104TH CONGRESS
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HOUSE OF REPRESENTATIVES
REPT. 104–80
Part 1

MEDICARE PRESIDENTIAL BUDGET SAVINGS EXTENSION ACT OF 1995

MARCH 15, 1995.—Ordered to be printed

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

REPORT

[To accompany H.R. 1134]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 1134) to amend title XVIII of the Social Security Act to extend certain savings provisions under the medicare program, as incorporated in the budget submitted by the President for fiscal year 1996, having considered the same, report favorably thereon without amendment and recommend that the bill do pass.

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I. INTRODUCTION

A. PURPOSE AND SUMMARY

H.R. 1134: (1) maintains the savings resulting from the temporary freeze on payment increases for Skilled Nursing Facility ("SNF") services; (2) sets the part B premium at 25 percent of program expenditures permanently; (3) permanently extends certain Medicare secondary payer ("MSP") provisions; and (4) maintains the savings resulting from the temporary freeze on payment increases for Home Health services.

B. BACKGROUND AND NEED FOR LEGISLATION

These proposals are extensions of Medicare law which would otherwise expire or not continue

The Committee on Ways and Means marked up the bill on March 8, 1995, and ordered H.R. 1134 favorably reported, by voice vote, without amendment.

C. LEGISLATIVE HISTORY

Committee bill

H.R. 1134 was introduced on March 6, 1995, by Mr. Thomas of California and referred to the Committee on Ways and Means and, in addition, to the Committee on Commerce. The bill as introduced contained four provisions: (1) maintaining the savings resulting from the temporary freeze on payment increases for Skilled Nursing Facility services; (2) setting the Part B premium at 25 percent of program expenditures permanently; (3) permanently extending certain Medicare secondary payer provisions; and (4) maintaining the savings resulting from the temporary freeze on payment increases for Home Health services.

The Committee on Ways and Means marked up the bill on March 8, 1995, and ordered H.R. 1134 favorably reported, by voice vote, without amendment.

Legislative hearings

The Subcommittee on Health of the Committee on Ways and Means held two public hearings which reviewed several aspects of the provisions included in H.R. 1134. The hearing on February 6, 1995, focused on areas of extraordinary growth in Medicare costs, including home health and skilled nursing facility costs. The hearing on February 23, 1995, reviewed the Medicare provisions included in the President's fiscal year 1996 Budget.

Further, the Committee on Ways and Means held four public hearings on February 7, 1995, February 8, 1995, and February 9, 1995. The subject of the hearings was the Administration's fiscal year 1996 revenue and budget proposals, including the Medicare provisions of H.R. 1134.

II. EXPLANATION OF THE BILL

A. MAINTAINING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES FOR SKILLED NURSING FACILITIES (SEC. 101 OF THE BILL AND 42 U.S.C. SEC. 1395yy(a))

Present law

Payments for SNF services are made on a reasonable cost basis, subject to per diem cost limits. The limits are applied to the per diem routine service costs (nursing, room and board, administrative, and other overhead) of a facility. Freestanding SNF limits are set at 112 percent of the mean per diem labor-related and nonlabor costs. Hospital-based SNF cost limits are set at the limit for freestanding SNFs, plus 50 percent of the difference between the freestanding limit and 112 percent of the mean per diem routine service costs of hospital-based SNFs. Certain SNFs can be paid at a prospective rate at 105 percent of the regional mean for all SNFs in the region. OBRA 93 eliminated the update for SNF limits for cost reporting periods beginning in FY 1994 and FY 1995. Beginning in FY 1996, new cost limits would be established that do not reflect the effects of the freeze.

Explanation of provision

The provision would permanently extend the savings stream (but not the freeze) in setting future SNF limits by not allowing for the inflation that occurred during the freeze years (FY 1994 and FY 1995). Without new legislation, the baseline would revert to pre-freeze levels.

Reason for change

The provision savings would otherwise not continue.

Effective date

The provision is effective upon enactment.

