

NEWS

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CONTACT: Ari Fleischer or Scott Brenner

(202) 225-8933

Subcommittee on Health

Thomas Releases Bill to Save Medicare

Four Key Areas: Voluntary Choices; Anti-Fraud Initiatives; Program Modernization; and new Prevention Package

Washington - Congressman Bill Thomas, Chairman of the Health Subcommittee on Ways and Means, today released the details of his Chairman's mark to save Medicare from bankruptcy.

"This legislation extends the life of our nation's much-valued Medicare program for ten years," Thomas said. "The proposal focuses on policy reforms that give seniors more choices as we modernize and preserve Medicare, while building a foundation so Medicare can also be saved for the next generation."

"In addition," Thomas continued, "this package contains several tough provisions to fight Medicare fraud and abuse and it includes a series of new preventive benefits that will make Medicare more helpful to those in need."

Under the Budget Agreement, Medicare spending will increase from \$209 billion in 1997 to \$280 billion in 2002, an average annual growth rate of 6.0% and total growth of 34% over five years. Per-beneficiary spending will increase from \$5480 in 1997 to \$6911 in 2002. These spending levels represent a savings of \$115 billion over five years compared to current Medicare spending projections. Roughly \$13 billion of the savings results from maintaining a 25% premium rate for part B services as proposed by President Clinton, and approximately \$100 billion comes from reimbursement changes to health care providers.

Total Spending (billions of dollars):

	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>'98-'02</u>
1997 Agreement	\$221 billion	\$233 billion	\$253 billion	\$261 billion	\$280 billion	\$1.148 trillion
Per Capita Spending	\$5720	\$5974	\$6413	\$6523	\$6911	

Highlights

1.) Voluntary Choices for Seniors - Medicare Plus

The bill to save Medicare includes five items designed to increase the number of voluntary choices seniors will have, including private market health plans, as they choose the Medicare program that's best for them. The choices include:

1. *Traditional Fee-for-Service Medicare:*
Under the bill, seniors will continue to enjoy traditional fee-for-service Medicare, as well as the right to return to fee-for-service Medicare. Similar to the Federal Employee Health Plan, seniors will receive from the Secretary of HHS consumer information about Medicare and private sector options on an annual basis. Seniors can make a yearly choice about the plan that best suits their needs, while maintaining the right to return to fee-for-service Medicare.
2. *Provider Sponsored Organizations:*
A cooperative effort between hospitals and doctors, PSOs are similar to HMOs, except they are run by medical providers, not insurance companies. PSOs were originally passed by the Congress in the 1995 Medicare Preservation Act and were included in President Clinton's budget for fiscal year 1998. Rural areas that are underserved by HMOs will particularly gain from the availability of PSOs.
3. *Medical Savings Accounts*
Designed to empower seniors with increased control of their health care decisions, Medicare MSAs allow for the Department of Health and Human Services to make tax-free annual contributions into a Medicare MSA that is individually controlled and used to pay for qualified medical expenses. The MSA would be combined with a high-deductible insurance policy to provide for protection against catastrophic injuries or illnesses. The Thomas proposal, similar to the Democrat blue-dog budget proposal, includes a pilot project covering 500,000 seniors, the Democrat proposal covered 300,000.
4. *Private Plans/Health Maintenance Organizations (HMOs):*
Currently used by 4.4 million Medicare beneficiaries (12% of the senior population), HMOs are the only private plan option presently available to senior citizens. By committing beneficiaries to the coordinated care of pre-selected providers, HMOs generally provide for more benefits than traditional Medicare at lower costs to patients. The Congressional Budget Office estimates that HMO enrollment, under current law, will grow to 9.3 million seniors (23%) by 2002. This legislation is expected to maintain that same level of growth.
5. *Preferred Provider Organizations (PPOs):*
PPOs are HMOs that combine the low cost additional benefits of an HMO with greater choices for Medicare beneficiaries by allowing them to choose services outside their HMO provider network.

2.) Preventive Services - a New Package of Benefits:

The bill includes six items designed to give seniors increased health care coverage when they need it the most - before they become ill.

1. *Mammography Screening:*

The bill provides annual preventive mammography screening for all elderly and disabled women aged forty and older who are eligible for the Medicare program. Current law limits annual screenings to women aged 50-65, and for women who are determined to be at increased risk of breast cancer. To encourage more women to receive preventive screenings, the bill waives the Part B deductible for mammography screenings

2. *Pap Smears:*

The bill guarantees *annual* pap smears and pelvic examinations for high-risk women, while continuing to provide coverage to non-high risk women on an every third year basis. To encourage more women to receive preventive treatment, the bill waives the Part B deductible for pap smears and pelvic exams.

3. *Prostate Cancer Screening:*

Under current law, there is no coverage for prostate cancer screening, a leading cause of death among men. The bill provides annual prostate cancer screening for all male Medicare beneficiaries fifty-years and older.

4. *Colorectal Cancer Screening:*

Colorectal cancer screenings are not covered under existing law. The bill provides colorectal cancer screenings consistent with recommendations of the U.S. Preventive Health Services Task Force. The screenings will be made available to beneficiaries fifty-years and older.

5. *Diabetes Self-Management:*

The bill provides coverage for new diabetes benefits recommended by the American Diabetes Association. This includes training to help patients protect themselves against the side effects of diabetes through dietary and other lifestyle changes and other outpatient management services, including blood testing strips.

6. *Vaccine Outreach:*

The bill authorizes \$8 million annually for HCFA's outreach campaign to educate seniors about avoiding pneumonia and influenza through annual vaccinations.

To help Congress consider additional preventive benefits, the bill directs the National Academy of Sciences to analyze benefits to seniors and the cost to the Medicare program of expanding and modernizing preventive benefits. Specifically, the Academy is directed to analyze and make specific findings regarding nutritional therapy, bone mass measurement, and health coverage for patients enrolled in clinical trials.

Finally, the bill expands the PACE demonstration project (Program of All-Inclusive Care for the Elderly) into a national, permanent program which would provide all the health, medical, and social services needed by the frailest of the elderly, without limits on dollars or duration of services, including preventive, rehabilitative, curative and supportive services in day health centers, homes, hospitals, and nursing homes. PACE programs are responsible for the needs of their patients 24-hours a day, 365-days a year. PACE receives fixed payments from Medicare, unaffected by the type, intensity, or duration of services provided.

3.) New, Tough Anti-fraud and Abuse Efforts

As part of the newly enacted Health Insurance Portability and Accountability Act of 1996, Congress increased anti-fraud funding for the Health Care Financing Administration and the Department of Justice. It also created several new categories of criminal and civil health care fraud punishable by prosecution and increased penalties.

The Thomas mark goes beyond these measures by creating nine new anti-fraud provisions, including the following:

1. *Three Strikes, You're Out - Mandatory:*
The penalty imposed on any health care provider found guilty of defrauding any federal health program for the second time will be increased from five-years banishment from all federal health programs to a mandatory ten-year banishment. Three offenses triggers a mandatory lifelong exclusion from participation in any federal health care program. Violators would also be subject to other criminal and civil penalties.
2. *One Strike, You're Out - Optional:*
Any health care provider or entity convicted of a felony (medical or otherwise) can be denied entry into Medicare and Medicaid at the discretion of the Secretary of HHS.
3. *Surety Bonds and Disclosure of Owner Interest:*
To fight the existence of fly-by-night operators that seek to defraud Medicare, certain providers, including but not limited to home health agencies, ambulance services, equipment suppliers, and rehabilitation agencies that seek to do business with Medicare will be required to post a \$50,000 surety bond to ensure that they are legitimate businesses.
4. *Binding Advisory Opinions for Physician Self-Referrals:*
The Stark II law prohibits physicians from referring patients to certain entities in which the physician has a common ownership interest. To help physicians comply with the law in the absence of regulatory guidance, this bill allows physicians to receive binding opinions to help them make legally permissible referrals.

4.) Medicare Modernization:

Cost Savings: The bill contains a wide-ranging series of changes designed to modernize Medicare's thirty-year old payment and health care delivery systems. These changes provide new formulas to pay for services provided by doctors, hospitals, and HMOs, including a one-year freeze in rates to hospitals.

In order to hold down health care costs, the bill creates a new prospective payment system for skilled nursing facilities, hospital outpatient departments, home health agencies, rehabilitation facilities and hospitals, and ambulance services.

[A complete listing of these changes, including savings figures, will be made available upon receipt from the Congressional Budget Office.]

Malpractice Reform, and a Baby-Boomer Commission: The bill reforms medical malpractice laws along the lines implemented in California, Indiana, and other states by capping non-economic damages at \$250,000. It creates a commission to address Medicare's long-term solvency crisis that will result upon the retirement of the baby-boom generation.

Assistance to Rural America: The modernization package changes reimbursement rates to expand health care options in rural areas by increasing payments to HMOs, PSOs and other private health plans. It provides a \$350 per-month floor on monthly premiums paid by Medicare to cover beneficiary costs of joining HMOs. Additionally, the measure includes formula adjustments to hospitals in rural areas to provide them with an increased share of Medicare payments.

Consumer Protections: The Modernization package also includes a number of consumer protections that go beyond those offered in the President's budget. They include requiring all Medicare plus plans to make medically necessary care available 7-days a week, 24-hours a day; prohibits Medicare Plus plans from restricting providers' advice to beneficiaries about medical care or treatment (the so-called Gag Rule); requires Medicare Plus plans to have grievance and appeal mechanisms in place to protect beneficiary rights; requires Medicare Plus plans to provide coverage for care that a 'prudent layperson' would consider to be an emergency; and protects patient confidentiality by requiring Medicare Plus plans to safeguard the confidentiality of beneficiaries' health information, while allowing patients access to their health records.

Beginning in 1999, the bill also replaces the outdated 50/50 rule that requires Medicare Plus plans to enroll at least 50% of their enrollees in non-Medicare plans. It replaces this restriction with enhanced quality and outcome measures for all Medicare Plus plans.

Medicare Amendments Act of 1997

SUBTITLE A--MEDICAREPLUS PROGRAM

Chapter 1 MedicarePlus

Section 10001. Establishment of Program

New Section 1851 of the Social Security Act. Eligibility, Election, and Enrollment

Current Law. Persons enrolling in Medicare have two basic coverage options. They may elect to obtain services through the traditional fee-for-service system under which program payments are made for each service rendered. Under section 1876 of the Social Security Act, they may also elect to enroll with a managed care organization which has entered into a payment agreement with Medicare. Three types of managed care organizations are authorized to contract with Medicare: an entity that has a risk contract with Medicare, an entity that has a cost contract with Medicare, or a health care prepayment plan (HCPP) that has a cost contract to provide Medicare Part B services. Risk-contracts are frequently referred to as TEFRA *risk* contracts and *cost* contracts are frequently referred to as TEFRA cost contracts. TEFRA refers to the 1982 legislation, the Tax Equity and Fiscal Responsibility Act of 1982, which established the rules governing these types of contracts.

A beneficiary in an area served by a health maintenance organization (HMO) or competitive medical plan (CMP) with a Medicare risk contract may voluntarily choose to enroll in the organization. (A CMP is a health plan that is not a federally qualified HMO but that meets specific Medicare requirements.) Medicare makes a single monthly capitation payment for each of its enrollees. In return, the entity agrees to provide or arrange for the full range of Medicare services through an organized system of affiliated physicians, hospitals and other providers. The beneficiary must obtain all covered services through the HMO or CMP, except in emergencies. The beneficiary may be charged the usual cost-sharing charges or pay the equivalent in the form of a monthly premium to the organization. Beneficiaries are expected to share in any of the HMO's/CMP's projected cost savings between Medicare's capitation payment and what it would cost the organization to provide Medicare benefits to its commercial enrollees through the provision of additional benefits. (It could also return the "savings" to Medicare.)

Beneficiaries may also enroll in organizations with TEFRA cost contracts. These entities must meet essentially the same conditions of participation as risk contractors; however they may have as few as 1,500 enrollees (rather than 5,000) to qualify. Under a cost contract, Medicare pays the actual cost the entity incurs in furnishing covered services (less the estimated value of beneficiary cost-sharing). Enrollees obtain supplemental benefits by paying a monthly premium. The entity must offer a basic package (which covers all or a portion of Medicare cost-sharing charges); any additional benefits must be priced separately. (Conversely, a risk-contractor may offer just one package.) Enrollees in TEFRA cost-contract entities may obtain services outside the

entity's network; however, the entity has no obligation to cover the beneficiary's cost-sharing in this case.

A third type of managed care arrangement is the HCPP. A HCPP arrangement is similar to a TEFRA cost-contract except that it provides only Part B services. Further, there are no specific statutory conditions to qualify for a HCPP contract. Some HCPPs are private market HMOs, while others are union or employer plans. HCPPs have no minimum enrollment requirements, no requirement that the plan have non-Medicare enrollees, or a requirement for an open enrollment period. Unlike TEFRA cost contractors (but like risk contractors), HCPPs may offer a single supplemental package that includes both Part B cost-sharing and other benefits; cost-sharing benefits need not be priced separately.

Any Medicare beneficiary residing in the area served by an HMO/CMP may enroll, with two exceptions. The first exception applies to beneficiaries not enrolled in Part B. The second exception applies to persons qualifying for Medicare on the basis of end-stage renal disease (ESRD); however, persons already enrolled who later develop ESRD may remain enrolled in the entity.

The HMO/CMP must have an annual open enrollment period of at least 30 days duration. During this period, it must accept beneficiaries in the order in which they apply up to the limits of its capacity, unless to do so would lead to violation of the 50 percent Medicare-Medicaid maximum or to an enrolled population unrepresentative of the population in the area served by the HMO.

