY.—Specifically the Commission shall review the effect of payment policies under this title on the delivery of health care services under this title and assess the implications of changes in the health services market on the medicare program.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 15 members appointed by Comptroller General.

(2) QUALIFICATIONS.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, actuarial science, health facility management, health plans and integrated delivery systems, reimbursement of health facilities, physicians, and other providers of services, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives, including physicians and other health professionals, employers, third party payors, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research and expertise in outcomes and effectiveness research and technology assessment. Such membership shall also include representatives of consumers and the elderly.

(3) CONSIDERATIONS IN INITIAL APPOINTMENT.—To the extent possible, in first appointing members to the Commission shall consider appointing individuals who (as of the date of the enactment of this section) were serving on the Prospective Payment Assessment Commission or the Physician Payment Review Commission.

(4) TERMS.—

(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that the Comptroller General shall designate staggered terms for the members first appointed.

(B) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor

has taken office. A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

(5) COMPENSATION.—While serving on the business of the Commission (including traveltime), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and member's regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

(6) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment.

(7) MEETINGS.—The Commission shall meet at the call of the Chairman.

(d) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General deems necessary to assure the efficient administration of the Commission, the Commission may—

(1) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

(2) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

(4) make advance, progress, and other payments which relate to the work of the Commission;

(5) provide transportation and subsistence for persons serving without compensation; and

(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

(e) POWERS.—

(1) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon

request of the Chairman, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

(2) DATA COLLECTION.—In order to carry out its functions, the Commission shall collect and assess information

(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate, and

(C) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and data of the Commission, immediately upon request.

(4) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the General Accounting Office.

(f) AUTHORIZATION OF APPROPRIATIONS.—

(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

(2) AUTHORIZATION.—There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. 60 percent of such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and 40 percent of such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund.

STANDARDS FOR MEDICARE INFORMATION TRANSACTIONS AND DATA ELEMENTS

SEC. 1807. (a) ADOPTION OF STANDARDS FOR DATA ELEMENTS.—

(1) IN GENERAL.—Pursuant to subsection (b), the Secretary shall adopt standards for information transactions and data elements of medicare information and modifications to the standards under this section that are—

(A) consistent with the objective of reducing the administrative costs of providing and paying for health care; and

(B) developed or modified by a standard setting organization (as defined in subsection (h)(8)).

(2) SPECIAL RULE RELATING TO DATA ELEMENTS.—The Secretary may adopt or modify a standard relating to data elements that is different from the standard developed by a standard setting organization, if—

(A) the different standard or modification will substantially reduce administrative costs to health care providers and health plans compared to the alternative; and

(B) the standard or modification is promulgated in accordance with the rulemaking procedures of subchapter III of chapter 5 of title 5, United States Code.

(3) SECURITY STANDARDS FOR HEALTH INFORMATION NETWORK.—

(A) IN GENERAL.—Each person, who maintains or transmits medicare information or data elements of medicare information and is subject to this section, shall maintain reasonable and appropriate administrative, technical, and physical safeguards—

(i) to ensure the integrity and confidentiality of the information;

(ii) to protect against any reasonably anticipated—

(I) threats or hazards to the security or integrity of the information; and

(II) unauthorized uses or disclosures of the information; and

(iii) to otherwise ensure compliance with this section by the officers and employees of such person.

(B) SECURITY STANDARDS.—The Secretary shall establish security standards and modifications to such standards with respect to medicare information network services, health plans, and health care providers that—

(i) take into account—

(I) the technical capabilities of record systems used to maintain medicare information;

(II) the costs of security measures;

(III) the need for training persons who have access to medicare information; and

(IV) the value of audit trails in computerized record systems; and

(ii) ensure that a medicare information network service, if it is part of a larger organization, has policies and security procedures which isolate the activities of such service with respect to processing information in a manner that prevents unauthorized access to such information by such larger organization.

The security standards established by the Secretary shall be based on the standards developed or modified by standard setting organizations. If such standards do not exist, the Secretary shall rely on the recommendations of the Medicare Information Advisory Committee (established under subsection (g)) and shall consult with appropriate government agencies and private organizations in accordance with paragraph (5).

(4) IMPLEMENTATION SPECIFICATIONS.—The Secretary shall establish specifications for implementing each of the standards and the modifications to the standards adopted pursuant to paragraph (1) or (3).

(5) ASSISTANCE TO THE SECRETARY.—In complying with the requirements of this section, the Secretary shall rely on recommendations of the Medicare Information Advisory Committee established under subsection (g) and shall consult with appropriate Federal and State agencies and private organizations. The Secretary shall publish in the Federal Register the recommendations of the Medicare Information Advisory Committee regarding the adoption of a standard under this section.

(b) STANDARDS FOR INFORMATION TRANSACTIONS AND DATA ELEMENTS.—

(1) IN GENERAL.—The Secretary shall adopt standards for transactions and data elements to make medicare information uniformly available to be exchanged electronically, that is—

(A) appropriate for the following financial and administrative transactions: claims (including coordination of benefits) or equivalent encounter information, enrollment and disenrollment, eligibility, premium payments, and referral certification and authorization; and

(B) related to other financial and administrative transactions determined appropriate by the Secretary consistent with the goals of improving the operation of the health care system and reducing administrative costs.

(2) UNIQUE HEALTH IDENTIFIERS.—

(A) ADOPTION OF STANDARDS.—The Secretary shall adopt standards providing for a standard unique health identifier for each individual, employer, health plan, and health care provider for use in the medicare information system. In developing unique health identifiers for each health plan and health care provider, the Secretary shall take into account multiple uses for identifiers and multiple locations and specialty classifications for health care providers.

(B) PENALTY FOR IMPROPER DISCLOSURE.—A person who knowingly uses or causes to be used a unique health identifier under subparagraph (A) for a purpose that is not authorized by the Secretary shall—

(i) be fined not more than $50,000, imprisoned not more than 1 year, or both; or

(ii) if the offense is committed under false pretenses, be fined not more than $100,000, imprisoned not more than 5 years, or both.

(3) CODE SETS.—

(A) IN GENERAL.—The Secretary, in consultation with the Medicare Information Advisory Committee, experts from the private sector, and Federal and State agencies, shall—

(i) select code sets for appropriate data elements from among the code sets that have been developed by private and public entities; or

(ii) establish code sets for such data elements if no code sets for the data elements have been developed.

(B) DISTRIBUTION.—The Secretary shall establish efficient and low-cost procedures for distribution (including electronic distribution) of code sets and modifications made to such code sets under subsection (c)(2).

(4) ELECTRONIC SIGNATURE.—

(A) IN GENERAL.—The Secretary, after consultation with the Medicare Information Advisory Committee, shall promulgate regulations specifying procedures for the electronic transmission and authentication of signatures, compliance with which will be deemed to satisfy Federal and State statutory requirements for written signatures with respect to information transactions required by this section and written signatures on enrollment and disenrollment forms.

(B) PAYMENTS FOR SERVICES AND PREMIUMS.—Nothing in this section shall be construed to prohibit the payment of health care services or health plan premiums by debit, credit, payment card or numbers, or other electronic means.

(5) TRANSFER OF INFORMATION BETWEEN HEALTH PLANS.—The Secretary shall develop rules and procedures—

(A) for determining the financial liability of health plans when health care benefits are payable under two or more health plans; and

(B) for transferring among health plans appropriate standard data elements needed for the coordination of benefits, the sequential processing of claims, and other data elements for individuals who have more than one health plan.

(6) COORDINATION OF BENEFITS.—If, at the end of the 5-year period beginning on the date of the enactment of this section, the Secretary determines that additional transaction standards for coordinating benefits are necessary to reduce administrative costs or duplicative (or inappropriate) payment of claims, the Secretary shall establish further transaction standards for the coordination of benefits between health plans.

(7) PROTECTION OF TRADE SECRETS.—Except as otherwise required by law, the standards adopted under this section shall not require disclosure of trade secrets or confidential commercial information by an entity operating a medicare information network.

(c) TIMETABLES FOR ADOPTION OF STANDARDS.—

(1) INITIAL STANDARDS.—Not later than 18 months after the date of the enactment of this section, the Secretary shall adopt standards relating to the information transactions, data elements of medicare information and security described in subsections (a) and (b).

(2) ADDITIONS AND MODIFICATIONS TO STANDARDS.—

(A) IN GENERAL.—The Secretary shall review the standards adopted under this section and shall adopt additional or modified standards, that have been developed or modified by a standard setting organization, as determined appropriate, but not more frequently than once every 12 months. Any addition or modification to such standards shall be completed in a manner which minimizes the disruption and cost of compliance.

(B) ADDITIONS AND MODIFICATIONS TO CODE SETS.—

(i) IN GENERAL.—The Secretary shall ensure that procedures exist for the routine maintenance, testing, enhancement, and expansion of code sets.

(ii) ADDITIONAL RULES.—If a code set is modified under this paragraph, the modified code set shall include instructions on how data elements of medicare information that were encoded prior to the modification may be converted or translated so as to preserve the informational value of the data elements that existed before the modification. Any modification to a code set under this paragraph shall be implemented in

a manner that minimizes the disruption and cost of complying with such modification.

(d) REQUIREMENTS FOR HEALTH PLANS.—

(1) IN GENERAL.—If a person desires to conduct any of the information transactions described in subsection (b)(1) with a health plan as a standard transaction, the health plan shall conduct such standard transaction in a timely manner and the information transmitted or received in connection with such transaction shall be in the form of standard data elements of medicare information.

(2) SATISFACTION OF REQUIREMENTS.—A health plan may satisfy the requirement imposed on such plan under paragraph (1) by directly transmitting standard data elements of medicare information or submitting nonstandard data elements to a medicare information network service for processing into standard data elements and transmission.

(3) TIMETABLES FOR COMPLIANCE WITH REQUIREMENTS.—Not later than 24 months after the date on which standards are adopted under subsections (a) and (b) with respect to any type of information transaction or data element of medicare information or with respect to security, a health plan shall comply with the requirements of this section with respect to such transaction or data element.

(4) COMPLIANCE WITH MODIFIED STANDARDS.—If the Secretary adopts a modified standard under subsection (a) or (b), a health plan shall be required to comply with the modified standard at such time as the Secretary determines appropriate taking into account the time needed to comply due to the nature and extent of the modification. However, the time determined appropriate under the preceding sentence shall be not earlier than the last day of the 180-day period beginning on the date such modified standard is adopted. The Secretary may extend the time for compliance for small health plans, if the Secretary determines such extension is appropriate.

(e) GENERAL PENALTY FOR FAILURE TO COMPLY WITH REQUIREMENTS AND STANDARDS.—

(1) GENERAL PENALTY.—

(A) IN GENERAL.—Except as provided in paragraph (2), the Secretary shall impose on any person that violates a requirement or standard—

(i) with respect to medicare information transactions, data elements of medicare information, or security imposed under subsection (a) or (b); or

(ii) with respect to health plans imposed under subsection (d);

a penalty of not more than $100 for each such violation of a specific standard or requirement, but the total amount imposed for all such violations of a specific standard or requirement during the calendar year shall not exceed $25,000.

(B) PROCEDURES.—The provisions of section 1128A (other than subsections (a) and (b) and the second sentence of subsection (f)) shall apply to the imposition of a civil money penalty under this paragraph in the same manner as such

provisions apply to the imposition of a penalty under such section 1128A.

(C) DENIAL OF PAYMENT.—Except as provided in paragraph (2), the Secretary may deny payment under this title for an item or service furnished by a person if the person fails to comply with an applicable requirement or standard for medicare information relating to that item or service.

(2) LIMITATIONS.—

(A) NONCOMPLIANCE NOT DISCOVERED.—A penalty may not be imposed under paragraph (1) if it is established to the satisfaction of the Secretary that the person liable for the penalty did not know, and by exercising reasonable diligence would not have known, that such person failed to comply with the requirement or standard described in paragraph (1).

(B) FAILURES DUE TO REASONABLE CAUSE.—

(i) IN GENERAL.—Except as provided in clause (ii), a penalty may not be imposed under paragraph (1) if—

(I) the failure to comply was due to reasonable cause and not to willful neglect; and

(II) the failure to comply is corrected during the 30-day period beginning on the first date the person liable for the penalty knew, or by exercising reasonable diligence would have known, that the failure to comply occurred.

(ii) EXTENSION OF PERIOD.—

(I) NO PENALTY.—The period referred to in clause (i)(II) may be extended as determined appropriate by the Secretary based on the nature and extent of the failure to comply.

(II) ASSISTANCE.—If the Secretary determines that a health plan failed to comply because such plan was unable to comply, the Secretary may provide technical assistance to such plan during the period described in clause (i)(II). Such assistance shall be provided in any manner determined appropriate by the Secretary.

(C) REDUCTION.—In the case of a failure to comply which is due to reasonable cause and not to willful neglect, any penalty under paragraph (1) that is not entirely waived under subparagraph (B) may be waived to the extent that the payment of such penalty would be excessive relative to the compliance failure involved.

(f) EFFECT ON STATE LAW.—

(1) GENERAL EFFECT.—

(A) GENERAL RULE.—Except as provided in subparagraph (B), a provision, requirement, or standard under this section shall supersede any contrary provision of State law, including a provision of State law that requires medical or health plan records (including billing information) to be maintained or transmitted in written rather than electronic form.

(B) EXCEPTIONS.—A provision, requirement, or standard under this section shall not supersede a contrary provision

of State law if the Secretary determines that the provision of State law should be continued for any reason, including for reasons relating to prevention of fraud and abuse or regulation of controlled substances.

(2) PUBLIC HEALTH REPORTING.—Nothing in this section shall be construed to invalidate or limit the authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention.

(g) MEDICARE INFORMATION ADVISORY COMMITTEE.—

(1) ESTABLISHMENT.—There is established a committee to be known as the Medicare Information Advisory Committee (in this subsection referred to as the "committee").

(2) DUTIES.—The committee shall—

(A) advise the Secretary in the development of standards under this section; and

(B) be generally responsible for advising the Secretary and the Congress on the status and the future of the medicare information network.

(3) MEMBERSHIP.—

(A) IN GENERAL.—The committee shall consist of 9 members of whom—

(i) 3 shall be appointed by the President;

(ii) 3 shall be appointed by the Speaker of the House of Representatives after consultation with the minority leader of the House of Representatives; and

(iii) 3 shall be appointed by the President pro tempore of the Senate after consultation with the minority leader of the Senate.

The appointments of the members shall be made not later than 60 days after the date of the enactment of this section. The President shall designate 1 member as the Chair.

(B) EXPERTISE.—The membership of the committee shall consist of individuals who are of recognized standing and distinction in the areas of information systems, information networking and integration, consumer health, or health care financial management, and who possess the demonstrated capacity to discharge the duties imposed on the committee.

(C) TERMS.—Each member of the committee shall be appointed for a term of 5 years, except that the members first appointed shall serve staggered terms such that the terms of not more than 3 members expire at one time.

(D) INITIAL MEETING.—Not later than 30 days after the date on which a majority of the members have been appointed, the committee shall hold its first meeting.

(4) REPORTS.—Not later than 1 year after the date of the enactment of this section, and annually thereafter, the committee shall submit to Congress and the Secretary a report regarding—

(A) the extent to which entities using the medicare information network are meeting the standards adopted under this section and working together to form an integrated network that meets the needs of its users;

(B) the extent to which such entities are meeting the security standards established pursuant to this section and the types of penalties assessed for noncompliance with such standards;

(C) any problems that exist with respect to implementation of the medicare information network; and

(D) the extent to which timetables under this section are being met.

Reports made under this subsection shall be made available to health care providers, health plans, and other entities that use the medicare information network to exchange medicare information.

(h) DEFINITIONS.—For purposes of this section:

(1) CODE SET.—The term "code set" means any set of codes used for encoding data elements, such as tables of terms, enrollment information, and encounter data.

(2) COORDINATION OF BENEFITS.—The term "coordination of benefits" means determining and coordinating the financial obligations of health plans when health care benefits are payable under such a plan and under this title (including under a MedicarePlus product).

(3) MEDICARE INFORMATION.—The term "medicare information" means any information that relates to the enrollment of individuals under this title (including information relating to elections of MedicarePlus products under section 1805) and the provision of health benefits (including benefits provided under such products) under this title.

(4) MEDICARE INFORMATION NETWORK.—The term "medicare information network" means the medicare information system that is formed through the application of the requirements and standards established under this section.

(5) MEDICARE INFORMATION NETWORK SERVICE.—The term "medicare information network service" means a public or private entity that—

(A) processes or facilitates the processing of nonstandard data elements of medicare information into standard data elements;

(B) provides the means by which persons may meet the requirements of this section; or

(C) provides specific information processing services.

(6) HEALTH PLAN.—The term "health plan" means a plan which provides, or pays the cost of, health benefits. Such term includes the following, or any combination thereof:

(A) Part A or part B of this title, and includes a MedicarePlus product.

(B) The medicaid program under title XIX and the MediGrant program under title XXI.

(C) A medicare supplemental policy (as defined in section 1882(g)(1)).

(D) Worker's compensation or similar insurance.

(E) Automobile or automobile medical-payment insurance.

(F) A long-term care policy, other than a fixed indemnity policy.

(G) The Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code.

(H) An employee welfare benefit plan, as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(1)), but only to the extent the plan is established or maintained for the purpose of providing health benefits.

(7) INDIVIDUALLY IDENTIFIABLE MEDICARE INFORMATION.—The term "individually identifiable medicare information" means medicare enrollment information, including demographic information collected from an individual, that—

(A) is created or received by a health care provider, health plan, employer, or medicare information network service, and

(B) identifies an individual.

(8) STANDARD SETTING ORGANIZATION.—The term "standard setting organization" means a standard setting organization accredited by the American National Standards Institute.

(9) STANDARD TRANSACTION.—The term "standard transaction" means, when referring to an information transaction or to data elements of medicare information, any transaction that meets the requirements and implementation specifications adopted by the Secretary under subsections (a) and (b).

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PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

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CONDITIONS OF AND LIMITATIONS ON PAYMENT FOR SERVICES

Requirement of Requests and Certifications

SEC. 1814. (a) * * *

Amount Paid to Providers

(b) The amount paid to any provider of services (other than a hospice program providing hospice care, other than a rural primary care hospital providing inpatient rural primary care hospital services, and other than a home health agency with respect to durable medical equipment) with respect to services for which payment may be made under this part shall, subject to the provisions of sections [1813 and 1886] *1813, 1886, 1888, 1888A, and 1894*, be—

(1) * * *

* * * * * * *

Payments to Home Health Agencies for Durable Medical Equipment

(k) The amount paid to any home health agency with respect to durable medical equipment *and prosthetics and orthotics* for which

payment may be made under this part shall be the amount described in section 1834(a)(1) *and 1834(h), respectively*.

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FEDERAL HOSPITAL INSURANCE TRUST FUND

SEC. 1817. (a) * * *

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(k) Each annual report provided in subsection (b)(2) shall include information regarding the annual rate of growth in program expenditures that would be required to maintain the financial solvency of the Trust Fund and the extent to which the provisions of section 1895 restrain the rate of growth of expenditures under this part in order to achieve such solvency.

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REQUIREMENTS FOR, AND ASSURING QUALITY OF CARE IN, SKILLED NURSING FACILITIES

SEC. 1819. (a) SKILLED NURSING FACILITY DEFINED.—In this title, the term "skilled nursing facility" means an institution (or a distinct part of an institution) which—

(1) * * *

* * * * * * *

[(3) meets the requirements for a skilled nursing facility described in subsections (b), (c), and (d) of this section.]

(3)(A) is certified by the Secretary as meeting the standards established under subsection (b), or (B) is a State-certified facility (as defined in subsection (d)).

[(b) REQUIREMENTS RELATING TO PROVISION OF SERVICES.—

[(1) QUALITY OF LIFE.—

[(A) IN GENERAL.—A skilled nursing facility must care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

[(B) QUALITY ASSESSMENT AND ASSURANCE.—A skilled nursing facility must maintain a quality assessment and assurance committee, consisting of the director of nursing services, a physician designated by the facility, and at least 3 other members of the facility's staff, which (i) meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and (ii) develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this subparagraph.

[(2) Scope of services and activities under plan of care.—A skilled nursing facility must provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care which—

[(A) describes the medical, nursing, and psychosocial needs of the resident and how such needs will be met;

[(B) is initially prepared, with the participation to the extent practicable of the resident or the resident's family or legal representative, by a team which includes the resident's attending physician and a registered professional nurse with responsibility for the resident; and

[(C) is periodically reviewed and revised by such team after each assessment under paragraph (3).

[(3) RESIDENTS' ASSESSMENT.—

[(A) REQUIREMENT.—A skilled nursing facility must conduct a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity, which assessment—

[(i) describes the resident's capability to perform daily life functions and significant impairments in functional capacity;

[(ii) is based on a uniform minimum data set specified by the Secretary under subsection (f)(6)(A);

[(iii) uses an instrument which is specified by the State under subsection (e)(5); and

[(iv) includes the identification of medical problems.

[(B) CERTIFICATION.—

[(i) IN GENERAL.—Each such assessment must be conducted or coordinated (with the appropriate participation of health professionals) by a registered professional nurse who signs and certifies the completion of the assessment. Each individual who completes a portion of such an assessment shall sign and certify as to the accuracy of that portion of the assessment.

[(ii) PENALTY FOR FALSIFICATION.—

[(I) An individual who willfully and knowingly certifies under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 with respect to each assessment.

[(II) An individual who willfully and knowingly causes another individual to certify under clause (i) a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 with respect to each assessment.

[(III) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under this clause in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

[(iii) USE OF INDEPENDENT ASSESSORS.—If a State determines, under a survey under subsection (g) or otherwise, that there has been a knowing and willful certification of false assessments under this paragraph, the State may require (for a period specified by the State) that resident assessments under this paragraph be conducted and certified by individuals who

are independent of the facility and who are approved by the State.

[(C) FREQUENCY.—

[(i) IN GENERAL.—Such an assessment must be conducted—

[(I) promptly upon (but no later than 14 days after the date of) admission for each individual admitted on or after October 1, 1990, and by not later than January 1, 1991, for each resident of the facility on that date;

[(II) promptly after a significant change in the resident's physical or mental condition; and

[(III) in no case less often than once every 12 months.

[(ii) RESIDENT REVIEW.—The skilled nursing facility must examine each resident no less frequently than once every 3 months and, as appropriate, revise the resident's assessment to assure the continuing accuracy of the assessment.

[(D) USE.—The results of such an assessment shall be used in developing, reviewing, and revising the resident's plan of care under paragraph (2).

[(E) COORDINATION.—Such assessments shall be coordinated with any State-required preadmission screening program to the maximum extent practicable in order to avoid duplicative testing and effort.

[(4) PROVISION OF SERVICES AND ACTIVITIES.—

[(A) IN GENERAL.—To the extent needed to fulfill all plans of care described in paragraph (2), a skilled nursing facility must provide, directly or under arrangements (or, with respect to dental services, under agreements) with others for the provision of—

[(i) nursing services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

[(ii) medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident;

[(iii) pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident;

[(iv) dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident;

[(v) an on-going program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental, and psychosocial well-being of each resident;

[(vi) routine and emergency dental services to meet the needs of each resident; and

[(vii) treatment and services required by mentally ill and mentally retarded residents not otherwise pro-

vided or arranged for (or required to be provided or arranged for) by the State.

The services provided or arranged by the facility must meet professional standards of quality. Nothing in clause (vi) shall be construed as requiring a facility to provide or arrange for dental services described in that clause without additional charge.

[(B) Qualified persons providing services.—Services described in clauses (i), (ii), (iii), (iv), and (vi) of subparagraph (A) must be provided by qualified persons in accordance with each resident's written plan of care.

[(C) REQUIRED NURSING CARE.—

[(i) IN GENERAL.—Except as provided in clause (ii), a skilled nursing facility must provide 24-hour licensed nursing service which is sufficient to meet nursing needs of its residents and must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week.

[(ii) EXCEPTION.—To the extent that clause (i) may be deemed to require that a skilled nursing facility engage the services of a registered professional nurse for more than 40 hours a week, the Secretary is authorized to waive such requirement if the Secretary finds that—

[(I) the facility is located in a rural area and the supply of skilled nursing facility services in such area is not sufficient to meet the needs of individuals residing therein,

[(II) the facility has one full-time registered professional nurse who is regularly on duty at such facility 40 hours a week,

[(III) the facility either has only patients whose physicians have indicated (through physicians' orders or admission notes) that each such patient does not require the services of a registered nurse or a physician for a 48-hour period, or has made arrangements for a registered professional nurse or a physician to spend such time at such facility as may be indicated as necessary by the physician to provide necessary skilled nursing services on days when the regular full-time registered professional nurse is not on duty,

[(IV) the Secretary provides notice of the waiver to the State long-term care ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965) and the protection and advocacy system in the State for the mentally ill and the mentally retarded, and

[(V) the facility that is granted such a waiver notifies residents of the facility (or, where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

A waiver under this subparagraph shall be subject to annual renewal.

[(5) REQUIRED TRAINING OF NURSE AIDES.—

[(A) IN GENERAL.—(i) Except as provided in clause (ii), a skilled nursing facility must not use on a full-time basis any individual as a nurse aide in the facility on or after October 1, 1990 for more than 4 months unless the individual—

[(I) has completed a training and competency evaluation program, or a competency evaluation program, approved by the State under subsection (e)(1)(A), and

[(II) is competent to provide nursing or nursing-related services.

[(ii) A skilled nursing facility must not use on a temporary, per diem, leased, or on any basis other than as a permanent employee any individual as a nurse aide in the facility on or after January 1, 1991, unless the individual meets the requirements described in clause (i).

[(B) OFFERING COMPETENCY EVALUATION PROGRAMS FOR CURRENT EMPLOYEES.—A skilled nursing facility must provide, for individuals used as a nurse aide by the facility as of January 1, 1990, for a competency evaluation program approved by the State under subsection (e)(1) and such preparation as may be necessary for the individual to complete such a program by October 1, 1990.

[(C) COMPETENCY.—The skilled nursing facility must not permit an individual, other than in a training and competency evaluation program approved by the State, to serve as a nurse aide or provide services of a type for which the individual has not demonstrated competency and must not use such an individual as a nurse aide unless the facility has inquired of any State registry established under subsection (e)(2)(A) that the facility believes will include information concerning the individual.

[(D) RE-TRAINING REQUIRED.—For purposes of subparagraph (A), if, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual performed nursing or nursing-related services for monetary compensation, such individual shall complete a new training and competency evaluation program or a new competency evaluation program.

[(E) REGULAR IN-SERVICE EDUCATION.—The skilled nursing facility must provide such regular performance review and regular in-service education as assures that individuals used as nurse aides are competent to perform services as nurse aides, including training for individuals providing nursing and nursing-related services to residents with cognitive impairments.

[(F) NURSE AIDE DEFINED.—In this paragraph, the term "nurse aide" means any individual providing nursing or

nursing-related services to residents in a skilled nursing facility, but does not include an individual—

[(i) who is a licensed health professional (as defined in subparagraph (G)) or a registered dietician, or

[(ii) who volunteers to provide such services without monetary compensation.

[(G) LICENSED HEALTH PROFESSIONAL DEFINED.—In this paragraph, the term "licensed health professional" means a physician, physician assistant, nurse practitioner, physical, speech, or occupational therapist, physical or occupational therapy assistant, registered professional nurse, licensed practical nurse, licensed or certified social worker, registered respiratory therapist, or certified respiratory therapy technician.

[(6) PHYSICIAN SUPERVISION AND CLINICAL RECORDS.—A skilled nursing facility must—

[(A) require that the medical care of every resident be provided under the supervision of a physician;

[(B) provide for having a physician available to furnish necessary medical care in case of emergency; and

[(C) maintain clinical records on all residents, which records include the plans of care (described in paragraph (2)) and the residents' assessments (described in paragraph (3)).

[(7) REQUIRED SOCIAL SERVICES.—In the case of a skilled nursing facility with more than 120 beds, the facility must have at least one social worker (with at least a bachelor's degree in social work or similar professional qualifications) employed full-time to provide or assure the provision of social services.

[(c) REQUIREMENTS RELATING TO RESIDENTS' RIGHTS.—

[(1) GENERAL RIGHTS.—

[(A) SPECIFIED RIGHTS.—A skilled nursing facility must protect and promote the rights of each resident, including each of the following rights:

[(i) FREE CHOICE.—The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and (except with respect to a resident adjudged incompetent) to participate in planning care and treatment or changes in care and treatment.

[(ii) FREE FROM RESTRAINTS.—The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed—

[(I) to ensure the physical safety of the resident or other residents, and

[(II) only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used (except

in emergency circumstances specified by the Secretary until such an order could reasonably be obtained).

[(iii) PRIVACY.—The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups.

[(iv) CONFIDENTIALITY.—The right to confidentiality of personal and clinical records and to access to current clinical records of the resident upon request by the resident or the resident's legal representative, within 24 hours (excluding hours occurring during a weekend or holiday) after making such a request.

[(v) ACCOMMODATION OF NEEDS.—The right—

[(I) to reside and receive services with reasonable accommodation of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered, and

[(II) to receive notice before the room or roommate of the resident in the facility is changed.

[(vi) GRIEVANCES.—The right to voice grievances with respect to treatment or care that is (or fails to be) furnished, without discrimination or reprisal for voicing the grievances and the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

[(vii) PARTICIPATION IN RESIDENT AND FAMILY GROUPS.—The right of the resident to organize and participate in resident groups in the facility and the right of the resident's family to meet in the facility with the families of other residents in the facility.

[(viii) PARTICIPATION IN OTHER ACTIVITIES.—The right of the resident to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

[(ix) EXAMINATION OF SURVEY RESULTS.—The right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the Secretary or a State with respect to the facility and any plan of correction in effect with respect to the facility.

[(x) REFUSAL OF CERTAIN TRANSFERS.—The right to refuse a transfer to another room within the facility, if a purpose of the transfer is to relocate the resident from a portion of the facility that is a skilled nursing facility (for purposes of this title) to a portion of the facility that is not such a skilled nursing facility.

[(xi) Other rights.—Any other right established by the Secretary.

Clause (iii) shall not be construed as requiring the provision of a private room. A resident's exercise of a right to refuse transfer under clause (x) shall not affect the resi-

dent's eligibility or entitlement to benefits under this title or to medical assistance under title XIX of this Act.

[(B) NOTICE OF RIGHTS AND SERVICES.—A skilled nursing facility must—

[(i) inform each resident, orally and in writing at the time of admission to the facility, of the resident's legal rights during the stay at the facility;

[(ii) make available to each resident, upon reasonable request, a written statement of such rights (which statement is updated upon changes in such rights) including the notice (if any) of the State developed under section 1919(e)(6); and

[(iii) inform each other resident, in writing before or at the time of admission and periodically during the resident's stay, of services available in the facility and of related charges for such services, including any charges for services not covered under this title or by the facility's basic per diem charge.

The written description of legal rights under this subparagraph shall include a description of the protection of personal funds under paragraph (6) and a statement that a resident may file a complaint with a State survey and certification agency respecting resident abuse and neglect and misappropriation of resident property in the facility.

[(C) RIGHTS OF INCOMPETENT RESIDENTS.—In the case of a resident adjudged incompetent under the laws of a State, the rights of the resident under this title shall devolve upon, and, to the extent judged necessary by a court of competent jurisdiction, be exercised by, the person appointed under State law to act on the resident's behalf.

[(D) USE OF PSYCHOPHARMACOLOGIC DRUGS.—Psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the written plan of care described in paragraph (2)) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each resident receiving such drugs. In determining whether such a consultant is qualified to conduct reviews under the preceding sentence, the Secretary shall take into account the needs of nursing facilities under this title to have access to the services of such a consultant on a timely basis.

[(E) INFORMATION RESPECTING ADVANCE DIRECTIVES.—A skilled nursing facility must comply with the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).

[(2) TRANSFER AND DISCHARGE RIGHTS.—

[(A) IN GENERAL.—A skilled nursing facility must permit each resident to remain in the facility and must not transfer or discharge the resident from the facility unless—

[(i) the transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the facility;

[(ii) the transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;

[(iii) the safety of individuals in the facility is endangered;

[(iv) the health of individuals in the facility would otherwise be endangered;

[(v) the resident has failed, after reasonable and appropriate notice, to pay (or to have paid under this title or title XIX on the resident's behalf) for a stay at the facility; or

[(vi) the facility ceases to operate.

In each of the cases described in clauses (i) through (v), the basis for the transfer or discharge must be documented in the resident's clinical record. In the cases described in clauses (i) and (ii), the documentation must be made by the resident's physician, and in the cases described in clauses (iii) and (iv) the documentation must be made by a physician.

[(B) PRE-TRANSFER AND PRE-DISCHARGE NOTICE.—

[(i) IN GENERAL.—Before effecting a transfer or discharge of a resident, a skilled nursing facility must—

[(I) notify the resident (and, if known, a family member of the resident or legal representative) of the transfer or discharge and the reasons therefor,

[(II) record the reasons in the resident's clinical record (including any documentation required under subparagraph (A)), and

[(III) include in the notice the items described in clause (iii).

[(ii) TIMING OF NOTICE.—The notice under clause (i)(I) must be made at least 30 days in advance of the resident's transfer or discharge except—

[(I) in a case described in clause (iii) or (iv) of subparagraph (A);

[(II) in a case described in clause (ii) of subparagraph (A), where the resident's health improves sufficiently to allow a more immediate transfer or discharge;

[(III) in a case described in clause (i) of subparagraph (A), where a more immediate transfer or discharge is necessitated by the resident's urgent medical needs; or

[(IV) in a case where a resident has not resided in the facility for 30 days.

In the case of such exceptions, notice must be given as many days before the date of the transfer or discharge as is practicable.

[(iii) ITEMS INCLUDED IN NOTICE.—Each notice under clause (i) must include—

[(I) for transfers or discharges effected on or after October 1, 1990, notice of the resident's right to appeal the transfer or discharge under the

State process established under subsection (e)(3); and

[(II) the name, mailing address, and telephone number of the State long-term care ombudsman (established under title III or VII of the Older Americans Act of 1965 in accordance with section 712 of the Act).

[(C) ORIENTATION.—A skilled nursing facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

[(3) ACCESS AND VISITATION RIGHTS.—A skilled nursing facility must—

[(A) permit immediate access to any resident by any representative of the Secretary, by any representative of the State, by an ombudsman described in paragraph (2)(B)(iii)(II), or by the resident's individual physician;

[(B) permit immediate access to a resident, subject to the resident's right to deny or withdraw consent at any time, by immediate family or other relatives of the resident;

[(C) permit immediate access to a resident, subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, by others who are visiting with the consent of the resident;

[(D) permit reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and

[(E) permit representatives of the State ombudsman (described in paragraph (2)(B)(iii)(II)), with the permission of the resident (or the resident's legal representative) and consistent with State law, to examine a resident's clinical records.

[(4) Equal access to quality care.—A skilled nursing facility must establish and maintain identical policies and practices regarding transfer, discharge, and covered services under this title for all individuals regardless of source of payment.

[(5) ADMISSIONS POLICY.—

[(A) ADMISSIONS.—With respect to admissions practices, a skilled nursing facility must—

[(i)(I) not require individuals applying to reside or residing in the facility to waive their rights to benefits under this title or under a State plan under title XIX, (II) not require oral or written assurance that such individuals are not eligible for, or will not apply for, benefits under this title or such a State plan, and (III) prominently display in the facility and provide to such individuals written information about how to apply for and use such benefits and how to receive refunds for previous payments covered by such benefits; and

[(ii) not require a third party guarantee of payment to the facility as a condition of admission (or expedited admission) to, or continued stay in, the facility.

[(B) CONSTRUCTION.—

[(i) NO PREEMPTION OF STRICTER STANDARDS.— Subparagraph (A) shall not be construed as preventing States or political subdivisions therein from prohibiting, under State or local law, the discrimination against individuals who are entitled to medical assistance under this title with respect to admissions practices of skilled nursing facilities.

[(ii) CONTRACTS WITH LEGAL REPRESENTATIVES.— Subparagraph (A)(ii) shall not be construed as preventing a facility from requiring an individual, who has legal access to a resident's income or resources available to pay for care in the facility, to sign a contract (without incurring personal financial liability) to provide payment from the resident's income or resources for such care.

[(6) PROTECTION OF RESIDENT FUNDS.—

[(A) IN GENERAL.—The skilled nursing facility—

[(i) may not require residents to deposit their personal funds with the facility, and

[(ii) upon the written authorization of the resident, must hold, safeguard, and account for such personal funds under a system established and maintained by the facility in accordance with this paragraph.

[(B) MANAGEMENT OF PERSONAL FUNDS.—Upon written authorization of a resident under subparagraph (A)(ii), the facility must manage and account for the personal funds of the resident deposited with the facility as follows:

[(i) Deposit.—The facility must deposit any amount of personal funds in excess of $100 with respect to a resident in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts and credits all interest earned on such separate account to such account. With respect to any other personal funds, the facility must maintain such funds in a non-interest bearing account or petty cash fund.

[(ii) ACCOUNTING AND RECORDS.—The facility must assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a resident deposited with the facility, and afford the resident (or a legal representative of the resident) reasonable access to such record.

[(iii) CONVEYANCE UPON DEATH.—Upon the death of a resident with such an account, the facility must convey promptly the resident's personal funds (and a final accounting of such funds) to the individual administering the resident's estate.

[(C) ASSURANCE OF FINANCIAL SECURITY.—The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.

[(D) LIMITATION ON CHARGES TO PERSONAL FUNDS.—The facility may not impose a charge against the personal

funds of a resident for any item or service for which payment is made under this title or title XIX.

[(d) REQUIREMENTS RELATING TO ADMINISTRATION AND OTHER MATTERS.—

[(1) ADMINISTRATION.—

[(A) IN GENERAL.—A skilled nursing facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical mental, and psychosocial well-being of each resident (consistent with requirements established under subsection (f)(5)).

[(B) REQUIRED NOTICES.—If a change occurs in—

[(i) the persons with an ownership or control interest (as defined in section 1124(a)(3)) in the facility,

[(ii) the persons who are officers, directors, agents, or managing employees (as defined in section 1126(b)) of the facility,

[(iii) the corporation, association, or other company responsible for the management of the facility, or

[(iv) the individual who is the administrator or director of nursing of the facility,—the skilled nursing facility must provide notice to the State agency responsible for the licensing of the facility, at the time of the change, of the change and of the identity of each new person, company, or individual described in the respective clause.

[(C) SKILLED NURSING FACILITY ADMINISTRATOR.—The administrator of a skilled nursing facility must meet standards established by the Secretary under subsection (f)(4).

[(2) LICENSING AND LIFE SAFETY CODE.—

[(A) LICENSING.—A skilled nursing facility must be licensed under applicable State and local law.

[(B) LIFE SAFETY CODE.—A skilled nursing facility must meet such provisions of such edition (as specified by the Secretary in regulation) of the Life Safety Code of the National Fire Protection Association as are applicable to nursing homes; except that—

[(i) the Secretary may waive, for such periods as he deems appropriate, specific provisions of such Code which if rigidly applied would result in unreasonable hardship upon a facility, but only if such waiver would not adversely affect the health and safety of residents or personnel, and

[(ii) the provisions of such Code shall not apply in any State if the Secretary finds that in such State there is in effect a fire and safety code, imposed by State law, which adequately protects residents of and personnel in skilled nursing facilities.

[(3) SANITARY AND INFECTION CONTROL AND PHYSICAL ENVIRONMENT.—A skilled nursing facility must—

[(A) establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the

development and transmission of disease and infection, and

[(B) be designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents, personnel, and the general public.

[(4) MISCELLANEOUS.—

[(A) COMPLIANCE WITH FEDERAL, STATE, AND LOCAL LAWS AND PROFESSIONAL STANDARDS.—A skilled nursing facility must operate and provide services in compliance with all applicable Federal, State, and local laws and regulations (including the requirements of section 1124) and with accepted professional standards and principles which apply to professionals providing services in such a facility.

[(B) OTHER.—A skilled nursing facility must meet such other requirements relating to the health, safety, and well-being of residents or relating to the physical facilities thereof as the Secretary may find necessary.

[(e) STATE REQUIREMENTS RELATING TO SKILLED NURSING FACILITY REQUIREMENTS.—The requirements, referred to in section 1864(d), with respect to a State are as follows:

[(1) SPECIFICATION AND REVIEW OF NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS AND OF NURSE AIDE COMPETENCY EVALUATION PROGRAMS.—The State must—

[(A) by not later than January 1, 1989, specify those training and competency evaluation programs, and those competency evaluation programs, that the State approves for purposes of subsection (b)(5) and that meet the requirements established under subsection (f)(2), and

[(B) by not later than January 1, 1990, provide for the review and reapproval of such programs, at a frequency and using a methodology consistent with the requirements established under subsection (f)(2)(A)(iii).

The failure of the Secretary to establish requirements under subsection (f)(2) shall not relieve any State of its responsibility under this paragraph.

[(2) NURSE AIDE REGISTRY.—

[(A) IN GENERAL.—By not later than January 1, 1989, the State shall establish and maintain a registry of all individuals who have satisfactorily completed a nurse aide training and competency evaluation program, or a nurse aide competency evaluation program, approved under paragraph (1) in the State, or any individual described in subsection (f)(2)(B)(ii) or in subparagraph (B), (C), or (D) of section 6901(b)(4) of the Omnibus Budget Reconciliation Act of 1989.

[(B) INFORMATION IN REGISTRY.—The registry under subparagraph (A) shall provide (in accordance with regulations of the Secretary) for the inclusion of specific documented findings by a State under subsection (g)(1)(C) of resident neglect or abuse or misappropriation of resident property involving an individual listed in the registry, as well as any brief statement of the individual disputing the findings, but shall not include any allegations of resident abuse or neglect or misappropriation of resident property

that are not specifically documented by the State under such subsection. The State shall make available to the public information in the registry. In the case of inquiries to the registry concerning an individual listed in the registry, any information disclosed concerning such a finding shall also include disclosure of any such statement in the registry relating to the finding or a clear and accurate summary of such a statement.

[(C) PROHIBITION AGAINST CHARGES.—A State may not impose any charges on a nurse aide relating to the registry established and maintained under subparagraph (A).

[(3) STATE APPEALS PROCESS FOR TRANSFERS AND DISCHARGES.—The State, for transfers and discharges from skilled nursing facilities effected on or after October 1, 1989, must provide for a fair mechanism for hearing appeals on transfers and discharges of residents of such facilities. Such mechanism must meet the guidelines established by the Secretary under subsection (f)(3); but the failure of the Secretary to establish such guidelines shall not relieve any State of its responsibility to provide for such a fair mechanism.

[(4) SKILLED NURSING FACILITY ADMINISTRATOR STANDARDS.—By not later than January 1, 1990, the State must have implemented and enforced the skilled nursing facility administrator standards developed under subsection (f)(4) respecting the qualification of administrators of skilled nursing facilities.

[(5) SPECIFICATION OF RESIDENT ASSESSMENT INSTRUMENT.—Effective July 1, 1990, the State shall specify the instrument to be used by nursing facilities in the State in complying with the requirement of subsection (b)(3)(A)(iii). Such instrument shall be—

[(A) one of the instruments designated under subsection (f)(6)(B), or

[(B) an instrument which the Secretary has approved as being consistent with the minimum data set of core elements, common definitions, and utilization guidelines specified by the Secretary under subsection (f)(6)(A).

[(f) RESPONSIBILITIES OF SECRETARY RELATING TO SKILLED NURSING FACILITY REQUIREMENTS.—

[(1) GENERAL RESPONSIBILITY.—It is the duty and responsibility of the Secretary to assure that requirements which govern the provision of care in skilled nursing facilities under this title, and the enforcement of such requirements, are adequate to protect the health, safety, welfare, and rights of residents and to promote the effective and efficient use of public moneys.

[(2) REQUIREMENTS FOR NURSE AIDE TRAINING AND COMPETENCY EVALUATION PROGRAMS AND FOR NURSE AIDE COMPETENCY EVALUATION PROGRAMS.—

[(A) IN GENERAL.—For purposes of subsections (b)(5) and (e)(1)(A), the Secretary shall establish, by not later than September 1, 1988—

[(i) requirements for the approval of nurse aide training and competency evaluation programs, including requirements relating to (I) the areas to be covered in such a program (including at least basic nursing

skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, and residents' rights) and content of the curriculum, (II) minimum hours of initial and ongoing training and retraining (including not less than 75 hours in the case of initial training), (III) qualifications of instructors, and (IV) procedures for determination of competency;

[(ii) requirements for the approval of nurse aide competency evaluation programs, including requirement relating to the areas to be covered in such a program, including at least basic nursing skills, personal care skills, recognition of mental health and social service needs, care of cognitively impaired residents, basic restorative services, residents' rights, and procedures for determination of competency;

[(iii) requirements respecting the minimum frequency and methodology to be used by a State in reviewing such programs' compliance with the requirements for such programs; and

[(iv) requirements, under both such programs, that—

[(I) provide procedures for determining competency that permit a nurse aide, at the nurse aide's option, to establish competency through procedures or methods other than the passing of a written examination and to have the competency evaluation conducted at the nursing facility at which the aide is (or will be) employed (unless the facility is described in subparagraph (B)(iii)(I)),

[(II) prohibit the imposition on a nurse aide who is employed by (or who has received an offer of employment from) a facility on the date on which the aide begins either such program of any charges (including any charges for textbooks and other required course materials and any charges for the competency evaluation) for either such program, and

[(III) in the case of a nurse aide not described in subclause (II) who is employed by (or who has received an offer of employment from) a facility not later than 12 months after completing either such program, the State shall provide for the reimbursement of costs incurred in completing such program on a prorata basis during the period in which the nurse aide is so employed.

[(B) APPROVAL OF CERTAIN PROGRAMS.—Such requirements—

[(i) may permit approval of programs offered by or in facilities (subject to clause (iii)), as well as outside facilities (including employee organizations), and of programs in effect on the date of the enactment of this section;

[(ii) shall permit a State to find that an individual who has completed (before July 1, 1989) a nurse aide training and competency evaluation program shall be deemed to have completed such a program approved under subsection (b)(5) if the State determines that, at the time the program was offered, the program met the requirements for approval under such paragraph; and

[(iii) shall prohibit approval of such a program—

[(I) offered by or in a skilled nursing facility which, within the previous 2 years—

[(a) has operated under a waiver under subsection (b)(4)(C)(ii)(II);

[(b) has been subject to an extended (or partial extended) survey under subsection (g)(2)(B)(i) or section 1919(g)(2)(B)(i), unless the survey shows that the facility is in compliance with the requirements of subsections (b), (c), and (d) of this section; or

[(c) has been assessed a civil money penalty described in subsection (h)(2)(B)(ii) or section 1919(h)(2)(A)(ii) of not less than $5,000, or has been subject to a remedy described in clause (i) or (iii) of subsection (h)(2)(B), subsection (h)(4), section 1919(h)(1)(B)(i), or in clause (i), (iii), or (iv) of section 1919(h)(2)(A), or

[(II) offered by or in a skilled nursing facility unless the State makes the determination, upon an individual's completion of the program, that the individual is competent to provide nursing and nursing-related services in skilled nursing facilities.

A State may not delegate (through subcontract or otherwise) its responsibility under clause (iii)(II) to the skilled nursing facility.

[(3) FEDERAL GUIDELINES FOR STATE APPEALS PROCESS FOR TRANSFERS AND DISCHARGES.—For purposes of subsections (c)(2)(B)(iii)(I) and (e)(3), by not later than October 1, 1988, the Secretary shall establish guidelines for minimum standards which State appeals processes under subsection (e)(3) must meet to provide a fair mechanism for hearing appeals on transfers and discharges of residents from skilled nursing facilities.

[(4) SECRETARIAL STANDARDS FOR QUALIFICATION OF ADMINISTRATORS.—For purposes of subsections (d)(1)(C) and (e)(4), the Secretary shall develop, by not later than March 1, 1989, standards to be applied in assuring the qualifications of administrators of skilled nursing facilities.

[(5) CRITERIA FOR ADMINISTRATION.— The Secretary shall establish criteria for assessing a skilled nursing facility's compliance with the requirement of subsection (d)(1) with respect to—

[(A) its governing body and management,

[(B) agreements with hospitals regarding transfers of residents to and from the hospitals and to and from other skilled nursing facilities,

[(C) disaster preparedness,

[(D) direction of medical care by a physician,

[(E) laboratory and radiological services,

[(F) clinical records, and

[(G) resident and advocate participation.

[(6) SPECIFICATION OF RESIDENT ASSESSMENT DATA SET AND INSTRUMENTS.—The Secretary shall—

[(A) not later than January 1, 1989, specify a minimum data set of core elements and common definitions for use by nursing facilities in conducting the assessments required under subsection (b)(3), and establish guidelines for utilization of the data set; and

[(B) by not later than April 1, 1990, designate one or more instruments which are consistent with the specification made under subparagraph (A) and which a State may specify under subsection (e)(5)(A) for use by nursing facilities in complying with the requirements of subsection (b)(3)(A)(iii).

[(7) LIST OF ITEMS AND SERVICES FURNISHED IN SKILLED NURSING FACILITIES NOT CHARGEABLE TO THE PERSONAL FUNDS OF A RESIDENT.—

[(A) REGULATIONS REQUIRED.— Pursuant to the requirement of section 21(b) of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977, the Secretary shall issue regulations, on or before the first day of the seventh month to begin after the date of enactment of this section, that define those costs which may be charged to the personal funds of residents in skilled nursing facilities who are individuals receiving benefits under this part and those costs which are to be included in the reasonable cost (or other payment amount) under this title for extended care services.

[(B) RULE IF FAILURE TO PUBLISH REGULATIONS.—If the Secretary does not issue the regulations under subparagraph (A) on or before the date required in such subparagraph, in the case of a resident of a skilled nursing facility who is eligible to receive benefits under this part, the costs which may not be charged to the personal funds of such resident (and for which payment is considered to be made under this title) shall include, at a minimum, the costs for routine personal hygiene items and services furnished by the facility.

[(g) SURVEY AND CERTIFICATION PROCESS.—

[(1) STATE AND FEDERAL RESPONSIBILITY.—

[(A) IN GENERAL.—Pursuant to an agreement under section 1864, each State shall be responsible for certifying, in accordance with surveys conducted under paragraph (2), the compliance of skilled nursing facilities (other than facilities of the State) with the requirements of subsections (b), (c), and (d). The Secretary shall be responsible for certifying, in accordance with surveys conducted under para-

graph (2), the compliance of State skilled nursing facilities with the requirements of such subsections.

[(B) EDUCATIONAL PROGRAM.—Each State shall conduct periodic educational programs for the staff and residents (and their representatives) of skilled nursing facilities in order to present current regulations, procedures, and policies under this section.

[(C) INVESTIGATION OF ALLEGATIONS OF RESIDENT NEGLECT AND ABUSE AND MISAPPROPRIATION OF RESIDENT PROPERTY.—The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility in providing services to such a resident. The State shall, after providing the individual involved with a written notice of the allegations (including a statement of the availability of a hearing for the individual to rebut the allegations) and the opportunity for a hearing on the record, make a written finding as to the accuracy of the allegations. If the State finds that a nurse aide has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the nurse aide and the registry of such finding. If the State finds that any other individual used by the facility has neglected or abused a resident or misappropriated resident property in a facility, the State shall notify the appropriate licensure authority. A State shall not make a finding that an individual has neglected a resident if the individual demonstrates that such neglect was caused by factors beyond the control of the individual.

[(D) CONSTRUCTION.— The failure of the Secretary to issue regulations to carry out this subsection shall not relieve a State of its responsibility under this subsection.

[(2) SURVEYS.—

[(A) STANDARD SURVEY.—

[(i) IN GENERAL.—Each skilled nursing facility shall be subject to a standard survey, to be conducted without any prior notice to the facility. Any individual who notifies (or causes to be notified) a skilled nursing facility of the time or date on which such a survey is scheduled to be conducted is subject to a civil money penalty of not to exceed $2,000. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a). The Secretary shall review each State's procedures for the scheduling and conduct of standard surveys to assure that the State has taken all reasonable steps to avoid giving notice of such a survey through the scheduling procedures and the conduct of the surveys themselves.

[(ii) CONTENTS.—Each standard survey shall include, for a case-mix stratified sample of residents—

[(I) a survey of the quality of care furnished, as measured by indicators of medical, nursing, and rehabilitative care, dietary and nutrition services, activities and social participation, and sanitation, infection control, and the physical environment,

[(II) written plans of care provided under subsection (b)(2) and an audit of the residents' assessments under subsection (b)(3) to determine the accuracy of such assessments and the adequacy of such plans of care, and

[(III) a review of compliance with residents' rights under subsection (c).

[(iii) FREQUENCY.—

[(I) IN GENERAL.—Each skilled nursing facility shall be subject to a standard survey not later than 15 months after the date of the previous standard survey conducted under this subparagraph. The Statewide average interval between standard surveys of skilled nursing facilities under this subsection shall not exceed 12 months.

[(II) SPECIAL SURVEYS.—If not otherwise conducted under subclause (I), a standard survey (or an abbreviated standard survey) may be conducted within 2 months of any change of ownership, administration, management of a skilled nursing facility, or the director of nursing in order to determine whether the change has resulted in any decline in the quality of care furnished in the facility.

[(B) EXTENDED SURVEYS.—

[(i) IN GENERAL.—Each skilled nursing facility which is found, under a standard survey, to have provided substandard quality of care shall be subject to an extended survey. Any other facility may, at the Secretary's or State's discretion, be subject to such an extended survey (or a partial extended survey).

[(ii) TIMING.—The extended survey shall be conducted immediately after the standard survey (or, if not practicable, not later than 2 weeks after the date of completion of the standard survey).

[(iii) CONTENTS.—In such an extended survey, the survey team shall review and identify the policies and procedures which produced such substandard quality of care and shall determine whether the facility has complied with all the requirements described in subsections (b), (c), and (d). Such review shall include an expansion of the size of the sample of residents' assessments reviewed and a review of the staffing, of in-service training, and, if appropriate, of contracts with consultants.

[(iv) CONSTRUCTION.—Nothing in this paragraph shall be construed as requiring an extended or partial

extended survey as a prerequisite to imposing a sanction against a facility under subsection (h) on the basis of findings in a standard survey.

[(C) SURVEY PROTOCOL.— Standard and extended surveys shall be conducted—

[(i) based upon a protocol which the Secretary has developed, tested, and validated by not later than January 1, 1990, and

[(ii) by individuals, of a survey team, who meet such minimum qualifications as the Secretary establishes by not later than such date.

The failure of the Secretary to develop, test, or validate such protocols or to establish such minimum qualifications shall not relieve any State of its responsibility (or the Secretary of the Secretary's responsibility) to conduct surveys under this subsection.

[(D) CONSISTENCY OF SURVEYS.—Each State and the Secretary shall implement programs to measure and reduce inconsistency in the application of survey results among surveyors.

[(E) SURVEY TEAMS.—

[(i) IN GENERAL.—Surveys under this subsection shall be conducted by a multidisciplinary team of professionals (including a registered professional nurse).

[(ii) PROHIBITION OF CONFLICTS OF INTEREST.—A State may not use as a member of a survey team under this subsection an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the facility surveyed respecting compliance with the requirements of subsections (b), (c), and (d), or who has a personal or familial financial interest in the facility being surveyed.

[(iii) TRAINING.—The Secretary shall provide for the comprehensive training of State and Federal surveyors in the conduct of standard and extended surveys under this subsection, including the auditing of resident assessments and plans of care. No individual shall serve as a member of a survey team unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary.

[(3) VALIDATION SURVEYS.—

[(A) IN GENERAL.—The Secretary shall conduct onsite surveys of a representative sample of skilled nursing facilities in each State, within 2 months of the date of surveys conducted under paragraph (2) by the State, in a sufficient number to allow inferences about the adequacies of each State's surveys conducted under paragraph (2). In conducting such surveys, the Secretary shall use the same survey protocols as the State is required to use under paragraph (2). If the State has determined that an individual skilled nursing facility meets the requirements of subsections (b), (c), and (d), but the Secretary determines that the facility

does not meet such requirements, the Secretary's determination as to the facility's noncompliance with such requirements is binding and supersedes that of the State survey.

[(B) SCOPE.—With respect to each State, the Secretary shall conduct surveys under subparagraph (A) each year with respect to at least 5 percent of the number of skilled nursing facilities surveyed by the State in the year, but in no case less than 5 skilled nursing facilities in the State.

[(C) REMEDIES FOR SUBSTANDARD PERFORMANCE.—If the Secretary finds, on the basis of such surveys, that a State has failed to perform surveys as required under paragraph (2) or that a State's survey and certification performance otherwise is not adequate, the Secretary shall provide for an appropriate remedy, which may include the training of survey teams in the State.

[(D) SPECIAL SURVEYS OF COMPLIANCE.—Where the Secretary has reason to question the compliance of a skilled nursing facility with any of the requirements of subsections (b), (c), and (d), the Secretary may conduct a survey of the facility and, on the basis of that survey, make independent and binding determinations concerning the extent to which the skilled nursing facility meets such requirements.

[(4) INVESTIGATION OF COMPLAINTS AND MONITORING COMPLIANCE.—Each State shall maintain procedures and adequate staff to—

[(A) investigate complaints of violations of requirements by skilled nursing facilities, and

[(B) monitor, on-site, on a regular, as needed basis, a skilled nursing facility's compliance with the requirements of subsections (b), (c), and (d), if—

[(i) the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

[(ii) the facility was previously found not to be in compliance with such requirements, has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

[(iii) the State has reason to question the compliance of the facility with such requirements.

A State may maintain and utilize a specialized team (including an attorney, an auditor, and appropriate health care professionals) for the purpose of identifying, surveying, gathering and preserving evidence, and carrying out appropriate enforcement actions against substandard skilled nursing facilities.

[(5) DISCLOSURE OF RESULTS OF INSPECTIONS AND ACTIVITIES.—

[(A) PUBLIC INFORMATION.—Each State, and the Secretary, shall make available to the public—

[(i) information respecting all surveys and certifications made respecting skilled nursing facilities, including statements of deficiencies, within 14 calendar

days after such information is made available to those facilities, and approved plans of correction,

[(ii) copies of cost reports of such facilities filed under this title or title XIX,

[(iii) copies of statements of ownership under section 1124, and

[(iv) information disclosed under section 1126.

[(B) NOTICE TO OMBUDSMAN.—Each State shall notify the State long-term care ombudsman (established under title III or VII of the Older Americans Act of 1965 in accordance with section 712 of the Act) of the State's findings of noncompliance with any of the requirements of subsections (b), (c), and (d), or of any adverse action taken against a skilled nursing facility under paragraph (1), (2), or (4) of subsection (h), with respect to a skilled nursing facility in the State.

[(C) NOTICE TO PHYSICIANS AND SKILLED NURSING FACILITY ADMINISTRATOR LICENSING BOARD.—If a State finds that a skilled nursing facility has provided substandard quality of care, the State shall notify—

[(i) the attending physician of each resident with respect to which such finding is made, and

[(ii) the State board responsible for the licensing of the skilled nursing facility administrator at the facility.

[(D) ACCESS TO FRAUD CONTROL UNITS.—Each State shall provide its State medicaid fraud and abuse control unit (established under section 1903(q)) with access to all information of the State agency responsible for surveys and certifications under this subsection.

[(h) ENFORCEMENT PROCESS.—

[(1) IN GENERAL.—If a State finds, on the basis of a standard, extended, or partial extended survey under subsection (g)(2) or otherwise, that a skilled nursing facility no longer meets a requirement of subsection (b), (c), or (d), and further finds that the facility's deficiencies—

[(A) immediately jeopardize the health or safety of its residents, the State shall recommend to the Secretary that the Secretary take such action as described in paragraph (2)(A)(i); or

[(B) do not immediately jeopardize the health or safety of its residents, the State may recommend to the Secretary that the Secretary take such action as described in paragraph (2)(A)(ii).

If a State finds that a skilled nursing facility meets the requirements of subsections (b), (c), and (d), but, as of a previous period, did not meet such requirements, the State may recommend a civil money penalty under paragraph (2)(B)(ii) for the days in which it finds that the facility was not in compliance with such requirements.

[(2) SECRETARIAL AUTHORITY.—

[(A) IN GENERAL.—With respect to any skilled nursing facility in a State, if the Secretary finds, or pursuant to a recommendation of the State under paragraph (1) finds,

that a skilled nursing facility no longer meets a requirement of subsection (b), (c), (d), or (e), and further finds that the facility's deficiencies—

[(i) immediately jeopardize the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in subparagraph (B)(iii), or terminate the facility's participation under this title and may provide, in addition, for one or more of the other remedies described in subparagraph (B); or

[(ii) do not immediately jeopardize the health or safety of its residents, the Secretary may impose any of the remedies described in subparagraph (B).

Nothing in this subparagraph shall be construed as restricting the remedies available to the Secretary to remedy a skilled nursing facility's deficiencies. If the Secretary finds, or pursuant to the recommendation of the State under paragraph (1) finds, that a skilled nursing facility meets such requirements but, as of a previous period, did not meet such requirements, the Secretary may provide for a civil money penalty under subparagraph (B)(ii) for the days on which he finds that the facility was not in compliance with such requirements.

