

IX. LONG TERM CARE AND SUPPLEMENTAL INSURANCE STANDARDS

A. LONG TERM CARE INSURANCE STANDARDS

Present Law

No provision.

Description of Proposal

1. Definition of Long Term Care Policies

Policies covered under this Part include any insurance policy, rider or certificate that is advertised, marketed, offered or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity prepaid or other basis for one or more diagnostic, preventive, therapeutic, rehabilitative, maintenance or personal care services, provided in a setting other than an acute care hospital. Policies not covered under this Part include policies designed to provide basic Medicare supplemental coverage, basic hospital expense coverage, basic medical-surgical expense coverage, disability income or related asset protection coverage, accident-only coverage, specified disease coverage or limited health benefit coverage. Policies that accelerate death benefits and that provide the option of lump sum payments are not covered in this Part.

2. Regulatory Oversight

a. Participating States would be required to certify policies as meeting new Federal standards. An insurer selling a policy not certified by the State would be subject to a civil monetary penalty not to exceed 50 percent of gross premiums received from sale of the policy. States would be permitted to develop stricter standards as long as no State provision is inconsistent with Federal standards.

b. The Secretary of HHS, in consultation with the National Association of Insurance Commissioners (NAIC), would be required to develop model standards incorporating the requirements of this Part within one year of enactment.

c. Participating States would be required to develop a long term care insurance standard regulatory and enforcement program, which includes adoption of the NAIC model act standards, a process for individuals to file complaints about violations of the standards, consumer access to those complaints, and a premium review and approval process.

3. Marketing Requirements

a. Insurers or agents would be prohibited from knowingly making any misleading representation, or incomplete or fraudulent comparison, of any

long term care insurance policy. They would be prohibited from using any force, fright, threat, or undue pressure, whether implicit or explicit. They also would be prohibited from employing any marketing method that fails to be explicit that the purpose of the marketing is solicitation of insurance.

b. The Secretary of HHS in consultation with the NAIC would be required to develop minimum financial standards for the purpose of advising potential purchasers as to the costs and amounts of coverage needed.

c. Insurers and agents would be prohibited from knowingly selling a long term care insurance policy to an individual who is eligible for Medicaid.

d. Insurers and agents could not knowingly sell policies that duplicate coverage already held by the potential purchaser unless the purchaser provides written documentation that the new coverage did not duplicate the coverage already held or that the new policy would replace existing coverage.

e. Any agent who sells, or offers for sale, a policy in violation of the marketing and sales standards would be subject to a civil monetary penalty not to exceed \$15,000 for each violation. An insurer or carrier that offers for sale a policy in violation of these requirements would be subject to a civil monetary penalty not to exceed \$25,000 for each violation.

f. The Secretary in consultation with the NAIC would be required to establish standards for the training of agents who sell long term care policies and specify procedures for the certification of agents who have completed such training.

4. Requirements Relating to Coverage Under a Policy

a. If an application for coverage is denied by an insurer, the insurer would be required to return directly to the applicant any premiums paid within 30 days of the date of denial.

b. If an application for coverage is accepted, the insurer shall provide the insurance policy and an outline of coverage within 30 days of coverage approval.

c. If a claim for coverage under a policy is denied, the insurer would be required to notify the policyholder in writing within 15 days of the reason(s) for the denial of coverage. The insurer shall make available all records related to the denial and inform the policyholder how to appeal the denial.

5. Reporting Requirements

Insurers would be required to report annually, to the State Insurance Commissioner, information including the number and type of long term care

policies in effect and the associated premiums, the rate of premium increase for these policies, the lapse rates and replacement rates for these policies, and the number of claims denied.

6. Agent Compensation

Agent commissions from the sale of a long term care policy to a first-time holder of the policy would be limited to no more than 200 percent of the commission paid for renewing the policy in the second year. Agent commissions, if based on a percent of premium costs, could not exceed 50 percent of the first year premium. Agent commissions or compensation would be required to be level for policy renewals over the next 5 years.

7. Rules for Issue, Renewals and Cancellations

a. A long term care policy could only be canceled due to nonpayment of premiums, or material misrepresentation or fraud on the part of the policyholder.

b. Each group long term care insurance policy would be required to provide covered individuals with the option for continuation or conversion from a group to an individual policy that meets certain criteria. Conversions from a group policy would be required meet certain premium pricing requirements.

c. Insurers and agents would be required to guarantee the issue of a policy if the individual meets the minimum medical underwriting guidelines.

d. The Secretary in consultation with the NAIC would be required to develop standards concerning policy rating and pricing of policy benefit upgrades.

e. The Secretary in consultation with the NAIC would be required to develop standards concerning policy rate stabilization.

f. A long term care policy must allow for reinstatement of a policy canceled due to non-payment of premium if the policyholder is determined to be cognitively incapacitated and the policyholder acts to reinstate (with full payment of back premiums) within five months.

8. Use of Standardized Definitions and Terminology

The Secretary of HHS, in consultation with the NAIC, would be required to develop standard definitions and terminology, and standard policy description formats for use in all long term care policies.

9. Benefits Standards

a. Benefits would not be permitted to be conditioned on the need for, or receipt of, any other service, nor on the medical necessity for the benefit, nor on services furnished by providers or facilities meeting conditions beyond those required by State licensure or certification.

b. If home health benefits are covered under a policy, the policy would not be permitted to restrict these services to those provided by registered nurses or licensed practical nurses, nor to services provided by Medicare certified agencies. Services would be required to include those of a home health aide or other home care employee under certain conditions, and would be required to provide personal care, respite, and certain other basic community-based services.

c. If nursing facility benefits are covered under a policy, the policy would not be permitted to restrict the type of nursing facility covered.

d. A per diem policy could not condition benefit payments on the receipt of specific services nor on the receipt of services from specific types of providers.

e. A long term care policy would not be permitted to treat covered benefits for individuals with Alzheimer's disease, other progressive degenerative dementia, mental illness, or mental retardation differently from benefits for individuals with a functional impairment.

f. An insurer would be permitted to exclude or condition benefits based on a medical condition for which the policyholder received treatment or was otherwise diagnosed within 6 months before the issuance of the policy. The policy would be permitted to exclude coverage of that pre-existing condition for up to 6 months from the start of coverage under the policy.

g. An insurer could not deny coverage due to a pre-existing condition if the application for coverage did not request such information with respect to such condition.

10. Functional Assessments and Appeals Process

Functional assessments would be conducted by individuals or organizations not under the control of the insurer. Each insurer would provide for an independent process, meeting certain standards, for appeal of functional assessments and claims denials.

11. Inflation Protection

Long term care policies would be required to include inflation protection meeting minimum Federal standards unless the insurer obtains from the policyholder a written rejection of this coverage.

12. Non-Forfeiture

Long term care policies would be required to include mandatory non-forfeiture benefits in a form to be established by the Secretary, in consultation with the NAIC.

Effective Date

States would be required to implement enforcement programs by April 1, 1997. States without such a program would be subject to a loss of Federal Medicaid matching payments for long term care services.

B. STANDARDS FOR SUPPLEMENTAL INSURANCE

1. Definition of Supplemental Health Benefits Policies

Present Law

Health plans that supplement private health benefits purchased by employers and individuals are not subject to Federal standards. Policies that supplement Medicare benefits are subject to Federal regulation under Section 1882 of the Social Security Act.

Description of Proposal

Supplemental health benefits policies would be defined to include two types of policies: (a) supplemental services policies, and (b) cost-sharing policies. Supplemental services policies would include: (a) coverage for services and items not offered in the certified standard health plan, and (b) coverage for items in the certified standard health plan, but not covered because of limitation in amount, duration or scope. Cost-sharing policies would include those that provide coverage for out-of-pocket payments, including co-insurance, deductibles and copayments.

In order to be certified, health plans or insurers offering a supplemental health benefits policy would be required to meet Federal standards. States, or in the case of multistate self-insured plans the Secretary of Labor, would be required to certify that the supplemental health benefits policies meet the Federal standards. A health plan or insurer offering a supplemental health benefits plan in violation of Federal standards would be subject to civil penalties not to exceed 50 percent of gross premiums from the provision of policies in violation of the standards.

The following types of policies would not be defined as supplemental health benefits policies and would not be covered by Federal standards regarding supplemental health benefits policies: (a) insurance that provides benefits only with respect to specific diseases; (b) hospital or nursing home indemnity policies; (c) Medicare supplemental insurance policies; (d) insurance with respect to accidents; (e) coverage only for disability income; (f) coverage issued as a supplement to liability insurance; and (g) employees' compensation or similar insurance. Long term care insurance policies are not included in the definition of supplemental health insurance plans and are regulated elsewhere in this Part.

2. Standards for Supplemental Service Policies

Health plans or insurers offering policies that supplement services in the certified standard health plan would be required to meet the following

Federal standards: (a) guaranteed issue, with one annual open enrollment period of at least 30 days, except in cases where supplemental service policies are offered to employees by their employer or to individuals based on their membership in a fraternal, religious, professional, educational or other similar organization; (b) guaranteed renewal, except for nonpayment of premiums, fraud, or misrepresentation of a material fact; and (c) community rating, with rates modified by community-rating area, family size and age, as in certified standard health plans. Health plans or insurers would not be permitted to deny coverage or vary premiums for eligible persons based on health status, medical condition, claims experience, receipt of health care, or medical necessity.

Health plans or insurers would be prohibited from offering: (a) a supplemental health benefits policy that duplicates coverage provided in the standardized benefit package of a certified standard health plan; and (b) a supplemental health benefits policy that duplicates coverage provided under Medicare to a Medicare eligible individual.

Not later than January 1, 1996, the Secretary would be required to develop minimum standards that prohibit marketing practices by health plans or insurers offering supplemental services policies that involve: (a) tying or otherwise conditioning the sale of a supplemental services policy to the sale of a certified standard health plan sold by the same company; (b) using or disclosing any information about the health status or claims experience of participants in a certified standard health plan; or (c) prohibiting managed care plans which provide the certified standard health plan from offering a supplemental services policy to a person not enrolled in the managed care plan.

3. Standards for Cost-Sharing Policies

Persons are only permitted to obtain a cost-sharing policy from the same certified standard health plan in which they are enrolled. Health plans would only be permitted to offer cost-sharing policies to persons enrolled in their certified standard health plan. Nothing would require a person to obtain a cost-sharing policy and nothing would require a health plan to provide one.

Certified standard health plans offering cost-sharing policies would be required to offer them to all individuals enrolled in their certified standard health plan. Cost-sharing policies would be offered during the same open enrollment period established for certified standard health plans and supplemental services policies. Certified standard health plans would be required to provide coverage for items and services in the cost-sharing health plan to the same extent as provided in the certified standard health plan. Certified standard health plans would be required to offer a cost-sharing policy at the same price to all individuals (community rating). The price at which the cost-sharing policy is offered would be required to take into account any increase in utilization for items and services in the certified standard health plan.