TEFRA risk contractors are required to hold an additional open enrollment period if any other risk-based entity serving part of the same geographic area does not renew its Medicare contract, has its contract terminated, or has reduced its service area to exclude any portion of the service area previously served by both contractors. In such cases, the Secretary must establish a single coordinated open enrollment period for the remaining contractors. These remaining HMOs/CMPs must then accept its enrollees during an enrollment period of 30 days.

An enrollee may request termination of his or her enrollment at any time. An individual may file disenrollment requests directly with the HMO or at the local social security office. Disenrollment takes effect on the first day of the month following the month during which the request is filed. The HMO may not disenroll or refuse to re-enroll a beneficiary on the basis of health status or need for health services.

The requirement for an open enrollment period does not apply to HCPPs. These entities may deny enrollment or terminate enrollment on medical or other grounds, if in doing so they use the same criteria for Medicare and non-Medicare enrollees. As a result, employer or union plans may restrict enrollment to covered retirees.

The Secretary is authorized to prescribe procedures and conditions under which

eligible organizations contracting with Medicare may inform beneficiaries about the organization. Brochures, applications forms, or other promotional or informational material may be distributed only after review and approval by the Secretary of HHS. HMOs may not disenroll or refuse to re-enroll a beneficiary because of health status or need for health care services. HMOs must provide enrollees, at the time of enrollment and annually thereafter, an explanation of rights to benefits, restrictions on services provided through nonaffiliated providers, out-of-area coverage, coverage of emergency and urgently needed services, and appeal rights. A terminating HMO must arrange for supplementary coverage for Medicare enrollees for the duration of any preexisting condition exclusion under their successor coverage for the lesser of 6 months or the duration of the exclusion period.

Explanation of Provision. The Social Security Act would be amended to insert a new Part C, MedicarePlus Program. New section 1851 of Part C of the Social Security Act would specify requirements related to eligibility, election of coverage, and enrollment.

a. Types of Choices. Under the provision, every individual entitled to Medicare Part A and enrolled under Part B could elect to receive benefits through two options: (i) the existing Medicare fee-for-service program (Medicare FFS) or (ii) through a MedicarePlus plan. The exception to this would be individuals medically determined to have ESRD. They would not be able to elect MedicarePlus. Individuals who developed ESRD while enrolled in a plan could continue in that plan. A MedicarePlus plan could be offered by: (i) a coordinated care plan (including an HMO or preferred provider organization (PPO)), (ii) a provider sponsored organization (PSO); and (iii) a combination of a medical savings account (MSA) and contributions to a MedicarePlus MSA.

b. Special Rules. In general, an individual would be eligible to elect a MedicarePlus plan offered by a MedicarePlus organization only if the organization served the geographic area in which the individual resided. Enrollment could continue if the plan provided benefits for enrollees located in the area to which the individual moved. An individual eligible for an annuity under the Federal Employee Health Benefits Program would not be eligible for an MSA plan until the Office of Management and Budget adopted policies to ensure that such enrollment did not result in increased expenditures for the federal government to FEHBP plans. The Secretary could apply similar rules in the case of individuals who are eligible for Departments of Defense or Veterans' Affairs health care. An individual who is a qualified Medicare beneficiary (QMB), a qualified disabled and working individual, a specified low-income Medicare beneficiary (SLMB), or otherwise entitled to Medicare cost-sharing assistance under a state Medicaid program, would not be eligible to enroll in an MSA plan.

In addition, individuals would not be eligible to enroll in an MSA plan on or after January 1, 2003, or as of any date if the number of individuals enrolled in MSA plans reached 500,000. Individuals enrolling in MSA plans prior to either of those two events would be allowed to continue such enrollment. The Secretary is required to regularly

evaluate and report to Congress on the impact of permitting enrollment of MSA plans on selection, adverse selection, use of preventive care, access to care, and the financial status of the Trust Funds. In addition, the Secretary is required to submit to Congress periodic reports on the number of individuals enrolled in MSA plans and to submit a report to Congress by no later than March 1, 2002 on whether the four-year time limitation should be extended or removed, and whether any change should be made to the number of individuals permitted to enroll in Medicare MSAs.

c. Process for Exercising Choice. The Secretary would be required to establish a process for elections (and changing elections) of Medicare FFS and MedicarePlus options. Elections would be made (or changed) only during specified coverage election periods. An individual who wished to elect a MedicarePlus plan would do so by filing an election form with the organization. Disenrollment would be accomplished the same way. An individual failing to make an election during the initial election period would be deemed to have chosen the Medicare FFS option. The Secretary would be required to establish procedures under which individuals enrolled with a MedicarePlus organization at the time of the initial election period and who failed to elect to receive coverage other than through the organization would be deemed to have elected the MedicarePlus plan offered by the organization (or, if the organization offered more than one such plan, such plan as the Secretary provided for under such procedures). An individual who made (or was deemed to have made) an election would be considered to have continued such election until the individual changed the election or the plan was discontinued.

d. Providing Information to Promote Informed Choice. The Secretary would provide for activities to disseminate broadly information to current and prospective Medicare beneficiaries on the coverage options available in order to promote an active, informed selection among such options. At least 30 days before each annual, coordinated election period, the Secretary would send to each MedicarePlus eligible person a notice containing the information specified below in order to assist the individual in making an election. This would include general information, a list of plan options and comparative plan option information, the MedicarePlus monthly capitation rate, and other information determined by the Secretary to be helpful in making elections. This information would have to be written in language easily understood by Medicare beneficiaries. The Secretary would be required to coordinate the mailing of this information with annual mailing of other Medicare information required under current law. To the extent practicable, the Secretary would provide such information to new MedicarePlus individuals at least two months prior to their initial enrollment period.

The required general election information would include information on: (i) services covered and not covered by Medicare FFS (including benefits, cost-sharing, and beneficiary liability for balance billing); (ii) the Part B premium amount, (iii) election procedures, (iv) rights including grievance and appeals procedures and the right to be protected against discrimination, (v) information on Medigap and Medicare Select policies, and (vi) the right of the organization to terminate the contract and what this would mean for enrollees.

Comparative plan option information would have to include: (i) a description of benefits including any covered beyond Medicare FFS, any reductions in cost-sharing and any maximum limits on out-of-pocket costs, and in the case of MSA plans, the differences in their cost sharing compared to other MedicarePlus plans; (ii) the monthly premium (and net monthly premium) for the plan; (iii) to the extent available, quality indicators (compared with indicators for Medicare FFS) including disenrollment rates, enrollee satisfaction and health outcomes, and whether the plan is out of compliance with any federal requirements; and (iv) information on any supplemental coverage. The required information would be updated at least annually.

The Secretary would be required to maintain a toll-free number and Internet site for inquiries regarding MedicarePlus options and plans. A MedicarePlus organization would be required to provide the Secretary with such information on the organization and its plans as the Secretary needed to prepare the information described above for Medicare beneficiaries. The Secretary could enter into contracts with appropriate non-Federal entities to carry out these information activities.

e. Coverage Election Periods. Individuals would first have a choice ("initial election") between Medicare FFS and MedicarePlus plans (if there were one or more MedicarePlus plans to choose from in their area) upon eligibility for Medicare. The Secretary would designate a time for the election such that coverage would become effective when the individual was eligible to begin coverage.

From 1998 through 2000, there would be continuous open enrollment and disenrollment, when eligible individuals could switch MedicarePlus plans or move into or out of the Medicare FFS program option. For the first 6 months during 2001, there would also be continuous open enrollment and disenrollment, but individuals could only change their election once during 2001 (except for during the annual coordinated open enrollment period or a special enrollment period (as described below)). During subsequent years, individuals would be able to enroll in a MedicarePlus option and disenroll from it at any time during the first 3 months of a year (or during the first 3 months after an individual became eligible to enroll in a MedicarePlus plan). Such changes could be made only once a year except during annual coordinated election and special enrollment periods.

Beginning in October, 2000, there would be an annual, coordinated election period during which individuals could change elections for the following calendar year. The Secretary would be required to hold MedicarePlus health fairs in October of each year, beginning with 1998. Such fairs would provide for nationally, coordinated educational and publicity campaigns to inform MedicarePlus eligibles about MedicarePlus plans and the election process, including the annual, coordinated election periods.

Starting January 1, 2001, special election periods would be provided in which an individual could discontinue an election of a MedicarePlus plan and make a new election if: (i) the organization's or plan's certification was terminated or the organization terminated or otherwise discontinued providing the plan; (ii) the person who elected a

MedicarePlus plan was no longer eligible because of a change in residence or certain other changes in circumstances; (iii) the individual demonstrated that the organization offering the plan violated its contract with Medicare (including the failure to provide the enrollee on a timely basis medically necessary care or to provide such care in accordance with applicable quality standards), or misrepresented the plan in its marketing; or (4) the individual encountered other exceptional conditions specified by the Secretary.

Special rules would apply for MSA plans. Individuals could elect a MSA plan only during: (I) an initial open enrollment period; (ii) an annual, coordinated election period, or (iii) October 1998 and October 1999. Such individuals could not discontinue an election of an MSA plan except during an annual, coordinated election period, October 1998 and October 1999, or if the MSA plan had been decertified or terminated.

f. Effectiveness of Elections. An election made during the initial election period would become effective when the individual became entitled to Medicare benefits, except as the Secretary might provide in order to prevent retroactive coverage. During continuous open enrollment periods, an election or change of elections would take effect with the first calendar month after the election was made. An election or change of coverage made during a coordinated election period would take effect as of the first day of the following year. Elections during other periods would take effect in the manner specified by the Secretary to protect continuity of coverage.

g. Guaranteed Issue and Renewal. MedicarePlus organizations would be required to accept MedicarePlus eligibles without restriction during election periods. If the organization had a capacity limit, it could limit enrollment but only if priority were given to those who had already elected the plan and then to other persons in a manner that did not discriminate on the basis of health-status related factors (which include health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability). This would not apply if it would result in enrollment that is substantially misrepresentative of the Medicare population in the service area.

MedicarePlus organizations could not terminate an enrollee's election except for failure to pay premiums on a timely basis, disruptive behavior, or because of plan termination of all MedicarePlus individuals. Individuals terminated for cause would be deemed to have elected Medicare FFS. An individual whose plan was terminated would have a special election period to change into another MedicarePlus plan. If the individual failed to make an election, he or she would be deemed to be Medicare FFS. Plans would have to transmit to the Secretary a copy of each enrollee's election form.

h. Approval of marketing material. The provision would require MedicarePlus plans to submit marketing material to the Secretary at least 45 days before distribution. The material could then be distributed if not disapproved by the Secretary. Medicare's new standards for plans (established as described below) would have to include guidelines

for the review of all marketing material submitted. Under these guidelines, the Secretary would have to disapprove marketing materials if they were materially inaccurate or misleading.

Each MedicarePlus organization would have to conform to fair marketing standards, including a prohibition on a MedicarePlus organization (or its agent) completing any portion of any election form on behalf of any individual.

1. Effect of Election of MedicarePlus Plan Option. Payments under a contract with a MedicarePlus organization with respect to an individual electing a MedicarePlus plan offered by an organization would be instead of the amounts which otherwise would have been payable under Medicare Parts A and B.

New Section 1852. Benefits and Beneficiary Protections

Current Law. Section 1876 provides for requirements relating to benefits, payment to the plans by Medicare, and payments to the plans by beneficiaries. In addition, it specifies standards for patient protection and quality assurance.

A Medicare beneficiary enrolled in an HMO/CMP is entitled to receive all services and supplies covered under Medicare Parts A and B (or Part B only, if only enrolled in Part B). These services must be provided directly by the organization or under arrangements with the organization. Enrollees in risk-based organizations are required to receive all services from the HMO/CMP except in emergencies.

In general, HMOs/CMPs offer benefits in addition to those provided under Medicare's benefit package. In certain cases, the beneficiary has the option of selecting the additional benefits, while in other cases some or all of the supplementary benefits are mandatory.

Some entities may require members to accept additional benefits (and pay extra for them in some cases). These required additional services may be approved by the Secretary if it is determined that the provision of such additional services will not discourage enrollment in the organization by other Medicare beneficiaries.

Medicare HMOs/CMPs must provide enrollees, at the time of enrollment and annually thereafter, an explanation of: rights to benefits, restrictions on services provided through nonaffiliated providers, out-of-area coverage, coverage of emergency and urgently needed services, and appeal rights.

Medicare HMOs/CMPs must make all Medicare covered services and all other services contracted for available and accessible within its service area, with reasonable promptness and in a manner that assures continuity of care. Urgent care must be available and accessible 24 hours a day and 7 days a week. HMOs must also pay for services provided by nonaffiliated providers when services are medically necessary and

immediately required because of an unforeseen illness, injury, or condition and it is not reasonable, given the circumstances, to obtain the services through the HMO.

HMOs/CMPs are required to have arrangements for an ongoing quality assurance program that stresses health outcomes and provides review by physicians and other health care professionals of the process followed in the provision of health services. External review is conducted by a peer review organization (PRO), one of the groups that has contracted with the Secretary for review of the quality and appropriateness of hospital services. PRO reviews of HMOs/CMPs covers both inpatient and outpatient care. The Secretary also has the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided and the facilities of the organization when there is reasonable evidence of some need for inspection.

In up to 25 States, the Secretary is authorized to designate another external agency, known as a quality review organization or QRO to perform reviews. QROs must meet many of the same standards as PROs, but have not contracted with the Department of HHS for the review of services other than those provided by an HMO/CMP.

HMOs/CMPs must have meaningful grievance procedures for the resolution of individual enrollee complaints, about such problems as failure to receive covered services or unpaid bills. In addition, an enrollee who believes that the HMO has improperly denied a service or imposed an excessive charge has the right to a hearing before the Secretary if the amount involved is greater than \$100. If the amount is greater than \$1,000, either the enrollee or the HMO may seek judicial review. On April 30, 1997, HCFA issued final rules for establishing an expedited review process for Medicare beneficiaries enrolled in HMOs and CMPs.