[(B) SPECIFIED REMEDIES.—The Secretary may take the following actions with respect to a finding that a facility has not met an applicable requirement:

[(i) DENIAL OF PAYMENT.—The Secretary may deny any further payments under this title with respect to all individuals entitled to benefits under this title in the facility or with respect to such individuals admitted to the facility after the effective date of the finding.

[(ii) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—The Secretary may impose a civil money penalty in an amount not to exceed $10,000 for each day of noncompliance. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

[(iii) APPOINTMENT OF TEMPORARY MANAGEMENT.—In consultation with the State, the Secretary may appoint temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents, where there is a need for temporary management while—

[(I) there is an orderly closure of the facility, or

[(II) improvements are made in order to bring the facility into compliance with all the requirements of subsections (b), (c), and (d).

The temporary management under this clause shall not be terminated under subclause (II) until the Secretary has determined that the facility has the man-

agement capability to ensure continued compliance with all the requirements of subsections (b), (c), and (d).

The Secretary shall specify criteria, as to when and how each of such remedies is to be applied, the amounts of any fines, and the severity of each of these remedies, to be used in the imposition of such remedies. Such criteria shall be designed so as to minimize the time between the identification of violations and final imposition of the remedies and shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies. In addition, the Secretary may provide for other specified remedies, such as directed plans of correction.

[(C) CONTINUATION OF PAYMENTS PENDING REMEDIATION.—The Secretary may continue payments, over a period of not longer than 6 months after the effective date of the findings, under this title with respect to a skilled nursing facility not in compliance with a requirement of subsection (b), (c), or (d), if—

[(i) the State survey agency finds that it is more appropriate to take alternative action to assure compliance of the facility with the requirements than to terminate the certification of the facility,

[(ii) the State has submitted a plan and timetable for corrective action to the Secretary for approval and the Secretary approves the plan of corrective action, and

[(iii) the facility agrees to repay to the Federal Government payments received under this subparagraph if the corrective action is not taken in accordance with the approved plan and timetable.

The Secretary shall establish guidelines for approval of corrective actions requested by States under this subparagraph.

[(D) ASSURING PROMPT COMPLIANCE.—If a skilled nursing facility has not complied with any of the requirements of subsections (b), (c), and (d), within 3 months after the date the facility is found to be out of compliance with such requirements, the Secretary shall impose the remedy described in subparagraph (B)(i) for all individuals who are admitted to the facility after such date.

[(E) REPEATED NONCOMPLIANCE.—In the case of a skilled nursing facility which, on 3 consecutive standard surveys conducted under subsection (g)(2), has been found to have provided substandard quality of care, the Secretary shall (regardless of what other remedies are provided)—

[(i) impose the remedy described in subparagraph (B)(i), and

[(ii) monitor the facility under subsection (g)(4)(B), until the facility has demonstrated, to the satisfaction of the Secretary, that it is in compliance with the requirements of subsections (b), (c), and (d), and that it will remain in compliance with such requirements.

[(3) EFFECTIVE PERIOD OF DENIAL OF PAYMENT.—A finding to deny payment under this subsection shall terminate when the Secretary finds that the facility is in substantial compliance with all the requirements of subsections (b), (c), and (d).

[(4) IMMEDIATE TERMINATION OF PARTICIPATION FOR FACILITY WHERE SECRETARY FINDS NONCOMPLIANCE AND IMMEDIATE JEOPARDY.—If the Secretary finds that a skilled nursing facility has not met a requirement of subsection (b), (c), or (d), and finds that the failure immediately jeopardizes the health or safety of its residents, the Secretary shall take immediate action to remove the jeopardy and correct the deficiencies through the remedy specified in paragraph (2)(B)(iii), or the Secretary shall terminate the facility's participation under this title. If the facility's participation under this title is terminated, the State shall provide for the safe and orderly transfer of the residents eligible under this title consistent with the requirements of subsection (c)(2).

[(5) CONSTRUCTION.—The remedies provided under this subsection are in addition to those otherwise available under State or Federal law and shall not be construed as limiting such other remedies, including any remedy available to an individual at common law. The remedies described in clauses (i), and (iii) of paragraph (2)(B) may be imposed during the pendency of any hearing.

[(6) SHARING OF INFORMATION.—Notwithstanding any other provision of law, all information concerning skilled nursing facilities required by this section to be filed with the Secretary or a State agency shall be made available by such facilities to Federal or State employees for purposes consistent with the effective administration of programs established under this title and title XIX, including investigations by State medicaid fraud control units.

[(i) CONSTRUCTION.—Where requirements or obligations under this section are identical to those provided under section 1919 of this Act, the fulfillment of those requirements or obligations under section 1919 shall be considered to be the fulfillment of the corresponding requirements or obligations under this section.]

(b) STANDARDS FOR AND CERTIFICATION OF FACILITIES.—

(1) STANDARDS FOR FACILITIES.—

(A) IN GENERAL.—The Secretary shall provide for the establishment and maintenance of standards consistent with the contents described in subparagraph (B) for skilled nursing facilities which furnish services for which payment may be made under this title.

(B) CONTENTS OF STANDARDS.—The standards established for facilities under this paragraph shall contain provisions relating to the following items:

(i) The treatment of resident medical records.

(ii) Policies, procedures, and bylaws for operation.

(iii) Quality assurance systems.

(iv) Resident assessment procedures, including care planning and outcome evaluation.

(v) The assurance of a safe and adequate physical plant for the facility.

(vi) Qualifications for staff sufficient to provide adequate care.

(vii) Utilization review.

(viii) The protection and enforcement of resident rights described in subparagraph (C).

(C) RESIDENT RIGHTS DESCRIBED.—The resident rights described in this subparagraph are the rights of residents to the following:

(i) To exercise the individual's rights as a resident of the facility and as a citizen or resident of the United States.

(ii) To receive notice of rights and services.

(iii) To be protected against the misuse of resident funds.

(iv) To be provided privacy and confidentiality.

(v) To voice grievances.

(vi) To examine the results of inspections under the certification program.

(vii) To refuse to perform services for the facility.

(viii) To be provided privacy in communications and to receive mail.

(ix) To have the facility provide immediate access to any resident by any representative of the certification program, the resident's individual physician, the State long term care ombudsman, and any person the resident has designated as a visitor.

(x) To retain and use personal property.

(xi) To be free from abuse, including verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion.

(xii) To be provided with prior written notice of a pending transfer or discharge.

(D) REQUIRING NOTICE AND COMMENT.—The standards established for facilities under this paragraph may only take effect after the Secretary has provided the public with notice and an opportunity for comment.

(2) CERTIFICATION PROGRAM.—

(A) IN GENERAL.—The Secretary shall provide for the establishment and operation of a program consistent with the requirements of subparagraph (B) for the certification of skilled nursing facilities which meet the standards established under paragraph (1) and the decertification of facilities which fail to meet such standards.

(B) REQUIREMENTS FOR PROGRAM.—In addition to any other requirements the Secretary may impose, in establishing and operating the certification program under subparagraph (A), the Secretary shall ensure the following:

(i) The Secretary shall ensure public access (as defined by the Secretary) to the certification program's evaluations of participating facilities, including compliance records and enforcement actions and other reports by the Secretary regarding the ownership, compliance histories, and services provided by certified facilities.

(ii) Not less often than every 4 years, the Secretary shall audit its expenditures under the program, through an entity designated by the Secretary which is not affiliated with the program, as designated by the Secretary.

(c) INTERMEDIATE SANCTION AUTHORITY.—

(1) AUTHORITY.—In addition to any other authority, where the Secretary determines that a nursing facility which is certified for participation under this title (whether certified by the Secretary as meeting the standards established under subsection (b) or a State-certified facility) no longer or does not substantially meet the requirements for such a facility under this title as specified under subsection (b) and further determines that the facility's deficiencies—

(A) immediately jeopardize the health and safety of its residents, the Secretary shall at least provide for the termination of the facility's certification for participation under this title, or

(B) do not immediately jeopardize the health and safety of its residents, the Secretary may, in lieu of providing for terminating the facility's certification for participation under the plan, provide lesser sanctions including one that provides that no payment will be made under this title with respect to any individual admitted to such facility after a date specified by the Secretary.

(2) NOTICE.—The Secretary shall not make such a decision with respect to a facility until the facility has had a reasonable opportunity, following the initial determination that it no longer or does not substantially meets the requirements for such a facility under the plan, to correct its deficiencies, and, following this period, has been given reasonable notice and opportunity for a hearing.

(3) EFFECTIVENESS.—The Secretary's decision to deny payment may be made effective only after such notice to the public and to the facility as may be provided for by the Secretary, and its effectiveness shall terminate (A) when the Secretary finds that the facility is in substantial compliance (or is making good faith efforts to achieve substantial compliance) with the requirements for such a facility under this title, or (B) in the case described in paragraph (1)(B), with the end of the eleventh month following the month such decision is made effective, whichever occurs first. If a facility to which clause (B) of the previous sentence applies still fails to substantially meet the provisions of the respective section on the date specified in such clause, the Secretary shall terminate such facility's certification for participation under this title effective with the first day of the first month following the month specified in such clause.

(d) STATE-CERTIFIED FACILITY DEFINED.—In subsection (a), a "State-certified facility" means a facility licensed or certified as a skilled nursing facility by the State in which it is located, or a facility which otherwise meets the requirements applicable to providers of nursing facility services under the State plan under title XIX or the MediGrant program under title XXI.

ESSENTIAL ACCESS COMMUNITY HOSPITAL PROGRAM

SEC. 1820. (a) * * *

* * * * * * *

(i) ELIGIBILITY OF HOSPITALS OR FACILITIES FOR DESIGNATION BY SECRETARY.—

(1) ESSENTIAL ACCESS COMMUNITY HOSPITAL.—(A) The Secretary shall designate a hospital as an essential access community hospital if the hospital—

(i) is located in a State receiving a grant under subsection (a)(1) (except as provided in subsection (k))**[**;**]**, *or in a State which the Secretary finds would receive a grant under such subsection during a fiscal year if funds were appropriated for grants under such subsection for the fiscal year;*

* * * * * * *

(2) RURAL PRIMARY CARE HOSPITAL.—(A) The Secretary shall designate a facility as a rural primary care hospital if the facility—

(i) is located in a State receiving a grant under subsection (a)(1) (except as provided in subsection (k))**[**;**]**, *or in a State which the Secretary finds would receive a grant under such subsection during a fiscal year if funds were appropriated for grants under such subsection for the fiscal year;*

* * * * * * *

SCOPE OF BENEFITS

SEC. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) entitlement to have payment made to him or on his behalf (subject to the provisions of this part) for medical and other health services, except those described in subparagraphs (B) and (D) of paragraph **[**(2);**]** *(2) and subparagraphs (E) and (F) of section 1842(b)(6);* and

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) * * *

* * * * * * *

(I) prosthetic devices and orthotics and prosthetics (described in section 1834(h)(4)) furnished by a provider of services or by others under arrangements with them made by a provider of services; **[**and**]**

(J) partial hospitalization services provided by a community mental health center (as described in section 1861(ff)(2)(B))**[**.**]**; *and*

(K) rural emergency access care hospital services (as defined in section 1861(oo)(2)).

* * * * * * *

PAYMENT OF BENEFITS

SEC. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) * * *

(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraphs (D), (E), (F), (G), (H), and (I) of such section and unless otherwise specified in section 1881)—

[(A) with respect to home health services (other than a covered osteoporosis drug (as defined in section 1861(kk))), and to items and services described in section 1861(s)(10)(A), the lesser of—

[(i) the reasonable cost of such services, as determined under section 1861(v), or

[(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);]

(A) with respect to home health services—

(i) that are a type of home health service described in section 1894(a)(2), and which are furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home health agency, the amount determined under section 1894; or

(ii) that are not described in clause (i) (other than a covered osteoporosis drug) (as defined in section 1861(kk)), the lesser of—

(I) the reasonable cost of such services, as determined under section 1861(v), or

(II) the customary charges with respect to such services;

* * * * * * *

(E) with respect to—

(i) outpatient hospital radiology services (including diagnostic and therapeutic radiology, nuclear medicine and CAT scan procedures, magnetic resonance imaging, and ultrasound and other imaging services, but excluding screening mammography), and

(ii) effective for procedures performed on or after October 1, 1989, diagnostic procedures (as defined by the Secretary) described in section 1861(s)(3) (other than diagnostic x-ray tests and diagnostic laboratory tests),

the amount determined under subsection (n); [and]

(F) with respect to a covered osteoporosis drug (as defined in section 1861(kk)) furnished by a home health agency, 80 percent of the reasonable cost of such service, as determined under section 1861(v); *and*

(G) with respect to items and services described in section 1861(s)(10)(A), the lesser of—

(i) the reasonable cost of such services, as determined under section 1861(v), or

(ii) the customary charges with respect to such services,

or, if such services are furnished by a public provider of services, or by another provider which demonstrates to the satisfaction of the Secretary that a significant portion of its patients are low-income (and requests that payment be made under this provision), free of charge or at nominal charges to the public, the amount determined in accordance with section 1814(b)(2);

* * * * * * *

(6) in the case of outpatient rural primary care hospital [services,] *services and rural emergency access care hospital services,* the amounts described in section 1834(g); and

* * * * * * *

(h)(1)(A) The Secretary shall establish fee schedules for clinical diagnostic laboratory tests for which payment is made under this part, other than such tests performed by a provider of services for an inpatient of such provider.

* * * * * * *

(2)(A)(i) Except as provided in paragraph (4), the Secretary shall set the fee schedules at 60 percent (or, in the case of a test performed by a qualified hospital laboratory (as defined in paragraph (1)(D)) for outpatients of such hospital, 62 percent) of the prevailing charge level determined pursuant to the third and fourth sentences of section 1842(b)(3) for similar clinical diagnostic laboratory tests for the applicable region, State, or area for the 12-month period beginning July 1, 1984, adjusted annually (to become effective on January 1 of each year) by a percentage increase or decrease equal to the percentage increase or decrease in the Consumer Price Index for All Urban Consumers (United States city average), and subject to such other adjustments as the Secretary determines are justified by technological changes.

(ii) Notwithstanding clause (i)—

(I) * * *

* * * * * * *

(IV) the annual adjustment in the fee schedules determined under clause (i) for each of the years [1994 and 1995] *1994 through 2002* shall be 0 percent.

* * * * * * *

(4)(A) In establishing any fee schedule under this subsection, the Secretary may provide for an adjustment to take into account, with respect to the portion of the expenses of clinical diagnostic laboratory tests attributable to wages, the relative difference between a

region's or local area's wage rates and the wage rate presumed in the data on which the schedule is based.

(B) For purposes of subsections (a)(1)(D)(i) and (a)(2)(D)(i), the limitation amount for a clinical diagnostic laboratory test performed—

(i) * * *

* * * * * * *

(vi) after December 31, 1994, and before January 1, 1996, is equal to 80 percent of such median, [and]

(vii) after December 31, 1995, *and before January 1, 1997,* is equal to 76 percent of such median[.], *and*

(viii) after December 31, 1996, is equal to 65 percent of such median.

* * * * * * *

(i)(1) The Secretary shall, in consultation with appropriate medical organizations—

(A) * * *

* * * * * * *

(3)(A) The aggregate amount of the payments to be made under this part for outpatient hospital facility services or rural primary care hospital services furnished in connection with surgical procedures specified under paragraph (1)(A) in a cost reporting period shall be equal to the lesser of—

(i) * * *

* * * * * * *

(B)(i) The blend amount for a cost reporting period is the sum of—

(I) the cost proportion (as defined in clause (ii)(I)) of the amount described in subparagraph (A)(i), and

(II) the ASC proportion (as defined in clause (ii)(II)) [of 80 percent] of the standard overhead amount payable with respect to the same surgical procedure as if it were provided in an ambulatory surgical center in the same area, as determined under paragraph (2)(A)[.], *less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).*

* * * * * * *

(n)(1)(A) The aggregate amount of the payments to be made for all or part of a cost reporting period for services described in subsection (a)(2)(E)(i) furnished under this part on or after October 1, 1988, and for services described in subsection (a)(2)(E)(ii) furnished under this part on or after October 1, 1989, shall be equal to the lesser of—

(i) * * *

(B)(i) The blend amount for radiology services and diagnostic procedures for a cost reporting period is the sum of—

(I) the cost proportion (as defined in clause (ii)) of the amount described in subparagraph (A)(i); and

(II) the charge proportion (as defined in clause (ii)(II)) of 62 percent (for services described in subsection (a)(2)(E)(i)), or (for procedures described in subsection (a)(2)(E)(ii)), 42 percent or such other percent established by the Secretary (or carriers

acting pursuant to guidelines issued by the Secretary) based on prevailing charges established with actual charge data, [of 80 percent] of the prevailing charge or (for services described in subsection (a)(2)(E)(i) furnished on or after January 1, 1989) the fee schedule amount established for participating physicians for the same services as if they were furnished in a physician's office in the same locality as determined under section 1842(b)[.], *less the amount a provider may charge as described in clause (ii) of section 1866(a)(2)(A).*

* * * * * * *

SPECIAL PAYMENT RULES FOR PARTICULAR ITEMS AND SERVICES

SEC. 1834. (a) PAYMENT FOR DURABLE MEDICAL EQUIPMENT.—

(1) * * *

* * * * * * *

(9) MONTHLY PAYMENT AMOUNT RECOGNIZED WITH RESPECT TO OXYGEN AND OXYGEN EQUIPMENT.—For purposes of paragraph (5), the amount that is recognized under this paragraph for payment for oxygen and oxygen equipment is the monthly payment amount described in subparagraph (C) of this paragraph. Such amount shall be computed separately (i) for all items of oxygen and oxygen equipment (other than portable oxygen equipment) and (ii) for portable oxygen equipment (each such group referred to in this paragraph as an "item").

(A) * * *

* * * * * * *

(C) MONTHLY PAYMENT AMOUNT RECOGNIZED.—For purposes of paragraph (5), the amount that is recognized under this paragraph as the base monthly payment amount for each item furnished—

(i) * * *

* * * * * * *

(iii) in 1992, is the sum of (I) 33 percent of the local average monthly payment rate computed under subparagraph (A)(ii)(II) for the item for 1992, and (II) 67 percent of the national limited monthly payment rate computed under subparagraph (B)(ii) for the item for 1992; [and]

(iv) in [a subsequent year] *1993, 1994, and 1995,* is the national limited monthly payment rate computed under subparagraph (B) for the item for that year[.]*;*

(v) in 1996, is 80 percent of the national limited monthly payment rate computed under subparagraph (B) for the item for the year; and

(vi) in a subsequent year, is the national limited monthly payment rate computed under subparagraph (B) for the item for the year.

* * * * * * *

(14) COVERED ITEM UPDATE.—In this subsection, the term "covered item update" means, with respect to a year—

(A) for 1991 and 1992, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year reduced by 1 percentage point; [and]

(B) for [a subsequent year] *1993, 1994, and 1995*, the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year[.]*;*

(C) for each of the years 1996 through 2002, 0 percentage points; and

(D) for a subsequent year, the percentage increase in the consumer price index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.

(15) ADVANCE DETERMINATIONS OF COVERAGE FOR CERTAIN ITEMS.—

(A) * * *

* * * * * * *

(D) APPLICATION BY CARRIERS.—A carrier may develop (and periodically update) a list of items under subparagraph (A) and a list of suppliers under subparagraph (B) in the same manner as the Secretary may develop (and periodically update) such lists.

(E) WAIVER OF PUBLICATION REQUIREMENT.—A carrier may make an advance determination under subparagraph (C) with respect to an item or supplier on a list developed by the Secretary or the carrier without regard to whether or not the Secretary has promulgated a regulation with respect to the list, except that the carrier may not make such an advance determination with respect to an item or supplier on a list until the expiration of the 30-day period beginning on the date the Secretary or the carrier places the item or supplier on the list.

* * * * * * *

(b) FEE SCHEDULES FOR RADIOLOGIST SERVICES.—

(1) * * *

(2) CONSULTATION.—In carrying out paragraph (1), the Secretary shall regularly consult closely with the [Physician Payment Review Commission] *Medicare Payment Review Commission*, the American College of Radiology, and other organizations representing physicians or suppliers who furnish radiologist services and shall share with them the data and data analysis being used to make the determinations under paragraph (1), including data on variations in current medicare payments by geographic area, and by service and physician specialty.

* * * * * * *

(g) PAYMENT FOR OUTPATIENT RURAL PRIMARY CARE HOSPITAL [SERVICES] *SERVICES AND RURAL EMERGENCY ACCESS CARE HOSPITAL SERVICES*.—

(1) IN GENERAL.—The amount of payment for outpatient rural primary care hospital services provided during a year be-

fore the prospective payment system described in paragraph (2) is in effect in a rural primary care hospital under this part shall be determined by one of the 2 following methods, as elected by the rural primary care hospital:

(A) * * *

* * * * * * *

(2) DEVELOPMENT AND IMPLEMENTATION OF ALL INCLUSIVE, PROSPECTIVE PAYMENT SYSTEM.—Not later than January 1, 1996, the Secretary shall develop and implement a prospective payment system for determining payments under this part for outpatient rural primary care hospital services using a methodology that includes all costs in providing all such services (including related professional medical services) and that determines the payment amount for such services on a prospective basis. *The amount of payment for rural emergency access care hospital services provided during a year shall be determined using the applicable method provided under this subsection for determining payment for outpatient rural primary care hospital services during the year.*

(h) PAYMENT FOR PROSTHETIC DEVICES AND ORTHOTICS AND PROSTHETICS.—

(1) * * *

* * * * * * *

(4) DEFINITIONS.—In this subsection—

(A) the term "applicable percentage increase" means—

(i) * * *

* * * * * * *

(iii) for 1994 and 1995, 0 percent, [and]

(iv) for each of the years 1996 through 2002, 1 percent, and

[(iv)] *(v)* for a subsequent year, the percentage increase in the consumer price index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year;

* * * * * * *

ENROLLMENT PERIODS

SEC. 1837. (a) * * *

* * * * * * *

(i)(1) In the case of an individual who—

(A) at the time the individual first satisfies paragraph (1) or (2) of section 1836, is enrolled in a group health plan described in section 1862(b)(1)(A)(v) by reason of the individual's (or the individual's spouse's) current employment status, and

(B) has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period,

there shall be a special enrollment period described in paragraph (3). In the case of an individual not described in the previous sentence who has not attained the age of 65, at the time the individual first satisfies paragraph (1) of section 1836, is enrolled in a large group health plan (as that term is defined in section

[1862(b)(1)(B)(iv)] *1862(b)(1)(B)(iii)*) by reason of the individual's current employment status (or the current employment status of a family member of the individual), and has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period, there shall be a special enrollment period described in paragraph (3)(B).

(2) In the case of an individual who—

(A)(i) has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period, or (ii) is an individual described in paragraph (1)(A);

(B) has enrolled in such program during any subsequent special enrollment period under this subsection during which the individual was not enrolled in a group health plan described in section 1862(b)(1)(A)(v) by reason of the individual's (or individual's spouse's) current employment status; and

(C) has not terminated enrollment under this section at any time at which the individual is not enrolled in such a group health plan by reason of the individual's (or individual's spouse's) current employment status,

there shall be a special enrollment period described in paragraph (3). In the case of an individual not described in the previous sentence who has not attained the age of 65, has enrolled (or has been deemed to have enrolled) in the medical insurance program established under this part during the individual's initial enrollment period, or is an individual described in the second sentence of paragraph (1), has enrolled in such program during any subsequent special enrollment period under this subsection during which the individual was not enrolled in a large group health plan (as that term is defined in section [1862(b)(1)(B)(iv)] *1862(b)(1)(B)(iii)*) by reason of the individual's current employment status (or the current employment status of a family member of the individual), and has not terminated enrollment under this section at any time at which the individual is not enrolled in such a large group health plan by reason of the individual's current employment status (or the current employment status of a family member of the individual), there shall be a special enrollment period described in paragraph (3)(B).

(3)(A) The special enrollment period referred to in the first sentences of paragraphs (1) and (2) is the period including each month during any part of which the individual is enrolled in a group health plan described in section 1862(b)(1)(A)(v) by reason of current employment status ending with the last day of the eighth consecutive month in which the individual is at no time so enrolled.

(B) The special enrollment period referred to in the second sentences of paragraphs (1) and (2) is the period including each month during any part of which the individual is enrolled in a large group health plan (as that term is defined in section [1862(b)(1)(B)(iv)] *1862(b)(1)(B)(iii)*) by reason of the individual's current employment status (or the current employment status of a family member of the individual) ending with the last day of the eighth consecutive month in which the individual is at no time so enrolled.

* * * * * * *

AMOUNTS OF PREMIUMS

SEC. 1839. (a) * * *

(b) In the case of an individual whose coverage period began pursuant to an enrollment after his initial enrollment period (determined pursuant to subsection (c) or (d) of section 1837), the monthly premium determined under subsection (a) or (e) shall be increased by 10 percent of the monthly premium so determined for each full 12 months (in the same continuous period of eligibility) in which he could have been but was not enrolled. For purposes of the preceding sentence, there shall be taken into account (1) the months which elapsed between the close of his initial enrollment period and the close of the enrollment period in which he enrolled, plus (in the case of an individual who reenrolls) (2) the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which he reenrolled, but there shall not be taken into account months for which the individual can demonstrate that the individual was enrolled in a group health plan described in section 1862(b)(1)(A)(v) by reason of the individual's (or the individual's spouse's) current employment or months during which the individual has not attained the age of 65 and for which the individual can demonstrate that the individual was enrolled in a large group health plan as an active individual (as those terms are defined in section [1862(b)(1)(B)(iv)] *1862(b)(1)(B)(iii)*). Any increase in an individual's monthly premium under the first sentence of this subsection with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which such individual may have.

* * * * * * *

(e)(1)(A) Notwithstanding the provisions of subsection (a), the monthly premium for each individual enrolled under this part for each month after after December 1995 [and prior to January 1999] shall be an amount equal to 50 percent *(or, if higher, the percent described in subparagraph (C))* of the monthly actuarial rate for enrollees age 65 and over, as determined under subsection (a)(1) and applicable to such month.

* * * * * * *

(C) For purposes of subparagraph (A), the percent described in this subparagraph is the ratio (expressed as a percentage) of the monthly premium established under this section for months in 1995 to the monthly actuarial rate for enrollees age 65 and over applicable to such months (as specified in the most recent report of the Board of Trustees of the Federal Supplementary Medical Insurance Trust Fund published prior to the date of the enactment of the Medicare Preservation Act of 1995).

* * * * * * *

(f) For any calendar year after 1988, [if an individual] *if an individual (other than an individual subject to an increase in the monthly premium under this section pursuant to subsection (h))* is entitled to monthly benefits under section 202 or 223 or to a monthly annuity under section 3(a), 4(a), or 4(f) of the Railroad Retirement Act of 1974 for November and December of the preceding

year, and if the monthly premium of the individual under this section for December and for January is deducted from those benefits under section 1840(a)(1) or section 1840(b)(1), the monthly premium otherwise determined under this section for an individual for that year shall not be increased, pursuant to this subsection, to the extent that such increase would reduce the amount of benefits payable to that individual for that December below the amount of benefits payable to that individual for that November (after the deduction of the premium under this section). For purposes of this subsection, retroactive adjustments or payments and deductions on account of work shall not be taken into account in determining the monthly benefits to which an individual is entitled under section 202 or 223 or under the Railroad Retirement Act of 1974.

* * * * * * *

(h)(1) Notwithstanding the previous subsections of this section, in the case of an individual whose modified adjusted gross income for a taxable year ending with or within a calendar year (as initially determined by the Secretary in accordance with paragraph (3)) exceeds the threshold amount described in paragraph (4), the Secretary shall increase the amount of the monthly premium for months in the calendar year by an amount equal to the difference between—

(A) 200 percent of the monthly actuarial rate for enrollees age 65 and over as determined under subsection (a)(1) for that calendar year; and

(B) the total of the monthly premiums paid by the individual under this section (determined without regard to subsection (b)) during such calendar year.

(2) In the case of an individual described in paragraph (1) whose modified adjusted gross exceeds the threshold amount by less than $25,000, the amount of the increase in the monthly premium applicable under paragraph (1) shall be an amount which bears the same ratio to the amount of the increase described in paragraph (1) (determined without regard to this paragraph) as such excess bears to $25,000. In the case of a joint return filed under section 6013 of the Internal Revenue Code of 1986 by spouses both of whom are enrolled under this part, the previous sentence shall be applied by substituting "$50,000" for "$25,000". The preceding provisions of this paragraph shall not apply to any individual whose threshold amount is zero.

(3) The Secretary shall make an initial determination of the amount of an individual's adjusted gross income for a taxable year ending with or within a calendar year for purposes of this subsection as follows:

(A) Not later than October 1 of the year preceding the year, the Secretary shall provide notice to each individual whom the Secretary finds (on the basis of the individual's actual adjusted gross income for the most recent taxable year for which such information is available or other information provided to the Secretary by the Secretary of the Treasury) will be subject to an increase under this subsection that the individual will be subject to such an increase, and shall include in such notice the Secretary's estimate of the individual's adjusted gross income for the year.

(B) If, during the 30-day period beginning on the date notice is provided to an individual under subparagraph (A), the individual provides the Secretary with information on the individual's anticipated adjusted gross income for the year, the amount initially determined by the Secretary under this paragraph with respect to the individual shall be based on the information provided by the individual.

(C) If an individual does not provide the Secretary with information under subparagraph (B), the amount initially determined by the Secretary under this paragraph with respect to the individual shall be the amount included in the notice provided to the individual under subparagraph (A).

(4)(A) If the Secretary determines (on the basis of final information provided by the Secretary of the Treasury) that the amount of an individual's actual adjusted gross income for a taxable year ending with or within a calendar year is less than or greater than the amount initially determined by the Secretary under paragraph (3), the Secretary shall increase or decrease the amount of the individual's monthly premium under this section (as the case may be) for months during the following calendar year by an amount equal to 1/12 of the difference between—

(i) the total amount of all monthly premiums paid by the individual under this section during the previous calendar year; and

(ii) the total amount of all such premiums which would have been paid by the individual during the previous calendar year if the amount of the individual's adjusted gross income initially determined under paragraph (3) were equal to the actual amount of the individual's adjusted gross income determined under this paragraph.

(B) In the case of an individual who is not enrolled under this part for any calendar year for which the individual's monthly premium under this section for months during the year would be increased pursuant to subparagraph (A) if the individual were enrolled under this part for the year, the Secretary may take such steps as the Secretary considers appropriate to recover from the individual the total amount by which the individual's monthly premium for months during the year would have been increased under subparagraph (A) if the individual were enrolled under this part for the year.

(C) In the case of a deceased individual for whom the amount of the monthly premium under this section for months in a year would have been decreased pursuant to subparagraph (A) if the individual were not deceased, the Secretary shall make a payment to the individual's surviving spouse (or, in the case of an individual who does not have a surviving spouse, to the individual's estate) in an amount equal to the difference between—

(i) the total amount by which the individual's premium would have been decreased for all months during the year pursuant to subparagraph (A); and

(ii) the amount (if any) by which the individual's premium was decreased for months during the year pursuant to subparagraph (A).

(5) In this subsection, the following definitions apply:

(A) The term "modified adjusted gross income" means, with respect to an individual for a taxable year, the individual's adjusted gross income under the Internal Revenue Code of 1986—

(i) determined without regard to sections 135, 911, 931, and 933 of such Code, and

(ii) increased by the amount of interest received or accrued by the individual during the taxable year which is exempt from tax under such Code.

(B) The term "threshold amount" means—

(i) except as otherwise provided in this paragraph, $75,000,

(ii) $125,000, in the case of a joint return, and

(iii) zero in the case of a taxpayer who—

(I) is married at the close of the taxable year but does not file a joint return for such year, and

(II) does not live apart from his spouse at all times during the taxable year.

* * * * * * *

MEDICARE GROWTH REDUCTION TRUST FUND

SEC. 1841A. (a)(1) There is hereby created on the books of the Treasury of the United States a trust fund to be known as the "Federal Medicare Growth Reduction Trust Fund" (in this section referred to as the "Trust Fund"). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1) and amounts appropriated under paragraph (2).

(2) There are hereby appropriated to the Trust Fund amounts equivalent to 100 percent of the Secretary's estimate of the reductions in expenditures under this part that are attributable to the Medicare Preservation Act of 1995. The amounts appropriated by the preceding sentence shall be transferred from time to time (not less frequently than monthly) from the general fund in the Treasury to the Trust Fund.

(3)(A) Subject to subparagraph (B), with respect to monies transferred to the Trust Fund, no transfers, authorizations of appropriations, or appropriations are permitted.

(B) Beginning with fiscal year 2003, the Secretary may expend funds in the Trust Fund to carry out this title, but only to the extent provided by Congress in advance through a specific amendment to this section.

(b) The provisions of subsections (b) through (e) of section 1841 shall apply to the Trust Fund in the same manner as they apply to the Federal Supplementary Medical Insurance Trust Fund, except that the Board of Trustees and Managing Trustee of the Trust Fund shall be composed of the members of the Board of Trustees and the Managing Trustee, respectively, of the Federal Supplementary Medical Insurance Trust Fund.

USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842. (a) * * *

(b)(1) * * *

(2)(A) * * *

* * * * * * *

(C) In the case of residents of nursing facilities who receive services described in clause (i) or (ii) of section 1861(s)(2)(K) performed by a member of a team, the Secretary shall instruct carriers to develop mechanisms which permit routine payment under this part for up to 1.5 visits per month per resident. In the previous sentence, the term "team" refers to a physician and includes a physician assistant acting under the supervision of the physician or a nurse practitioner working in collaboration with that physician, or both.

* * * * * * *

(6) No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that (A) payment may be made (i) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (ii) (where the service was provided in a hospital, rural primary care hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service, (B) payment may be made to an entity (i) which provides coverage of the services under a health benefits plan, but only to the extent that payment is not made under this part, (ii) which has paid the person who provided the service an amount (including the amount payable under this part) which that person has accepted as payment in full for the service, and (iii) to which the individual has agreed in writing that payment may be made under this part, (C) in the case of services described in clauses (i), (ii), or (iv) of section 1861(s)(2)(K) payment shall be made to the employer of the physician assistant or nurse practitioner involved, **[**and**]** (D) payment may be made to a physician for physicians' services (and services furnished incident to such services) furnished by a second physician to patients of the first physician if (i) the first physician is unavailable to provide the services; (ii) the services are furnished pursuant to an arrangement between the two physicians that (I) is informal and reciprocal, or (II) involves per diem or other fee-for-time compensation for such services; (iii) the services are not provided by the second physician over a continuous period of more than 60 days; and (iv) the claim form submitted to the carrier for such services includes the second physician's unique identifier (provided under the system established under subsection (r)) and indicates that the claim meets the requirements of this subparagraph for payment to the first physician**[**.**]**, *(E) in the case of an item or service (other than physicians' services and other than a portable X-ray or portable electrocardiogram treated as a physician's service for purposes of section 1848(j)(3)) furnished to an individual who (at the time the item or service is furnished) is a resident of a skilled nursing facility, payment shall be made to the facility (without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, or otherwise), and (F) in the case of types of home health services described in section*

1894(a)(2) furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home health agency, payment shall be made to the agency (without regard to whether or not the item or service was furnished by the agency, by others under arrangement with them made by the agency, or otherwise). No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.

* * * * * * *

(9)(A) * * *

* * * * * * *

(D) In addition to carrying out its functions under section 1845, the [Physician Payment Review Commission] *Medicare Payment Review Commission* (in this paragraph referred to as the "Commission") shall comment on any such proposal within the period of comment allowed by the Secretary pursuant to subparagraph (C).

* * * * * * *

(14)(A) * * *

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(C) For purposes of this paragraph:

(i) The physicians' services specified in this clause are the procedures specified (by code and description) in the Overvalued Procedures List for Finance Committee, Revised September 20, 1989, prepared by the [Physician Payment Review Commission] *Medicare Payment Review Commission* which specification is of physicians' services that have been identified as overvalued by at least 10 percent based on a comparison of payments for such services under a resource-based relative value scale and of the national average prevailing charges under this part.

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[PHYSICIAN PAYMENT REVIEW COMMISSION

[SEC. 1845. (a)(1) The Director of the Congressional Office of Technology Assessment (hereinafter in this section referred to as the "Director" and the "Office", respectively) shall provide for the appointment of a Physician Payment Review Commission (hereinafter in this section referred to as the "Commission"), to be composed of individuals with national recognition for their expertise in health economics, physician reimbursement, medical practice, and other related fields appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service).

[(2) The Commission shall consist of 13 individuals. Members of the Commission shall first be appointed no later than May 1, 1986, for a term of three years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than four members expire in any one year.

[(3) The membership of the Commission shall include (but need not be limited to) physicians, other health professionals, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research, and representatives of consumers and the elderly.

[(b)(1) The Commission shall make recommendations to the Congress, not later than March 31 of each year (beginning with 1987), regarding adjustments to the reasonable charge levels for physicians' services recognized under section 1842(b) and changes in the methodology for determining the rates of payment, and for making payment, for physicians' services under this title and other items and services under this part.

[(2) In making its recommendations, the Commission shall—

[(A) assess the likely impact of different adjustments in payment rates, particularly their impact on physician participation in the participation program established under section 1842(h) and on beneficiary access to necessary physicians' services;

[(B) make recommendations on ways to increase physician participation in that participation program and the acceptance of payment under this part on an assignment-related basis;

[(C) identify those procedures, involving the use of assistants at surgery, for which payment for those assistants should not be made under this title without prior approval;

[(D) identify those procedures for which an opinion of a second physician should be required before payment is made under this title;

[(E) consider policies for moderating the rate of increase in expenditures under this part and the rate of increase in utilization of services under this part;

[(F) make recommendations regarding major issues in the implementation of the resource-based relative value scale established under section 1848(c);

[(G) make recommendations regarding further development of the volume performance standards established under section 1848(f), including the development of State-based programs;

[(H) consider policies to provide payment incentives to increase patient access to primary care and other physician services in large urban and rural areas, including policies regarding payments to physicians pursuant to title XIX;

[(I) review and consider the number and practice specialties of physicians in training and payments under this title for graduate medical education costs;

[(J) make recommendations regarding issues relating to utilization review and quality of care, including the effectiveness of peer review procedures and other quality assurance programs applicable to physicians and providers under this title and physician certification and licensing standards and procedures;

[(K) make recommendations regarding options to help constrain the costs of health insurance to employers, including incentives under this title;

[(L) comment on the recommendations affecting physician payment under the medicare program that are included in the budget submitted by the President pursuant to section 1105 of title 31, United States Code; and

[(M) make recommendations regarding medical malpractice liability reform and physician certification and licensing standards and procedures.

[(c)(1) The following provisions of section 1886(e)(6) shall apply to the Commission in the same manner as they apply to the Prospective Payment Assessment Commission:

[(A) Subparagraph (C) (relating to staffing and administration generally).

[(B) Subparagraph (D) (relating to compensation of members).

[(C) Subparagraph (F) (relating to access to information).

[(D) Subparagraph (G) (relating to use of funds).

[(E) Subparagraph (H) (relating to periodic GAO audits).

[(F) Subparagraph (J) (relating to requests for appropriations).

[(2) In order to carry out its functions, the Commission shall collect and assess information on medical and surgical procedures and services, including information on regional variations of medical practice. In collecting and assessing information, the Commission shall—

[(A) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

[(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate for the development of useful and valid guidelines by the Commission, and

[(C) adopt procedures allowing any interested party to submit information with respect to physicians' services (including new practices, such as the use of new technologies and treatment modalities), which information the Commission shall consider in making reports and recommendations to the Secretary and Congress.

[(d) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this section. Such sums shall be payable from the Federal Supplementary Medical Insurance Trust Fund.

[(e)(1) Not later than December 31st of each year (beginning with 1988), the Secretary shall transmit to the Physician Payment Review Commission, to the Congressional Budget Office, and to the Congressional Research Service of the Library of Congress national data (known as the Part B Medicare Annual Data System) for the previous year respecting part B of this title.

[(2) The Secretary, in consultation with the Physician Payment Review Commission, the Congressional Budget Office, and the Congressional Research Service of the Library of Congress, shall establish and annually revise standards for the data reporting system described in paragraph (1).

[(3) The Secretary shall also provide to the entities described in paragraph (1) additional data respecting the program under this part as may be reasonably requested by them on an agreed-upon schedule.

[(4) The Secretary shall develop, in consultation with the Physician Payment Review Commission, the Congressional Budget Office, and the Congressional Research Service of the Library of Congress, a system for providing to each of such entities on a quarterly basis summary data on aggregate expenditures under this part by type of service and by type of provider. Such data shall be provided not later than 90 days after the end of each quarter (for quarters beginning with the calendar quarter ending on March 31, 1989).]

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PAYMENT FOR PHYSICIANS' SERVICES

SEC. 1848. (a) * * *

* * * * * * *

(c) DETERMINATION OF RELATIVE VALUES FOR PHYSICIANS' SERVICES.—

(1) * * *

(2) DETERMINATION OF RELATIVE VALUES.—

(A) IN GENERAL.—

(i) * * *

(ii) EXTRAPOLATION.—The Secretary may use extrapolation and other techniques to determine the number of relative value units for physicians' services for which specific data are not available and shall take into account recommendations of the [Physician Payment Review Commission] *Medicare Payment Review Commission* and the results of consultations with organizations representing physicians who provide such services.

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(2) DETERMINATION OF RELATIVE VALUES.—

(A) * * *

(B) PERIODIC REVIEW AND ADJUSTMENTS IN RELATIVE VALUES.—

(i) * * *

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(iii) CONSULTATION.—The Secretary, in making adjustments under clause (ii), shall consult with the [Physician Payment Review Commission] *Medicare Payment Review Commission* and organizations representing physicians.

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(5) CODING.—The Secretary shall establish a uniform procedure coding system for the coding of all physicians' services. The Secretary shall provide for an appropriate coding structure for visits and consultations. The Secretary may incorporate the use of time in the coding for visits and consultations. The Secretary, in establishing such coding system, shall consult with the [Physician Payment Review Commission] *Medicare Payment Review Commission* and other organizations representing physicians.

* * * * * * *

(d) CONVERSION FACTORS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The conversion factor [(or factors)] for each year shall be the conversion factor [(or factors)] established under this subsection for the previous year (or, in the case of 1992, specified in subparagraph (B)) adjusted by the update [or updates] (established under paragraph (3)) for the year involved.

* * * * * * *

(C) SPECIAL RULE FOR 1996.—For 1996, the conversion factor under this subsection shall be $34.60 for all physicians' services.

[(C)] *(D)* PUBLICATION.—The Secretary shall cause to have published in the Federal Register, during the last 15 days of October of—

(i) 1991, the conversion factor which will apply to physicians' services for 1992, and the update (or updates) determined under paragraph (3) for 1992 and

(ii) each succeeding year, the conversion factor [(or factors)] which will apply to physicians' services for the following year and the update [(or updates)] determined under paragraph (3) for such year.

[(2) RECOMMENDATION OF UPDATE.—

[(A) IN GENERAL.—Not later than April 15 of each year (beginning with 1991), the Secretary shall transmit to the Congress a report that includes a recommendation on the appropriate update (or updates) in the conversion factor (or factors) for all physicians' services (as defined in subsection (f)(5)(A)) in the following year. The Secretary may recommend a uniform update or different updates for different categories or groups of services. In making the recommendation, the Secretary shall consider—

[(i) the percentage change in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for that year;

[(ii) the percentage by which actual expenditures for all physicians' services and for the services involved under this part for the fiscal year ending in the year preceding the year in which such recommendation is made were greater or less than actual expenditures for such services in the fiscal year ending in the second preceding year;

[(iii) the relationship between the percentage determined under clause (ii) for a fiscal year and the performance standard rate of increase (established under subsection (f)(2)) for that fiscal year;

[(iv) changes in volume or intensity of services;

[(v) access to services; and

[(vi) other factors that may contribute to changes in volume or intensity of services or access to services.

[For purposes of making the comparison under clause (iii), the Secretary shall adjust the performance standard rate of increase for a fiscal year to reflect changes in the actual proportion of individuals who are enrolled under this part who are HMO enrollees (as defined in subsection (f)(5)(B)) in that fiscal year compared with such proportion for the previous fiscal year.

[(B) ADDITIONAL CONSIDERATIONS.—In making recommendations under subparagraph (A), the Secretary may also consider—

[(i) unexpected changes by physicians in response to the implementation of the fee schedule;

[(ii) unexpected changes in outlay projections;

[(iii) changes in the quality or appropriateness of care; and

[(iv) any other relevant factors not measured in the resource-based payment methodology.

[(C) SPECIAL RULE FOR 1992 UPDATE.—In considering the update for 1992, the Secretary shall make a separate determination of the percentage and relationship described in clauses (ii) and (iii) of subparagraph (A) with respect to the category of surgical services (as defined by the Secretary pursuant to subsection (j)(1)).

[(D) EXPLANATION OF UPDATE.—The Secretary shall include in each report under subparagraph (A)—

[(i) the update recommended for each category of physicians' services (established by the Secretary under subsection (j)(1)) and for each of the following groups of physicians' services: nonsurgical services, visits, consultations, and emergency room services;

[(ii) the rationale for the recommended update (or updates) for each category and group of services described in clause (i); and

[(iii) the data and analyses underlying the update (or updates) recommended.

[(E) COMPUTATION OF BUDGET-NEUTRAL ADJUSTMENT.—

[(i) IN GENERAL.—The Secretary shall include in the report made under subparagraph (A) in a year a statement of the percentage by which (I) the actual expenditures for physicians' services under this part (during the fiscal year ending in the preceding year, as set forth in the most recent annual report made pursuant to section 1841(b)(2)), exceeded, or was less than (II) the expenditures projected for the fiscal year under clause (ii).

[(ii) PROJECTED EXPENDITURES.—For purposes of clause (i), the expenditures projected under this clause for a fiscal year is the actual expenditures for physicians' services made under this part in the second preceding fiscal year—

[(I) increased by the weighted average percentage increase permitted under this part for payments for physicians' services in the preceding fiscal year;

[(II) adjusted to reflect the percentage change in the average number of individuals enrolled under this part (who are not enrolled with a risk-sharing contract under section 1876) for the preceding fiscal year compared with the second preceding fiscal year;

[(III) adjusted to reflect the average annual percentage growth in the volume and intensity of physicians' services under this part for the five-fiscal-year period ending with the second preceding fiscal year; and

[(IV) adjusted to reflect the percentage change in expenditures for physicians' services under this part in the preceding fiscal year (compared with the second preceding fiscal year) which result from changes in law or regulations.

[(F) COMMISSION REVIEW.—The Physician Payment Review Commission shall review the report submitted under subparagraph (A) in a year and shall submit to the Congress, by not later than May 15 of the year, a report including its recommendations respecting the update (or updates) in the conversion factor (or factors) for the following year.

[(3) UPDATE.—

[(A) BASED ON INDEX.—

[(i) IN GENERAL.—Unless Congress otherwise provides, subject to subparagraph (B), except as provided in clauses (iii) through (v), for purposes of this section the update for a year is equal to the Secretary's estimate of the percentage increase in the appropriate update index (as defined in clause (ii)) for the year.

[(ii) APPROPRIATE UPDATE INDEX DEFINED.—In clause (i), the term "appropriate update index" means—

[(I) for services for which prevailing charges in 1989 were subject to a limit under the fourth sen-

tence of section 1842(b)(3), the medicare economic index (referred to in that sentence), and

[(II) for other services, such index (such as the consumer price index) that was applicable under this part in 1989 to increases in the payment amounts recognized under this part with respect to such services.

[(iii) ADJUSTMENT IN PERCENTAGE INCREASE.—In applying clause (i) for services furnished in 1992 for which the appropriate update index is the index described in clause (ii)(I), the percentage increase in the appropriate update index shall be reduced by 0.4 percentage points.

[(iv) ADJUSTMENT IN PERCENTAGE INCREASE FOR 1994.—In applying clause (i) for services furnished in 1994, the percentage increase in the appropriate update index shall be reduced by—

[(I) 3.6 percentage points for services included in the category of surgical services (as defined for purposes of subsection (j)(1)), and

[(II) 2.6 percentage points for other services.

[(v) ADJUSTMENT IN PERCENTAGE INCREASE FOR 1995.—In applying clause (i) for services furnished in 1995, the percentage increase in the appropriate update index shall be reduced by 2.7 percentage points.

[(vi) EXCEPTION FOR CATEGORY OF PRIMARY CARE SERVICES.—Clauses (iv) and (v) shall not apply to services included in the category of primary care services (as defined for purposes of subsection (j)(1)).

[(B) ADJUSTMENT IN UPDATE.—

[(i) IN GENERAL.— The update for a category of physicians' services for a year provided under subparagraph (A) shall, subject to clause (ii), be increased or decreased by the same percentage by which (I) the percentage increase in the actual expenditures for services in such category in the second previous fiscal year over the third previous fiscal year, was less or greater, respectively, than (II) the performance standard rate of increase (established under subsection (f)) for such category of services for the second previous fiscal year.

[(ii) RESTRICTIONS ON ADJUSTMENT.—The adjustment made under clause (i) for a year may not result in a decrease of more than—

[(I) 2 percentage points for the update for 1992 or 1993,

[(II) 2½ percentage points for the update for 1994, and

[(III) 5 percentage points for the update for any succeeding year.]

(3) UPDATE.—

(A) IN GENERAL.—Subject to subparagraph (E), for purposes of this section the update for a year (beginning with 1997) is equal to the product of—

(i) 1 plus the Secretary's estimate of the percentage increase in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for the year (divided by 100), and

(ii) 1 plus the Secretary's estimate of the update adjustment factor for the year (divided by 100),

minus 1 and multiplied by 100.

(B) UPDATE ADJUSTMENT FACTOR.—The "update adjustment factor" for a year is equal to the quotient of—

(i) the difference between (I) the sum of the allowed expenditures for physicians' services furnished during each of the years 1995 through the year involved and (II) the sum of the amount of actual expenditures for physicians' services furnished during each of the years 1995 through the previous year; divided by

(ii) the Secretary's estimate of allowed expenditures for physicians' services furnished during the year.

(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of subparagraph (B), allowed expenditures for physicians' services shall be determined as follows (as estimated by the Secretary):

(i) In the case of allowed expenditures for 1995, such expenditures shall be equal to actual expenditures for services furnished during the 12-month period ending with June of 1995.

(ii) In the case of allowed expenditures for 1996 and each subsequent year, such expenditures shall be equal to allowed expenditures for the previous year, increased by the sustainable growth rate under subsection (f) for the fiscal year which begins during the year.

(D) DETERMINATION OF ACTUAL EXPENDITURES.—For purposes of subparagraph (B), the amount of actual expenditures for physicians' services furnished during a year shall be equal to the amount of expenditures for such services during the 12-month period ending with June of the previous year.

(E) RESTRICTION ON VARIATION FROM MEDICARE ECONOMIC INDEX.—Notwithstanding the amount of the update adjustment factor determined under subparagraph (B) for a year, the update in the conversion factor under this paragraph for the year may not be—

(i) greater than 103 percent of 1 plus the Secretary's estimate of the percentage increase in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for the year (divided by 100); or

(ii) except as required to carry out section 1895, less than 93 percent of 1 plus the Secretary's estimate of the percentage increase in the medicare economic index (described in the fourth sentence of section 1842(b)(3)) for the year (divided by 100).

(4) REPORTING REQUIREMENTS.—

(A) IN GENERAL.—Not later than November 1 of each year (beginning with 1996), the Secretary shall transmit to the Congress a report that describes the update in the conver-

sion factor for physicians' services (as defined in subsection (f)(3)(A)) in the following year.

(B) COMMISSION REVIEW.—The Medicare Payment Review Commission shall review the report submitted under subparagraph (A) for a year and shall submit to the Congress, by not later than December 1 of the year, a report containing its analysis of the conversion factor for the following year.

* * * * * * *

[(f) MEDICARE VOLUME PERFORMANCE STANDARD RATES OF INCREASE.—

[(1) PROCESS FOR ESTABLISHING MEDICARE VOLUME PERFORMANCE STANDARD RATES OF INCREASE.—

[(A) SECRETARY'S RECOMMENDATION.—By not later than April 15 of each year (beginning with 1990), the Secretary shall transmit to the Congress a recommendation on performance standard rates of increase for all physicians' services and for each category of such services for the fiscal year beginning in such year. In making the recommendation, the Secretary shall confer with organizations representing physicians and shall consider—

[(i) inflation,

[(ii) changes in numbers of enrollees (other than HMO enrollees) under this part,

[(iii) changes in the age composition of enrollees (other than HMO enrollees) under this part,

[(iv) changes in technology,

[(v) evidence of inappropriate utilization of services,

[(vi) evidence of lack of access to necessary physicians' services, and

[(vii) such other factors as the Secretary considers appropriate.

[(B) COMMISSION REVIEW.—The Physician Payment Review Commission shall review the recommendation transmitted during a year under subparagraph (A) and shall make its recommendation to Congress, by not later than May 15 of the year, respecting the performance standard rates of increase for the fiscal year beginning in that year.

[(C) PUBLICATION OF PERFORMANCE STANDARD RATES OF INCREASE.—The Secretary shall cause to have published in the Federal Register, in the last 15 days of October of each year (beginning with 1991), the performance standard rates of increase for all physicians' services and for each category of physicians' services for the fiscal year beginning in that year. The Secretary shall cause to have published in the Federal Register, by not later than January 1, 1990, the performance standard rate of increase under subparagraph (D) for fiscal year 1990.

[(D) PERFORMANCE STANDARD RATE OF INCREASE FOR FISCAL YEAR 1990.—The performance standard rate of increase for fiscal year 1990 is equal to the sum of—

[(i) the Secretary's estimate of the weighted average percentage increase in the reasonable charges for physicians' services (as defined in subsection (f)(5)(A))

under this part for portions of calendar years included in fiscal year 1990,

[(ii) the Secretary's estimate of the percentage increase or decrease in the average number of individuals enrolled under this part (other than HMO enrollees) from fiscal year 1989 to fiscal year 1990,

[(iii) the Secretary's estimate of the average annual percentage growth in volume and intensity of physicians' services under this part for the 5-fiscal-year period ending with fiscal year 1989 (based upon information contained in the most recent annual report made pursuant to section 1841(b)(2)), and

[(iv) the Secretary's estimate of the percentage increase or decrease in expenditures for physicians' services (as defined in subsection (f)(5)(A)) in fiscal year 1990 (compared with fiscal year 1989) which will result from changes in law or regulations and which is not taken into account in the percentage increase described in clause (i),

[reduced by ½ percent.

[(2) SPECIFICATION OF PERFORMANCE STANDARD RATES OF INCREASE FOR SUBSEQUENT FISCAL YEARS.—

[(A) IN GENERAL.—Unless Congress otherwise provides, subject to paragraph (4), the performance standard rate of increase, for all physicians' services and for each category of physicians' services, for a fiscal year (beginning with fiscal year 1991) shall be equal to the product of—

[(i) 1 plus the Secretary's estimate of the weighted average percentage increase (divided by 100) in the fees for all physicians' services or for the category of physicians' services, respectively, under this part for portions of calendar years included in the fiscal year involved,

[(ii) 1 plus the Secretary's estimate of the percentage increase or decrease (divided by 100) in the average number of individuals enrolled under this part (other than HMO enrollees) from the previous fiscal year to the fiscal year involved,

[(iii) 1 plus the Secretary's estimate of the average annual percentage growth (divided by 100) in volume and intensity of all physicians' services or of the category of physicians' services, respectively, under this part for the 5-fiscal-year period ending with the preceding fiscal year (based upon information contained in the most recent annual report made pursuant to section 1841(b)(2)), and

[(iv) 1 plus the Secretary's estimate of the percentage increase or decrease (divided by 100) in expenditures for all physicians' services or of the category of physicians' services, respectively, in the fiscal year (compared with the preceding fiscal year) which will result from changes in law or regulations including changes in law and regulations affecting the percentage increase described in clause (i) and which is not

taken into account in the percentage increase described in clause (i),

minus 1, multiplied by 100, and reduced by the performance standard factor (specified in subparagraph (B)). In clause (i), the term "fees" means, with respect to 1991, reasonable charges and, with respect to any succeeding year, fee schedule amounts.

[(B) PERFORMANCE STANDARD FACTOR.—For purposes of subparagraph (A), the performance standard factor—

[(i) for 1991 is 1 percentage point,

[(ii) for 1992 is 1½ percentage points,

[(iii) for 1993 is 2 percentage points,

[(iv) for 1994 is 3½ percentage points, and

[(v) for each succeeding year is 4 percentage points.

[(C) PERFORMANCE STANDARD RATES OF INCREASE FOR FISCAL YEAR 1991.—Notwithstanding subparagraph (A), the performance standard rate of increase for a category of physicians' services for fiscal year 1991 shall be the sum of—

[(i) the Secretary's estimate of the percentage by which actual expenditures for the category of physicians' services under this part for fiscal year 1991 exceed actual expenditures for such category of services in fiscal year 1990 (determined without regard to the amendments made by the Omnibus Budget Reconciliation Act of 1990), and

[(ii) the Secretary's estimate of the percentage increase or decrease in expenditures for the category of services in fiscal year 1991 (compared with fiscal year 1990) that will result from changes in law and regulations (including the Omnibus Budget Reconciliation Act of 1990), reduced by 2 percentage points.

[(3) Quarterly reporting.—The Secretary shall establish procedures for providing, on a quarterly basis to the Physician Payment Review Commission, the Congressional Budget Office, the Congressional Research Service, the Committees on Ways and Means and Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate, information on compliance with performance standard rates of increase established under this subsection.

[(4) SEPARATE GROUP-SPECIFIC PERFORMANCE STANDARD RATES OF INCREASE.—

[(A) IMPLEMENTATION OF PLAN.—Subject to subparagraph (B), the Secretary shall, after completion of the study required under section 6102(e)(3) of the Omnibus Budget Reconciliation Act of 1989, but not before October 1, 1991, implement a plan under which qualified physician groups could elect annually separate performance standard rates of increase other than the performance standard rate of increase established for the year under paragraph (2) for such physicians. The Secretary shall develop criteria to determine which physician groups are eligible to elect to have applied to such groups separate performance standard rates of increase and the methods by which such

group-specific performance standard rates of increase would be accomplished. The Secretary shall report to the Congress on the criteria and methods by April 15, 1991. The Physician Payment Review Commission shall review and comment on such recommendations by May 15, 1991. Before implementing group-specific performance standard rates of increase, the Secretary shall provide for notice and comment in the Federal Register and consult with organizations representing physicians.

[(B) APPROVAL.—The Secretary may not implement the plan described in subparagraph (A), unless specifically approved by law.

[(5) DEFINITIONS.—In this subsection:

[(A) SERVICES INCLUDED IN PHYSICIANS' SERVICES.—The term "physicians' services" includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to an HMO enrollee under a risk-sharing contract under section 1876.

[(B) HMO ENROLLEE.—The term "HMO enrollee" means, with respect to a fiscal year, an individual enrolled under this part who is enrolled with an entity under a risk-sharing contract under section 1876 in the fiscal year.]

(f) SUSTAINABLE GROWTH RATE.—

(1) SPECIFICATION OF GROWTH RATE.—

(A) FISCAL YEAR 1996.—The sustainable growth rate for all physicians' services for fiscal year 1996 shall be equal to the product of—

(i) 1 plus the Secretary's estimate of the percentage change in the medicare economic index for 1996 (described in the fourth sentence of section 1842(b)(3)) (divided by 100),

(ii) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than private plan enrollees) from fiscal year 1995 to fiscal year 1996,

(iii) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from fiscal year 1995 to fiscal year 1996, plus 2 percentage points, and

(iv) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in fiscal year 1996 (compared with fiscal year 1995) which will result from changes in law, determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians' services or changes in expenditures resulting from changes in the update to the conversion factor under subsection (d),

minus 1 and multiplied by 100.

(B) SUBSEQUENT FISCAL YEARS.—The sustainable growth rate for all physicians' services for fiscal year 1997 and each subsequent fiscal year shall be equal to the product of—

(i) 1 plus the Secretary's estimate of the percentage change in the medicare economic index for the fiscal year involved (described in the fourth sentence of section 1842(b)(3)) (divided by 100),

(ii) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than private plan enrollees) from the previous fiscal year to the fiscal year involved,

(iii) 1 plus the Secretary's estimate of the projected percentage growth in real gross domestic product per capita (divided by 100) from the previous fiscal year to the fiscal year involved, plus 2 percentage points, and

(iv) 1 plus the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the fiscal year (compared with the previous fiscal year) which will result from changes in law (including changes made by the Secretary in response to section 1895), determined without taking into account estimated changes in expenditures due to changes in the volume and intensity of physicians' services or changes in expenditures resulting from changes in the update to the conversion factor under subsection (d)(3),

minus 1 and multiplied by 100.

(2) EXCLUSION OF SERVICES FURNISHED TO PRIVATE PLAN ENROLLEES.—In this subsection, the term "physicians' services" with respect to a fiscal year does not include services furnished to an individual enrolled under this part who has elected to receive benefits under this title for the fiscal year through a MedicarePlus product offered under part C or through enrollment with an eligible organization with a risk-sharing contract under section 1876.