4. Prohibiting Offer of Multiple Plans to Individuals

Health plans or insurers would be prohibited from offering a supplemental health benefits policy to an individual covered under another supplemental plan of the same type, unless the individual's coverage under the new policy begins after the old coverage is terminated.

Effective Date

January 1, 1997.

X. MEDICARE

A. INDIVIDUAL ELECTION TO REMAIN IN PRIVATE HEALTH PLANS

Present Law

Under current law, individuals who become eligible for Medicare cannot choose to remain in a private managed care plan unless that plan has a risk or cost contract with Medicare.

Description of Proposal

The proposed change would require health maintenance organizations that have or would be eligible for a Medicare risk contract under Section 1876 of the Social Security Act to offer continued membership in the health plan (with the same benefits) to enrollees who become eligible for Medicare and their spouse and dependents. Payment would be made to such health plans on the same basis as Medicare payments to risk contracting organizations. Individuals electing this option would be charged a premium by the health plan equal to the difference between the health plan's premium (adjusted to reflect the actuarial difference between the Medicare beneficiaries and other plan enrollees) and the Medicare payment amount. Payments would begin in the first month an individual is eligible for Medicare and would cease in the open enrollment month specified by the Secretary, or the month in which the individual ceases to be eligible for Medicare. Payments under this section would be the sole Medicare payment to which the beneficiary is entitled.

B. PROVISIONS RELATED TO PART A

1. Payment Updates for Prospective Payment System (PPS) for Inpatient Hospital Services

Present Law

Under the prospective payment system, there are different standardized base payment amounts for hospitals located in large urban areas (metropolitan statistical areas with a population over 1 million or 970,000 in New England), other urban areas, and rural areas. Different update factors apply to the urban and rural base payment amounts. Medicare dependent and sole community hospitals are paid based on the higher of the applicable standardized amount or a hospital-specific rate updated annually. The update factors are based on the projected increase in the hospital market basket, an index that measures changes in the prices of goods and services purchased by hospitals. The update factors are as follows:

- (a) Fiscal year 1995: For urban hospitals, the estimated percentage increase in the hospital market basket minus 2.5 percentage points; for rural hospitals, the amount necessary to equalize the

rural and "other urban" standardized amounts. The update factors for the hospital-specific rates applicable to a sole community hospital or a Medicare-dependent, small rural hospital are set equal to the percentage increase in the hospital market basket minus 2.2 percentage points.

(b) Fiscal year 1996: For all hospitals, the percentage increase in the hospital market basket minus 2.0 percentage points.

(c) Fiscal year 1997: For all hospitals, the percentage increase in the hospital market basket minus 0.5 percentage point.

(d) For fiscal years 1998 and thereafter, the update factor for all hospitals is set equal to the percentage increase in the hospital market basket.

Description of Proposal

For fiscal years 1997 through 2000, the update factor for all hospitals (urban, rural, sole community, and Medicare-dependent) would be set equal to the percentage increase in the hospital market basket minus 2.0 percentage points.

Effective Date

Upon enactment.

2. Reduction in Payments for Capital-Related Costs for Inpatient Hospital Services

Present Law

Medicare pays hospitals for inpatient capital expenses under a prospective payment system. During a ten-year transition that began in fiscal year 1992, hospitals are paid based on a blend of Federal rates and hospital-specific capital rates. The initial Federal rate was computed based on unaudited 1989 cost-report data, trended forward to 1992. The hospital-specific rates were based on data from each hospital's 1990 cost report, trended forward to 1992. The Federal and hospital-specific rates are updated annually for inflation.

The Omnibus Budget Reconciliation Act of 1993 reduced the Federal capital rate by 7.4 percent to correct errors in the inflation forecasts used to establish the Federal rates.

Hospitals excluded from the prospective payment system (psychiatric, rehabilitation, children's, cancer, and long-term hospitals and psychiatric and rehabilitation distinct part units) are paid on a reasonable cost basis for the capital-related costs of inpatient services.

Description of Proposal

Adjustments would be made to the Federal and hospital-specific capital payment rates. For discharges occurring after September 30, 1995 the Secretary would reduce by 7.31 percent the unadjusted standard Federal capital rate in effect as of the date of enactment, and would reduce by 10.4 percent the unadjusted hospital specific rate in effect on that date.

Payment for capital-related costs for hospitals excluded from the PPS payment system would be reduced by 15 percent.

Effective Date

Effective for hospital discharges occurring on or after October 1, 1995.

3. Reductions in Payment Adjustments for Disproportionate Share Hospitals

Present Law

Under the prospective payment system, Medicare provides additional payments to hospitals serving a disproportionate share of low income patients. The adjustment amount is determined using formulas based on the disproportionate share patient percentage. The disproportionate share patient percentage is defined as the sum of the percentage of total patient days that are attributed to non-Medicare-eligible Medicaid beneficiaries and the percentage of Medicare patient days that are attributed to Medicare beneficiaries that are also eligible for Supplemental Security Income benefits. Separate formulas are provided for various categories of urban and rural hospitals.

Description of Proposal

The Secretary would be required to reduce payments that would otherwise be made under the disproportionate share adjustment by 25 percent.

Effective Date

Effective for hospital discharges occurring on or after October 1, 1997.

4. Changes in Payment Methodology for PPS-Excluded Hospitals

Present Law

Hospitals excluded from the prospective payment system (psychiatric, rehabilitation, children's, cancer, and long-term hospitals and psychiatric and rehabilitation distinct part units) are paid on a reasonable cost basis subject to a rate of increase limit on operating costs per discharge. The per discharge limit, or target amount, is updated annually.

Description of Proposal

Rehabilitation hospitals and distinct part units would be assigned their 1990 and 1991 Medicare cost reporting periods as a new base year. Limits for subsequent periods would be determined based on per-discharge Medicare operating cost averaged over the two year period. The rebasing would:

- (a) Hold harmless those hospitals and units under their limits by paying them their costs plus incentive payments;
- (b) Provide a floor of 70 percent of the national average for each type of facility for those facilities with very low limits; and
- (c) Provide a ceiling of 110 percent of the national average for each type of facility for new facilities.

The Secretary would be required to complete development of a prospective payment system for rehabilitation hospitals and distinct part units, including a patient classification system, and present recommendations to Congress by October 1, 1996.

Conditions for exclusion of rehabilitation hospitals and distinct part units from the PPS would be expanded to account for the impact of new technologies and survival rates and the changes in the practice of rehabilitation medicine over the past decade.

Any long term hospital meeting a two year financial loss test and a low-income patient load test, would be assigned an average of their 1990 and 1991 Medicare cost reporting periods as a new base year. In any subsequent two year period in which both tests were met, the Secretary would be required to assign the hospital a new base year averaging the costs of the two years. A hospital meets the financial loss test if it has had two consecutive years of losses where its costs exceed its limit. A hospital satisfies the low-income patient load test if it has a Medicare disproportionate share patient percentage of greater than 25 percent.

Effective Date

October 1, 1994.

5. Extension of Freeze on Updates to Routine Service Costs of Skilled Nursing Facilities

Present Law

Medicare payment for skilled nursing facility services is made on a reasonable cost basis subject to a limit on routine costs per diem. The limit is based on 112 percent of the mean per diem routine service costs for freestanding facilities. There is an add-on to the limit for hospital-based facilities equal to 50 percent of the difference between 112 percent of the mean per diem routine costs for freestanding facilities and 112 percent of the mean per diem routine costs for hospital-based facilities. OBRA 1993 prohibited the Secretary from applying an update factor to the cost limits for skilled nursing facility cost reporting periods beginning in fiscal years 1994 and 1995.

Description of Proposal

The Secretary would be required to limit to 100 percent the upper limit on payment for reasonable routine service costs for services in skilled nursing facilities.

Effective Date

October 1, 1995.

6. Payments for Sole Community Hospitals with Teaching Programs and Multi-Hospital Campuses

Present Law

The Secretary is required to determine diagnosis-related group (DRG) specific rates for hospitals in different areas. Requirements to reimburse multi-campus facilities based on the location of the discharge applies only to hospitals not exempt from PPS and to hospitals reimbursed on the basis of DRGs and not to hospitals reimbursed on a cost basis.

Description of Proposal

The Secretary would establish separate rates of payment for each facility of a sole community hospital with multi-hospital campuses when at least one of the hospitals of the multi-hospital campus is eligible to receive indirect medical education payments.

Effective Date

October 1, 1993 for hospitals that merged after October 1, 1987.

7. Medicare Dependent Hospitals

Present Law

To qualify for Medicare Dependent Hospital (MDH) status, a hospital must be located in a rural area, have no more than 100 beds, and have at least 60 percent of its inpatient days or discharges attributed to Medicare patients during the cost reporting period beginning during fiscal year 1987. MDHs are eligible for payment under the same rules as sole community hospitals for cost reporting periods beginning on or after April 1, 1990 and ending before April 1, 1993. For discharges occurring during any cost reporting period beginning on or after April 1, 1993, through September 30, 1994, an MDH would receive 50 percent of the difference between its payment under the MDH rules and the payment regularly provided under the prospective payment system.

Description of Proposal

The proposal would clarify that payment amounts are determined by using a 36 month cost reporting period. The target amount definitions needed to make the calculations for MDHs would be extended to September 30, 1998.

MDHs would receive 50 percent of the difference between their payment under the MDH rules and the payment regularly provided under the prospective payment system through September 30, 1998.

Effective Date

Effective beginning with hospital discharges occurring on or after October 1, 1994.

8. Rural Health Transition Grants

Present Law

OBRA 87 instituted grant programs to assist rural hospitals with fewer than 100 beds in developing and implementing projects to modify the type and extent of services they provide. Grants may be used to develop health systems with other providers, diversify services, recruit physicians, improve management systems, and provide instruction and consultation via telecommunications to physicians in health professional shortage areas. The program was authorized at \$25 million per year for fiscal years 1990 through 1992.

Description of Proposal

Appropriations for the rural health transition grant program would be

authorized at \$30 million per year for fiscal years 1993 through 1999. Rural primary care hospitals would be eligible for grants.

Effective Date

Upon enactment.

9. Limited Service Hospitals, Essential Access Community Hospitals and Medical Assistance Facilities

Present Law

Under the Essential Access Community Hospitals/Rural Primary Care Hospital (EACH/ RPCH) program, up to 7 States may be designated by the Secretary to receive grants to develop rural health networks consisting of EACHs and RPCHs.

The Medical Assistance Facility (MAF) program currently operates a demonstration project that exempts small rural hospitals from certain licensure laws, expands the role of mid-level practitioners and improves Medicare payment.

There is no provision for limited service hospital programs or for rural emergency medical services programs.