B. SETTING THE PART B PREMIUM AT 25 PERCENT OF PROGRAM EXPENDITURES PERMANENTLY (SEC. 201 OF THE BILL AND 42 U.S.C. 1395(a)(3))

Present law

Premiums under the supplementary medical insurance ("SMI") program are specified in the Medicare law for years 1991 through 1995, will be set at 25 percent of SMI program costs for 1996 through 1998, and will increase only by the Social Security cost of living adjustment ("COLA") percentage for subsequent years.

Explanation of provision

This provision would permanently set Part B premiums at 25 percent of SMI program costs.

Reason for change

The provision would otherwise expire.

Effective date

The provision would be effective upon enactment.

C. PERMANENT EXTENSION OF CERTAIN SECONDARY PAYER PROVISIONS (SEC. 301 OF THE BILL AND 42 U.S.C. SEC. 1395y(b)(5)(C))

Present law

Under current law, Medicare is a secondary payer under specified circumstances when beneficiaries are covered by other third-party payers. Medicare is secondary payer to workers' compensation, automobile, medical, no-fault, and liability insurance. In order to identify primary payers, under these provisions, a data match was authorized through fiscal year 1998, between the Health Care Financing Administration ("HCFA"), the Social Security Administration ("SSA"), and the Internal Revenue Service ("IRS"). Medicare is secondary payer for large group health plans in the case of disabled beneficiaries, and Medicare is secondary payer for beneficiaries with end stage renal disease ("ESRD") for 18 months.

Explanation of provision

The Medicare secondary payer provisions that would otherwise expire in fiscal year 1998 are extended permanently.

Reason for change

The provision would otherwise expire.

Effective date

The provision would be effective upon enactment.

D. MAINTAINING SAVINGS RESULTING FROM TEMPORARY FREEZE ON PAYMENT INCREASES FOR HOME HEALTH SERVICES (SEC. 302 OF THE BILL AND 42 U.S.C. SEC. 1395x(v)(1)(L)(iii))

Present law

Medicare pays for covered home health services on a reasonable cost basis, subject to cost limits that are updated annually. These limits are set at 112% of the mean labor-related and nonlabor-related per visit costs for freestanding home health care agencies. The Omnibus Budget Reconciliation Act of 1993 ("OBRA '93") eliminated the update for home health cost limits for cost reporting periods beginning on or after July 1, 1994, and before July 1, 1996. Beginning July 1, 1996, new cost limits would be established that do not reflect the effects of the freeze.

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 (FY 1994 and FY 1995). Without new legislation, the baseline would revert to pre-freeze levels.

Reason for change

The provision savings would otherwise not continue.

Effective date

The provision would be effective upon enactment.

III. VOTES OF THE COMMITTEE

In compliance with clause 2(l)(2)(B) of rule XI of the Rules of the House of Representatives, the following statements are made concerning the votes of the Committee in its consideration of the bill, H.R. 1134.

Motion to report the bill

The bill, H.R. 1134, was ordered favorably reported, without amendment, by voice vote on March 8, 1995, with a quorum present.

Votes on amendment

The Committee defeated an amendment (13 yeas and 21 nays) offered by Mr. Stark to dedicate amounts equal to the reductions in spending resulting from the provisions of H.R. 1134 to the Deficit Reduction Fund established by Executive Order 12858 (58 Fed. Reg. 42185). The roll call vote was as follows:

YEAS	NAYS
Mr. Stark	Mr. Archer
Mr. Jacobs	Mr. Crane
Mr. Ford	Mr. Thomas
Mr. Matsui	Mr. Shaw
Mrs. Kennelly	Mrs. Johnson
Mr. Coyne	Mr. Bunning
Mr. Levin	Mr. Houghton
Mr. Cardin	Mr. Herger
Mr. McDermott	Mr. McCrery
Mr. Kleczka	Mr. Hancock
Mr. Lewis	Mr. Camp
Mr. Payne	Mr. Ramstad
Mr. Neal	Mr. Zimmer
	Mr. Nussle
	Mr. Johnson
	Ms. Dunn
	Mr. Collins
	Mr. Portman
	Mr. English
	Mr. Ensign
	Mr. Christensen

IV. BUDGET EFFECTS

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. 1134, as reported:

The Committee agrees with the estimate prepared by CBO, which is included below.