(g) LIMITATION ON BENEFICIARY LIABILITY.—

(1) * * *

* * * * * * *

(6) MONITORING OF CHARGES.—

(A) * * *

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(C) PLAN.—If the Secretary finds that there has been a significant decrease in the proportions described in subclauses (I) and (II) of subparagraph (A)(ii) or an increase in the amounts described in subclause (III) of that subparagraph, the Secretary shall develop a plan to address such a problem and transmit to Congress recommendations regarding the plan. The [Physician Payment Review Commission] *Medicare Payment Review Commission* shall review the Secretary's plan and rec-

ommendations and transmit to Congress its comments regarding such plan and recommendations.

(7) MONITORING OF UTILIZATION AND ACCESS.—

(A) * * *

* * * * * * *

(C) RECOMMENDATIONS.—The Secretary shall include in each annual report under subparagraph (B) recommendations—

(i) addressing any identified patterns of inappropriate utilization,

(ii) on utilization review,

(iii) on physician education or patient education,

(iv) addressing any problems of beneficiary access to care made evident by the monitoring process, and

(v) on such other matters as the Secretary deems appropriate.

The [Physician Payment Review Commission] *Medicare Payment Review Commission* shall comment on the Secretary's recommendations and in developing its comments, the Commission shall convene and consult a panel of physician experts to evaluate the implications of medical utilization patterns for the quality of and access to patient care.

* * * * * * *

(i) MISCELLANEOUS PROVISIONS.—

(1) RESTRICTION ON ADMINISTRATIVE AND JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869 or otherwise of—

(A) * * *

* * * * * * *

(C) the determination of [conversion factors] *the conversion factor* under subsection (d),

* * * * * * *

PART C—PROVISIONS RELATING TO MEDICAREPLUS

REQUIREMENTS FOR MEDICAREPLUS ORGANIZATIONS; HIGH DEDUCTIBLE/MEDISAVE PRODUCTS

SEC. 1851. (a) MEDICAREPLUS ORGANIZATION DEFINED.—In this part, subject to the succeeding provisions of this section, the term "MedicarePlus organization" means a public or private entity that is certified under section 1857 as meeting the requirements and standards of this part for such an organization.

(b) ORGANIZED AND LICENSED UNDER STATE LAW.—

(1) IN GENERAL.—A MedicarePlus organization shall be organized and licensed under State law to offer health insurance or health benefits coverage in each State in which it offers a MedicarePlus product.

(2) EXCEPTION FOR TAFT-HARTLEY SPONSORS.—Paragraph (1) shall not apply to a MedicarePlus organization that is a Taft-Hartley sponsor (as defined in section 1852(c)(4)).

(3) EXCEPTION FOR PROVIDER-SPONSORED ORGANIZATIONS.—Paragraph (1) shall not apply to a MedicarePlus organization that is a provider-sponsored organization (as defined in section 1854(a)) except to the extent provided under section 1857(c).

(4) EXCEPTION FOR QUALIFIED ASSOCIATIONS.—Paragraph (1) shall not apply to a MedicarePlus organization that is a qualified association (as defined in section 1852(c)(4)(B)).

(c) PREPAID PAYMENT.—A MedicarePlus organization shall be compensated (except for deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members by a payment which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided to a member.

(d) ASSUMPTION OF FULL FINANCIAL RISK.—The MedicarePlus organization shall assume full financial risk on a prospective basis for the provision of the health care services (other than hospice care) for which benefits are required to be provided under section 1852(a)(1), except that the organization—

(1) may obtain insurance or make other arrangements for the cost of providing to any enrolled member such services the aggregate value of which exceeds $5,000 in any year,

(2) may obtain insurance or make other arrangements for the cost of such services provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization,

(3) may obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and

(4) may make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

In the case of a MedicarePlus organization that is a Taft-Hartley sponsor (as defined in section 1852(c)(4)(A)) or a qualified association (as defined in section 1852(c)(4)(B)), this subsection shall not apply with respect to MedicarePlus products offered by such organization and issued by an organization to which subsection (b)(1) applies or by a provider-sponsored organization (as defined in section 1854(a)).

(e) PROVISION AGAINST RISK OF INSOLVENCY.—

(1) IN GENERAL.—Each MedicarePlus organization shall meet standards under section 1856 relating to the financial solvency and capital adequacy of the organization. Such standards shall take into account the nature and type of MedicarePlus products offered by the organization.

(2) TREATMENT OF TAFT-HARTLEY SPONSORS.—An entity that is a Taft-Hartley sponsor is deemed to meet the requirement of paragraph (1).

(3) TREATMENT OF CERTAIN QUALIFIED ASSOCIATIONS.—An entity that is a qualified association is deemed to meet the requirement of paragraph (1) with respect to MedicarePlus products offered by such association and issued by an organization to which subsection (b)(1) applies or by a provider-sponsored organization.

(f) HIGH DEDUCTIBLE/MEDISAVE PRODUCT DEFINED.—

(1) IN GENERAL.—In this part, the term "high deductible/medisave product" means a MedicarePlus product that—

(A) provides reimbursement for at least the items and services described in section 1852(a)(1) in a year but only after the enrollee incurs countable expenses (as specified under the product) equal to the amount of a deductible (described in paragraph (2));

(B) counts as such expenses (for purposes of such deductible) at least all amounts that would have been payable under parts A and B or by the enrollee if the enrollee had elected to receive benefits through the provisions of such parts; and

(C) provides, after such deductible is met for a year and for all subsequent expenses for benefits referred to in subparagraph (A) in the year, for a level of reimbursement that is not less than—

(i) 100 percent of such expenses, or

(ii) 100 percent of the amounts that would have been paid (without regard to any deductibles or coinsurance) under parts A and B with respect to such expenses,

whichever is less. Such term does not include the MedicarePlus MSA itself or any contribution into such account.

(2) DEDUCTIBLE.—The amount of deductible under a high deductible/medisave product—

(A) for contract year 1997 shall be not more than $10,000; and

(B) for a subsequent contract year shall be not more than the maximum amount of such deductible for the previous contract year under this paragraph increased by the national average per capita growth rate under section 1855(c)(3) for the year.

If the amount of the deductible under subparagraph (B) is not a multiple of $50, the amount shall be rounded to the nearest multiple of $50.

(g) ORGANIZATIONS TREATED AS MEDICAREPLUS ORGANIZATIONS DURING TRANSITION.—Any of the following organizations shall be considered to qualify as a MedicarePlus organization for contract years beginning before January 1, 1998:

(1) HEALTH MAINTENANCE ORGANIZATIONS.—An organization that is organized under the laws of any State and that is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act), an organization recognized under State law as a health maintenance organization, or a similar organization regulated under State law for solvency in the same manner and to the same extent as such a health maintenance organization.

(2) LICENSED INSURERS.—An organization that is organized under the laws of any State and—

(A) is licensed by a State agency as an insurer for the offering of health benefit coverage, or

(B) is licensed by a State agency as a service benefit plan, but only for individuals residing in an area in which the organization is licensed to offer health insurance coverage.

(3) CURRENT RISK-CONTRACTORS.—An organization that is an eligible organization (as defined in section 1876(b)) and that has a risk-sharing contract in effect under section 1876 as of the date of the enactment of this section.

REQUIREMENTS RELATING TO BENEFITS, PROVISION OF SERVICES, ENROLLMENT, AND PREMIUMS

SEC. 1852. (a) BENEFITS COVERED.—

(1) IN GENERAL.—Except as provided in section 1851(f)(1) with respect to high deductible/medisave products, each MedicarePlus product offered under this part shall provide benefits for at least the items and services for which benefits are available under parts A and B consistent with the standards for coverage of such items and services applicable under this title.

(2) ORGANIZATION AS SECONDARY PAYER.—Notwithstanding any other provision of law, a MedicarePlus organization may (in the case of the provision of items and services to an individual under this part under circumstances in which payment under this title is made secondary pursuant to section 1862(b)(2)) charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law or policy—

(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

(B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

(3) SATISFACTION OF REQUIREMENT.—A MedicarePlus product (other than a high deductible/medisave product) offered by a MedicarePlus organization satisfies paragraph (1) with respect to benefits for items and services if the following requirements are met:

(A) FEE FOR SERVICE PROVIDERS.—In the case of benefits furnished through a provider that does not have a contract with the organization, the product provides for at least the dollar amount of payment for such items and services as would otherwise be provided under parts A and B.

(B) PARTICIPATING PROVIDERS.—In the case of benefits furnished through a provider that has such a contract, the individual's liability for payment for such items and services does not exceed (after taking into account any deductible, which does not exceed any deductible under parts A and B) the lesser of the following:

(i) NON-MEDICAREPLUS LIABILITY.—The amount of the liability that the individual would have had (based

on the provider being a participating provider) if the individual had elected the non-MedicarePlus option.

(ii) MEDICARE COINSURANCE APPLIED TO PRODUCT PAYMENT RATES.—The applicable coinsurance or copayment rate (that would have applied under the non-MedicarePlus option) of the payment rate provided under the contract.

(b) ANTIDISCRIMINATION.—A MedicarePlus organization may not deny, limit, or condition the coverage or provision of benefits under this part based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual.

(c) GUARANTEED ISSUE AND RENEWAL.—

(1) IN GENERAL.—Except as provided in this subsection, a MedicarePlus organization shall provide that at any time during which elections are accepted under section 1805 with respect to a MedicarePlus product offered by the organization, the organization will accept without restrictions individuals who are eligible to make such election.

(2) PRIORITY.—If the Secretary determines that a MedicarePlus organization, in relation to a MedicarePlus product it offers, has a capacity limit and the number of eligible individuals who elect the product under section 1805 exceeds the capacity limit, the organization may limit the election of individuals of the product under such section but only if priority in election is provided—

(A) first to such individuals as have elected the product at the time of the determination, and

(B) then to other such individuals in such a manner that does not discriminate among the individuals (who seek to elect the product) on a basis described in paragraph (1).

(3) LIMITATION ON TERMINATION OF ELECTION.—

(A) IN GENERAL.—Subject to subparagraph (B), a MedicarePlus organization may not for any reason terminate the election of any individual under section 1805 for a MedicarePlus product it offers.

(B) BASIS FOR TERMINATION OF ELECTION.—A MedicarePlus organization may terminate an individual's election under section 1805 with respect to a MedicarePlus product it offers if—

(i) any premiums required with respect to such product are not paid on a timely basis (consistent with standards under section 1856 that provide for a grace period for late payment of premiums),

(ii) the individual has engaged in disruptive behavior (as specified in such standards), or

(iii) the product is terminated with respect to all individuals under this part.

Any individual whose election is so terminated is deemed to have elected the Non-MedicarePlus option (as defined in section 1805(a)(3)(A)).

(C) ORGANIZATION OBLIGATION WITH RESPECT TO ELECTION FORMS.—Pursuant to a contract under section 1858, each MedicarePlus organization receiving an election form under sec-

tion 1805(c)(2) shall transmit to the Secretary (at such time and in such manner as the Secretary may specify) a copy of such form or such other information respecting the election as the Secretary may specify.

(4) SPECIAL RULES FOR LIMITED ENROLLMENT MEDICAREPLUS ORGANIZATIONS.—

(A) TAFT-HARTLEY SPONSORS.—

(i) IN GENERAL.—Subject to subparagraph (C), a MedicarePlus organization that is a Taft-Hartley sponsor (as defined in clause (ii)) shall limit eligibility of enrollees under this part for MedicarePlus products it offers to individuals who are entitled to obtain benefits through such products under the terms of an applicable collective bargaining agreement.

(ii) TAFT-HARTLEY SPONSOR.—In this part and section 1805, the term "Taft-Hartley sponsor" means, in relation to a group health plan that is established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of parties who establish or maintain the plan.

(B) QUALIFIED ASSOCIATIONS.—

(i) IN GENERAL.—Subject to subparagraph (C), a MedicarePlus organization that is a qualified association (as defined in clause (iii)) shall limit eligibility of individuals under this part for products it offers to individuals who are members of the association (or who are spouses of such individuals).

(ii) LIMITATION ON TERMINATION OF COVERAGE.—Such a qualifying association offering a MedicarePlus product to an individual may not terminate coverage of the individual on the basis that the individual is no longer a member of the association except pursuant to a change of election during an open election period occurring on or after the date of the termination of membership.

(iii) QUALIFIED ASSOCIATION.—In this part and section 1805, the term "qualified association" means an association, religious fraternal organization, or other organization (which may be a trade, industry, or professional association, a chamber of commerce, or a public entity association) that the Secretary finds—

(I) has been formed for purposes other than the sale of any health insurance and does not restrict membership based on the health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability, of an individual,

(II) does not exist solely or principally for the purpose of selling insurance, and

(III) has at least 1,000 individual members or 200 employer members.

Such term includes a subsidiary or corporation that is wholly owned by one or more qualified organizations.

(C) LIMITATION.—Rules of eligibility to carry out the previous subparagraphs of this paragraph shall not have the effect of denying eligibility to individuals on the basis of health status, claims experience, receipt of health care, medical history, or lack of evidence of insurability.

(D) LIMITED ENROLLMENT MEDICAREPLUS ORGANIZATION.—In this part and section 1805, the term "limited enrollment MedicarePlus organization" means a MedicarePlus organization that is a Taft-Hartley sponsor or a qualified association.

(E) EMPLOYER, ETC..—In this paragraph, the terms "employer", "employee organization", and "group health plan" have the meanings given such terms for purposes of part 6 of subtitle B of title I of the Employee Retirement Income Security Act of 1974.

(d) SUBMISSION AND CHARGING OF PREMIUMS.—

(1) IN GENERAL.—Each MedicarePlus organization shall file with the Secretary each year, in a form and manner and at a time specified by the Secretary—

(A) the amount of the monthly premiums for coverage under each MedicarePlus product it offers under this part in each payment area (as determined for purposes of section 1855) in which the product is being offered; and

(B) the enrollment capacity in relation to the product in each such area.

(2) AMOUNTS OF PREMIUMS CHARGED.—The amount of the monthly premium charged by a MedicarePlus organization for a MedicarePlus product offered in a payment area to an individual under this part shall be equal to the amount (if any) by which—

(A) the amount of the monthly premium for the product for the period involved, as established under paragraph (3) and submitted under paragraph (1), exceeds

(B)(i) 1/12 of the annual MedicarePlus capitation rate specified in section 1855(b)(2) for the area and period involved, or (ii) in the case of a high deductible/medisave product, the monthly adjusted MedicarePlus capitation rate specified in section 1855(b)(1) for the individual and period involved.

(3) UNIFORM PREMIUM.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the premiums charged by a MedicarePlus organization under this part may not vary among individuals who reside in the same payment area.

(B) EXCEPTION FOR HIGH DEDUCTIBLE/MEDISAVE PRODUCTS.—A MedicarePlus organization shall establish premiums for any high deductible/medisave product it offers in a payment area based on each of the risk adjustment categories established for purposes of determining the amount of the payment to MedicarePlus organizations under section 1855(b)(1) and using the identical demographic and other adjustments among such categories as are used for such purposes.

(4) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each MedicarePlus organization shall permit the payment of monthly premiums on a monthly basis and may terminate election of individuals for a MedicarePlus product for failure to make premium payments only in accordance with subsection (c)(3)(B).

(5) RELATION OF PREMIUMS AND COST-SHARING TO BENEFITS.—In no case may the portion of a MedicarePlus organization's premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (to the extent attributable to the minimum benefits described in subsection (a)(1) and not count any amount attributable to balance billing) to individuals who are enrolled under this part with the organization exceed the actuarial value of the coinsurance and deductibles that would be applicable on the average to individuals enrolled under this part with the organization (or, if the Secretary finds that adequate data are not available to determine that actuarial value, the actuarial value of the coinsurance and deductibles applicable on the average to individuals in the area, in the State, or in the United States, eligible to enroll under this part with the organization, or other appropriate data) and entitled to benefits under part A and enrolled under part B if they were not members of a MedicarePlus organization.

(e) REQUIREMENT FOR ADDITIONAL BENEFITS, PART B PREMIUM DISCOUNT REBATES, OR BOTH.—

(1) REQUIREMENT.—

(A) IN GENERAL.—Each MedicarePlus organization (in relation to a MedicarePlus product it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the product for a contract year, subject to the succeeding provisions of this subsection, the organization shall provide to individuals such additional benefits (as the organization may specify), a monetary rebate (paid on a monthly basis) of the part B monthly premium, or a combination thereof, in an total value which is at least equal to the adjusted excess amount (as defined in subparagraph (C)).

(B) EXCESS AMOUNT.—For purposes of this paragraph, the "excess amount", for an organization for a product, is the amount (if any) by which—

(i) the average of the capitation payments made to the organization under this part for the product at the beginning of contract year, exceeds

(ii) the actuarial value of the minimum benefits described in subsection (a)(1) under the product for individuals under this part, as determined based upon an adjusted community rate described in paragraph (5).

(C) ADJUSTED EXCESS AMOUNT.—For purposes of this paragraph, the "adjusted excess amount", for an organization for a product, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (3).

(D) NO APPLICATION TO HIGH DEDUCTIBLE/MEDISAVE PRODUCT.—Subparagraph (A) shall not apply to a high deductible/medisave product.

(E) UNIFORM APPLICATION.—This paragraph shall be applied uniformly for all enrollees for a product in a service area.

(F) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a MedicarePlus organization from providing health care benefits that are in addition to the benefits otherwise required to be provided under this paragraph and from imposing a premium for such additional benefits.

(2) LIMITATION ON AMOUNT OF PART B PREMIUM DISCOUNT REBATE.—In no case shall the amount of a part B premium discount rebate under paragraph (1)(A) exceed, with respect to a month, the amount of premiums imposed under part B (not taking into account section 1839(b) (relating to penalty for late enrollment) or 1839(h) (relating to affluence testing)), for the individual for the month. Except as provided in the previous sentence, a MedicarePlus organization is not authorized to provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

(3) STABILIZATION FUND.—A MedicarePlus organization may provide that a part of the value of an excess actuarial amount described in paragraph (1) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits and rebates offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the MedicarePlus product in accordance with such paragraph prior to the end of such periods, shall revert for the use of such trust funds.

(4) DETERMINATION BASED ON INSUFFICIENT DATA.—For purposes of this subsection, if the Secretary finds that there is insufficient enrollment experience (including no enrollment experience in the case of a provider-sponsored organization) to determine an average of the capitation payments to be made under this part at the beginning of a contract period, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this part.

(5) ADJUSTED COMMUNITY RATE.—

(A) IN GENERAL.—For purposes of this subsection, subject to subparagraph (B), the term "adjusted community rate" for a service or services means, at the election of a MedicarePlus organization, either—

(i) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a MedicarePlus product under this part if the rate of payment were determined under a "community rating system" (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)), or

(ii) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to such an individual, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the individuals electing coverage under this part and the utilization characteristics of the other enrollees with the organization (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of individuals selecting other MedicarePlus coverage, or individuals in the area, in the State, or in the United States, eligible to elect MedicarePlus coverage under this part and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

(B) SPECIAL RULE FOR PROVIDER-SPONSORED ORGANIZATIONS.—In the case of a MedicarePlus organization that is a provider-sponsored organization, the adjusted community rate under subparagraph (A) for a MedicarePlus product may be computed (in a manner specified by the Secretary) using data in the general commercial marketplace or (during a transition period) based on the costs incurred by the organization in providing such a product.

(f) RULES REGARDING PHYSICIAN PARTICIPATION.—

(1) PROCEDURES.—Each MedicarePlus organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under MedicarePlus products offered by the organization under this part. Such procedures shall include—

(A) providing notice of the rules regarding participation,

(B) providing written notice of participation decisions that are adverse to physicians, and

(C) providing a process within the organization for appealing adverse decisions, including the presentation of information and views of the physician regarding such decision.

(2) CONSULTATION IN MEDICAL POLICIES.—A MedicarePlus organization shall consult with physicians who have entered into participation agreements with the organization regarding the organization's medical policy, quality, and medical management procedures.

(3) LIMITATIONS ON PHYSICIAN INCENTIVE PLANS.—

(A) IN GENERAL.—Each MedicarePlus organization may not operate any physician incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

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

(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization—

(I) provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or the physician group, and

(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.

(B) PHYSICIAN INCENTIVE PLAN DEFINED.—In this paragraph, the term "physician incentive plan" means any compensation arrangement between a MedicarePlus organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization under this part.

(4) EXCEPTION FOR CERTAIN FEE-FOR-SERVICE PLANS.—The previous provisions of this subsection shall not apply in the case of a MedicarePlus organization in relation to a MedicarePlus product if the organization does not have agreements between physicians and the organization for the provision of benefits under the product.

(g) PROVISION OF INFORMATION.—A MedicarePlus organization shall provide the Secretary with such information on the organization and each MedicarePlus product it offers as may be required for the preparation of the information booklet described in section 1805(d)(3)(A).

(h) COORDINATED ACUTE AND LONG-TERM CARE BENEFITS UNDER A MEDICAREPLUS PRODUCT.—Nothing in this part shall be construed as preventing a State from coordinating benefits under its MediGrant program under title XXI with those provided under a MedicarePlus product in a manner that assures continuity of a full-range of acute care and long-term care services to poor elderly or disabled individuals eligible for benefits under this title and under such program.

(i) TRANSITIONAL FILE AND USE FOR CERTAIN REQUIREMENTS.—

(1) IN GENERAL.—In the case of a MedicarePlus product proposed to be offered before the end of the transition period (as defined in section 1805(e)(1)(B)), by a MedicarePlus organization described in section 1851(g)(3) or by a MedicarePlus organization with a contract in effect under section 1858, if the organization submits complete information to the Secretary regarding the product demonstrating that the product meets the requirements and standards under subsections (a), (d), and (e)

(relating to benefits and premiums), the product shall be deemed as meeting such requirements and standards under such subsections unless the Secretary disapproves the product within 60 days after the date of submission of the complete information.

(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as waiving the requirement of a contract under section 1858 or waiving requirements and standards not referred to in paragraph (1).

PATIENT PROTECTION STANDARDS

SEC. 1853. (a) DISCLOSURE TO ENROLLEES.—A MedicarePlus organization shall disclose in clear, accurate, and standardized form, information regarding all of the following for each MedicarePlus product it offers:

(1) Benefits under the MedicarePlus product offered, including exclusions from coverage and, if it is a high deductible/medisave product, a comparison of benefits under such a product with benefits under other MedicarePlus products.

(2) Rules regarding prior authorization or other review requirements that could result in nonpayment.

(3) Potential liability for cost-sharing for out-of-network services.

(4) The number, mix, and distribution of participating providers.

(5) The financial obligations of the enrollee, including premiums, deductibles, co-payments, and maximum limits on out-of-pocket losses for items and services (both in and out of network).

(6) Statistics on enrollee satisfaction with the product and organization, including rates of reenrollment.

(7) Enrollee rights and responsibilities, including the grievance process provided under subsection (f).

(8) A statement that the use of the 911 emergency telephone number is appropriate in emergency situations and an explanation of what constitutes an emergency situation.

(9) A description of the organization's quality assurance program under subsection (d).

Such information shall be disclosed to each enrollee under this part at the time of enrollment and at least annually thereafter.

(b) ACCESS TO SERVICES.—

(1) IN GENERAL.—A MedicarePlus organization offering a MedicarePlus product may restrict the providers from whom the benefits under the product are provided so long as—

(A) the organization makes such benefits available and accessible to each individual electing the product within the product service area with reasonable promptness and in a manner which assures continuity in the provision of benefits;

(B) when medically necessary the organization makes such benefits available and accessible 24 hours a day and 7 days a week;

(C) the product provides for reimbursement with respect to services which are covered under subparagraphs (A) and

(B) and which are provided to such an individual other than through the organization, if—

(i) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition, and

(ii) it was not reasonable given the circumstances to obtain the services through the organization; and

(D) coverage is provided for emergency services (as defined in paragraph (4)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization.

(2) MINIMUM PAYMENT LEVELS WHERE PROVIDING POINT-OF-SERVICE COVERAGE.—If a MedicarePlus product provides benefits for items and services (not described in paragraph (1)(C)) through a network of providers and also permits payment to be made under the product for such items and services not provided through such a network, the payment level under the product with respect to such items and services furnished outside the network shall be at least 70 percent (or, if the effective cost-sharing rate is 50 percent, at least 35 percent) of the lesser of—

(A) the payment basis (determined without regard to deductibles and cost-sharing) that would have applied for such items and services under parts A and B, or

(B) the amount charged by the entity furnishing such items and services.

(3) PROTECTION OF ENROLLEES FOR CERTAIN EMERGENCY SERVICES.—

(A) PARTICIPATING PROVIDERS.—In the case of emergency services described in subparagraph (C) which are furnished by a participating physician or provider of services to an individual enrolled with a MedicarePlus organization under this section, the applicable participation agreement is deemed to provide that the physician or provider of services will accept as payment in full from the organization the amount that would be payable to the physician or provider of services under part B and from the individual under such part, if the individual were not enrolled with such an organization under this part.

(B) NONPARTICIPATING PROVIDERS.—In the case of emergency services described in subparagraph (C) which are furnished by a nonparticipating physician, the limitations on actual charges for such services otherwise applicable under part B (to services furnished by individuals not enrolled with a MedicarePlus organization under this section) shall apply in the same manner as such limitations apply to services furnished to individuals not enrolled with such an organization.

(C) EMERGENCY SERVICES DESCRIBED.—The emergency services described in this subparagraph are emergency services which are furnished to an enrollee of a MedicarePlus organization under this part by a physician or provider of services that is not under a contract with the organization.

(4) DEFINITION OF EMERGENCY SERVICES.—In this subsection, the term "emergency services" means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

(A) are furnished by an appropriate source other than the organization,

(B) are needed immediately because of an injury or sudden illness, and

(C) are needed because the time required to reach the organization's providers or suppliers would have meant risk of serious damage to the patient's health.

(c) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Each MedicarePlus organization shall establish procedures—

(1) to safeguard the privacy of individually identifiable enrollee information, and

(2) to maintain accurate and timely medical records for enrollees.

(d) QUALITY ASSURANCE PROGRAM.—

(1) IN GENERAL.—Each MedicarePlus organization must have arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for health care services it provides to such individuals.

(2) ELEMENTS OF PROGRAM.—The quality assurance program shall—

(A) stress health outcomes;

(B) provide for the establishment of written protocols for utilization review, based on current standards of medical practice;

(C) provide review by physicians and other health care professionals of the process followed in the provision of such health care services;

(D) monitors and evaluates high volume and high risk services and the care of acute and chronic conditions;

(E) evaluates the continuity and coordination of care that enrollees receive;

(F) has mechanisms to detect both underutilization and overutilization of services;

(G) after identifying areas for improvement, establishes or alters practice parameters;

(H) takes action to improve quality and assesses the effectiveness of such action through systematic follow-up;

(I) makes available information on quality and outcomes measures to facilitate beneficiary comparison and choice of health coverage options (in such form and on such quality and outcomes measures as the Secretary determines to be appropriate);

(J) is evaluated on an ongoing basis as to its effectiveness; and

(K) provide for external accreditation or review, by a utilization and quality control peer review organization under part B of title XI or other qualified independent review organization, of the quality of services furnished by the organization meets professionally recognized standards of

health care (including providing adequate access of enrollees to services).

(3) EXCEPTION FOR CERTAIN FEE-FOR-SERVICE PLANS.—Paragraph (1) and subsection (c)(2) shall not apply in the case of a MedicarePlus organization in relation to a MedicarePlus product to the extent the organization provides for coverage of benefits without restrictions relating to utilization and without regard to whether the provider has a contract or other arrangement with the plan for the provision of such benefits.

(4) TREATMENT OF ACCREDITATION.—The Secretary shall provide that a MedicarePlus organization is deemed to meet the requirements of paragraphs (1) and (2) of this subsection and subsection (c) if the organization is accredited (and periodically reaccredited) by a private organization under a process that the Secretary has determined assures that the organization meets standards that are no less stringent than the standards established under section 1856 to carry out this subsection and subsection (c).

(e) COVERAGE DETERMINATIONS.—

(1) DECISIONS ON NONEMERGENCY CARE.—A MedicarePlus organization shall make determinations regarding authorization requests for nonemergency care on a timely basis, depending on the urgency of the situation.

(2) APPEALS.—

(A) IN GENERAL.—Appeals from a determination of an organization denying coverage shall be decided within 30 days of the date of receipt of medical information, but not later than 60 days after the date of the decision.

(B) PHYSICIAN DECISION ON CERTAIN APPEALS.—Appeal decisions relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician.

(C) EMERGENCY CASES.—Appeals from such a determination involving a life-threatening or emergency situation shall be decided on an expedited basis.

(f) GRIEVANCES AND APPEALS.—

(1) GRIEVANCE MECHANISM.—Each MedicarePlus organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and enrollees under this part.

(2) APPEALS.—An enrollee with an organization under this part who is dissatisfied by reason of the enrollee's failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is $1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the organization shall be entitled to be parties to that judicial review. In apply-

ing sections 205(b) and 205(g) as provided in this subparagraph, and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

(3) COORDINATION WITH SECRETARY OF LABOR.—The Secretary shall consult with the Secretary of Labor so as to ensure that the requirements of this subsection, as they apply in the case of grievances referred to in paragraph (1) to which section 503 of the Employee Retirement Income Security Act of 1974 applies, are applied in a manner consistent with the requirements of such section 503.

(g) INFORMATION ON ADVANCE DIRECTIVES.—Each MedicarePlus organization shall meet the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).

(h) APPROVAL OF MARKETING MATERIALS.—

(1) SUBMISSION.—Each MedicarePlus organization may not distribute marketing materials unless—

(A) at least 45 days before the date of distribution the organization has submitted the material to the Secretary for review, and

(B) the Secretary has not disapproved the distribution of such material.

(2) REVIEW.—The standards established under section 1856 shall include guidelines for the review of all such material submitted and under such guidelines the Secretary shall disapprove such material if the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.

(3) DEEMED APPROVAL (1-STOP SHOPPING).—In the case of material that is submitted under paragraph (1)(A) to the Secretary or a regional office of the Department of Health and Human Services and the Secretary or the office has not disapproved the distribution of marketing materials under paragraph (1)(B) with respect to a MedicarePlus product in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the product and organization.

(4) PROHIBITION OF CERTAIN MARKETING PRACTICES.—Each MedicarePlus organization shall conform to fair marketing standards in relation to MedicarePlus products offered under this part, included in the standards established under section 1856. Such standards shall include a prohibition against an organization (or agent of such an organization) completing any portion of any election form under section 1805 on behalf of any individual.

PROVIDER-SPONSORED ORGANIZATIONS

SEC. 1854. (a) PROVIDER-SPONSORED ORGANIZATION DEFINED.—

(1) IN GENERAL.—In this part, the term "provider-sponsored organization" means a public or private entity that (in accordance with standards established under subsection (b)) is a provider, or group of affiliated providers, that provides a substantial proportion (as defined by the Secretary under such stand-

ards) of the health care items and services under the contract under this part directly through the provider or affiliated group of providers.

(2) SUBSTANTIAL PROPORTION.—In defining what is a "substantial proportion" for purposes of paragraph (1), the Secretary—

(A) shall take into account the need for such an organization to assume responsibility for a substantial proportion of services in order to assure financial stability and the practical difficulties in such an organization integrating a very wide range of service providers; and

(B) may vary such proportion based upon relevant differences among organizations, such as their location in an urban or rural area.

(3) AFFILIATION.—For purposes of this subsection, a provider is "affiliated" with another provider if, through contract, ownership, or otherwise—

(A) one provider, directly or indirectly, controls, is controlled by, or is under common control with the other,

(B) each provider is a participant in a lawful combination under which each provider shares, directly or indirectly, substantial financial risk in connection with their operations,

(C) both providers are part of a controlled group of corporations under section 1563 of the Internal Revenue Code of 1986, or

(D) both providers are part of an affiliated service group under section 414 of such Code.

(4) CONTROL.—For purposes of paragraph (3), control is presumed to exist if one party, directly or indirectly, owns, controls, or holds the power to vote, or proxies for, not less than 51 percent of the voting rights or governance rights of another.

(b) PROCESS FOR ESTABLISHING STANDARDS FOR PROVIDER-SPONSORED ORGANIZATIONS.—For process of establishing of standards for provider-sponsored organizations, see section 1856(c).

(c) PROCESS FOR STATE CERTIFICATION OF PROVIDER-SPONSORED ORGANIZATIONS.—For process of State certification of provider-sponsored organizations, see section 1857(c).

(d) PREEMPTION OF STATE INSURANCE LICENSING REQUIREMENTS.—

(1) IN GENERAL.—This section supersedes any State law which—

(A) requires that a provider-sponsored organization meet requirements for insurers of health services or health maintenance organizations doing business in the State with respect to initial capitalization and establishment of financial reserves against insolvency, or

(B) imposes requirements that would have the effect of prohibiting the organization from complying with the applicable requirements of this part,

insofar as such the law applies to individuals enrolled with the organization under this part.

(2) EXCEPTION.—Paragraph (1) shall not apply with respect to any State law to the extent that such law provides standards

or requirements, or provides for enforcement thereof, so as to meet the requirements of section 1857(c)(2) with respect to approval by the Secretary of State certification requirements thereunder.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as affecting the operation of section 514 of the Employee Retirement Income Security Act of 1974.

PAYMENTS TO MEDICAREPLUS ORGANIZATIONS

SEC. 1855. (a) PAYMENTS.—

(1) IN GENERAL.—Under a contract under section 1858 the Secretary shall pay to each MedicarePlus organization, with respect to coverage of an individual under this part in a payment area for a month, an amount equal to the monthly adjusted MedicarePlus capitation rate (as provided under subsection (b)) with respect to that individual for that area.

(2) ANNUAL ANNOUNCEMENT.—The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than September 7 before the calendar year concerned—

(A) the annual MedicarePlus capitation rate for each payment area for the year, and

(B) the factors to be used in adjusting such rates under subsection (b) for payments for months in that year.

(3) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under paragraph (2) for a year, the Secretary shall provide for notice to MedicarePlus organizations of proposed changes to be made in the methodology or benefit coverage assumptions from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

(4) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (2) for a year, the Secretary shall include an explanation of the assumptions (including any benefit coverage assumptions) and changes in methodology used in the announcement in sufficient detail so that MedicarePlus organizations can compute monthly adjusted MedicarePlus capitation rates for classes of individuals located in each payment area which is in whole or in part within the service area of such an organization.

(b) MONTHLY ADJUSTED MEDICAREPLUS CAPITATION RATE.—

(1) IN GENERAL.—For purposes of this section, the "monthly adjusted MedicarePlus capitation rate" under this subsection, for a month in a year for an individual in a payment area (specified under paragraph (3)) and in a class (established under paragraph (4)), is 1/12 of the annual MedicarePlus capitation rate specified in paragraph (2) for that area for the year, adjusted to reflect the actuarial value of benefits under this title with respect to individuals in such class compared to the national average for individuals in all classes.

(2) ANNUAL MEDICAREPLUS CAPITATION RATES.—For purposes of this section, the annual MedicarePlus capitation rate for a payment area for a year is equal to the annual MedicarePlus

capitation rate for the area for the previous year (or, in the case of 1996, the average annual per capita rate of payment described in section 1876(a)(1)(C) for the area for 1995) increased by the per capita growth rate for that area and year (as determined under subsection (c)).

(3) PAYMENT AREA DEFINED.—In this section, the term "payment area" means a county (or equivalent area specified by the Secretary), except that in the case of the population group described in paragraph (5)(C), the payment area shall be each State.

(4) CLASSES.—

(A) IN GENERAL.—For purposes of this section, the Secretary shall define appropriate classes of enrollees, consistent with paragraph (5), based on age, gender, welfare status, institutionalization, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence.

(B) RESEARCH.—The Secretary shall conduct such research as may be necessary to provide for greater accuracy in the adjustment of capitation rates under this subsection. Such research may include research into the addition or modification of classes under subparagraph (A). The Secretary shall submit to Congress a report on such research by not later than January 1, 1997.

(5) DIVISION OF MEDICARE POPULATION.—In carrying out paragraph (4) and this section, the Secretary shall recognize the following separate population groups:

(A) AGED.—Individuals 65 years of age or older who are not described in subparagraph (C).

(B) DISABLED.—Disabled individuals who are under 65 years of age and not described in subparagraph (C).

(C) INDIVIDUALS WITH END STAGE RENAL DISEASE.—Individuals who are determined to have end stage renal disease.

(c) PER CAPITA GROWTH RATES.—

(1) FOR 1996.—

(A) IN GENERAL.—For purposes of this section and subject to subparagraph (B), the per capita growth rates for 1996, for a payment area assigned to a service utilization cohort under subsection (d), shall be the following:

(i) LOWEST SERVICE UTILIZATION COHORT.—For areas assigned to the lowest service utilization cohort, 9.7 percent.

(ii) LOWER SERVICE UTILIZATION COHORT.—For areas assigned to the lower service utilization cohort, 8.0 percent.

(iii) MEDIAN SERVICE UTILIZATION COHORT.—For areas assigned to the median service utilization cohort, 5.3 percent.

(iv) HIGHER SERVICE UTILIZATION COHORT.—For areas assigned to the higher service utilization cohort, 4.7 percent.

(v) HIGHEST SERVICE UTILIZATION COHORT.—For areas assigned to the highest service utilization cohort, 4.0 percent.

(B) BUDGET NEUTRAL ADJUSTMENT.—The Secretary shall adjust the per capita growth rates specified in subparagraph (A) for all the areas by such uniform factor as may be necessary to assure that the total capitation payments under this section during 1996 are the same as the amount such payments would have been if the per capita growth rate for all such areas for 1996 were equal to the national average per capita growth rate, specified in paragraph (3) for 1996.

(2) FOR SUBSEQUENT YEARS.—

(A) IN GENERAL.—For purposes of this section and subject to subparagraph (B), the Secretary shall compute a per capita growth rate for each year after 1996, for each payment area as assigned to a service utilization cohort under subsection (d), consistent with the following rules:

(i) MEDIAN SERVICE UTILIZATION COHORT SET AT NATIONAL AVERAGE PER CAPITA GROWTH RATE.—The per capita growth rate for areas assigned to the median service utilization cohort for the year shall be the national average per capita growth rate for the year (as specified under paragraph (3)).

(ii) HIGHEST SERVICE UTILIZATION COHORT SET AT 75 PERCENT OF NATIONAL AVERAGE PER CAPITA GROWTH RATE.—The per capita growth rate for areas assigned to the highest service utilization cohort for the year shall be 75 percent of the national average per capita growth rate for the year.

(iii) LOWEST SERVICE UTILIZATION COHORT SET AT 187.5 PERCENT OF NATIONAL AVERAGE PER CAPITA GROWTH RATE.—The per capita growth rate for areas assigned to the lowest service utilization cohort for the year shall be 187.5 percent of the national average per capita growth rate for the year.

(iv) LOWER SERVICE UTILIZATION COHORT SET AT 150 PERCENT OF NATIONAL AVERAGE PER CAPITA GROWTH RATE.—

(I) IN GENERAL.—Subject to subclause (II), the per capita growth rate for areas assigned to the lower service utilization cohort for the year shall be 150 percent of the national average per capita growth rate for the year.

(II) ADJUSTMENT.—If the Secretary has established under clause (v) the per capita growth rate for areas assigned to the higher service utilization cohort for the year at 75 percent of the national average per capita growth rate, the Secretary may provide for a reduced per capita growth rate under subclause (I) to the extent necessary to comply with subparagraph (B).

(v) HIGHER SERVICE UTILIZATION COHORT.—The per capita growth rate for areas assigned to the higher

service utilization cohort for the year shall be such percent (not less than 75 percent) of the national average per capita growth rate, as the Secretary may determine consistent with subparagraph (B).

(B) AVERAGE PER CAPITA GROWTH RATE AT NATIONAL AVERAGE TO ASSURE BUDGET NEUTRALITY.—The Secretary shall compute per capita growth rates for a year under subparagraph (A) in a manner so that the weighted average per capita growth rate for all areas for the year (weighted to reflect the number of medicare beneficiaries in each area) is equal to the national average per capita growth rate under paragraph (3) for the year.

(3) NATIONAL AVERAGE PER CAPITA GROWTH RATES.—In this subsection, the "national average per capita growth rate" for—

(A) 1996 is 5.3 percent,

(B) 1997 is 3.8 percent,

(C) 1998 is 4.6 percent,

(D) 1999 is 4.3 percent,

(E) 2000 is 3.8 percent,

(F) 2001 is 5.5 percent,

(G) 2002 is 5.6 percent, and

(H) each subsequent year is 5.0 percent.

(d) ASSIGNMENT OF PAYMENT AREAS TO SERVICE UTILIZATION COHORTS.—

(1) IN GENERAL.—For purposes of determining per capita growth rates under subsection (c) for areas for a year, the Secretary shall assign each payment area to a service utilization cohort (based on the service utilization index value for that area determined under paragraph (2)) as follows:

(A) LOWEST SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of less than .80 shall be assigned to the lowest service utilization cohort.

(B) LOWER SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of at least .80 but less than .90 shall be assigned to the lower service utilization cohort.

(C) MEDIAN SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of at least .90 but less than 1.10 shall be assigned to the median service utilization cohort.

(D) HIGHER SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of at least 1.10 but less than 1.20 shall be assigned to the higher service utilization cohort.

(E) HIGHEST SERVICE UTILIZATION COHORT.—Areas with a service utilization index value of at least 1.20 shall be assigned to the highest service utilization cohort.

(2) DETERMINATION OF SERVICE UTILIZATION INDEX VALUES.—In order to determine the per capita growth rate for a payment area for each year (beginning with 1996), the Secretary shall determine for such area and year a service utilization index value, which is equal to—

(A) the annual MedicarePlus capitation rate under this section for the area for the year in which the determination is made (or, in the case of 1996, the average annual per

capita rate of payment (described in section 1876(a)(1)(C)) for the area for 1995); divided by

(B) the input-price-adjusted annual national MedicarePlus capitation rate (as determined under paragraph (3)) for that area for the year in which the determination is made.

(3) DETERMINATION OF INPUT-PRICE-ADJUSTED RATES.—

(A) IN GENERAL.—For purposes of paragraph (2), the "input-price-adjusted annual national MedicarePlus capitation rate" for a payment area for a year is equal to the sum, for all the types of medicare services (as classified by the Secretary), of the product (for each such type) of—

(i) the national standardized MedicarePlus capitation rate (determined under subparagraph (B)) for the year,

(ii) the proportion of such rate for the year which is attributable to such type of services, and

(iii) an index that reflects (for that year and that type of services) the relative input price of such services in the area compared to the national average input price of such services.

In applying clause (iii), the Secretary shall, subject to subparagraph (C), apply those indices under this title that are used in applying (or updating) national payment rates for specific areas and localities.

(B) NATIONAL STANDARDIZED MEDICAREPLUS CAPITATION RATE.—In this paragraph, the "national standardized MedicarePlus capitation rate" for a year is equal to—

(i) the sum (for all payment areas) of the product of (I) the annual MedicarePlus capitation rate for that year for the area under subsection (b)(2), and (II) the average number of medicare beneficiaries residing in that area in the year; divided by

(ii) the total average number of medicare beneficiaries residing in all the payment areas for that year.

(C) SPECIAL RULES FOR 1996.—In applying this paragraph for 1996—

(i) medicare services shall be divided into 2 types of services: part A services and part B services;

(ii) the proportions described in subparagraph (A)(ii) for such types of services shall be—

(I) for part A services, the ratio (expressed as a percentage) of the average annual per capita rate of payment for the area for part A for 1995 to the total average annual per capita rate of payment for the area for parts A and B for 1995, and

(II) for part B services, 100 percent minus the ratio described in subclause (I);

(iii) for the part A services, 70 percent of payments attributable to such services shall be adjusted by the index used under section 1886(d)(3)(E) to adjust payment rates for relative hospital wage levels for hospitals located in the payment area involved;

(iv) for part B services—

(I) 66 percent of payments attributable to such services shall be adjusted by the index of the geographic area factors under section 1848(e) used to adjust payment rates for physicians' services furnished in the payment area, and

(II) of the remaining 34 percent of the amount of such payments, 70 percent shall be adjusted by the index described in clause (iii);

(v) the index values shall be computed based only on the beneficiary population described in subsection (b)(5)(A).

The Secretary may continue to apply the rules described in this subparagraph (or similar rules) for 1997.

(e) PAYMENT PROCESS.—

(1) IN GENERAL.—Subject to subsection (f), the Secretary shall make monthly payments under this section in advance and in accordance with the rate determined under subsection (a) to the plan for each individual enrolled with a MedicarePlus organization under this part.

(2) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—

(A) IN GENERAL.—The amount of payment under this subsection may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled with an organization under this part and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

(B) SPECIAL RULE FOR CERTAIN ENROLLEES.—

(i) IN GENERAL.—Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a MedicarePlus organization under a product operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part, except that for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.

(ii) EXCEPTION.—No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the disclosure statement described in section 1853(a) at the time the individual enrolled with the organization.

(f) SPECIAL RULES FOR INDIVIDUALS ELECTING HIGH DEDUCTIBLE/MEDISAVE PRODUCT.—

(1) IN GENERAL.—In the case of an individual who has elected a high deductible/medisave product, notwithstanding the preceding provisions of this section—

(A) the amount of the payment to the MedicarePlus organization offering the high deductible/medisave product shall not exceed the premium for the product, and

(B) subject to paragraph (2), the difference between the amount of payment that would otherwise be made and the amount of payment to such organization shall be made directly into a MedicarePlus MSA established (and, if applicable, designated) by the individual under paragraph (2).

(2) ESTABLISHMENT AND DESIGNATION OF MEDICAREPLUS MEDICAL SAVINGS ACCOUNT AS REQUIREMENT FOR PAYMENT OF CONTRIBUTION.—In the case of an individual who has elected coverage under a high deductible/medisave product, no payment shall be made under paragraph (1)(B) on behalf of an individual for a month unless the individual—

(A) has established before the beginning of the month (or by such other deadline as the Secretary may specify) a MedicarePlus MSA (as defined in section 137(b) of the Internal Revenue Code of 1986), and

(B) if the individual has established more than one MedicarePlus MSA, has designated one of such accounts as the individual's MedicarePlus MSA for purposes of this part.

Under rules under this section, such an individual may change the designation of such account under subparagraph (B) for purposes of this part.

(3) LUMP SUM DEPOSIT OF MEDICAL SAVINGS ACCOUNT CONTRIBUTION.—In the case of an individual electing a high deductible/medisave product effective beginning with a month in a year, the amount of the contribution to the MedicarePlus MSA on behalf of the individual for that month and all successive months in the year shall be deposited during that first month. In the case of a termination of such an election as of a month before the end of a year, the Secretary shall provide for a procedure for the recovery of deposits attributable to the remaining months in the year.

(g) PAYMENTS FROM TRUST FUND.—The payment to a MedicarePlus organization under this section for individuals enrolled under this part with the organization, and payments to a MedicarePlus MSA under subsection (f)(1)(B), shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under part A and under part B represents of the actuarial value of the total benefits under this title.

(h) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual's—

(1) election under this part of a MedicarePlus product offered by a MedicarePlus organization—

(A) payment for such services until the date of the individual's discharge shall be made under this title through the MedicarePlus product or Non-MedicarePlus option (as

the case may be) elected before the election with such organization,

(B) the elected organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

(C) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this part; or

(2) termination of election with respect to a MedicarePlus organization under this part—

(A) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

(B) payment for such services during the stay shall not be made under section 1886(d) or by any succeeding MedicarePlus organization, and

(C) the terminated organization shall not receive any payment with respect to the individual under this part during the period the individual is not enrolled.

ESTABLISHMENT OF STANDARDS FOR MEDICAREPLUS ORGANIZATIONS AND PRODUCTS

SEC. 1856. (a) STANDARDS APPLICABLE TO STATE-REGULATED ORGANIZATIONS AND PRODUCTS.—

(1) RECOMMENDATIONS OF NAIC.—The Secretary shall request the National Association of Insurance Commissioners to develop and submit to the Secretary, not later than 12 months after the date of the enactment of the Medicare Preservation Act of 1995, proposed standards consistent with the requirements of this part for MedicarePlus organizations (other than Taft-Hartley sponsors and provider-sponsored organizations) and MedicarePlus products offered by such organizations, except that such proposed standards may relate to MedicarePlus organizations that are qualified associations only with respect to MedicarePlus products offered by them and only if such products are issued by organizations to which section 1851(b)(1) applies.

(2) REVIEW.—If the Association submits such standards on a timely basis, the Secretary shall review such standards to determine if the standards meet the requirements of the part. The Secretary shall complete the review of the standards not later than 90 days after the date of their submission. The Secretary shall promulgate such proposed standards to apply to organizations and products described in paragraph (1) except to the extent that the Secretary modifies such proposed standards because they do not meet such requirements.

(3) FAILURE TO SUBMIT.—If the Association does not submit such standards on a timely basis, the Secretary shall promulgate such standards by not later than the date the Secretary would otherwise have been required to promulgate standards under paragraph (2).

(4) USE OF INTERIM RULES.—For the period in which this part is in effect and standards are being developed and established under the preceding provisions of this subsection, the

Secretary shall provide by not later than June 1, 1996, for the application of such interim standards (without regard to any requirements for notice and public comment) as may be appropriate to provide for the expedited implementation of this part. Such interim standards shall not apply after the date standards are established under the preceding provisions of this subsection.

(b) TAFT-HARTLEY SPONSORS, QUALIFIED ASSOCIATIONS, AND PRODUCTS.—

(1) IN GENERAL.—The Secretary shall develop and promulgate by regulation standards consistent with the requirements of this part for Taft-Hartley sponsors, for qualified associations, and for MedicarePlus products offered by such organizations (other than MedicarePlus products offered by qualified associations that are issued by organizations to which section 1851(b)(1) applies).

(2) CONSULTATION WITH LABOR.—The Secretary shall consult with the Secretary of Labor with respect to such standards for such sponsors and products.

(3) TIMING.—Standards under this subsection shall be promulgated at or about the time standards are promulgated under subsection (a).

(c) ESTABLISHMENT OF STANDARDS FOR PROVIDER-SPONSORED ORGANIZATIONS.—

(1) IN GENERAL.—The Secretary shall establish, on an expedited basis and using a negotiated rulemaking process under subchapter 3 of chapter 5 of title 5, United States Code, standards that entities must meet to qualify as provider-sponsored organizations under this part.

(2) PUBLICATION OF NOTICE.—In carrying out the rulemaking process under this subsection, the Secretary, after consultation with the National Association of Insurance Commissioners, the American Academy of Actuaries, organizations representative of medicare beneficiaries, and other interested parties, shall publish the notice provided for under section 564(a) of title 5, United States Code, by not later than 45 days after the date of the enactment of Medicare Preservation Act of 1995.

(3) TARGET DATE FOR PUBLICATION OF RULE.—As part of the notice under paragraph (2), and for purposes of this subsection, the "target date for publication" (referred to in section 564(a)(5) of such title) shall be September 1, 1996.

(4) ABBREVIATED PERIOD FOR SUBMISSION OF COMMENTS.—In applying section 564(c) of such title under this subsection, "15 days" shall be substituted for "30 days".

(5) APPOINTMENT OF NEGOTIATED RULEMAKING COMMITTEE AND FACILITATOR.—The Secretary shall provide for—

(A) the appointment of a negotiated rulemaking committee under section 565(a) of such title by not later than 30 days after the end of the comment period provided for under section 564(c) of such title (as shortened under paragraph (4)), and

(B) the nomination of a facilitator under section 566(c) of such title by not later than 10 days after the date of appointment of the committee.

(6) PRELIMINARY COMMITTEE REPORT.—The negotiated rulemaking committee appointed under paragraph (5) shall report to the Secretary, by not later than June 1, 1996, regarding the committee's progress on achieving a concensus with regard to the rulemaking proceeding and whether such consensus is likely to occur before one month before the target date for publication of the rule. If the committee reports that the committee has failed to make significant progress towards such consensus or is unlikely to reach such consensus by the target date, the Secretary may terminate such process and provide for the publication of a rule under this subsection through such other methods as the Secretary may provide.

(7) FINAL COMMITTEE REPORT.—If the committee is not terminated under paragraph (6), the rulemaking committee shall submit a report containing a proposed rule by not later than one month before the target publication date.

(8) INTERIM, FINAL EFFECT.—The Secretary shall publish a rule under this subsection in the Federal Register by not later than the target publication date. Such rule shall be effective and final immediately on an interim basis, but is subject to change and revision after public notice and opportunity for a period (of not less than 60 days) for public comment. In connection with such rule, the Secretary shall specify the process for the timely review and approval of applications of entities to be certified as provider-sponsored organizations pursuant to such rules and consistent with this subsection.

(9) PUBLICATION OF RULE AFTER PUBLIC COMMENT.—The Secretary shall provide for consideration of such comments and republication of such rule by not later than 1 year after the target publication date.

(10) PROCESS FOR APPROVAL OF APPLICATIONS FOR CERTIFICATION.—

(A) IN GENERAL.—The Secretary shall establish a process for the receipt and approval of applications of entities for certification as provider-sponsored organizations under this part. Under such process, the Secretary shall act upon a complete application submitted within 60 days after the date it is received.

(B) CIRCULATION OF PROPOSED APPLICATION FORM.—By March 1, 1996, the Secretary, after consultation with the negotiated rulemaking committee, shall circulate a proposed application form that could be used by entities considering becoming certified as a provider-sponsored organization under this part.

(d) COORDINATION AMONG FINAL STANDARDS.—In establishing standards (other than on an interim basis) under the previous provisions of this section, the Secretary shall seek to provide for consistency (as appropriate) across the different types of MedicarePlus organizations, in order to promote equitable treatment of different types of organizations and consistent protection for individuals who elect products offered by the different types of MedicarePlus organizations.

(e) USE OF CURRENT STANDARDS FOR INTERIM STANDARDS.—To the extent practicable and consistent with the requirements of this

part, standards established on an interim basis to carry out requirements of this part may be based on currently applicable standards, such as the rules established under section 1876 (as in effect as of the date of the enactment of this section) to carry out analogous provisions of such section or standards established or developed for application in the private health insurance market.

(f) APPLICATION OF NEW STANDARDS TO ENTITIES WITH A CONTRACT.—In the case of a MedicarePlus organization with a contract in effect under this part at the time standards applicable to the organization under this section are changed, the organization may elect not to have such changes apply to the organization until the end of the current contract year (or, if there is less than 6 months remaining in the contract year, until 1 year after the end of the current contract year).

(g) RELATION TO STATE LAWS.—The standards established under this section shall supersede any State law or regulation with respect to MedicarePlus products which are offered by MedicarePlus organizations and are issued by organizations to which section 1851(b)(1) applies, to the extent such law or regulation is inconsistent with such standards.

MEDICARE-PLUS CERTIFICATION

SEC. 1857. (a) STATE CERTIFICATION PROCESS FOR STATE-REGULATED ORGANIZATIONS.—

(1) APPROVAL OF STATE PROCESS.—The Secretary shall approve a MedicarePlus certification and enforcement program established by a State for applying the standards established under section 1856 to MedicarePlus organizations (other than Taft-Hartley sponsors and provider-sponsored organizations) and MedicarePlus products offered by such organizations if the Secretary determines that the program effectively provides for the application and enforcement of such standards in the State with respect to such organizations and products. Such program shall provide for certification of compliance of MedicarePlus organizations and products with the applicable requirements of this part not less often than once every 3 years.

(2) EFFECT OF CERTIFICATION UNDER STATE PROCESS.—A MedicarePlus organization and MedicarePlus product offered by such an organization that is certified under such program is considered to have been certified under this subsection with respect to the offering of the product to individuals residing in the State.

(3) USER FEES.—The State may impose user fees on organizations seeking certification under this subsection in such amounts as the State deems sufficient to finance the costs of such certification. Nothing in this paragraph shall be construed as restricting a State's authority to impose premium taxes, other taxes, or other levies.

(4) REVIEW.—The Secretary periodically shall review State programs approved under paragraph (1) to determine if they continue to provide for certification and enforcement described in such paragraph. If the Secretary finds that a State program no longer so provides, before making a final determination, the Secretary shall provide the State an opportunity to adopt such

a plan of correction as would permit the State program to meet the requirements of paragraph (1). If the Secretary makes a final determination that the State program, after such an opportunity, fails to meet such requirements, the provisions of subsection (b) shall apply to MedicarePlus organizations and products in the State.

(5) EFFECT OF NO STATE PROGRAM.—Beginning on the date standards are established under section 1856, in the case of organizations and products in States in which a certification program has not been approved and in operation under paragraph (1), the Secretary shall establish a process for the certification of MedicarePlus organizations (other than Taft-Hartley sponsors and provider-sponsored organizations) and products of such organizations as meeting such standards.

(6) PUBLICATION OF LIST OF APPROVED STATE PROGRAMS.—The Secretary shall publish (and periodically update) a list of those State programs which are approved for purposes of this subsection.

(b) FEDERAL CERTIFICATION PROCESS FOR TAFT-HARTLEY SPONSORS AND PROVIDER-SPONSORED ORGANIZATIONS.—

(1) ESTABLISHMENT.—The Secretary shall establish a process for the certification of Taft-Hartley sponsors and provider-sponsored organizations and MedicarePlus products offered by such sponsors and organizations as meeting the applicable standards established under section 1856.

(2) INVOLVEMENT OF SECRETARY OF LABOR.—Such process shall be established and operated in cooperation with the Secretary of Labor with respect to Taft-Hartley sponsors.

(3) USE OF STATE LICENSING AND PRIVATE ACCREDITATION PROCESSES.—

(A) IN GENERAL.—The process under this subsection shall, to the maximum extent practicable, provide that MedicarePlus organizations and products that are licensed or certified through a qualified private accreditation process that the Secretary finds applies standards that are no less stringent than the requirements of this part are deemed to meet the corresponding requirements of this part for such an organization or product.

(B) PERIODIC ACCREDITATION.—The use of an accreditation under subparagraph (A) shall be valid only for such period as the Secretary specifies.

(4) USER FEES.—The Secretary may impose user fees on entities seeking certification under this subsection in such amounts as the Secretary deems sufficient to finance the costs of such certification.

(c) CERTIFICATION OF PROVIDER-SPONSORED ORGANIZATIONS BY STATES.—

(1) IN GENERAL.—The Secretary shall establish a process under which a State may propose to provide for certification of entities as meeting the requirements of this part to be provider-sponsored organizations.

(2) CONDITIONS FOR APPROVAL.—The Secretary may not approve a State program for certification under paragraph (1) unless the Secretary determines that the certification program ap-

plies standards and requirements that are identical to the standards and requirements of this part and the applicable provisions for enforcement of such standards and requirements do not result in a lower level or quality of enforcement than that which is otherwise applicable under this title.

(d) NOTICE TO ENROLLEES IN CASE OF DECERTIFICATION.—If a MedicarePlus organization or product is decertified under this section, the organization shall notify each enrollee with the organization and product under this part of such decertification.

(e) QUALIFIED ASSOCIATIONS.—In the case of MedicarePlus products offered by a MedicarePlus organization that is a qualified association (as defined in section 1854(c)(4)(C)) and issued by an organization to which section 1851(b)(1) applies or by a provider-sponsored organization (as defined in section 1854(a)), nothing in this section shall be construed as limiting the authority of States to regulate such products.

CONTRACTS WITH MEDICAREPLUS ORGANIZATIONS

SEC. 1858. (a) IN GENERAL.—The Secretary shall not permit the election under section 1805 of a MedicarePlus product offered by a MedicarePlus organization under this part, and no payment shall be made under section 1856 to an organization, unless the Secretary has entered into a contract under this section with an organization with respect to the offering of such product. Such a contract with an organization may cover more than one MedicarePlus product. Such contract shall provide that the organization agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

(b) MINIMUM ENROLLMENT REQUIREMENTS.—

(1) IN GENERAL.—Subject to paragraphs (1) and (2), the Secretary may not enter into a contract under this section with a MedicarePlus organization (other than a Taft-Hartley sponsor) unless the organization has at least 5,000 individuals (or 1,500 individuals in the case of an organization that is a provider-sponsored organization) who are receiving health benefits through the organization, except that the standards under section 1856 may permit the organization to have a lesser number of beneficiaries (but not less than 500 in the case of an organization that is a provider-sponsored organization) if the organization primarily serves individuals residing outside of urbanized areas.

(2) EXCEPTION FOR HIGH DEDUCTIBLE/MEDISAVE PRODUCT.—Paragraph (1) shall not apply with respect to a contract that relates only to a high deductible/medisave product.

(3) ALLOWING TRANSITION.—The Secretary may waive the requirement of paragraph (1) during the first 3 contract years with respect to an organization.

(c) CONTRACT PERIOD AND EFFECTIVENESS.—

(1) PERIOD.—Each contract under this section shall be for a term of at least one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term.

(2) TERMINATION AUTHORITY.—In accordance with procedures established under subsection (h), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in an applicable paragraph of subsection (g) on the MedicarePlus organization if the Secretary determines that the organization—

(A) has failed substantially to carry out the contract;

(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part;

(C) is operating in a manner that is not in the best interests of the individuals covered under the contract; or

(D) no longer substantially meets the applicable conditions of this part.

(3) EFFECTIVE DATE OF CONTRACTS.—The effective date of any contract executed pursuant to this section shall be specified in the contract, except that in no case shall a contract under this section which provides for coverage under a high deductible/medisave account be effective before January 1997 with respect to such coverage.