Hospitals and other providers are required under Medicare as a condition of participation to ask whether an individual has an advance directive and make a notice of such in the patient's record. Such hospitals and other providers also have to provide upon admission and at other specified times written information to adult patients: on applicable advance directive laws of the relevant state and of the advance directive policies of the provider.

Payments to Medicare HMOs/CMPs include amounts that reflect Medicare's fee-for-service payments to hospitals in an area for indirect and direct medical education costs and disproportionate share adjustments.

Penalties apply for violations of limits on the use of "physician incentive plans," i.e., compensation arrangements between HMOs and physicians that might induce physicians to withhold services. An HMO may not make a specific payment to a physician as an inducement to reduce or limit services to a specific enrollee. In addition, if physicians or physician groups are placed at substantial financial risk for services other than their own, the HMO must provide adequate stop-loss protection to limit the physicians' potential liability and must periodically survey enrollee satisfaction.

There are no provisions in current law for provider protections. In addition, there is no provision in current law for medical savings account plans for Medicare beneficiaries.

Explanation of Provision. The provision establishes a new section 1852 specifying federal requirements related to MedicarePlus plan benefits and beneficiary protections.

a. Basic Benefits. Each MedicarePlus plan, except an MSA plan, would be required to provide benefits for at least the items and services for which benefits are available under parts A and B of Medicare and any additional health services as the Secretary may approve. A MedicarePlus plan would meet this requirement if:

(I) in the case of benefits furnished through providers with a contract with the organization (i.e., plan providers), the individual's liability for payment for item and services did not exceed (after taking into account any deductible which did not exceed any deductible under Medicare FFS) the lesser of: (a) the amount of liability that the individual would have had (based on the provider being a participating provider) if the individual had not elected coverage under MedicarePlus, or (b) the applicable coinsurance or copayment amounts that would have applied under Medicare FFS provided under the contract, and

(ii) in the case of benefits furnished through providers without contracts with the organization (i.e., out-of-plan providers), the MedicarePlus plan provided for at least the dollar amount of payment for such items and services as would otherwise have been provided under Medicare FFS. Such providers could not bill any more than they could under the balance billing limits applicable under Medicare FFS.

These cost-sharing limitations would not apply to an individual enrolled under an MSA plan.

MedicarePlus organizations could offer under their MedicarePlus plans supplemental benefits. If the supplemental benefits were offered only to MedicarePlus enrollees, the additional premium would have to be the same for all enrollees in the area. The benefits could be marketed and sold outside of the enrollment process described above. A MedicarePlus plan could seek payment from other payors, such as insurers or employer plans, in circumstances where secondary payor rules apply.

The provision would establish a policy relating to a national coverage determination made between the annual announcements of MedicarePlus payment rates. The application of the determination would be delayed if the determination would result in a significant change in costs to the MedicarePlus plan, and such change was not incorporated in the MedicarePlus payment rate established for that period. In such cases, the national coverage determination would apply to the first contract year beginning after such period. If the determination provided for coverage of additional benefits or benefits under additional circumstances, it would also apply to the first contract year beginning after such period, unless otherwise required by law.

b. Antidiscrimination. A MedicarePlus organization could not deny, limit, or condition the coverage or provision of benefits under this part based on any health-status related factor (health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence) and disability). This requirement should not be construed to mean that a MedicarePlus organization had to enroll individuals determined to have ESRD.

c. Detailed Description of Plan Provisions. The provision would require each MedicarePlus plan to disclose in clear, accurate and standardized form to each enrollee at the time of enrollment and annually thereafter, the following information about the plan: (I) its service area; (ii) its benefits and exclusions from coverage (and, in the case of an MSA plan, a comparison with other MedicarePlus plans); (iii) the number, mix, and distribution of participating providers, (iv) permitted out-of-area coverage; (v) coverage of and procedures for obtaining emergency services (including the appropriate use of 911 or local equivalent); (vi) any optional supplemental coverage, including the benefits and premium price; (vii) any prior authorization or other rules that could result in nonpayment; (viii) any plan-specific grievance and appeals procedures; and (ix) its quality assurance program.

d. Access to services. The provision would permit a MedicarePlus organization offering a MedicarePlus plan to restrict the providers from whom benefits could be provided so long as: (I) the organization makes the benefits available and accessible to each individual electing the plan within the service area with reasonable promptness and in a manner which assures continuity in the provision of benefits; (ii) when medically necessary, the organization makes benefits available and accessible 24 hours a day, 7 days a week; (iii) the plan provides reimbursement for out-of-network services if the services are medically necessary and immediately required because of unforeseen illness, injury, or condition and it is not reasonable to provide the services through the organization or met other conditions; (iv) the organization provides access to appropriate providers, including credentialed specialists, for medically necessary treatment and services; and (v) coverage is provided for emergency services without regard to either prior authorization requirements or the emergency care entity's contractual relationship with the organization.

The provision specifies that in the case of emergency services furnished to a MedicarePlus enrollee by a Medicare participating physician or provider, the applicable participation agreement is deemed to provide that the physician or provider accept as payment in full the amount that would have been paid under Medicare part B (including beneficiary cost-sharing). In the event services are furnished by a physician or health care professional not participating in Medicare, the Medicare part B limitation on actual charges would apply. Emergency services described in this paragraph mean covered inpatient and outpatient services that are furnished to an enrollee of a MedicarePlus organization by a physician or provider of services that is not under a contract with the organization.

A MedicarePlus organization would be required to comply with such guidelines as the Secretary may prescribe relating to promoting efficiency and timely coordination of appropriate maintenance and post-stabilization care provided to an enrollee determined to be stable by a medical screening examination required under the Examination and Treatment under Emergency Medical Conditions and Women in Labor requirements of the Social Security Act (section 1867).

Emergency services are covered inpatient and outpatient services furnished by an appropriate source other than the organization and are needed to evaluate or stabilize an emergency medical condition. An emergency medical condition is one manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the individual in serious jeopardy (and in case of a pregnant women, her health or that of her unborn child); (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

e. Quality assurance program. The provision would require a MedicarePlus organization to have arrangements (established in accordance with regulations of the Secretary) for an ongoing quality assurance program for services provided to its MedicarePlus enrollees. The program has to: (i) stress health outcomes and provide for the collection, analysis, and reporting of data that will permit measurement of outcomes and other indices of MedicarePlus plans and organizations; (ii) provide for written protocols for utilization review; (iii) provide review by physicians and other health care professionals of the process followed in the provision of health services; (iv) monitor and evaluate high volume and high risk services and the care of acute and chronic conditions; (v) evaluate the continuity and coordination of care; (vi) have mechanisms in place to detect both underutilization and overutilization; (vii) after identifying areas for improvement, establish or alter practice parameters; (viii) take action to improve quality and assess effectiveness of such actions; (ix) make available information on quality and outcomes measures to facilitate beneficiary comparison and choice; (x) be evaluated on an ongoing basis; (xi) include measures of consumer satisfaction; and (xii) provide the Secretary with such access to information collected as may be appropriate to monitor and ensure quality.

Each organization would be required to have an agreement with an independent quality review and improvement organization, approved by the Secretary, for each plan it operates, to perform functions such as quality review, review for the appropriateness of setting of care, adequacy of access, beneficiary outreach, and review of complaints about poor quality of care. A MedicarePlus organization would be deemed to meet the requirements for quality assurance external review if it is accredited by a private organization under a process that the Secretary has determined assures that the organization applies and enforces standards that are no less stringent than those specified under the plan standards requirements established by this provision (see new section 1856

as described below).

f. Coverage Determinations. A MedicarePlus organization would be required to make determinations regarding authorization requests for nonemergency care on a timely basis. Appeals of denials would generally have to be decided within 30 days of receiving medical information, but not later than 60 days after the coverage determination. Physicians would be the only individuals permitted to make decisions to deny coverage based on medical necessity. Appeals of determinations involving a life-threatening or emergency situation would have to be made on an expedited basis.

g. Grievances and Appeals. The provision would require each MedicarePlus organization to provide meaningful procedures for hearing and resolving grievances. An enrollee dissatisfied by reason of the enrollee's failure to receive health services would be entitled, if the amount in controversy was \$100 or more, to a hearing before the Secretary. If the amount in controversy was \$1,000 or more, the individual or organization, upon notifying the other party, would be entitled to judicial review. The Secretary would be required to contract with an independent, outside entity to review and resolve appeals of denials of coverage related to urgent or emergency services.

An enrollee in a MedicarePlus plan could request an expedited determination by the organization regarding an appeal. Such requests could also come from physicians. The organization would have to maintain procedures for expediting organization determinations when, upon request of an enrollee, the organization determined that the application of a normal time frame for making a determination or a reconsideration could seriously jeopardize the life or health of an enrollee or the enrollee's ability to regain maximum function. In an urgent case, the organization would have to notify the enrollee (and physician involved) of the determination as expeditiously as the enrollee's condition requires, but not later than 72 hours (or 24 hours in the case of a reconsideration), or such longer period as the Secretary may permit in specified cases.

h. Confidentiality and Accuracy of Enrollee Records. Each MedicarePlus organization would be required to establish procedures to safeguard the privacy of individually identifiable enrollee information, to maintain accurate and timely medical records and other health information, and to assure timely access of enrollees to their medical records.

i. Information on Advance Directives. Each MedicarePlus organization would be required to maintain written policies and procedures respecting advance directives.

j. Rules Regarding Physician Participation. Each MedicarePlus organization would be required to establish reasonable procedures relating to the participation of physicians under a MedicarePlus plan offered by the organization. The procedures would include: (i) providing notice of the rules regarding participation; (ii) providing written notice of adverse participation decisions; and (iii) providing a process for appealing adverse decisions. The organization would be required to consult with physicians who have

entered into participation agreements regarding the organization's medical policy, quality, and medical management procedures.

The provision would prohibit interference with physician advice to enrollees. A MedicarePlus organization could not prohibit a covered health professional from advising a patient about the patient's health status or about medical care or treatment for the patient's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan if the professional is acting within the lawful scope of practice. "Health care provider" is defined to include physicians, and other health care professionals (as specified). This provision should not be construed as preventing a MedicarePlus organization from restricting a health care provider's advising of an individual concerning care or treatment if the organization objects to the provision of the care or treatment on moral or religious grounds, and discloses such restriction to enrollees at the time of enrollment and reenrollment.

The provision would limit the use of physician incentive plans. The provision would define a physician incentive plan as any compensation arrangement between a MedicarePlus organization and a physician group that has the effect, directly or indirectly, of reducing or limiting services provided. The provision would prohibit MedicarePlus plans from operating such a physician incentive plan unless the following conditions were met. No specific payment could be made, directly or indirectly, to a physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual. If the plan placed a physician or physician group at substantial financial risk, the organization would be required to provide adequate and appropriate stop-loss protection and to conduct periodic surveys of currently and previously enrolled individuals to determine the degree of access to and satisfaction with the quality of services. Further, the organization would be required to provide the Secretary with sufficient descriptive information for the Secretary to determine compliance with these requirements.

A MedicarePlus organization would not be able to provide (directly or indirectly) for a provider (or group of providers) to indemnify the organization against any liability resulting from a civil action brought by or on behalf of an enrollee for any damage caused to the enrollee by the organization's denial of medically necessary care.

Each MedicarePlus organization would have to provide the Secretary with information on (i) the extent to which it provides inpatient and outpatient hospital benefits under MedicarePlus through the use of hospitals that are eligible for disproportionate share hospital adjustments or through the use of teaching hospitals that receive indirect and direct graduate medical education payments, and (ii) the extent to which differences between payment rates to different hospitals reflect the disproportionate share percentage of low-income patients and the presence of medical residency training programs in those hospitals.

New Section 1853. Payments to MedicarePlus Organizations

Current Law. Under a Medicare risk contract, an HMO agrees to provide or arrange for the full scope of covered Medicare services in return for a single monthly capitation payment issued by Medicare for each enrolled beneficiary. One of the numbers used to determine this payment is the adjusted average per capita cost, or AAPCC. The other, the adjusted community rate or ACR, is discussed below (see new section 1854).

The AAPCC is Medicare's estimate of the average per capita amount it would spend for a given beneficiary (classified by certain demographic characteristics and county of residence) who was not enrolled in an HMO and who obtained services on the usual fee-for-service basis. Separate AAPCCs are established for enrollees on the basis of age, sex, whether they are in a nursing home or other institution, whether they are also eligible for Medicaid, whether they are working and being covered under an employer plan, and the county of their residence. These AAPCC values are calculated in three basic steps:

- Medicare national average calendar year per capita costs are projected for the future year under consideration. These numbers are known as the U.S. per capita costs (USPCCs) and are estimated average incurred benefit costs per Medicare enrollee and adjusted to include program administration costs. USPCCs are developed separately for Parts A and B of Medicare, and for costs incurred by the aged, disabled, and those with ESRD in those two parts of the program.
- Geographic adjustment factors that reflect the historical relationships between the county's and the Nation's per capita costs are used to convert the national average per capita costs to the county level. Expected Medicare per capita costs for the county are calculated only for fee-for-service beneficiaries by removing both reimbursement and enrollment attributable to Medicare beneficiaries in prepaid plans.
- Once the county AAPCC is calculated, it is then adjusted for the demographic variables described above, such as age, sex, and Medicaid status.

For each Medicare beneficiary enrolled under a risk contract, Medicare will pay the HMO 95 percent of the rate corresponding to the demographic class to which the beneficiary is assigned.