Description of Proposal

The Secretary would be required to establish a limited hospital service program to coordinate rural hospital payment methodologies and delivery systems, including MAF, EACH/ RPCH, and rural emergency medical services.

The MAF demonstration program would be made permanent, and all States would be permitted to participate. Funding of \$5,000,000 per year for MAF would be authorized for fiscal years 1996 through 1999.

The Essential Access Community Hospital (EACH)/Rural Primary Care Hospital program (RPCH) would be extended to all States and authorized for \$15,000,000 per year for fiscal year 1990 through fiscal year 1998. The requirement that RPCH hospitals not have a length of stay exceeding 72 hours would be changed to allow an average length of stay not exceeding 96 hours. The requirement that hospitals be designated as EACHs would be discontinued. RPCHs, however, would be required to establish linkages with other providers. The requirement that the Secretary develop a prospective payment system for RPCHs would be repealed. Instead, RPCHs would be reimbursed using the MAF reimbursement methodology, including costs of contracts for services with other providers. Hospitals currently certified as EACHs would be permitted to retain Sole Community Hospital status.

A rural emergency medical services program would be established to

improve emergency medical services (EMS) operating in rural and frontier communities. Funding of \$5,000,000 per year for fiscal years 1996 through 1999 would be authorized to provide grants to States to coordinate EMS programs.

Effective Date

Effective for hospital discharges on or after October 1, 1994.

C. PROVISIONS RELATED TO PART B

1. Updates for Physicians' Services

Present Law

Under current law, payments for some services covered under Part B are updated each year by an inflation index. Prior to 1984, physician fees were updated annually by the Medicare Economic Index (MEI). The MEI measures inflation in the cost of providing physician services. From 1984 through 1991, the MEI update was often set in reconciliation legislation. The MEI is currently estimated to be 2.2 percent for 1995.

Beginning in 1992, Medicare physician fees are updated annually by a default formula, unless Congress acts. This update is based on two things: (1) the MEI; and (2) a comparison of actual physician spending in a base period compared to an expenditure goal known as the Medicare Volume Performance Standard (MVPS). Separate goals are set for surgical, primary care, and non-surgical services (excluding primary care).

If the MVPS was exceeded in the base period, the update for services within the category is equal to the MEI reduced by the percentage by which the target was exceeded. If expenditures were less than the MVPS, the update is the MEI increased by the percentage by which expenditures in the category were below the target.

The Omnibus Budget Reconciliation Act of 1993 (OBRA 93) reduced the default updates for 1994 by 3.6 percentage points for surgical services, and 2.6 percentage points for all other services (including anesthesia services), except for primary care, which received the full default update. The 1994 updates are 10.0 percentage points for surgical services, 5.3 percentage points for non-surgical service (including anesthesia services), except for primary care services, which received a 7.9 percent update.

OBRA 93 also reduced the default updates for 1995. The default update is reduced by 2.7 percentage points for surgical services and all other services (including anesthesia services), except primary care services, which receive the full update.

Under the default formula, the Secretary of HHS has estimated that the 1995 updates will be as follows: 13.2 percentage points for surgical services; 6.7 percentage points for non-surgical services (excluding

primary care services); and 9.4 percentage points for primary care services.

Description of Proposal

The proposed change would reduce the 1995 default update by 4.0 percentage points for surgical services, 4.0 percentage points for non-surgical services, and 1.0 percentage point for primary care services.

Effective Date

Upon enactment.

2. Substitution of Real Gross Domestic Product (GDP) for Volume and Intensity in the Volume Performance Standard

Present Law

The Omnibus Budget Reconciliation Act of 1989 (OBRA 89) established a system of Medicare volume performance standards (MVPS) which is used to calculate the annual update in fees (conversion factor) for physician and certain other Part B services after January 1, 1992. Under this system, Congress would enact a specific level of increase in expenditures for a subsequent calendar year. In the absence of Congressional action, the rate of increase in expenditures is determined by a formula set in law. The MVPS is based on an estimate of: (1) the percentage increase in Medicare fees; (2) the increase in the number of Part B enrollees, excluding enrollees in HMO risk-contracts; (3) an estimate of the historical rate of increase in the volume and intensity of services delivered; and (4) any change in payment due to legislation or regulation. This is reduced by a performance standard factor, which equals 3.5 percentage points in 1994 and 4.0 percentage points in each subsequent year.

Under current law, there is a lower limit on the default updates to the physician fee schedule. The annual update to the fee schedule can be no lower than the MEI minus 3.0 percentage points in calendar 1994 and minus 5.0 percentage points in 1995 and succeeding years.

Description of Proposal

The proposed change would specify that the historical rate of increase in the volume and intensity of services delivered would be deleted from the MVPS. Substituted in its place would be the average per capita growth in real (inflation-adjusted) GDP for the 5 year-period beginning with the previous fiscal year (1994). The performance standard factor would be repealed. In addition, the lower limit on the default update would be repealed.

Effective Date

Upon enactment.

3. Payments for Physician Services Relating to Inpatient Stays in Certain Hospitals

Present Law

There generally are no adjustments to amounts payable to physicians when covered services are provided to inpatients of hospitals. Each physician submits claims for services rendered, and the amounts paid are determined in accordance with the Medicare physician fee schedule. The only exceptions to this general rule are when physicians provide services as part of a surgical team or when they supervise services provided by certified registered nurse anesthetists.

Description of Proposal

The Secretary would be directed to develop for all hospitals paid under the prospective payment system, annual, hospital-specific case-mix adjusted relative value units per admission and determine whether a hospital exceeds the allowable average per admission relative value units applicable to the medical staff for the year. If the Secretary determines that the rate for the hospital exceeds the allowable average per admission, the Secretary would reduce payments for physician services to hospital inpatients. By October 1 of each year, the Secretary would notify each hospital of its specific relative values.

In the case of urban hospitals, the allowable average per admission relative value units would be equal to 125 percent for admissions in 1998 and 1999, and 120 percent thereafter of the median 1996 hospital-specific relative value units per admission for all hospital medical staffs.

In the case of rural hospitals for each year beginning with 1998, the allowable per admission relative value units would be equal to 140 percent of the median 1996 hospital-specific relative value units per admission for all hospital medical staffs.

The hospital specific projected relative value units for a hospital would be equal to the average relative value units per admission for physician services furnished to inpatients during 1996 by the hospital's medical staff and billed to Medicare, adjusted for variations in case mix, the disproportionate share adjustment, and indirect teaching adjustment, if applicable.

The projected excess relative value units for a year would mean the number of percentage points (as determined by the Secretary) by which a medical staff's hospital specific per admission relative value units exceed the allowable average per admission relative value units.

The amount of payments otherwise due would be reduced by 15 percent for each service furnished for hospitals whose relative value units per admission exceed the allowable average per admission.

Not later than October 1 each year, beginning in 1999, the Secretary

would be required to determine each hospital's actual average per admission relative value units using claims forms submitted not later than 90 days after the last day of the previous year, adjusted for case mix, and the disproportionate share and indirect teaching adjustments.

In cases in which a hospital's actual average per admission relative value units were reduced and were also below the allowable average rate, the Secretary would reimburse the hospital medical staff's fiduciary agent the amount that was withheld plus accrued interest. In cases where the actual average relative value units were less than 15 percentage points above the allowable average, the Secretary would reimburse the hospital medical staff's fiduciary agent an amount equal to the difference between 15 percentage points and the actual number of percentage points by which the staff exceeded the allowable average per admission relative value units plus accrued interest.

Hospital medical executive committees would be given a one-year advance notice of projected excessive relative values and would designate a fiduciary agent to receive and disburse amounts withheld by the Secretary that are subsequently returned. Alternatively, the Secretary could distribute such amounts directly to physicians who treated patients in the hospital on a pro-rata basis based on the proportion of services provided by each physician during the year.

Effective Date

Effective for services furnished on or after January 1, 1998.

4. Incentives for Physicians to Provide Primary Care

Present Law

Physicians providing services in health professional shortage areas, as defined in Sec. 332 of the Public Health Services Act, currently receive a bonus equal to 10 percent of the Medicare payment amount for each physician service delivered.

Description of Proposal

The proposed change would increase the bonus payment for primary care services, as defined in Sec. 1842(i)(a) of the Social Security Act, to 20 percent for each physician service. The bonus payment for other physician services (excluding primary care) would be set at 10 percent for services delivered in health professional shortage areas located in rural areas. The 10 percent bonus payment for non-primary care services delivered in health professional shortage areas located in urban areas would be eliminated.

Effective Date

Upon enactment.

5. Development and Implementation of Resource-Based Methodology for Practice Expenses

Present Law

From 1992 to 1996, Medicare is phasing in a fee schedule with separate components for physician work, practice expense and malpractice expense. Practice expense includes office rents, employees wages, physician compensation, and physician fringe benefits. Payment for the physician work component of the fee schedule is based on a resource-based relative value scale (RBRVS), but payment for practice expense and malpractice expense are based on historical charges.

Description of Proposal

The Secretary would be required to develop a methodology for implementing in 1997 a resource-based system for determining practice expense relative value units for each physician service. In developing the methodology, the Secretary would consider the staff, equipment and supplies used in the provision of various medical and surgical services in various settings. The Secretary would be required to report to Congress on the methodology by January 1, 1996. The existing payment methodology would be repealed when the new payment methodology takes effect in 1997.

Effective Date

Upon enactment.

6. Elimination of Formula-Driven Overpayment for Certain Hospital Outpatient Services

Present Law

The aggregate amount of Medicare payments made for hospital outpatient services (or rural primary care hospital services) furnished in connection with ambulatory surgery, radiology and diagnostic tests equals the lesser of: (1) the lower of a hospital's reasonable costs or its customary charges, net of deductible or co-insurance amounts, and (2) a blended amount comprised of a cost portion and a charge portion. The cost portion of the blend is based on the lower of a hospital's costs or charges net of beneficiary cost-sharing. The cost portion of the blend is 42 percent for ambulatory surgery and radiology services and 50 percent for diagnostic tests. The charge portion of the blend is 58 percent of the ambulatory surgery center (ASC) payment rates net of beneficiary co-insurance, and 58 percent of the physician fee schedule amount for radiology services net of co-insurance, and 50 percent of the physician fee schedule for diagnostic tests net of co-insurance.

A hospital may bill a beneficiary for co-insurance equal to twenty percent of its charge for an outpatient service. However, the blended amounts are calculated after application of beneficiary cost sharing (e.g. lower of hospital cost or charges net of cost sharing and 80 percent of the

ASC rate). This inconsistency in application of cost-sharing results in an anomaly whereby the amount a beneficiary pays in co-insurance does not result in a dollar for dollar decrease in Medicare program payment.