(4) PREVIOUS TERMINATIONS.—The Secretary may not enter into a contract with a MedicarePlus organization if a previous contract with that organization under this section was terminated at the request of the organization within the preceding five-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

(5) NO CONTRACTING AUTHORITY.—The authority vested in the Secretary by this part may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

(d) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—

(1) INSPECTION AND AUDIT.—Each contract under this section shall provide that the Secretary, or any person or organization designated by the Secretary—

(A) shall have the right to inspect or otherwise evaluate (i) the quality, appropriateness, and timeliness of services performed under the contract and (ii) the facilities of the organization when there is reasonable evidence of some need for such inspection, and

(B) shall have the right to audit and inspect any books and records of the MedicarePlus organization that pertain (i) to the ability of the organization to bear the risk of potential financial losses, or (ii) to services performed or determinations of amounts payable under the contract.

(2) ENROLLEE NOTICE AT TIME OF TERMINATION.—Each contract under this section shall require the organization to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled with the organization under this part.

(3) DISCLOSURE.—

(A) IN GENERAL.—Each MedicarePlus organization shall, in accordance with regulations of the Secretary, report to the Secretary financial information which shall include the following:

(i) Such information as the Secretary may require demonstrating that the organization has a fiscally sound operation.

(ii) A copy of the report, if any, filed with the Health Care Financing Administration containing the information required to be reported under section 1124 by disclosing entities.

(iii) A description of transactions, as specified by the Secretary, between the organization and a party in interest. Such transactions shall include—

(I) any sale or exchange, or leasing of any property between the organization and a party in interest;

(II) any furnishing for consideration of goods, services (including management services), or facilities between the organization and a party in interest, but not including salaries paid to employees for services provided in the normal course of their employment and health services provided to members by hospitals and other providers and by staff, medical group (or groups), individual practice association (or associations), or any combination thereof; and

(III) any lending of money or other extension of credit between an organization and a party in interest.

The Secretary may require that information reported respecting an organization which controls, is controlled by, or is under common control with, another entity be in the form of a consolidated financial statement for the organization and such entity.

(B) PARTY IN INTEREST DEFINED.—For the purposes of this paragraph, the term "party in interest" means—

(i) any director, officer, partner, or employee responsible for management or administration of a MedicarePlus organization, any person who is directly or indirectly the beneficial owner of more than 5 percent of the equity of the organization, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5 percent of the organization, and, in the case of a MedicarePlus organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

(ii) any entity in which a person described in clause (i)—

(I) is an officer or director;

(II) is a partner (if such entity is organized as a partnership);

(III) has directly or indirectly a beneficial interest of more than 5 percent of the equity; or

(IV) has a mortgage, deed of trust, note, or other interest valuing more than 5 percent of the assets of such entity;

(iii) any person directly or indirectly controlling, controlled by, or under common control with an organization; and

(iv) any spouse, child, or parent of an individual described in clause (i).

(C) ACCESS TO INFORMATION.—Each MedicarePlus organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

(4) LOAN INFORMATION.—The contract shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties.

(e) ADDITIONAL CONTRACT TERMS.—The contract shall contain such other terms and conditions not inconsistent with this part (including requiring the organization to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

(f) INTERMEDIATE SANCTIONS.—

(1) IN GENERAL.—If the Secretary determines that a MedicarePlus organization with a contract under this section—

(A) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, if the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual;

(B) imposes premiums on individuals enrolled under this part in excess of the premiums permitted;

(C) acts to expel or to refuse to re-enroll an individual in violation of the provisions of this part;

(D) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this part) by eligible individuals with the organization whose medical condition or history indicates a need for substantial future medical services;

(E) misrepresents or falsifies information that is furnished—

(i) to the Secretary under this part, or

(ii) to an individual or to any other entity under this part;

(F) fails to comply with the requirements of section 1852(f)(3); or

(G) employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provi-

sion (directly or indirectly) through such an excluded individual or entity of such services;

the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2).

(2) REMEDIES.—The remedies described in this paragraph are—

(A) civil money penalties of not more than $25,000 for each determination under paragraph (1) or, with respect to a determination under subparagraph (D) or (E)(i) of such paragraph, of not more than $100,000 for each such determination, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(D), $15,000 for each individual not enrolled as a result of the practice involved,

(B) suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

(C) suspension of payment to the organization under this part for individuals enrolled after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

(3) OTHER INTERMEDIATE SANCTIONS.—In the case of a MedicarePlus organization for which the Secretary makes a determination under subsection (c)(2) the basis of which is not described in paragraph (1), the Secretary may apply the following intermediate sanctions:

(A) civil money penalties of not more than $25,000 for each determination under subsection (c)(2) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract;

(B) civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under subsection (h) during which the deficiency that is the basis of a determination under subsection (c)(2) exists; and

(C) suspension of enrollment of individuals under this part after the date the Secretary notifies the organization of a determination under subsection (c)(2) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.

(4) PROCEDURES FOR IMPOSING SANCTIONS.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under paragraph (1) or (2) in the same

manner as they apply to a civil money penalty or proceeding under section 1128A(a).

(g) PROCEDURES FOR IMPOSING SANCTIONS.—The Secretary may terminate a contract with a MedicarePlus organization under this section or may impose the intermediate sanctions described in subsection (f) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

(1) the Secretary provides the organization with the opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under subsection (c)(2);

(2) the Secretary shall impose more severe sanctions on organizations that have a history of deficiencies or that have not taken steps to correct deficiencies the Secretary has brought to their attention;

(3) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

(4) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.

PART [C] *D*—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) * * *

* * * * * * *

(e) The term "hospital" (except for purposes of sections 1814(d), 1814(f), and 1835(b), subsection (a)(2) of this section, paragraph (7) of this subsection, and subsection (i) of this section) means an institution which—

(1) * * *

* * * * * * *

For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of sections 1814(d) and 1835(b) (including determination of whether an individual received inpatient hospital services or diagnostic services for purposes of such sections), section 1814(f)(2), and subsection (i) of this section, such term includes any institution which (i) meets the requirements of paragraphs (5) and (7) of this subsection, (ii) is not primarily engaged in providing the services described in section 1861(j)(1)(A) and (iii) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of section 1861(r), to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. For purposes of section 1814(f)(1), such term includes an institution which (i) is a hospital for purposes of sections 1814(d),

1814(f)(2), and 1835(b) and (ii) is accredited by the Joint Commission on Accreditation of Hospitals, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals. Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2), include any institution which is primarily for the care and treatment of mental diseases unless it is a psychiatric hospital (as defined in subsection (f)). The term "hospital" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, *or by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.*, but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1865. The term "hospital" also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in subparagraph (A) of paragraph (5) of this subsection and which meets the other requirements of this subsection, except that—

(A) * * *

* * * * * * *

Physician

(r) The term "physician", when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)), (2) a doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions, (3) a doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections 1814(a), 1832(a)(2)(F)(ii), and 1835 but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them, (4) a doctor of optometry, but only with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or (5) a chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, [but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treat-

ment by means of manual manipulation of the spine (to correct a subluxation demonstrated by X-ray to exist) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided.] *but only with respect to the provision of items and services which the chiropractor is legally authorized to provide by the State in which the chiropractor provides them.* For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4)) are furnished.

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2)(A) * * *

* * * * * * *

(N) clinical social worker services (as defined in subsection (hh)(2)); [and]

(O) erythropoietin for dialysis patients competent to use such drug without medical or other supervision with respect to the administration of such drug, subject to methods and standards established by the Secretary by regulation for the safe and effective use of such drug, and items related to the administration of such drug; [and]

(Q) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an anticancer chemotherapeutic agent for a given indication, and containing an active ingredient (or ingredients), which is the same indication and active ingredient (or ingredients) as a drug which the carrier determines would be covered pursuant to subparagraph (A) or (B) if the drug could not be self-administered; *and*

(R) an oral drug (which is approved by the Federal Food and Drug Administration) prescribed for use as an anti-emetic used as part of an anticancer chemotherapeutic regimen, if the drug is prescribed or dispensed—

(i) for use not later than 12 hours after the administration of the anticancer chemotherapeutic agent; and

(ii) as a substitute for any other anti-emetic therapy which would otherwise be administered intravenously.

* * * * * * *

Reasonable Cost

(v)(1)(A) * * *

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(E) Such regulations may, in the case of skilled nursing facilities in any State, provide for the use of rates, developed by the State in which such facilities are located, for the payment of the cost of skilled nursing facility services furnished under the State's plan approved under title XIX (and such rates may be increased by the

Secretary on a class or size of institution or on a geographical basis by a percentage factor not in excess of 10 percent to take into account determinable items or services or other requirements under this title not otherwise included in the computation of such State rates), if the Secretary finds that such rates are reasonably related to (but not necessarily limited to) analyses undertaken by such State of costs of care in comparable facilities in such State. [Notwithstanding the previous sentence, such regulations with respect to skilled nursing facilities shall take into account (in a manner consistent with subparagraph (A) and based on patient-days of services furnished) the costs (including the costs of services required to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident eligible for benefits under this title) of such facilities complying with the requirements of subsections (b), (c), and (d) of section 1819 (including the costs of conducting nurse aide training and competency evaluation programs and competency evaluation programs).]

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(L)(i) * * *

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(iii) Not later than July 1, 1991, and annually thereafter (but not for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996), the Secretary shall establish limits under this subparagraph for cost reporting periods beginning on or after such date by utilizing the area wage index applicable under section 1886(d)(3)(E) and determined using the survey of the most recent available wages and wage-related costs of hospitals located in the geographic area in which the home health agency is located (determined without regard to whether such hospitals have been reclassified to a new geographic area pursuant to section 1886(d)(8)(B), a decision of the Medicare Geographic Classification Review Board under section 1886(d)(10), or a decision of the Secretary). *In establishing limits under this subparagraph, the Secretary may not take into account any changes in the costs of the provision of services furnished by home health agencies with respect to cost reporting periods which began on or after July 1, 1994, and before July 1, 1996.*

(iv) This subparagraph shall apply only to services furnished by home health agencies during cost reporting periods ending on or before September 30, 1996.

* * * * * * *

(S)(i) Such regulations shall not include provision for specific recognition of any return on equity capital with respect to hospital outpatient departments.

(ii)(I) Such regulations shall provide that, in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of outpatient hospital services, the Secretary shall reduce the amounts of such payments otherwise established under this title by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1990, by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal year 1991, and by 10 percent for payments attributable to portions of cost reporting

periods occurring during fiscal years 1992 [through 1998] *through 2002*.

(II) The Secretary shall reduce the reasonable cost of outpatient hospital services (other than the capital-related costs of such services) otherwise determined pursuant to section 1833(a)(2)(B)(i)(I) by 5.8 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1991 [through 1998] *through 2002*.

* * * * * * *

(T)(i) In determining such reasonable costs for hospitals, the amount of bad debts otherwise treated as allowable costs which are attributable to the deductibles and coinsurance amounts under this title shall be reduced by—

(I) 75 percent for cost reporting periods beginning during fiscal year 1996,

(II) 60 percent for cost reporting periods beginning during fiscal year 1997, and

(III) 50 percent for subsequent cost reporting periods.

(ii) Clause (i) shall not apply with respect to bad debt of a hospital described in section 1886(d)(1)(B)(iv) if the debt is attributable to uncollectable deductible and coinsurance payments owed by individuals enrolled in a State plan under title XIX or under the MediGrant program under title XXI.

(U) Such regulations shall provide that, in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of skilled nursing facilities, the Secretary shall reduce the amounts of such payments otherwise established under this title by 15 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1996 through 2002.

(V) In the case of an item or service furnished by a skilled nursing facility (or by others under arrangement with them made by a skilled nursing facility) for which payment is made under part B in an amount determined in accordance with section 1833(a)(2)(B), the Secretary shall reduce the reasonable cost for such item or service otherwise determined under clause (i)(I) of such section by 5.8 percent for payments attributable to portions of cost reporting periods occurring during fiscal years 1996 through 2002.

* * * * * * *

Extended Care in Christian Science Skilled Nursing Facilities

(y)(1) The term "skilled nursing facility" also includes a Christian Science sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, Boston, Massachusetts, *or by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.*, but only (except for purposes of subsection (a)(2)) with respect to items and services ordinarily furnished by such an institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and

requirements otherwise applicable) as may be provided in regulations.

* * * * * * *

Rural Emergency Access Care Hospital; Rural Emergency Access Care Hospital Services

(oo)(1) The term "rural emergency access care hospital" means, for a fiscal year, a facility with respect to which the Secretary finds the following:

(A) The facility is located in a rural area (as defined in section 1886(d)(2)(D)).

(B) The facility was a hospital under this title at any time during the 5-year period that ends on the date of the enactment of this subsection.

(C) The facility is in danger of closing due to low inpatient utilization rates and operating losses, and the closure of the facility would limit the access to emergency services of individuals residing in the facility's service area.

(D) The facility has entered into (or plans to enter into) an agreement with a hospital with a participation agreement in effect under section 1866(a), and under such agreement the hospital shall accept patients transferred to the hospital from the facility and receive data from and transmit data to the facility.

(E) There is a practitioner who is qualified to provide advanced cardiac life support services (as determined by the State in which the facility is located) on-site at the facility on a 24-hour basis.

(F) A physician is available on-call to provide emergency medical services on a 24-hour basis.

(G) The facility meets such staffing requirements as would apply under section 1861(e) to a hospital located in a rural area, except that—

(i) the facility need not meet hospital standards relating to the number of hours during a day, or days during a week, in which the facility must be open, except insofar as the facility is required to provide emergency care on a 24-hour basis under subparagraphs (E) and (F); and

(ii) the facility may provide any services otherwise required to be provided by a full-time, on-site dietitian, pharmacist, laboratory technician, medical technologist, or radiological technologist on a part-time, off-site basis.

(H) The facility meets the requirements applicable to clinics and facilities under subparagraphs (C) through (J) of paragraph (2) of section 1861(aa) and of clauses (ii) and (iv) of the second sentence of such paragraph (or, in the case of the requirements of subparagraph (E), (F), or (J) of such paragraph, would meet the requirements if any reference in such subparagraph to a "nurse practitioner" or to "nurse practitioners" were deemed to be a reference to a "nurse practitioner or nurse" or to "nurse practitioners or nurses"); except that in determining whether a facility meets the requirements of this subparagraph, subparagraphs (E) and (F) of that paragraph shall be applied

as if any reference to a "physician" is a reference to a physician as defined in section 1861(r)(1).

(2) The term "rural emergency access care hospital services" means the following services provided by a rural emergency access care hospital and furnished to an individual over a continuous period not to exceed 24 hours (except that such services may be furnished over a longer period in the case of an individual who is unable to leave the hospital because of inclement weather):

(A) An appropriate medical screening examination (as described in section 1867(a)).

(B) Necessary stabilizing examination and treatment services for an emergency medical condition and labor (as described in section 1867(b)).

EXCLUSIONS FROM COVERAGE AND MEDICARE AS SECONDARY PAYER

SEC. 1862. (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1)(A) * * *

* * * * * * *

(D) in the case of clinical care items and services provided with the concurrence of the Secretary and with respect to research and experimentation conducted by, or under contract with, the [Prospective Payment Assessment Commission] *Medicare Payment Review Commission* or the Secretary, which are not reasonable and necessary to carry out the purposes of section 1886(e)(6),

* * * * * * *

(14) which are other than physicians' services (as defined in regulations promulgated specifically for purposes of this paragraph), services described by section 1861(s)(2)(K)(i) or 1861(s)(2)(K)(iii), certified nurse-midwife services, qualified psychologist services, and services of a certified registered nurse anesthetist, and which are furnished to an individual who is a patient of a hospital or rural primary care hospital by an entity other than the hospital or rural primary care hospital, unless the services are furnished under arrangements (as defined in section 1861(w)(1)) with the entity made by the hospital or rural primary care hospital; [or]

(15)(A) which are for services of an assistant at surgery in a cataract operation (including subsequent insertion of an intraocular lens) unless, before the surgery is performed, the appropriate utilization and quality control peer review organization (under part B of title XI) or a carrier under section 1842 has approved of the use of such an assistant in the surgical procedure based on the existence of a complicating medical condition, orrespect to deeming approval.

(B) which are for services of an assistant at surgery to which section 1848(i)(2)(B) applies[.]*;*

(16) where such expenses are for covered non-routine services (as defined in section 1888A(a)(1)) (other than a portable X-ray or portable electrocardiogram treated as a physician's service for purposes of section 1848(j)(3)) furnished to an individual

who is a resident of a skilled nursing facility and for which the claim for payment under this title is not submitted by the facility;

(17) where such expenses are for home health services furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency; or

(18) where such expenses are for items or services, or to assist in the purchase, in whole or in part, of health benefit coverage that includes items or services, for the purpose of causing, or assisting in causing, the death, suicide, euthanasia, or mercy killing of a person.

Paragraph (7) shall not apply to Federally qualified health center services described in section 1861(aa)(3)(B).

(b) MEDICARE AS SECONDARY PAYER.—

(1) REQUIREMENTS OF GROUP HEALTH PLANS.—

(A) * * *

(B) DISABLED INDIVIDUALS IN LARGE GROUP HEALTH PLANS.—

(i) IN GENERAL.—A large group health plan (as defined in [clause (iv)] *clause (iii)*) may not take into account that an individual (or a member of the individual's family) who is covered under the plan by virtue of the individual's current employment status with an employer is entitled to benefits under this title under section 226(b).

* * * * * * *

[(iii) SUNSET.—Clause (i) shall only apply to items and services furnished on or after January 1, 1987, and before October 1, 1998.

[(iv)] *(iii)* LARGE GROUP HEALTH PLAN DEFINED.—In this subparagraph, the term "large group health plan" has the meaning given such term in section 5000(b)(2) of the Internal Revenue Code of 1986, without regard to section 5000(d) of such Code.

(C) INDIVIDUALS WITH END STAGE RENAL DISEASE.—A group health plan (as defined in subparagraph (A)(v))—

(i) may not take into account that an individual is entitled to or eligible for benefits under this title under section 226A during the [12-month] *24-month* period which begins with the first month in which the individual becomes entitled to benefits under part A under the provisions of section 226A, or, if earlier, the first month in which the individual would have been entitled to benefits under such part under the provisions of section 226A if the individual had filed an application for such benefits; and

(ii) may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner;

except that clause (ii) shall not prohibit a plan from paying benefits secondary to this title when an individual is enti-

tled to or eligible for benefits under this title under section 226A after the end of the [12-month] *24-month* period described in clause (i). [Effective for items and services furnished on or after February 1, 1991, and before October 1, 1998 (with respect to periods beginning on or after February 1, 1990), this subparagraph shall be applied by substituting "18- month" for "12-month" each place it appears.]

* * * * * * *

(2) MEDICARE SECONDARY PAYER.—

(A) * * *

(B) CONDITIONAL PAYMENT.—

(i) * * *

(ii) ACTION BY UNITED STATES.—In order to recover payment under this title for such an item or service, the United States may bring an action against any entity which is required or responsible [under this subsection to pay] *(directly, as a third-party administrator, or otherwise) to make payment* with respect to such item or service (or any portion thereof) under a primary plan (and may, in accordance with paragraph (3)(A) collect double damages against that entity), or against any other entity (including any physician or provider) that has received payment from that entity with respect to the item or service, and may join or intervene in any action related to the events that gave rise to the need for the item or service. *The United States may not recover from a third-party administrator under this clause in cases where the third-party administrator would not be able to recover the amount at issue from the employer or group health plan for whom it provides administrative services due to the insolvency or bankruptcy of the employer or plan.*

* * * * * * *

(v) CLAIMS-FILING PERIOD.—Notwithstanding any other time limits that may exist for filing a claim under an employer group health plan, the United States may seek to recover conditional payments in accordance with this subparagraph where the request for payment is submitted to the entity required or responsible under this subsection to pay with respect to the item or service (or any portion thereof) under a primary plan within the 3-year period beginning on the date on which the item or service was furnished.

* * * * * * *

(5) IDENTIFICATION OF SECONDARY PAYER SITUATIONS.—

(A) * * *

(B) DISCLOSURE TO FISCAL INTERMEDIARIES AND CARRIERS.—In addition to any other information provided under this title to fiscal intermediaries and carriers, the Administrator shall disclose to such intermediaries and carriers (or to such a single intermediary or carrier as the

Secretary may designate) the information received under[—

[(i) subparagraph (A), and

[(ii) section 1144,

[for purposes of carrying out this subsection.] *subparagraph (A) for purposes of carrying out this subsection.*

(C) CONTACTING EMPLOYERS.—

(i) IN GENERAL.—With respect to each individual (in this subparagraph referred to as an "employee") who was furnished a written statement under section 6051 of the Internal Revenue Code of 1986 by a qualified employer (as defined in section 6103(l)(12)(E)(iii) of such Code), as disclosed under [subparagraph (B)(i)] *subparagraph (B),* the appropriate fiscal intermediary or carrier shall contact the employer in order to determine during what period the employee or employee's spouse may be (or have been) covered under a group health plan of the employer and the nature of the coverage that is or was provided under the plan (including the name, address, and identifying number of the plan).

* * * * * * *

[(iii) SUNSET ON REQUIREMENT.—Clause (ii) shall not apply to inquiries made after September 30, 1998.]

* * * * * * *

(i) In order to supplement the activities of the [Prospective Payment Assessment Commission] *Medicare Payment Review Commission* under section 1886(e) in assessing the safety, efficacy, and cost-effectiveness of new and existing medical procedures, the Secretary may carry out, or award grants or contracts for, original research and experimentation of the type described in clause (ii) of section 1886(e)(6)(E) with respect to such a procedure if the Secretary finds that—

(1) * * *

* * * * * * *

(j)(1) Notwithstanding any other provision of this title, no payment may be made under part B for physicians' services furnished by a chiropractor (or services and supplies furnished as an incident to such services) unless such services are described in paragraphs (1) or (2)(A) of section 1861(s) and are for treatment by means of manual manipulation of the spine (to correct a subluxation demonstrated by X-ray to exist).

(2) Nothing in this title shall exclude coverage of X-ray and other tests described in section 1861(s)(3) that are ordered by, or upon referral from, a chiropractor if such tests are otherwise covered under this title.

* * * * * * *

USE OF STATE AGENCIES TO DETERMINE COMPLIANCE BY PROVIDERS OF SERVICES WITH CONDITIONS OF PARTICIPATION

SEC. 1864. (a) * * *

* * * * * * *

[(d) The Secretary may not enter an agreement under this section with a State with respect to determining whether an institution therein is a skilled nursing facility unless the State meets the requirements specified in section 1819(e) and section 1819(g) and the establishment of remedies under sections 1819(h)(2)(B) and 1819(h)(2)(C) (relating to establishment and application of remedies).]

* * * * * * *

AGREEMENTS WITH PROVIDERS OF SERVICES

SEC. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) * * *

* * * * * * *

(O) in the case of hospitals and skilled nursing facilities, to accept as payment in full for inpatient hospital and extended care services that are covered under this title and are furnished to any individual enrolled with an eligible organization (i) with a risk-sharing contract under section 1876, under section 1876(i)(2)(A) (as in effect before February 1, 1985), under section 402(a) of the Social Security Amendments of 1967, or under section 222(a) of the Social Security Amendments of 1972, and (ii) which does not have a contract establishing payment amounts for services furnished to members of the organization the amounts (in the case of hospitals) or limits (in the case of skilled nursing facilities) that would be made as a payment in full under this title if the individuals were not so enrolled *and in the case of hospitals to accept as payment in full for inpatient hospital services that are emergency services (as defined in section 1853(b)(4)) that are covered under this title and are furnished to any individual enrolled under part C with a MedicarePlus organization which does not have a contract establishing payment amounts for services furnished to members of the organization the amounts that would be made as a payment in full under this title if the individuals were not so enrolled*;

* * * * * * *

(f)(1) For purposes of subsection (a)(1)(Q) and sections [1819(c)(2)(E),] 1833(s), *1853(g),* 1876(c)(8), and 1891(a)(6), the requirement of this subsection is that a provider of services, *MedicarePlus organization,* or prepaid or eligible organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization—

(A) * * *

* * * * * * *

(4) Nothing in this subsection shall be construed to require the provision of information regarding assisted suicide, euthanasia, or mercy killing.

* * * * * * *

EXAMINATION AND TREATMENT FOR EMERGENCY MEDICAL CONDITIONS AND WOMEN IN LABOR

SEC. 1867. (a) * * *

* * * * * * *

(e) DEFINITIONS.—In this section:

(1) * * *

* * * * * * *

(5) The term "hospital" includes a rural primary care hospital (as defined in section [1861(mm)(1))] *1861(mm)(1)) and a rural emergency access care hospital (as defined in section 1861(oo)(1)).*

* * * * * * *

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SEC. 1876. (a) * * *

* * * * * * *

(c)(1) * * *

* * * * * * *

(3)(A)(i) Each eligible organization must have an open enrollment period, for the enrollment of individuals under this section, of at least 30 days duration every year and including the period or periods specified under clause (ii), and must provide that at any time during which enrollments are accepted, the organization will accept up to the limits of its capacity (as determined by the Secretary) and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under subsection (d) in the order in which they apply for enrollment, unless to do so [would result in failure to meet the requirements of subsection (f) or] would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the geographic area served by the organization.

* * * * * * *

[(f)(1) Each eligible organization with which the Secretary enters into a contract under this section shall have, for the duration of such contract, an enrolled membership at least one-half of which consists of individuals who are not entitled to benefits under this title or under a State plan approved under title XIX.

[(2) The Secretary may modify or waive the requirement imposed by paragraph (1) only—

[(A) to the extent that more than 50 percent of the population of the area served by the organization consists of individuals who are entitled to benefits under this title or under a State plan approved under title XIX, or

[(B) in the case of an eligible organization that is owned and operated by a governmental entity, only with respect to a period of three years beginning on the date the organization first enters into a contract under this section, and only if the organization has taken and is making reasonable efforts to enroll individuals who are not entitled to benefits under this title or under a State plan approved under title XIX.

[(3) If the Secretary determines that an eligible organization has failed to comply with the requirements of this subsection, the Secretary may provide for the suspension of enrollment of individuals under this section or of payment to the organization under this section for individuals newly enrolled with the organization, after the date the Secretary notifies the organization of such noncompliance.]

* * * * * * *

(i)(1) Each contract under this section shall be for a term of at least one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that [the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the eligible organization involved as he may provide in regulations), if he finds that the organization—

[(A) has failed substantially to carry out the contract,

[(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section, or

[(C) no longer substantially meets the applicable conditions of subsections (b), (c), (e), and (f).] *in accordance with procedures established under paragraph (9), the Secretary may at any time terminate any such contract or may impose the intermediate sanctions described in paragraph (6)(B) or (6)(C) (whichever is applicable) on the eligible organization if the Secretary determines that the organization—*

(A) has failed substantially to carry out the contract;

(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section;

(C) is operating in a manner that is not in the best interests of the individuals covered under the contract; or

(D) no longer substantially meets the applicable conditions of subsections (b), (c), and (e).

* * * * * * *

(6)(A) * * *

(B) The remedies described in this subparagraph are—

(i) * * *

* * * * * * *

[The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under clause (i) in the

same manner as they apply to a civil money penalty or proceeding under section 1128A(a).]

(C) In the case of an eligible organization for which the Secretary makes a determination under paragraph (1) the basis of which is not described in subparagraph (A), the Secretary may apply the following intermediate sanctions:

(i) civil money penalties of not more than $25,000 for each determination under paragraph (1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract;

(ii) civil money penalties of not more than $10,000 for each week beginning after the initiation of procedures by the Secretary under paragraph (9) during which the deficiency that is the basis of a determination under paragraph (1) exists; and

(iii) suspension of enrollment of individuals under this section after the date the Secretary notifies the organization of a determination under paragraph (1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.

(D) The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (A) or (B) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

* * * * * * *

(9) The Secretary may terminate a contract with an eligible organization under this section or may impose the intermediate sanctions described in paragraph (6) on the organization in accordance with formal investigation and compliance procedures established by the Secretary under which—

(A) the Secretary provides the organization with the opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1);

(B) the Secretary shall impose more severe sanctions on organizations that have a history of deficiencies or that have not taken steps to correct deficiencies the Secretary has brought to their attention;

(C) there are no unreasonable or unnecessary delays between the finding of a deficiency and the imposition of sanctions; and

(D) the Secretary provides the organization with reasonable notice and opportunity for hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.

* * * * * * *

LIMITATION ON CERTAIN PHYSICIAN REFERRALS

SEC. 1877. (a) PROHIBITION OF CERTAIN REFERRALS.—

(1) * * *

(2) FINANCIAL RELATIONSHIP SPECIFIED.—For purposes of this section, a financial relationship of a physician (or an immediate family member of such physician) with an entity specified in this paragraph [is—

[(A) except as provided in subsections (c) and (d), an ownership or investment interest in the entity, or

[(B) except as provided in subsection (e), a compensation arrangement (as defined in subsection (h)(1)) between the physician (or an immediate family member of such physician) and the entity.

An ownership or investment interest described in subparagraph (A) may be through equity,] *is (except as provided in subsection (c)) an ownership or investment interest in the entity through equity,* debt, or other means and includes an interest in an entity that holds an ownership or investment interest in any entity providing the designated health service.

(b) GENERAL EXCEPTIONS [TO BOTH OWNERSHIP AND COMPENSATION ARRANGEMENT PROHIBITIONS] *WHERE FINANCIAL RELATIONSHIP EXISTS*.—Subsection (a)(1) shall not apply in the following cases:

(1) * * *

(2) [IN-OFFICE ANCILLARY SERVICES] *ANCILLARY SERVICES FURNISHED PERSONALLY OR THROUGH GROUP PRACTICE*.—In the case of [services (other than durable medical equipment (excluding infusion pumps) and parenteral and enteral nutrients, equipment, and supplies)—] *services—*

[(A) that are furnished—

[(i) personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individuals who are directly supervised by the physician or by another physician in the group practice, and

[(ii)(I) in a building in which the referring physician (or another physician who is a member of the same group practice) furnishes physicians' services unrelated to the furnishing of designated health services, or

[(II) in the case of a referring physician who is a member of a group practice, in another building which is used by the group practice—

[(aa) for the provision of some or all of the group's clinical laboratory services, or

[(bb) for the centralized provision of the group's designated health services (other than clinical laboratory services),

unless the Secretary determines other terms and conditions under which the provision of such services does not present a risk of program or patient abuse, and]

(A) that are furnished personally by the referring physician, personally by a physician who is a member of the same group practice as the referring physician, or personally by individuals who are under the general supervision of the physician or of another physician in the group practice, and

(B) that are billed by the physician performing or supervising the services, by a group practice of which such physician is a member under a billing number assigned to the group practice, or by an entity that is wholly owned by

such [physician or such group practice] *physician, such group practice, or the physician owners of such group practice,*

if the ownership or investment interest in such services meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

(3) PREPAID PLANS *MANAGED CARE ARRANGEMENTS*.—In the case of services furnished by an [organization—] *organization, directly or through contractual arrangements with other entities, to individuals enrolled with the organization—*

(A) with a contract under section 1876 *or part C* to an individual enrolled with the organization,

(B) described in section 1833(a)(1)(A) to an individual enrolled with the organization,

(C) receiving payments on a prepaid basis, under a demonstration project under section 402(a) of the Social Security Amendments of 1967 or under section 222(a) of the Social Security Amendments of 1972, to an individual enrolled with the organization, [or]

(D) that is a qualified health maintenance organization (within the meaning of section 1310(d) of the Public Health Service Act) to an individual enrolled with the organization[.],

(E) with a contract with a State to provide services under the State plan under title XIX (in accordance with section 1903(m)) or a State MediGrant plan under title XXI; or

(F) which is a MedicarePlus organization under part C or which provides or arranges for the provision of health care items or services pursuant to a written agreement between the organization and an individual or entity if the written agreement places the individual or entity at substantial financial risk for the cost or utilization of the items or services which the individual or entity is obligated to provide, whether through a withhold, capitation, incentive pool, per diem payment, or any other similar risk arrangement which places the individual or entity at substantial financial risk.

(4) SHARED FACILITY SERVICES.—In the case of a designated health service consisting of a shared facility service of a shared facility—

(A) that is furnished—

(i) personally by the referring physician who is a shared facility physician or personally by an individual directly employed or under the general supervision of such a physician,

(ii) by a shared facility in a building in which the referring physician furnishes substantially all of the services of the physician that are unrelated to the furnishing of shared facility services, and

(iii) to a patient of a shared facility physician; and

(B) that is billed by the referring physician or a group practice of which the physician is a member.

(5) NO ALTERNATIVE PROVIDERS IN AREA.—In the case of a designated health service furnished in any area with respect to

which the Secretary determines that individuals residing in the area do not have reasonable access to such a designated health service for which subsection (a)(1) does not apply.

(6) SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.—In the case of a designated health service furnished in an ambulatory surgical center described in section 1832(a)(2)(F)(i).

(7) SERVICES FURNISHED IN RENAL DIALYSIS FACILITIES.—In the case of a designated health service furnished in a renal dialysis facility under section 1881.

(8) SERVICES FURNISHED BY A HOSPICE PROGRAM.—In the case of a designated health service furnished by a hospice program under section 1861(dd)(2).

(9) SERVICES FURNISHED IN A COMPREHENSIVE OUTPATIENT REHABILITATION FACILITY.—In the case of a designated health service furnished in a comprehensive outpatient rehabilitation facility (as defined in section 1861(cc)(2)).

[(1)**]** *(10)* HOSPITALS IN PUERTO RICO.—In the case of designated health services provided by a hospital located in Puerto Rico.

[(2)**]** *(11)* RURAL PROVIDER.—In the case of designated health services furnished in a rural area (as defined in section 1886(d)(2)(D)) by an entity, if **[**substantially all**]** *not less than 75 percent* of the designated health services furnished by such entity are furnished to individuals residing in such a rural area.

[(3)**]** *(12)* HOSPITAL OWNERSHIP.—In the case of designated health services provided by a hospital (other than a hospital described in **[**paragraph (1)**]** *paragraph (4)*) if—

(A) the referring physician is authorized to perform services at the hospital, and

(B) the ownership or investment interest is in the hospital itself (and not merely in a subdivision of the hospital).

[(4)**]** *(13)* OTHER PERMISSIBLE EXCEPTIONS.—In the case of any other financial relationship which the Secretary determines, and specifies in regulations, does not pose a risk of program or patient abuse.

(c) **[**GENERAL EXCEPTION RELATED ONLY TO OWNERSHIP OR INVESTMENT PROHIBITION FOR OWNERSHIP IN PUBLICLY TRADED SECURITIES AND MUTUAL FUNDS**]** *EXCEPTION FOR OWNERSHIP OR INVESTMENT INTEREST IN PUBLICLY TRADED SECURITIES AND MUTUAL FUNDS*.—Ownership of the following shall not be considered to be an ownership or investment interest described in **[**subsection (a)(2)(A)**]** *subsection (a)(2)*:

(1) * * *

* * * * * * *

[(d) ADDITIONAL EXCEPTIONS RELATED ONLY TO OWNERSHIP OR INVESTMENT PROHIBITION.—The following, if not otherwise excepted under subsection (b), shall not be considered to be an ownership or investment interest described in subsection (a)(2)(A):

[(1) HOSPITALS IN PUERTO RICO.—In the case of designated health services provided by a hospital located in Puerto Rico.

[(2) RURAL PROVIDER.—In the case of designated health services furnished in a rural area (as defined in section 1886(d)(2)(D)) by an entity, if substantially all of the designated health services furnished by such entity are furnished to individuals residing in such a rural area.

[(3) HOSPITAL OWNERSHIP.—In the case of designated health services provided by a hospital (other than a hospital described in paragraph (1)) if—

[(A) the referring physician is authorized to perform services at the hospital, and

[(B) the ownership or investment interest is in the hospital itself (and not merely in a subdivision of the hospital).

[(e) EXCEPTIONS RELATING TO OTHER COMPENSATION ARRANGEMENTS.—The following shall not be considered to be a compensation arrangement described in subsection (a)(2)(B):

[(1) RENTAL OF OFFICE SPACE; RENTAL OF EQUIPMENT.—

[(A) OFFICE SPACE.—Payments made by a lessee to a lessor for the use of premises if—

[(i) the lease is set out in writing, signed by the parties, and specifies the premises covered by the lease,

[(ii) the space rented or leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease or rental and is used exclusively by the lessee when being used by the lessee, except that the lessee may make payments for the use of space consisting of common areas if such payments do not exceed the lessee's pro rata share of expenses for such space based upon the ratio of the space used exclusively by the lessee to the total amount of space (other than common areas) occupied by all persons using such common areas,

[(iii) the lease provides for a term of rental or lease for at least 1 year,

[(iv) the rental charges over the term of the lease are set in advance, are consistent with fair market value, and are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

[(v) the lease would be commercially reasonable even if no referrals were made between the parties, and

[(vi) the lease meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

[(B) EQUIPMENT.—Payments made by a lessee of equipment to the lessor of the equipment for the use of the equipment if—

[(i) the lease is set out in writing, signed by the parties, and specifies the equipment covered by the lease,

[(ii) the equipment rented or leased does not exceed that which is reasonable and necessary for the legitimate business purposes of the lease or rental and is

used exclusively by the lessee when being used by the lessee,

[(iii) the lease provides for a term of rental or lease of at least 1 year,

[(iv) the rental charges over the term of the lease are set in advance, are consistent with fair market value, and are not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

[(v) the lease would be commercially reasonable even if no referrals were made between the parties, and

[(vi) the lease meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

[(2) BONA FIDE EMPLOYMENT RELATIONSHIPS.—Any amount paid by an employer to a physician (or an immediate family member of such physician) who has a bona fide employment relationship with the employer for the provision of services if—

[(A) the employment is for identifiable services,

[(B) the amount of the remuneration under the employment—

[(i) is consistent with the fair market value of the services, and

[(ii) is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician,

[(C) the remuneration is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the employer, and

[(D) the employment meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

Subparagraph (B)(ii) shall not prohibit the payment of remuneration in the form of a productivity bonus based on services performed personally by the physician (or an immediate family member of such physician).

[(3) PERSONAL SERVICE ARRANGEMENTS.—

[(A) IN GENERAL.—Remuneration from an entity under an arrangement (including remuneration for specific physicians' services furnished to a nonprofit blood center) if—

[(i) the arrangement is set out in writing, signed by the parties, and specifies the services covered by the arrangement,

[(ii) the arrangement covers all of the services to be provided by the physician (or an immediate family member of such physician) to the entity,

[(iii) the aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement,

[(iv) the term of the arrangement is for at least 1 year,

[(v) the compensation to be paid over the term of the arrangement is set in advance, does not exceed

fair market value, and except in the case of a physician incentive plan described in subparagraph (B), is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

[(vi) the services to be performed under the arrangement do not involve the counseling or promotion or a business arrangement or other activity that violates any State or Federal law, and

[(vii) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

[(B) PHYSICIAN INCENTIVE PLAN EXCEPTION.—

[(i) IN GENERAL.—In the case of a physician incentive plan (as defined in clause (ii)) between a physician and an entity, the compensation may be determined in a manner (through a withhold, capitation, bonus, or otherwise) that takes into account directly or indirectly the volume or value of any referrals or other business generated between the parties, if the plan meets the following requirements:

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

[(II) In the case of a plan that places a physician or a physician group at substantial financial risk as determined by the Secretary pursuant to section 1876(i)(8)(A)(ii), the plan complies with any requirements the Secretary may impose pursuant to such section.

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

[(ii) PHYSICIAN INCENTIVE PLAN DEFINED.—For purposes of this subparagraph, the term "physician incentive plan" means any compensation arrangement between an entity and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the entity.

[(4) REMUNERATION UNRELATED TO THE PROVISION OF DESIGNATED HEALTH SERVICES.—In the case of remuneration which is provided by a hospital to a physician if such remuneration does not relate to the provision of designated health services.

[(5) PHYSICIAN RECRUITMENT.—In the case of remuneration which is provided by a hospital to a physician to induce the physician to relocate to the geographic area served by the hospital in order to be a member of the medical staff of the hospital, if—

[(A) the physician is not required to refer patients to the hospital,

[(B) the amount of the remuneration under the arrangement is not determined in a manner that takes into account (directly or indirectly) the volume or value of any referrals by the referring physician, and

[(C) the arrangement meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

[(6) ISOLATED TRANSACTIONS.—In the case of an isolated financial transaction, such as a one-time sale of property or practice, if—

[(A) the requirements described in subparagraphs (B) and (C) of paragraph (2) are met with respect to the entity in the same manner as they apply to an employer, and

[(B) the transaction meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

[(7) CERTAIN GROUP PRACTICE ARRANGEMENTS WITH A HOSPITAL.—

[(A) IN GENERAL.—An arrangement between a hospital and a group under which designated health services are provided by the group but are billed by the hospital if—

[(i) with respect to services provided to an inpatient of the hospital, the arrangement is pursuant to the provision of inpatient hospital services under section 1861(b)(3),

[(ii) the arrangement began before December 19, 1989, and has continued in effect without interruption since such date,

[(iii) with respect to the designated health services covered under the arrangement, substantially all of such services furnished to patients of the hospital are furnished by the group under the arrangement,

[(iv) the arrangement is pursuant to an agreement that is set out in writing and that specifies the services to be provided by the parties and the compensation for services provided under the agreement,

[(v) the compensation paid over the term of the agreement is consistent with fair market value and the compensation per unit of services is fixed in advance and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties,

[(vi) the compensation is provided pursuant to an agreement which would be commercially reasonable even if no referrals were made to the entity, and

[(vii) the arrangement between the parties meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

[(8) PAYMENTS BY A PHYSICIAN FOR ITEMS AND SERVICES.—Payments made by a physician—

[(A) to a laboratory in exchange for the provision of clinical laboratory services, or

[(B) to an entity as compensation for other items or services if the items or services are furnished at a price that is consistent with fair market value.

[(f) REPORTING REQUIREMENTS.—Each entity providing covered items or services for which payment may be made under this title shall provide the Secretary with the information concerning the entity's ownership, investment, and compensation arrangements, including—

[(1) the covered items and services provided by the entity, and

[(2) the names and unique physician identification numbers of all physicians with an ownership or investment interest (as described in subsection (a)(2)(A)), or with a compensation arrangement (as described in subsection (a)(2)(B)), in the entity, or whose immediate relatives have such an ownership or investment interest or who have such a compensation relationship with the entity.

Such information shall be provided in such form, manner, and at such times as the Secretary shall specify. The requirement of this subsection shall not apply to designated health services provided outside the United States or to entities which the Secretary determines provides services for which payment may be made under this title very infrequently.]

(g) SANCTIONS.—

(1) * * *

* * * * * * *

[(5) FAILURE TO REPORT INFORMATION.—Any person who is required, but fails, to meet a reporting requirement of subsection (f) is subject to a civil money penalty of not more than $10,000 for each day for which reporting is required to have been made. The provisions of section 1128A (other than the first sentence of subsection (a) and other than subsection (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).]

(h) DEFINITIONS AND SPECIAL RULES.—For purposes of this section:

[(1) COMPENSATION ARRANGEMENT; REMUNERATION.—(A) The term "compensation arrangement" means any arrangement involving any remuneration between a physician (or an immediate family member of such physician) and an entity other than an arrangement involving only remuneration described in subparagraph (C).

[(B) The term "remuneration" includes any remuneration, directly or indirectly, overtly or covertly, in cash or in kind.

[(C) Remuneration described in this subparagraph is any remuneration consisting of any of the following:

[(i) The forgiveness of amounts owed for inaccurate tests or procedures, mistakenly performed tests or procedures, or the correction of minor billing errors.

[(ii) The provision of items, devices, or supplies that are used solely to—

[(I) collect, transport, process, or store specimens for the entity providing the item, device, or supply, or

[(II) order or communicate the results of tests or procedures for such entity.

[(iii) A payment made by an insurer or a self-insured plan to a physician to satisfy a claim, submitted on a fee for service basis, for the furnishing of health services by that physician to an individual who is covered by a policy with the insurer or by the self-insured plan, if—

[(I) the health services are not furnished, and the payment is not made, pursuant to a contract or other arrangement between the insurer or the plan and the physician,

[(II) the payment is made to the physician on behalf of the covered individual and would otherwise be made directly to such individual,

[(III) the amount of the payment is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account directly or indirectly the volume or value of any referrals, and

[(IV) the payment meets such other requirements as the Secretary may impose by regulation as needed to protect against program or patient abuse.

[(2) EMPLOYEE.—An individual is considered to be "employed by" or an "employee" of an entity if the individual would be considered to be an employee of the entity under the usual common law rules applicable in determining the employer-employee relationship (as applied for purposes of section 3121(d)(2) of the Internal Revenue Code of 1986).

[(3) FAIR MARKET VALUE.—The term "fair market value" means the value in arms length transactions, consistent with the general market value, and, with respect to rentals or leases, the value of rental property for general commercial purposes (not taking into account its intended use) and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee.]

(1) SHARED FACILITY RELATED DEFINITIONS.—

(A) SHARED FACILITY SERVICE.—The term "shared facility service" means, with respect to a shared facility, a designated health service furnished by the facility to patients of shared facility physicians.

(B) SHARED FACILITY.—The term "shared facility" means an entity that furnishes shared facility services under a shared facility arrangement.

(C) SHARED FACILITY PHYSICIAN.—The term "shared facility physician" means, with respect to a shared facility, a physician (or a group practice of which the physician is a member) who has a financial relationship under a shared facility arrangement with the facility.

(D) SHARED FACILITY ARRANGEMENT.—The term "shared facility arrangement" means, with respect to the provision

of shared facility services in a building, a financial arrangement—

(i) which is only between physicians who are providing services (unrelated to shared facility services) in the same building,

(ii) in which the overhead expenses of the facility are shared, in accordance with methods previously determined by the physicians in the arrangement, among the physicians in the arrangement, and

(iii) which, in the case of a corporation, is wholly owned and controlled by shared facility physicians.

(4) GROUP PRACTICE.—

(A) DEFINITION OF GROUP PRACTICE.—The term "group practice" means a group of 2 or more physicians legally organized as a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association—

(i) * * *

* * * * * * *

[(iv) except as provided in subparagraph (B)(i), in which no physician who is a member of the group directly or indirectly receives compensation based on the volume or value of referrals by the physician,]

(v) in which members of the group personally conduct no less than 75 percent of the physician-patient encounters of the group practice, and

[(vi) which meets such other standards as the Secretary may impose by regulation.]

(B) SPECIAL [RULES.—

[(i) PROFITS AND PRODUCTIVITY BONUSES.—A physician in a group practice may be paid a share of overall profits of the group, or a productivity bonus based on services personally performed or services incident to such personally performed services, so long as the share or bonus is not determined in any manner which is directly related to the volume or value of referrals by such physician.

[(ii) FACULTY] *RULES FOR FACULTY* PRACTICE PLANS.—In the case of a faculty practice plan associated with a hospital, institution of higher education, or medical school with an approved medical residency training program in which physician members may provide a variety of different specialty services and provide professional services both within and outside the group, as well as perform other tasks such as research, subparagraph (A) shall be applied only with respect to the services provided within the faculty practice plan.

(C) MEMBER OF A GROUP.—A physician is a "member" of a group if the physician is an owner or a bona fide employee, or both, of the group.

(5) REFERRAL; REFERRING PHYSICIAN.—

(A) PHYSICIANS' SERVICES.—Except as provided in subparagraph (C), in the case of [an item or service] *a des-*

ignated health service for which payment may be made under part B, the request by a physician for [the item or service] *the designated health service*, including the request by a physician for a consultation with another physician (and any test or procedure ordered by, or to be performed by (or under the supervision of) that other physician), constitutes a "referral" by a "referring physician".

* * * * * * *

(C) CLARIFICATION RESPECTING CERTAIN SERVICES INTEGRAL TO A CONSULTATION BY CERTAIN SPECIALISTS.—A request by a pathologist for clinical diagnostic laboratory tests and pathological examination services[, a request by a radiologist for diagnostic radiology services, and a request by a radiation oncologist for radiation therapy,] *and a request by a radiologist for magnetic resonance imaging or for computerized tomography* if such services are furnished by (or under the supervision of) such pathologist, [radiologist, or radiation oncologist] *or radiologist* pursuant to a consultation requested by another physician does not constitute a "referral" by a "referring physician".

(6) DESIGNATED HEALTH SERVICES.—The term "designated health services" means any of the following items or services:

(A) * * *

[(B) Physical therapy services.

[(C) Occupational therapy services.

[(D) Radiology services, including magnetic resonance imaging, computerized axial tomography scans, and ultrasound services.

[(E) Radiation therapy services and supplies.

[(F) Durable medical equipment and supplies.

[(G) Parenteral and enteral nutrients, equipment, and supplies.

[(H) Prosthetics, orthotics, and prosthetic devices and supplies.

[(I) Home health services.

[(J) Outpatient prescription drugs.

[(K) Inpatient and outpatient hospital services.]

(B) Parenteral and enteral nutrients, equipment, and supplies.

(C) Magnetic resonance imaging and computerized tomography services.

(D) Outpatient physical or occupational therapy services.

(7) GENERAL SUPERVISION.—An individual is considered to be under the "general supervision" of a physician if the physician (or group practice of which the physician is a member) is legally responsible for the services performed by the individual and for ensuring that the individual meets licensure and certification requirements, if any, applicable under other provisions of law, regardless of whether or not the physician is physically present when the individual furnishes an item or service.

(i) PREEMPTION OF STATE LAW.—This section preempts State law to the extent State law is inconsistent with this section.

* * * * * * *

PART C—MISCELLANEOUS PROVISIONS

* * * * * * *

CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES

SEC. 1882. (a) * * *

* * * * * * *

(d)(1) Whoever knowingly and willfully makes or causes to be made or induces or seeks to induce the making of any false statement or representation of a material fact with respect to the compliance of any policy with the standards and requirements set forth in subsection (c) or in regulations promulgated pursuant to such subsection, or with respect to the use of the emblem designed by the Secretary under subsection (a), shall be fined under title 18, United States Code, or imprisoned not more than 5 years, or both, and, in addition to or in lieu of such a criminal penalty, is subject to a civil money penalty of not to exceed $5,000 for each such prohibited act.

* * * * * * *

(3)(A)**[**(i) It is unlawful for a person to sell or issue to an individual entitled to benefits under part A or enrolled under part B of this title—

[(I) a health insurance policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this title or title XIX,

[(II) a medicare supplemental policy with knowledge that the individual is entitled to benefits under another medicare supplemental policy, or

[(III) a health insurance policy (other than a medicare supplemental policy) with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled, other than benefits to which the individual is entitled under a requirement of State or Federal law.**]**

(i) It is unlawful for a person to sell or issue to an individual entitled to benefits under part A or enrolled under part B of this title or electing a MedicarePlus product under section 1805—

(I) a health insurance policy (other than a medicare supplemental policy) with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this title or title XIX,

(II) in the case of an individual not electing a MedicarePlus product, a medicare supplemental policy with knowledge that the individual is entitled to benefits under another medicare supplemental policy, or

(III) in the case of an individual electing a MedicarePlus product, a medicare supplemental policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under this title or under another medicare supplemental policy.

* * * * * * *

(iii) A seller (who is not the issuer of a health insurance policy) shall not be considered to violate **[**clause (i)**]** *clause (i)(II)* with re-

spect to the sale of a medicare supplemental policy if the policy is sold in compliance with subparagraph (B).

(iv) For purposes of this subparagraph a health insurance policy shall be considered to "duplicate" benefits under this title only when, under its terms, the policy provides specific reimbursement for identical items and services to the extent paid for under this title, and a health insurance policy providing for benefits which are payable to or on behalf of an individual without regard to other health benefit coverage of such individual is not considered to "duplicate" any health benefits under this title.

(v) For purposes of this subparagraph, a health insurance policy (or a rider to an insurance contract which is not a health insurance policy), including a policy (such as a long-term care insurance contract described in section 7702B(b) of the Internal Revenue Code of 1986, as added by the Contract with America Tax Relief Act of 1995 (H.R. 1215)) providing benefits for long-term care, nursing home care, home health care, or community-based care, that coordinates against or excludes items and services available or paid for under this title and (for policies sold or issued after January 1, 1996) that discloses such coordination or exclusion in the policy's outline of coverage, is not considered to 'duplicate' health benefits under this title. For purposes of this clause, the terms "coordinates" and "coordination" mean, with respect to a policy in relation to health benefits under this title, that the policy under its terms is secondary to, or excludes from payment, items and services to the extent available or paid for under this title.

(vi) Notwithstanding any other provision of law, no criminal or civil penalty may be imposed at any time under this subparagraph and no legal action may be brought or continued at any time in any Federal or State court if the penalty or action is based on an act or omission that occurred after November 5, 1991, and before the date of the enactment of this clause, and relates to the sale, issuance, or renewal of any health insurance policy during such period, if such policy meets the requirements of clause (iv) or (v).

(vii) A State may not impose, with respect to the sale or issuance of a policy (or rider) that meets the requirements of this title pursuant to clause (iv) or (v) to an individual entitled to benefits under part A or enrolled under part B or enrolled under a MedicarePlus product under part C, any requirement based on the premise that such a policy or rider duplicates health benefits to which the individual is otherwise entitled under this title.

(B)(i) It is unlawful for a person to issue or sell a medicare supplemental policy to an individual entitled to benefits under part A or enrolled under part B, whether directly, through the mail, or otherwise, unless—

(I) the person obtains from the individual, as part of the application for the issuance or purchase and on a form described in clause (II), a written statement signed by the individual stating, to the best of the individual's knowledge, what health insurance policies *(including any MedicarePlus product)* the individual has, from what source, and whether the individual is entitled to any medical assistance under title XIX, whether as a qualified medicare beneficiary or otherwise, and

* * * * * * *

(C) Subparagraph (A) shall not apply with respect to [(i)] the sale or issuance of a group policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations[, (ii) the sale or issuance of a policy or plan described in subparagraph (A)(i)(I) (other than a medicare supplemental policy to an individual entitled to any medical assistance under title XIX) under which all the benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual but only if (for policies sold or issued more than 60 days after the date the statements are published or promulgated under subparagraph (D)) there is disclosed in a prominent manner as part of (or together with) the application the applicable statement (specified under subparagraph (D)) of the extent to which benefits payable under the policy or plan duplicate benefits under this title, or (iii) the sale or issuance of a policy or plan described in subparagraph (A)(i)(III) under which all the benefits are fully payable directly to or on behalf of the individual without regard to other health benefit coverage of the individual.

[(D)(i) If—

[(I) within the 90-day period beginning on the date of the enactment of this subparagraph, the National Association of Insurance Commissioners develops (after consultation with consumer and insurance industry representatives) and submits to the Secretary a statement for each of the types of health insurance policies (other than medicare supplemental policies and including, but not limited to, as separate types of policies, policies paying directly to the beneficiary fixed, cash benefits, and policies that limit benefit payments to specific diseases) which are sold or issued to persons entitled to health benefits under this title, of the extent to which benefits payable under the policy or plan duplicate benefits under this title, and

[(II) the Secretary approves all the statements submitted as meeting the requirements of subclause (I),

each such statement shall be (for purposes of subparagraph (C)) the statement specified under this subparagraph for the type of policy involved. The Secretary shall review and approve (or disapprove) all the statements submitted under subclause (I) within 30 days after the date of their submittal. Upon approval of such statements, the Secretary shall publish such statements.

[(ii) If the Secretary does not approve the statements under clause (i) or the statements are not submitted within the 90-day period specified in such clause, the Secretary shall promulgate (after consultation with consumer and insurance industry representatives and not later than 90 days after the date of disapproval or the end of such 90-day period (as the case may be)) a statement for each of the types of health insurance policies (other than medicare supplemental policies and including, but not limited to, as separate types of policies, policies paying directly to the beneficiary fixed, cash benefits, and policies that limit benefit payments to specific diseases) which are sold or issued to persons entitled to

health benefits under this title, of the extent to which benefits payable under the policy or plan duplicate benefits under this title, and each such statement shall be (for purposes of subparagraph (C)) the statement specified under this subparagraph for the type of policy involved.]

* * * * * * *

(g)(1) For purposes of this section, a medicare supplemental policy is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this title, which provides reimbursement for expenses incurred for services and items for which payment may be made under this title but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this title; but does not include any such policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations and does not include *a MedicarePlus product or* a policy or plan of an eligible organization (as defined in section 1876(b)) if the policy or plan provides benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, or, during the period beginning on the date specified in subsection (p)(1)(C) and ending on December 31, 1995, a policy or plan of an organization if the policy or plan provides benefits pursuant to an agreement under section 1833(a)(1)(A). For purposes of this section, the term "policy" includes a certificate issued under such policy.

* * * * * * *

(u)(1) Notwithstanding the previous provisions of this section, the following provisions shall not apply to a health insurance policy (other than a medicare supplemental policy) provided to an individual who has elected the MedicarePlus option under section 1805:

(A) Subsections (o)(1), (o)(2), (p)(1)(A)(i), (p)(2), (p)(3), (p)(8), and (p)(9) (insofar as they relate to limitations on benefits or groups of benefits that may be offered).

(B) Subsection (r) (relating to loss-ratios).

(2)(A) It is unlawful for a person to sell or issue a policy described in subparagraph (B) to an individual with knowledge that the individual has in effect under section 1805 an election of a high deductible/medisave product.

(B) A policy described in this subparagraph is a health insurance policy that provides for coverage of expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under the high deductible/medisave product.

HOSPITAL PROVIDERS OF EXTENDED CARE SERVICES

SEC. 1883. (a) * * *

* * * * * * *

(f) [A hospital which enters into an agreement with the Secretary under this section shall be required to meet those conditions applicable to skilled nursing facilities relating to discharge planning and the social services function (and staffing requirements to satisfy it) which are promulgated by the Secretary under section 1819.] Services furnished by [such a hospital] *a hospital which enters into an agreement with the Secretary under this section* which would otherwise constitute post-hospital extended care services if furnished by a skilled nursing facility shall be subject to the same requirements applicable to such services when furnished by a skilled nursing facility except for those requirements the Secretary determines are inappropriate in the case of these services being furnished by a hospital under this section.

* * * * * * *

PAYMENT TO HOSPITALS FOR INPATIENT HOSPITAL SERVICES

SEC. 1886. (a)(1)(A)(i) The Secretary,

* * * * * * *

(b)(1) Notwithstanding section 1814(b) but subject to the provisions of section 1813, if the operating costs of inpatient hospital services (as defined in subsection (a)(4)) of a hospital (other than a subsection (d) hospital, as defined in subsection (d)(1)(B)) for a cost reporting period subject to this paragraph—

* * * * * * *

(3)(A) Except as provided in subparagraphs (C), (D), [and *(E)*] *(E), and (F)* for purposes of this subsection, the term "target amount" means, with respect to a hospital for a particular 12-month cost reporting period—

(i) * * *

* * * * * * *

(B)(i) For purposes of subsection (d) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—

(I) * * *

* * * * * * *

[(XI) for fiscal year 1996, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,

[(XII) for fiscal year 1997, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas, and

[(XIII) for fiscal year 1998 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.]

(XI) for fiscal year 1996, the market basket percentage increase minus 2.5 percentage points for hospitals in all areas,

(XII) for each of the fiscal years 1997 through 2002, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas, and

(XIII) for fiscal year 2003 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.

(ii) For purposes of subparagraphs [(A) and (E)] *(A), (E), and (F),* the "applicable percentage increase" for 12-month cost reporting periods beginning during—

(I) fiscal year 1986, is 0.5 percent,

(II) fiscal year 1987, is 1.15 percent,

(III) fiscal year 1988, is the market basket percentage increase minus 2.0 percentage points,

(IV) a subsequent fiscal year ending on or before September 30, 1993, is the market basket percentage increase,

(V) fiscal years 1994 through [1997] *2002,* is the market basket percentage increase minus the applicable reduction (as defined in clause (v)(II)), or in the case of a hospital for a fiscal year for which the hospital's update adjustment percentage (as defined in clause (v)(I)) is at least 10 percent, the market basket percentage increase, and

(VI) subsequent fiscal years is the market basket percentage increase.

* * * * * * *

(iv) For purposes of subparagraphs (C) and (D), the "applicable percentage increase" is—

(I) for 12-month cost reporting periods beginning during fiscal years 1986 through 1993, the applicable percentage increase specified in clause (ii),

(II) for fiscal year 1994, the market basket percentage increase minus 2.3 percentage points (adjusted to exclude any portion of a cost reporting period beginning during fiscal year 1993 for which the applicable percentage increase is determined under subparagraph (I)),

(III) for fiscal year 1995, the market basket percentage increase minus 2.2 percentage points, [and

[(IV) for fiscal year 1996 and each subsequent fiscal year, the applicable percentage increase under clause (i).]

(IV) for each of the fiscal years 1996 through 2000, the market basket percentage increase minus 1 percentage points, and

(V) for fiscal year 2001 and each subsequent fiscal year, the applicable percentage increase under clause (i).

* * * * * * *

(F)(i) In the case of a qualified long-term care hospital (as defined in clause (ii)), the term "target amount" means—

(I) with respect to the first 12-month cost reporting period in which this subparagraph is applied to the hospital, the allowable operating costs of inpatient hospital services (as defined in subsection (a)(4)) recognized under this title for the hospital for the 12-month cost reporting period beginning during fiscal year 1991; or

(II) with respect to a later cost reporting period, the target amount for the preceding cost reporting period, increase by the applicable percentage increase under subparagraph (B)(ii) for that later cost reporting period.