Explanation of Provision. The provision would establish a new section 1853 specifying the methodology for determining payment to MedicarePlus plans and the procedures for announcing rates and paying plans.

a. In General. Under a MedicarePlus contract, the Secretary would be required to make monthly payments in advance to each MedicarePlus organization for each covered individual in a payment area in an amount equal to 1/12 of the annual MedicarePlus capitation rate with respect to that individual for that area. The payment would be adjusted for such risk factors as age, disability status, gender, institutional status, and

other such factors as the Secretary determined to be appropriate, so as to ensure actuarial equivalence. The Secretary could add to, modify, or substitute for such factors, if such changes would improve the determination of actuarial equivalence. The Secretary would be required to establish separate rates of payment with respect to individuals with end stage renal disease (ESRD). Payments to organizations could be retroactively adjusted for (i) actual versus the estimated enrollment used to determine the amount of advance payment; and (ii) individuals' change of enrollment from a MedicarePlus organization sponsored or contributed to by an employer to a MedicarePlus organization.

Risk Adjustment: The Secretary would be required to develop and submit to Congress by no later than October 1, 1999, a report on a method of risk adjustment of payment rates that accounts for variations in per capita costs based on health status. This report would have to include an evaluation of the proposal by an independent actuary of the actuarial soundness of the proposal. The Secretary would have to require MedicarePlus organizations (and risk-contract plans) to submit, for periods beginning on or after January 1, 1998, data regarding inpatient hospital and other services and other information the Secretary deems necessary. The Secretary would have to provide for implementation of a risk adjustment methodology that accounts for variations in per capita costs based on health status by no later than January 1, 2000.

b. Annual Announcement of Payment Rates. Payments to plans would be calculated based on the *annual MedicarePlus capitation rate*. The Secretary would be required to annually determine and announce no later than August 1 before the calendar year concerned: (i) the annual MedicarePlus capitation rate for each MedicarePlus payment area for the year, and (ii) the risk and other factors to be used in adjusting such rates for payments for months in that year. An explanation of the assumptions and changes in methodology would have to be included in sufficient detail so that organizations could compute monthly adjusted MedicarePlus capitation rates. The Secretary would be required to provide advance notice (at least 45 days prior to the announcement) of the proposed changes in the methodology and assumptions used to develop the rates, and give organizations an opportunity to comment.

c. Calculation of Annual MedicarePlus Capitation Rates. The *annual MedicarePlus capitation rate*, for a payment area (for a contract for a calendar year) would be equal to the greatest of the following:

(A) A *blended capitation rate*, defined as the sum of:

- (1) the area-specific percentage (as defined below) of the *annual area-specific MedicarePlus capitation rate* for the year for the payment area, and
- (2) the national percentage (as defined below) of the *input-price adjusted annual national MedicarePlus capitation rate* for the year. (This sum is multiplied by the budget neutrality adjustment factors (described below);

(B) A *minimum* (i.e. "floor") monthly payment amount set at \$350 for 1998 (but not to exceed, in the case of an area outside the 50 states and the District of Columbia, 150% of the 1997 AAPCC). For a subsequent year, this payment amount would be increased by the national per capita MedicarePlus growth percentage for that year.

© A *minimum percentage increase*. In 1998, the payment area would receive a rate that is 102% of its 1997 AAPCC. For a subsequent year, it would be 102% of the annual MedicarePlus capitation rate for the previous year.

There are four elements in the blended capitation rate referred to in "A" above: First, the area-specific and national percentages are as follows:

1998 -- the area-specific percentage is 90% and the national percentage is 10%.
 1999 -- the area-specific percentage is 85% and the national percentage is 15%.
 2000 -- the area-specific percentage is 80% and the national percentage is 20%.
 2001 -- the area-specific percentage is 75% and the national percentage is 25%.
 After 2001-- the area-specific percentage is 70% and the national percentage is 30%.

Second, the annual area-specific MedicarePlus capitation rate for a MedicarePlus payment area would be:

For 1998-- the annual per capita rate of payment for 1997 (as determined under the current law calculation to derive the AAPCC), increased by the *national average per capita growth percentage* for 1998 (as defined below), or

For a subsequent year -- the annual area-specific MedicarePlus capitation rate for the previous year, increased by the *national per capita MedicarePlus growth percentage* for such subsequent year.

Third, the input-price-adjusted annual national MedicarePlus capitation rate for a MedicarePlus payment area for a year would be equal to the sum, for all types of Medicare services, of the product of three amounts: (i) the *national standardized annual MedicarePlus capitation rate* for the year (defined as the weighted average of area-specific MedicarePlus capitation rates), (ii) the proportion of such rate for the year which is attributable to such type of services, and (iii) an index that reflects (for that year and that type of service) the relative input price of such services in the area as compared to the national average input price of such services. (In applying (iii), the Secretary would use those indices that are used in applying (or updating) national payment rates for specific areas and localities.) Special rules specified in the provision would apply for 1998 (and optionally for 1999) in providing for the input price adjustment.

Fourth, in calculating the payment rates, the Secretary would be required to apply a budget neutrality adjustment to the *blended rate payments*. This adjustment would ensure that the aggregate of payments equals that which would have been made if the payment was based on 100% of the area-specific MedicarePlus capitation rates for each payment

area. In doing this, the budget neutral amount for each county would be equal to the sum of the area-specific rates used to compute the blended rates multiplied by the product of the update factor and the number of enrollees in that county.

With respect to the blended and the minimum payment rate categories described in "A" and "B" above, the *national per capita MedicarePlus growth percentage* is the percentage determined by the Secretary, by April 30th before the beginning of the year involved, to reflect the Secretary's estimate of the projected per capita rate of growth in expenditures under Medicare parts A and B, reduced by 0.5 percentage points for 1998-2002, and by 0 percentage points for years thereafter. Separate determinations would have to be made for aged enrollees, disabled enrollees, and enrollees with ESRD. The percentage adjustment would have to reflect an adjustment for over or under projecting in the growth percentage for previous years.

In the case of a MedicarePlus payment area for which the AAPCC for 1997 varies by more than 20% from such rate for 1996, the Secretary, where appropriate, could substitute for the 1997 rate a rate that is more representative of the cost of the enrollees in the area.

d. MedicarePlus Payment Area. The provision defines a MedicarePlus payment area as a county or equivalent area specified by the Secretary. In the case of individuals determined to have ESRD, the MedicarePlus payment area would be each state, or other payment areas as the Secretary specified.

Upon request of a state for a contract year (beginning after 1998) made at least 7 months before the beginning of the year, the Secretary would redefine MedicarePlus payment areas in the state to: (1) a single statewide MedicarePlus payment area; (2) a metropolitan system (described in the provision); or (3) a single MedicarePlus payment area consolidating noncontiguous counties (or equivalent areas) within a state. This adjustment would be effective for payments for months beginning with January of the year following the year in which the request was received. The Secretary would be required to make an adjustment to payment areas in the state to ensure budget neutrality.

e. Special Rules for Individuals Electing MSA Plans. If the monthly premium for a MSA plan for a MedicarePlus payment area was less than 1/12 of the annual MedicarePlus capitation rate for the area and year involved, the Secretary would deposit the difference in a MedicarePlus MSA established by the individual. No payment would be made unless the individual had established the MedicarePlus MSA before the beginning of the month or by such other deadline the Secretary specifies. If the individual had more than one account, he or she would designate one to receive the payment. The payment for the first month for which a MSA plan was effective for a year would also include amounts for successive months in the year. For cases when an MSA election was terminated before the end of the year, the Secretary would establish a procedure to recover deposits attributable to the remaining months.

f. Payments from Trust Funds. Payments to the MedicarePlus organizations and payments to MedicarePlus MSAs, would be made from the HI and SMI trust funds in such proportion as the Secretary determined reflected the relative weights that benefits under Parts A and B represented of Medicare's actuarial value of the total benefits.

h. Special Rule for Certain Inpatient Hospital Stays. In the case of an individual receiving inpatient hospital services from a hospital covered under Medicare's prospective payment system as of the effective date of the (1) individual's election of a MedicarePlus plan: (a) payment for such services until the date of the individual's discharge would be made as if the individual did not elect coverage under the MedicarePlus plan; (b) the elected organization would not be financially responsible for payment for such services until the date of the individual's discharge; and © the organization would nevertheless be paid the full amount otherwise payable to the organization; or (2) termination of enrollment with a MedicarePlus organization: (a) the organization would be financially responsible for payment for such services after the date of termination and until the date of discharge; (b) payment for such services during the stay would not be made under Medicare's PPS system; and © the terminated organization would not receive any payment with respect to the individual during the period in which the individual was not enrolled.

New Section 1854. Premiums

Current Law. Section 1876 provides for requirements relating to benefits, payment to the plans by Medicare, and payments to the plans by beneficiaries. A Medicare beneficiary enrolled in an HMO/CMP is entitled to receive all services and supplies covered under Medicare Parts A and B (or Part B only, if only enrolled in Part B). These services must be provided directly by the organization or under arrangements with the organization. Enrollees in risk-based organizations are required to receive all services from the HMO/CMP except in emergencies.

In general, HMOs/CMPs offer benefits in addition to those provided under Medicare's benefit package. In certain cases, the beneficiary has the option of selecting the additional benefits, while in other cases some or all of the supplementary benefits are mandatory.

Some entities may require members to accept additional benefits (and pay extra for them in some cases). These required additional services may be approved by the Secretary if it is determined that the provision of such additional services will not discourage enrollment in the organization by other Medicare beneficiaries.

The amount an HMO/CMP may charge for additional benefits is based on a comparison of the entity's adjusted community rate (ACR, essentially the estimated market price) for the Medicare package and the average of the Medicare per capita payment rate. A risk-based organization is required to offer "additional benefits" at no additional charge if the organization achieves a savings from Medicare. This "savings"

occurs if the ACR for the Medicare package is less than the average of the per capita Medicare payment rates. The difference between the two is the amount available to pay additional benefits to enrollees. These may include types of services not covered, such as outpatient prescription drugs, or waivers of coverage limits, such as Medicare's lifetime limit on reserve days for inpatient hospital care. The organization might also waive some or all of the Medicare's cost-sharing requirements.

The entity may elect to have a portion of its "savings" placed in a benefit stabilization fund. The purpose of this fund is to permit the entity to continue to offer the same set of benefits in future years even if the revenues available to finance those benefits diminish. Any amounts not provided as additional benefits or placed in a stabilization fund would be offset by a reduction in Medicare's payment rate.

If the difference between the average Medicare payment rate and the adjusted ACR is insufficient to cover the cost of additional benefits, the HMO/CMP may charge a supplemental premium or impose additional cost-sharing charges. If, on the other hand, the HMO does not offer additional benefits equal in value to the difference between the ACR and the average Medicare payment, the Medicare payments are reduced until the average payment is equal to the sum of the ACR and the value of the additional benefits.

For the basic Medicare covered services, premiums and the projected average amount of any other cost-sharing may not exceed what would have been paid by the average enrollee under Medicare rules if she or he had not joined the HMO. For supplementary services, premiums and projected average cost-sharing may not exceed what the HMO would have charged for the same set of services in the private market.

Explanation of Provision. The provision creates a new section 1854 specifying requirements for the determination of premiums charged by MedicarePlus organizations to MedicarePlus enrollees.

a. Submission and Charging of Premiums. Each MedicarePlus organization would be required annually to file with the Secretary the amount of the monthly premium for coverage under each of the plans it would be offering in each payment area, and the enrollment capacity in relation to the plan in each such area.

b. Net Monthly Premium. The monthly premium charged for a plan offered in a payment area would equal 1/12 of the amount (if any) by which the premium exceeded the MedicarePlus capitation rate.

c. Uniform Premium. Premiums could not vary among individuals who resided in the same payment area.

d. Terms and Conditions of Imposing Premiums. Each MedicarePlus organization would have to permit monthly payment of premiums. An organization could terminate election of individuals for a MedicarePlus plan for failure to make premium payments but

only under specified conditions. A MedicarePlus organization could not provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

e. Limitation on Enrollee Cost-Sharing. In no case could the actuarial value of the premium rate, deductibles, coinsurance, and copayments applicable on average to individuals enrolled with a MedicarePlus plan with respect to required benefits exceed the actuarial value of the premium rate, deductibles, coinsurance, and copayments applicable in Medicare FFS. This provision would not apply to an MSA plan. If the Secretary determined that adequate data were not available to determine the actuarial value of the cost-sharing elements of the plan, the Secretary could determine the amount.

f. Requirement for Additional Benefits. The extent to which a MedicarePlus plan (other than a MSA plan) would have to provide additional benefits would depend on whether the plan's adjusted community rate (ACR) was lower than its average capitation payments. The ACR would mean, at the election of the MedicarePlus organization, either: (i) the rate of payment for services which the Secretary annually determined would apply to the individuals electing a MedicarePlus plan if the payment were determined under a community rating system, or (ii) the portion of the weighted aggregate premium which the Secretary annually estimated would apply to the individual but adjusted for differences between the utilization of individuals under Medicare and the utilization of other enrollees (or through another specified manner). For PSOs, the ACR could be computed using data in the general commercial marketplace or (during a transition period) based on the costs incurred by the organization in providing such a plan.

If the actuarial value of the benefits under the MedicarePlus plan (as determined based upon the ACR) for individuals was less than the average of the capitation payments made to the organization for the plan at the beginning of a contract year, the organization would have to provide additional benefits in a value which was at least as much as the amount by which the capitation payment exceeded the ACR. These benefits would have to be uniform for all enrollees in a plan area. (The excess amount could, however, be lower if the organization elected to withhold some of it for a stabilization fund.) A MedicarePlus organization could provide additional benefits (over and above those required to be added as a result of the excess payment), and could impose a premium for such additional benefits.

g. Periodic Auditing. The Secretary would be required to provide annually for the auditing of the financial records (including data relating to utilization and computation of the ACR) of at least one-third of the MedicarePlus organizations offering MedicarePlus plans. The General Accounting Office would be required to monitor such auditing activities.

h. Prohibition of State Imposition of Premium Taxes. No state could impose a premium tax or similar tax on the premiums of MedicarePlus plans or the offering of such plans.