B. STATEMENT REGARDING NEW BUDGET AUTHORITY AND TAX EXPENDITURES

In compliance with subdivision (B) of clause 2(l)(3) of rule XI of the Rules of the House of Representatives, the Committee states that the bill, H.R. 1134, extends current budget authority.

The Committee further states that the bill, H.R. 1134, has no effect on tax expenditures.

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 Representatives, 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, March 13, 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. 1134, as ordered reported by the House Committee on Ways and Means on March 8, 1995. Enactment of H.R. 1134 would affect direct spending and thus would be subject to pay-as-you-go procedures under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985.

If you wish further details on this estimate, we will be pleased to provide them.

Sincerely,

JAMES L. BLUM
(For June E. O'Neill, Director).

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

1. Bill number: H.R.1134.

2. Bill title: Medicare Presidential Budget Savings Extension Act of 1995.

3. Bill status: As ordered reported by the House Committee on Ways and Means on March 8, 1995.

4. Bill purpose: To amend title XVIII of the Social Security Act to extend certain savings provisions under the Medicare program, as incorporated in the budget submitted by the President for fiscal year 1996.

5. Estimated cost to the Federal Government: The bill would affect Medicare benefits, Medicare premiums, and Medicaid. The following table shows projected outlays for these programs under current law, the changes that would stem from the bill, and the projected outlays for each program if the bill were enacted.

[Outlays by fiscal year, in millions of dollars]

	1995	1996	1997	1998	1999	2000
Projected spending under current law:						
Medicare mandatory outlays [1]	178,155	199,066	219,411	240,412	263,397	288,095
Medicare premium receipts	−20,090	−20,321	−21,956	−24,494	−26,057	−27,337

[Outlays by fiscal year, in millions of dollars]

	1995	1996	1997	1998	1999	2000
Federal Medicaid outlays	89,216	99,292	110,021	122,060	134,830	148,116
Total	247,281	278,037	307,475	337,977	372,170	408,874
Proposed changes:						
Medicare mandatory outlays [1]	0	−95	−514	−741	−2,083	−2,311
Medicare premium receipts	0	0	0	0	−1,325	−3,883
Federal Medicaid outlays	0	0	0	0	106	310
Total	0	−95	−514	−741	−3,302	−5,884
Projected spending under H.R. 1134:						
Medicare mandatory outlays [1]	178,155	198,971	218,897	239,671	261,315	285,784
Medicare premium receipts	−20,090	−20,321	−21,956	−24,494	−27,382	−31,220
Federal Medicaid outlays	89,216	99,292	110,021	122,060	134,936	148,426
Total	247,281	277,942	306,961	337,237	368,869	402,990

[1] Primarily payments for benefits.

The costs of this bill fall within budget functions 550 and 570.

6. Basis of estimate: Four provisions of the bill would have a significant budgetary impact. Their effects are described below and itemized in the table at the end of this section.

SNF Cost Limits.—Section 101 of H.R. 1134 would maintain the savings from the provision in the Omnibus Budget Reconciliation Act of 1993 (OBRA–93) that froze the cost limits for Medicare payments to skilled nursing facilities (SNFs). Medicare's routine service payments to most SNFs are based on the facility's cost, subject to specified limits. Usually, the cost limits are computed each year so that they reflect the average growth in costs among skilled nursing providers. A provision in OBRA–93, however, froze the limits for two years ending on October 1, 1995. H.R. 1134 would maintain the savings from the freeze by ignoring cost growth during those two years when setting cost limits for future years.

Home Health Cost Limits.—Section 302 would maintain the savings from the provision in OBRA–93 that froze the cost limits for Medicare payments to home health agencies (HHAs). Medicare's payments to HHAs are based on the agency's cost, subject to specified limits. Usually, the cost limits are computed each year so that they reflect the average growth in costs among home health providers. A provision in OBRA–93, however, froze the limits for two years ending on July 1, 1996. H.R. 1134 would maintain the savings from the freeze by ignoring cost growth during those two years when setting cost limits for future years.