(ii) In clause (i), a "qualified long-term care hospital" means, with respect to a cost reporting period, a hospital described in clause (iv) of subsection (d)(1)(B) during fiscal year 1995 for which the hospital's allowable operating costs of inpatient hospital services recog-

nized under this title for each of the two most recent previous 12-month cost reporting periods exceeded the hospital's target amount determined under this paragraph for such cost reporting periods, if the hospital—

(I) has a disproportionate patient percentage during such cost reporting period (as determined by the Secretary under subsection (d)(5)(F)(vi) as if the hospital were a subsection (d) hospital) of at least 25 percent, or

(II) is located in a State for which no payment is made under the State plan under title XIX for days of inpatient hospital services furnished to any individual in excess of the limit on the number of days of such services furnished to the individual for which payment may be made under this title.

* * * * * * *

(d)(1)(A) Notwithstanding section 1814(b) but subject to the provisions of section 1813, the amount of the payment with respect to the operating costs of inpatient hospital services (as defined in subsection (a)(4)) of a subsection (d) hospital (as defined in subparagraph (B)) for inpatient hospital discharges in a cost reporting period or in a fiscal year—

(i) * * *

* * * * * * *

(B) As used in this section, the term "subsection (d) hospital" means a hospital located in one of the fifty States or the District of Columbia other than—

(i) * * *

* * * * * * *

(v) a hospital that the Secretary has classified, at any time on or before December 31, 1990, (or, in the case of a hospital that, as of the date of the enactment of this clause, is located in a State operating a demonstration project under section 1814(b), on or before December 31, 1991) for purposes of applying exceptions and adjustments to payment amounts under this subsection, as a hospital involved extensively in treatment for or research on cancer;

and, in accordance with regulations of the Secretary, does not include a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital (as defined by the Secretary)**[.]**, *or a hospital classified by the Secretary as a long-term care hospital on or before September 30, 1995, and located in the same building as, or on the same campus as, another hospital.*

* * * * * * *

(2)(A) * * *

* * * * * * *

(C) STANDARDIZING AMOUNTS.—The Secretary shall standardize the amount updated under subparagraph (B) for each hospital by—

(i) excluding an estimate of indirect medical education costs (taking into account, for discharges occurring after September 30, 1986, the amendments made by section 9104(a) of the Medicare and Medicaid Budget Reconcili-

ation Amendments of [1985] *1985, but (for discharges occurring after September 30, 1995) not taking into account any reductions in such costs resulting from the amendments made by section 15412(a) of the Medicare Preservation Act of 1995*),

* * * * * * *

(iv) for discharges occurring on or after October 1, 1986, excluding an estimate of the additional payments to certain hospitals to be made under paragraph (5)(F), except that the Secretary shall not exclude additional payments under such paragraph made as a result of the enactment of section 6003(c) of the Omnibus Budget Reconciliation Act of 1989 or the enactment of section 4002(b) of the Omnibus Budget Reconciliation Act of 1990[.], *and the Secretary shall not take into account any reductions in the amount of such additional payments resulting from the amendments made by section 15502(a) of the Medicare Preservation Act of 1995.*

* * * * * * *

(5)(A)(i) For discharges occurring during fiscal years ending on or before September 30, 1997, the Secretary shall provide for an additional payment for a subsection (d) hospital for any discharge in a diagnosis-related group, the length of stay of which exceeds the mean length of stay for discharges within that group by a fixed number of days, or exceeds such mean length of stay by some fixed number of standard deviations, whichever is the fewer number of days.

* * * * * * *

(B) [The Secretary shall provide] *For discharges occurring on or before September 30, 1996, the Secretary shall provide* for an additional payment amount for subsection (d) hospitals with indirect costs of medical education, in an amount computed in the same manner as the adjustment for such costs under regulations (in effect as of January 1, 1983) under subsection (a)(2), except as follows:

(i) The amount of such additional payment shall be determined by multiplying (I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and the amount paid to the hospital under subparagraph (A), by (II) the indirect teaching adjustment factor described in clause (ii).

(ii) For purposes of clause (i)(II), the indirect teaching adjustment factor for discharges occurring on or after October 1, [1988,] *1999*, is equal to [1.89] *1.38* × (((1+r) to the nth power) −1), where "r" is the ratio of the hospital's full-time equivalent interns and residents to beds and "n" equals .405. *In the case of discharges occurring on or after October 1, 1995, and before October 1, 1999, the preceding sentence applies to the same extent and in the same manner as the sentence applies to discharges occurring on or after October 1, 1999, except that the term "1.38" is deemed to be "1.48".*

* * * * * * *

(F)(i) For discharges occurring on or after May 1, 1986, the Secretary shall provide, in accordance with this subparagraph, for an additional payment amount for each subsection (d) hospital which—

(I) * * *

* * * * * * *

(ii) [The amount] *Subject to clause (ix), the amount* of such payment for each discharge shall be determined by multiplying (I) the sum of the amount determined under paragraph (1)(A)(ii)(II) (or, if applicable, the amount determined under paragraph (1)(A)(iii)) and the amount paid to the hospital under subparagraph (A) for that discharge, by (II) the disproportionate share adjustment percentage established under clause (iii) or (iv) for the cost reporting period in which the discharge occurs.

* * * * * * *

(ix) In the case of discharges occurring on or after October 1, 1995, the additional payment amount otherwise determined under clause (ii) shall be reduced as follows:

(I) For discharges occurring on or after October 1, 1995, and on or before September 30, 1996, by 20 percent.

(II) For discharges occurring on or after October 1, 1996, and on or before September 30, 1997, by 25 percent.

(III) For discharges occurring on or after October 1, 1997, by 30 percent.

* * * * * * *

(10)(A) There is hereby established the Medicare Geographic Classification Review Board (hereinafter in this paragraph referred to as the "Board").

* * * * * * *

(D)(i) The Secretary shall publish guidelines to be utilized by the Board in rendering decisions on applications submitted under this paragraph, and shall include in such guidelines the following:

(I) * * *

* * * * * * *

(iii) Under the guidelines published by the Secretary under clause (i), in the case of a hospital which is classified by the Secretary as a rural referral center under paragraph (5)(C), the Board may not reject the application of the hospital under this paragraph on the basis of any comparison between the average hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located.

[(iii)] *(iv)* The Secretary shall publish the guidelines described in clause (i) by July 1, 1990.

(e)(1)(A) For cost reporting periods of hospitals beginning in fiscal year 1984 or fiscal year 1985, the Secretary shall provide for such proportional adjustment in the applicable percentage increase (otherwise applicable to the periods under subsection (b)(3)(B)) as may be necessary to assure that—

(i) * * *

* * * * * * *

[(2)(A) The Director of the Congressional Office of Technology Assessment (hereinafter in this subsection referred to as the "Director" and the "Office", respectively) shall provide for appointment of a Prospective Payment Assessment Commission (hereinafter in this subsection referred to as the "Commission"), to be composed of independent experts appointed by the Director (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service). The Commission shall review the applicable percentage increase factor described in subsection (b)(3)(B) and make recommendations to the Secretary on the appropriate percentage change which should be effected for hospital inpatient discharges under subsections (b) and (d) for fiscal years beginning with fiscal year 1986. In making its recommendations, the Commission shall take into account changes in the hospital market-basket described in subsection (b)(3)(B), hospital productivity, technological and scientific advances, the quality of health care provided in hospitals (including the quality and skill level of professional nursing required to maintain quality care), and long-term cost-effectiveness in the provision of inpatient hospital services.

[(B) In order to promote the efficient and effective delivery of high-quality health care services, the Commission shall, in addition to carrying out its functions under subparagraph (A), study and make recommendations for each fiscal year regarding changes in each existing reimbursement policy under this title under which payments to an institution are based upon prospectively determined rates and the development of new institutional reimbursement policies under this title, including recommendations relating to payments during such fiscal year under the prospective payment system established under this section for determining payments for the operating costs of inpatient hospital services, including changes in the number of diagnosis-related groups used to classify inpatient hospital discharges under subsection (d), adjustments to such groups to reflect severity of illness, and changes in the methods by which hospitals are reimbursed for capital-related costs, together with general recommendations on the effectiveness and quality of health care delivery systems in the United States and the effects on such systems of institutional reimbursements under this title.

[(C) By not later than June 1 of each year, the Commission shall submit a report to Congress containing an examination of issues affecting health care delivery in the United States, including issues relating to—

[(i) trends in health care costs;

[(ii) the financial condition of hospitals and the effect of the level of payments made to hospitals under this title on such condition;

[(iii) trends in the use of health care services; and

(iv) new methods used by employers, insurers, and others to constrain growth in health care costs.]

(3)[(A) The Commission, not later than the March 1 before the beginning of each fiscal year (beginning with fiscal year 1986), shall report its recommendations to Congress on an appropriate change factor which should be used for inpatient hospital services for discharges in that fiscal year, together with its general rec-

ommendations under paragraph (2)(B) regarding the effectiveness and quality of health care delivery systems in the United States.

[(B)] The Secretary, not later than April 1, 1987, for fiscal year 1988 and not later than March 1 before the beginning of each fiscal year (beginning with fiscal year 1989), shall report to the Congress the Secretary's initial estimate of the percentage change that the Secretary will recommend under paragraph (4) with respect to that fiscal year.

* * * * * * *

[(6)(A) The Commission shall consist of 17 individuals. Members of the Commission shall first be appointed no later than April 1, 1984, for a term of three years, except that the Director may provide initially for such shorter terms as will insure that (on a continuing basis) the terms of no more than seven members expire in any one year.

[(B) The membership of the Commission shall include individuals with national recognition for their expertise in health economics, health facility management, reimbursement of health facilities or other providers of services which reflect the scope of the Commission's responsibilities, and other related fields, who provide a mix of different professionals, broad geographic representation, and a balance between urban and rural representatives, including physicians and registered professional nurses, employers, third party payors, individuals skilled in the conduct and interpretation of biomedical, health services, and health economics research, and individuals having expertise in the research and development of technological and scientific advances in health care.

[(C) Subject to such review as the Office deems necessary to assure the efficient administration of the Commission, the Commission may—

[(i) employ and fix the compensation of an Executive Director (subject to the approval of the Director of the Office) and such other personnel (not to exceed 25) as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

[(ii) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

[(iii) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

[(iv) make advance, progress, and other payments which relate to the work of the Commission;

[(v) provide transportation and subsistence for persons serving without compensation; and

[(vi) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

Section 10(a)(1) of the Federal Advisory Committee Act shall not apply to any portion of a Commission meeting if the Commission, by majority vote, determines that such portion of such meeting should be closed.

[(D) While serving on the business of the Commission (including traveltime), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and his regular place of business, a member may be allowed travel expenses, as authorized by the Chairman of the Commission. Physicians serving as personnel of the Commission may be provided a physician comparability allowance by the Commission in the same manner as Government physicians may be provided such an allowance by an agency under section 5948 of title 5, United States Code, and for such purpose subsection (i) of such section shall apply to the Commission in the same manner as it applies to the Tennessee Valley Authority. For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

[(E) In order to identify medically appropriate patterns of health resources use in accordance with paragraph (2), the Commission shall collect and assess information on medical and surgical procedures and services, including information on regional variations of medical practice and lengths of hospitalization and on other patient-care data, giving special attention to treatment patterns for conditions which appear to involve excessively costly or inappropriate services not adding to the quality of care provided. In order to assess the safety, efficacy, and cost-effectiveness of new and existing medical and surgical procedures, the Commission shall, in coordination to the extent possible with the Secretary, collect and assess factual information, giving special attention to the needs of updating existing diagnosis-related groups, establishing new diagnosis-related groups, and making recommendations on relative weighting factors for such groups to reflect appropriate differences in resource consumption in delivering safe, efficacious, and cost-effective care. In collecting and assessing information, the Commission shall—

[(i) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this paragraph;

[(ii) carry out, or award grants or contracts for, original research and experimentation, including clinical research, where existing information is inadequate for the development of useful and valid guidelines by the Commission; and

[(iii) adopt procedures allowing any interested party to submit information with respect to medical and surgical procedures and services (including new practices, such as the use of new technologies and treatment modalities), which information the Commission shall consider in making reports and recommendations to the Secretary and Congress.

[(F) The Commission shall have access to such relevant information and data as may be available from appropriate Federal agencies and shall assure that its activities, especially the conduct of original research and medical studies, are coordinated with the activities of Federal agencies.

[(G)(i) The Office shall have unrestricted access to all deliberations, records, and data of the Commission, immediately upon its request.

[(ii) In order to carry out its duties under this paragraph, the Office is authorized to expend reasonable and neccessary funds as mutually agreed upon by the Office and the Commission. The Office shall be reimbursed for such funds by the Commission from the appropriations made with respect to the Commission.

[(H) The Commission shall be subject to periodic audit by the General Accounting Office.

[(I)(i) There are authorized to be appropriated such sums as may be necessary to carry out the provisions of this paragraph.

[(ii) Eighty-five percent of such appropriation shall be payable from the Federal Hospital Insurance Trust Fund, and 15 percent of such appropriation shall be payable from the Federal Supplementary Medical Insurance Trust Fund.

[(J) The Commission shall submit requests for appropriations in the same manner as the Office submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Office.]

* * * * * * *

(g)(1)(A) Notwithstanding section 1861(v), instead of any amounts that are otherwise payable under this title with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary shall, for hospital cost reporting periods beginning on or after October 1, 1991, provide for payments for such costs in accordance with a prospective payment system established by the Secretary. Aggregate payments made under subsection (d) and this subsection during fiscal years 1992 through [1995] *2002* shall be reduced in a manner that results in a reduction (as estimated by the Secretary) in the amount of such payments equal to a 10 percent reduction *(or a 15 percent reduction in the case of payments during fiscal years 1996 through 2002)* in the amount of payments attributable to capital-related costs that would otherwise have been made during such fiscal year had the amount of such payments been based on reasonable costs (as defined in section 1861(v)). For discharges occurring after September 30, 1993, the Secretary shall reduce by 7.4 percent the unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993) and shall (for hospital cost reporting periods beginning on or after October 1, 1993) redetermine which payment methodology is applied to the hospital under such system to take into account such reduction. *In addition to the reduction described in the preceding sentence, for discharges occurring after September 30, 1995, the Secretary shall reduce by 7.47 percent the unadjusted standard Federal capital payment rate (as described in 42 CFR 412.308(c), as in effect on the date of the enactment of the Medicare Preservation Act of 1995) and shall reduce by 8.27 percent the unadjusted hospital-specific rate (as described in 42 CFR 412.328(e)(1), as in effect on such date of enactment).*

(B) Such system—

(i) * * *

* * * * * * *

(iii) [may provide] *shall provide (in accordance with subparagraph (D))* for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and

(iv) may provide for suitable adjustment to reflect hospital occupancy rate.

(C)(i) For discharges occurring after September 30, 1995, such system shall provide for an adjustment in an amount equal to the amount determined under clause (iv) for capital-related tax costs for each hospital that is eligible for such adjustment.

(ii) Subject to clause (iii), a hospital is eligible for an adjustment under this subparagraph, with respect to discharges occurring in a fiscal year, if the hospital—

(I) is a hospital that may otherwise receive payments under this subsection,

(II) is not a public hospital, and

(III) incurs capital-related tax costs for the fiscal year.

(iii)(I) In the case of a hospital that first incurs capital-related tax costs in a fiscal year after fiscal year 1992 because of a change from nonproprietary to proprietary status or because the hospital commenced operation after such fiscal year, the first fiscal year for which the hospital shall be eligible for such adjustment is the second full fiscal year following the fiscal year in which the hospital first incurs such costs.

(II) In the case of a hospital that first incurs capital-related tax costs in a fiscal year after fiscal year 1992 because of a change in State or local tax laws, the first fiscal year for which the hospital shall be eligible for such adjustment is the fourth full fiscal year following the fiscal year in which the hospital first incurs such costs.

(iv) The per discharge adjustment under this clause shall be equal to the hospital-specific capital-related tax costs per discharge of a hospital for fiscal year 1992 (or, in the case of a hospital that first incurs capital-related tax costs for a fiscal year after fiscal year 1992, for the first full fiscal year for which such costs are incurred), updated to the fiscal year to which the adjustment applies. Such per discharge adjustment shall be added to the Federal capital rate, after such rate has been adjusted as described in 42 CFR 412.312 (as in effect on the date of the enactment of the Medicare Preservation Act of 1995), and before such rate is multiplied by the applicable Federal rate percentage.

(v) For purposes of this subparagraph, capital-related tax costs include—

(I) the costs of taxes on land and depreciable assets owned by a hospital (or related organization) and used for patient care,

(II) payments in lieu of such taxes (made by hospitals that are exempt from taxation), and

(III) the costs of taxes paid by a hospital (or related organization) as lessee of land, buildings, or fixed equipment from a lessor that is unrelated to the hospital (or related organization) under the terms of a lease that requires the lessee to pay all expenses (including mortgage, interest, and amortization) and

leaves the lessor with an amount free of all claims (sometimes referred to as a "net net net" or "triple net" lease).

In determining the adjustment required under clause (i), the Secretary shall not take into account any capital-related tax costs of a hospital to the extent that such costs are based on tax rates and assessments that exceed those for similar commercial properties.

(vi) The system shall provide that the Federal capital rate for any fiscal year after September 30, 1995, shall be reduced by a percentage sufficient to ensure that the adjustments required to be paid under clause (i) for a fiscal year neither increase nor decrease the total amount that would have been paid under this system but for the payment of such adjustments for such fiscal year.

(D) The exceptions under the system provided by the Secretary under subparagraph (B)(iii) shall include the provision of exception payments under the special exceptions process provided under 42 CFR 412.348(g) (as in effect on September 1, 1995), except that the Secretary shall revise such process as follows:

(i) A hospital with at least 100 beds which is located in an urban area shall be eligible under such process without regard to its disproportionate patient percentage under subsection (d)(5)(F) or whether it qualifies for additional payment amounts under such subsection.

(ii) The minimum payment level for qualifying hospitals shall be 85 percent.

(iii) A hospital shall be considered to meet the requirement that it completes the project involved no later than the end of the hospital's last cost reporting period beginning after October 1, 2001, if—

(I) the hospital has obtained a certificate of need for the project approved by the State or a local planning authority, and

(II) by September 1, 1995, the hospital has expended on the project at least $750,000 or 10 percent of the estimated cost of the project.

(iv) The amount of the exception payment made shall not be reduced by any offsetting amounts.

[(C)**]** *(E)* In this paragraph, the term "capital-related costs" has the meaning given such term by the Secretary under subsection (a)(4) as of September 30, 1987, and does not include a return on equity capital.

* * * * * * *

(4)(A) Except as provided in subparagraph (B), in determining the amount of the payments that may be made under this title with respect to all the capital-related costs of inpatient hospital services furnished during fiscal years 1996 through 2002 of a hospital which is not a subsection (d) hospital or a subsection (d) Puerto Rico hospital, the Secretary shall reduce the amounts of such payments otherwise determined under this title by 15 percent.

(B) Subparagraph (A) shall not apply to payments with respect to the capital-related costs of any hospital that is a sole community hospital (as defined in subsection (d)(5)(D)(iii) or a rural primary care hospital (as defined in section 1861(mm)(1)).

(h) PAYMENTS FOR DIRECT GRADUATE MEDICAL EDUCATION COSTS.—

(1) SUBSTITUTION OF SPECIAL PAYMENT RULES.—Notwithstanding section 1861(v), instead of any amounts that are otherwise payable under this title with respect to the reasonable costs of hospitals for direct graduate medical education costs, [the Secretary shall provide] *the Secretary shall, subject to paragraph (6), provide* for payments for such costs in accordance with paragraph (3) of this subsection. In providing for such payments, the Secretary shall provide for an allocation of such payments between part A and part B (and the trust funds established under the respective parts) as reasonably reflects the proportion of direct graduate medical education costs of hospitals associated with the provision of services under each respective part.

* * * * * * *

(4) DETERMINATION OF FULL-TIME-EQUIVALENT RESIDENTS.—

(A) * * *

* * * * * * *

[(C) WEIGHTING FACTORS FOR CERTAIN RESIDENTS.—Subject to subparagraph (D), such rules shall provide, in calculating the number of full-time-equivalent residents in an approved residency program—

[(i) before July 1, 1986, for each resident the weighting factor is 1.00,

[(ii) on or after July 1, 1986, for a resident who is in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is 1.00,

[(iii) on or after July 1, 1986, and before July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is .75, and

[(iv) on or after July 1, 1987, for a resident who is not in the resident's initial residency period (as defined in paragraph (5)(F)), the weighting factor is .50.]

(C) WEIGHTING FACTORS FOR RESIDENTS.—Effective for cost reporting periods beginning on or after October 1, 1997, such rules shall provide that, in the calculation of the number of full-time-equivalent residents in an approved residency program, the weighting factor for a resident who is in the initial residency period (as defined in paragraph (5)(F)) is 1.0 and the weighting factor for a resident who has completed such period is 0.0. (In the case of cost reporting periods beginning before October 1, 1997, the weighting factors that apply in such calculation are the weighting factors that were applicable under this subparagraph on the day before the date of the enactment of the Medicare Preservation Act of 1995.)

* * * * * * *

(F) LIMITATION ON NUMBER OF RESIDENTS FOR CERTAIN FISCAL YEARS.—Such rules shall provide that for purposes of a cost reporting period beginning on or after October 1, 1995, and on or before September 30, 2002, the number of full-time-equivalent residents determined under this para-

graph with respect to an approved medical residency training program may not exceed the number of full-time-equivalent residents with respect to the program as of August 1, 1995 (except that this subparagraph does not apply to any nonphysician teaching program that is approved for purposes of section 1861(b)(6) and that, under paragraph (5)(A), is an approved medical residency training program).

(G) SPECIAL RULES FOR ALIEN RESIDENTS.—In the case of individuals who are not citizens or nationals of the United States and who are not citizens of Canada, in the calculation of the number of full-time-equivalent residents in an approved medical residency program, the following rules shall apply with respect to such individuals who are residents in the program:

(i) For a cost reporting period beginning during fiscal year 1996, for each such individual the Secretary shall apply a weighting factor of .75.

(ii) For a cost reporting period beginning during fiscal year 1997, for each such individual the Secretary shall apply a weighting factor of .50.

(iii) For a cost reporting period beginning during fiscal year 1998, for each such individual the Secretary shall apply a weighting factor of .25.

(iv) For a cost reporting period beginning during fiscal year 1999 or any subsequent fiscal year, such individuals shall be excluded from the calculation of the number of full-time-equivalent residents in an approved medical residency program under this paragraph.

* * * * * * *

(6) LIMITATION.—

(A) IN GENERAL.—The authority to make payments under this subsection applies only with respect to cost reporting periods ending on or before September 30, 1996, except as provided in subparagraph (B).

(B) RULE REGARDING PORTION OF LAST COST REPORTING PERIOD.—In the case of a cost reporting period that extends beyond September 30, 1996, payments under this subsection shall be made with respect to such portion of the period as has lapsed as of such date.

(C) RULE OF CONSTRUCTION.—This paragraph may not be construed as authorizing any payment under section 1861(v) with respect to graduate medical education.

* * * * * * *

(j) TRANSFERS TO TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND.—

(1) INDIRECT COSTS OF MEDICAL EDUCATION.—

(A) IN GENERAL.—From the Federal Hospital Insurance Trust Fund, the Secretary shall, for fiscal year 1997 and each subsequent fiscal year, transfer to the Indirect-Costs Medical Education Account (under section 2201) an amount determined by the Secretary in accordance with subparagraph (B).

(B) DETERMINATION OF AMOUNTS.—The Secretary shall make an estimate for the fiscal year involved of the nationwide total of the amounts that would have been paid under subsection (d)(5)(B) to hospitals during the fiscal year if such payments had not been terminated for discharges occurring after September 30, 1996. For purposes of subparagraph (A), the amount determined under this subparagraph for the fiscal year is the estimate made by the Secretary under the preceding sentence.

(2) DIRECT COSTS OF MEDICAL EDUCATION.—

(A) IN GENERAL.—From the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, the Secretary shall, for fiscal year 1997 and each subsequent fiscal year, transfer to the Medicare Direct-Costs Medical Education Account (under section 2201) the sum of—

(i) an amount determined by the Secretary in accordance with subparagraph (B); and

(ii) as applicable, an amount determined by the Secretary in accordance with subparagraph (C)(ii).

(B) DETERMINATION OF AMOUNTS.—For each hospital (other than a hospital that is a member of a qualifying consortium referred to in subparagraph (C)), the Secretary shall make an estimate for the fiscal year involved of the amount that would have been paid under subsection (h) to the hospital during the fiscal year if such payments had not been terminated for cost reporting periods ending on or before September 30, 1996. For purposes of subparagraph (A)(i), the amount determined under this subparagraph for the fiscal year is the sum of all estimates made by the Secretary under the preceding sentence.

(C) ESTIMATES REGARDING QUALIFYING CONSORTIA.—If the Secretary elects to authorize one or more qualifying consortia for purposes of section 2233(a), the Secretary shall carry out the following:

(i) The Secretary shall establish a methodology for making payments to qualifying consortia with respect to the reasonable direct costs of such consortia in carrying out programs of graduate medical education. The methodology shall be the methodology established in subsection (h), modified to the extent necessary to take into account the participation in such programs of entities other than hospitals.

(ii) For each qualifying consortium, the Secretary shall make an estimate for the fiscal year involved of the amount that would have been paid to the consortium during the fiscal year if, using the methodology under clause (i), payments had been made to the consortium for the fiscal year as reimbursements with respect to cost reporting periods. For purposes of subparagraph (A)(ii), the amount determined under this clause for the fiscal year is the sum of all estimates made by the Secretary under the preceding sentence.

(D) ALLOCATION BETWEEN FUNDS.—In providing for a transfer under subparagraph (A) for a fiscal year, the Secretary shall provide for an allocation of the amounts involved between part A and part B (and the trust funds established under the respective parts) as reasonably reflects the proportion of direct graduate medical education costs of hospitals associated with the provision of services under each respective part.

(3) APPLICABILITY OF CERTAIN AMENDMENTS.—Amendments made to subsection (d)(5)(B) and subsection (h) that are effective on or after October 1, 1996, apply only for purposes of estimates under paragraphs (1) and (2) and for purposes of determining the amount of payments under 2211. Such amendments do not require any adjustment to amounts paid under subsection (d)(5)(B) or (h) with respect to fiscal year 1996 or any prior fiscal year.

(4) RELATIONSHIP TO CERTAIN DEMONSTRATION PROJECTS.—In the case of a State for which a demonstration project under section 1814(b)(3) is in effect, the Secretary, in making determinations of the rates of increase under such section, shall include all amounts transferred under this subsection. Such amounts shall be so included to the same extent and in the same manner as amounts determined under subsections (d)(5)(B) and (h) were included in such determination under the provisions of this title in effect on September 30, 1996.

* * * * * * *

PAYMENT TO SKILLED NURSING FACILITIES FOR ROUTINE SERVICE *AND CERTAIN ANCILLARY* COSTS

SEC. 1888. (a) The Secretary, in determining the amount of the payments which may be made under this title with respect to routine service costs of extended care services *(for any cost reporting period for which payment is made under this title to the skilled nursing facility for such services)* shall not recognize as reasonable (in the efficient delivery of health services) per diem costs of such services to the extent that such per diem costs exceed the following per diem limits, except as otherwise provided in this section:

(1) * * *

* * * * * * *

In applying this subsection the Secretary shall make appropriate adjustments to the labor related portion of the costs based upon an appropriate wage index, and shall, for cost reporting periods beginning on or after October 1, 1992, on or after October 1, 1995, and every 2 years thereafter, provide for an update to the per diem cost limits described in this subsection *(except that such updates may not take into account any changes in the routine service costs of skilled nursing facilities occurring during cost reporting periods which began during fiscal year 1994 or fiscal year 1995).*

* * * * * * *

[(c) The Secretary**]** *(c)(1) Subject to paragraph (2), the Secretary* may make adjustments in the limits set forth in subsection (a) with respect to any skilled nursing facility to the extent the Secretary

deems appropriate, based upon case mix or circumstances beyond the control of the facility. The Secretary shall publish the data and criteria to be used for purposes of this subsection on an annual basis[.], *and may only make adjustments under this subsection with respect to a facility which applies for an adjustment during an annual application period established by the Secretary.*

(2) The Secretary may not make any adjustments under this subsection in the limits set forth in subsection (a) for a cost reporting period beginning during a fiscal year to the extent that the total amount of the additional payments made under this title as a result of such adjustments is greater than an amount equal to—

(A) for cost reporting periods beginning during fiscal year 1997, the total amount of the additional payments made under this title as a result of adjustments under this subsection for cost reporting periods beginning during fiscal year 1996 increased by the SNF market basket percentage increase (as defined in section 1888A(e)(3)) for fiscal year 1997; and

(B) for cost reporting periods beginning during a subsequent fiscal year, the amount determined under this paragraph for the previous fiscal year increased by the SNF market basket percentage increase for such subsequent fiscal year.

* * * * * * *

(e) For purposes of this section, the "routine service costs" of a skilled nursing facility are all costs which are attributable to nursing services, room and board, administrative costs, other overhead costs, and all other ancillary services (including supplies and equipment), excluding costs attributable to covered non-routine services subject to payment limits under section 1888A.

INCENTIVES FOR COST-EFFECTIVE MANAGEMENT OF COVERED NON-ROUTINE SERVICES OF SKILLED NURSING FACILITIES

SEC. 1888A. (a) DEFINITIONS.—For purposes of this section:

(1) COVERED NON-ROUTINE SERVICES.—The term "covered non-routine services" means post-hospital extended care services consisting of any of the following:

(A) Physical or occupational therapy or speech-language pathology services, or respiratory therapy, including supplies and support services incident to such services and therapy.

(B) Prescription drugs.

(C) Complex medical equipment.

(D) Intravenous therapy and solutions (including enteral and parenteral nutrients, supplies, and equipment).

(E) Radiation therapy.

(F) Diagnostic services, including laboratory, radiology (including computerized tomography services and imaging services), and pulmonary services.

(2) SNF MARKET BASKET PERCENTAGE INCREASE.—The term "SNF market basket percentage increase" for a fiscal year means a percentage equal to the percentage increase in routine service cost limits for the year under section 1888(a).

(3) STAY.—The term "stay" means, with respect to an individual who is a resident of a skilled nursing facility, a period of

continuous days during which the facility provides extended care services for which payment may be made under this title with respect to the individual during the individual's spell of illness.

(b) NEW PAYMENT METHOD FOR COVERED NON-ROUTINE SERVICES.—

(1) IN GENERAL.—Subject to subsection (c), a skilled nursing facility shall receive interim payments under this title for covered non-routine services furnished to an individual during a cost reporting period beginning during a fiscal year (after fiscal year 1996) in an amount equal to the reasonable cost of providing such services in accordance with section 1861(v). The Secretary may adjust such payments if the Secretary determines (on the basis of such estimated information as the Secretary considers appropriate) that payments to the facility under this paragraph for a cost reporting period would substantially exceed the cost reporting period limit determined under subsection (c)(1)(B).

(2) RESPONSIBILITY OF SKILLED NURSING FACILITY TO MANAGE BILLINGS.—

(A) CLARIFICATION RELATING TO PART A BILLING.—In the case of a covered non-routine service furnished to an individual who (at the time the service is furnished) is a resident of a skilled nursing facility who is entitled to coverage under section 1812(a)(2) for such service, the skilled nursing facility shall submit a claim for payment under this title for such service under part A (without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise).

(B) PART B BILLING.—In the case of a covered non-routine service (other than a portable X-ray or portable electrocardiogram treated as a physician's service for purposes of section 1848(j)(3)) furnished to an individual who (at the time the service is furnished) is a resident of a skilled nursing facility who is not entitled to coverage under section 1812(a)(2) for such service but is entitled to coverage under part B for such service, the skilled nursing facility shall submit a claim for payment under this title for such service under part B (without regard to whether or not the item or service was furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise).

(C) MAINTAINING RECORDS ON SERVICES FURNISHED TO RESIDENTS.—Each skilled nursing facility receiving payments for extended care services under this title shall document on the facility's cost report all covered non-routine services furnished to all residents of the facility to whom the facility provided extended care services for which payment was made under part A during a fiscal year (beginning with fiscal year 1996) (without regard to whether or not the services were furnished by the facility, by others under arrangement with them made by the facility, under

any other contracting or consulting arrangement, or otherwise).

(c) RECONCILIATION OF AMOUNTS.—

(1) LIMIT BASED ON PER STAY LIMIT AND NUMBER OF STAYS.—

(A) IN GENERAL.—If a skilled nursing facility has received aggregate payments under subsection (b) for covered non-routine services during a cost reporting period beginning during a fiscal year in excess of an amount equal to the cost reporting period limit determined under subparagraph (B), the Secretary shall reduce the payments made to the facility with respect to such services for cost reporting periods beginning during the following fiscal year in an amount equal to such excess. The Secretary shall reduce payments under this subparagraph at such times and in such manner during a fiscal year as the Secretary finds necessary to meet the requirement of this subparagraph.

(B) COST REPORTING PERIOD LIMIT.—The cost reporting period limit determined under this subparagraph is an amount equal to the product of—

(i) the per stay limit applicable to the facility under subsection (d) for the period; and

(ii) the number of stays beginning during the period for which payment was made to the facility for such services.

(C) PROSPECTIVE REDUCTION IN PAYMENTS.—In addition to the process for reducing payments described in subparagraph (A), the Secretary may reduce payments made to a facility under this section during a cost reporting period if the Secretary determines (on the basis of such estimated information as the Secretary considers appropriate) that payments to the facility under this section for the period will substantially exceed the cost reporting period limit for the period determined under this paragraph.

(2) INCENTIVE PAYMENTS.—

(A) IN GENERAL.—If a skilled nursing facility has received aggregate payments under subsection (b) for covered non-routine services during a cost reporting period beginning during a fiscal year in an amount that is less than the amount determined under paragraph (1)(B), the Secretary shall pay the skilled nursing facility in the following fiscal year an incentive payment equal to 50 percent of the difference between such amounts, except that the incentive payment may not exceed 5 percent of the aggregate payments made to the facility under subsection (b) for the previous fiscal year (without regard to subparagraph (B)).

(B) INSTALLMENT INCENTIVE PAYMENTS.—The Secretary may make installment payments during a fiscal year to a skilled nursing facility based on the estimated incentive payment that the facility would be eligible to receive with respect to such fiscal year.

(d) DETERMINATION OF FACILITY PER STAY LIMIT.—

(1) LIMIT FOR FISCAL YEAR 1997.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the Secretary shall establish separate per stay limits

for hospital-based and freestanding skilled nursing facilities for the 12-month cost reporting period beginning during fiscal year 1997 that are equal to the sum of—

(i) 50 percent of the facility-specific stay amount for the facility (as determined under subsection (e)) for the last 12-month cost reporting period ending on or before September 30, 1994, increased (in a compounded manner) by the SNF market basket percentage increase for fiscal years 1995 through 1997; and

(ii) 50 percent of the average of all facility-specific stay amounts for all hospital-based facilities or all freestanding facilities (whichever is applicable) during the cost reporting period described in clause (i), increased (in a compounded manner) by the SNF market basket percentage increase for fiscal years 1995 through 1997.

(B) FACILITIES NOT HAVING 1994 COST REPORTING PERIOD.—In the case of a skilled nursing facility for which payments were not made under this title for covered non-routine services for the last 12-month cost reporting period ending on or before September 30, 1994, the per stay limit for the 12-month cost reporting period beginning during fiscal year 1997 shall be twice the amount determined under subparagraph (A)(ii).

(2) LIMIT FOR SUBSEQUENT FISCAL YEARS.—The per stay limit for a skilled nursing facility for a 12-month cost reporting period beginning during a fiscal year after fiscal year 1997 is equal to the per stay limit established under this subsection for the 12-month cost reporting period beginning during the previous fiscal year, increased by the SNF market basket percentage increase for such subsequent fiscal year minus 2 percentage points.

(3) REBASING OF AMOUNTS.—

(A) IN GENERAL.—The Secretary shall provide for an update to the facility-specific amounts used to determine the per stay limits under this subsection for cost reporting periods beginning on or after October 1, 1999, and every 2 years thereafter.

(B) TREATMENT OF FACILITIES NOT HAVING REBASED COST REPORTING PERIODS.—Paragraph (1)(B) shall apply with respect to a skilled nursing facility for which payments were not made under this title for covered non-routine services for the 12-month cost reporting period used by the Secretary to update facility-specific amounts under subparagraph (A) in the same manner as such paragraph applies with respect to a facility for which payments were not made under this title for covered non-routine services for the last 12-month cost reporting period ending on or before September 30, 1994.

(e) DETERMINATION OF FACILITY-SPECIFIC STAY AMOUNTS.—The "facility-specific stay amount" for a skilled nursing facility for a cost reporting period is the sum of—

(1) the average amount of payments made to the facility under part A during the period which are attributable to covered non-routine services furnished during a stay; and

(2) the Secretary's best estimate of the average amount of payments made under part B during the period for covered non-routine services furnished to all residents of the facility to whom the facility provided extended care services for which payment was made under part A during the period (without regard to whether or not the services were furnished by the facility, by others under arrangement with them made by the facility, under any other contracting or consulting arrangement, or otherwise), as estimated by the Secretary.

(f) INTENSIVE NURSING OR THERAPY NEEDS.—

(1) IN GENERAL.—In applying subsection (b) to covered non-routine services furnished during a stay beginning during a cost reporting period beginning during a fiscal year to a resident of a skilled nursing facility who requires intensive nursing or therapy services, the per stay limit determined for the fiscal year under the methodology for such resident shall be the per stay limit developed under paragraph (2) instead of the per stay limit determined under subsection (d)(1)(A).

(2) PER STAY LIMIT FOR INTENSIVE NEED RESIDENTS.—Not later than June 30, 1996, the Secretary, after consultation with the Medicare Payment Review Commission and skilled nursing facility experts, shall develop and publish a methodology for determining on an annual basis a per stay limit for residents of a skilled nursing facility who require intensive nursing or therapy services.

(3) BUDGET NEUTRALITY.—The Secretary shall adjust payments under subsection (b) in a manner that ensures that total payments for covered non-routine services under this section are not greater or less than total payments for such services would have been but for the application of paragraph (1).

(g) SPECIAL TREATMENT FOR MEDICARE LOW VOLUME SKILLED NURSING FACILITIES.—This section shall not apply with respect to a skilled nursing facility for which payment is made for routine service costs during a cost reporting period on the basis of prospective payments under section 1888(d).

(h) EXCEPTIONS AND ADJUSTMENTS TO LIMITS.—

(1) IN GENERAL.—The Secretary may make exceptions and adjustments to the cost reporting limits applicable to a skilled nursing facility under subsection (c)(1)(B) for a cost reporting period, except that the total amount of any additional payments made under this section for covered non-routine services during the cost reporting period as a result of such exceptions and adjustments may not exceed 5 percent of the aggregate payments made to all skilled nursing facilities for covered non-routine services during the cost reporting period (determined without regard to this paragraph).

(2) BUDGET NEUTRALITY.—The Secretary shall adjust payments under subsection (b) in a manner that ensures that total payments for covered non-routine services under this section are not greater or less than total payments for such services would have been but for the application of paragraph (1).

(i) SPECIAL RULE FOR X-RAY SERVICES.—Before furnishing a covered non-routine service consisting of an X-ray service for which payment may be made under part A or part B to a resident, a

skilled nursing facility shall consider whether furnishing the service through a provider of portable X-ray service services would be appropriate, taking into account the cost effectiveness of the service and the convenience to the resident.

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APPROPRIATIONS FOR COMBATING FRAUD AND ABUSE

SEC. 1893. (a) DIRECT SPENDING FOR PAYMENT SAFEGUARD ACTIVITIES.—

(1) IN GENERAL.—There are appropriated from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund for each fiscal year such amounts as are necessary to carry out the payment safeguard activities described in paragraph (2), subject to paragraph (3).

(2) ACTIVITIES DESCRIBED.—The payment safeguard activities described in this paragraph are as follows:

(A) Review of activities of providers of services or other individuals and entities furnishing items and services for which payment may be made under this title (including skilled nursing facilities and home health agencies), including medical and utilization review and fraud review.

(B) Audit of cost reports.

(C) Determinations as to whether payment should not be, or should not have been, made under this title by reason of section 1862(b), and recovery of payments that should not have been made.

(D) Education of providers of services, beneficiaries, and other persons with respect to payment integrity and benefit quality assurance issues.

(3) AMOUNTS SPECIFIED.—The amount appropriated under paragraph (1) for a fiscal year is as follows:

(A) For fiscal year 1996, such amount shall be not less than $430,000,000 and not more than $440,000,000.

(B) For fiscal year 1997, such amount shall be not less than $490,000,000 and not more than $500,000,000.

(C) For fiscal year 1998, such amount shall be not less than $550,000,000 and not more than $560,000,000.

(D) For fiscal year 1999, such amount shall be not less than $620,000,000 and not more than $630,000,000.

(E) For fiscal year 2000, such amount shall be not less than $670,000,000 and not more than $680,000,000.

(F) For fiscal year 2001, such amount shall be not less than $690,000,000 and not more than $700,000,000.

(G) For fiscal year 2002, such amount shall be not less than $710,000,000 and not more than $720,000,000.

(b) DIRECT SPENDING FOR MEDICARE-RELATED ACTIVITIES OF INSPECTOR GENERAL.—

(1) IN GENERAL.—There are appropriated from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to the Inspector General of the Department of Health and Human Services for each fiscal year such amounts as are necessary to enable the Inspector General

to carry out activities relating to the medicare program (as described in paragraph (2)), subject to paragraph (3).

(2) ACTIVITIES DESCRIBED.—The activities described in this paragraph are as follows:

(A) Prosecuting medicare-related matters through criminal, civil, and administrative proceedings.

(B) Conducting investigations relating to the medicare program.

(C) Performing financial and performance audits of programs and operations relating to the medicare program.

(D) Performing inspections and other evaluations relating to the medicare program.

(E) Conducting provider and conumer education activities regarding the requirements of this title.

(3) AMOUNTS SPECIFIED.—The amount appropriated under paragraph (1) for a fiscal year is as follows:

(A) For fiscal year 1996, such amount shall be $130,000,000.

(B) For fiscal year 1997, such amount shall be $181,000,000.

(C) For fiscal year 1998, such amount shall be $204,000,000.

(D) For each subsequent fiscal year, the amount appropriated for the previous fiscal year, increased by the percentage increase in aggregate expenditures under this title for the fiscal year involved over the previous fiscal year.

(c) ALLOCATION OF PAYMENTS AMONG TRUST FUNDS.—The appropriations made under subsection (a) and subsection (b) shall be in an allocation as reasonably reflects the proportion of such expenditures associated with part A and part B.

PAYMENT FOR HOME HEALTH SERVICES

SEC. 1894. (a) IN GENERAL.—

(1) PER VISIT PAYMENTS.—Subject to subsection (c), the Secretary shall make per visit payments beginning with fiscal year 1997 to a home health agency in accordance with this section for each type of home health service described in paragraph (2) furnished to an individual who at the time the service is furnished is under a plan of care by the home health agency under this title (without regard to whether or not the item or service was furnished by the agency or by others under arrangement with them made by the agency, or otherwise).

(2) TYPES OF SERVICES.—The types of home health services described in this paragraph are the following:

(A) Part-time or intermittent nursing care provided by or under the supervision of a registered professional nurse.

(B) Physical therapy.

(C) Occupational therapy.

(D) Speech-language pathology services.

(E) Medical social services under the direction of a physician.

(F) To the extent permitted in regulations, part-time or intermittent services of a home health aide who has suc-

cessfully completed a training program approved by the Secretary.

(b) ESTABLISHMENT OF PER VISIT RATE FOR EACH TYPE OF SERVICES.—

(1) IN GENERAL.—The Secretary shall, subject to paragraph (3), establish a per visit payment rate for a home health agency in an area for each type of home health service described in subsection (a)(2). Such rate shall be equal to the national per visit payment rate determined under paragraph (2) for each such type, except that the labor-related portion of such rate shall be adjusted by the area wage index applicable under section 1886(d)(3)(E) for the area in which the agency is located (as determined without regard to any reclassification of the area under section 1886(d)(8)(B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under section 1886(d)(10) for cost reporting periods beginning after October 1, 1995).

(2) NATIONAL PER VISIT PAYMENT RATE.—The national per visit payment rate for each type of service described in subsection (a)(2)—

(A) for fiscal year 1997, is an amount equal to the national average amount paid per visit under this title to home health agencies for such type of service during the most recent 12-month cost reporting period ending on or before June 30, 1994, increased (in a compounded manner) by the home health market basket percentage increase for fiscal years 1995, 1996, and 1997; and

(B) for each subsequent fiscal year, is an amount equal to the national per visit payment rate in effect for the preceding fiscal year, increased by the home health market basket percentage increase for such subsequent fiscal year minus 2 percentage points.

(3) REBASING OF RATES.—The Secretary shall provide for an update to the national per visit payment rates under this subsection for cost reporting periods beginning not later than the first day of the fifth fiscal year which begins after fiscal year 1997, and not later than every 5 years thereafter, to reflect the most recent available data.

(4) HOME HEALTH MARKET BASKET PERCENTAGE INCREASE.—For purposes of this subsection, the term "home health market basket percentage increase" means, with respect to a fiscal year, a percentage (estimated by the Secretary before the beginning of the fiscal year) determined and applied with respect to the types of home health services described in subsection (a)(2) in the same manner as the market basket percentage increase under section 1886(b)(3)(B)(iii) is determined and applied to inpatient hospital services for the fiscal year.

(c) PER EPISODE LIMIT.—

(1) AGGREGATE LIMIT.—

(A) IN GENERAL.—Except as provided in paragraph (2), a home health agency may not receive aggregate per visit payments under subsection (a) for a fiscal year in excess of an amount equal to the sum of the following products de-

termined for each case-mix category for which the agency receives payments:

(i) The number of episodes of each case-mix category during the fiscal year; multiplied by

(ii) the per episode limit determined for such case-mix category for such fiscal year.

(B) ESTABLISHMENT OF PER EPISODE LIMITS.—

(i) IN GENERAL.—The per episode limit for a fiscal year for any case-mix category for the area in which a home health agency is located is equal to—

(I) the mean number of visits for each type of home health service described in subsection (a)(2) furnished during an episode of such case-mix category in such area during fiscal year 1994, adjusted by the case-mix adjustment factor determined in clause (ii) for the fiscal year involved; multiplied by

(II) the per visit payment rate established under subsection (b) for such type of home health service for the fiscal year for which the determination is being made.

(ii) CASE MIX ADJUSTMENT FACTOR.—For purposes of clause (i), the case-mix adjustment factor for a year is the factor determined by the Secretary to assure that aggregate payments for home health services under this section during the year will not exceed the payment for such services during the previous year as a result of changes in the number and type of home health visits within case-mix categories over the previous year.

(iii) REBASING OF PER EPISODE AMOUNTS.—Beginning with fiscal year 1999 and every 2 years thereafter, the Secretary shall revise the mean number of home health visits determined under clause (i)(I) for each type of home health service visit described in subsection (a)(2) furnished during an episode in a case-mix category to reflect the most recently available data on the number of visits.

(iv) DETERMINATION OF APPLICABLE AREA.—For purposes of determining per episode limits under this subparagraph, the area in which a home health agency is considered to be located shall be such area as the Secretary finds appropriate for purposes of this subparagraph.

(C) CASE-MIX CATEGORY.—For purposes of this paragraph, the term "case-mix category" means each of the 18 case-mix categories established under the Phase II Home Health Agency Prospective Payment Demonstration Project conducted by the Health Care Financing Administration. The Secretary may develop an alternate methodology for determining case-mix categories.

(D) EPISODE.—

(i) IN GENERAL.—For purposes of this paragraph, the term "episode" means the continuous 120-day period that—

(I) begins on the date of an individual's first visit for a type of home health service described in subsection (a)(2) for a case-mix category, and

(II) is immediately preceded by a 60-day period in which the individual did not receive visits for a type of home health service described in subsection (a)(2).

(ii) TREATMENT OF EPISODES SPANNING COST REPORTING PERIODS.—The Secretary shall provide for such rules as the Secretary considers appropriate regarding the treatment of episodes under this paragraph which begin during a cost reporting period and end in a subsequent cost reporting period.

(E) EXEMPTIONS AND EXCEPTIONS.—The Secretary may provide for exemptions and exceptions to the limits established under this paragraph for a fiscal year as the Secretary deems appropriate, to the extent such exemptions and exceptions do not result in greater payments under this section than the exemptions and exceptions provided under section 1861(v)(1)(L)(ii) in fiscal year 1994, increased by the home health market basket percentage increase for the fiscal year involved (as defined in subsection (b)(4)).

(2) RECONCILIATION OF AMOUNTS.—

(A) OVERPAYMENTS TO HOME HEALTH AGENCIES.—Subject to subparagraph (B), if a home health agency has received aggregate per visit payments under subsection (a) for a fiscal year in excess of the amount determined under paragraph (1) with respect to such home health agency for such fiscal year, the Secretary shall reduce payments under this section to the home health agency in the following fiscal year in such manner as the Secretary considers appropriate (including on an installment basis) to recapture the amount of such excess.

(B) EXCEPTION FOR HOME HEALTH SERVICES FURNISHED OVER A PERIOD GREATER THAN 165 DAYS.—

(i) IN GENERAL.—For purposes of subparagraph (A), the amount of aggregate per visit payments determined under subsection (a) shall not include payments for home health visits furnished to an individual on or after a continuous period of more than 165 days after an individual begins an episode described in subsection (c)(1)(D) (if such period is not interrupted by the beginning of a new episode).

(ii) REQUIREMENT OF CERTIFICATION.—Clause (i) shall not apply if the agency has not obtained a physician's certification with respect to the individual requiring such visits that includes a statement that the individual requires such continued visits, the reason for the need for such visits, and a description of such services furnished during such visits.

(C) SHARE OF SAVINGS.—

(i) BONUS PAYMENTS.—If a home health agency has received aggregate per visit payments under subsection (a) for a fiscal year in an amount less than the amount

determined under paragraph (1) with respect to such home health agency for such fiscal year, the Secretary shall pay such home health agency a bonus payment equal to 50 percent of the difference between such amounts in the following fiscal year, except that the bonus payment may not exceed 5 percent of the aggregate per visit payments made to the agency for the year.

(ii) INSTALLMENT BONUS PAYMENTS.—The Secretary may make installment payments during a fiscal year to a home health agency based on the estimated bonus payment that the agency would be eligible to receive with respect to such fiscal year.

(d) MEDICAL REVIEW PROCESS.—The Secretary shall implement a medical review process (with a particular emphasis on fiscal years 1997 and 1998) for the system of payments described in this section that shall provide an assessment of the pattern of care furnished to individuals receiving home health services for which payments are made under this section to ensure that such individuals receive appropriate home health services. Such review process shall focus on low-cost cases described in subsection (e)(3) and cases described in subsection (c)(2)(B) and shall require recertification by intermediaries at 30, 60, 90, 120, and 165 days into an episode described in subsection (c)(1)(D).

(e) ADJUSTMENT OF PAYMENTS TO AVOID CIRCUMVENTION OF LIMITS.—

(1) IN GENERAL.—The Secretary shall provide for appropriate adjustments to payments to home health agencies under this section to ensure that agencies do not circumvent the purpose of this section by—

(A) discharging patients to another home health agency or similar provider;

(B) altering corporate structure or name to avoid being subject to this section or for the purpose of increasing payments under this title; or

(C) undertaking other actions considered unnecessary for effective patient care and intended to achieve maximum payments under this title.

(2) TRACKING OF PATIENTS THAT SWITCH HOME HEALTH AGENCIES DURING EPISODE.—

(A) DEVELOPMENT OF SYSTEM.—The Secretary shall develop a system that tracks home health patients that receive home health services described in subsection (a)(2) from more than 1 home health agency during an episode described in subsection (c)(1)(D).

(B) ADJUSTMENT OF PAYMENTS.—The Secretary shall adjust payments under this section to each home health agency that furnishes an individual with a type of home health service described in subsection (a)(2) to ensure that aggregate payments on behalf of such individual during such episode do not exceed the amount that would be paid under this section if the individual received such services from a single home health agency.

(3) LOW-COST CASES.—The Secretary shall develop a system designed to adjust payments to a home health agency for a fiscal year to eliminate any increase in growth of the percentage of low-cost episodes for which home health services are furnished by the agency over such percentage determined for the agency for the 12-month cost reporting period ending on June 30, 1994. The Secretary shall define a low-cost episode in a manner that provides that a home health agency has an incentive to be cost efficient in delivering home health services and that the volume of such services does not increase as a result of factors other than patient needs.

(f) REPORT BY MEDICARE PAYMENT REVIEW COMMISSION.—During the first 3 years in which payments are made under this section, the Medicare Payment Review Commission shall annually submit a report to Congress on the effectiveness of the payment methodology established under this section that shall include recommendations regarding the following:

(1) Case-mix and volume increases.

(2) Quality monitoring of home health agency practices.

(3) Whether a capitated payment for home care patients receiving care during a continuous period exceeding 165 days is warranted.

(4) Whether public providers of service are adequately reimbursed.

(5) The adequacy of the exemptions and exceptions to the limits provided under subsection (c)(1)(E).

(6) The appropriateness of the methods provided under this section to adjust the per episode limits and annual payment updates to reflect changes in the mix of services, number of visits, and assignment to case categories to reflect changing patterns of home health care.

(7) The geographic areas used to determine the per episode limits.

FAILSAFE BUDGET MECHANISM

SEC. 1895. (a) REQUIREMENT OF PAYMENT ADJUSTMENTS TO ACHIEVE MEDICARE BUDGET TARGETS.—If the Secretary determines under subsection (e)(3)(C) before a fiscal year (beginning with fiscal year 1998) that—

(1) the fee-for-service expenditures (as defined in subsection (f)) for a sector of medicare services (as defined in subsection (b)) for the fiscal year, will exceed

(2) the allotment specified under subsection (c)(2) for such fiscal year (taking into account any adjustment in the allotment under subsection (h) for that fiscal year),

then, notwithstanding any other provision of this title, there shall be an adjustment (consistent with subsection (d)) in applicable payment rates or payments for items and services included in the sector in the fiscal year so that such expenditures for the sector for the year will be reduced by 133⅓ percent of the amount of such excess.

(b) SECTORS OF MEDICARE SERVICES DESCRIBED.—

(1) IN GENERAL.—For purposes of this section, items and services included under each of the following subparagraphs shall be considered to be a separate "sector" of medicare services:

(A) Inpatient hospital services.

(B) Home health services.

(C) Extended care services (for inpatients of skilled nursing facilities).

(D) Hospice care.

(E) Physicians' services (including services and supplies described in section 1861(s)(2)(A)) and services of other health care professionals (including certified registered nurse anesthetists, nurse practitioners, physician assistants, and clinical psychologists) for which separate payment is made under this title.

(F) Outpatient hospital services and ambulatory facility services.

(G) Durable medical equipment and supplies, including prosthetic devices and orthotics.

(H) Diagnostic tests (including clinical laboratory services and x-ray services).

(I) Other items and services.

(2) CLASSIFICATION OF ITEMS AND SERVICES.—The Secretary shall classify each type of items and services covered and paid for separately under this title into one of the sectors specified in paragraph (1). After publication of such classification under subsection (e)(1), the Secretary is not authorized to make substantive changes in such classification.

(c) ALLOTMENT.—

(1) ALLOTMENTS FOR EACH SECTOR.—For purposes of this section, subject to subsection (h)(1), the allotment for a sector of medicare services for a fiscal year is equal to the product of—

(A) the total allotment for the fiscal year established under paragraph (2), and

(B) the allotment proportion (specified under paragraph (3)) for the sector and fiscal year involved.

(2) TOTAL ALLOTMENT.—

(A) IN GENERAL.—For purposes of this section, the total allotment for a fiscal year is equal to—

(i) the medicare benefit budget for the fiscal year (as specified under subparagraph (B)), reduced by

(ii) the amount of payments the Secretary estimates will be made in the fiscal year under the MedicarePlus program under part C.

In making the estimate under clause (ii), the Secretary shall take into account estimated enrollment and demographic profile of individuals electing MedicarePlus products.

(B) MEDICARE BENEFIT BUDGET.—For purposes of this subsection, subject to subparagraph (C), the "medicare benefit budget"—

(i) for fiscal year 1997 is $203.1 billion;

(ii) for fiscal year 1998 is $214.3 billion;

(iii) for fiscal year 1999 is $227.2 billion;

(iv) for fiscal year 2000 is $241.0 billion;

(v) for fiscal year 2001 is $259.1 billion;

(vi) for fiscal year 2002 is $280.0 billion; and

(vii) for a subsequent fiscal year is equal to the medicare benefit budget under this subparagraph for the preceding fiscal year increased by the product of (I) 1.05, and (II) 1 plus the annual percentage increase in the average number of medicare beneficiaries from the previous fiscal year to the fiscal year involved.

(3) MEDICARE ALLOTMENT PROPORTION DEFINED.—

(A) IN GENERAL.—For purposes of this section and with respect to a sector of medicare services for a fiscal year, the term "medicare allotment proportion" means the ratio of—

(i) the baseline-projected medicare expenditures (as determined under subparagraph (B)) for the sector for the fiscal year, to

(ii) the sum of such baseline expenditures for all such sectors for the fiscal year.

(B) BASELINE-PROJECTED MEDICARE EXPENDITURES.—In this paragraph, the "baseline-projected medicare expenditures" for a sector of medicare services—

(i) for fiscal year 1996 is equal to fee-for-service expenditures for such sector during fiscal year 1995, increased by the baseline annual growth rate for such sector of medicare services for fiscal year 1996 (as specified in table in subparagraph (C)); and

(ii) for a subsequent fiscal year is equal to the baseline-projected medicare expenditures under this subparagraph for the sector for the previous fiscal year increased by the baseline annual growth rate for such sector for the fiscal year involved (as specified in such table).

(C) BASELINE ANNUAL GROWTH RATES.—The following table specifies the baseline annual growth rates for each of the sectors for different fiscal years:

For the following sector—	*Baseline annual growth rates for fiscal year—*						
	1996	*1997*	*1998*	*1999*	*2000*	*2001*	*2002 and thereafter*
(A) Inpatient hospital services	*5.7%*	*5.6%*	*6.0%*	*6.1%*	*5.7%*	*5.5%*	*5.2%*
(B) Home health services	*17.2%*	*15.1%*	*11.7%*	*9.1%*	*8.4%*	*8.1%*	*7.9%*
(C) Extended care services	*19.7%*	*12.3%*	*9.3%*	*8.7%*	*8.6%*	*8.4%*	*8.0%*
(D) Hospice care	*32.0%*	*24.0%*	*18.0%*	*15.0%*	*12.0%*	*10.0%*	*9.0%*
(E) Physicians' services	*12.4%*	*9.7%*	*8.7%*	*9.0%*	*9.3%*	*9.6%*	*10.1%*
(F) Outpatient hospital services	*14.7%*	*13.9%*	*14.5%*	*15.0%*	*14.1%*	*13.9%*	*14.0%*
(G) Durable medical equipment and supplies	*16.1%*	*15.5%*	*13.7%*	*12.4%*	*13.2%*	*13.9%*	*14.5%*

For the following sector—	Baseline annual growth rates for fiscal year—						
	1996	1997	1998	1999	2000	2001	2002 and thereafter
(H) Diagnostic tests	13.1%	11.3%	11.0%	11.4%	11.4%	11.5%	11.9%
(I) Other items and services	11.2%	10.2%	10.9%	12.0%	11.6%	11.6%	11.8%

(d) MANNER OF PAYMENT ADJUSTMENT.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall apply a payment reduction for a sector for a fiscal year in such a manner as to—

(A) make a change in payment rates (to the maximum extent practicable) at the time payment rates are otherwise changed or subject to change for that fiscal year; and

(B) provide for the full appropriate adjustment so that the fee-for-service expenditures for the sector for the fiscal year will approximate (and not exceed) the allotment for the sector for the fiscal year.

(2) TAKING INTO ACCOUNT VOLUME AND CASH FLOW.—In providing for an adjustment in payments under this subsection for a sector for a fiscal year, the Secretary shall take into account (in a manner consistent with actuarial projections)—

(A) the impact of such an adjustment on the volume or type of services provided in such sector (and other sectors), and

(B) the fact that an adjustment may apply to items and services furnished in a fiscal year (payment for which may occur in a subsequent fiscal year),

in a manner that is consistent with assuring that total fee-for-services expenditures for each sector for the fiscal year will not exceed the allotment under subsection (c)(1) for such sector for such year.

(3) PROPORTIONALITY OF REDUCTIONS WITHIN A SECTOR.—In making adjustments under this subsection in payment for items and services included within a sector of medicare services for a fiscal year, the Secretary shall provide for such an adjustment that results (to the maximum extent feasible) in the same percentage reductions in aggregate Federal payments under parts A and B for the different classes of items and services included within the sector for the fiscal year.

(4) APPLICATION TO PAYMENTS MADE BASED ON PROSPECTIVE PAYMENT RATES DETERMINED ON A FISCAL YEAR BASIS.—

(A) IN GENERAL.—In applying subsection (a) with respect to items and services for which payment is made under part A or B on the basis of rates that are established on a prospective basis for (and in advance of) a fiscal year, the Secretary shall provide for the payment adjustment under such subsection through an appropriate reduction in such rates established for items and services furnished (or, in the case of payment for operating costs of inpatient hospital services of subsection (d) hospitals and subsection (d) Puer-

to Rico hospitals (as defined in paragraphs (1)(B) and (9)(A) of section 1886(d)), discharges occurring) during such year.