New Section 1855. Organizational and Financial Requirements for MedicarePlus Organizations; Provider-Sponsored Organizations

Current Law. Under section 1876 of the Social Security Act, Medicare specifies requirements to be met by an organization seeking to become a managed care contractor with Medicare. In general, these include the following: (1) the entity must be organized under the laws of the State and be a Federally qualified HMO or a competitive medical plan (CMP) which is an organizations that meets specified requirements (it provides physician, inpatient, laboratory, and other services, and provides out-of-area coverage); (2) the organization is paid a predetermined amount without regard to the frequency, extent, or kind of services actually delivered to a member; (3) the entity provides physicians' services primarily through physicians who are either employees or partners of the organization or through contracts with individual physicians or physician groups; (4) the entity assumes full financial risk on a prospective basis for the provision of covered services, except that it may obtain stop-loss coverage and other insurance for catastrophic and other specified costs; and (5) the entity has made adequate protection against the risk of insolvency.

Provider Sponsored Organizations (PSOs) that are not organized under the laws of a state and are neither a federally qualified HMO or CMP are not eligible to contract with Medicare under the risk contract program. A PSO is a term generally used to describe a cooperative venture of a group of providers who control its health service delivery and financial arrangements.

Explanation of Provision. The provision adds a new section 1855 to the Social Security Act providing organizational and financial requirements for MedicarePlus organizations, including PSOs.

a. Organized and Licensed under State Law. In general, a MedicarePlus organization would have to be organized and licensed under state law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each state in which it offers a MedicarePlus plan. Special rules would apply for PSOs. In general, a PSO seeking to offer a MedicarePlus plan could apply to the Secretary for a waiver of the state licensing requirement. The Secretary would be required to grant or deny a waiver application within 60 days of a completed application.

The Secretary would grant a waiver of the state licensing requirement for an organization that is a PSO if the Secretary determined that: (i) the state had failed to substantially complete action on a licensing application within 90 days of the receipt of a completed application (not including any period before the date of enactment), or (ii) the state denied such a licensing application and (a) the state had imposed documentation or information requirements not related to solvency requirements that are not generally applicable to other entities engaged in substantially similar business, or (b) the state's standards or review process imposed any material requirements, procedures, or standards (other than requirements relating to solvency) on such organizations that were not

generally applicable to other entities engaged in substantially similar business; or (iii) the state used its own solvency requirements which were not the same as the federal requirements to deny the licensing application, or the state had imposed as a condition of licensure approval any documentation requirements relating to solvency or other material requirements, procedures, or standards that were different from the requirements, procedures, or standards applied by the Secretary.

In the case of a waiver granted under this paragraph for a PSO: (I) the waiver would be effective for a 36-month period, except it could be renewed based on a subsequent application filed during the last 6 months of such period; and (ii) any provision of State law related to the licensing of the organization which prohibited the organization from providing coverage pursuant to a MedicarePlus contract would be preempted. Waivers could be renewed more than once.

This requirement would not apply to a MedicarePlus organization in a state if the state required the organization, as a condition of licensure, to offer any plan other than a MedicarePlus plan. The fact that an organization was licensed under state law would not substitute for or constitute certification.

b. Prepaid Payment. A MedicarePlus organization would have to be compensated (except for deductibles, coinsurance, and copayments) by a fixed payment paid on a periodic basis and without regard to the frequency, extent, or kind of health care services actually provided to an enrollee.

c. Assumption of Full Financial Risk. The MedicarePlus organization would have to assume full financial risk on a prospective basis for the provision of health services (other than hospice care) except the organization could obtain insurance or make other arrangements for costs in excess of \$5,000, services needing to be provided other than through the organization; and obtain insurance or make other arrangements for not more than 90 percent of the amount by which its fiscal year costs exceed 115 percent of its income for such year. It could also make arrangements with providers or health institutions to assume all or part of the risk on a prospective basis for the provision of basic services.

d. Certification of Provision Against Risk of Insolvency for Unlicensed PSOs. Each MedicarePlus PSO, that is not licensed by a state and for which a waiver of state law has been approved by the Secretary, would be required to meet federal financial solvency and capital adequacy standards (see new section 1856 as described below). These standards would have to ensure that enrollees would not be held financially liable in the event of a plan sponsor's insolvency. The Secretary would be required to establish a process for the receipt and approval of applications of entities for certification (and periodic recertification) of a PSO as meeting the federal solvency standards. The Secretary would be required to act upon the PSO's certification application within 60 days of its receipt.

e. Provider-Sponsored Organization (PSO) Defined. A PSO is a public or private entity that is a provider or group of affiliated providers that provides a substantial portion of health care under the contract directly through the provider or affiliated group of providers, and with respect to those affiliated providers that share, directly or indirectly, substantial financial risk, have at least a majority interest in the entity. In defining substantial proportion, the Secretary would be required to consider the need for such an organization to assume responsibility for a substantial portion of services in order to assure financial stability and other factors. "Affiliation," "control," and "health care provider" are specifically defined. The Secretary would be required to issue regulations to carry out this provision.

New Section 1856. Establishment of Standards; Certification of Organizations and Plans

Current Law. Under section 1876 of the Social Security Act, Medicare specifies requirements to be met by an organization seeking to become a managed care contractor with Medicare. There is no provision for Provider Sponsored Organizations (PSOs).

Explanation of Provision. The provision would add a new section 1856 providing for the establishment of federal standards for MedicarePlus plans, including solvency standards for PSOs.

a. Establishment of Solvency Standards for PSOs. The provision would require the Secretary of HHS to establish, on an expedited basis and using a negotiated rulemaking process, final standards related to financial solvency and capital adequacy of organizations seeking to qualify as PSOs. The target date for publication of the resulting rules would be April 1, 1998. The Secretary would be required to consult with interested parties and to take into account: (i) the delivery system assets of such an organization and ability of it to provide services directly to enrollees through affiliated providers, and (ii) alternative means of protection against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, etc. The negotiated rule-making committee would be appointed by the Secretary. If the committee reported by January 1, 1998 that it had failed to make significant progress towards consensus or was unlikely to reach consensus by a target date, the Secretary could terminate the process and provide for the publication of a rule. If the committee was not terminated, it would have to report with the proposed rule by March 1, 1998. The Secretary would then publish the rule on a final, interim basis, but be subject to change after public notice and comment. In connection with the rule, the Secretary would specify the process for timely review and approval of applications of entities to be certified as PSOs consistent with this subsection. The Secretary would be required to provide for consideration of such comments and republication of the rule within one year if its publication.

b. Establishment of Other Standards. The Secretary would be required to establish by regulation other standards (not included in (a)) for MedicarePlus organizations and

plans consistent with, and to carry out, this part. By June 1, 1998, the Secretary would be required to issue interim standards based on currently applicable standards for Medicare HMOs/CMPs. The new standards established under this provision would supersede any state law or regulation with respect to MedicarePlus plans offered by Medicare contractors to the extent that such state law or regulations was inconsistent with such standards.

New Section 1857. Contracts with MedicarePlus Organizations

Current Law. Contracts with HMOs are for 1 year, and may be made automatically renewable. However, the contract may be terminated by the Secretary at any time (after reasonable notice and opportunity for a hearing) in the event that the organization fails substantially to carry out the contract, carries out the contract in a manner inconsistent with the efficient and effective administration of Medicare HMO law, or no longer meets the requirements specified for Medicare HMOs. The Secretary also has authority to impose lesser sanctions, including suspension of enrollment or payment and imposition of civil monetary penalties. These sanctions may be applied for denial of medically necessary services, overcharging, enrollment violations, misrepresentation, failure to pay promptly for services, or employment of providers barred from Medicare participation.

To be eligible as a risk contractor, HMOs/CMPs generally must have at least 5,000 members. However, if HMOs/CMPs primarily serve members outside urbanized areas, they may have fewer members (regulations specify at least 1,500). Organizations eligible for Medicare cost contracts also may have fewer than 5,000 members (regulations specify at least 1,500).

No more than 50 percent of the organization's enrollees may be Medicare or Medicaid beneficiaries. This rule may be waived, however, for an organization that serves a geographic area where Medicare and Medicaid beneficiaries make up more than 50 percent of the population or (for 3 years) for an HMO that is owned and operated by a governmental entity.

During its annual open enrollment period of at least 30 days duration, HMOs must accept beneficiaries in the order in which they apply, up to the limits of its capacity, unless doing so would lead to violation of the 50 percent Medicare-Medicaid maximum or to an enrolled population unrepresentative of the population in the area served by the HMO. If an HMO chooses to limit enrollment because of its capacity, regulation provides that it must notify HCFA at least 90 days before the beginning of its open enrollment period and, at that time, provide HCFA with its reasons for limiting enrollment.

In areas where Medicare has risk contracts with more than one HMO and an HMO's contract is not renewed or is terminated, the other HMOs serving the area must have an open enrollment period of 30 days for persons enrolled under the terminated contract.

Explanation of Provision. The provision establishes a new section 1857 specifying requirements for organizations to become MedicarePlus contractors with the Medicare program.

a. In General. The Secretary would not permit the election of a MedicarePlus plan and no payment would be made to an organization unless the Secretary had entered into a contract with the organization with respect to the plan. A contract with an organization could cover more than one MedicarePlus plan. Contracts would provide that organizations agree to comply with applicable requirements and standards.

b. Minimum Enrollment Requirements. The Secretary would be prohibited from entering into a contract with a MedicarePlus organization unless the organization had at least 5,000 individuals (or 1,500 individuals in the case of a PSO) who were receiving health benefits through the organization. An exception would apply if the MedicarePlus standards (as established in new section 1856 described above) permitted the organization to have a lesser number of beneficiaries (but not less than 500 for a PSO) if the organization primarily served individuals residing outside of urbanized areas. The Secretary could waive this requirement during an organization's first 3 contract years. Minimum enrollment requirements would not apply to a contract that related only to an MSA plan.

c. Contract Period and Effectiveness. Contracts would be for at least one year, and could be made automatically renewable in the absence of notice by either party of intention to terminate. The Secretary could terminate a contract at any time or impose intermediate sanctions described below if the Secretary determined that the organization: (i) had failed substantially to carry out the contract; (ii) was carrying it out in a manner substantially inconsistent with the efficient and effective administration of MedicarePlus; or (iii) no longer substantially met MedicarePlus conditions. Contracts would specify their effective date, but contracts providing coverage under an MSA plan could not take effect before January 1999. The Secretary would not contract with an organization that had terminated its MedicarePlus contract within the previous 5 years, except in special circumstances as determined by the Secretary. The authority of the Secretary with respect to MedicarePlus plans could be performed without regard to laws or regulations relating to contracts of the United States that the Secretary determined were inconsistent with the purposes of Medicare.

d. Protections Against Fraud and Beneficiary Protections. Contracts would provide that the Secretary or his or her designee would have the right to inspect or otherwise evaluate the quality, appropriateness and timeliness of services, as well as the organization's facilities if there were reasonable evidence of need for such inspection; in addition, they would have the right to audit and inspect any books and records that pertain either to the ability of the organization to bear the risk of potential financial loss or to services performed or determinations of amounts payable under the contract. Contracts would also require the organization to provide and pay for advance written notice to each enrollee of a termination, along with a description of alternatives for obtaining benefits.

They would also require that organizations notify the Secretary of loans and other special financial arrangements made with subcontractors, affiliates, and related parties.

MedicarePlus organizations would be required to report financial information to the Secretary, including information demonstrating that the organization was fiscally sound, a copy of the financial report filed with HCFA containing information required under section 1124 of the Social Security Act, and a description of transactions between the organization and parties in interest. These transactions would include: (i) any sale, exchange, or leasing of property; (ii) any furnishing for consideration of goods, services, and facilities (but generally not including employees' salaries or health services provided to members); and (iii) any lending of money or other extension of credit. Financial information would be available to enrollees upon reasonable request. Consolidated financial statements could be required when the organization controls, is controlled by, or is under common control with another entity.

With respect to financial information, the term "party in interest" means: (i) any director, officer, partner, or employee responsible for management or administration of a MedicarePlus organization; any person who directly or indirectly is a beneficial owner of more than 5 percent of its equity; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5% of the organization; and in the case of a nonprofit MedicarePlus organization, an incorporator or member of such corporation; (ii) any entity in which a person described in (i) is an officer or director; a partner; has directly or indirectly a beneficial interest in more than 5 percent of the equity; or has a mortgage, deed of trust, note, or other interest valuing more than 5 percent of the assets of the entity; (iii) any person directly or indirectly controlling, controlled by, or under common control with an organization; and (iv) any spouse, child, or parent of an individual described in (i).

e. Additional Contract Terms. Contracts would contain other terms and conditions (including requirements for information) as the Secretary found necessary and appropriate. Contracts would require payments to the Secretary for the organization's pro rata share of the estimated costs to be incurred by the Secretary relating to enrollment and dissemination of information. These payments would be appropriated to defray such costs and would remain available until expended. If a contract with a MedicarePlus organization was terminated, the organization would notify each enrollee.

f. Prompt Payment by MedicarePlus Organization. Contracts would require a MedicarePlus organization to provide prompt payment of claims submitted for services and supplies furnished to individuals pursuant to the contract, if they are not furnished under a contract between the organization and the provider or supplier. If the Secretary determined (after notice and opportunity for a hearing) that the organization had failed to pay claims promptly, the Secretary could provide for direct payment of the amounts owed providers and suppliers. In these cases, the Secretary would reduce MedicarePlus payments otherwise made to the organization to reflect the amount of the payments and the Secretary's cost in making them.

g. Intermediate Sanctions. The Secretary would be authorized to carry out specific remedies in the event that a MedicarePlus organization: (i) failed substantially to provide medically necessary items and services required to be provided, if the failure adversely affected (or had the substantial likelihood of adversely affecting) the individual; (ii) imposed net monthly premiums on individuals that were in excess of the net monthly premiums permitted; (iii) acted to expel or refused to re-enroll an individual in violation of MedicarePlus requirements; (iv) engaged in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by MedicarePlus) of eligible individuals whose medical condition or history indicates a need for substantial future medical services; (v) misrepresented or falsified information to the Secretary or others; (vi) failed to comply with rules regarding physician participation; or (vii) employed or contracted with any individual or entity that was excluded from participation in Medicare under section 1128 or 1128A of the Social Security Act (relating to sanctions for program violations) for the provision of health care, utilization review, medical social work, or administrative services, or employed or contracted with any entity for the provision (directly or indirectly) through such an excluded individual or entity.