Description of Proposal

Using the current blend percentages, the payment formula would be changed to determine the blended payment limit prior to the application of beneficiary cost-sharing provisions. Medicare's payment amount would be determined based on the lesser of (1) the lower of the hospital's reasonable costs or customary charges, or (2) the blended payment limit. Medicare would then pay the lesser of (1) 80 percent of the lowest amount, or (2) the lowest amount less the beneficiary cost-sharing amounts.

Effective Date

Effective for services furnished during portions of cost-reporting periods occurring on or after January 1, 1995.

7. Payments to Eye and to Eye and Ear Specialty Hospitals

Present Law

Hospitals designated as eye, or as eye and ear hospitals receive a blended payment rate for ambulatory surgery for which 75 percent is based on the hospital's costs and 25 percent is based on the rate paid to freestanding ASCs. In general, the blended payment rate to hospitals for outpatient surgery is based 42 percent on costs and 58 percent on the ASC rate. This rule applies for cost reporting periods beginning on or after October 1, 1988, and before January 1, 1995.

Description of Proposal

The use of the 75/25 blend for eye hospitals, and eye and ear hospitals would be extended to services provided until September 30, 1997.

Effective Date

January 1, 1995.

8. Imposition of Co-insurance for Laboratory Services

Present Law

Medicare beneficiaries are required to make co-insurance payments equal to 20 percent of Medicare's approved payment amount for certain services. Since 1987, payment of co-insurance has not been required for clinical laboratory services.

Description of Proposal

The proposed change would require Medicare beneficiaries to pay co-insurance equal to 20 percent of the approved Medicare payment amount for clinical laboratory services.

Effective Date

January 1, 1995.

9. Application of Competitive Acquisition Process for Part B Items and Services

Present Law

Medicare pays for computer axial tomography (CT) scans and magnetic resonance imaging (MRI) tests on the basis of the Medicare physician fee schedule. The fee schedule has two parts: a technical component for performing the test and a professional component for interpreting the test. Either part of the test can be billed separately.

Payments for oxygen and oxygen equipment are made on the basis of a fee schedule for durable medical equipment.

Description of Proposal

The proposed change would direct the Secretary to establish competitive acquisition areas for procurement of CT scans, MRI tests and oxygen and oxygen equipment.

The Secretary would be permitted to establish different competitive acquisition areas for different items and services. The competitive acquisition areas would be required to be, or be within, metropolitan statistical areas (MSAs). They would be chosen by the Secretary based on the availability and accessibility of suppliers and the probable savings to be realized from the use of competitive bidding.

The Secretary would be required to conduct a competition among individuals and entities supplying items and services for each competitive acquisition area. The Secretary would only be permitted to award a contract if the individual or entity meets quality standards specified by the Secretary.

A competitive acquisition contract would specify: (1) the quantity of items and services to be provided; and (2) other terms and conditions specified by the Secretary.

If competitive acquisition failed to result in at least a 10 percent reduction in the payment amount for these services, the Secretary would be required to make reductions in payment levels for these services to achieve a 10 percent reduction.

Effective Date

January 1, 1995.

10. Application of Competitive Acquisition Process for Clinical Laboratory Services

Present Law

Medicare payments for clinical laboratory services are made on the basis of local fees in payment areas designated by the Secretary. Each fee schedule payment is limited by a national cap. The cap is set at 84 percent of the median of all fee schedule payments for a particular test in 1994, 80 percent in 1995, and 76 percent in 1996 and thereafter.

Description of Proposal

The proposed change would direct the Secretary to establish competitive acquisition areas for procurement of clinical laboratory services.

The Secretary would be permitted to establish different competitive acquisition areas for different items and services. The competitive acquisition areas would be required to be, or be within, metropolitan statistical areas (MSAs). They would be chosen by the Secretary based on the availability and accessibility of suppliers and the probable savings to be realized from the use of competitive bidding.

The Secretary would be required to conduct a competition among individuals and entities supplying items and services for each competitive acquisition area. The Secretary would only be permitted to award a contract if the individual or entity meets quality standards specified by the Secretary.

A competitive acquisition contract would specify: (1) the quantity of items and services to be provided; and (2) other terms and conditions specified by the Secretary.

If competitive acquisition failed to result in at least a 10 percent reduction in the payment amount for laboratory services, the Secretary would be required to make reductions in payment levels for these services to achieve a 10 percent reduction.

Effective Date

January 1, 1995.

11. Part B Premium

Present Law

From 1984 through 1990, the Part B premium was set to cover 25 percent of Part B spending for aged beneficiaries. The remaining 75 percent was funded from general revenues. The Omnibus Budget Reconciliation Act of

1990 established the monthly Part B premium in statute through 1995 to cover 25 percent of Part B spending as follows: \$29.90 in 1991, \$31.80 in 1992, \$36.60 in 1993, \$41.10 in 1994 and \$46.10 in 1995. The Omnibus Budget Reconciliation Act of 1993 extended the 25 percent Part B premium policy through 1998, but did not specify actual premiums in law.

Description of Proposal

The proposed change would permanently set Part B premiums at 25 percent of Part B spending for aged beneficiaries.

Effective Date

Upon enactment.

D. PROVISIONS RELATED TO MEDICARE PARTS A AND B

1. Medicare Secondary Payer

Present Law

(a) Extension of Transfer of Data

OBRA 89 authorized the establishment of a database to identify working beneficiaries and their spouses to improve identification of cases in which Medicare is secondary to third-party payers. The data match links Internal Revenue Service (IRS) tax records with data from the Health Care Financing Administration (HCFA). The Omnibus Budget Reconciliation Act of 1993 authorized an extension of the transfer of data through September 30, 1998.

(b) Extension of Medicare Secondary Payer for Disabled Beneficiaries

Medicare is the secondary payer to certain group health plans offered by employers of 100 or more employees for disabled beneficiaries. The authority for this provision expires September 30, 1998.

(c) Extension of 18-Month Rule for ESRD Beneficiaries

Medicare is the secondary payer to certain employer group health plans covering beneficiaries with end stage renal disease (ESRD) during the first 18 months of a beneficiary's entitlement to Medicare on the basis of ESRD. The authority for this provision expires September 30, 1998.

Description of Proposal

(a) Extension of Transfer of Data

The authority for the transfer of data would be made permanent.

(b) Extension of Medicare Secondary Payer for Disabled Beneficiaries

The Medicare secondary payer requirements for disabled beneficiaries

would be made permanent.

(c) Extension of 18-Month Rule for ESRD Beneficiaries

The Medicare secondary payer requirements for beneficiaries with end stage renal disease would be made permanent.

Effective Date

Upon enactment.

2. Expand Centers of Excellence

Present Law

Medicare currently has two demonstration projects that involve competitive contracts with "centers of excellence" to perform coronary artery bypass graft surgery and cataract surgery for one payment that includes all services provided in connection with these procedures. The bypass surgery demonstration is currently being conducted in seven cities and the cataract surgery demonstration is being conducted in three cities.

Description of Proposal

The proposed change would direct the Secretary to expand the demonstration projects for coronary artery bypass and cataract surgery in urban areas. Payment would be made on the basis of a negotiated or all-inclusive rate, beginning with fiscal year 1995.

The amount of payment would be required to be less than the aggregate amounts of payments the Secretary would have made if the demonstrations were not conducted. Payment for coronary artery bypass surgery would include the bypass procedure and related services.

The Secretary would be required to make a payment to each beneficiary to whom services are provided under this demonstration equal to 10 percent of the difference between what the Secretary would have paid for these services in the absence of this provision and what the Secretary actually paid for the services under this provision.

Effective Date

Upon enactment.

3. Medicare Select

Present Law

The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) requires that all Medigap policies conform to one of ten standard benefit packages, including a core benefit package that must be made available by all Medigap insurers, and nine other packages that an insurer has the option of

offering. In general, Medigap policies may not be canceled and must be guaranteed renewable as long as premiums are paid. OBRA 90 also permitted the offering of a new Medicare supplement policy, known as Medicare Select, in 15 States. The only difference between standard Medigap and Medicare Select is that Select policies will only pay full benefits if covered services are obtained through selected health professionals.

Description of Proposal

The proposed change would permit Medicare Select policies to be offered in all States. The three year limitation would be eliminated. A health maintenance organization could offer a Medicare supplemental policy that does not conform to at least one of the ten standard benefit packages if: (1) the benefits include at least the core benefits package, although the plan could charge nominal copayments, and (2) the benefit package including any copayments, when combined with Medicare benefits, is substantially similar to benefits provided to non-Medicare enrollees of the health maintenance organization. A Medicare Select policy may be canceled or not renewed in the case of an individual who leaves the service area of the policy, except that if the individual moves to an area for which the issuer of the Medicare Select policy (or an affiliate) offers a Medigap policy, the alternative must be made available to the individual.

Effective Date

The National Association of Insurance Commissioners (NAIC) would have nine months after the date of enactment to revise the current model regulations to reflect this provision and to make other changes of a technical nature. If the NAIC does not revise its model regulations within the stated time frame, the Secretary would be required to develop a regulation and would have 9 months to do so.

The revised model regulations or Federal regulations would apply in each State on the date the State adopts such regulations or one year after the regulations are developed, whichever is earlier. Special provisions are included for States whose legislatures will not meet during the one year period following the development of the regulations.

4. Medicare Supplemental Insurance Policies (Medigap)

Present Law

Medical underwriting and certain other practices are prohibited with respect to Medicare supplemental policies for which an individual age 65 or older applies during the six-month period beginning with the first month which an individual is first enrolled for benefits under Medicare Part B.

Description of Proposal

The proposed change would require Medicare supplemental policies (Medigap) to have an annual open enrollment period of 30 days.

Effective Date

January 1, 1996.

5. Reduction in Routine Cost Limits for Home Health Care Services

Present Law

Home health care services are reimbursed on a reasonable cost basis, subject to aggregate cost limits which are updated annually. The Omnibus Budget Reconciliation Act of 1987 limited payment for home health agency costs to 112 percent of the mean labor-related and non-labor per visit costs for freestanding home health agencies (HHAs). OBRA 1993 prohibited the Secretary from applying an update factor to the cost limits for home health services for cost reporting periods beginning in fiscal years 1994 and 1995. OBRA 1993 also eliminated additional payments for administrative and general costs of hospital-based HHAs.

Description of Proposal

The upper limit on payment for allowable visit-related costs for home health services would be limited to 100 percent. The cost limits are changed from a percentage of the mean cost to a percentage of the median cost.

Effective Date

October 1, 1995.

6. Improvements in Risk Contracts

Present Law

Approximately 5 percent of beneficiaries are enrolled in health maintenance organizations (HMOs) under risk contracts with Medicare. Under risk contracts, Medicare pays HMOs 95 percent of the estimated amount it would have cost to provide Medicare benefits to demographically comparable beneficiaries in the same county who had not enrolled in an HMO. The payment amount is the average adjusted per capita cost (AAPCC).