(B) DESCRIPTION OF APPLICATION TO SPECIFIC SERVICES.—The payment adjustment described in subparagraph (A) applies for a fiscal year to at least the following:

(i) UPDATE FACTOR FOR PAYMENT FOR OPERATING COSTS OF INPATIENT HOSPITAL SERVICES OF PPS HOSPITALS.—To the computation of the applicable percentage increase specified in section 1886(d)(3)(B)(i) for discharges occurring in the fiscal year.

(ii) HOME HEALTH SERVICES.—To the extent payment amounts for home health services are based on per visit payment rates under section 1894, to the computation of the increase in the national per visit payment rates established for the year under section 1894(b)(2)(B).

(iii) HOSPICE CARE.—To the update of payment rates for hospice care under section 1814(i) for services furnished during the fiscal year.

(iv) UPDATE FACTOR FOR PAYMENT OF OPERATING COSTS OF INPATIENT HOSPITAL SERVICES OF PPS-EXEMPT HOSPITALS.—To the computation of the target amount under section 1886(b)(3) for discharges occurring during the fiscal year.

(v) COVERED NON-ROUTINE SERVICES OF SKILLED NURSING FACILITIES.—To the computation of the facility per stay limits for the year under section 1888A(d) for covered non-routine services of a skilled nursing facility (as described in such section).

(5) APPLICATION TO PAYMENTS MADE BASED ON PROSPECTIVE PAYMENT RATES DETERMINED ON A CALENDAR YEAR BASIS.—

(A) IN GENERAL.—In applying subsection (a) for a fiscal year with respect to items and services for which payment is made under part A or B on the basis of rates that are established on a prospective basis for (and in advance of) a calendar year, the Secretary shall provide for the payment adjustment under such subsection through an appropriate reduction in such rates established for items and services furnished at any time during such calendar year as follows:

(i) For fiscal year 1997, the reduction shall be made for payment rates during calendar year 1997 in a manner so as to achieve the necessary payment reductions for such fiscal year for items and services furnished during the first 3 quarters of calendar year 1997.

(ii) For a subsequent fiscal year, the reduction shall be made for payment rates during the calendar year in which the fiscal year ends in a manner so as to achieve the necessary payment reductions for such fiscal year for items and services furnished during the first 3 quarters of the calendar year, but also taking into account the payment reductions made in the first quarter of the fiscal year resulting from payment reductions

made under this paragraph for the previous calendar year.

(iii) Payment rate reductions effected under this subparagraph for a calendar year and applicable to the last 3 quarters of the fiscal year in which the calendar year ends shall continue to apply during the first quarter of the succeeding fiscal year.

(B) APPLICATION IN SPECIFIC CASES.—The payment adjustment described in subparagraph (A) applies for a fiscal year to at least the following:

(i) UPDATE IN CONVERSION FACTOR FOR PHYSICIANS' SERVICES.—To the computation of the conversion factor under subsection (d) of section 1848 used in the fee schedule established under subsection (b) of such section, for items and services furnished during the calendar year in which the fiscal year ends.

(ii) PAYMENT RATES FOR OTHER HEALTH CARE PROFESSIONALS.—To the computation of payments for professional services of certified registered nurse anesthetists under section 1833(l), nurse midwives, physician assistants, nurse practitioners and clinical nurse specialists under section 1833(r), clinical psychologists, clinical social workers, physical or occupational therapists, and any other health professionals for which payment rates are based (in whole or in part) on payments for physicians' services, for services furnished during the calendar year in which the fiscal year ends.

(iii) UPDATE IN LAB FEE SCHEDULE.—To the computation of the fee schedule amount under section 1833(h)(2) for clinical diagnostic laboratory services furnished during the calendar year in which the fiscal year ends.

(iv) UPDATE IN REASONABLE CHARGES FOR VACCINES.—To the computation of the reasonable charge for vaccines described in section 1861(s)(10) for vaccines furnished during the calendar year in which the fiscal year ends.

(v) DURABLE MEDICAL EQUIPMENT-RELATED ITEMS.—To the computation of the payment basis under section 1834(a)(1)(B) for covered items described in section 1834(a)(13), for items furnished during the calendar year in which the fiscal year ends.

(vi) RADIOLOGIST SERVICES.—To the computation of conversion factors for radiologist services under section 1834(b), for services furnished during the calendar year in which the fiscal year ends.

(vii) SCREENING MAMMOGRAPHY.—To the computation of payment rates for screening mammography under section 1834(c)(1)(C)(ii), for screening mammography performed during the calendar year in which the fiscal year ends.

(viii) PROSTHETICS AND ORTHOTICS.—To the computation of the amount to be recognized under section 1834(h) for payment for prosthetic devices and

orthotics and prosthetics, for items furnished during the calendar year in which the fiscal year ends.

(ix) SURGICAL DRESSINGS.—To the computation of the payment amount referred to in section 1834(i)(1)(B) for surgical dressings, for items furnished during the calendar year in which the fiscal year ends.

(x) PARENTERAL AND ENTERAL NUTRITION.—To the computation of reasonable charge screens for payment for parenteral and enteral nutrition under section 1834(h), for nutrients furnished during the calendar year in which the fiscal year ends.

(xi) AMBULANCE SERVICES.—To the computation of limits on reasonable charges for ambulance services, for services furnished during the calendar year in which the fiscal year ends.

(6) APPLICATION TO PAYMENTS MADE BASED ON COSTS DURING A COST REPORTING PERIOD.—

(A) IN GENERAL.—In applying subsection (a) for a fiscal year with respect to items and services for which payment is made under part A or B on the basis of costs incurred for items and services in a cost reporting period, the Secretary shall provide for the payment adjustment under such subsection for a fiscal year through a appropriate proportional reduction in the payment for costs for such items and services incurred at any time during each cost reporting period any part of which occurs during the fiscal year involved, but only (for each such cost reporting period) in the same proportion as the fraction of the cost reporting period that occurs during the fiscal year involved.

(B) APPLICATION IN SPECIFIC CASES.—The payment adjustment described in subparagraph (A) applies for a fiscal year to at least the following:

(i) CAPITAL-RELATED COSTS OF HOSPITAL SERVICES.—To the computation of payment amounts for inpatient and outpatient hospital services under sections 1886(g) and 1861(v) for portions of cost reporting periods occurring during the fiscal year.

(ii) OPERATING COSTS FOR PPS-EXEMPT HOSPITALS.—To the computation of payment amounts under section 1886(b) for operating costs of inpatient hospital services of PPS-exempt hospitals for portions of cost reporting periods occurring during the fiscal year.

(iii) DIRECT GRADUATE MEDICAL EDUCATION.—To the computation of payment amounts under section 1886(h) for reasonable costs of direct graduate medical education costs for portions of cost reporting periods occurring during the fiscal year.

(iv) INPATIENT RURAL PRIMARY CARE HOSPITAL SERVICES.—To the computation of payment amounts under section 1814(j) for inpatient rural primary care hospital services for portions of cost reporting periods occurring during the fiscal year.

(v) EXTENDED CARE SERVICES OF A SKILLED NURSING FACILITY.—To the computation of payment amounts

under section 1861(v) for post-hospital extended care services of a skilled nursing facility (other than covered non-routine services subject to section 1888A) for portions of cost reporting periods occurring during the fiscal year.

(vi) REASONABLE COST CONTRACTS.—To the computation of payment amounts under section 1833(a)(1)(A) for organizations for portions of cost reporting periods occurring during the fiscal year.

(vii) HOME HEALTH SERVICES.—Subject to paragraph (4)(B)(ii), for payment amounts for home health services, for portions of cost reporting periods occurring during such fiscal year.

(7) OTHER.—In applying subsection (a) for a fiscal year with respect to items and services for which payment is made under part A or B on a basis not described in a previous paragraph of this subsection, the Secretary shall provide for the payment adjustment under such subsection through an appropriate proportional reduction in the payments (or payment bases for items and services furnished) during the fiscal year.

(8) ADJUSTMENT OF PAYMENT LIMITS.—The Secretary shall provide for such proportional adjustment in any limits on payment established under part A or B for payment for items and services within a sector as may be appropriate based on (and in order to properly carry out) the adjustment on the amount of payment under this subsection in the sector.

(9) REFERENCES TO PAYMENT RATES.—Except as the Secretary may provide, any reference in this title (other than this section) to a payment rate is deemed a reference to such a rate as adjusted under this subsection.

(e) PUBLICATION OF DETERMINATIONS; JUDICIAL REVIEW.—

(1) ONE-TIME PUBLICATION OF SECTORS AND GENERAL PAYMENT ADJUSTMENT METHODOLOGY.—Not later than October 1, 1996, the Secretary shall publish in the Federal Register the classification of medicare items and services into the sectors of medicare services under subsection (b) and the general methodology to be used in applying payment adjustments to the different classes of items and services within the sectors.

(2) INCLUSION OF INFORMATION IN PRESIDENT'S BUDGET.—

(A) IN GENERAL.—With respect to fiscal years beginning with fiscal year 1999, the President shall include in the budget submitted under section 1105 of title 31, United States Code, information on—

(i) the fee-for-service expenditures, within each sector, for the second previous fiscal year, and how such expenditures compare to the adjusted sector allotment for that sector for that fiscal year; and

(ii) actual annual growth rates for fee-for-service expenditures in the different sectors in the second previous fiscal year.

(B) RECOMMENDATIONS REGARDING GROWTH FACTORS.—The President may include in such budget for a fiscal year (beginning with fiscal year 1998) recommendations regarding percentages that should be applied (for one or more fis-

cal years beginning with that fiscal year) instead of the baseline annual growth rates under subsection (c)(3)(C). Such recommendations shall take into account medically appropriate practice patterns.

(3) DETERMINATIONS CONCERNING PAYMENT ADJUSTMENTS.—

(A) RECOMMENDATIONS OF COMMISSION.—By not later than March 1 of each year (beginning with 1997), the Medicare Payment Review Commission shall submit to the Secretary and the Congress a report that analyzes the previous operation (if any) of this section and that includes recommendations concerning the manner in which this section should be applied for the following fiscal year.

(B) PRELIMINARY NOTICE BY SECRETARY.—Not later than May 15 preceding the beginning of each fiscal year (beginning with fiscal year 1998), the Secretary shall publish in the Federal Register a notice containing the Secretary's preliminary determination, for each sector of medicare services, concerning the following:

(i) The projected allotment under subsection (c) for such sector for the fiscal year.

(ii) Whether there will be a payment adjustment for items and services included in such sector for the fiscal year under subsection (a).

(iii) If there will be such an adjustment, the size of such adjustment and the methodology to be used in making such a payment adjustment for classes of items and services included in such sector.

(iv) Beginning with fiscal year 1999, the fee-for-service expenditures for such sector for the second preceding fiscal year.

Such notice shall include an explanation of the basis for such determination. Determinations under this subparagraph and subparagraph (C) shall be based on the best data available at the time of such determinations.

(C) FINAL DETERMINATION.—Not later than September 1 preceding the beginning of each fiscal year (beginning with fiscal year 1998), the Secretary shall publish in the Federal Register a final determination, for each sector of medicare services, concerning the matters described in subparagraph (B) and an explanation of the reasons for any differences between such determination and the preliminary determination for such fiscal year published under subparagraph (B).

(4) LIMITATION ON ADMINISTRATIVE OR JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1878 or otherwise of—

(A) the classification of items and services among the sectors of medicare services under subsection (b),

(B) the determination of the amounts of allotments for the different sectors of medicare services under subsection (c),

(C) the determination of the amount (or method of application) of any payment adjustment under subsection (d), or

(D) any adjustment in an allotment effected under subsection (h).

(f) FEE-FOR-SERVICE EXPENDITURES DEFINED.—In this section, the term "fee-for-service expenditures", for items and services within a sector of medicare services in a fiscal year, means amounts payable for such items and services which are furnished during the fiscal year, and—

(1) includes types of expenses otherwise reimbursable under parts A and B (including administrative costs incurred by organizations described in sections 1816 and 1842) with respect to such items and services, and

(2) does not include amounts paid under part C.

(g) EXPEDITED PROCESS FOR ADJUSTMENT OF SECTOR GROWTH RATES.—

(1) OPTIONAL INCLUSION OF LEGISLATIVE PROPOSAL.—The President may include in recommendations under subsection (e)(2)(B) submitted with respect to a fiscal year a specific legislative proposal that provides only for the substitution of percentages specified in the proposal for one or more of the baseline annual growth rates (specified in the table in subsection (c)(3)(C) or in a previous legislative proposal under this subsection) for that fiscal year or any subsequent fiscal year.

(2) CONGRESSIONAL CONSIDERATION.—

(A) IN GENERAL.—The percentages contained in a legislative proposal submitted under paragraph (1) shall apply under this section if a joint resolution (described in subparagraph (B)) approving such proposal is enacted, in accordance with the provisions of subparagraph (C), before the end of the 60-day period beginning on the date on which such proposal was submitted. For purposes of applying the preceding sentence and subparagraphs (B) and (C), the days on which either House of Congress is not in session because of an adjournment of more than three days to a day certain shall be excluded in the computation of a period.

(B) JOINT RESOLUTION OF APPROVAL.—A joint resolution described in this subparagraph means only a joint resolution which is introduced within the 10-day period beginning on the date on which the President submits a proposal under paragraph (1) and—

(i) which does not have a preamble;

(ii) the matter after the resolving clause of which is as follows: "That Congress approves the proposal of the President providing for substitution of percentages for certain baseline annual growth rates under section 1895 of the Social Security Act, as submitted by the President on _____.", the blank space being filled in with the appropriate date; and

(iii) the title of which is as follows: "Joint resolution approving Presidential proposal to substitute certain specified percentages for baseline annual growth rates under section 1895 of the Social Security Act, as submitted by the President on _____.", the blank space being filled in with the appropriate date.

(C) PROCEDURES FOR CONSIDERATION OF RESOLUTION OF APPROVAL.—Subject to subparagraph (D), the provisions of section 2908 (other than subsection (a)) of the Defense Base Closure and Realignment Act of 1990 shall apply to the consideration of a joint resolution described in subparagraph (B) in the same manner as such provisions apply to a joint resolution described in section 2908(a) of such Act.

(D) SPECIAL RULES.—For purposes of applying subparagraph (C) with respect to such provisions—

(i) any reference to the Committee on Armed Services of the House of Representatives shall be deemed a reference to an appropriate Committee of the House of Representatives (specified by the Speaker of the House of Representatives at the time of submission of a legislative proposal under paragraph (1)) and any reference to the Committee on Armed Services of the Senate shall be deemed a reference to the Committee on Finance of the Senate; and

(ii) any reference to the date on which the President transmits a report shall be deemed a reference to the date on which the President submits the legislative proposal under paragraph (1).

(h) LOOK-BACK ADJUSTMENT IN ALLOTMENTS TO REFLECT ACTUAL EXPENDITURES.—

(1) IN GENERAL.—If the Secretary determines under subsection (e)(3)(B) with respect to a particular fiscal year (beginning with fiscal year 1999) that the fee-for-service expenditures for a sector of medicare services for the second preceding fiscal year—

(A) exceeded the adjusted allotment for such sector for such year (as defined in paragraph (2)), then the allotment for the sector for the particular fiscal year shall be reduced by 133⅓ percent of the amount of such excess, or

(B) was less than the adjusted allotment for such sector for such year, then the allotment for the sector for the particular fiscal year shall be increased by the amount of such deficit.

(2) ADJUSTED ALLOTMENT.—The adjusted allotment under this paragraph for a sector for a fiscal year is—

(A) the amount that would be computed as the allotment under subsection (c) for the sector for the fiscal year if the actual amount of payments made in the fiscal year under the MedicarePlus program under part C in the fiscal year were substituted for the amount described in subsection (c)(2)(A)(ii) for that fiscal year,

(B) adjusted to take into account the amount of any adjustment under paragraph (1) for that fiscal year (based on expenditures in the second previous fiscal year).

(i) PROSPECTIVE APPLICATION OF CERTAIN NATIONAL COVERAGE DETERMINATIONS.—In the case of a national coverage determination that the Secretary projects will result in significant additional expenditures under this title (taking into account any substitution for existing procedures or technologies), such determination shall not become effective before the beginning of the fiscal year that begins

after the date of such determination and shall apply to contracts under part C entered into (or renewed) after the date of such determination.

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TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

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STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;

* * * * * * *

(25) provide—

(A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, and health maintenance organizations) to pay for care and services available under the plan, including—

(i) the collection of sufficient information ([including the use of information collected by the Medicare and Medicaid Coverage Data Bank under section 1144 and any additional measures] as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and

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TITLE XXII—TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND

PART A—ESTABLISHMENT OF FUND

SEC. 2201. ESTABLISHMENT OF FUND.

(a) IN GENERAL.—There is established in the Treasury of the United States a fund to be known as the Teaching Hospital and Graduate Medical Education Trust Fund (in this title referred to as the "Fund"), consisting of amounts appropriated to the Fund in subsection (d) and subsection (e)(3), amounts transferred to the Fund under section 1886(j), and such gifts and bequests as may be deposited in the Fund pursuant to subsection (f). Amounts in the Fund are available until expended.

(b) EXPENDITURES FROM FUND.—Amounts in the Fund are available to the Secretary for making payments under section 2211.

(c) ACCOUNTS IN FUND.—There are established within the Fund the following accounts:

(1) The Indirect-Costs Medical Education Account.

(2) The Medicare Direct-Costs Medical Education Account.

(3) The General Direct-Costs Medical Education Account.

(d) GENERAL TRANSFERS TO FUND.—

(1) IN GENERAL.—For fiscal year 1997 and each subsequent fiscal year, there are appropriated to the Fund (effective on the applicable date under paragraph (2)), out of any money in the Treasury not otherwise appropriated, the following amounts (as applicable to the fiscal year involved):

(A) For fiscal year 1997, $400,000,000.

(B) For fiscal year 1998, $600,000,000.

(C) For fiscal year 1999, $2,000,000,000.

(D) For fiscal year 2000, $3,000,000,000.

(E) For fiscal year 2001, $4,000,000,000.

(F) For fiscal year 2002, $5,800,000,000.

(G) For fiscal year 2003 and each subsequent fiscal year, the greater of the amount appropriated for the preceding fiscal year or an amount equal to the product of—

(i) the amount appropriated for the preceding fiscal year; and

(ii) 1 plus the percentage increase in the nominal gross domestic product for the one-year period ending upon July 1 of such preceding fiscal year.

(2) EFFECTIVE DATE FOR ANNUAL APPROPRIATION.—For purposes of paragraph (1) (and for purposes of section 2221(a)(1), and subsections (b)(1)(A) and (c)(1)(A) of section 2231)), the applicable date for a fiscal year is the first day of the fiscal year, exclusive of Saturdays, Sundays, and Federal holidays.

(3) ALLOCATION AMONG CERTAIN ACCOUNTS.—Of the amount appropriated in paragraph (1) for a fiscal year—

(A) there shall be allocated to the Indirect-Costs Medical Education Account the percentage determined under paragraph (4)(B); and

(B) there shall be allocated to the General Direct-Costs Medical Education Account the percentage determined under paragraph (4)(C).

(4) DETERMINATION OF PERCENTAGES.—The Secretary of Health and Human Services, acting through the Administrator of the Health Care Financing Administration, shall determine the following:

(A) The total amount of payments that were made under subsections (d)(5)(B) and (h) of section 1886 for fiscal year 1994.

(B) The percentage of such total that was constituted by payments under subsection (d)(5)(B) of such section.

(C) The percentage of such total that was constituted by payments under subsection (h) of such section.

(e) INVESTMENT.—

(1) IN GENERAL.—The Secretary of the Treasury shall invest such amounts of the Fund as such Secretary determines are not required to meet current withdrawals from the Fund. Such investments may be made only in interest-bearing obligations of the United States. For such purpose, such obligations may be acquired on original issue at the issue price, or by purchase of outstanding obligations at the market price.

(2) SALE OF OBLIGATIONS.—Any obligation acquired by the Fund may be sold by the Secretary of the Treasury at the market price.

(3) AVAILABILITY OF INCOME.—Any interest derived from obligations acquired by the Fund, and proceeds from any sale or redemption of such obligations, are hereby appropriated to the Fund.

(f) ACCEPTANCE OF GIFTS AND BEQUESTS.—The Fund may accept on behalf of the United States money gifts and bequests made unconditionally to the Fund for the benefit of the Fund or any activity financed through the Fund.

PART B—PAYMENTS TO TEACHING HOSPITALS

Subpart 1—Requirement of Payments

SEC. 2211. FORMULA PAYMENTS TO TEACHING HOSPITALS.

(a) IN GENERAL.—Subject to subsection (d), in the case of each teaching hospital that in accordance with subsection (b) submits to the Secretary a payment document for fiscal year 1997 or any subsequent fiscal year, the Secretary shall make payments for the year to the teaching hospital for the costs of operating approved medical residency training programs. Such payments shall be made from the Fund, and the total of the payments to the hospital for the fiscal year shall equal the sum of the following:

(1) An amount determined under section 2221 (relating to the indirect costs of graduate medical education).

(2) An amount determined under section 2231 (relating to the direct costs of graduate medical education).

(b) PAYMENT DOCUMENT.—For purposes of subsection (a), a payment document is a document containing such information as may be necessary for the Secretary to make payments under such subsection to a teaching hospital for a fiscal year. The document is submitted in accordance with this subsection if the document is submitted not later than the date specified by the Secretary, and the document is in such form and is made in such manner as the Secretary may require. The Secretary may require that information under this subsection be submitted to the Secretary in periodic reports.

(c) ADMINISTRATOR OF PROGRAMS.—This part, and the subsequent parts of this title, shall be carried out by the Secretary acting through the Administrator of the Health Care Financing Administration.

(d) SPECIAL RULES.—

(1) AUTHORITY REGARDING PAYMENTS TO CONSORTIA OF PROVIDERS.—In the case of payments under subsection (a) that are determined under section 2231:

(A) The requirement under such subsection to make the payments to teaching hospitals is subject to the authority of the Secretary under section 2233(a) to make payments to qualifying consortia.

(B) If the Secretary authorizes such a consortium for purposes of section 2233(a), subsections (a) and (b) of this section apply to the consortium to the same extent and in the same manner as the subsections apply to teaching hospitals.

(2) CERTAIN HOSPITALS.—Paragraph (1) of subsection (a) is subject to sections 2222 and 2223 of subpart 2. Paragraph (2) of subsection (a) is subject to sections 2232 through 2234 of subpart 3.

(e) APPROVED MEDICAL RESIDENCY TRAINING PROGRAM.—For purposes of this title, the term "approved medical residency training program" has the meaning given such term in section 1886(h)(5)(A).

Subpart 2—Amount Relating to Indirect Costs of Graduate Medical Education

SEC. 2221. DETERMINATION OF AMOUNT RELATING TO INDIRECT COSTS.

(a) IN GENERAL.—For purposes of section 2211(a)(1), the amount determined under this section for a teaching hospital for a fiscal year is the product of—

(1) the amount in the Indirect-Costs Medical Education Account on the applicable date under section 2201(d) (once the appropriation under such section is made); and

(2) the percentage determined for the hospital under subsection (b).

(b) HOSPITAL-SPECIFIC PERCENTAGE.—

(1) IN GENERAL.—For purposes of subsection (a)(2), the percentage determined under this subsection for a teaching hospital is the mean average of the respective percentages determined under paragraph (3) for each fiscal year of the applicable period (as defined in paragraph (2)), adjusted by the Secretary (upward or downward, as the case may be) on a pro rata basis to the extent necessary to ensure that the sum of the percentages determined under this paragraph for all teaching hospitals is equal to 100 percent. The preceding sentence is subject to sections 2222 and 2223.

(2) APPLICABLE PERIOD REGARDING RELEVANT DATA; FISCAL YEARS 1992 THROUGH 1994.—For purposes of this part, the term "applicable period" means the period beginning on the first day of fiscal year 1992 and continuing through the end of fiscal year 1994.

(3) RESPECTIVE DETERMINATIONS FOR FISCAL YEARS OF APPLICABLE PERIOD.—For purposes of paragraph (1), the percentage determined under this paragraph for a teaching hospital for a fiscal year of the applicable period is the percentage constituted by the ratio of—

(A) the total amount of payments received by the hospital under section 1886(d)(5)(B) for discharges occurring during the fiscal year involved; to

(B) the sum of the respective amounts determined under subparagraph (A) for the fiscal year for all teaching hospitals.

(c) AVAILABILITY OF DATA.—If a teaching hospital received the payments specified in subsection (b)(3)(A) during the applicable period but a complete set of the relevant data is not available to the Secretary for purposes of determining an amount under such subsection for the fiscal year involved, the Secretary shall for purposes of such subsection make an estimate on the basis of such data as are available to the Secretary for the applicable period.

SEC. 2222. INDIRECT COSTS; SPECIAL RULES REGARDING DETERMINATION OF HOSPITAL-SPECIFIC PERCENTAGE.

(a) SPECIAL RULE REGARDING FISCAL YEARS 1995 AND 1996.—

(1) IN GENERAL.—In the case of a teaching hospital whose first payments under 1886(d)(5)(B) were for discharges occurring in fiscal year 1995 or in fiscal year 1996 (referred to in this subsection individually as a "first payment year"), the percentage determined under paragraph (2) for the hospital is deemed to be the percentage applicable under section 2221(b) to the hospital, except that the percentage under paragraph (2) shall be adjusted in accordance with section 2221(b)(1) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent.

(2) DETERMINATION OF PERCENTAGE.—For purposes of paragraph (1), the percentage determined under this paragraph for a teaching hospital is the percentage constituted by the ratio of the amount determined under subparagraph (A) to the amount determined under subparagraph (B), as follows:

(A)(i) If the first payment year for the hospital is fiscal year 1995, the amount determined under this subparagraph is the total amount of payments received by the hospital under section 1886(d)(5)(B) for discharges occurring during fiscal year 1995.

(ii) If the first payment year for the hospital is fiscal year 1996, the amount determined under this subparagraph is an amount equal to an estimate by the Secretary of the total amount of payments that would have been paid to the hospital under section 1886(d)(5)(B) for discharges occurring during fiscal year 1995 if such section, as in effect for fiscal year 1996, had applied to the hospital for discharges occurring during fiscal year 1995.

(B)(i) If the first payment year for the hospital is fiscal year 1995, the amount determined under this subparagraph is the aggregate total of the payments received by teaching hospitals under section 1886(d)(5)(B) for discharges occurring during fiscal year 1995.

(ii) If the first payment year for the hospital is fiscal year 1996—

(I) the Secretary shall make an estimate in accordance with subparagraph (A)(ii) for all teaching hospitals; and

(II) the amount determined under this subparagraph is the sum of the estimates made by the Secretary under subclause (I).

(b) NEW TEACHING HOSPITALS.—

(1) IN GENERAL.—In the case of a teaching hospital that did not receive payments under section 1886(d)(5)(B) for any of the fiscal years 1992 through 1996, the percentage determined under paragraph (3) for the hospital is deemed to be the percentage applicable under section 2221(b) to the hospital, except that the percentage under paragraph (3) shall be adjusted in accordance with section 2221(b)(1) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent. This subsection does not apply to a teaching hos-

pital described in the preceding sentence if the hospital is in a State for which a demonstration project under section 1814(b)(3) is in effect.

(2) DESIGNATED FISCAL YEAR REGARDING DATA.—The determination under paragraph (3) of a percentage for a teaching hospital described in paragraph (1) shall be made for the most recent fiscal year for which the Secretary has sufficient data to make the determination (referred to in this subsection as the "designated fiscal year").

(3) DETERMINATION OF PERCENTAGE.—For purposes of paragraph (1), the percentage determined under this paragraph for the teaching hospital involved is the percentage constituted by the ratio of the amount determined under subparagraph (A) to the amount determined under subparagraph (B), as follows:

(A) The amount determined under this subparagraph is an amount equal to an estimate by the Secretary of the total amount of payments that would have been paid to the hospital under section 1886(d)(5)(B) for the designated fiscal year if such section, as in effect for the first fiscal year for which payments pursuant to this subsection are to be made to the hospital, had applied to the hospital for the designated fiscal year.

(B) The Secretary shall make an estimate in accordance with subparagraph (A) for all teaching hospitals. The amount determined under this subparagraph is the sum of the estimates made by the Secretary under the preceding sentence.

(c) CONSOLIDATIONS AND MERGERS.—In the case of two or more teaching hospitals that have each received payments pursuant to section 2221 for one or more fiscal years and that undergo a consolidation or merger, the percentage applicable to the resulting teaching hospital for purposes of section 2221(b) is the sum of the respective percentages that would have applied pursuant to such section if the hospitals had not undergone the consolidation or merger.

SEC. 2223. INDIRECT COSTS; ALTERNATIVE PAYMENTS REGARDING TEACHING HOSPITALS IN CERTAIN STATES.

(a) IN GENERAL.—In the case of a teaching hospital in a State for which a demonstration project under section 1814(b)(3) is in effect, this section applies in lieu of section 2221. For purposes of section 2211(a)(1), the amount determined for a teaching hospital for a fiscal year is the product of—

(1) the amount in the Indirect-Costs Medical Education Account for the fiscal year pursuant to the allocation under section 2201(d)(3)(A) for the year; and

(2) the percentage determined under subsection (b) for the hospital.

(b) DETERMINATION OF PERCENTAGE.—For purposes of subsection (a)(2):

(1) The Secretary shall make an estimate of the total amount of payments that would have been received under section 1886(d)(5)(B) by the hospital involved with respect to each of the fiscal years of the applicable period if such section (as in effect for such fiscal years) had applied to the hospital for such years.

(2) The percentage determined under this subsection for the hospital for a fiscal year is a mean average percentage determined for the hospital in accordance with the methodology of section 2221(b)(1), except that the estimate made by the Secretary under paragraph (1) of this subsection for a fiscal year of the applicable period is deemed to be the amount that applies for purposes of section 2221(b)(3)(A) for such year.

(c) RULE REGARDING PAYMENTS FROM CERTAIN AMOUNTS.—In the case of a teaching hospital in a State for which a demonstration project under section 1814(b)(3) is in effect, this section does not provide any payment to the hospital from amounts transferred to the Fund under section 1886(j).

(d) ADJUSTMENT REGARDING PAYMENTS TO OTHER HOSPITALS.—In the case of a fiscal year for which payments pursuant to subsection (a) are made to one or more teaching hospitals, the following applies:

(1) The Secretary shall determine a percentage equal to the sum of the respective percentages determined for the hospitals under subsection (b).

(2) The Secretary shall determine an amount equal to the product of—

(A) the percentage determined under paragraph (1); and

(B) the amount in the Indirect-Costs Medical Education Account for the fiscal year pursuant to the transfer under section 1886(j)(1).

(3) The Secretary shall, for each hospital (other than hospitals described in subsection (a)), make payments to the hospital whose sum is equal to the product of—

(A) the amount determined under paragraph (2); and

(B) the percentage that applies to the hospital for purposes of section 2221(b), except that such percentage shall be adjusted in accordance with the methodology of section 2221(b)(1) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent.

Subpart 3—Amount Relating to Direct Costs of Graduate Medical Education

SEC. 2231. DETERMINATION OF AMOUNT RELATING TO DIRECT COSTS.

(a) IN GENERAL.—For purposes of section 2211(a)(2), the amount determined under this section for a teaching hospital for a fiscal year is the sum of—

(1) the amount determined under subsection (b) (relating to the General Direct-Costs Medical Education Account); and

(2) the amount determined under subsection (c) (relating to the Medicare Direct-Costs Medical Education Account).

(b) PAYMENT FROM GENERAL ACCOUNT.—

(1) IN GENERAL.—For purposes of subsection (a)(1), the amount determined under this subsection for a teaching hospital for a fiscal year is the product of—

(A) the amount in the General Direct-Costs Medical Education Account on the applicable date under section 2201(d) (once the appropriation under such section is made); and

(B) the percentage determined for the hospital under paragraph (2).

(2) HOSPITAL-SPECIFIC PERCENTAGE.—

(A) IN GENERAL.—For purposes of paragraph (1)(B), the percentage determined under this paragraph for a teaching hospital is the mean average of the respective percentages determined under subparagraph (B) for each fiscal year of the applicable period (as defined in section 2221(b)(2)), adjusted by the Secretary (upward or downward, as the case may be) on a pro rata basis to the extent necessary to ensure that the sum of the percentages determined under this subparagraph for all teaching hospitals is equal to 100 percent. The preceding sentence is subject to sections 2232 through 2234.

(B) RESPECTIVE DETERMINATIONS FOR FISCAL YEARS OF APPLICABLE PERIOD.—For purposes of subparagraph (A), the percentage determined under this subparagraph for a teaching hospital for a fiscal year of the applicable period is the percentage constituted by the ratio of—

(i) the total amount of payments received by the hospital under section 1886(h) for cost reporting periods beginning during the fiscal year involved; to

(ii) the sum of the respective amounts determined under clause (i) for the fiscal year for all teaching hospitals.

(3) AVAILABILITY OF DATA.—If a teaching hospital received the payments specified in paragraph (2)(B)(i) during the applicable period but a complete set of the relevant data is not available to the Secretary for purposes of determining an amount under such paragraph for the fiscal year involved, the Secretary shall for purposes of such paragraph make an estimate on the basis of such data as are available to the Secretary for the applicable period.

(c) PAYMENT FROM MEDICARE ACCOUNT.—

(1) IN GENERAL.—For purposes of subsection (a)(2), the amount determined under this subsection for a teaching hospital for a fiscal year is the product of—

(A) the amount in the Medicare Direct-Costs Medical Education Account on the applicable date under section 2201(d) (once the appropriation under such section is made); and

(B) the percentage determined for the hospital under paragraph (2).

(2) HOSPITAL-SPECIFIC PERCENTAGE.—For purposes of paragraph (1)(B), the percentage determined under this subsection for a teaching hospital for a fiscal year is the percentage constituted by the ratio of—

(A) the estimate made by the Secretary for the hospital for the fiscal year under section 1886(j)(2)(B); to

(B) the sum of the respective estimates referred to in subparagraph (A) for all teaching hospitals.

SEC. 2232. DIRECT COSTS; SPECIAL RULES REGARDING DETERMINATION OF HOSPITAL-SPECIFIC PERCENTAGE.

(a) SPECIAL RULE REGARDING FISCAL YEARS 1995 AND 1996.—

(1) IN GENERAL.—In the case of a teaching hospital whose first payments under 1886(h) were for cost reporting period beginning in fiscal year 1995 or in fiscal year 1996 (referred to

in this subsection individually as a "first payment year"), the percentage determined under paragraph (2) for the hospital is deemed to be the percentage applicable under section 2231(b)(2) to the hospital, except that the percentage under paragraph (2) shall be adjusted in accordance with section 2231(b)(2)(A) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent.

(2) DETERMINATION OF PERCENTAGE.—For purposes of paragraph (1), the percentage determined under this paragraph for a teaching hospital is the percentage constituted by the ratio of the amount determined under subparagraph (A) to the amount determined under subparagraph (B), as follows:

(A)(i) If the first payment year for the hospital is fiscal year 1995, the amount determined under this subparagraph is the total amount of payments received by the hospital under section 1886(h) for cost reporting periods beginning in fiscal year 1995.

(ii) If the first payment year for the hospital is fiscal year 1996, the amount determined under this subparagraph is an amount equal to an estimate by the Secretary of the total amount of payments that would have been paid to the hospital under section 1886(h) for cost reporting periods beginning in fiscal year 1995 if such section, as in effect for fiscal year 1996, had applied to the hospital for fiscal year 1995.

(B)(i) If the first payment year for the hospital is fiscal year 1995, the amount determined under this subparagraph is the aggregate total of the payments received by teaching hospitals under section 1886(h) for cost reporting periods beginning in fiscal year 1995.

(ii) If the first payment year for the hospital is fiscal year 1996—

(I) the Secretary shall make an estimate in accordance with subparagraph (A)(ii) for all teaching hospitals; and

(II) the amount determined under this subparagraph is the sum of the estimates made by the Secretary under subclause (I).

(b) NEW TEACHING HOSPITALS.—

(1) IN GENERAL.—In the case of a teaching hospital that did not receive payments under section 1886(h) for any of the fiscal years 1992 through 1996, the percentage determined under paragraph (3) for the hospital is deemed to be the percentage applicable under section 2231(b)(2) to the hospital, except that the percentage under paragraph (3) shall be adjusted in accordance with section 2231(b)(2)(A) to the extent determined by the Secretary to be necessary with respect to a sum that equals 100 percent. This subsection does not apply to a teaching hospital described in the preceding sentence if the hospital is in a State for which a demonstration project under section 1814(b)(3) is in effect.

(2) DESIGNATED FISCAL YEAR REGARDING DATA.—The determination under paragraph (3) of a percentage for a teaching hospital described in paragraph (1) shall be made for the most

recent fiscal year for which the Secretary has sufficient data to make the determination (referred to in this subsection as the "designated fiscal year").

(3) DETERMINATION OF PERCENTAGE.—For purposes of paragraph (1), the percentage determined under this paragraph for the teaching hospital involved is the percentage constituted by the ratio of the amount determined under subparagraph (A) to the amount determined under subparagraph (B), as follows:

(A) The amount determined under this subparagraph is an amount equal to an estimate by the Secretary of the total amount of payments that would have been paid to the hospital under section 1886(h) for the designated fiscal year if such section, as in effect for the first fiscal year for which payments pursuant to this subsection are to be made to the hospital, had applied to the hospital for cost reporting periods beginning in the designated fiscal year.

(B) The Secretary shall make an estimate in accordance with subparagraph (A) for all teaching hospitals. The amount determined under this subparagraph is the sum of the estimates made by the Secretary under the preceding sentence.

(c) CONSOLIDATIONS AND MERGERS.—In the case of two or more teaching hospitals that have each received payments pursuant to section 2231 for one or more fiscal years and that undergo a consolidation or merger, the percentage applicable to the resulting teaching hospital for purposes of section 2231(b) is the sum of the respective percentages that would have applied pursuant to such section if the hospitals had not undergone the consolidation or merger.

SEC. 2233. DIRECT COSTS; AUTHORITY FOR PAYMENTS TO CONSORTIA OF PROVIDERS.

(a) IN GENERAL.—In lieu of making payments to teaching hospitals pursuant to section 2231, the Secretary may make payments under this section to consortia that meet the requirements of subsection (b).

(b) QUALIFYING CONSORTIUM.—For purposes of subsection (a), a consortium meets the requirements of this subsection if the consortium is in compliance with the following:

(1) The consortium consists of an approved medical residency training program, a teaching hospital, and one or more of the following entities:

(A) Schools of medicine or osteopathic medicine.

(B) Other teaching hospitals (or the approved medical residency training programs of the hospitals).

(C) Community health centers (under section 330 of the Public Health Service Act), migrant health centers (under section 329 of such Act), or facilities described in section 340 of such Act.

(D) Medical group practices.

(E) Managed care entities.

(F) Entities furnishing outpatient services.

(G) Such other entities as the Secretary determines to be appropriate.

(2) The members of the consortium have agreed to participate in the programs of graduate medical education that are operated by the teaching hospitals in the consortium.

(3) With respect to the receipt by the consortium of payments made pursuant to this section, the members of the consortium have agreed on a method for allocating the payments among the members.

(4) The consortium meets such additional requirements as the Secretary may establish.

(c) PAYMENTS FROM ACCOUNTS.—

(1) IN GENERAL.—Subject to subsection (d), the total of payments to a qualifying consortium for a fiscal year pursuant to subsection (a) shall be the sum of—

(1) the aggregate amount determined for the teaching hospitals of the consortium pursuant to paragraph (1) of section 2231(a); and

(2) an amount determined in accordance with the methodology that applies pursuant to paragraph (2) of such section, except that the estimate used for purposes of subsection (c)(2)(A) of such section shall be the estimate made for the consortium under section 1886(j)(2)(C)(ii).

(d) LIMITATION ON AGGREGATE TOTAL OF PAYMENTS TO CONSORTIA.—The aggregate total of the amounts paid under subsection (c)(2) to qualifying consortia for a fiscal year may not exceed the sum of—

(1) the aggregate total of the amounts that would have been paid under section 2231(c) for the fiscal year to the teaching hospitals of the consortia if the hospitals had not been participants in the consortia; and

(2) an amount equal to 1 percent of the amount that applies under paragraph (1)(A) of such section for the fiscal year (relating to the Medicare Direct-Costs Medical Education Account).

(e) DEFINITION.—For purposes of this title, the term "qualifying consortium" means a consortium that meets the requirements of subsection (b).

SEC. 2234. DIRECT COSTS; ALTERNATIVE PAYMENTS REGARDING TEACHING HOSPITALS IN CERTAIN STATES.

(a) IN GENERAL.—In the case of a teaching hospital in a State for which a demonstration project under section 1814(b)(3) is in effect, this section applies in lieu of section 2231. For purposes of section 2211(a)(2), the amount determined for a teaching hospital for a fiscal year is the product of—

(1) the amount in the General Direct-Costs Medical Education Account on the applicable date under section 2201(d) (once the appropriation under such section is made); and

(2) the percentage determined under subsection (b) for the hospital.

(b) DETERMINATION OF PERCENTAGE.—For purposes of subsection (a)(2):

(1) The Secretary shall make an estimate of the total amount of payments that would have been received under section 1886(h) by the hospital involved with respect to each of the fiscal years of the applicable period if such section (as in effect for such fiscal years) had applied to the hospital for such years.

(2) The percentage determined under this subsection for the hospital for a fiscal year is a mean average percentage determined for the hospital in accordance with the methodology of section 2231(b)(2)(A), except that the estimate made by the Secretary under paragraph (1) of this subsection for a fiscal year of the applicable period is deemed to be the amount that applies for purposes of section 2231(b)(2)(B)(i) for such year.

(c) RULE REGARDING PAYMENTS FROM CERTAIN AMOUNTS.—In the case of a teaching hospital in a State for which a demonstration project under section 1814(b)(3) is in effect, this section does not provide any payment to the hospital from amounts transferred to the Fund under section 1886(j).

Subpart 4—General Provisions

SEC. 2241. ADJUSTMENTS IN PAYMENT AMOUNTS.

(a) COLLECTION OF DATA ON ACCURACY OF ESTIMATES.—The Secretary shall collect data on whether the estimates made by the Secretary under section 1886(j) for a fiscal year were substantially accurate.

(b) ADJUSTMENTS.—If the Secretary determines under subsection (a) that an estimate for a fiscal year was not substantially accurate, the Secretary shall, for the first fiscal year beginning after the Secretary makes the determination—

(1) make adjustments accordingly in transfers to the Fund under section 1886(j); and

(2) make adjustments accordingly in the amount of payments to teaching hospitals pursuant to 2231(c) (or, as applicable, to qualifying consortia pursuant to section 2233(c)(2)).

PART C—OTHER MATTERS

SEC. 2251. ADVISORY PANEL ON REFORM IN FINANCING OF TEACHING HOSPITALS AND GRADUATE MEDICAL EDUCATION.

(a) ESTABLISHMENT.—The Chair of the Medicare Payment Review Commission under section 1806 shall establish a temporary advisory panel to be known as the Advisory Panel on Financing for Teaching Hospitals and Graduate Medical Education (in this section referred to as the "Panel").

(b) DUTIES.—The Panel shall develop recommendations on whether and to what extent Federal policies regarding teaching hospitals and graduate medical education should be reformed, including recommendations regarding the following:

(1) The financing of graduate medical education, including consideration of alternative broad-based sources of funding for such education.

(2) The financing of teaching hospitals, including consideration of the difficulties encountered by such hospitals as competition among health care entities increases. Matters considered under this paragraph shall include consideration of the effects on teaching hospitals of the method of financing used for the MedicarePlus program under part C of title XVIII.

(3) The methodology for making payments for graduate medical education, and the selection of entities to receive the pay-

ments. Matters considered under this paragraph shall include the following:

(A) The methodology under part B for making payments from the Fund, including the use of data from the fiscal years 1992 through 1994, and including the methodology that applies with respect to consolidations and mergers of participants in the program under such part and with respect to the inclusion of additional participants in the program.

(B) Issues regarding children's hospitals, and approved medical residency training programs in pediatrics.

(C) Whether and to what extent payments are being made (or should be made) for graduate training in the various nonphysician health professions.

(4) Federal policies regarding international medical graduates.

(5) The dependence of schools of medicine on service-generated income.

(6) The effects of the amendments made by section 15412 of the Medicare Preservation Act of 1995, including adverse effects on teaching hospitals that result from modifications in policies regarding international medical graduates.

(7) Whether and to what extent the needs of the United States regarding the supply of physicians will change during the 10-year beginning on October 1, 1995, and whether and to what extent any such changes will have significant financial effects on teaching hospitals.

(8) The appropriate number and mix of residents.

(c) COMPOSITION.—Not later than three months after being designated as the initial chairman of the Medicare Payment Review Commission, the chairman of the Commission shall appoint to the Panel 19 individuals who are not members of the Commission, who are not officers or employees of the United States, and who possess expertise on matters on which the Panel is to make recommendations under subsection (b). Such individuals shall include the following:

(1) Deans from allopathic and osteopathic schools of medicine.

(2) Chief executive officers (or equivalent administrative heads) from academic health centers, integrated health care systems, and approved medical residency training programs.

(3) Chairs of departments or divisions from allopathic and osteopathic schools of medicine, schools of dentistry, and approved medical residency training programs in oral surgery.

(4) Individuals with leadership experience from each of the fields of advanced practice nursing, physician assistants, and podiatric medicine.

(5) Individuals with substantial experience in the study of issues regarding the composition of the health care workforce of the United States.

(6) Individuals with expertise on the financing of health care.

(7) Representatives from health insurance organizations and health plan organizations.

(d) RELATIONSHIP OF PANEL TO MEDICARE PAYMENT REVIEW COMMISSION.—From amounts appropriated under subsection (n), the Medicare Review Payment Commission shall provide for the Panel such staff and administrative support (including quarters for the Panel) as may be necessary for the Panel to carry out the duties under subsection (b).

(e) CHAIR.—The Panel shall designate a member of the Panel to serve as the Chair of the Panel.

(f) MEETINGS.—The Panel shall meet at the call of the Chair or a majority of the members, except that the first meeting of the Panel shall be held not later than three months after the date on which appointments under subsection (c) are completed.

(g) TERMS.—The term of a member of the Panel is the duration of the Panel.

(h) VACANCIES.—

(1) IN GENERAL.—A vacancy in the membership of the Panel does not affect the power of the remaining members to carry out the duties under subsection (b). A vacancy in the membership of the Panel shall be filled in the manner in which the original appointment was made.

(2) INCOMPLETE TERM.—If a member of the Panel does not serve the full term applicable to the member, the individual appointed to fill the resulting vacancy shall be appointed for the remainder of the term of the predecessor of the individual.

(i) COMPENSATION; REIMBURSEMENT OF EXPENSES.—

(1) COMPENSATION.—Members of the Panel shall receive compensation for each day (including traveltime) engaged in carrying out the duties of the Committee. Such compensation may not be in an amount in excess of the daily equivalent of the annual maximum rate of basic pay payable under the General Schedule (under title 5, United States Code) for positions above GS–15.

(2) REIMBURSEMENT.—Members of the Panel may, in accordance with chapter 57 of title 5, United States Code, be reimbursed for travel, subsistence, and other necessary expenses incurred in carrying out the duties of the Panel.

(j) CONSULTANTS.—The Panel may procure such temporary and intermittent services of consultants under section 3109(b) of title 5, United States Code, as the Panel may determine to be useful in carrying out the duties under subsection (b). The Panel may not procure services under this subsection at any rate in excess of the daily equivalent of the maximum annual rate of basic pay payable under the General Schedule for positions above GS–15. Consultants under this subsection may, in accordance with chapter 57 of title 5, United States Code, be reimbursed for travel, subsistence, and other necessary expenses incurred for activities carried out on behalf of the Panel pursuant to subsection (b).

(k) POWERS.—

(1) IN GENERAL.—For the purpose of carrying out the duties of the Panel under subsection (b), the Panel may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Panel considers appropriate.

(2) OBTAINING OFFICIAL INFORMATION.—Upon the request of the Panel, the heads of Federal agencies shall furnish directly to the Panel information necessary for the Panel to carry out the duties under subsection (b).

(3) USE OF MAILS.—The Panel may use the United States mails in the same manner and under the same conditions as Federal agencies.

(l) REPORTS.—

(1) FIRST INTERIM REPORT.—Not later than one year after the date of the enactment of the Medicare Preservation Act of 1995, the Panel shall submit to the Congress a report providing the recommendations of the Panel regarding the matters specified in paragraphs (1) through (4) of subsection (b).

(2) SECOND INTERIM REPORT.—Not later than 2 years after the date of enactment specified in paragraph (1), the Panel shall submit to the Congress a report providing the recommendations of the Panel regarding the matters specified in paragraphs (5) and (6) of subsection (b).

(3) FINAL REPORT.—Not later than 3 years after the date of enactment specified in paragraph (1), the Panel shall submit to the Congress a final report providing the recommendations of the Panel under subsection (b).

(m) DURATION.—The Panel terminates upon the expiration of the 180-day period beginning on the date on which the final report under subsection (l)(3) is submitted to the Congress.

(n) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—Subject to paragraph (2), for the purpose of carrying out this section, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 1996 through 2000.

(2) LIMITATION.—The authorization of appropriations established in paragraph (1) is effective only with respect to appropriations made from allocations under section 302(b) of the Congressional Budget Act of 1974—

(A) for the Subcommittee on Labor, Health and Human Services, and Education, Committee on Appropriations of the House of Representatives, in the case of any bill, resolution, or amendment considered in the House; and

(B) for the Subcommittee on Labor, Health and Human Services, and Education, Committee on Appropriations of the Senate, in the case of any bill, resolution, or amendment considered in the Senate.

INTERNAL REVENUE CODE OF 1986

Subtitle A—Income Taxes

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CHAPTER 1—NORMAL TAXES AND SURTAXES

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Subchapter B—Computation of Taxable Income

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PART III—ITEMS SPECIFICALLY EXCLUDED FROM GROSS INCOME

Sec. 101. Certain death benefits.
Sec. 102. Gifts and inheritances.
Sec. 103. Interest on state and local bonds.

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[Sec. 137. Cross reference to other Acts.]
Sec. 137. MedicarePlus MSA's.
Sec. 138. Cross references to other Acts.

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Sec. 105. AMOUNT RECEIVED UNDER ACCIDENT AND HEALTH PLANS.

(a) * * *

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(j) CERTAIN REBATES UNDER SOCIAL SECURITY ACT.—Gross income does not include any rebate received under section 1852(e)(1)(A) of the Social Security Act during the taxable year.

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SEC. 137. MEDICAREPLUS MSA'S.

(a) EXCLUSION.—Gross income shall not include any payment to the MedicarePlus MSA of an individual by the Secretary of Health and Human Services under section 1855(f)(1)(B) of the Social Security Act.

(b) MEDICAREPLUS MSA.—For purposes of this section—

(1) MEDICAREPLUS MSA.—The term "MedicarePlus MSA" means a trust created or organized in the United States exclusively for the purpose of paying the qualified medical expenses of the account holder, but only if the written governing instrument creating the trust meets the following requirements:

(A) Except in the case of a trustee-to-trustee transfer described in subsection (d)(4), no contribution will be accepted unless it is made by the Secretary of Health and Human Services under section 1855(f)(1)(B) of the Social Security Act.

(B) The trustee is a bank (as defined in section 408(n)), an insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

(C) No part of the trust assets will be invested in life insurance contracts.

(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

(E) The interest of an individual in the balance in his account is nonforfeitable.

(F) Trustee-to-trustee transfers described in subsection (d)(4) may be made to and from the trust.

(2) QUALIFIED MEDICAL EXPENSES.—

(A) IN GENERAL.—The term "qualified medical expenses" means, with respect to an account holder, amounts paid by such holder—

(i) for medical care (as defined in section 213(d)) for the account holder, but only to the extent such amounts are not compensated for by insurance or otherwise, or

(ii) for long-term care insurance for the account holder.

(B) HEALTH INSURANCE MAY NOT BE PURCHASED FROM ACCOUNT.—Subparagraph (A)(i) shall not apply to any payment for insurance.

(3) ACCOUNT HOLDER.—The term "account holder" means the individual on whose behalf the MedicarePlus MSA is maintained.

(4) CERTAIN RULES TO APPLY.—Rules similar to the rules of subsections (g) and (h) of section 408 shall apply for purposes of this section.

(c) TAX TREATMENT OF ACCOUNTS.—

(1) IN GENERAL.—A MedicarePlus MSA is exempt from taxation under this subtitle unless such MSA has ceased to be a MedicarePlus MSA by reason of paragraph (2). Notwithstanding the preceding sentence, any such MSA is subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

(2) ACCOUNT ASSETS TREATED AS DISTRIBUTED IN THE CASE OF PROHIBITED TRANSACTIONS OR ACCOUNT PLEDGED AS SECURITY FOR LOAN.—Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to MedicarePlus MSA's, and any amount treated as distributed under such rules shall be treated as not used to pay qualified medical expenses.

(d) TAX TREATMENT OF DISTRIBUTIONS.—

(1) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—No amount shall be included in the gross income of the account holder by reason of a payment or distribution from a MedicarePlus MSA which is used exclusively to pay the qualified medical expenses of the account holder. Any amount paid or distributed from a MedicarePlus MSA which is not so used shall be included in the gross income of such holder.

(2) PENALTY FOR DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES IN MINIMUM BALANCE NOT MAINTAINED.—

(A) IN GENERAL.—The tax imposed by this chapter for any taxable year in which there is a payment or distribution from a MedicarePlus MSA which is not used exclusively to pay the qualified medical expenses of the account holder shall be increased by 50 percent of the excess (if any) of—

(i) the amount of such payment or distribution, over

(ii) the excess (if any) of—

(I) the fair market value of the assets in the MedicarePlus MSA as of the close of the calendar year preceding the calendar year in which the taxable year begins, over

(II) an amount equal to 60 percent of the deductible under the high deductible/medisave product covering the account holder as of January 1 of the calendar year in which the taxable year begins.

(B) EXCEPTIONS.—Subparagraph (A) shall not apply if the payment or distribution is made on or after the date the account holder—

(i) becomes disabled within the meaning of section 72(m)(7), or

(ii) dies.

(C) SPECIAL RULES.—For purposes of subparagraph (A)—

(i) all MedicarePlus MSA's of the account holder shall be treated as 1 account,

(ii) all payments and distributions not used exclusively to pay the qualified medical expenses of the account holder during any taxable year shall be treated as 1 distribution, and

(iii) any distribution of property shall be taken into account at its fair market value on the date of the distribution.

(3) WITHDRAWAL OF ERRONEOUS CONTRIBUTIONS.—Paragraphs (1) and (2) shall not apply to any payment or distribution from a MedicarePlus MSA to the Secretary of Health and Human Services of an erroneous contribution to such MSA and of the next income attributable to such contribution.

(4) TRUSTEE-TO-TRUSTEE TRANSFERS.—Paragraphs (1) and (2) shall not apply to any trustee-to-trustee transfer from a Medicare Plus MSA of an account holder to another MedicarePlus MSA of such account holder.

(5) COORDINATION WITH MEDICAL EXPENSE DEDUCTION.—For purposes of section 213, any payment or distribution out of a MedicarePlus MSA for qualified medical expenses shall not be treated as an expense paid for medical care.

(e) TREATMENT OF ACCOUNT AFTER DEATH OF ACCOUNT HOLDER.—

(1) TREATMENT IF DESIGNATED BENEFICIARY IS SPOUSE.—

(A) IN GENERAL.—In the case of an account holder's interest in a MedicarePlus MSA which is payable to (or for the benefit of) such holder's spouse upon the death of such holder, such MedicarePlus MSA shall be treated as a MedicarePlus MSA of such spouse as of the date of such death.

(B) SPECIAL RULES IF SPOUSE NOT MEDICARE ELIGIBLE.—If, as of the date of such death, such spouse is not entitled to benefits under title XVIII of the Social Security Act, then after the date of such death—

(i) the Secretary of Health and Human Services may not make any payments to such MedicarePlus MSA, other than payments attributable to periods before such date,

(ii) in applying subsection (b)(2) with respect to such MedicarePlus MSA, references to the account holder shall be treated as including references to any depend-

ent (as defined in section 152) of such spouse and any subsequent spouse of such spouse, and

(iii) in lieu of applying subsection (d)(2), the rules of section 220(f)(2) shall apply.

(2) TREATMENT IF DESIGNATED BENEFICIARY IS NOT SPOUSE.—In the case of an account holder's interest in a MedicarePlus MSA which is payable to (or for the benefit of) any person other than such holder's spouse upon the death of such holder—

(A) such account shall cease to be a MedicarePlus MSA as of the date of death, and

(B) an amount equal to the fair market value of the assets in such account on such date shall be includible—

(i) if such person is not the estate of such holder, in such person's gross income for the taxable year which includes such date, or

(ii) if such person is the estate of such holder, in such holder's gross income for last taxable year of such holder.

(f) REPORTS.—

(1) IN GENERAL.—The trustee of a MedicarePlus MSA shall make such reports regarding such account to the Secretary and to the account holder with respect to—

(A) the fair market value of the assets in such MedicarePlus MSA as of the close of each calendar year, and

(B) contributions, distributions, and other matters,

as the Secretary may require by regulations.

(2) TIME AND MANNER OF REPORTS.—The reports required by this subsection—

(A) shall be filed at such time and in such manner as the Secretary prescribes in such regulations, and

(B) shall be furnished to the account holder—

(i) not later than January 31 of the calendar year following the calendar year to which such reports relate, and

(ii) in such manner as the Secretary prescribes in such regulations.

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SEC.[137.] *138.* CROSS REFERENCES TO OTHER ACTS.

(a) For exemption of—

(1) Allowances and expenditures to meet losses sustained by persons serving the United States abroad, due to appreciation of foreign currencies, see section 5943 of title 5, United States Code.

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Subchapter F—Exempt Organizations

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PART I—GENERAL RULE

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SEC. 501. EXEMPTION FROM TAX ON CORPORATIONS, CERTAIN TRUSTS, ETC.

(a) * * *

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(n) TREATMENT OF HOSPITALS PARTICIPATING IN PROVIDER-SPONSORED ORGANIZATIONS.—An organization shall not fail to be treated as organized and operated exclusively for a charitable purpose for purposes of subsection (c)(3) solely because a hospital which is owned and operated by such organization participates in a provider-sponsored organization (as defined in section 1854(a)(1) of the Social Security Act), whether or not the provider-sponsored organization is exempt from tax. For purposes of subsection (c)(3), any person with a material financial interest in such a provider-sponsored organization shall be treated as a private shareholder or individual with respect to the hospital.

[n] *(o)* CROSS REFERENCE.—

For nonexemption of Communist-Controlled organizations, see section 11(b) of the Internal Security Act of 1950 (64 Stat. 997; 50 U.S.C. 790 (b)).

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Subtitle B—Estate and Gift Taxes

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CHAPTER 11—ESTATE TAX

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Subchapter A—Estates of Citizens or Residents

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PART IV—TAXABLE ESTATE

Sec. 2051. Definition of taxable estate.
Sec. 2053. Expenses, indebtedness, and taxes.
Sec. 2054. Losses.
Sec. 2055. Transfers for public, charitable, and religious uses.
Sec. 2056. Bequests, etc., to surviving spouse.
Sec. 2056A. Qualified domestic trust.
Sec. 2057. MedicarePlus MSA's.

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SEC. 2057. MEDICAREPLUS MSA'S.

For purposes of the tax imposed by section 2001, the value of the taxable estate shall be determined by deducting from the value of the gross estate an amount equal to the value of any MedicarePlus MSA (as defined in section 137(b)) included in the gross estate.

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Subtitle D—Miscellaneous Excise Taxes

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CHAPTER 43—QUALIFIED PENSION, ETC., PLANS

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SEC. 4975. TAX ON PROHIBITED TRANSACTIONS.

(a) * * *

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(c) PROHIBITED TRANSACTION.—

(1) GENERAL RULE.—For purposes of this section, the term "prohibited transaction" means any direct or indirect—

(A) sale or exchange, or leasing, of any property between a plan and a disqualified person;

* * * * * * *

(4) SPECIAL RULE FOR MEDICAREPLUS MSA's.—An individual for whose benefit a MedicarePlus MSA (within the meaning of section 137(b)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a MedicarePlus MSA by reason of the application of section 137(c)(2) to such account.

* * * * * * *

(e) DEFINITIONS.—

[(1) PLAN.—For purposes of this section, the term "plan" means a trust described in section 401(a) which forms a part of a plan, or a plan described in section 403(a), which trust or plan is exempt from tax under section 501(a), an individual retirement account described in section 408(a) or an individual retirement annuity described in section 408(b) (or a trust, plan, account, or annuity which, at any time, has been determined by the Secretary to be such a trust, plan, or account).]