The remedies would include civil money penalties of not more than \$25,000 for each determination of a failure described above or not more than \$100,000 with respect to misrepresenting information furnished to the Secretary or denying enrollment to persons with a preexisting medical condition. In cases of the latter failure, the Secretary could also levy a \$15,000 fine for each individual not enrolled. In cases of excess premium charges, the Secretary could also recover twice the excess amount and return the excess amount to the affected individual. In addition, the Secretary could suspend enrollment of individuals and payment for them after notifying the organization of an adverse determination, until the Secretary was satisfied that the failure had been corrected and would not likely recur.

Other intermediate sanctions could be imposed if the Secretary determined that a failure had occurred other than those described above. These include: (i) civil money penalties up to \$25,000 if the deficiency directly adversely affected (or had the likelihood of adversely affecting) an individual under the organization's contract; (ii) civil money penalties of not more than \$10,000 for each week after the Secretary initiated procedures for imposing sanctions; and (iii) suspension of enrollment until the Secretary is satisfied the deficiency had been corrected and would not likely recur.

h. Procedures for Imposing Sanctions. The Secretary could terminate a contract or impose the sanctions described above in accordance with formal investigation and compliance procedures under which (i) the Secretary provides the organization with an opportunity to develop and implement a corrective action plan, (ii) the Secretary imposes more severe sanctions on organizations that have a history of deficiencies or have not taken steps to correct those the Secretary brought to their attention, (iii) there are no unreasonable or unnecessary delays between finding a deficiency and imposing sanctions, and (iv) the Secretary provides reasonable notice and opportunity for a hearing, including

the right to appeal an initial decision, before imposing any sanction or terminating the contract. The provisions of section 1128A (other than subsections (a) and (b)) would apply to a civil money penalty in the same manner as they apply to a civil money penalty or proceeding under that section.

New Section 1859. Definitions and Miscellaneous Provisions

Current Law. No provision.

Explanation of Provision. The provision establishes a new section 1859 including definitions and other provisions.

Definition of MedicarePlus Organization. A MedicarePlus organization is a public or private entity that is certified under section 1856 as meeting the MedicarePlus requirements and standards for such an organization (described above).

Definition of MedicarePlus Plan. A MedicarePlus plan is a health benefits coverage offered under a policy, contract, or plan by a MedicarePlus organization pursuant to and in accordance with a contract under section 1857 (described above).

Definition of MSA Plan. A MSA plan is a MedicarePlus plan that (i) provides reimbursement for at least the items and services for which benefits are available under Medicare parts A and B to individuals residing in the area served by the plan and additional health services the Secretary may approve, but only after the enrollee incurs countable expenses (as specified in the plan) equal to the amount of the annual deductible; (ii) counts as such expenses at least all amounts that would have been payable under parts A and B or by the enrollee as deductibles, coinsurance, or copayments if the enrollee had elected to receive benefits through those parts; and (iii) provides, after the deductible is met for a year (and for all subsequent expenses referred to in (i) in the year) for a level of reimbursement that is not less than the lesser of (A) 100 percent of such expenses; or (B) 100 percent of the amount that would have been paid (without regard to any deductibles or coinsurance) under Medicare parts A and B. For contract year 1999, the annual deductible under a MSA plan could not be more than \$6,000. For a subsequent contract year, the annual deductible could not be more than the maximum amount for the previous contract year increased by the national per capita MedicarePlus growth percentage and rounded to the nearest multiple of \$50.

Coordinated Acute and Long-Term Care Benefits under a MedicarePlus Plan. A state would not be prevented from coordinating benefits under a Medicaid plan and a MedicarePlus plan in a manner that assures continuity of a full range of acute care and long-term care services to poor elderly or disabled individuals eligible for Medicare benefits under a MedicarePlus plan.

Restrictions on Enrollment for Certain MedicarePlus Plans. A MedicarePlus religious fraternal benefit society plan could restrict enrollment to individuals who are

members of the church, convention, or group with which the society is affiliated. A MedicarePlus religious fraternal benefit society plan would be a MedicarePlus plan that (i) is offered by a religious fraternal benefit society only to members of the church, convention, or affiliated group, and (ii) permits all members to enroll without regard to health status-related factors. This provision could not be construed as waiving plan requirements for financial solvency. In developing solvency standards, the Secretary would take into account open contract and assessment features characteristic of fraternal insurance certificates. Under regulations, the Secretary would provide for adjustments to payment amounts under section 1854 to assure an appropriate payment level, taking account of the actuarial characteristics of the individuals enrolled in such a plan.

A religious fraternal benefit society is an organization that (i) is exempt from Federal income taxation under section 501(c)(8) of the Internal Revenue Code; (ii) is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches; (iii) offers, in addition to a MedicarePlus religious fraternal benefit society plan, at least the same level of health coverage to individuals entitled to Medicare benefits who are members of such church, convention, or group; and (iv) does not impose any limitation on membership in the society based on any health status-related factor.

Reports. (1) The Secretary would provide for a study on the feasibility and impact of removing the restriction on beneficiaries with end-stage renal disease from enrolling in a MSA MedicarePlus plan. No later than October 1, 1998, the Secretary would submit to Congress a report on this study and include recommendations regarding removing or restricting the limitation as may be appropriate. (2) No later than October 1, 1999, the Secretary would submit to Congress a report on the extent to which MedicarePlus organizations are providing payments to disproportionate share hospitals and teaching hospitals. The report would be based on information provided to the Secretary under section 1852(k) and other information, such as hospital claims data, the Secretary obtains.

Section 10002. Transitional Rules for Current Medicare HMO Program

Current Law. No provision for transition rules. Current law requires that to be a risk contractor, no more than 50 percent of the organization's enrollees may be Medicare or Medicaid beneficiaries. The rule may be waived, however, for an organization that serves a geographic area where Medicare and Medicaid beneficiaries make up more than 50 percent of the population or (for 3 years) for an HMO that is owned and operated by a governmental entity.

Explanation of Provision. Effective for contract periods beginning after December 31, 1996, the Secretary could waive or modify the 50:50 rule to the extent the Secretary finds the waiver is in the public interest.

The Secretary would be prohibited from entering into, renewing, or continuing any risk-sharing contract under section 1876 for any contract year beginning on or after the date MedicarePlus standards are first established for MedicarePlus organizations that are insurers or HMOs. If the organization had a contract in effect on that date, the prohibition would be effective one year later. The Secretary could not enter into, renew, or continue a risk-sharing contract for any contract year beginning on or after January 1, 2000. An individual who is enrolled in Medicare part B only and also in an organization with a risk-sharing contract on December 31, 1998 could continue enrollment in accordance with regulations issued not later than July 1, 1998.

For individuals enrolled under both Medicare part A and part B, payments for risk-sharing contracts for months beginning with January 1998 would be computed by substituting the MedicarePlus payment rates specified in this bill. For individuals enrolled only under part B, the substitution would be based upon the proportion of those rates that reflects the proportion of payments under title XVIII of the Social Security Act (i.e., Medicare) attributable to part B. With respect to months in 1998, the Secretary would compute, announce, and apply the MedicarePlus payment rates in as timely manner as possible (notwithstanding deadlines in section 1853(a) as described above) and could provide for retroactive adjustments in risk-sharing contract payments not in accordance with those rates.

An individual who is enrolled on December 31, 1998 with an organization having a section 1876 contract would be considered to be enrolled with that organization under MedicarePlus if the organization has a MedicarePlus contract for providing services on January 1, 1999, unless the individual had disenrolled effective that date.

Hospitals would accept Medicare payment rates as payment in full for inpatient emergency services covered under Medicare that an out-of-plan provider furnishes enrollees in a MedicarePlus plan which does not have a contract establishing such payment amounts.

Any reference in law in effect before the date of enactment of this legislation to part C of Medicare would be deemed a reference to part D as in effect after such date.

Not later than 90 days after enactment of this legislation, the Secretary would submit to Congress a legislative proposal providing for technical and conforming amendments as the MedicarePlus provisions require.

Required MedicarePlus organization contributions for costs related to enrollment and dissemination of information would apply to demonstrations if their enrollment were effected or coordinated under section 1851.

In order to carry out the MedicarePlus provisions in a timely manner, the Secretary could (after notice and opportunity for public comment) promulgate regulations that take effect on an interim basis.

Section 10003. Changes in Medigap Program

Current law. Current law contains rules regarding the sale of Medicare supplement policies (generally referred to as “Medigap” policies). Included are prohibitions governing the sale of duplicative policies and exceptions to the general prohibitions.

Explanation of Provision. The provision would include conforming language to the duplication provisions for persons electing a MedicarePlus plan. Included in the general prohibitions would be a general prohibition against selling to a person electing a MedicarePlus plan a Medicare supplemental policy with the knowledge that it duplicated benefits to which the individual was otherwise entitled to under Medicare or another supplemental policy. The provision would further specify that a MedicarePlus policy is not included within the definition of a Medicare supplementary policy.

The provision would prohibit the sale of certain policies to a person electing a high deductible plan. Specifically, the prohibition would apply to the sale of policies providing coverage for expenses that are otherwise required to be counted toward meeting the annual deductible amount provided under a medical savings account (MSA) plan.

Subchapter B. Special Rules for MedicarePlus Medical Savings Accounts

Section 10006. MedicarePlus MSA

CHAPTER 2. - INTEGRATED LONG-TERM CARE PROGRAMS

Subchapter A - Programs of All-Inclusive Care for the Elderly (PACE)

Section 10011-10014. Coverage of PACE under the Medicare Program

Current Law. OBRA 86 required the Secretary to grant waivers of certain Medicare and Medicaid requirements to not more than 10 public or non-profit private community-based organizations to provide health and long-term care services on a capitated basis to frail elderly persons at risk of institutionalization. These projects, known as the Programs of All Inclusive Care for the Elderly, or PACE projects, were intended to determine whether an earlier demonstration program, ON LOK, could be replicated across the country. OBRA 90 expanded the number of organizations eligible for waivers to 15.

Explanation of Provision. The provision would repeal current ON LOK and PACE project demonstration waiver authority and establish in Medicare law PACE as a permanent benefit category eligible for coverage and reimbursement under the Medicare program. PACE providers would offer comprehensive health care services to eligible individuals in accordance with a PACE program agreement and regulations. In general, PACE providers would be public or private nonprofit entities, except for entities (up to 10) participating in a demonstration to test the operation of a PACE program by private, for-profit entities.

PACE program eligible individuals would be those persons who are 55 years of age or older; who require nursing facility level of care that would be covered under a State's Medicaid program; who reside in the service area of the PACE program; and who meet such other eligibility conditions as may be imposed under the PACE program agreement. Enrollees would be required to receive Medicare benefits solely through the program.

Eligibility determinations would be made in accordance with the PACE program agreement. For persons entitled to Medicaid, eligibility determinations would be made by the State agency responsible for administering PACE program agreements. An eligible individual's health status would have to be comparable to the health status of persons who have participated in the PACE demonstration waivers. Information on health status and related indicators would be part of a uniform minimum data set collected by PACE providers. Persons would be reevaluated annually to determine if they continue to need nursing facility level of care, except for those cases where the State determines that there is no reasonable expectation of improvement or significant change in an individual's condition during the period because of advanced age, severity of chronic condition, or degree of impairment. A person could continue to be considered a PACE eligible individual, even though that person no longer requires nursing facility level of care, if in the absence of continued coverage under a PACE program, the individual reasonably would be expected to meet the requirement within the succeeding 6-month

period. Enrollment and disenrollment in a PACE program would be done according to regulation and enrollees would be permitted to voluntarily disenroll without cause at any time.

Under a PACE program agreement, a PACE provider would be required to provide to eligible persons, regardless of source of payment and directly or under contracts with other entities, at a minimum, all items and services covered under Medicare and Medicaid. Services would be provided without any limitation or condition as to amount, duration, or scope and without application of deductibles, copayments, coinsurance, or other cost-sharing that would otherwise apply under Medicare or Medicaid. Providers would also have to provide all additional items and services specified in regulations, based on those required under a PACE protocol. PACE providers would be required to provide enrollees access to necessary covered items and services 24 hours per day, every day of the year. They would have to provide services through a comprehensive, multidisciplinary health and social services delivery system which integrates acute and long-term care services according to regulations. Providers would also have to specify the covered items and services that would not be provided directly by the entity, and to arrange for delivery of these services through contracts meeting the requirements of regulations.

PACE providers would be required to have in effect, at a minimum, a written plan of quality assurance and improvement and procedures implementing the plan as well as written safeguards of the rights of enrolled participants (including a patient bill of rights and procedures for grievances and appeals), in accordance with regulations.

The Secretary would be required to make prospective monthly capitation payments for each PACE program enrollee in the same manner and from the same sources as payments are made to a MedicarePlus organization. The amount would be adjusted to take into account the comparative frailty of PACE enrollees and such other factors as the Secretary determines to be appropriate. The total payment level for all PACE program enrollees would be required to be less than the projected payment under Medicare for a comparable population not enrolled under in PACE.