Description of Proposal

Health plans entering into Medicare risk contracts would be required to meet the standards for integrated health plans specified in Part XV. Such plans would also be required to maintain compliance with the following: (1) Section 1876 (f), which requires that at least 50 percent of enrolled membership consists of non-Medicare or Medicaid eligible individuals; (2) Section 1876 (i)(7), which requires that health plans with a risk contract maintain an agreement with a utilization and quality control peer review organization; and Section 1876 (i)(6), which authorizes

the Secretary to impose civil monetary penalties and other sanctions for failure to provide medically necessary items and services, charging premiums in excess of those permitted, and other violations.

The Secretary would be required to use community-rating areas, rather than counties, as the basis for calculating the AAPCC. The Secretary would be required to provide uniform marketing materials to all Medicare beneficiaries in a community-rating area for purposes of enrolling in a health plan.

Effective date

January 1, 1996.

E. MEDICARE AND MEDICAID COVERAGE BANK DATA

Present Law

The Omnibus Budget Reconciliation Act of 1993 established a Medicare and Medicaid Coverage Data Bank within the Department of Health and Human Services. The Secretary was required to establish the data bank for the purposes of identifying and collecting from third parties responsible for payment of health care items and services furnished to Medicare beneficiaries, and assisting in the collection of, or collecting amounts due from third parties liable to reimburse costs incurred by any State plan under the Medicaid program. Employers are required to report certain information to the Data Bank concerning employee health coverage on an annual basis for years beginning with calendar year 1994 and ending with calendar year 1997. The first filing is to occur on February 28, 1995.

Description of Proposal

The proposal would repeal the Medicare and Medicaid Coverage Data Bank.

Effective Date

Upon enactment.

**XI. ACADEMIC HEALTH CENTERS, GRADUATE MEDICAL
AND NURSING EDUCATION, AND RESEARCH**

A. ACADEMIC HEALTH CENTERS TRUST FUND

Present Law

The Indirect Medical Education (IME) adjustment factor under Medicare's prospective payment system for inpatient hospital services increases payments to teaching hospitals compared with non-teaching hospitals. The IME payments are intended to reflect differences in patient care costs due to the indirect costs associated with graduate medical education, the severity of illness treated, and the complexity of highly specialized care. Payments to major teaching hospitals based on diagnosis-related groups (DRGs) are increased by about one-third, under a statutory formula that increases payments for each discharge by about 7.65 percent for each 0.1 increase in the ratio of residents to beds (section 1886(d)(5)(B)(ii) of the Social Security Act). The formula is calculated on a curvilinear basis, so that the increase in the payment tapers off somewhat in hospitals with very high resident-to-bed ratios.

Description of Proposal

1. A trust fund would be established to make payments to teaching hospitals and to academic health centers that operate teaching hospitals, to high intensity non-teaching rural hospitals, and to dental schools for dental education.
2. Payments would be made to hospitals, academic health centers, and high intensity non-teaching rural hospitals to assist with specialized costs they incur that are not routinely incurred by other entities in providing health services and that are unlikely to be covered by payments for hospital services under managed competition.
3. An "academic health center" would be defined as a teaching hospital or a school of medicine or osteopathy that operates a teaching hospital. A teaching hospital is a hospital that operates a residency training program that is accredited by a specialty or subspecialty. A high intensity non-teaching rural hospital would be defined as one with substantially more patients who are severely ill as measured by their case mix index.
4. Annual payments from the trust fund would total \$6,280,000,000 in 1996; \$7,250,000,000 in 1997; \$8,220,000,000 in 1998; \$9,400,000,000 in 1999; \$10,640,000,000 in 2000; and in each subsequent year, \$10,640,000,000 increased by the change in the national premium targets (as defined in Part VI) for such years; of those sums, \$50,000,000 in 1996, increased by the change in the national premium targets in subsequent years, would be available for dental education.
5. Distribution of funds among teaching hospitals and academic health centers would be according to a formula modeled after the current Medicare IME adjustment factor. The current IME payment formula, which is based on

DRGs, would be modified to reflect the varying methods of hospital payment in the private sector. It would also be adjusted to compensate for the higher costs of research-intensive academic centers and to provide for payments to dental schools for dental education. Distribution of funds to high intensity non-teaching rural hospitals would be according to a formula based on the case mix index and would result in an increase in payments of approximately five percent.

6. The Secretary of HHS would be required to report to the Committee on Finance and the Committee on Ways and Means by July 1, 1996, with any recommendations for further modifications of the formula.

7. Funds for the Academic Health Center Trust Fund would come from all payers. Medicare would contribute at the rate at which it would otherwise have made IME payments under current law. The remainder of the funds would come from a portion of a 1.75 percent assessment on premiums for health plans (including self-insured health plans). Payments in any year would be pro-rated if necessary on the basis of available funds.

Effective Date

Upon enactment.

B. BIOMEDICAL AND BEHAVIORAL RESEARCH TRUST FUND

Present Law

No provision (biomedical and behavioral research conducted or supported by the National Institutes of Health (NIH) is funded by appropriations authorized under Titles III and IV of the Public Health Service Act).

Description of Proposal

1. A Health Research Trust Fund would be established to fund expanded biomedical and behavioral research through the NIH.

2. Funds for the Health Research Trust Fund would come from a portion of the 1.75 percent assessment on premiums for certified health plans (including self-insured health plans). Payments in any year would be equal to 0.25 percent, or one-seventh of the funds raised by the 1.75 percent premium assessment.

3. Payments for biomedical and behavioral research conducted or supported by the NIH from the Trust Fund would be in addition to any monies appropriated for that purpose. Monies from the Trust Fund could not be allotted unless total NIH appropriations in that year equaled or exceeded the appropriations for the prior year.

Effective Date

Upon enactment.

C. GRADUATE MEDICAL AND NURSING EDUCATION TRUST FUND

Present Law

1. Graduate Medical and Nursing Education Trust Fund

No provision.

2. Graduate Medical Education Payments

Under Medicare's payments to hospitals, the direct costs of graduate medical education are paid separately from the DRG-based payments. Payments are made on a formula that are based on each hospital's historical costs per resident. Each hospital's costs per resident are calculated for the hospital's cost reports for fiscal year 1984, generally updated to the present. The number of residents is the weighted average number of residents who are within the minimum number of years required for board eligibility plus 1, not to exceed 5 years, and one-half the number of residents in additional years of training. Payments include resident and faculty salaries and other related direct costs.

3. Graduate Nursing Education Payments

No provision (the direct costs of training for nurses working toward the RN degree in provider-operated programs are paid by Medicare on a reasonable cost basis, but not those in graduate education programs).

4. Medical School Account

No provision.

Description of Proposal

1. Graduate Medical and Nursing Education Trust Fund

A trust fund for payments for Graduate Medical and Nursing Education and transitional payments would be established. Payments into the trust fund would consist of payments that would otherwise have been made for Medicare direct medical education under current law, plus a portion of revenues from the 1.75 percent assessment on premiums for health plans (including self-insured health plans).

2. Payments for Graduate Medical Education

The Secretary of HHS would make payments from the Trust Fund for the operation of approved graduate physician and dental training programs, beginning in calendar year 1996. Payments would total \$3,200,000,000 in 1996; \$3,550,000,000 in 1997; \$5,800,000,000 in 1998; and in subsequent years, \$5,800,000,000 increased by the change in the national premium targets for each year.

Payments to each eligible applicant would equal the full-time-

equivalent number of residents in the program multiplied by the historical costs of training residents as determined under current Medicare direct medical education law. The full-time-equivalent number of residents would be calculated as under Medicare. Both calculations would be adjusted to account for costs and residents in programs not based in teaching hospitals. Payments in any year would be pro-rated if necessary on the basis of available funds.

3. Graduate Nursing Education Payments

A program would be established to pay for the costs of graduate nurse education. Eligible applicants would be programs for advanced nurse education, nurse practitioners, nurse midwives, nurse anesthetists, and other training in clinical nurse specialties determined by the Secretary to require advanced education. The amount available for graduate nurse training programs from the Trust Fund would be \$200,000,000 in 1996, increased annually thereafter by the change in the national premium targets for each year. Payments in any year would be pro-rated if necessary on the basis of available funds.

4. Medical School Account

Payments would be made to medical schools to assist in meeting additional teaching and research costs associated with the transition to managed competition and expanded ambulatory and teaching. Payments would total \$200,000,000 in 1996, \$300,000,000 in 1997, \$400,000,000 in 1998, \$500,000,000 in 1999, and \$600,000,000 in 2000, increased annually thereafter by changes in the national premium targets. Payments in any year would be pro-rated if necessary on the basis of available funds.

Effective Date

Upon enactment.

XII. ACCESS TO HEALTH CARE IN DESIGNATED URBAN AND RURAL AREAS

A. INVESTMENT IN INFRASTRUCTURE DEVELOPMENT

Present Law

No provision.

Description of Proposal

An infrastructure development account is created within the Health Security Trust Fund to support the development of community health networks and certified community health plans, and to provide operating and capital assistance to such networks and plans. The Secretary of Health and Human Services would be required to deposit \$1.3 billion in the account annually and to administer all programs funded through the account.

"Community health networks" are organizations that provide some services included in the standardized benefit package either directly through their members or through affiliations with other entities. A network must ensure that services are available and accessible to each enrollee with reasonable promptness, and that clients have a primary care provider. The network would have to include one or more of the following: 1) institutions, physicians, and other providers serving a Health Professional Shortage Area (HPSA) or serving large numbers of medically underserved individuals; 2) qualified migrant and community health centers; 3) qualified homeless programs; 4) family planning providers; 5) HIV providers; 6) maternal and child health block grant recipients; 7) rural health clinics and other Federally Qualified Health Centers; 8) providers of services in urban areas under Title V of the Indian Health Care Improvement Act, or providers of services under the Indian Self-Determination Act; 8) State or local public health agencies; and 9) isolated rural facilities.

A "certified community health plan" is a public or nonprofit private health plan that provides a significant volume of services to medically underserved populations or individuals residing in HPSAs; includes at least one of the providers listed above under the definition of a community health network; and meets all of the other criteria of a certified health plan.

The Secretary of Health and Human Services would be required to develop standards for identifying "designated urban and rural areas" taking into account financial and geographic access to certified health plans; the availability, adequacy, and quality of providers and health care facilities; and the health status of the area's residents. States would have the authority to identify designated urban and rural areas, subject to the approval of the Secretary.

Effective Date

Upon enactment.

B. NETWORK AND PLAN DEVELOPMENT GRANT PROGRAM

Present Law

No provision.

Description of Proposal

The Secretary would be directed to award grants to public and private non-profit health care organizations to assist them in becoming community health networks and certified community health plans.