Medicare Secondary Payer.—Section 301 would permanently extend certain Medicare Secondary Payer (MSP) provisions from OBRA–93. Under current law, MSP for the disabled, MSP for End Stage Renal Disease (ESRD) patients, and the MSP data match would expire in 1998. These provisions make Medicare the secondary payer for disabled beneficiaries and those with ESRD. The data match provision authorizes a link between Medicare, Social Security, and the Internal Revenue Service to obtain information about cases where another primary payer exists.

Extension of 25 Percent SMI Premium.—Section 201 would permanently extend the 25 percent Supplementary Medical Insurance

premium. Under current law, the premium is set to cover 25 percent of the costs of the aged population in calendar years 1996 through 1998; in 1999 and beyond, the SMI premium will increase by the amount of the Social Security cost-of-living adjustment (COLA). Basing the premium on program costs, which are projected to grow much more rapidly than the COLA, will increase receipts from premiums in 1999 and 2000. Extending the 25-percent SMI premium increases costs to the Medicaid program, which pays the premium for the approximately 15 percent of the Medicare population with low income.

[Outlays by fiscal year, in millions of dollars]

	1996	1997	1998	1999	2000
SNF cost limits	−85	−214	−284	−317	−347
Home health cost limits	−10	−299	−457	−515	−564
Medicare Secondary Payer	0	0	0	−1,250	−1,400
Extension of 25 percent SMI premium:					
Medicare premium receipts	0	0	0	−1,325	−3,883
Medicaid offset	0	0	0	106	310
Total	−95	−514	−741	−3,302	−5,884

7. Pay-as-you-go considerations: Section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985 sets up pay-as-you-go procedures for legislation affecting direct spending or receipts through 1998. The pay-as-you-go effects of the bill are as follows:

[By fiscal year, in millions of dollars]

	1995	1996	1997	1998
Outlays	0	−95	−514	−741
Receipts	(1)	(1)	(1)	(1)

[1] Not applicable.

8. Estimated cost to state and local governments: The Medicaid program is financed jointly by the federal and state governments. The extension of the 25 percent SMI premium would require state and local governments to spend an additional $80 million in 1999 and $234 million in 2000 to help pay the premiums of low-income beneficiaries.

9. Estimate comparison: None.

10. Previous CBO estimate: None.

11. Estimate prepared by: Scott Harrison and Lori Housman.

12. Estimate approved by: Paul N. Van de Water, Assistant Director for Budget Analysis.

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 expiration of certain Medicare provisions 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 cost in the operation of the national economy. As is indicated above (in Part IV of this report), the bill is projected to reduce federal outlays by $10.536 billion over fiscal years 1995–2000.

VI. 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 italics, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

* * * * * * *

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

* * * * * * *

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)]*(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)]*(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) * * *

(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)]*(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)(1) * * *

(2) The monthly premium of each individual enrolled under this part of each month after December 1983 shall, except as provided in subsections [(b) and (e)] *(b), (c), (e), and (f),* be the amount determined under paragraph (3).

(3) The Secretary shall, during September of 1983 and of each year thereafter, determine and promulgate the monthly premium applicable for individuals enrolled under this part for the succeeding calendar year. [The monthly premium shall (except as otherwise provided in subsection (e)) be equal to the smaller of—

[(A) the monthly actuarial rate for enrollees age 65 and over, determined according to paragraph (1) of this subsection, for that calendar year, or

[(B) the monthly premium rate most recently promulgated by the Secretary under this paragraph, increased by a percentage determined as follows: The Secretary shall ascertain the primary insurance amount computed under section 215(a)(1), based upon average indexed monthly earnings of $900, that applied to individuals who became eligible for and entitled to old-age insurance benefits on November 1 of the year before the year of the promulgation. He shall increase the monthly premium rate by the same percentage by which that primary insurance amount is increased when, by reason of the law in effect at the time the promulgation is made, it is so computed to apply to those individuals for the following November 1.] *The monthly premium shall be equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, as determined according to paragraph (1), for that succeeding calendar year.*

Whenever the Secretary promulgates the dollar amount which shall be applicable as the monthly premium for any period, he shall, at the time such promulgation is announced, issue a public statement setting forth the actuarial assumptions and bases employed by him in arriving at the amount of an adequate actuarial rate for enrollees age 65 and older as provided in paragraph (1) [and the derivation of the dollar amounts specified in this paragraph].