The Secretary, in close cooperation with the State administering agency, would be required to establish procedures for entering into, extending, and terminating PACE program agreements with entities that meet Medicare requirements for PACE providers, Medicaid requirements, and regulations. The Secretary could not enter into more than 40 agreements (including those in effect as the result of demonstration waivers) as of the date of enactment, and 20 additional agreements for each succeeding anniversary date (without regard to the actual number of agreements in effect as of a previous anniversary date). This numeric limitation would not apply to a PACE provider that is operating under the for-profit demonstration or that subsequently qualifies for PACE provider status.

A PACE program agreement would designate the service area of the program and could provide additional requirements for individuals to qualify as PACE program

eligible individuals. The Secretary (in consultation with the State administering agency) could exclude from designation an area that is already covered under another PACE agreement, in order to avoid unnecessary duplication of services and impairing the financial and service viability of an existing program. The PACE program agreement would be effective for a contract year, but could be extended for additional contract years in the absence of a notice to terminate and would be subject to termination by the Secretary and the State administering agency at any time for cause. PACE providers would be required to meet all applicable State and local laws and requirements and would have such additional terms and conditions as the parties agree to, consistent with the law and regulations.

Under a PACE program agreement, PACE providers would be required to collect data; maintain and provide the Secretary and State administering agency access to the records relating to the program, including pertinent financial, medical and personnel records; and make reports to the Secretary and the State that are necessary to monitor the operation, cost, and effectiveness of the PACE program. During the trial period of the first 3 years of operation, a PACE provider would be required to provide additional data the Secretary specifies in order to perform a comprehensive annual review of its operation. After the trial period, the Secretary would continue to conduct a review of the operation of PACE providers as may be appropriate, taking into account the performance level of a provider and compliance with requirements of law and regulations.

In accordance with regulations establishing procedures for termination of PACE agreements, the Secretary or State could terminate an agreement for, among other reasons, significant deficiencies in the quality of care, failure to comply substantially with conditions for participation, or failure to develop and successfully initiate within 30 days of notice a plan to correct deficiencies.

If the Secretary determines (after consultation with a State) that a PACE provider is failing substantially to comply with the requirements for participation, the Secretary and State could take any or all of the following actions: (1) condition the continuation of the PACE program agreement upon timely execution of a corrective action plan; (2) withhold some or all further payments until the deficiencies have been corrected; (3) terminate the agreement. Under regulations, the Secretary could provide for the application of intermediate sanctions for certain deficiencies. Procedures for termination and sanctions of PACE programs would be the same as those that apply to managed care entities participating in Medicare.

An application for PACE provider program status would be deemed approved unless the Secretary, within 90 days after the date of submission, either denies the request in writing or informs the applicant in writing that additional information is needed. After the date the Secretary receives the additional information, the application would be deemed approved unless the Secretary, within 90 days, denies the request.

The Secretary would be required to issue interim and final regulations to carry out

Medicare and Medicaid statutory provisions on PACE. In issuing regulations, the Secretary would be required to incorporate the requirements applied to PACE demonstration waiver programs under the PACE protocol, to the extent they are consistent with this section. The Secretary (in close consultation with States) could modify or waive provisions of the PACE protocol in order to provide for reasonable flexibility in adapting the PACE service delivery model to the needs of particular organizations (such as those in rural areas or those that may wish to use non-staff physicians) where flexibility is not inconsistent with and would not impair the essential elements, objectives, and requirements of the PACE program. The Secretary could also apply to PACE programs and providers Medicare and Medicaid requirements that apply to managed care plans, taking into account differences in populations served and not including requirements that restrict the proportion of enrollees eligible for Medicare and Medicaid.

For purposes of carrying out a PACE program, certain Medicare requirements would be waived, including those pertaining to limits on coverage of institutional services, rules for payment for benefits, limits on coverage of SNF and home health services, the 3-day prior hospitalization requirement for SNF care, and other coverage rules.

A PACE provider could enter into contracts with other governmental or nongovernmental payers for the care of PACE program eligible persons who are not eligible for Medicare or Medicaid.

The Secretary would be required to promulgate regulations for PACE in a timely manner so that entities may establish and operate PACE programs under Medicare and Medicaid beginning not later than 1 year after enactment.

During the transition from demonstration waiver authority to permanent provider status, applications for waivers (subject to the numerical limitation) would be deemed approved unless the Secretary, within 90 days after the date of submission, either denies the request in writing or informs the applicant in writing that additional information is needed. After the date the Secretary receives the additional information, the application would be deemed approved unless the Secretary, within 90 days, denies the request.

During the 3-year period beginning on the date of enactment, the Secretary would be required to give priority, in processing applications of entities seeking to qualify as PACE programs under Medicare or Medicaid (1) first, to entities that are operating a PACE demonstration waiver program, (2) then, to entities that have applied to operate a program as of May 1, 1997. In awarding additional waivers under the original PACE demonstration authority, the Secretary would be required to give priority to any entities that have applied for a waiver as of May 1, 1997, and to any entity that as of May 1, 1997, has formally contracted with a State to provide services on a capitation basis with an understanding that the entity was seeking to become a PACE provider. The Secretary would be required to give special consideration, in the processing of applications for

PACE provider status and for demonstration waivers, to entities which as of May 1, 1997, have indicated through formal activities (such as entering into contracts for feasibility studies) a specific intent to become a PACE provider. Repeal of waiver demonstration authority would not apply to waivers granted before the initial effective date of regulations. Repeals would apply to waivers granted before this date only after allowing organizations a transition period (of up to 24 months) in order to permit sufficient time for an orderly transition from demonstration project authority to general authority.

The Secretary (in close consultation with States) would be required to conduct a study of the quality and cost of providing PACE program services under the Medicare and Medicaid programs. This study would be required specifically to compare the costs, quality, and access to services offered by private for-profit entities operating under the new demonstration described above with the costs, quality, and access to services of other PACE providers. The Secretary would be required to report to Congress on findings of the study (including specific finding on private for-profit providers), together with recommendations for changes, not later than 4 years after enactment. The Medicare Payment Evaluation Commission would be required to include in its annual report to Congress recommendations on the methodology and level of payments made to PACE providers and on the treatment of private for-profit PACE providers.

Subchapter B - Social Health Maintenance Organizations (SHMOs)

Section 10015. Social Health Maintenance Organizations (SHMOs)

Current Law. The Deficit Reduction Act of 1984 required the Secretary to grant 3-year waivers for demonstrations of social health maintenance organizations (SHMOs) which provide integrated health and long-term care services on a prepaid capitation basis. The waivers have been extended on several occasions since then and a second generation of projects was authorized by OBRA 90.

Explanation of Provision. The provision would require the Secretary to extend waivers for SHMOs through December 31, 2000, and to submit a final report on the projects by March 31, 2001. The limit on the number of persons served per site would be expanded from 12,000 to 24,000. The Secretary also would be required to submit to Congress by January 1, 1999, a plan, including an appropriate transition, for the integration of health plans offered by first and second generation SHMOs and similar plans into the MedicarePlus program. The report on the plan would be required to include recommendations on appropriate payment levels for SHMO plans, including an analysis of the extent to which it is appropriate to apply the MedicarePlus risk adjustment factors to SHMO populations.

Subchapter C - Other Programs

Section 10018. Orderly Transition of Municipal Health Service Demonstration Projects

Current Law. Under a general demonstration authority, the Health Care Financing Administration began waiving in the late 1970s certain Medicare requirements to conduct the Municipal Health Services Demonstration. This project has been conducted in four cities--Baltimore, Cincinnati, Milwaukee, and San Jose. As originally conceived, the project was intended to encourage the use of municipal health centers, in place of more costly hospital emergency rooms and outpatient departments, by eliminating coinsurance and deductibles, expanding the range of covered services, and paying the cities the full cost of delivering services at the clinics. Waivers have been extended several times since the inception of the project by budget reconciliation bills.

Explanation of Provision. The provision would extend the demonstration through December 31, 2000, but only with respect to persons enrolled in the projects before January 1, 1998. The Secretary would be required to work with each demonstration project to develop a plan, to be submitted to the House Ways and Means and Senate Finance Committees by March 31, 1998, for the orderly transition of projects and project enrollees to a non-demonstration health plan, such as a Medicaid managed care or MedicarePlus plan. A demonstration project which does not develop and submit a transition plan by March 31, 1998 or within 6 months after enactment of the Act, whichever is later, would be discontinued as of December 31, 1998. The Secretary would be required to provide appropriate technical assistance to assist in the transition so that disruption of medical services to project enrollees would be minimized.

Section 10019. Community Nursing Organization Demonstration Projects

Current Law. OBRA 87 required the Secretary to conduct demonstration projects to test a prepaid capitated, nurse-managed system of care. Covered services include home health care, durable medical equipment, and certain ambulatory care services. Four sites (Mahomet, Illinois; Tucson, Arizona; New York, New York; and St. Paul, Minnesota) were awarded contracts in September, 1992, and represent a mix of urban and rural sites and different types of health provider, including a home health agency, a hospital-based system, and a large multi-specialty clinic. The community nursing organization (CNO) sites completed development activities and implemented the demonstration in January 1994, with service delivery beginning February 1994.

Explanation of Provision. The provision would extend the CNO demonstration for an additional period of 2 years, and the deadline for the report on the results of the demonstration would be not later than 6 months before the end of the extension.

CHAPTER 3 - MEDICARE PAYMENT ADVISORY COMMISSION

Section 10021. Medicare Payment Advisory Commission

Current Law. The Prospective Payment Assessment Commission was established by Congress through the Social Security Act Amendments of 1983 (P.L. 98-21). The Commission is charged with reporting each year its recommendation of an update factor for PPS payment rates and for other changes in reimbursement policy. It is also required each year to submit a report to Congress which provides background information on trends in health care delivery and financing. The Physician Payment Review Commission was established by the Congress through the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272). It was charged with advising and making recommendations to the Congress on methods to reform payment to physicians under the Medicare program. In subsequent laws, Congress mandated additional responsibilities relating to the Medicare and Medicaid programs as well as the health care system more generally.

The law specified that both Commissions were to be appointed by the Director of the Office of Technology Assessment and funded through appropriations from the Medicare trust funds. In 1995, the Office of Technology Assessment was abolished. In May 1997, P.L. 105-13 was enacted; this legislation extended the terms of those Commission members whose terms were slated to expire in 1997 to May 1, 1998.

Explanation of Provision. The provision would establish the Medicare Payment Advisory Commission (hereafter referred to as the Commission) to review and make recommendations to Congress concerning payment policies under Medicare. The Commission would be required to submit a report to Congress by March 1 of each year (beginning in 1998) containing the results of its reviews of payment policies and its recommendations concerning such policies and an examination of issues affecting the Medicare program.

The Commission would be charged with the following specific review responsibilities with respect to the MedicarePlus program: (1) the methodology for making payments to the plans, including the making of differential payments and the distribution of differential updates among different payment areas; (2) the risk adjustment mechanisms and the need to adjust such mechanisms to take into account health status; (3) the implications of risk selection among MedicarePlus organizations and between the MedicarePlus option and the Medicare fee-for-service option; (4) in relation to payment under MedicarePlus, the development and implementation of quality assurance mechanisms for those enrolled with MedicarePlus organizations; (5) the impact of the MedicarePlus program on beneficiary access to care; and (6) other major issues in implementation and further development of the MedicarePlus program.

In addition, the Commission would be required to review payments policies under

Medicare parts A and B fee-for-service system, including: (1) factors affecting expenditures in different sectors, including the process for updating hospital, skilled nursing facility, physician, and other fees; (2) payment methodologies; and (3) the relationship of payment policies to access and quality of care. It would also review the effect of Medicare payment policies on the delivery of health care services not provided under Medicare and assess the implications of changes in the health services market on Medicare.

The Commission would be required to evaluate required reports on payment policies submitted by the Secretary to Congress (or a committee of Congress). The Commission would be required to submit a report on the evaluation within six months of the Secretary's report. The commission would also be required to consult with the chairmen and ranking members of the appropriate committees of Congress (House Ways and Means, House Commerce, and Senate Finance) regarding its agenda. The Commission would be authorized to submit from time to time other reports as requested by such chairman and members and as it deemed appropriate. The reports would be made public.

The Commission would be composed of 13 members appointed by the Comptroller General, with the first appointments being made by September 30, 1997. These members would have to meet specific qualifications (such as national recognition for their expertise). Commission membership would consist of a broad mix of different professionals, a broad geographic representation, and a balance between urban and rural representatives. It would include representatives of consumers and the elderly. Health care providers could not constitute a majority of the membership. Commissioners would serve for 3-year staggered terms. The provision would include a mechanism for filling vacancies, compensating commissioners, appointing a chair and vice chair; convening meetings; and providing for the executive director and other staff, experts, and consultants. The Commission would be authorized to secure directly from any department or agency information to carry out these provisions. It would be required to collect and assess information (which would be available on an unrestricted basis to GAO). The Commission would be subject to periodic audit by GAO.

The provision would require the Commission to submit appropriations requests in the same manner as the Comptroller General does; however, the amounts appropriated for each would be separate. It would authorize such sums as may be necessary to be appropriated from the Medicare trust funds (60 percent from part A and 40 percent from part B).

The Commission would require that the Comptroller first provide for appointment of members of the Commission (to be known as MedPAC) by not later than September 30, 1997. As quickly as possible after they were first appointed, the Comptroller General (in consultation with ProPac and PPRC) would provide for termination of these entities. As of that date, ProPac and PPRC would be abolished. To the extent possible, the Comptroller General would be required to provide for the transfer to the new commission

assets and staff of the former commissions without any loss of benefits or seniority by virtue of such transfers. Fund balances available to the former commissions would be transferred to the new commission. MedPAC would be responsible for the preparation and submission of reports required by law to be submitted (and which had not been submitted by the time it was established) by the former commissions.