Grant funds could be used to assist in recruitment and retention of health care professionals; to develop information, billing, and reporting systems; to link providers together (including through information systems); to meet reserve requirements; and to support other activities related to developing certified community health plans and community health networks.

In awarding grants, the Secretary would be directed to give priority to networks and plans that include the largest number of entities listed under the definition of a community health network, and that are serving populations with the highest degree of unmet need.

In exchange for funding, grantees would be required to serve a designated urban or rural area, and to serve all individuals regardless of their financial and insurance status.

Effective Date

Upon enactment.

C. OPERATING ASSISTANCE

Present Law

No provision.

Description of Proposal

The Secretary would be required to use funds from the infrastructure development account to provide operating assistance to certified community health plans and community health networks to address geographic, financial, and other barriers to health care services in designated urban and rural areas. Grant funds could be used to provide consumer information and related services that will increase access to care. Related services could include rural and frontier emergency transportation systems and translation services. In exchange for funding, grantees would be required to serve a designated urban or rural area and to provide care to all individuals regardless of their financial or insurance status.

Effective Date

Upon enactment.

D. CAPITAL INVESTMENT

Present Law

No provision.

Description of Proposal

The Secretary would be directed to use funds from the infrastructure development account to provide capital assistance to community health plans, community health networks, and isolated rural facilities in designated urban and rural areas. The assistance would be provided in the form of loans, loan guarantees, and direct grants.

Funds could be used for the acquisition, modernization, conversion, and expansion of facilities, and for the purchase of major equipment, including hardware for information systems. The Secretary would be required to develop criteria for restricting the use of direct grants to urgent capital needs.

At least ten percent of the funds available for capital assistance would be reserved for applicants seeking to serve designated rural areas, provided that a sufficient number of such qualified applications were approved.

The Secretary would be required to give preference to applicants who need capital assistance to prevent or eliminate safety hazards in essential facilities; to avoid noncompliance with licensure or accreditation standards; and to improve the provision of essential services.

In exchange for receiving capital assistance, grantees would be required to serve a designated urban and rural area. They would also be required to serve all individuals regardless of their financial and insurance status.

Any loans made under this part would be required, subject to the Federal Credit Reform Act of 1990, to meet such terms and conditions as the Secretary determined to be necessary to protect the financial interests of the United States.

Effective Date

Upon enactment.

E. TELEMEDICINE DEMONSTRATION PROJECTS

Present Law

The Department of Health and Human Services and the Department of Commerce fund various telemedicine and related telecommunications projects. None of these projects are focused on developing a reimbursement methodology for telemedicine services. There is no formal interagency task force to coordinate various telemedicine projects.

Description of Proposal

The Secretary of HHS would be authorized to use \$20 million from the infrastructure development account to establish telemedicine demonstration projects. Four of the projects funded under this section would be used to develop a Medicare reimbursement methodology for telemedicine services.

Health care providers located in rural areas would be eligible to receive funding under this section if they established partnerships with other community institutions to identify and implement telemedicine projects. They would be required to match Federal grants at a rate of at least twenty percent.

Grants could be used to support the establishment and operation of a telemedicine system that provides specialty consultation to rural communities; to demonstrate the application of telemedicine for preceptorship of medical and other health professions students; to pay for transmission costs, salaries, maintenance of equipment, and compensation of specialists and referring practitioners; and to facilitate collaboration among physicians and other health care providers.

The Secretary would establish an Interagency Task Force on Rural Telemedicine. The Task Force would be required to identify effective uses of telemedicine, review and coordinate evaluations of all federally funded telemedicine demonstration projects, help rural entities to conduct local needs assessments and develop consortia, and review the Health Care Financing Administration's policy for reimbursement of telemedicine services.

Effective Date

Upon enactment.

F. PROVISIONS RELATING TO INDIAN HEALTH

Present Law

Health care for Indians is primarily funded through the Indian Health Service (IHS). Tribes are currently eligible to apply to State governments for Federal money the State receives for health initiatives.

Description of Proposal

The Indian Health Service would remain as a provider of health care for the Indian population.

Indian Tribes would be eligible to apply for appropriated funds and grants created under this legislation, at levels not less than any other qualified entities.

G. OFFICE OF THE ASSISTANT SECRETARY FOR RURAL HEALTH

Present Law

The Office of Rural Health was established under the Social Security Act and resides within the Public Health Services Health Resource Services Administration.

Description of Proposal

The position of the Director of the Office of Rural Health would be elevated to the position of the Assistant Secretary for Rural Health.

Effective Date

January 1, 1996.

XIII. STATE FLEXIBILITY

Present Law

State laws that relate to employee benefit plans, other than laws that regulate the business of insurance, generally are preempted by the Employee Retirement Income Security Act of 1974 (ERISA). Some courts have interpreted this to mean that even State laws that have only an indirect effect on the cost of providing health coverage through an employer-provided health plan are preempted, even if there is no direct impact on the administration of such plans.

Description of Proposal

A. STATE LAWS THAT DO NOT AFFECT THE ADMINISTRATION OF HEALTH PLANS

Certain State laws that are intended to increase health care coverage, fund uncompensated care, or control health care costs and which do not interfere with the administration of multistate health plans would not be preempted by Federal law.

The following State laws, to the extent they do not discriminate against self-insured or other employer-provided health plans, would not be preempted: All-payer provider reimbursement systems; uniform provider rate schedules; rate surcharges and premium or other health care assessments or allowances, the proceeds of which are used to fund uncompensated care or other State health programs; and community-rating standards that do not permit variation by age, apply to a larger share of the market, or that apply before January 1, 1996.

With the approval of the Secretary of Health and Human Services (HHS), a State's all-payer provider reimbursement system or uniform provider rate schedules also would apply to Medicare beneficiaries in the State.

B. COMPREHENSIVE STATE PROGRAMS

A comprehensive State program for the management of all health care benefits provided in the State, if approved by the Secretary of HHS, would not be preempted by Federal law. With the permission of the Secretary, the program also would apply to Medicaid and Medicare beneficiaries in the State.

To secure HHS approval, the State program would have to demonstrate that it would be expected to significantly increase coverage or lower health care spending in the State relative to baseline projections. Examples of the type of program for which a State may seek approval include a State single-payer or other public plan, an employer mandate, a combination of public and private coverage, or managed competition. The State program could not increase Federal outlays to the State.

Any certified self-insured Taft-Hartley multiemployer plan that covers participants in two or more States, or any certified single-employer plan

maintained by a multistate employer that has at least 5,000 employees nationally, would not have to participate in an approved State benefits management program.

Effective Date

For State laws that are not preempted under paragraph A, the provision would be effective before and after the date of enactment of the proposal. The Secretary would be permitted to approve comprehensive State benefit management programs described in paragraph B after the date of enactment.

XIV. PRIVACY AND CONFIDENTIALITY

Present Law

The Privacy Act of 1974 and the Computer Security Act of 1987 address the protection and disclosure of information under Federal control. The Federal Freedom of Information Act, which requires disclosure of many Federal records, explicitly excludes from disclosure most individual medical files held by the Federal government. Federal law also specifically protects the confidentiality of patient records held by alcohol and drug abuse treatment programs receiving Federal assistance.

Description of Proposal

A. RULE OF NONDISCLOSURE FOR PROTECTED HEALTH INFORMATION

All health information that could reasonably be related to a specific individual would be protected from disclosure. Comprehensive protections of this protected health information would apply regardless of form or medium, whether kept in paper files or in electronic databases, whether retained in doctors' offices or insurance company files, or available from an information system or over a computer network.

B. PENALTIES

Unauthorized disclosures of protected health information would be subject to criminal sanctions, civil actions, and administrative penalties. Penalties would range from fines of up to \$50,000 and prison terms of up to one year for wrongful disclosure or obtaining of protected health information, to fines of up to \$100,000 and prison terms of up to five years for violations committed under false pretenses, to fines of up to \$250,000 and prison terms of up to ten years for offenses committed with intent to sell protected health information for commercial advantage or personal gain.

C. INDIVIDUAL AUTHORIZATION OF DISCLOSURES

An individual would be able to authorize disclosure of protected health information about himself or herself under circumstances that ensure the authorization is a knowing and meaningful choice, that circumscribe the uses of the disclosure, and that allow for time limitation and revocation of permission. Requests for authorization for disclosure would be structured to serve these purposes.

D. LIMIT ON AMOUNT OF INFORMATION DISCLOSED

When protected health information is disclosed, it would be limited to the minimum necessary to accomplish the purposes for which the information was disclosed.

E. PROHIBITION OF REDISCLOSURE

Protected health information obtained in accordance with law for a necessary and limited purpose could not be redisclosed or used for an unauthorized purpose.

F. PATIENT RIGHTS

An individual would have the right to inspect and annotate records of health information about himself or herself through his or her health care providers. He or she would also have the right to prohibit the disclosure of sensitive and personal information so that it would not be included in the health information that providers are otherwise permitted to share.

G. SECURITY AND INTEGRITY SAFEGUARDS

Administrative, technical, and physical safeguards of the security and integrity of protected health information would be required of all trustees of such information.

H. EXCEPTIONS TO THE RULE OF NONDISCLOSURE

An exception to the rule of nondisclosure would be created for each of the following:

1. Health Care

Health care providers would be permitted to share relevant protected health information in the process of diagnosis and treatment.

2. Payment for Health Care

Health care providers and plans would be permitted to share protected health information for the purposes of payment and for such other financial and administrative functions as necessary to the effective operations of the health system.

3. Oversight of Health Care

Oversight agencies would be permitted to have access to protected health information in order to deter, uncover, and remedy health care fraud and other abuses of the health care system. Except for an action or investigation arising out of receipt of health care or payment for health care, no information about an individual disclosed for oversight purposes could be used in an action against the individual.

4. Public Health

Disclosure of protected health information required to meet the requirements of public health authorities and the need for disease and injury reporting, public health surveillance, and public health investigations or interventions would be permitted.

5. Medical Emergencies

Disclosure of protected health information required to protect the health of an individual from imminent harm would be permitted. Disclosures pursuant to this exception could not be used in an action against the individual who was the subject of the information disclosed.

6. Health Research

Disclosure of protected health information to health research projects, for which an institutional review board has determined that disclosures are necessary, would be permitted. Use of the protected health information would be limited to the research project and identifying information would have to be kept secure and confidential. For research that involves direct contact with the subject of the information, the subject would have to be given prior notice and given an opportunity to object to being included in the research project.

7. Judicial Proceedings

Court ordered examinations and disclosure of protected health information when a party has placed his or her medical condition at issue would be permitted. Disclosure would be limited to the minimum necessary and could be used only for the purpose for which it was received.

8. General Law Enforcement Requests

Disclosure of protected health information would be permitted to law enforcement authorities to investigate or prosecute a health care provider or plan or to identify a victim or witness in a law enforcement inquiry. Disclosed information could not be used against the subject of the protected health information.