(1) PLAN.—For purposes of this section, the term "plan" means—

(A) a trust described in section 401(a) which forms a part of a plan, or a plan described in section 403(a), which trust or plan is exempt from tax under section 501(a),

(B) an individual retirement account described in section 408(a),

(C) an individual retirement annuity described in section 408(b),

(D) a medical savings account described in section 220(d),

(E) a MedicarePlus MSA described in section 137(b), or

(F) a trust, plan, account, or annuity which, at any time, has been determined by the Secretary to be described in any preceding subparagraph of this paragraph.

* * * * * * *

Subtitle F—Procedure and Administration

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CHAPTER 61—INFORMATION AND RETURNS

* * * * * * *

Subchapter B—Miscellaneous Provisions

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SEC. 6103. CONFIDENTIALITY AND DISCLOSURE OF RETURNS AND RETURN INFORMATION.

(a) * * *

* * * * * * *

(l) DISCLOSURE OF RETURNS AND RETURN INFORMATION FOR PURPOSES OTHER THAN TAX ADMINISTRATION.—

(1) * * *

* * * * * * *

(12) DISCLOSURE OF CERTAIN TAXPAYER IDENTITY INFORMATION FOR VERIFICATION OF EMPLOYMENT STATUS OF MEDICARE BENEFICIARY AND SPOUSE OF MEDICARE BENEFICIARY.—

(A) * * *

* * * * * * *

[(F) TERMINATION.—Subparagraphs (A) and (B) shall not apply to—

[(i) any request made after September 30, 1988, and

[(ii) any request made before such date for information relating to—

[(I) 1997 or thereafter in the case of subparagraph (A), or

[(II) 1998 or thereafter in the case of subparagraph (B).]

* * * * * * *

CHAPTER 68—ADDITIONS TO THE TAX, ADDITIONAL AMOUNTS, AND ASSESSABLE PENALTIES

* * * * * * *

Subchapter B—Assessable Penalties

Part I. General provisions.
Part II. Failure to comply with certain information reporting requirements.

PART I—GENERAL PROVISIONS

Sec. 6671. Rules for application of assessable penalties.
Sec. 6672. Failure to collect and pay over tax, or attempt to evade or defeat tax.
Sec. 6673. Sanctions and costs awarded by courts.

* * * * * * *

[Sec. 6693. Failure to provide reports on individual retirement accounts or annuities; penalties relating to designated nondeductible contributons.]

Sec. 6693. Failure to file reports on individual retirement plans and certain other tax-favored accounts; penalties relating to designated nondeductible contributions.

* * * * * * *

[SEC. 6693. FAILURE TO PROVIDE REPORTS ON INDIVIDUAL RETIREMENT ACCOUNTS OR ANNUITIES; PENALTIES RELATING TO DESIGNATED NONDEDUCTIBLE CONTRIBUTIONS.

[(a) The person required by subsection (i) or (l) of section 408 to file a report regarding an individual retirement account or individual retirement annuity at the time and in the manner required by such subsecton shall pay a penalty of $50 for each failure unless it is shown that such failure is due to reasonable cause.]

SEC. 6693. FAILURE TO FILE REPORTS ON INDIVIDUAL RETIREMENT PLANS AND CERTAIN OTHER TAX-FAVORED ACCOUNTS; PENALTIES RELATING TO DESIGNATED NONDEDUCTIBLE CONTRIBUTIONS.

(a) Reports.—

(1) IN GENERAL.—If a person required to file a report under a provision referred to in paragraph (2) fails to file such report at the time and in the manner required by such provision, such person shall pay a penalty of $50 for each failure unless it is shown that such failure is due to reasonable cause.

(2) PROVISIONS.—The provisions referred to in this paragraph are—

(A) subsections (i) and (l) of section 408 (relating to individual retirement plans),

(B) section 220(h) (relating to medical savings accounts), and

(C) section 137(f) (relating to MedicarePlus MSA's).

* * * * * * *

SECTION 13562 OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1993

SEC. 13562. PHYSICIAN OWNERSHIP AND REFERRAL.

(a) * * *

(b) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in [paragraph (2)] *paragraphs (2) and (3)*, the amendments made by this section shall apply to referrals—

(A) made on or after January 1, 1992, in the case of clinical laboratory services, and

(B) made after December 31, 1994, in the case of other designated health services.

* * * * * * *

(3) PROMULGATION OF REGULATIONS.—Notwithstanding paragraphs (1) and (2), the amendments made by this section shall not apply to any referrals made before the effective date of final regulations promulgated by the Secretary of Health and Human Services to carry out such amendments.

* * * * * * *

SECTION 101 OF EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

DUTY OF DISCLOSURE AND REPORTING

SEC. 101. (a) * * *

* * * * * * *

[(f) INFORMATION NECESSARY TO COMPLY WITH MEDICARE AND MEDICAID COVERAGE DATA BANK REQUIREMENTS.—

[(1) PROVISION OF INFORMATION BY GROUP HEALTH PLAN UPON REQUEST OF EMPLOYER.—

[(A) IN GENERAL.—An employer shall comply with the applicable requirements of section 1144 of the Social Security Act (as added by section 13581 of the Omnibus Budget Reconciliation Act of 1993). Upon the request of an employer maintaining a group health plan, any plan sponsor, plan administrator, insurer, third-party administrator, or other person who maintains under the plan the information necessary to enable the employer to comply with the applicable requirements of section 1144 of the Social Security Act shall, in such form and manner as may be prescribed in regulations of the Secretary (in consultation with the Secretary of Health and Human Services), provide such information (not inconsistent with paragraph (2))—

[(i) in the case of a request by an employer described in subparagraph (B) and a plan that is not a multiemployer plan or a component of an arrangement described in subparagraph (C), to the Medicare and Medicaid Coverage Data Bank;

[(ii) in the case of a plan that is a multiemployer plan or is a component of an arrangement described in subparagraph (C), to the employer or to such Data Bank, at the option of the plan; and

[(iii) in any other case, to the employer or to such Data Bank, at the option of the employer.

[(B) EMPLOYER DESCRIBED.—An employer is described in this subparagraph for any calendar year if such employer normally employed fewer than 50 employees on a typical business day during such calendar year.

[(C) ARRANGEMENT DESCRIBED.—An arrangement described in this subparagraph is any arrangement in which two or more employers contribute for the purpose of providing group health plan coverage for employees.

[(2) INFORMATION NOT REQUIRED TO BE PROVIDED.—Any plan sponsor, plan administrator, insurer, third-party administrator, or other person described in paragraph (1)(A) (other than the employer) that maintains the information under the plan shall not provide to an employer in order to satisfy the requirements of section 1144 of the Social Security Act, and shall not provide to the Data Bank under such section, information that pertains in any way to—

[(A) the health status of a participant, or of the participant's spouse, dependent child, or other beneficiary,

[(B) the cost of coverage provided to any participant or beneficiary, or

[(C) any limitations on such coverage specific to any participant or beneficiary.

[(3) REGULATIONS.—The Secretary may, in consultation with the Secretary of Health and Human Services, prescribe such regulations as are necessary to carry out this subsection.]

* * * * * * *

SECTION 552A OF TITLE 5, UNITED STATES CODE

§ 552a. Records maintained on individuals

(a) DEFINITIONS.—For purposes of this section—

(1) * * *

* * * * * * *

(8) the term "matching program"—

(A) * * *

(B) but does not include—

(i) * * *

* * * * * * *

(v) matches—

(I) using records predominantly relating to Federal personnel, that are performed for routine administrative purposes (subject to guidance provided by the Director of the Office of Management and Budget pursuant to subsection (v)); or

(II) conducted by an agency using only records from systems of records maintained by that agency;

if the purpose of the match is not to take any adverse financial, personnel, disciplinary, or other adverse action against Federal personnel*; or*

(vi) matches performed for foreign counterintelligence purposes or to produce background checks for security clearances of Federal personnel or Federal contractor personnel; [or

[(vii) matches performed pursuant to section 6103(l)(12) of the Internal Revenue Code of 1986 and section 1144 of the Social Security Act;]

* * * * * * *

SECTION 6011 OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1989

SEC. 6011. PASS THROUGH PAYMENT FOR HEMOPHILIA INPATIENTS.

(a) * * *

* * * * * * *

(d) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to items furnished 6 months after the date of enactment of this Act [and shall expire September 30, 1994].

SECTION 9305 OF THE OMNIBUS BUDGET RECONCILITATION ACT OF 1986

SEC. 9305. IMPROVING QUALITY OF CARE WITH RESPECT TO PART A SERVICES.

(a) * * *

* * * * * * *

(g) EXTENSION WAIVER OF LIABILITY PROVISIONS TO HOSPICE PROGRAMS.—

(1) * * *

* * * * * * *

(3) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to coverage denials occurring on or after July 1, 1987, and before [December 31, 1995] *September 30, 1996.*

* * * * * * *

SECTION 353 OF THE PUBLIC HEALTH SERVICE ACT

CERTIFICATION OF LABORATORIES

SEC. 353. (a) * * *

* * * * * * *

(d) REQUIREMENTS FOR CERTIFICATES.—

(1) * * *

(2) EXEMPTION OF PHYSICIAN OFFICE LABORATORIES.—

(A) IN GENERAL.—Except as provided in subparagraph (B), a clinical laboratory in a physician's office (including an office of a group of physicians) which is directed by a physician and in which examinations and procedures are either performed by a physician or by individuals supervised by a physician solely as an adjunct to other services provided by the physician's office is exempt from this section.

(B) EXCEPTION.—A clinical laboratory described in subparagraph (A) is not exempt from this section when it performs a pap smear (Papanicolaou Smear) analysis.

(C) DEFINITION.—For purposes of subparagraph (A), the term "physician" has the same meaning as is prescribed for such term by section 1861(r) of the Social Security Act (42 U.S.C. 1395x(r)).

[(2)] *(3)* REQUIREMENTS FOR CERTIFICATES OF WAIVER.—

(A) IN GENERAL.—A laboratory which only performs laboratory examinations and procedures described in paragraph [(3)] *(4)* shall be issued a certificate of waiver or have its certificate of waiver renewed if—

(i) the laboratory submits an application—

(I) in such form and manner as the Secretary shall prescribe,

(II) that describes the characteristics of the laboratory examinations and other procedures performed by the laboratory, including the number and types of laboratory examinations and other procedures performed, the methodologies for laboratory examinations and other procedures employed, and the qualifications (educational background, training, and experience) of the personnel directing and supervising the laboratory and performing the laboratory examinations and other procedures, and

(III) that contains such other information as the Secretary may reasonably require to determine compliance with this section, and

(ii) the laboratory agrees to make records available and submit reports to the Secretary as the Secretary may require.

(B) CHANGES.—If a laboratory makes changes in the examinations and other procedures performed by it only with respect to examinations and procedures which are described in paragraph (3), the laboratory shall report such changes to the Secretary not later than 6 months after the change has been put into effect. If a laboratory proposes to make changes in the examinations and procedures performed by it such that the laboratory will perform an examination or procedure not described in paragraph (3), the laboratory shall report such change to the Secretary before the change takes effect.

(C) EFFECT.—Subsections (f) and (g) shall not apply to a laboratory to which has been issued a certificate of waiver.

[(3)**]** *(4)* EXAMINATIONS AND PROCEDURES.—The examinations and procedures identified in paragraph **[**(2)**]** *(3)* are simple laboratory examinations and procedures which, as determined by the Secretary, have an insignificant risk of an erroneous result, including those which—

(A) have been approved by the Food and Drug Administration for home use,

(B) employ methodologies that are so simple and accurate as to render the likelihood of erroneous results negligible, or

(C) the Secretary has determined pose no reasonable risk of harm to the patient if performed incorrectly.

[(4)**]** *(5)* DEFINITION.—As used in this section, the term "certificate" includes a certificate of waiver issued under paragraph **[**(2)**]** *(3)*.

* * * * * * *

IX. DISSENTING VIEWS

MINORITY VIEWS OF THE DEMOCRATIC MEMBERS OF THE COMMITTEE ON WAYS AND MEANS

MEDICARE—OUR CONTRACT WITH AMERICA'S SENIORS

Medicare is one of the finest achievement of our country. All Americans can be justifiably proud that we as a people provide health security to those who have retired after a lifetime of hard work.

The enactment of Medicare in 1965 under the leadership of President Johnson revolutionized the health security of the Nation's senior citizens. In 1963, half the elderly had no health insurance because private health insurance companies avoided covering the elderly. Many of our seniors could not afford the expensive coverage that was available to them, and the few policies which were written provided inadequate coverage.

Today, over 99 percent of the elderly are covered. They face no discrimination, no risk selection, and no pre-existing condition exclusions. Over 6,000 hospitals, 3000,000 physicians, and 250 health maintenance organizations (HMOs) contract with Medicare to provide care to 37 million Americans. Medicare is popular with beneficiaries and providers. Polls show the American public consistently and strongly support Medicare—three-quarters of the under-65 population favor having the option to choose Medicare for their health insurance coverage. Seniors consistently rate their Medicare coverage more highly than non-seniors rate their private coverage.

THE REPUBLICAN MEDICARE-LESS PLAN

We would not have this proud record of achievement for Medicare if the country had listened to the Republican Party. The fact that Republicans have voted to slash $270 billion from Medicare in order to pay for tax cuts for those who don't need them should come as no surprise. The Republican Party has never supported the Medicare program.

The historical record is unmistakably clear—if it had been up to the Republican Party, the Medicare program never would have been enacted. In 1965, 93 percent of House Republicans voted against establishing Medicare. Their attitude hasn't changed today. As recently as July 10, 1995, Republican Majority Leader Armey said that he believed that Medicare was "a program I would have no part of in a free world."

Now the Republican majority of the Committee on Ways and Means has reported a bill making the largest cuts in the history of the Medicare program. And they don't need to.

For months the Republicans have cried wolf about the so-called bankruptcy of Medicare—even though the Trustees said it was in worse shape last year—a year in which the Republicans opposed all efforts to deal with the problem.

Democrats have dealt with the solvency of the Medicare Trust Fund nine times, without fanfare or partisan propaganda. This issue is not, therefore, either new or surprising or—as Republicans allege so glibly—a "crisis." We all have been here before. In 1977, the Trustees of the Part A Trust Fund reported that the fund would become insolvent in 1987. By 1984, the insolvency date was 1991. Today, the insolvency date is 2002, due to prudent action by the Congress to keep Medicare solvent.

In fact, the last people who have the right to say anything about Medicare and its funding are our colleagues on the Republican side. Last year, the Medicare Trustees reported that the Fund would be exhausted in 2001. No one on the Republican side pointed with alarm to last year's report, although insolvency was estimated to be just as imminent, seven years in the future.

Ironically, the only action taken in 1995 thus far relating to the solvency of the Hospital Insurance (Part A) Trust Fund is approval by the Republicans in the House of Representatives of the Republican Contract with America provision which takes money out of the Part A Trust Fund through a reduction in the amount of Social Security benefits subject to taxation. Over $36 billion would be removed from the Fund over seven years through this legislation. It is at best disingenuous to wring your hands about the future solvency of the Trust Fund when you have already voted to take money out of the Fund. We understand that the "Contract" provision will be combined with this bill and voted on again as part of the budget reconciliation legislation for this year—the height of hypocrisy.

In addition, the question of Trust Fund insolvency has nothing to do with Medicare's Supplementary Medical Insurance program, Part B. The report of the Part B Trustees states that Part B is actuarially sound. Therefore, if reductions in Medicare are being made solely to "save" the Trust Funds, there is no reason to cut Part B at all, since Part B's Trust Fund doesn't need "saving."

Of course, this bill has nothing to do with "saving" the Medicare Part A Trust Fund. The huge cuts in Medicare, $270 billion over seven years, proposed in this bill are far beyond any amount that is needed reasonably to extend the solvency of the Part A Trust Fund. The bill makes large cuts in Part B and takes billions of dollars right out of the pockets of beneficiaries. Not one penny of these funds will be paid into the Medicare Trust Fund. The dollars will all go into general revenue.

In fact, the current Medicare Trustees, publicly and in correspondence with the Congress, have expressed deep concern about the Republicans' distorted use of the latest Trustees' report. The Trustees and every other responsible authority have stated that cuts of the size proposed by the Republicans are not needed to address the solvency of the Medicare Trust Fund. They have repeatedly noted that a reduction in Part A outlays of approximately $89 billion would be sufficient to assure solvency at least until 2006.

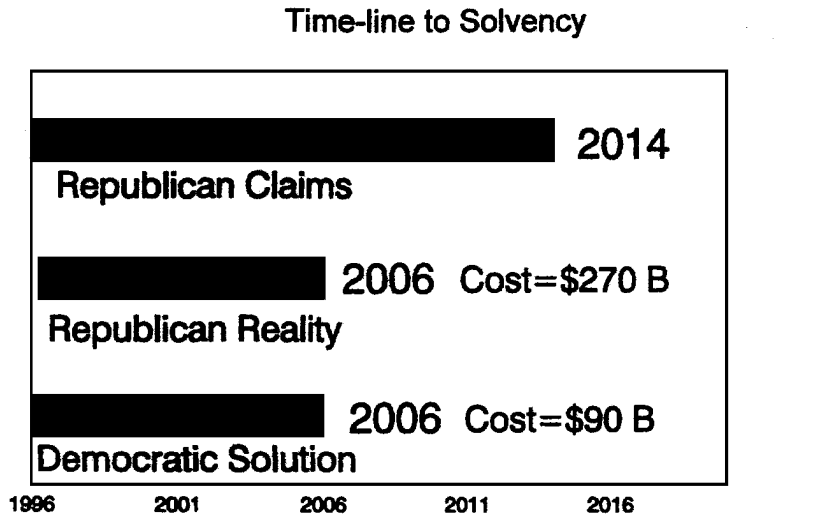
So why do the Republicans want to cut three times what is needed to assure Medicare solvency? The answer is simple: to finance tax breaks for the wealthy. Why do they want to cut $140 billion from Part B—$53.6 billion of which comes out of the pockets of seniors—when it does nothing to assure Medicare solvency? The answer is simple: to finance tax breaks for the wealthy. Why did they do it without having a single hearing to shine the tiniest flashlight on the details of this bill? The answer is that they don't want anyone to know that they are gutting Medicare to pay for tax cuts for the wealthiest Americans.

THE REPUBLICAN PLAN DOES NO MORE FOR THE SOLVENCY OF PART A THAN DEMOCRATIC SUBSTITUTES, WHILE SLASHING MEDICARE THREE TIMES AS MUCH

The Republicans propose to cut $270 billion from Medicare over the next seven years. This is a 24 percent cut in the program in 2002. According to their rhetoric, doing so will "save" Medicare. Nothing could be further from the truth. Even using the Republicans' own standard, their plan falls short.

As Committee Chairman Bill Archer stated in a press release on September 27, 1995, "any 'proposal' that fails to save Medicare until the eve of the baby boomer retirement must be considered a failure." On July 20, 1995, on C–SPAN, Representative McCrery said that under the Republican plan Medicare "should remain solvent as far as the eye can see." Unfortunately, their plan doesn't come anywhere close to meeting their own standard when the "Contract" revenue loss to the Medicare Trust Fund is taken into account. According to the actuaries for the Medicare Trust Fund, the Republican plan "would extend the life of the HI [Part A] Trust Fund through the third quarter of calendar year 2006" [from a letter dated October 11, 1995, to Representative Sam Gibbons from Bruce Vladeck, Administrator of the Health Care Financing Administration (HCFA), based on data from the Medicare actuaries]. 2006 is many years short of the earliest year the baby boomers will begin to retire—2011—and it certainly does not mean the plan will remain solvent "as far as the eye can see."

This result comes from an honest examination of the figures. The Republican bill reduces expected Medicare Part A spending by $130 billion over the next seven years. However, to understand the true impact of Republican proposals on Medicare solvency, this amount must be reduced by $36.6 billion, the amount which will be lost because the House Republicans voted to shrink the amount of Social Security benefits subject to income taxation, an action that will rob the Medicare Trust Fund of $36.6 billion. Therefore, the net impact of Republican proposals on the Medicare Trust Fund is a reduction in spending of only $93 billion, virtually the same impact in the Democratic Substitute would have had on the Fund if the Republicans had not rejected it on a straight party-line vote, as the following chart illustrates.



Source: Democratic staff of the Committee on Ways and Means based on information from the Health Care Financing Administration, October 11, 1995

The trust is now out, and the actuaries agree: the Republicans are jeopardizing the health and financial security of our families and our parents based on a false promise, and a big lie. They are taking three times as much out of Medicare as is needed, and they are treating the Medicare Trust Fund as though it were a slush fund to pay for tax cuts for the privileged few.

MEDICARE "MINUS"

When this effort to frighten the public into accepting huge cuts in Medicare fails, the Republicans will turn to a new smoke screen called "reform" in order to justify their unnecessary cuts. The ultimate Republican goal is to turn the Medicare program into a fractured, unworkable system. Their plan will subject seniors to the same kinds of redtape and harassment over paying claims which are becoming all too common in the private health insurance industry. Medicare's dollars will be soaked up by the private sector's profits and huge overhead.

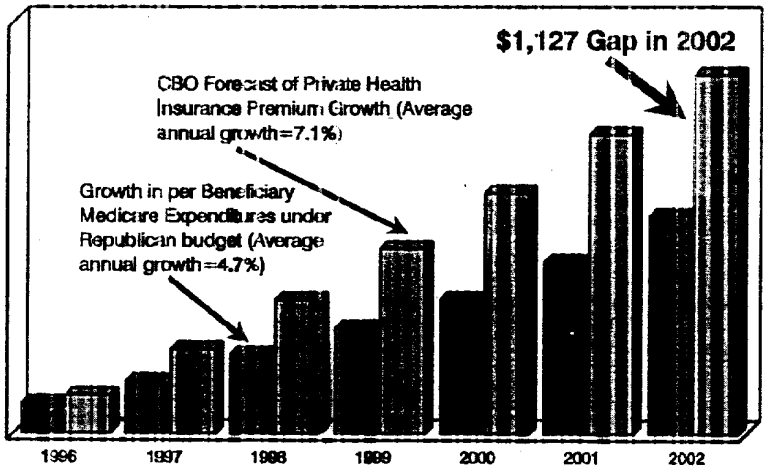
As the Committee plan already makes clear—the Republicans will provide vouchers for managed care. The value of those vouchers will not keep pace with the cost of benefits, thus eroding benefits along with the security seniors have today. The "choice" which the Republicans provide to seniors is based on a false promise because their so-called "Medicare Plus" plan changes Medicare's contribution to health plans into a "defined contribution" plan, a fixed-size voucher with which to purchase less and less health care.

The Republican plan sets the total annual growth in the size of the vouchers for health plans at 4.7 percent, only a little more than one percent above the effects of growth in inflation plus growth in

beneficiaries. Private health insurance premiums are projected by the Congressional Budget Office (CBO) to grow at 7.1 percent per year over the next several years, a rate 30 percent higher than the rate Medicare vouchers can grow under the Republican plan. The result is that the Republican voucher quickly will buy less and less coverage, since the Medicare growth rates allowed under the Republican plan bear no resemblance to actual or predicted growth in the cost of health care between now and 2002. This eventuality is illustrated by the chart below.

The Republican Road to Second-Class Health Care

The Steady Erosion of Seniors' Benefits Under the Republican Budget



Democratic staff of the Committee on Ways and Means, analysis of the Republican Budget Resolution, adjusted for age and enrollment, June 26, 1995; projections of private health insurance costs from CBO baseline, 3/95

Worst of all, the Republican-generated Medicare growth rates are *not* calculations based on health care cost or the needs of beneficiaries. The percentage growth rates for health plan payments included in this bill, in the words of the Republican staff director of the Health Subcommittee on C–SPAN, are the rates "necessary to meet the requirements of the budget resolution." In other words, they are arbitrary amounts designed to cut Medicare sufficiently to pay for tax breaks for those who don't need them. Moreover, as the CBO estimate makes clear, these arbitrary percentages are what "saves" money in Medicare and not the illusionary choice Republicans claim to offer beneficiaries.

When the artificial spending limits included in this bill reduce Medicare reimbursement to providers, as they will, providers will be allowed to bill beneficiaries for the "balance." The restrictions of current law on "balance billing" will not apply when seniors enroll

in a plan which does not have contracts with its doctors and hospitals, such as an indemnity plan or a point-of-service plan. There will be no protection for seniors against hidden charges which they will have to pay out of their own pockets.

The Congressional Budget Office has agreed that the Republican plan does not offer real choices to beneficiaries. CBO's analysis of virtually identical Senate Finance Committee Republican plan demonstrates that few additional seniors will choose to opt out of traditional Medicare under the Republican plan. In fact, CBO's analysis indicates that, of the additional 11 percent of beneficiaries who will opt out, most will do so because they are poor and have lost the protection of the present-law Qualified Medicare Beneficiary program under which Medicaid pays the Part B premium and other cost-sharing of low-income Medicare beneficiaries—not because they wanted some other "choice." The Republican assault on Medicaid will force low-income seniors into managed care only because the cost to the seniors will be less, and they won't be able to afford any other "choice."

The Republican plan fails in another important way as well. Republicans are throwing the doors wide open to every type of insurance plan that wants to snare Medicare beneficiaries and the premiums they represent. Literally any insurance plan, no matter how poorly financed or poorly managed, will be considered to have met the standards for health plans to contract with Medicare. In other words, there will be no standards. The Secretary of the Department of Health and Human Services (HHS) will have no recourse but to accept any plan desiring to come into Medicare. The problems with pre-paid health plans in California in the 1970's and in Florida in the 1980's will be dwarfed by this reckless scheme of the Republicans.

It's even more troubling that the Republicans rejected a Democratic amendment, on a party-line vote, to add to their plan basic consumer protections for Medicare beneficiaries. The amendment, if adopted, would have saved beneficiaries from on-going abuses by private plans that have been documented by the HHS Inspector General in an extensive survey which identified several problem areas with managed care plans. The amendment was supported by the American Association of Retired Persons (AARP), the National Committee to Preserve Social Security and Medicare, and the Consumers Union, but the Republicans chose not to add these needed protections to their bill.

The Republicans also appear to wish to punish the HCFA which has run Medicare for almost 20 years in a remarkably efficient manner. Under current law, HCFA administers both Medicare's fee-for-service and managed care programs. The reported bill would split HCFA, requiring a new agency within HHS to administer the MedicarePlus program. Such a provision cannot be justified from an administrative or policy perspective. Since the basic benefits and entitlement under traditional Medicare and MedicarePlus are the same, split responsibility would accomplish nothing other than generating confusion among beneficiaries who move between programs and increasing administrative costs because of duplicative overhead expenses. The inevitable disruption caused by splitting HCFA would occur at the same time that the new agency would

be attempting to meet the extremely ambitious implementation schedule for the MedicarePlus program included in the bill.

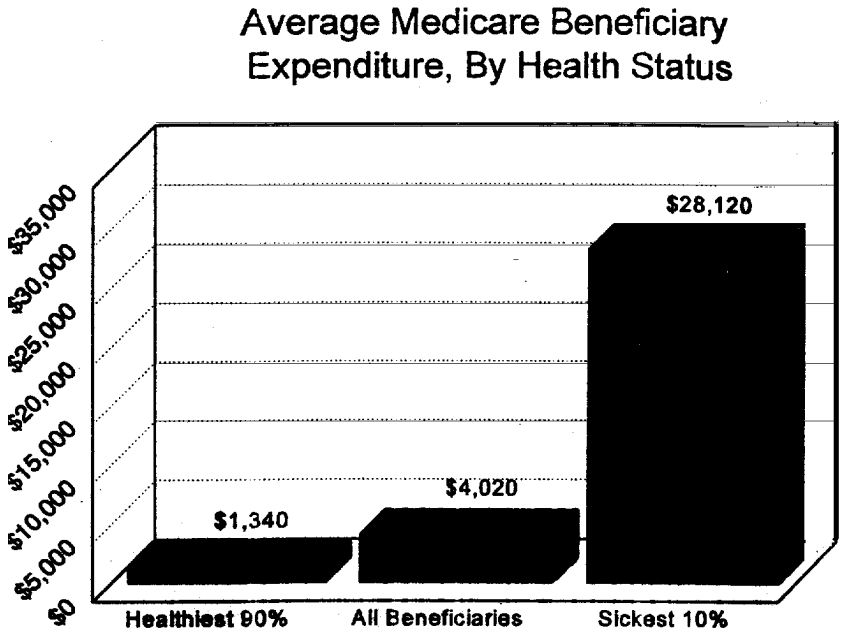
Elsewhere in the bill, future HCFA Administrators' status would be downgraded from Presidential appointees to appointees of the HHS Secretary. Although, under the reported bill, the HCFA Administrator would no longer be in charge of the private health plan portion of Medicare, the "residual" fee-for-service program left under HCFA's administration would still dwarf most other federal programs and would still be the largest health insurance program in the world. According to CBO's estimates, the vast majority of Medicare beneficiaries would still be in the fee-for-service program by 2005. It is hard to fathom why the Republicans would want such a key appointment no longer subjected to Senate approval. Apparently, their pique has gotten in the way of their good judgment.

MEDICAL SAVINGS ACCOUNTS

Medical savings accounts (MSAs) for the Medicare population is one of those ideas that comes along from time to time which appears reasonable at first, but fails to withstand the test of detailed scrutiny. Allowing beneficiaries to opt for a high-deductible plan coupled with a deposit into a medical savings account is risky, untested, and expensive for Medicare. In fact, under the Republican plan, it constitutes a raid on the Medicare Trust Fund, which the Republicans say they are trying to preserve.

Every legitimate health care policy expert, including the Congressional Budget Office, has concluded that the MSA option would result in extra costs for the Medicare program, resulting in a weakened Medicare Trust Fund. The CBO says that the MSAs in this bill will cost Medicare $2.3 billion—dollars which would otherwise have gone to purchase health services for seniors. This works out to $988 in extra Medicare costs per year per beneficiary choosing this option. Republicans claim that MSAs mean more choices for seniors, but offering a choice that threatens the actuarial soundness of the Medicare program will soon result in no choices at all.

Even Republican expert Gail Wilensky, Chair of the Physician Payment Review Commission, expressed grave doubts about the use of MSAs in the Medicare system when she testified before the Committee on Ways and Means on September 29, 1995. Since only the healthiest and wealthiest could afford to gamble with such a high-deductible policy, the MSA proposal would actually transfer scarce Medicare funds to the healthy, while leaving less to spend on the sick. Because there is no reliable method to adjust payments to health plans for the different risks posed by each Medicare beneficiary, experts have testified that MSAs could plunge Medicare into a "death spiral" as younger, healthier, low-cost beneficiaries chose MSAs, leaving sicker, older, more costly seniors in traditional Medicare. As the following chart illustrates, Medicare's current expenditure patterns makes this outcome all too likely.



Proponents of MSAs—i.e., those who plan to reap huge profits from their implementation—have made outrageous claims. Their claims are unsubstantiated, if not laughable. One group financed by the MSA lobby even prepared a report asserting that offering medical savings accounts would save Medicare $275 billion over the next 7 years. In contrast, impartial analysts like those at CBO have concluded that MSAs will cost Medicare money.

Claims by MSA lobbyists have been refuted by health care experts—like Joseph White of the Brookings Institution and Jack Rodgers of Price Waterhouse—that do not have a financial interest in seeing MSAs included in this legislation. In contrast to the hired guns of the MSA lobby, a recent study conducted by the health policy firm of Lewin-VHI concluded that: "The MSA model as currently conceived for Medicare is actuarially unsound because it will result in a net increase in Medicare program costs."

The Medicare program would lose money because healthier people would choose the MSA option, while Medicare would lack the ability to adjust payments accordingly. The Lewin-VHI report says: "Medicare would pay MSAs roughly twice what the predominantly healthy MSA enrollee population would have cost under the current Medicare program," even if the current adjustments for age, sex, and disability are made to plans.

Perhaps worst of all, the Republicans rejected on a straight party-line vote, a Democratic proposal at least to pilot-test this reckless approach to make sure that if works at all. After all, report after report emphasizes that MSAs and Medicare don't mix, although many true believers continue to assert that they will.

In the face of a total lack of evidence to support the belief that MSAs will reduce health expenditures, and overwhelming evidence that suggests just the opposite, the Republicans were not willing to adopt a prudent, reasonable course that would avoid a potentially serious drain on the Medicare Trust Fund. Instead, they chose to reward their wealthy contributors and the special interests who want to make money off of Medicare.

REPUBLICAN ANTI-FRAUD PROPOSALS ARE A FRAUD

The Republican proposals regarding fraud are themselves fraudulent because they make it easier for unethical and criminal provider to commit fraud, and they make it harder for the government to prosecute those fraudulent actions.

Fraud and abuse are among the American public's biggest concerns about the health care financing system. There is little disagreement that fraud, waste, and abuse in our health care system—both private and public—is excessive. The General Accounting Office (GAO) estimates that fraud and abuse in the health care industry accounts for an estimated 10 percent of our yearly private and public health care expenditures.

Based on this estimate, fraudulent payments were nearly $94 billion in 1994. That amounts to approximately $258 million a day or $11 million every single hour. Contrary to the Republican view, and as GAO has stated in testimony to the Committee, Medicare leads the private sector in its health care anti-fraud and -abuse efforts. With the Republican proposal, we would actually be inhibiting proven enforcement activities and letting providers get away with false and fraudulent claims for Medicare payment.

All three of the Federal Government's law enforcement officers in the health field have spoken out against the Republican plan. In letters to the Committee, the Attorney General, the HHS Inspector General, and the Comptroller General have each written to oppose the Republican plan. Copies of their letters are included at the end of these views.

In the words of HHS Inspector General June Gibbs Brown, the Republican plan "would cripple the efforts of law enforcement agencies to control health care fraud and abuse in the Medicare program and to bring wrongdoers to justice." The Republican plan would:

> Make the existing civil monetary penalty and anti-kickback laws considerably more lenient and place an insurmountable burden of proof on the Government to punish illegal kickbacks to providers;
>
> On the one hand, propose an increase in the amounts of civil monetary penalties, while on the other hand, significantly curtail enforcement of these sanction authorities by raising the level of culpability which must be proven by the Government in order to impose any penalty;
>
> Relieve providers of the legal duty to use reasonable diligence in ensuring that claims they submit to Medicare are true and accurate; and
>
> Divert to private contractors scarce resources currently devoted to law enforcement against fraud and abuse.

At the Committee's markup, Republican members refused, on a straight party-line basis, to vote for a tough anti-fraud package offered by Democrats which would have built upon Medicare's proven law enforcement strategy and improved it by increasing penalties, providing more funding for the Inspector General, providing for mandatory exclusion from Medicare for wrong-doers, and providing for a private right-of-action against fraudulent providers.

The only response offered by Republicans was that they were offering a new voluntary disclosure program and were providing an anti-fraud and abuse hotline. Ignorance is no excuse, but Republican members need to call 1–800–HHS–TIPS (1–800–447–8477) to reach the existing Medicare hotline, to find out that their proposal offers nothing new, and would weaken efforts to squeeze every dime of health care fraud out of Medicare.

Republicans also want to gut Medicare's protections against physician self-referral, the practice of physicians referring their patients to providers with which the physician has a financial relationship, whether due to ownership or due to a compensation arrangement. Without a doubt, physician self-referral is bad for the public and bad for the patient. Just like anyone else, physicians are vulnerable—vulnerable to greed, vulnerable to pay-offs, and vulnerable to temptation. Study after study has shown that this practice inevitable encourages unnecessary duplication and overutilization of facilities and services.

Unethical self-referral arrangements provide doctors with powerful incentives to bend their professional judgment. Without laws to prohibit abusive arrangements, doctors will continue to drift toward the opinion that medicine is just a business, and patients are theirs to be bought and sold. Physician self-referral has no inherent social value; it biases the judgment of physicians and compromises their loyalty.

As recently as September 20, 1995, the Journal of the American Medical Association stated that "the results of this study showed that physician self-referral of beneficiaries uniformly led to significantly higher utilization of imaging procedures by all physician specialties * * *." Physician self-referral results in an overall significant increase in cost to the patient and to the Treasury in higher Medicare and Medicaid payments. CBO estimated in 1993 that the expansion of the law to cover an extensive list of additional health services would save the Medicare program $350 million over five years.

The CBO estimate for this bill demonstrates that self-referral costs money—the gutting of self-referral protections in the Republican bill is estimated to cost $400 million over seven years.

The proposed Republican changes to the physician self-referral law are shocking and disappointing. They demonstrate a callous attitude toward beneficiaries and a reckless approach to cost savings. The bill creates numerous loopholes in the current law and deletes several sections that apply to well-documented areas of abuse.

The Republicans plan on self-referral will promote fraud, waste, and abuse. The quacks of the Nation will laugh all the way to the bank. Under this plan, a physician could get a cut of the money from every test he or she orders. There would be no limit—we would return to the days of patients receiving numerous unneces-

sary and harmful tests at great cost to the health care system and beneficiary.

Under this plan, hospitals could enter into largely fictitious contracts with physicians (paying large amounts of money to doctors who have high-volume referrals as a way to encourage increased referrals). Under this plan, a physician in a shared facility arrangement could be on vacation in Hawaii drinking a margarita on the beach and fall under the Republican's definition of "directly supervising" the tests.

The list of services subject to the ban on referrals would be reduced, ignoring studies that have found overutilization and abuse resulting from self-referral. For example, radiology and ultrasound tests would be dropped from the list even though GAO in 1994 found that 22 percent more ultrasound services and 22 percent more echocardiograms were performed in physician-owned versus non-physician-owned facilities. Radiation therapy would be dropped despite a study published in the New England Journal of Medicine in 1992 which found that radiation therapy centers developed as joint ventures with referring physicians had costs 40 to 60 percent higher than non-joint-venture facilities.

Ironically, the same Congress that wants to "empower" States would preempt existing State laws that are more restrictive in prohibiting self-referral. If this bill becomes laws, it is an open invitation for physicians to participate in unethical and immoral behavior.

RIPPING THE SAFETY NET—REPUBLICANS PLACE CRITICAL PROVIDERS IN JEOPARDY

Cutting more than $215 billion out of provider and health plan payments, as the Republican plan does, will cause severe disruption in health services, particularly for safety-net providers who take care of those without coverage.

The Republican bill directly assaults these providers through cuts in disproportionate share payments to hospitals that care for the poor and the medically indigent, cuts in the indirect medical education adjustment for hospitals which carry the extra costs of training our Nation's doctors, and because of the overall level of cuts on hospitals and doctors. Although the wealthy hospitals in suburban areas may survive this assault, the inner-city and rural safety-net hospitals may not.

It was bad enough that last year Republicans on this Committee voted unanimously to reject legislation providing Americans with the health security that every other advanced nation in the world provides to its citizens, leaving 41 million of our fellow citizens without health insurance. This year, Republicans want to cut $182 billion out of Medicaid, with a big chunk of those savings coming from disproportionate share payments under that program. Now Republicans want to cut the payments Medicare makes to ensure that safety-net hospitals can keep their doors open. How on earth do Republicans expect these hospitals to survive? Perhaps the answer is that they don't care.

It is hard to see how these hospitals and clinics will be able to continue providing services to 41 million uninsured Americans when all sources of support for them are cut off. Many of these pro-

viders are already in serious financial trouble—before all of these additional cuts hit them. The hospitals in this group have the lowest margins of revenue over costs of any type of hospital, a full 25 percent below the average, and the highest number of hospitals of any type with overall negative margins. These hospitals have physical plants which are, on average, more than 25 years old, as compared to 7 years for other hospitals.

Undoubtedly the conventional wisdom is that this is an issue only for poor people, or for certain parts of the inner city or for rural areas. But, which hospitals provide the trauma services at the medical centers where the ambulances will take our citizens who have accidents on the freeways? In Chicago, they will be taken to Cook County. In Los Angeles, they will be taken to L.A. County/U.S.C. Medical Center, the hospital which tried recently to send out pink slips to over 2,000 workers in order to solve its financial problems. If these hospitals fall apart, all Americans will suffer.

The Republicans' own words from last year's debate on health care reform make the case that the cuts in provider payments in this bill are reckless, too high, and too heavily focused on the hospitals and clinics who cannot survive them. These comments were made about a Democratic bill which reduced Medicare spending almost 40 percent less than this Democratic bill which reduced Medicare spending almost 40 percent less than this Republican bill, and would have invested every penny of that spending back into the health care system by assuring that every American was covered, and provided that every hospital and every doctor would be paid a reasonable amount for their services.

About those smaller cuts, Congressman Archer said on June 25, 1994, on C–SPAN: "Make no mistake about it for the elderly in this country, [these cuts are] going to devastate their program under Medicare," and in another statement, "I just don't believe that quality of care and availability of care can survive these additional cuts. And that is the price that is going to have to be paid to pay for these cuts."

Congressman Jim McCrery said that same day on C–SPAN: "I would love to believe that we could achieve the level of cuts you have in this bill * * *. But history tells us that this isn't possible. And I think we are just playing games here, we are just making the numbers match. That's all Democrats have done in your bill to make it revenue neutral. You have just estimated the number needed from Medicare to make the numbers match, and I think the public understands that."

Perhaps Congressman McCrery should review the percentage growth rates specified for Medicare in the Republican bill, and their uncanny resemblance to the percentage growth allowed under the Budget Resolution in order to finance the Republican tax cuts—the numbers match.

And from the "Minority Views" included with the Committee report on health care reform: "For more than a decade Congress has cut back on payments to doctors and hospitals until they no longer cover the costs for Medicare patients—and the additional massive cuts in reimbursement to providers proposed in this bill will reduce the quality of care for the Nation's elderly. There will be no place else to shift."

Apparently, Republicans now believe that a far larger set of cuts will not "reduce" the quality of care for the Nation's elderly.

THE REPUBLICAN "BLACK-BOX" CUTS IN PAYMENTS TO DOCTORS AND HOSPITALS

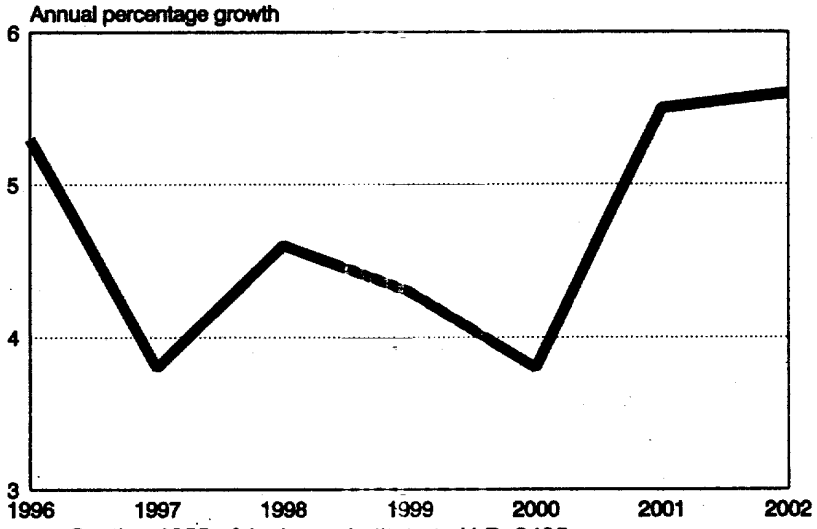
The Republican plan also incorporates a "black-box" mechanism requiring even more cuts if Medicare spending does not meet the arbitrary targets set forth in the Republican budget resolution. The so-called "fail safe" mechanism in the bill is a smoke screen for further large cuts in reimbursements to providers, without any opportunity for Congress, providers, or the public to understand the impact of the cuts on access or quality of service.

The $37 billion in cuts caused by the black-box mechanism would be on top of the $148 billion the Republican plan already takes from payments for provider services. The so-called "fail-safe" mechanism only affects the fee-for-service system. It is obvious that slashing reimbursements for doctors who stay in the basic Medicare fee-for-service system is going to result in more and more doctors moving out of traditional Medicare and into Provider Service Organizations, where the physicians can get out from under State regulation and where they can balance bill patients to make up for the reductions in Medicare payments. The end result is that Medicare beneficiaries who stay in traditional Medicare so that they can keep their choice of doctor are going to find their doctors leaving traditional Medicare without them.

The "fail-safe" is flawed in another important way as well. Under the system, Medicare spending would be capped at a flat dollar amount, which would increase at an average annual rate of 4.7 percent per beneficiary, without any adjustment for changes in the underlying inflation rate or for changes in the health status of the Medicare population. If a flu epidemic were to occur, or if the underlying inflation rate were to change, Medicare would be locked into the straight-jacket imposed by these arbitrary and extremely low caps. As has already been noted, these rates have nothing to do with the needs of the health care financing system—the growth rates are those into which the Budget Committee decided Medicare had to be shoe-horned in order to finance a tax cut for the privileged few. In fact, an examination of the annual rates demonstrates the completely arbitrary nature of the "fail-safe" mechanism, as the following chart illustrates:

Why?

Arbitrary Medicare Growth Rates Imposed by the Republican Plan



Source: Section 1855 of Archer substitute to H.R. 2425

Perhaps worst of all, the program is capped after 2002 at a flat annual growth rate of 5 percent per beneficiary, no matter what happens to inflation or anything else between now and that relatively far-off date. If the underlying inflation rate were to increase beyond its currently forecasted rate of around 3 percent to perhaps 6 or 7 percent, a rate well within the memory of most Americans, Medicare would be completely starved for adequate funding under the Republican plan. Whether that turns out to be too much to pull out of the system without affecting access and quality is evidently irrelevant.

TURNING BACK THE CLOCK ON NURSING HOME REFORM

The Republicans want to turn back the clock on protecting seniors from abuse in nursing homes. They have decided to repeal the nursing home reform standards enacted in 1987 and, instead, rely mostly on States to supervise nursing homes.

Prior to the enactment of the nursing home reform amendments of 1987, the States had substantial authority to protect senior citizens living in nursing homes. During this time, when States were entrusted with the safety and welfare of our most vulnerable population, there were countless GAO reports, public hearings, and sen-

sational and atrocious newspaper stories documenting the abuse of nursing home residents.

The failure of States to prevent these atrocities is what led to the enactment of the 1987 law. The 1987 nursing home reform amendments put in place minimum Federal standards designed to safeguard the well-being of elderly and disabled Americans living in nursing homes. These amendments were heralded by consumer groups, State regulators, and others concerned about long-term care. In fact, no one, not even the nursing home industry, actively opposed these provisions.

Despite the consensus about the need to improve the quality of care in nursing homes; despite the improvements that have been made as a direct result of this law; despite the absence of any reports, hearings, or debate about the necessity for making modifications to these provisions, the Republican proposal will totally dismantle this landmark legislation.

The nursing home reform regulations have had the following results;

A 25-percent reduction in hospital use by nursing home residents, without increases in mortality and with decreases in functional decline;

A 24-percent increase in the accuracy of nursing home residents' medical records;

A significant improvement in patient well-being, including a 25-percent decrease in the use of restraints and a 28-percent decrease in the percentage of residents who are left idle and unmoving in their beds;

Medicare savings of more than $2 billion annually as better nursing home care reduces hospitalizations.

The 1987 law ensured that nursing home residents have the right to be free from physical restraints. This protection is missing from the Republican bill. The 1987 law ensured that nursing home residents have the right to be free from over-medication, or chemical restraints. This protection is missing. The 1987 law ensured that nursing home residents have the right to pick their own doctor and be informed about their medical care. This protection is missing. The 1987 law protected nursing home residents from being transferred against their will. This protection is missing from the Republican plan.

In 1986, the Institute of Medicine of the National Academy of Sciences conducted a comprehensive, non-partisan year-long study of the quality of care in nursing homes. After a thorough investigation, they concluded: "[a] stronger Federal leadership role is essential for improving nursing home regulations because not all State governments have been willing to regulate nursing homes adequately unless required to do so by the Federal government." That conclusion was right then, and it is right now.

THE LOCKBOX THAT ISN'T LOCKED

The Republicans claim that their creation of a Medicare "lockbox" protects Medicare savings from paying for tax cuts for the wealthy few. The lockbox is nothing but a sham, a superficial budget gimmick to try to fool the American public.

They have written a provision that is an empty facade, an accounting trick. If the lockbox was genuinely intended to prevent savings created by cutting Medicare from paying for the $245 billion Republican tax cut, it is a miserable failure. It accomplishes nothing but a few accounting entries on the Department of the Treasury's books.

The Republicans apparently think that by simply depositing savings in a separate account, they can disguise the truth with accounting entries. They have ignored the fact that money is fungible—which Government account it is put into or taken out of just doesn't matter. Simply put, the Government must pay for what it does. It doesn't matter which "checking account" we use.

Republicans are quite sensitive, as well they should be, about the juxtaposition of Medicare cuts and tax cuts. The budget plan they put forth leaves no doubt about the fact that the Medicare cuts are necessary to pay for the tax cuts.

Democrats have focused on the facts: the Republican budget does not balance unless the Medicare cuts are included. If the Republicans' dual goals of cutting taxes and balancing the budget were satisfied without Medicare cuts, it would mean that the tax cuts had genuinely been funded through other sources. That is not true. The Medicare cuts are essential to the total tally. The Republican budget-balancing act relies critically on the Medicare cuts.

Why is that so? Because the Republican budget plan includes a $245 billion tax cut, most of which would benefit the wealthy. Without that tax cut, the Republicans' budget would balance without the need for the $270 billion in Medicare cuts that are reflected in this bill.

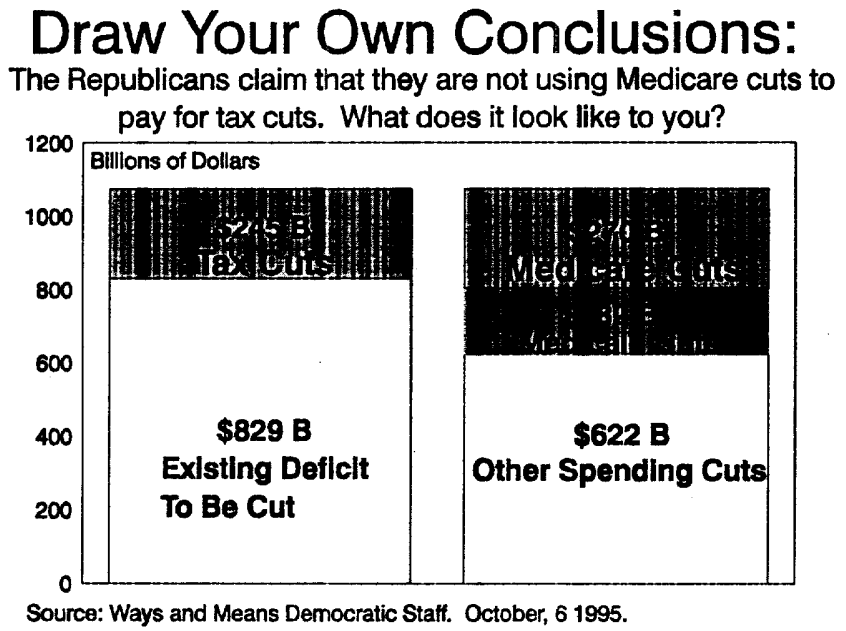
Republicans have two choices: find other ways to pay for their tax cut or fall short of their goal of a balanced budget. Those are the only ways to ensure that the Medicare cuts do not pay for tax cuts. The American people understand this. They deal with this reality every day in their household budgets. If your income goes down, you must curtail your expenditures to make up the difference. The Republicans are intentionally causing the Government's income to go down by cutting taxes by $245 billion. In order to make up for this in the context of balancing the budget, they must curtail the Government's expenditures.

The Republicans have chosen a heartless way to do so: they will pay less for health care for seniors and disabled Americans. The Republican Medicare plan will make health care more expensive and less available for seniors and the disabled. That would be unnecessary if they did not have to make up the difference for an unnecessary tax cut.

Even the structure of the lockbox itself belies the Republicans' claims. The lockbox is a new federal trust fund. A trust fund is nothing more than another Government account in the Treasury. The bill and the Republican rhetoric make it sound as if no spending is allowed out of this trust fund. However, the bill allows borrowing from the trust fund. In fact, the bill requires the trust fund to lend to the Department of the Treasury. Treasury will certainly need these additional funds, since it will be short $245 billion because of the Republican tax cut! Medicare savings not only go into the trust fund, they go right through the trust fund and into the

hands of wealthy taxpayers who will benefit from the Republican tax cut. The only thing left in the trust fund will be IOUs.

The lockbox is an empty gesture. It has no teeth. It is an attempt to mislead the American public. That attempt will not succeed, we are sure. People are smarter than that.



A RESPONSIBLE DEMOCRATIC ALTERNATIVE

Democrats proposed a sane and responsible alternative for Medicare in the Committee but was rejected on a straight party-line vote. The Democratic alternative contains a series of balanced reforms which would assure the solvency of the Medicare Trust Fund to exactly the same year as the Republican policies do—2006—but it would do so without taking three times what is needed from Medicare.

The Democratic plan starts with a responsible policy on hospital payments. Medicare is the single largest insurer in the United States today. Reductions in payments to providers under Medicare must be carefully planned and implemented to avoid severe negative consequences for Medicare beneficiaries and the American taxpayer. Excessive reductions in hospital costs—like those proposed by the Republican majority—could be counterproductive, negatively affecting the quality of care, reducing access to care, and resulting in higher costs for the private sector. Little would be accomplished by unnecessarily blunt reductions in Medicare payments to hospitals. Our most vulnerable hospitals—those that serve a large share of the 40 million Americans who are uninsured—would carry an unfair burden.

Under the Democratic plan, reasonable reductions would be made in hospital payments. Furthermore, there would be no reductions in payments made to compensate hospitals that care for a disproportionate share (DSH) of the uninsured. In addition, funding for DSH hospitals, now paid to HMO's, would be paid directly to these high-indigent-care hospitals.

The Democratic plan would retain essential protections for Medicare beneficiaries in nursing homes. In addition, the substitute would revamp the nursing facility reimbursement system through a series of prudent steps, including: (1) extending the skilled nursing facility (SNF) cost limits; (2) establishing a prospective payment system to control costs; and (3) reforming SNF transfer policies.

Efforts to control Medicare spending require that limits be placed on reimbursements to all providers, including physicians. Since the Nation's doctors have been supportive of the payment reforms included in H.R. 2425, the Democratic alternative includes those reforms with very slight modifications.

The Republican majority has proposed an unprecedented seven-year freeze on payments for clinical laboratory services, durable medical equipment, and ambulatory surgery, raising questions about whether these providers will, in the future, continue to serve Medicare beneficiaries. In addition, the Republican plan halts the steady progress Democrats have made over the past decade in improving preventive benefits—under the Republican plan, no new preventive benefits are offered, despite strong evidence that the basic Medicare benefit package needs improvement in this area.

The Democratic alternative offers a package of balanced changes combined with modest program improvements, including: (1) imposing a two-year freeze on clinical labs, durable medical equipment, and ambulatory surgery; (2) reducing effective beneficiary copayments for outpatient services by correcting the payment formula; and (3) adding new services to prevent breast, colorectal, and prostate cancer and the complications from diabetes.

Fully 83 percent of Medicare expenditures are for beneficiaries with incomes of less than $25,000 per year. Clearly, beneficiary premiums and copayments should be increased only as a very last resort. These senior citizens can ill-afford to pay any increase in the Part B premium, however small. Under the Democratic plan, Medicare beneficiaries are protected.

The following chart shows the premium amounts under current law, the Republican proposal (H.R. 2425), and the Democratic plan:

	1995	1996	1997	1998	1999	2000	2001	2002
Current law	$46	$43	$48	$53	$55	$57	$59	$61
Republican plan	46	54	57	60	64	72	78	87
Democratic alternative	46	46	47	51	52	54	56	58

Medicare beneficiaries currently select either traditional fee-for-service or an HMO for the delivery of their health care. Under the Democratic plan, additional managed care choices would be provided, including preferred provider organizations (PPOs), point-of-service (POS) plans, and provider service organizations.

Prudent reforms are needed in Medicare's policies for reimbursing the costs of graduate medical education. Instead, the Republican majority has chosen to slash support for hospitals dedicated to training the next generation of health professionals. Under the Democratic substitute, only the needed reforms would be made. Specifically, the plan would establish a graduate medical education trust fund with funds for teaching hospitals, now paid to HMO's, deposited into the new fund. A commission on graduate medical education would also be established to develop a method for assuring that academic medical centers train the types of physicians that will be required to meet the Nation's health needs. In addition, a number of needed improvements would be made in Medicare policies for reimbursing the costs of graduate medical education, including freezing the total number and number of non-primary-care residency positions reimbursed under Medicare.

Payments for home health services have been one of the fastest growing components of Medicare since the late 1980's. In fact, outlays for home health services more than quintupled between 1987 and 1994. Reforms are needed to control the growth in expenditures. Under the Democratic substitute, payments for home health services, over time, would shift from cost-based retrospective reimbursement, to a prospective payment system.

A commission would be established to analyze the health status of the Medicare-eligible population, make recommendations on actions to improve the health of that population, analyze the effects of changes in Medicare on the private health financing system, examine the impact of the increase in the eligible population occurring after 2010, and make recommendations to the Congress on actions to preserve the program during that period.

The Democratic plan would fill the holes in the Republican fraud-detection proposal by strengthening Federal anti-fraud and -abuse efforts through increased funding for the HHS Inspector General and for payment safeguards to fight fraudulent claims for payment.

Most importantly, the Democratic plan preserves Medicare without increasing premiums, and without using Medicare's trust fund like a slush fund so that people who are already among the very richest can add to their assets.

Unfortunately, it is probably true that facts will not sway many on the Republican side. The very idea that the Federal Government actually runs a program as efficiently and effectively as it runs Medicare must keep them up at night. They have a childlike faith that "managed care" or "entrepreneurial creativity" will yield huge savings for Medicare, or at least help finance their ill-conceived tax cuts.

Well, that's not what is going to happen. These cuts will hurt, and they will hurt badly. Real people—hard-working Americans who have paid into Medicare for years and years—won't get the benefits they were promised. Real hospitals, real rural clinics, and real community health centers will go bankrupt, and the safety-net system which provides care to the medically indigent will be destroyed.

Mindless slashing of Medicare will only disrupt the health services on which America's seniors depend. It is the vulnerable parts

of the health system, such as inner-city and rural hospitals, which would bear the brunt of that approach.

For 30 years we have been working successfully to uphold the true contract with America—Medicare. We have not, and will not, agree to breaking that contract in order to finance today's Republican tax cuts for the wealthiest Americans. Medicare is not about to fall off a cliff—we'll fix any problems that come up as we always have. Most importantly, we will do everything in our power to defeat this reckless Republican plan.

THE SECRETARY OF
HEALTH AND HUMAN SERVICES,
Washington, DC, October 3, 1995.

Hon. SAM GIBBONS,
Ranking Member, Committee on Ways and Means, House of Representatives, Washington, DC.

DEAR CONGRESSMAN GIBBONS: This letter presents the Administration's views in strong opposition to H.R. 2425, "The Medicare Preservation Act of 1995."

Medicare reform should promote efficiency, improve quality of care, expand beneficiary choice, fight fraud and abuse, and update aspects of the program to reflect current developments in the health care delivery system. The Clinton Administration supports this kind of Medicare reform.

"The Medicare Preservation Act of 1995," however, cuts the Medicare program by $270 billion over the next seven years, far beyond what is necessary to safeguard the Medicare Part A trust fund and far beyond what could be absorbed by hospitals and providers without harming beneficiary access and quality of care. H.R. 2425 imposes new and heavy burdens, both direct and hidden, on Medicare beneficiaries, and it opens up new avenues for health care fraud and abuse.

Because it needlessly and recklessly threatens the future of Medicare in these ways, I will strongly recommend that the President veto H.R. 2425, "The Medicare Preservation Act of 1995" if it reaches his desk in its current form.

MEDICARE SPENDING CUTS IN H.R. 2425 ARE EXCESSIVE

H.R. 2425 cuts $270 billion from Medicare spending over the next seven years. While Republican Members of Congress justify this level of spending cuts as necessary to "save" the Medicare Part A Trust Fund, only a fraction of these reductions would actually be returned to the Part A trust fund. Most of the cuts in H.R. 2425—$140 billion over seven years—are in Medicare Part B. None of these savings would strengthen the Part A trust fund. Of the $130 billion in Part A cuts, which would be returned to the Part A trust fund, $36 billion would be needed to offset trust fund revenue losses caused by action taken by House Republicans earlier this year.[1] Consequently, the $270 billion Medicare cuts in H.R. 2425 yield only a net $93.4 billion in savings to strengthen the Part A trust fund.

[1] This spring, the House of Representatives voted to repeal a portion of the Social Security payroll tax revenue which was dedicated to the Medicare Part A trust fund under the Omnibus Budget Reconciliation Act of 1993.

The legislation seeks to obscure this fact by establishing a so-called "lock box" that would deposit remaining savings from H.R. 2425 into a new trust fund. It has been claimed that the "lock box" will prevent excess Medicare savings from financing the Republican tax cut for the wealthy. However, under the Congress' own budget rules these monies would, in fact, offset the cost of the tax cut.

Further, H.R. 2425 imposes $54 billion in new financial burdens on beneficiaries in the form of higher Medicare Part B premiums. Most of this increase results from setting the Medicare Part B premium to cover 31.5 percent of program costs. This increase is unnecessary and excessive and does nothing to strengthen the Medicare Part A trust fund. In addition, higher income Medicare beneficiaries will see their Part B premiums more than triple. H.R. 2425 then compounds these direct new burdens on beneficiaries by many hidden cuts that will force them, over time, to pay much more for their health care services.