* * * * * * *

(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 an 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 status 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 that term is defined in section 1862(b)(1)(B)[(iv)]*(iii)*) by reason of the individual's current employment status (or the current employment status of a family member of the individual). 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 December 1995 and prior to January 1999 shall be an amount equal to 50 percent of the monthly actuarial rate for enrollees age 65 and over, as determined under subsection (a)(1) and applicable to such month.

(B)] Notwithstanding the provisions of subsection (a), the monthly premium for each individual enrolled under this part for each month in—

[(i)]*(1)* 1991 shall be $29.90,

[(ii)]*(2)* 1992 shall be $31.80,

[(iii)]*(3)* 1993 shall be $36.60,

[(iv)]*(4)* 1994 shall be $41.10, and

[(v)]*(5)* 1995 shall be $46.10.

[(2) Any increases in premium amounts taking effect prior to January 1998 by reason of paragraph (1) shall be taken into account for purposes of determining increases thereafter under subsection (a)(3).]

* * * * * * *

PART C—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) * * *

* * * * * * *

Reasonable Cost

(v)(1)(A) * * *

* * * * * * *

(L)(i) * * *

* * * * * * *

(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 Medical 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.*

* * * * * * *

EXCLUSION FROM COVERAGE AND MEDICARE AS SECONDARY PAYER

SEC. 1862. (a) * * *

(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)]*(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).

(ii) EXCEPTION FOR INDIVIDUALS WITH END STAGE RENAL DISEASE.—Subparagraph (C) shall apply instead of clause (i) to an item or service furnished in a month to an individual if for the month the individual is, or (without regard to entitlement under section 226) would upon application be, entitled to benefits under section 226A.

[(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)* LARGER 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] *18-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 of 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 entitled to or eligible for benefits under this title under section 226A after the end of the [12-month] *18-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.]

* * * * * * *

(5) IDENTIFICATION OF SECONDARY PAYER SITUATIONS.—

(A) * * *

* * * * * * *

(C) CONTACTING EMPLOYERS.—

(i) * * *

* * * * * * *

[(iii) SUNSET ON REQUIREMENT.—Clause (ii) shall not apply to inquiries made after September 30, 1998.]

* * * * * * *

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 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) * * *

* * * * * * *

(4) With respect to hospital-based skilled nursing facilities located in rural areas, the limit shall be equal to the sum of the limit for freestanding skilled nursing facilities located in rural areas, plus 50 percent of the amount by which 112 percent of the mean per diem routine service costs for hospital-based skilled nursing facilities located in rural areas exceeds the limit for freestanding skilled nursing facilities located in rural areas.

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,[488] 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).

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SECTION 6103 OF THE INTERNAL REVENUE CODE OF 1986

SEC. 6103. CONFIDENTIALITY AND DISCLOSURE OF RETURNS AND RETURN INFORMATION.

(a) * * *

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(l) DISCLOSURE OF RETURNS AND RETURN INFORMATION FOR PURPOSES OTHER THAN TAX ADMINISTRATION.—

(1) * * *

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(12) DISCLOSURE OF CERTAIN TAXPAYER IDENTITY INFORMATION FOR VERIFICATION OF EMPLOYMENT STATUS OF MEDICARE BENEFICIARY AND SPOUSE OF MEDICARE BENEFICIARY.—

(A) * * *

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[(F) TERMINATION.—Subparagraphs (A) and (B) shall not apply to—

[(i) any request made after September 30, 1998, 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).]

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