9. Subpoenas and Warrants

Disclosure of protected health information would be permitted when ordered by a subpoena or warrant. A probable cause standard of reason to believe the protected health information was relevant to a law enforcement inquiry would be provided and an opportunity for an individual to move to quash the warrant or subpoena would be included for general law enforcement subpoenas or warrants. For private party subpoenas, the party seeking the protected health information would have to justify to the court that the need for the information outweighs the intrusion into privacy.

Effective Date

Upon enactment.

XV. HEALTH PLAN STANDARDS

Present Law

The Secretary of HHS determines whether Health Maintenance Organizations (HMOs) meet standards for Federal qualification.

A. STANDARDS FOR ALL HEALTH PLANS

Description of Proposal

The Secretary, in consultation with the Health Plan Standards and Quality Advisory Committee (established below), would develop specific standards and evaluation criteria to be used in the certification of all health plans. These standards would be based on the following general standards set in law.

To be certified by the State, or in the case of a multistate self-insured plan by the Secretary of Labor, all health plans must conform to the following standards.

1. Health plans would be required to establish alternative dispute resolution procedures.

2. Health plans would be required to participate in the Health Information Network. Health plans would be required to have procedures to report to the Consumer Information Center, in a standardized format, the data required to produce comparative value information. Health care professionals and facilities would be required to report a standard set of data to the Consumer Information Center.

3. Health plans would be required to meet capital and solvency standards.

a. Guaranty Funds

Each state would be required to establish and operate two guaranty funds, each of which could assess up to 2% of health plan premiums each year to cover outstanding claims against failed health plans. One fund would cover self-insured plans, and the other would cover insured plans. All health plans (other than multistate self-insured plans) would be required to participate in the appropriate guaranty fund.

A Federal fund would be established for multistate self-insured plans.

b. Capital Requirements

The Secretary, in consultation with the National Association of Insurance Commissioners, would be required to develop a risk-based capital

standards formula for all insured health plans by July 1, 1995.

Nothing in Federal statute would preclude or preempt state law on, or regulation of, health plan deposit reserve requirements.

The Secretary, in consultation with the Health Plan Standards and Quality Advisory Committee, would be required to develop capital requirements for self-funded plans.

B. ADDITIONAL STANDARDS FOR INTEGRATED HEALTH PLANS

In addition to the standards under Section A, integrated health plans would be required to meet the following standards. An integrated health plan is organized to provide health care services, either directly or through arrangements with other providers, to an enrolled population in a service area. Integrated health plans can be self-insured or insured.

1. Quality Standards

a. Quality Improvement and Assurance

Integrated health plans would be required to develop and implement an internal quality improvement program designed to measure, assess and improve enrollee health status, enrollee outcomes, enrollee processes of care, and enrollee satisfaction.

Integrated health plans would be required to develop and implement quality improvement goals based on the results of population health status measurements.

Integrated health plans would be required to maintain a program to assure the quality of health care services furnished to enrollees meets minimum standards of safety and clinical practice.

b. Utilization Management

Integrated health plans would be required to use practicing health professionals with appropriate clinical training in making review determinations.

Integrated health plans would be required to base utilization management on current scientific knowledge, stress health outcomes, rely primarily on evaluating and comparing practice patterns rather than routine case-by-case review, and be consistent and timely in application.

Utilization management could not create direct financial incentives for reviewers to reduce or limit medically necessary or appropriate services.

Upon request, each integrated health plan would be required to disclose to a participating or prospective provider, enrollee or

prospective enrollee, utilization review protocols. The standards would address the need to protect proprietary business information.

c. Credentialing

Integrated health plans would be required to credential participating physicians and practitioners.

Integrated health plans would be required to ensure that participating providers and facilities are appropriately accredited, certified and licensed.

d. Continuity of Care

Integrated health plans would be required to develop and implement mechanisms for coordinating the delivery of care across provider settings.

e. Medical Recordkeeping

Integrated health plans would be required to maintain an adequate patient record system to assure that pertinent information is readily available to appropriate professionals.

2. Patient Protection Standards

a. Patient Information

Integrated health plans would be required to provide to enrollees clear descriptive information and information about their rights and responsibilities.

b. Advance Directives

Each integrated health plan would be required to notify enrollees of their rights to self-determination in health care decision-making, notify enrollees of the plan's policy regarding advance directives, and provide for educational activities for patients and providers. Patients' primary care physicians would be required to include in the patients' charts their wishes concerning advance directives.

c. Confidentiality of Patient Records

Integrated health plans would be required to have explicit procedures to protect the confidentiality of individual patient information.

d. Marketing (does not apply to self-insured plans)

Integrated health plans could not engage in selective marketing that would have the effect of avoiding high-risk subscribers within a health plan service area. Marketing materials could not contain false or materially misleading information.

e. Grievance Procedure

Integrated health plans would be required to establish a grievance process for patients dissatisfied with matters other than denial of payment or provision of benefits by the plan.

f. Consumer Protection

Integrated health plans would be prohibited from engaging, directly or through contractual arrangements, in any activity, including the selection of a service area, that has the effect of discriminating against an individual on the basis of health status, disability or anticipated need for health services.

In selecting among providers of health services for membership in a provider network, or in establishing the terms and conditions of such membership, an integrated health plan may not engage in any practice that has the effect of discriminating against a provider based on the health status, disability, or anticipated need for health services of a patient of the provider.

g. Physician Incentive Plans

Physician incentive plans operated by integrated health plans would have to meet the requirements of section 1876(i)(8)(A) of the Social Security Act, including the provision that 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 to enrollees.

h. Physician Participation

Integrated health plans would be required to ensure that physicians participate in policymaking affecting patient care, and that patients would be able to choose their primary care physician from available practitioners.

Integrated health plans would be required to provide notification to physicians of decisions to cancel or deny renewal of contracts and establish an internal review process for appeals.

i. Ethical Business Conduct

An integrated health plan would be required to develop and implement a code of ethical business conduct for its activities, including those of its components, and assure proficient management and planning functions.

j. Enrollment

An integrated health plan could not accept the enrollment of an individual who is currently enrolled in another health plan.

3. Access Standards

a. Essential Community Provider

Integrated health plans would be required to have a contractual relationship with Essential Community Providers that included adequate payment rates for services.

The Secretary would be required to certify as an Essential Community Provider (i) migrant health centers; (ii) community health centers; (iii) homeless program providers; (iv) public housing providers; (v) family planning clinics; (vi) service units of the Indian Health Service; (vii) HIV providers; (viii) public and private non-profit entities furnishing prenatal, pediatric, or ambulatory services to children, including children with special health care needs (ix) Federally qualified community health centers and rural health clinics; (x) providers of school health services; (xi) community networks receiving development funding in designated urban and rural underserved areas; (xii) non-profit hospitals meeting the criteria for public hospitals which are eligible entities under section 340B of the Public Health Service Act -- Medicare disproportionate share adjustment exceeding 11.75 percent -- and children's hospitals meeting comparable criteria determined appropriate by the Secretary.

During the four year transition, the Secretary could set standards for the designation of additional health professionals and institutions as Essential Community Providers if the Secretary determines that health plans operating in areas served by the applicant would not be able to assure adequate access to the comprehensive benefit package without contracting with the applicant. The Office of Technology Assessment would be required to conduct a study on improving access in underserved areas.

Essential Community Provider provisions would be in effect for five years.

b. Capacity to deliver services to enrollees.

After the expiration of Essential Community Provider provisions, integrated health plans would be required to have within their network, or contract with, a sufficient number, distribution, and variety of providers to assure that the standardized benefit package and any supplemental benefits are available and accessible in all parts of state-defined service areas, with reasonable promptness and in a manner which assures continuity. Emergency services would be required to be available and accessible twenty-four hours a day and seven days a week.

c. Capability to deliver services to enrollees.

Integrated health plans would be required to make available and accessible, translation, case management, and transportation services, if necessary to deliver the standardized benefit package, and any supplemental benefits.

Integrated health plans would be required to ensure that criteria for the selection of participating providers take into account the needs of

diverse populations.

The Essential Community Provider, capacity to deliver services to enrollees, and capability to deliver services to enrollees standards (Sections a,b,c) would apply to self-insured plans only to the extent necessary to deliver services to employees.

d. Specialized services

Integrated health plans would be required to have within their network, or contract with, a sufficient number, distribution, and variety of providers of specialized services to assure that such services would be available and accessible to adults, children, and persons with disabilities.

Integrated health plans would be required to demonstrate that adults, children, and persons with disabilities have access to specialized treatment expertise by meeting evaluation criteria established by the Secretary.

Integrated health plans could meet this criteria by referring adults, children, and persons with disabilities requiring specialized services to designated Centers of Excellence.

Centers of Excellence in the field of institutional care would deliver care for complex cases requiring specialized treatment and also meet two or more of the following requirements:

- i. Provide specialized education and training through approved graduate medical education programs with multi-specialty, multi-disciplinary teaching and services in both inpatient and outpatient settings, with medical staff with faculty appointments at an affiliated medical school;
- ii. Attract patients from outside the center's local geographic region, from across the state or nation;
- iii. Either sponsor or participate in, or have medical staff who participate in, peer-reviewed research.

The Secretary would be required to designate Centers of Excellence.

The Secretary would be required to establish evaluation criteria for health plans who choose to provide specialized services and treatments within network, including requirements for staff credentials and experience, and requirements for measured outcomes in the diagnosis and treatment of patients. The Secretary would develop evaluation criteria for outcomes of specialized treatment as research findings become available.

C. ADDITIONAL STANDARDS FOR FEE-FOR-SERVICE HEALTH PLANS

In addition to the standards under Section A, fee-for-service health

plans would be required to meet the following standards. Fee-for-service health plans do not have formal provider relationships. Payments are made to doctors chosen by the insured individuals. These plans can be self-insured or insured.

1. Quality Standards

The Secretary would be required to develop minimum standards applicable to fee-for-service health plans.

2. Patient Protection Standards

The Secretary would be required to develop minimum standards applicable to fee-for-service health plans.

3. Balance Billing

Fee-for-service plans would be required to establish a participating physician program under which physicians in the community would agree to take the plan's payment schedule as payment in full, and not to charge patients more than the 25 percent co-insurance. Each such plan would be required to make available the list of participating physicians to enrollees. Each plan would be required to have an appropriate number of physicians in each specialty as participating physicians.

D. ACCREDITATION, CERTIFICATION, AND ENFORCEMENT OF STANDARDS FOR CERTIFIED HEALTH PLANS

1. Accreditation and Certification

The Secretary would be required to develop guidelines for Accreditation, Certification, and Enforcement (ACE) programs, and approve ACE programs as meeting Federal guidelines.

The Secretary of Labor would be required to carry out all activities for certifying multistate self-insured plans.