H.R. 2425 OFFERS FALSE CHOICE AND FALSE PROMISES

Though it claims to offer beneficiaries a broader choice of health plan options, H.R. 2425 actually creates divisions and inequalities within Medicare. I am concerned that it will force beneficiaries to pay more or make do with less.

H.R. 2425 establishes a new program, called MedicarePlus, which will be available in addition to traditional, fee-for-service Medicare. Alternative fee-for-service and managed care plans will be offered under MedicarePlus, as will new types of specifically structured health plans such as provider sponsored organizations (PSOs), medical savings accounts (MSAs), and association plans. Republicans promise Medicare beneficiaries will have free choice between traditional Medicare and all the plan options under MedicarePlus. However, the legislation applies distinctly uneven rules to Medicare and MedicarePlus with the effect of making traditional Medicare much less attractive to providers than MedicarePlus. I am concerned these incentives, along with the provision of the bill that applies the "failsafe" mechanism of additional cuts only to the traditional Medicare program, would reduce the willingness of providers to serve beneficiaries in traditional Medicare. This will restrict beneficiary choice rather than enhance it.

I am also concerned that MedicarePlus, as structured in H.R. 2425, would promote adverse risk selection that could increase costs for the traditional Medicare program. We do not believe that it is appropriate to use Medicare beneficiaries to experiment with new, untested concepts that could weaken the program.

Traditional Medicare protects beneficiaries from "balance billing," the practice whereby providers charge beneficiaries more than Medicare approves. Traditional Medicare permits no balance billing by hospitals and only limited balance billing by physicians. However, balance billing will be widely permitted under MedicarePlus plans. Providers in fee-for-service MedicarePlus plans will be permitted to charge patients *any amount they want* for health care services. The same will be true for patients electing MSA plans. Balance billing will be permitted in managed care plans, as well, whenever patients receive non-emergency care outside of the plan, even if such care is authorized by the plan. Given the very tight

budget imposed by H.R. 2425, I am concerned that provider pressure to balance bill will grow. If providers begin to move to MedicarePlus plans in order to escape balance billing limits, beneficiaries will be faced with the choice of following them and paying more, or remaining in traditional Medicare where fewer doctors and hospitals are able to care for them.

H.R. 2425 IMPACT ON PROVIDERS IS SEVERE.

While the structure of MedicarePlus is designed to shift costs onto beneficiaries, the magnitude of cuts in H.R. 2425 threaten providers as well. We are concerned, particularly, about those providers who constitute the safety net of our health care system. Rural hospitals and clinics, already in precarious financial condition, will be hard pressed to absorb reductions required in H.R. 2425. In addition, urban safety net hospitals will face added reductions in special Medicare payments for uncompensated care.

H.R. 2425 INVITES FRAUD AND ABUSE.

Among our many concerns about H.R. 2425, we are particularly concerned about the provisions that would weaken our efforts to combat fraud and abuse. H.R. 2425 relaxes critical rules that today outlaw kickbacks and that require providers to exercise due diligence in submitting accurate and true Medicare claims. CBO has determined that these provisions of H.R. 2425 will cost the Medicare program over $1 billion from 1996 to 2002. Enactment of these provisions could harm the quality of beneficiary care, will offset the savings from efforts to fight fraud and abuse eleswhere in the bill, and will further burden law enforcement efforts to combat health care fraud and abuse.

TRUE MEDICARE REFORM IS POSSIBLE AND DESIRABLE.

President Clinton has presented a balanced budget plan that will safeguard Medicare while strengthening the Part A trust fund, increase beneficiary choices, and improve our health care system. The President's plan would reduce Medicare spending by a net $124 billion over seven years. Of this total, $89 billion would come from Part A savings and would therefore extend the life of the Part A trust fund through at least the next ten years. The President's plan also would expand the kinds of health plan choices available to Medicare beneficiaries while maintaining existing beneficiary protections throughout the program. This plan also adds important new preventive and long-term care benefits to Medicare. Finally, it is combined with broader health care reform initiatives so that coverage is expanded for working Americans and cost shifting is not fueled. This is the right approach to Medicare reform.

If H.R. 2425 is approved by the Congress, I will strongly recommend that the president veto this bill.

I have been advised by the Office of Management and Budget that there is no objection to the submission of this letter to Congress, and that enactment of H.R. 2425 would not be in accord with the program of the President.

An identical letter is being sent to Rep. Bill Archer, Chairman, Committee on Ways and Means.

Sincerely,

DONNA E. SHALALA.

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
HEALTH CARE FINANCING ADMINISTRATION,
Washington, DC, October 11, 1995.

Hon. SAM GIBBONS,
Ranking Member, Committee on Ways and Means,
House of Representatives, Washington, DC.

DEAR CONGRESSMAN GIBBONS: I am writing in response to your request for information on the combined impact on the Medicare Hospital Insurance (HI) Trust Fund of the Republican Medicare proposals in H.R. 2425 together with the repeal of the Social Security tax provision in the Omnibus Budget Reconciliation Act of 1993 (OBRA '93).

The OBRA '93 provision increased the portion of Social Security subject to Federal income tax and allocated this revenue to the Medicare HI Trust Fund. The repeal of this OBRA '93 provision would decrease HI Trust Fund revenues.

The cumulative effect of the Medicare Part A HI reductions included in H.R. 2425 for FY 1996—FY 2002, offset by the cost of repealing the OBRA '93 provision, would reduce Part A expenditures by approximately $93.4 billion. Based on estimates from the Health Care Financing Administration's actuaries, the resulting year-by-year "net" Medicare Part A savings would extend the life of the HI Trust Fund through the third quarter of calendar year 2006. This estimate is based on the intermediate set of assumptions in the 1995 Trustees Report.

Please let me know if I can provide any further information.

Sincerely,

BRUCE C. VLADECK, *Administrator.*

Attachment.

MEDICARE PART A "NET" SAVINGS ESTIMATES—NET EFFECT OF H.R. 2425 MEDICARE PART A SAVERS AND REPEAL OF OBRA '93 PROVISION [1]

[In billions of dollars]

Year	Medicare Part A savings	Repeal of OBRA '93 provision [1]	Net reduction in Part A spending
1996	−3	2.9	−0.1
1997	−7	4.3	−2.7
1998	−14	4.9	−9.1
1999	−20	5.3	−14.7
2000	−24	5.8	−18.2
2001	−29	[2] 6.4	−22.6
2002	−33	[2] 7.0	−26.0
Total	−130	36.6	−93.4

Based on CBO estimates 10/2/95.

[1] the OBRA '93 Social Security tax provision increased the portion of Social Security subject to Federal income tax and allocated this revenue to the Medicare HI Trust Fund. The repeal of this provision would decrease HI revenues.

[2] HHS projections based on CBO estimates for the years 2001–2002 for repeal of OBRA '93 provision.

September 21, 1995.

Hon. NEWT GINGRICH,
Speaker of the House, U.S. House of Representatives,
Washington, DC.

Hon. ROBERT DOLE,
Majority Leader, U.S. Senate,
Washington, DC.

DEAR MR. SPEAKER AND MR. MAJORITY LEADER: I understand the House Majority is releasing its plan to restructure Medicare today. I am writing to discuss the condition of the Medicare Hospital Trust Fund in the context of these reform plans.

As Managing Trustee of the Medicare Hospital Insurance (HI) Trust Fund, I am concerned by a growing number of statements by Members of Congress which appear to be based on a misunderstanding of what our annual report said. Because votes for significant changes in Medicare should not be cast without Members knowing the facts, I want to recount briefly what the Trustees reported about the funding status of Medicare.

Simply said, no Member of Congress should vote for $270 billion in Medicare cuts believing that reductions of this size have been recommended by the Medicare Trustees or that such reductions are needed now to prevent an imminent funding crisis. That would be factually incorrect.

In the annual report to Congress on the financial condition of Medicare, the Trustees concluded that the HI Trust Fund will not be depleted until 2002, seven years from now. When we issued our findings, we asked Congress to take remedial action to fix the HI Trust Fund on a near-term basis and then in the context of health care reform to make long-term changes in the system that would accommodate the influx of "baby-boomer" beneficiaries. At no time did the Trustees call the funding crisis "imminent." Without adequate time for reflection, a responsible, bi-partisan long-term solution to the financing problem could not be structured. We therefore did not imply that cuts of the magnitude being proposed now were needed.

Nevertheless, the Majority is asking for $270 billion in Medicare cuts, almost three times what is needed to guarantee the life of the Hospital Insurance (Part A) Trust Fund for the next ten years. Moreover, I understand that the $270 billion of cuts proposed by the Majority includes increases in costs to beneficiaries under Part B of the Medicare program, even though increases in Part B do not contribute to the solvency of the Part A Trust Fund. In this context it is clear that more than $100 billion in Medicare funding reductions are being used to pay for other purposes—not to shore up the Medicare HI Trust Fund.

By contrast, the President's proposal, by providing ten years of trust fund security, is consistent with actions by prior Congresses and would afford us far more than sufficient time to propose a bipartisan solution to the long-term fiscal needs of Medicare. Such a bipartisan solution will be needed regardless of whether the President's plan or Congress's plan is finally adopted.

To emphasize, the Trustees did not recommend $270 billion in Medicare cuts at this time nor state that the funding problems fac-

ing Medicare require actions of this magnitude now to deal with a financing problem that occurs in the next century.

I hope this information can be provided to Members of Congress on both sides of the aisle as they review the significant changes in Medicare that are being considered so that Members can have a clear understanding of the facts.

Sincerely,

ROBERT E. RUBIN.

U.S. DEPARTMENT OF JUSTICE,
OFFICE OF LEGISLATIVE AFFAIRS,
Washington, D.C, October 12, 1995.

Hon. SAM GIBBONS,
Ranking Minority Member, Committee on Ways and Means, U.S. House of Representatives, Washington, DC.

DEAR CONGRESSMAN GIBBONS: This letter provides the views of the Department of Justice on those aspects of H.R. 2425, the Medicare Preservation Act of 1995, relating to medical liability reform, specifically Subtitle D, Part 1, §§ 15301–15315. It is our view that this wholesale rewrite of the liability laws relating to the provision of medical services and products is totally inappropriate to the budget reconciliation process and represents an unacceptable extension of federal authority over an area of the law historically left to the states.

This legislation would effect a sweeping reform of the law governing medical liability and medical malpractice suits. Such suits are premised on State tort law and are, for the most part, governed by State court procedures. This legislation would preempt State law, both substantively and procedurally, in an unprecedented fashion, and would effectively immunize health care providers of all kinds from certain types of liability related to the negligent provision of medical services. In addition, the legislation mingles questionable product liability reform measures relating to the manufacture, distribution, and labeling of drugs and medical devices with medical malpractice reform proposals in a manner wholly inappropriate and unnecessary to the purpose of the underlying legislation; i.e., reform of the Medicare and Medicaid systems. In our opinion, the very purpose of the malpractice liability system—to fairly compensate injured victims and to deter future misconduct—would be severely compromised by enactment of this legislation.

During the 103rd Congress, senior officials of the Justice Department testified before Congress in support of a series of medical malpractice proposals included in the President's comprehensive health care reform measure, the Health Security Act. Those proposals were directed at three specific goals—to reduce the costs and delays of malpractice litigation, to reduce the practice of "defensive medicine" which adds to rising national health care costs, and to increase access to justice for malpractice victims. The President's proposals attempted to address some of the problems of the current malpractice system, while recognizing that medical malpractice litigation is an essential aspect of State tort law and jurisprudence. Over the past decade, virtually every state has adopted specific malpractice reforms tailored to the unique circumstances of the re-

spective State court and civil justice system involved. We strongly believe that medical malpractice cases should continue to be litigated primarily in the State courts and that medical malpractice reform should respect the fundamental nature of state law and procedure.

Despite considerable tort reform activity at the state level, there is, unfortunately, little empirical evidence about the practical effects of the various reforms. Calls for reform of the medical malpractice system have rested, at least in part, on arguments that such initiatives would result in health care cost savings by reducing the incentives to practice defensive medicine—procedures undertaken or avoided primarily to avoid malpractice risk. In 1994, the Office of Technology Assessment ("OTT") published an important study of defensive medicine and malpractice liability, ordered by Congress in an effort to determine how certain reforms of the liability system might alter these practices.[1] However, the OTA study revealed the inherent difficulty of measuring the level and cost of defensive medicine. OTA concluded that many aggressive procedures are performed because they are simply "good medicine" or because, in a fee-for-service system, physicians are paid for and make money from the services rendered. Further, it was found that a high percentage of defensive medical procedures "are ordered to minimize the risk of being wrong when the medical consequences of being wrong are severe."[2]

The findings of the OTA study are clearly relevant to consideration of the reforms proposed in the Medicare Preservation Act. Since the mid-1970's, most of the tort reforms implemented in the States were designed primarily to reduce medical malpractice insurance costs by limiting the payments made per claim, the frequency of suits, or the costs of resolving claims. These conventional reforms have retained the courts as the forum for resolving malpractice disputes, but have altered various legal rules to tilt more in favor of defendants, often restricting plaintiffs' access to the courts of limiting the amounts that can be recovered. OTA concluded, however, that the impact of these reforms on the practice of defensive medicine and health care costs remains largely unknown and is not likely to be significant.[3] Accordingly, the burden of proving the appropriateness of "nationalizing" reforms that would have the harshest impact on the most seriously injured patients should rest with the proponents of such measures. We do not believe that burden has been met. In addition to our general objection to this legislation, we offer the following specific comments:

Section 15301. Federal Reform of Health Care Liability Actions. This section would apply all of the various provisions of Subtitle D to any health care liability action brought in any State or Federal court, other than suits brought under the Vaccine Injury Compensation Act. The section further provides that Subtitle D shall preempt any state law "to the extent that such law is inconsistent with the limitations" set forth therein, except that any State law that provides for defenses or places limitations on a person's liability *in addition* to those contained in Subtitle D shall not be pre-

[1] Office of Technology Assessment, *Defensive Medicine and Medical Malpractice* (1994).
[2] *Id.* at 3.
[3] *Id.* at 92–93.

empted. The section provides that nothing shall be construed to create federal question jurisdiction under 28 U.S.C. § 1331 or § 1337, but in diversity action brought under 28 U.S.C. § 1332, the amount sought as noneconomic or punitive damages and attorney's fees and costs shall not be included in determining whether the amount in controversy meets the requisite $50,000 jurisdictional threshold.

The Department of Justice has several concerns about these provisions. First, section 15301(b) preempts those state laws that are less favorable to consumers and patients, but would leave in place those laws that impose "greater restrictions" on liability; i.e., those that favor doctors, hospitals, insurance companies, and other health care providers. The wording of the preemption provision could create substantial confusion, resulting in increased litigation as to which state laws or procedures actually are tougher than or "inconsistent" with the proposed reforms. In addition, the varying interpretations of these provisions by courts in 50 states and 94 federal districts would result in a profusion of legal conflict, forum shopping, and appellate litigation. For those seeking uniformity and predictability, the result could be just the opposite, instead significantly increasing the costs and delays of malpractice lawsuits.

The Department is also concerned about the curtailment of diversity jurisdiction contained in section 15301(d). Currently, the only financial criteria under 28 U.S.C. § 1332 is that the "matter in controversy" exceeds the sum or value of $50,000, exclusive of interest and costs. The proposed amendment would establish a special jurisdictional requirement for health care liability actions that would not be applicable to other types of tort cases or other actions generally. In the absence of broader diversity jurisdiction reform, which has primarily been proposed as a tool to reduce the caseload in the federal courts, there would seem to be no justification for this discriminatory provision.

Section 15302. Definitions.—This section sets forth the definition of a variety of terms used in Subtitle D, and in doing so, establishes the scope and breadth of the proposed reforms.

The definitions of "health care liability action" as set forth in section 15302(8) and "health care provider" set forth in section 15302(9) are particularly problematic. The first provision defines a "health care liability action" to be a civil action brought in State or federal court against (1) a health care provider, (2) an "entity which is obligated to provide or pay for health benefits under any health plan (including any person or entity acting under a contract or arrangement to provide or administer any health benefit)," or (3) "the manufacturer, distributor, supplier, marketer, promoter, or seller of a medical product" in which the claimant alleges a claim based upon the provision of or failure to provide or pay for health care services or the use of a medical product, regardless of the theory of liability on which the claim is based. The definition of "health care provider" would include doctors, nurses, hospitals, nursing homes, clinics (including fertility clinics), and any other institution or individual engaged in the delivery of health care services.

In simplified terms, these definitions assure sweeping application of the limitations on liability set forth in Subtitle D, including not

only conventional medical malpractice actions, but product liability suits, bad faith insurance claims, and breach of contract lawsuits as well.[4] The definition of "entity" would include insurance companies, health maintenance organizations ("HMOs"), and health plan administrators. The application of the proposed limitations on liability to such entities would provide insurance companies and HMOs with broad protection against certain types of liability for denial of health care benefits.

The liability system is an important complement to government regulation of the quality and adequacy of health care services. At just the time that there is a growing need to police the under-staffing of health care facilities and the denial of appropriate treatment by insurance claims managers, this legislation would place unprecedented limits on the ability of claimants to recover damages for their injuries, regardless of the theory of liability. While reform of the medical liability system might be germane to comprehensive health care reform, these unwise measures are neither necessary or appropriate in the context of legislation intended to restore solvency to the Medicare insurance fund.

Section 15311. Statute of Limitations.—This provision would limit the time period for filing claims in health care liability actions to no more than two years after the date on which the injury that is the subject of the action was discovered or should reasonably have been discovered, but in no event more than five years after the initial injury occurred.

In medical malpractice actions, the statute of limitations is either measured from the date of the negligent treatment or from the date the injury could reasonably have been discovered. Some states also make a special exception to the statute of limitations for cases in which a foreign object was left inside a patient during invasive surgery, or in cases of fraud or deliberate misconduct. As of 1993, 32 states required that a malpractice suit be brought within two years or less after the injury is discovered or should have been discovered. Six states provide for a three year period from the date of discovery; the remaining states have no specific provision relating to discovery. In twelve states the maximum number of years in which a malpractice case must be brought is higher than the proposed five year period.

The disturbing aspect of section 15311 is its application, through the definitional provisions, to cases involving something other than medical malpractice. For example, the five year statute of limitations could potentially bar medical product liability actions involving latent diseases, such as AIDS or cancer. The provision would also affect a national statute of limitations for breach of contract or bad faith insurance claims. Such "nationalization" of state law has no justification as a means of reducing the practice of defensive medical or lowering health care costs, and there is little evidence

[4] Medical malpractice litigation encompasses all liability-producing conduct arise from the delivery of professional medical services. Negligent medical care does not exhaust all potential sources of professional liability. For example, liability may result from intentional misconduct, breaches of contract guaranteeing coverage of specific therapies or results, divulgence of confidential information, and failures to prevent injuries to patents. See, Joseph H. King, Jr., *The Law of Medical Malpractice 3,* (2d Ed. 1986).

that shorter status of limitations limit malpractice payouts or the number of claims.[5]

Section 15312. Calculation and Payment of Damages.

(a)(1) Limitation on Noneconomic Damages.—This provision would limit awards for pain and suffering (non-economic damages) to $250,000, regardless of the number of parties against whom the action is brought or the number of actions brought with respect to the jury.

Malpractice or product liability damage awards usually have two components: direct economic losses (such as medical or rehabilitation expenses and lost wages) and non-economic damages, such as payments for physical and emotional pain, emotional distress, disfigurement, loss of consortium, and other non-pecuniary losses. Losses for pain and suffering are very difficult to quantify and juries or provide no clear standards for determining them. Critics contend that the emotional desire in unpredictability high awards.

Approximately 14 states have placed some limit on non-economic damages. These limits range from $250,000 (California) to $1 million (Wisconsin, West Virginia), and in a number of states there are exceptions to the limit. A number of states have overturned caps on pain and suffering damages on state constitutional grounds, including guarantee of the right to trial by jury and access to the courts. Several State constitutions, such as those of Arizona, Pennsylvania, and Montana, specifically limit the legislature's right to restrict damages in tort actions.

Studies have shown and it is obvious that those affected by caps on non-economic damages are those claimants who have been most severely injured. It is those individuals who need to be compensated for the losses the have been suffered so they may get on with their lives with some degree of dignity, hope, and security. No one should want to tell persons who have been severely injured through the negligence of others that they will not receive fair compensation because there is some arbitrary limit legislation by Congress, and that they are simply out of luck. Such arbitrary limits seem particularly unjust when the result of negligence is serious lifetime impairment, disfigurement, pain, infertility, or even death. Non-economic damage caps also discriminate against women, minorities, the elderly, children, the poor, or other patients who often cannot demonstrate substantial economic losses (i.e., lost wages).

In light of the serious legal and constitutional issues involved, it seems ill-advised to nationalize the harshest and most restrictive limitation on non-economic damages. The Department of Justice does not endorse this proposal that would inflict the greatest financial and emotional harm on those victims of negligence or other malfeasance who have been the most severely injured.

(a)(2) Joint and Several Liability.—This provision would limit a defendant's liability for non-economic damages this or her proportionate share of the fault or responsibility for the claimant's actual damages, as determined by the trier of fact. Essentially, this section does away with the doctrine of "several liability" for pain and

[5] See, Zuckerman, S., Bovbjerg, R.R., and Slaon F., "Effect of Tort Reform and Other Factors on Medical Malpractice Insurance Premiums," *Inquiry* 27 (1990); Office of Technology Assessment, *supra*.;

suffering, although defendants would remain jointly and severally liable for a plaintiff's actual damages.

When multiple defendants are responsible for a plaintiff's injury (doctor, hospital, laboratory, etc.) the plaintiff has traditionally had the right to collect from each defendant in the amount of their responsibility (joint liability) or the plaintiff could collect the entire amount from a single defendant (several liability), forcing that defendant sue the other defendants for the amount of injury for which they were responsible by seeking "contribution." This rule effectively allocates the risk of one defendant's insolvency or inability to pay to the other defendants, rather than to the plaintiff. Some states have eliminated several liability, usually with respect to non-economic damages only. Other states have enacted modified joint and several liability reforms, usually requiring that several liability be limited depending on the relative degree of the defendant's fault or the ability of other defendants to pay the claim.

Again, this measure would have a disproportionately negative impact on women, the poor, children, the elderly, and other individuals who would tend to be awarded greater non-economic damages than economic damages. Combined with the other restrictions on the award of compensation for pain and suffering included in this bill (see discussion of section 15312(a)(1) and section 15312(f)), this provision would inflict the greatest harm on those who have been the most severely injured. Many states have already addressed reform of the doctrine of joint and several liability in a manner that reflects the public policy and legal decisions of the legislative and judicial branches of that State. A national rule limiting the application of joint and several liability in a broad array of legal actions is neither necessary or fair.

Section 15312(b) (1) and (2). Treatment of Punitive Damages.—This provision would limit punitive damages in health care liability actions, including medical malpractice cases, product liability cases, and bad faith insurance claims, to no more than three times the amount of economic loss, or $250,000, whichever is greater. In addition, the claimant must establish by "clear and convincing" evidence that the harm suffered was the result of conduct (1) specifically intended to cause harm; or (2) manifesting a conscious, flagrant indifference to the rights or safety of others. The limitation on punitive damages is to be "applied by the court and shall not be disclosed to the jury." To underscore the drafters' intent, the bill states that this section shall not preempt or supersede any State or federal law that imposes further limits on the award of punitive damages.

Punitive damages are awarded in cases where the defendant's conduct is intentional, malicious, or conscious, with a willful disregard for the plaintiff's well-being. The Justice Department has previously indicated that, in the context of product liability cases, it would support a national standard for the award of punitive damages requiring a findings of "conscious, flagrant indifference to the safety of those persons who might be harmed," but would oppose arbitrary caps on punitive damages in any amount. Such limited reform would be justified in the context of products manufactured in one state and sold throughout the country. However, the same reasoning would not necessarily apply to malpractice litiga-

tion, which usually involves a patient, and a local doctor or hospital.

Legal scholars generally do not regard punitive damages as contributing significantly to health care costs. A study by the American Bar Foundation identified only 18 punitive damage awards out of a total of 1,917 medical malpractice verdicts in 47 counties from 1981 to 1985.[6] The Rand Institute for Civil Justice discovered only four punitive damage awards in medical malpractice cases in San Francisco and Cook Counties between 1960 and 1984.[7] The first nationwide study of punitive damage verdicts in medial malpractice cases for the thirty year period 1963–1993 identified only 270 such awards.[8] This study concluded that punitive damages were seldom used to sanction incompetent physicians, but were of increasing importance to protect patients from harm caused by bureaucratic organizations, such as nursing homes, HMOs, and insurance companies and related utilization review providers.

Most states have reformed medical malpractice law in some respect and a majority of jurisdictions have restricted punitive damages. In 1985, Illinois abolished punitive damages in medical malpractice cases altogether. Kansas limits punitive damages in medical malpractice to the lesser of $3 million or 25 percent of the defendant's highest gross annual income for any one of the five years preceding the tort, and divides those punitive damages between the plaintiff and the state. State reforms include capping, state-sharing of awards, increased evidentiary burdens, judge-assessed punitive damages, and bifurcated trials.

Section 15312(b) would significantly reduce the deterrent effect of punitive damages just as the changing structure of health care in the United States exposes more and more consumers to decisions which might measure patient safety against cost saving strategies. Credible research has demonstrated that punitive damage awards are of little significance in conventional malpractice litigation against doctors and hospitals, but the liability system serves an important "regulatory" function with respect other health care providers and organizations. Medicare reform is not the context in which to evaluate the importance of this remedy in the rapidly changing world of health care delivery in the United States.

Section 15312(e). Drugs and Devices. This provision would provide immunity from punitive damages for the manufacturers of pharmaceutical products and medical devices that received premarket approval by the Food and Drug Administration ("FDA"), unless the defendant, before or after pre-market approval, intentionally and wrongfully withheld from or misrepresented to the FDA information that is "material and relevant to the harm suffered by the claimant," or bribed an official or employee of the FDA for the purpose of securing or maintaining approval of such drug or device. The measure also extends such immunity to those drugs and devices that are not FDA approved, but are "generally recognized as safe and effective" under conditions established by the

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[6] See, Stephen Daniels and Joanne Martin, "Myth and Reality in Punitive Damages," 75 *Minn. L. Rev.* 1 (1990).

[7] Mark Peterson, *Punitive Damages: Empirical Findings*, (1987).

[8] Michael Rustad and Thomas Koenig, "Reconceptualizing Punitive Damages in Medical Malpractice: Targeting Amoral Corporations, Not 'Moral Monsters'" 47 *Rutgers L. Rev.* 975 (1995).

FDA and applicable regulations. Punitive damages are also barred in health care liability actions for harm relating to the adequacy of tamper-resistant packaging unless the drug is found by the court by clear and convincing evidence to be "substantially out of compliance" with relevant regulations.

This measure relates to product liability suits involving defective drugs or medical devices which were approved for sale according to the complex regulatory process prescribed by the Food, Drug and Cosmetic Act, 21 U.S.C. § 301 et. seq., and the Medical Device Amendments, 21 U.S.C. § 360c–1. The broad immunity from punitive damages that would be established even goes far beyond the so-called "FDA defense" amendment adopted earlier this year by the House of Representatives during debate of H.R. 956, the Product Liability Fairness Act of 1995. Tort liability serves to complement and reinforce the FDA regulatory process, as exemplified by litigation involving products such as the Shiley heart valve, silicone breast implants, Dalkon Shield, and DES. Medicare reform is not the context in which to consider fundamental alterations to the food and drug liability regime.

Section 15312(f). Periodic Payments for Future Losses. This provision allows the defendant in a health care liability action to make periodic payments for future economic and non-economic damages in excess of $50,000, rather than in a lump sum. Such periodic payments shall be based on when the damages are found likely to occur, as determined by the court. In the absence of fraud, the judgment of the court awarding periodic payments may not reopen at any time to contest, amend, or modify the schedule or amount of the payments.

Periodic payments help to reduce the impact of large awards on malpractice insurers. If a victim is severely injured, the damages are based on medical and other expenses that will incur over a lifetime, as well as lost wages and pain and suffering. If the insurance company can pay out the award as the expenses are incurred, the net cost of the malpractice award will be lower. Structuring awards also reduces the risk that the injured party will deplete funds that are intended to be used to pay future medical and economic costs.

Fourteen states mandate periodic payments of future economic damages if the award exceeds a threshold level (usually $100,000–$250,000). In another 16 states, periodic payments are discretionary, but not mandatory. Many states require defendants (or their insurers) to purchase an annuity to insure the future payments, and other jurisdictions allow payment schedules to be modified in the event of a change in the patient's circumstances.

The Justice Department indicated that as part of comprehensive health care reform it supported the periodic payment of future damages, both economic and non-economic, consistent with the recommendations of the National Conference of Commissioners on Uniform State Laws. However, section 15312(f) sets the threshold for periodic payments at a level lower than most states, makes no provision for the defendant's (or its insurer's) insolvency, and does not allow the payment schedule to be amended or modified to accommodate changed circumstances.

Section 15313. Alternative Dispute Resolution. This provision requires any alternate dispute resolution system ("ADR") used to re-

solve a health care liability action to include the limitations on liability set forth in Subtitle D, including provisions relating to the statute of limitations, non-economic damages, joint and several liability, punitive damages, collateral source rule, and periodic payments.

ADR can be and is an effective tool in reducing the costs and delays of medical malpractice and other tort litigation. Many states have developed ADR rules and programs that encourage parties to resolve disputes before trial; the federal courts have also tested the use of ADR as part of the Civil Justice Reform Act experiment. However, this provision preempts all ADR procedures in the state and federal courts in an unprecedented fashion, imposing the proposed limitations on a dispute resolution mechanism designed to encourage openness and flexibility. This provision would also seem to impose such limitations on pre-treatment ADR contracts privately bargained for between the health care provider and the consumer. The Justice Department strongly opposes the wholesale extension of these stringent limitations on liability to the ADR setting.

Thank you for the opportunity to provide our views on these important proposals. Please do not hesitate to contact us if we may be of additional assistance with this or any other matter. The Office of Management and Budget has advised that there is no objection from the standpoint of the Administration's programs to the presentation of this report.

Sincerely,

ANDREW FOIS, *Assistant Attorney General.*

DEPARTMENT OF HEALTH AND HUMAN SERVICES,
OFFICE OF INSPECTOR GENERAL,
Washington, DC, September 29, 1995.

Re H.R. 2389: "Safeguarding Medicare Integrity Act of 1995."

Hon. SAM M. GIBBONS,
Ranking Minority Member, House Committee on Ways and Means, House of Representatives, Washington, DC.

DEAR MR. GIBBONS: We have had the opportunity to review the newly introduced H.R. 2389, and it is our understanding that many of the concepts in H.R. 2389 may be considered in the deliberations concerning the "Medicare Preservation Act." We strongly support the expressed objective of H.R. 2389 of reducing the fraud and abuse which plagues the Medicare program. The proposed legislation contains some meritorious provisions. However, if enacted, certain major provisions of H.R. 2389 would cripple the efforts of law enforcement agencies to control health care fraud and abuse in the Medicare program and to bring wrongdoers to justice.

The General Accounting Office estimates the loss to Medicare from fraud and abuse at 10 percent of total Medicare expenditures, or about $18 billion. We recommend two steps to decrease this problem: strengthen the relevant legal authorities, and increase the funding for law enforcement efforts. Some worthy concepts have been included in H.R. 2389, and we support them. For example, we support:

a voluntary disclosure program, which allows corporations to blow the whistle on themselves if upper management finds wrongdoing has occurred, with carefully defined relief for the corporation from *qui tam* suits under the False Claims Act (but not waiver by the Secretary of sanctions);

minimum periods of exclusion (mostly parallel with periods of exclusion currently in regulations) with respect to existing exclusion authorities from Medicare and Medicaid; and

increases in the maximum penalty amounts which may be imposed under the civil monetary penalty laws regarding health care fraud.

As stated above, however, H.R. 2389 contains several provisions which would seriously erode our ability to control Medicare fraud and abuse, including most notably: making the civil monetary penalty and anti-kickback laws considerably more lenient, the unprecedented creation of an advisory opinion mechanism on intent-based statutes, and a trust fund concept which would fund only private contractors (not law enforcement). Our specific comments on these matters follow.

1. MAKING CIVIL MONETARY PENALTIES FOR FRAUDULENT CLAIMS MORE LENIENT BY RELIEVING PROVIDERS OF THE DUTY TO USE REASONABLE DILIGENCE TO ENSURE THEIR CLAIMS ARE TRUE AND ACCURATE

Background: The existing civil monetary penalty (CMP) provisions regarding false claims were enacted by Congress in the 1980's as an administrative remedy, with cases tried by administrative law judges with appeals to Federal court. In choosing the "knows or should know" standard for the mental element of the offense, Congress chose a standard which is well defined in the *Restatement of Torts, Second,* Section 12. The term "should know" places a duty on health care providers to use "reasonable diligence" to ensure that claims submitted to Medicare are true and accurate. The reason this standard was chosen was that the Medicare system is heavily reliant on the honesty and good faith of providers in submitting their claims. The overwhelming majority of claims are never audited or investigated.

Note that the "should know" standard does not impose liability for honest mistakes. If the provider exercises reasonable diligence and still makes a mistake, the provider is not liable. No administrative complaint or decision issued by the Department of Health and Human Services (HHS) has found an honest mistake to be the basis for CMP sanction.

H.R. 2389 Proposal: Section 201 would redefine the term "should know" in a manner which does away with the duty on providers to exercise reasonable diligence to submit true and accurate claims. Under this definition, providers would only be liable if they act with "deliberate ignorance" of false claims or if they act with "reckless disregard" of false claims. In an era when there is great concern about fraud and abuse of the Medicare program, it would not be appropriate to relieve providers of the duty to use "reasonable diligence" to ensure that their claims are true and accurate.

In addition, the bill treats the CMP authority currently provided to the Secretary in an inconsistent manner. On one hand, it pro-

poses an increase in the amounts of most CMPs which may be imposed under the Social Security Act. Yet, it would significantly curtail enforcement of these sanction authorities by raising the level of culpability which must be proven by the Government in order to impose CMPs. It would be far preferable not to make any changes to the CMP statutes at this time.

2. MAKING THE ANTI-KICKBACK STATUTE MORE LENIENT BY REQUIRING THE GOVERNMENT TO PROVE THAT "THE SIGNIFICANT" INTENT OF THE DEFENDANT WAS UNLAWFUL

Background: The anti-kickback statute makes it a criminal offense knowingly and willfully (intentionally) to offer or receive anything of value in exchange for the referral of Medicare or Medicaid business. The statute is designed to ensure that medical decisions are not influenced by financial rewards from third parties. Kickbacks result in more Medicare services being ordered than otherwise, and law enforcement experts agree that unlawful kickbacks are very common and constitute a serious problem in the Medicare and Medicaid programs.

The two biggest health care fraud cases in history were largely based on unlawful kickbacks. In 1994, *National Medical Enterprises,* a chain of psychiatric hospitals, paid $379 million for giving kickbacks for patient referrals, and other improprieties. In 1995, *Caremark, Inc.* paid $161 million for giving kickbacks to physicians who ordered very expensive Caremark home infusion products.

Most kickbacks have sophisticated disguises, like consultation arrangements, returns on investments, etc. These disguises are hard for the Government to penetrate. Proving a kickback case is difficult. There is no record of trivial cases being prosecuted under this statute.

H.R. 2389 Proposal: Section 201 would require the Government to prove that "the significant purpose" of a payment was to induce referrals of business. The phrase "the significant" implies there can only be one "significant" purpose of a payment. If so, at least 51 percent of the motivation of a payment must be shown to be unlawful. Although this proposal may have a superficial appeal, if enacted it would threaten the Government's ability to prosecute all but the most blatant kickback arrangements.

The courts interpreting the anti-kickback statute agree that the statute applies to the payment of remuneration "if *one purpose* of the payment was to induce referrals." *United States* v. *Greber*, 760 F.2d 68, 69 (3d Cir. 1985) (emphasis added). If payments were intended to induce a physician to refer patients, the statute has been violated, even if the payments were also intended (in part) to compensate for legitimate services. Id, at 72. See also: *United States* v. *Kats*, 871 F.2d 105, 108 (1989); *United States* v. *Bay State Ambulance*, 874 F.2d 20, 29–30 (1st Cir. 1989).

The proposed amendment would overturn these court decisions.

However, the nature of kickbacks and the health care industry requires the interpretation adopted by *Greber* and its progeny. To provide that a defendant had the improper intent necessary to violate the anti-kickback statute, the prosecution must establish the defendant's state of mind, or intent. As with any intent-based statute, the prosecution cannot get directly inside the defendant's head.

The prosecution must rely on circumstantial evidence to prove improper intent. Circumstantial evidence consists of documents relevant to the transaction, testimony about what the defendant said to business associates or potential customers, etc. These types of evidence are rarely clear about the purposes and motivations of the defendant. The difficulties of establishing intent are multiplied by the complexity, size, and dynamism of the health care industry, as well as the sophistication of most kickback scheme participants. Documents are "pre-sanitized" by expert attorneys. Most defendants are careful what they say. In most kickback prosecutions, the Government has a difficult task to prove beyond a reasonable doubt that even one purpose of a payment is to induce referrals.

If the Government had to prove that inducement of referrals was "the significant" reason for the payment, many common kickback schemes would be allowed to proliferate. In today's health care industry, very few kickback arrangements involve the bald payment of money of patients. Most kickbacks have sophisticated disguises. Providers can usually argue that any suspect payment serves one or more "legitimate purposes." For example, payments made to induce referrals often also compensate a physician who is providing health care items or services. Some payments to referral sources may be disguised as returns on investments. Similarly,many lease arrangements that indisputably involve the bona fide use of space incorporate some inducement to refer in the lease rates. In all of these examples, and countless others, it is impossible to quantify what portions of payments are made for nefarious versus legitimate purposes.

Where the defendant could argue that there was some legitimate purpose for the payment, the prosecution would have to prove beyond a reasonable doubt, through circumstantial evidence, that the defendant actually had another motive that was "the significant" reason. For the vast majority of the present-day kickback schemes, the proposed amendment would place an insurmountable burden of proof on the Government.

3. C. CREATION OF AN EASILY ABUSED EXCEPTION FROM THE ANTI-KICKBACK STATUTE FOR CERTAIN MANAGED CARE ARRANGEMENTS.

Background: There is great variety and innovation occurring in the managed care industry. Some managed care organizations, such as most health maintenance organizations (HMOs) doing business with Medicare, consist of providers who assume financial risk for the quantity of medical services needed by the population they serve. In this context, the incentive to offer kickbacks for referrals of patients for additional services is minimized, since the providers are at risk for the additional costs of those services. IF anything, the incentives are to reduce services. Many other managed care organizations exist in the fee for service system, where the traditional incentives to order more services and pay kickbacks for referrals remain. In the fee for service system, the payer (like Medicare and private insurance plans) is at financial risk of additional services, not the managed care organization. While broad protection from the anti-kickback statute may be appropriate for capitated, at-risk entities like the HMO described above, such pro-

tection for managed care organizations in the fee for service system would invite serious abuse.

H.R. 2389 Proposal: Section 202 would establish broad new exceptions under the anti-kickback statute for "any capitation, risk-sharing, or disease management program." The lack of definition of these terms would result in a huge opportunity for abusive arrangements to fit within this proposed exception. What is "risk-sharing?" Is not any insurance a form of risk sharing? What is a "disease management program?" Does not that term include most of health care?

Nefarious organizations could easily escape the kickback statute by simply re-arranging their agreements to fit within the exception. For example, if a facility wanted to pay doctors for referrals, the facility could escape kickbacks liability by establishing some device whereby the doctors share in the business risk of profit and loss of the business (i.e., they would share some risk, at least theoretically). Then, the organization could pay blatant kickbacks for every referral with impunity.

If the concern is that the kickback statute is hurting innovation, as observed above, there is now an explosion of innovation in the health care industry, especially in managed care. No one in Government is suggesting that HMOs or preferred provider arrangements, etc., formed in good faith, violate the kickback statute. There has never been an action against any such arrangement under the statute.

4. INAPPROPRIATE EXPANSION OF THE EXCEPTION TO THE ANTI-KICKBACK STATUTE FOR DISCOUNTS.

Background. Medicare/Medicaid discounts are beneficial and to be encouraged with one critical condition: that Medicare and/or Medicaid receive and participate fully in the discount. For example, if the Medicare reasonable charge for a Part B item or service is $100, Medicare would pay $80 of the bill and the copayment would be $20. If a 20 percent discount is applied to this bill, the charge should be $80, and Medicare would pay $64 (80 percent of the $80) and the copayment would be $16. If the discount is not shared with Medicare (which would be improper), the bill to Medicare would falsely show a $100 charge. Medicare would pay $80, but the copayment would be $0. This discount has not been shared with Medicare.

Many discounting programs are designed expressly to transfer the benefit of discounts away from Medicare. The scheme is to give little or no discount on an item or service separately billed to Medicare, and give large discounts on items not separately billed to Medicare. This scheme results in Medicare paying a higher percentage for the separately billed item or service than it should.

For example, a lab offers a deep discount on lab work for which Medicare pays a predetermined fee (such as lab tests paid by Medicare to the facility as part of a bundled payment), if the facility refers to the lab its separately billed Medicare lab work, for which no discount is given. The lab calls this a "combination" discount, yet is a discount on some items and not on others. Another example is where ancillary or noncovered items are furnished free, if a provider pays full price for a separately billed item, such as where

the purchase of incontinence supplies is accompanied by a "free" adult diaper. Medicare has not shared in these combination discounts.

H.R. 2389 Proposal: Section 202 would permit discounts on one item in a combination to be treated as discounts on another item in the combination. This sounds innocent, but it is not. Medicare would be a big loser. Discounting should be permissible for a supplier to offer a discount on a combination of items or services, so long as every item or service separately billed to Medicare or Medicaid receives no less of a discount than is applied to other items in the combination. If the items or services separately billed to Medicare or Medicaid receive less of a discount than other items in the combination, Medicare and Medicaid are not receiving their fair share of the discounts.

5. UNPRECEDENTED MECHANISM FOR ADVISORY OPINIONS ON INTENT-BASED STATUTES, INCLUDING THE ANTI-KICKBACK STATUTE

Background: The Government already offers more advice on the anti-kickback statute than is provided regarding any other criminal provision in the United States Code.

Industry groups have been seeking advisory opinions under the anti-kickback statute for many years, with vigorous opposition by the Department of Justice (DOJ), and the HHS Office of Inspector General (OIG) under the last three administrations, as well as the National Association of Attorneys General. In 1987, Congress rejected calls to require advisory opinions under this statute. As a compromise, Congress required HHS, in consultation with the Attorney General, to issue "safe harbor" regulations describing conduct which would not be subject to criminal prosecution or exclusion. See Section 14 of Public Law 100–93.

To date, the OIG has issued 13 final anti-kickback "safe harbor" rules and solicited comment on 8 additional proposed safe harbor rules, for a total of 21 final and proposed safe harbors. Over 50 pages of explanatory material has been published in the Federal Register regarding these proposed and final rules. In addition, the OIG has issued six general "fraud alerts" describing activity which is suspect under the anti-kickback statute. Thus, the Government gives providers guidance on what is clearly permissible (safe harbors) under the anti-kickback statute and what we consider illegal (fraud alerts).

H.R. 2389 Proposal. HHS would be required to issue advisory opinions to the public on the Medicare/Medicaid anti-kickback statute (section 1128(b) of the Social Security (Act), as well as all other criminal authorities, civil monetary penalty and exclusion authorities pertaining to Medicare and Medicaid. HHS would be required to respond to requests for advisory opinions within 30 days.

HHS would be authorized to charge requestors a user fee, but there is no provision for this fee to be credited to HHS. Fees would therefore be deposited in the Treasury as miscellaneous receipts.

Major problems with anti-kickback advisory opinions include:

Advisory opinions on intent-based statutes (such as the anti-kickback statute) are impractical if not impossible.—Because of the inherently subjective, factual nature of intent, it would be impossible for HHS to determine intent based solely upon a

written submission from the requestor. Indeed, it does not make sense for a requestor to ask the Government to determine the requestor's own intent. Obviously, the requester already knows what their intent is.

None of the 11 existing advisory opinion processes in the Federal Government provide advisory opinions regarding the issue of the requestor's intent.—An advisory opinion process for an intent-based statute is without precedent in U.S. law.

The advisory opinion process in H.R. 2389 would severely hamper the Government's ability to prosecute health care fraud.—Even with appropriate written caveats, defense counsel will hold up a stack of advisory opinions before the jury and claim that the defendant read them and honestly believed (however irrationally) that he or she was not violating the law. The prosecution would have to disprove this defense beyond a reasonable doubt. This will seriously affect the likelihood of conviction of those offering kickbacks.

Advisory opinions would likely enormous resources and many full time equivalents (FTE) at HHS.—The user fees in the bill would go to the Treasury, not to HHS. Even if the did go to HHS, appropriations committees tend to view them as offsets to appropriations. There are no estimates of number of likely requests, number of FTE required, etc. Also, HHS is permanently downsizing, even as it faces massive structural and program changes. The possible result of the bill is a diversion of hundreds of anti-fraud workers to handle the advisory opinions.

For the above reasons, DOJ, HHS/OIG and the National Association of Attorneys General strongly oppose advisory opinions under the anti-kickback statute, and all other intent-based statutes.

6. CREATION OF TRUST FUND MECHANISM WHICH DOES NOT BENEFIT LAW ENFORCEMENT

Background: In our view, the most significant step Congress could undertake to reduce fraud and abuse would be to increase the resources devoted to investigating false claims, kickbacks and other serious misconduct. It is important to recognize that the law enforcement effort to control Medicare fraud is surprisingly small and diminishing. There is evidence of increasing Medicare fraud and abuse, and Medicare expenditures continue to grow substantially. Yet, the staff of the HHS/OIG, the agency with primary enforcement authority over Medicare, has declined from 1,411 employees in 1991 to just over 900 today. (Note: 259 of the 1,411 positions were transferred to the Social Security Administration). Approximately half of these FTE are devoted to Medicare investigations, audits and program and evaluations. As a result of downsizing, HHS/OIG has had to close 17 OIG investigative office and we now lack an investigative presence in 24 States. The OIG has only about 140 investigators for all Medicare cases nationwide. By way of contrast, the State of New York gainfully employs about 300 persons to control Medicaid fraud in that State alone.

Ironically, the investigative activity of OIG pays for itself many times over. Over the last 5 years, every dollar devoted to OIG in-

vestigations of health care fraud and abuse has yielded an average return of over $7 to the Federal Treasury, Medicare trust funds, and State Medicaid programs. In addition, an increase in enforcement also generates increased deterrence, due to the increased chance of fraud being caught. For these reasons, many fraud control bills contain a proposal to recycle monies recovered from wrongdoers into increased law enforcement. The amount an agency gets should not be related to how it generates, so that it should not be viewed as a "bounty." The Attorney General and the Secretary of HHS would decide on disbursements from the fund. We believe such proposals would strengthen our ability to protect Medicare from wrongdoers and at no cost to the taxpayers. The parties who actually perpetrate fraud would "foot the bill."

H.R. 2389 Proposal: Section 106 would create a funding mechanism using fines and penalties recovered by law enforcement agencies from serious wrongdoers. But none of the money would be used to help bring others to justice. Instead, all the funds would be used only by private contractors for "soft" claims review, such as, medical and utilization review, audits of cost reports, and provider education.

The above functions are indeed necessary, and they are now being conducted primarily by the Medicare carriers and intermediaries. Since the bill would prohibit carriers and intermediaries from performing these functions in the future, there appears to be no increase in these functions, but only a different funding mechanism.

These "soft" review and education functions are no substitute for investigation and prosecution of those who intend to defraud Medicare. The funding mechanism in H.R. 2389 will not result in any more Medicare convictions and sanctions.

In summary, H.R. 2389 would:

relieve providers of the legal duty to use reasonable diligence to ensure that the claims they submit are true and accurate; this is the effect of increasing the Government's burden of proof in civil monetary penalty cases;

substantially increase the Government's burden of proof in anti-kickback cases;

create new exemptions to the anti-kickback statute which could readily be exploited by those who wish to pay rewards to physicians for referrals of patients;

create an advisory opinion process on an intent-based criminal statute, a process without precedent in current law; since the fees for advisory opinions would not be available to HHS, our scarce law enforcement resources would be diverted into hiring advisory opinion writers; and

create a fund to use monies recovered from wrongdoers by law enforcement agencies, but the fund would not be available to assist the law enforcement efforts; all the monies would be used by private contractors only for "soft" payment review and education functions.

In our view, enactment of the bill with these provisions would cripple our ability to reduce fraud and abuse in the Medicare program and to bring wrongdoers to justice.

Thank you for your attention to our concerns.

Sincerely,

JUNE GIBBS BROWN,
Inspector General.

GENERAL ACCOUNTING OFFICE,
HEALTH, EDUCATION AND HUMAN SERVICES DIVISION,
Washington, DC, October 7, 1995.

Hon. FORTNEY H. (PETE) STARK,
Ranking Minority Leader, Subcommittee on Health, Committee on Ways and Means, House of Representatives.

DEAR MR. STARK: Your letter of October 4, 1995, asked us to review the fraud and abuse provisions of H.R. 2425, especially two provisions changing requirements of the anti-kickback and civil monetary penalty sections of the Social Security Act. You also forwarded comments you had received from the Department of Health and Human Services' (HHS) Office of the Inspector General (OIG) and the Department of Justice on H.R. 2389.[1] These agencies expressed serious concerns about the two provisions. Because of the limited time available, we concentrated on these two provisions and have not fully analyzed the other provisions in H.R. 2425.

PROPOSED CHANGE TO MEDICARE ANTI-KICKBACK LAW

Section 1128B(b)(2) of the Social Security Act[2] establishes criminal liability for "[w]hoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person" to refer persons to them for medical services covered by Medicare or certain other health programs. In our experience, such arrangements are often disguised to appear to provide compensation for professional services or as returns on investments. Even when a physician performs a service for the money received, the inducements for referrals can result in unnecessary payments from Medicare.

As the HHS OIG pointed out, courts have interpreted section 1128B(b)(2) to find liability whenever it is proven beyond a reasonable doubt that *one* purpose of a payment was to induce a referral.[3]

Section 15212(c) of H.R. 2425 would substitute for these judicial interpretations by amending the last part of the quoted material to read "to any person for the significant purpose of inducing." We are not convinced that the use of the modifier "the significant" would mean, as the OIG indicated, that 51 percent of the motivation for a payment would have to be to induce referrals in order to establish liability. However, "the significant" can only be read to mean that prosecutors would have to prove beyond a reasonable doubt that the primary or most compelling motivation for the payment was to induce referrals.

Providing knowledge is always very difficult because it requires determining what was in the mind of an individual or individuals.

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[1] H.R. 2389 was incorporated, with some changes, into H.R. 2425.

[2] 42 U.S.C. 1320a–7b(2).

[3] For example, *U.S.* v. *Bay State Ambulance and Hosp. Rental Serv.*, 874 F.2d 20, 29–30 (1st Cir. 1989).

Because it is not scientifically possible to provide knowledge directly, doing so requires marshalling a convincing argument based solely on circumstantial evidence. We agree that, as you surmise, this amendment will make proving the facts necessary to establish liability much more difficult. Moreover, the effect could well be to make it easier to disguise the intent behind kickback arrangements, or make disguises currently used more effective in evading prosecution. The result would be greater potential for fraud, with its negative financial effect on Medicare.

PROPOSED CHANGE TO CIVIL MONETARY PENALTY LAW

Section 1128A(a)(1) of the Social Security Act[4] authorizes civil monetary penalties, for example, for anyone who submits claims to Medicare and "knows or should know" that a claim is for services not actually rendered; for services that are false or fraudulent; for physicians' services not actually rendered by a physician; or for services performed by someone excluded from participating in the program.

The phrase "or should know" was substituted for "or has reason to know" by section 4118(e)(1) of the Omnibus Budget Reconciliation Act of 1987 (OBRA–87) (P.L. 100–203). This change originated in the House bill for OBRA–87 and was included unchanged in the final version. The relevant House report states that this change was intended to overturn *In the Matter of the Inspector General* v. *Frank P. Silver, M.D.,* Docket No. C–19 (Apr. 27, 1987).[5] In *Silver,* the reviewing official held that an employer could not be subject to civil monetary penalties for actions taken by his or her employees within the scope of their employment, and interpreted "reason to know" as imposing a duty on one submitting a claim to investigate the truth of the claim only if he or she had reason to suspect that the information in the claim was erroneous.

Although the interpretation of "reason to know" in *Silver* is consistent with the discussion of the phrase in the *Restatement of Torts, Second,* section 12, it troubled the drafters of the OBRA–87 amendment because they understood that it would make it easier for individuals to defraud Medicare by freeing them from a general duty to reasonably ensure the accuracy of the claims submitted. The amended language was expressly intended to "incorporate common law principles" into the civil monetary penalty provision.[6] In other words, under the current language, providers have an affirmative duty to ensure that the claims for payment that they submit, or that are submitted by their employees, are accurate. As pointed out by the OIG, the phrase "should know" is a standard American courts are accustomed to.

Section 15212(a)(2) of H.R. 2425 would require proof that the person acted "in deliberate ignorance" or "in reckless disregard" of the truth or falsity of the information. This would represent a significant change over the due diligence required of those submitting claims under the current standard.

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[4] U.S.C. 1320a–7a(1).

[5] H.R. Rpt. No. 391, 100th Cong., 1st Sess., pt. 1, at 533.

[6] The amendment was included under the title "Civil Monetary Penalty and Exclusion Clarifications," 101 Stat. 1330–155.

The new definition for "should know" is basically the statutory definition of the terms "knowing" and "knowingly" found in the federal False Claim Act.[7] The result is that the knowledge standard for Medicare civil Monetary penalties would be changed, in effect, from "know or should know" to "knowing" or "knowingly." Under the False Claim Act, individuals have been found not liable for innocent mistakes and, in addition, not liable in cases of negligence.[8]

We agree with the OIG that this new definition of "should know" would, as drafted, "significantly curtail enforcement" under the Medicare civil monetary penalty provisions. Assuming that this interpretation would be applied with respect to the virtually identical definition in the Medicare context, proving negligence in the filing of claims would no longer suffice to impose a civil monetary penalty. This would result in imposing a far greater burden on prosecutors. It would constitute a reversal of the action taken in OBRA–87 and reinstate a knowledge standard at least as lenient as the one articulated in *Silver*.

OTHER CONCERNS

Although we have not fully analyzed the other provisions in H.R. 2425, we noted a few general concerns during our review of the fraud and abuse provisions.

First, a number of additional responsibilities would be placed on HHS, its Health Care Financing Administration, and the HHS OIG. Such responsibilities include soliciting views from and responding to the public on (1) safe harbors, (2) ways to improve the administration of Medicare, and (3) complaints and allegations about fraud and abuse. However, no resources are provided to accomplish these tasks. While any of these provisions might be laudable on its own, in today's budgeting environment we are concerned that additional resources needed for administration might not be available. This could result in anti-fraud and abuse staff being spread more thinly than they are now with negative consequences for fraud and abuse detection and prevention efforts.[9] Further, it could result in insufficient resources to carry out the intent of the legislative provisions.

Second, the bill would make a number of changes to Medicare's prohibition on physician referrals to facilities and suppliers in which they have an ownership interest. We, as well as the HHS OIG and others, have conducted a number of studies that identified increased use of services when physicians refer patients to entities they own or in which they have substantial financial interests. Substantial savings were estimated to accrue from enactment of the provisions proposed for modification, and we are concerned that this could increase Medicare costs. We are particularly concerned about repeal of the provision requiring covered providers and suppliers to report to HHS on who their owners are. Without this information, it would be very difficult and expensive for HHS to enforce the prohibition or to identify violations.

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[7] 31 U.S.C. 3729(b).

[8] See, for example, *Wang* v. *FMC Corp.*, 975 F.2d 1412, 1420 (9th Cir. 1992).

[9] We have commented on many occasions on the need for adequate resources to effectively perform the tasks that comprise fraud and abuse detection and prosecution.

We are sending a copy of this letter to the Chairman, Subcommittee on Health. If you have any questions about the matters discussed in this letter, please contact Tom Dowdal, Assistant Director.

Sincerely yours,

SARA F. JAGGAR,
Director, Health Financing and Public Health Issues.

ADDITIONAL DISSENTING VIEWS

This bill, H.R. 2422, The Medicare Security Act, is the first introduced Democratic alternative to Republican Medicare proposal (H.R. 2425)—a simple 20 page solution to Medicare's short-term funding problem. H.R. 2422, which is cosponsored by thirty of my colleagues, including three Members of the Ways and Means Committee, sharply contrasts with H.R. 2425 and shows the American people that we can protect Medicare without punishing beneficiaries or disrupting our health care delivery system.

We do not dispute the facts that Medicare is growing rapidly and its rate of growth needs to be contained if we are to avoid bankrupting the Federal Government. But Medicare's growth is not so frenzied that it must be reduced by $270 billion over the next seven years. Cuts of that magnitude do nothing to save the Medicare program or extend the solvency of the Part A trust fund any longer than it is extended by my bill—to 2006. Medicare is targeted by the Republicans for a cut of $270 billion for one reason only and that is to balance the budget in seven years.

Many Republicans are using the promise of a balanced budget as an excuse to dismantle the most important functions of government—functions that the American people depend upon to protect the economic and physical security of their own families and their parents. The Republican Medicare bill, H.R. 2425, attacks not only seniors, but also middle-class families who will be forced to choose between paying the medical bills of their elderly parents or college tuition for their children. But this proposal demonstrates that cuts of $270 billion are *not* inevitable and that the rate of growth of Medicare can be controlled to protect the middle class and to preserve our national government as a partner with the American people, creating opportunity and providing security. The Medicare Security Act, H.R. 2422, slows Medicare spending by $90 billion over the next seven years, which will keep the Medicare Part A trust fund solvent through 2006. This allows 10 years to adjust the system to accommodate the baby-boomers entering Medicare, without imposing hidden costs on seniors or impeding their access to care.

But let's be clear that the current debate over Medicare springs in large part from the failure of systemic health care reform. The Republican Medicare Act does absolutely nothing to help the 41 million uninsured persons in this country. The cost-shifting this bill presumes no doubt will increase substantially the cost of health insurance premiums for the middle class, swelling the number of uninsured people.

If we had universal coverage in this country, the Medicare trust fund problem would be much easier to solve, and containing costs in Medicare would be much easier to accomplish. The cost problems of Medicare are nothing more than a reflection of the cost problems in the health care system as a whole. If this country had universal

coverage, the solvency of the Medicare Trust fund would not even be an issue. It will be impossible to make Medicare truly secure for the next generation until we have universal coverage. Until all Americans have health insurance, the cost of providing health care for the uninsured will continue to be shifted onto those persons with health insurance in the form of higher premiums and increased costs. But, unfortunately, we do not have universal coverage in this country. So, operating under the current system, H.R. 2422, the Medicare Security Act, extends the life of the Medicare trust fund for as long as the Congressional Budget Office will measure it—to 2006. This is achieved by cutting $90 billion from Medicare over 7 years.

Four of Medicare's trustees have stated that $89 billion is needed to stabilize the Trust Fund until 2006 and that the $270 billion in cuts proposed in the Republican bill are unnecessary.

A reasonable alternative, my proposal cuts only $67 billion from Medicare Part A and $23 billion from Part B, with all of the Part B savings directed into the Part A Trust Fund. These cuts are adjustments that the system can absorb and that preserve quality and service to beneficiaries, insuring that recipients continue to receive the same level of Medicare coverage and benefits that they have today. The Republican proposal can offer no such promise.

Equally important, my proposal insures that adjustments in the Medicare program will not cause profound disruptions throughout the entire health care delivery system, threaten our teaching hospitals, or affect Medicare recipients' access to high quality medical care. Moreover, this approach avoids the substantial increases in both the cost of private insurance and the number of uninsured Americans which the Republican plan guarantees. The cuts in H.R. 2422, the Medicare Security Act, are distributed equitably throughout the health care system to doctors, hospitals, home health agencies, and skilled nursing facilities. In this bill there is no increased costs to beneficiaries and adjustments in provider reimbursements have been tailored specifically to protect the basic elements of our health care infrastructure. This alternative Medicare proposal places no additional financial burden on our elderly poor nor on their families.

The real problem for Medicare starts in the year 2010 when the baby-boomers enter the program. The Republican proposal does nothing to solve this problem. Therefore, this bill, like the Republican bill, creates a bipartisan commission to address specifically the changes needed in Medicare and in health coverage and finance generally to accommodate the aging baby-boomers who will be entering Medicare after 2010.

We are calling for a bipartisan commission because we need to engage in a national debate about what kind of Medicare program we want for older Americans and whether or not we are willing to pay for that program. A Blue Ribbon commission will be charged with the responsibility of building a national consensus on the future of Medicare.

The Commission will make recommendations to Congress by January 1, 1998, eight years in advance of any foreseeable Medicare solvency problem, on how to finance Medicare for baby-boomers and what Medicare should offer beneficiaries. In our view,

the Commission is the most important part of the bill and the Medicare debate.

H.R. 2422, the Medicare Security Act, lays down a marker for integrity and simplicity. According to the Congressional Budget Office, this bill and the Republican Medicare bill take the nation to the same destination in 2006. Unfortunately, the Republicans' route takes the nation on a ride to the tune of $270 billion.

JIM MCDERMOTT.
CHARLES RANGEL.
GERALD KLECZKA.

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