States would be required to develop ACE programs to certify all health plans except multistate self-insured plans. States would be encouraged to use private accreditation organizations. The establishment of an ACE program would be a condition for receiving Medicaid funds.

2. Enforcement

Health plans not certified as meeting Federal standards would be subject to a civil penalty not to exceed 50 percent of gross premiums (50 percent of health expenses for self-insured plans), enforceable by the State.

Intermediate sanctions available to States would include prohibiting new member enrollment, allowing existing members to leave with no

penalties, and civil monetary penalties.

For health plans that do not meet certification requirements, State ACE programs may operate a health plan to provide transitional access, develop a correction program for the plan, or develop other options.

No Federal health care subsidies would be paid to any health plan not certified as meeting Federal standards.

3. Funding

The Secretary would be required to distribute funds to States from the Health Security Trust Fund in the amounts of \$100,000,000 in 1995, \$250,000,000 in each of 1996-1998, and \$175,000,000 in each of 1999-2004 for State ACE programs.

The Secretary would be required to develop a bonus payment schedule for States that institute Independent Review Committees to provide recommendations concerning health plans that fail certification.

Health plans and providers would be required to pay fees directly to the accrediting or certifying body.

E. NATIONAL HEALTH PLAN STANDARDS AND QUALITY ADVISORY COMMITTEE

The Secretary would be required to establish a National Health Plan Standards and Quality Advisory Committee by July 1, 1995 to advise on standards and evaluation criteria to be used in the certification of all health plans.

The Health Plan Standards and Quality Advisory Committee would interact with the Board of the Health Security Trust Fund concerning funding and program accountability.

Effective Date

The Secretary would be required to establish standards by April 1, 1995. Health plans would be required to be certified by January 1, 1996. States would be required to meet minimum Federal standards for guaranty funds and capital by January 1, 1996.

F. PREEMPTION OF CERTAIN STATE LAWS

Present Law

No provision.

Description of Proposal

1. Laws Pertaining to Managed Care

State laws would be preempted to the extent that they constrain the development of managed care plans. In particular, such laws would be preempted if they have the effect of making it unlawful for plans that are not fee-for-service plans (or fee-for-service components of plans) to do the following:

- (1) limit the number and types of participating providers;
- (2) require enrollees to obtain care from participating providers;
- (3) require enrollees to obtain referrals for specialty treatment;
- (4) establish different payment rates for network and non-network providers;
- (5) create incentives for the use of participating providers;
- (6) use single source suppliers for pharmacy services, medical equipment, and other supplies and services.

2. Laws With Respect to the Corporate Practice of Medicine

State laws related to the corporate practice of medicine would be preempted to the extent that they would apply to health plans that are not fee-for-service plans and their participating providers.

3. Laws With Respect to Health Professional Licensure

State laws restricting through licensure or otherwise the practice of any class of health professionals beyond what is justified by the skills and training of such professionals would be preempted.

Effective Date

January 1, 1996.

XVI. QUALITY, CONSUMER INFORMATION, AND HEALTH SERVICES RESEARCH

Present Law

A. ADMINISTRATION

No provision.

B. HEALTH SERVICES AND QUALITY IMPROVEMENT RESEARCH

The Secretary of HHS, through the Agency for Health Care Policy and Research (AHCPR) and the Health Care Financing Administration (HCFA), conducts and supports general health services research. AHCPR conducts and supports research on medical effectiveness and outcomes partially funded by the Hospital Insurance Trust Fund, and also funds the development of medical practice guidelines.

C. QUALITY IMPROVEMENT FOUNDATIONS

No provision.

D. CONSUMER INFORMATION

No provision.

E. REMEDIES AND ENFORCEMENT

An insured's remedies for denial of a benefit depend on whether the person is covered through an employment-based plan or through a plan purchased directly by the person. If the plan is an employee benefit plan, whether self-insured or insured, the remedies are limited to those provided under ERISA. If the plan is purchased by the individual and is not an employee benefit plan, remedies are determined under State law.

Under ERISA, plans must provide a process for reviewing claim denials within specific time periods. If the appeal fails again within that review process, the individual may file suit in State or Federal court. The court may award the person the benefits denied, as well as attorney fees and costs, may impose statutory penalties, and may grant declaratory or injunctive relief. Under ERISA, however, the court may not impose compensatory or punitive damages.

If the plan is not an employee benefit plan, and is one that the individual purchased directly, the individual may be awarded whatever damages are available under prevailing State law.

Description of Proposal

A. ADMINISTRATION

The National Health Plan Standards and Quality Advisory Committee established under Part XV would advise the Secretary of HHS concerning national quality performance measures, population health status measures, comparative value information criteria, and other aspects of quality and consumer information.

The Secretary would be required to produce an annual report which reviews the quality improvement research, evaluates quality improvement foundations and consumer information, tracks the evolution of national performance measures and other research, and discusses State, regional, and national trends on quality of health care.

B. HEALTH SERVICES AND QUALITY IMPROVEMENT RESEARCH

The Secretary would direct AHCPR and HCFA to conduct and support research on the effects of health care reform on health delivery systems and methods for risk adjustment.

AHCPR would be required to give priority to supporting research and evaluation on medical effectiveness through outcomes research, practice guidelines, technology assessment, and development of dissemination and implementation techniques.

The Secretary, in consultation with public health experts and the Health Plan Standards and Quality Advisory Committee, would be required to develop and define methods to measure population health status, including risk factor assessment.

The Secretary would be required to establish criteria for, develop, and continuously upgrade national quality performance measures for consumer information and evaluation of health care services.

To accomplish these purposes, there would be authorized to be appropriated \$150,000,000 for fiscal year 1995, \$400,000,000 for fiscal year 1996, \$500,000,000 for fiscal year 1997, and \$600,000,000 for each of the fiscal years 1998 through 2004, in addition to other authorizations of appropriations available for these purposes.

C. QUALITY IMPROVEMENT FOUNDATIONS

States would be required to establish independent, community-based, non-profit Quality Improvement Foundations. The Secretary would be required to develop standards which the Foundations would be required to meet. The Quality Improvement Foundations would be required to conduct activities to translate practice guidelines into clinical practice at the local and regional levels; to provide technical assistance to health plans and providers by identifying patterns of health care delivery, health

outcomes, and health status; to sponsor collaborations in quality improvement; and to develop programs in lifetime learning for health care professionals and patient education.

Quality Improvement Foundations would be governed by a board appointed by the Governor of the State. The board would be required to have a majority of members with no substantial personal, business, professional or pecuniary connection with health care organizations, education, or research. Other members of the board would include health professionals and representatives of health plans and providers, purchasers and consumers of care, and representatives of Academic Health Centers and Schools of Public Health.

The Secretary would be authorized to pay the States from the Health Security Trust Fund \$100,000,000 in 1995, \$150,000,000 per year in 1996-1997, \$200,000,000 per year in 1998-1999, and \$250,000,000 per year for 1998-2004 for the Quality Improvement Foundations.

D. CONSUMER INFORMATION

States would be required to establish Consumer Information Centers to produce annual, standardized comparative value information on the performance of all health plans in each community rating area, distribute, educate and provide outreach for consumers on comparative value information, and receive and seek to resolve complaints.

States would be authorized to establish Consumer Information Centers directly or through non-profit organizations selected by a competitive process.

Consumer Information Centers would be governed by a board appointed by the Governor of the State. The board would be required to have a majority of members with no substantial personal, business, professional or pecuniary connection with health care organizations, education, or research. Other members of the board would include health professionals and representatives of health plans and providers, purchasers and consumers of care, and representatives of Academic Health Centers and Schools of Public Health.

The Secretary would be required to create model formats for comparative value information, develop methods for case-mix adjusted comparisons, provide guidelines for handling areas which cross State lines, develop standard design and sampling strategies for consumer surveys, and provide technical assistance and training.

The Secretary would develop criteria for the Consumer Information Centers and determine whether each State meets the criteria. If the State fails to develop the program, the Secretary would be required to take the actions necessary to implement a comparable program.

The Secretary would be authorized to pay the States from the Health

Security Trust Fund \$100,000,000 in 1995, \$250,000,000 per year in 1996-1998, and \$175,000,000 per year for 1999-2004 for the Consumer Information Centers.

E. REMEDIES AND ENFORCEMENT

Individuals would have the same remedies for a denial, reduction or termination of benefits regardless of whether their plan is an employee benefit plan or an individual insurance policy.

Each plan would be required to provide notice of benefit denial, reduction or termination to enrollees. The plan would be required to establish an appeals process that includes procedures for the review of an initial decision, and for reconsideration of an adverse decision.

After the plan's appeals process renders a final decision, individuals would be free to pursue other remedies. These remedies would include participating in a State-run complaint review process, taking part in a non-binding dispute resolution program established by the State, or filing suit in State or Federal court.

Each participating State would be required to establish a complaint review process to hear complaints and render decisions with respect to benefit denial, reduction, or termination. The complaint review office would operate under procedures that include the use of independent medical experts, special processes in the case of emergency and urgent situations, and specific standards of evidence. If the review officer ruled that a plan had acted unreasonably in denying, reducing or terminating benefits, the officer could award all appropriate relief. States would also be required to establish dispute resolution procedures to provide an opportunity for mediation of the claim.

If the individual elected not to pursue the complaint review process, or if the individual pursued mediation but that process did not lead to a settlement, the individual would be permitted to file suit in any court of competent jurisdiction. If the court ruled that a plan had acted unreasonably in denying, reducing or terminating benefits, the court could award all appropriate relief.

The Secretary would be authorized to pay the States from the Health Security Trust Fund \$100,000,000 in 1995, \$150,000,000 per year in 1996-1998, and \$100,000,000 per year for 1999-2004 for establishing and maintaining the complaint review and dispute resolution procedures.

Effective Date

Upon enactment.

APPENDIX: HEALTH PLAN LEXICON

1. **Certified Health Plan.**--A standard health plan or a very high deductible health plan certified as meeting insurance reform, quality, and other standards set forth in this proposal.
 - a. **Standard Health Plan.**--A health plan described in Part IV of this proposal that provides the standard benefits package. A standard health plan can be a fee-for-service plan or an integrated plan such as a health maintenance organization, and can be insured or self-insured.
 - b. **Very-High Deductible Health Plan.**--A health insurance policy described in Part IV of this proposal that covers the standard set of services but with a deductible of \$5,000 for individuals and \$10,000 for families.
2. **Certified Supplemental Health Benefits Policy.**--A health plan described in Part IX of this proposal that covers services and benefits not covered under a certified health plan. A supplemental health benefits policy can be insured or self-insured. A certified supplemental health benefits plan is not a certified health plan.
3. **Certified Long-Term Care Insurance.**--An insurance policy described in Part IX that covers long-term care services. A certified long-term care policy is not a certified health plan.