Section 10031. Medigap Protections

Current Law. Medigap is the term used to describe individually-purchased Medicare supplement policies. In 1990, Congress provided for a standardization of Medigap policies; the intention was to enable consumers to better understand policy choices. Implementing regulations generally limit the number of different types of Medigap plans that can be sold in a state to no more than 10 standard benefit plans; these are known as Plans A through J. The Plan A standardized package covers a basic benefits package. Each of the other 9 plans includes the basic benefits plus a different combination of additional benefits.

All insurers offering Medigap policies are required to offer a 6-month open enrollment period for persons turning age 65. This is known as guaranteed open enrollment. There is no guaranteed open enrollment provision for the under-65 disabled population.

At the time insurers sell a Medigap policy, whether or not during an open enrollment period, they are permitted to limit or exclude coverage for services related to a preexisting health condition; such exclusions cannot be imposed for more than 6 months. An individual who has met the preexisting condition limitation in one Medigap policy does not have to meet the requirement under a new policy for previously covered benefits. However, an insurer could impose exclusions for newly covered benefits.

Federal requirements for open enrollment and limits on preexisting condition exclusions are designed to insure beneficiaries have access to Medigap protection. However, persons who disenroll (or wish to disenroll) from managed care plans and move back into fee-for-service Medicare may not have the same access to Medigap coverage as those who join during the open enrollment period.

Explanation of Provision. The provision would guarantee issuance of a Medigap "A", "B" or "C" policy without a pre-existing condition exclusion for certain continuously covered individuals. The insurer also would be prohibited from discriminating in the pricing of such policy on the basis of the individual's health status, medical condition, claims experience, and receipt of health care.

The provision would specify those persons covered under the guaranteed issuance provision. The provision would apply to an individual enrolled under an employee welfare benefit plan that provides benefits supplementing Medicare and the plan terminates or ceases to provide such benefits. The provision would apply to persons

enrolled with a MedicarePlus organization, a risk or cost contract HMO, a similar organization operating under a demonstration project authority, a Medicare SELECT policy, or under a Medigap policy and the enrollment ceases because: (1) the individual moves outside of the entity's service area; (2) the entity becomes bankrupt or insolvent or there is some other involuntary termination of coverage and state law has no provision for continuation of such coverage; or (3) the individual elects termination due to cause.

The provision would also apply to an individual who: (1) was enrolled under a Medigap policy; (2) subsequently terminates such enrollment and enrolls with a MedicarePlus organization, a risk or cost contract HMO, a similar organization operating under a demonstration project authority, or a Medicare SELECT policy; and (3) terminates such enrollment within 6 months (or within 3 months beginning in 2003), but only if the individual was never previously enrolled with such an entity. At the time of the event which results in the cessation of enrollment or loss of coverage, the organization, insurer, or plan administrator (whichever is appropriate) would notify the individual of his or her rights and the obligations of issuers of Medigap policies. The individual must seek to enroll under the Medigap "A", "B", or "C" policy not later than 63 days after termination of other enrollment and provide evidence of the date of termination or disenrollment along with the application for such Medicare supplemental policy.

The provision would limit the application of a preexisting condition exclusion during the initial 6-month open enrollment period. Specifically, such an exclusion could not be imposed on an individual who, on the date of application, had a continuous period of at least 6 months of health insurance coverage defined as "creditable coverage" under the Health Insurance Portability and Accountability Act (HIPAA). If the individual had less than 6 months coverage, the policy would reduce the period of any pre-existing exclusion by the aggregate of periods of "creditable coverage" applicable to the individual as of the enrollment date. The rules used to determine the reduction would be based on rules used under HIPAA.

The provision would give the National Association of Insurance Commissioners (NAIC) nine months to modify its regulations to conform to the new requirements. If the NAIC did not make the changes within this time, the Secretary would make the appropriate modification in the regulations.

The provision would be effective July 1, 1998. In general, a state would not be deemed out of compliance due solely to failure to make changes before one year after the date the NAIC or Secretary made changes in its regulations. A longer time may be permitted if a state requires legislation.

Section 10032. Medicare Prepaid Competitive Pricing Demonstration Project

Current Law. Under section 402 of the Social Security Amendments of 1967 (P.L. 90-248, 42 U.S.C. 1395b-1), the Secretary is authorized to develop and engage in experiments and demonstration projects for specified purposes, including to determine whether, and if so, which changes in methods of payment or reimbursement for Medicare services, including a change to methods based on negotiated rates, would have the effect

of increasing the efficiency and economy of such health services. Under this authority, HCFA is seeking to demonstrate the application of competitive bidding as a method for establishing payments for risk contract HMOs in the Denver area. HCFA's actions have been challenged in the courts.

Explanation of Provision. The provision requires the Secretary of HHS to provide for a demonstration of competitive pricing for private health plans participating in Medicare.

a. Establishment of Project. The Secretary would be required to provide, no later than one year after enactment, for implementation of a project to demonstrate the application of, and the consequences of applying, a market-oriented pricing system for the provision of a full range of Medicare benefits in several geographic areas.

b. Research Design Advisory Committee. Before implementing the project, the Secretary would be required to appoint a national advisory committee, including independent actuaries and individuals with expertise in competitive health plan pricing, to recommend to the Secretary the appropriate research design for implementing the project, including the method for area selection, benefit design among plans offered, structuring choice among health plans offered, methods for setting the price to be paid to plans, collection of plan information, information dissemination, and methods of evaluating the results of the project. Upon implementation of the project, the Committee would continue to advise the Secretary on the application of the design in different areas and changes in the project based on experience with its operations.

c. Area Selection. Taking into account the national advisory committee's recommendations, the Secretary would be required to designate demonstration areas. Upon such designation, the Secretary would be required to appoint an area advisory committee, composed of representatives of health plans, providers, and beneficiaries in each demonstration area. The committee could advise the Secretary on marketing and pricing of plans in the area, and other relevant factors.

d. Monitoring and Report. Taking into considerations the recommendations of the advisory committee (established under (b)), the Secretary would be required to closely monitor the impact of projects in areas on the price and quality of, and access to, Medicare covered services, choice of plans, changes in enrollment, and other relevant factors. The Secretary would be required to periodically report to Congress on project progress.

e. Waiver Authority. The provision authorizes the Secretary to waive such requirements of section 1876 (relating to Medicare risk, cost, and HCPP plans) and of MedicarePlus as may be needed to carry out the demonstration project.

Section 10041.

Please refer to the attachment entitled *Description of Health Related Tax Proposals* prepared by the staff of the Joint Committee on Taxation.

SUBTITLE B - PREVENTION INITIATIVES

Section 10101. Screening Mammography

Current Law. Medicare provides coverage for screening mammograms. Frequency of coverage is dependent on the age and risk factors of the woman. For women ages 35-39, one test is authorized. For women ages 40-49, a test is covered every 24 months, except, an annual test is authorized for women at high risk. Annual tests are covered for women ages 50-64. For women aged 65 and over, the program covers one test every 24 months. Medicare's Part B deductible and coinsurance apply for these services.

Explanation of Provision. The proposal would authorize coverage for annual mammograms for all women ages 40 and over. It would also waive the deductible for screening mammograms. These provisions would be effective January 1, 1998.

Section 10102. Screening Pap Smear and Pelvic Exams

Medicare covers a screening Pap smear once every 3 years. The Secretary is permitted to specify a shorter time period in the case of women at high risk of developing cervical cancer.

Explanation of Provision. The provision would authorize coverage, every 3 years, for a screening pelvic exam which would include a clinical breast examination. The provision would specify that for both Pap smears and screening pelvic exams, coverage would be authorized on a yearly basis for women at high risk of developing cervical cancer (as determined pursuant to factors identified by the Secretary). Coverage would also be authorized on a yearly basis for a woman of childbearing age who had not had a test in each of the preceding three years that did not indicate the presence of cervical cancer.

The provision would waive the deductible for screening Pap smears and screening pelvic exams.

The provisions would be effective January 1, 1998.

Section 10103. Prostate Cancer Screening Tests

Current Law. Medicare does not cover prostate cancer screening tests.

Explanation of Provision. The provision would authorize an annual prostate cancer screening test for men over age 50. The test could consist of any (or all) of the following procedures: (1) a digital rectal exam; (2) a prostate-specific antigen blood test;

and (3) after 2001, other procedures as the Secretary finds appropriate for the purpose of early detection of prostate cancer, taking into account such factors as changes in technology and standards of medical practice, availability, effectiveness, and costs.

The provision would specify that payment for prostate-specific antigen blood tests would be made under the clinical laboratory fee schedule. The provisions would be effective January 1, 1998.

Section 10104 Coverage of Colorectal Screening

Current Law. Medicare does not cover preventive colorectal screening procedures. Such services are covered only as diagnostic services.

Explanation of Provision. The provision would authorize coverage of colorectal cancer screening tests. A test covered under the provision would be any of the following procedures furnished for the purpose of early detection of colorectal cancer: (1) screening fecal-occult blood test; (2) screening flexible sigmoidoscopy; (3) screening colonoscopy for a high-risk individuals; (4) screening barium enema, if found by the Secretary to be an appropriate alternative to screening flexible sigmoidoscopy or screening colonoscopy; and (5) after 2002, other procedures as the Secretary finds appropriate for the purpose of early detection of colorectal cancer, taking into account such factors as changes in technology and standards of medical practice, availability, effectiveness, and costs. A high-risk individual (for purposes of coverage for screening colonoscopy) would be defined as one who faces a high risk for colorectal cancer because of family history, prior experience of cancer or precursor neoplastic polyps, a history of chronic digestive disease condition (including inflammatory bowel disease, Crohn's disease or ulcerative colitis), the presence of any appropriate recognized gene markers, or other predisposing factors. The Secretary would be required to make a decision with respect to coverage of screening barium enema tests within two years of enactment; the determination would be published.

The provision would establish frequency and payment limits for the tests. For screening fecal-occult blood tests, payment would be made under the lab fee schedule. In 1998, the payment amount could not exceed \$5; in future years the update would be limited to the update applicable under the fee schedule. Medicare could not make payments if the test were performed on an individual under age 50 or within 11 months of a previous screening fecal-occult blood test.

The provision would require the Secretary to establish a payment amount under the physician fee schedule for screening flexible sigmoidoscopies that is consistent with payment amounts for similar or related services. The payment amount could not exceed the amount the Secretary specifies, based upon the rates recognized for diagnostic flexible sigmoidoscopy services. For services performed in ambulatory surgical centers or hospital outpatient departments, the payment amount could not exceed the lesser of the payment rate that would apply to such services if they were performed at either site. Medicare could not make payments for a screening flexible sigmoidoscopy if the test

were performed on an individual under age 50 or within 47 months of a previous screening flexible sigmoidoscopy.

The provision would require the Secretary to establish a payment amount under the physician fee schedule for screening colonoscopy for high risk individuals that is consistent with payment amounts for similar or related services. The payment amount could not exceed the amount the Secretary specifies, based upon the rates recognized for diagnostic colonoscopy services. For services performed in ambulatory surgical centers or hospital outpatient departments, the payment amount could not exceed the lesser of the payment rate that would apply to such services if they were performed at either site. Medicare could not make payments if the test were performed on a high-risk individual within 23 months of a previous screening colonoscopy.

The provision would establish special payment rules, in the case of both a screening flexible sigmoidoscopy or screening colonoscopy, if a lesion or growth is discovered during the procedure which results in a biopsy or removal of the lesion or growth during the procedure. In these cases, payment would be made for the procedure classified as either a flexible sigmoidoscopy with such biopsy or removal or screening colonoscopy with such biopsy or removal.

The provision would require the Secretary to review from time to time the appropriateness of the amount of the payment limit for fecal-occult blood tests. The Secretary could, beginning after 2000, reduce the amount of the limit as it applies nationally or in a given area to the amount the Secretary estimates is required to assure that such tests of an appropriate quality are readily and conveniently available.

The provision would require the Secretary to review periodically the appropriate frequency for performing colorectal cancer screening tests based on age and other factors the Secretary believes to be pertinent. The Secretary may revise from time to time the frequency limitations, but no revisions could occur before January 1, 2001.

Nonparticipating physicians providing screening flexible sigmoidoscopies or screening colonoscopies for high risk individuals would be subject to limiting charge provisions applicable for physicians services. The Secretary could impose sanctions if a physician or supplier knowingly and willfully imposed a charge in violation of this requirement.

The provision would require the Secretary to establish payment limits and frequency limits for screening barium enema tests if the Secretary issues a determination that such tests should be covered. Payment limits would be consistent with those established for diagnostic barium enema procedures.

The provisions would be effective January 1, 1998.

Section 10105. Diabetes Screening Tests

Current Law. In general, Medicare covers only those items and services which are medically reasonable and necessary for the diagnosis or treatment of illness or injury. In addition, Medicare covers home blood glucose monitors and associated testing strips for certain diabetes patients. Home blood glucose monitors enable diabetics to measure their blood glucose levels and then alter their diets or insulin dosages to ensure that they are maintaining an adequate blood glucose level. Home glucose monitors and testing strips are covered under Medicare's durable medical equipment benefit. Coverage of home blood glucose monitors is currently limited to certain diabetics, formerly referred to as Type I diabetics, if: (1) the patient is an insulin-treated diabetic; (2) the patient is capable of being trained to use the monitor in an appropriate manner, or, in some cases, another responsible person is capable of being trained to use the equipment and monitor the patient to assure that the intended effect is achieved; and (3) the device is designed for home rather than clinical use.

Explanation of Provision. Effective January 1, 1998, the provision would include among Medicare's covered benefits diabetes outpatient self-management training services. These services would include educational and training services furnished to an individual with diabetes by or under arrangements with a certified provider in an outpatient setting meeting certain quality standards. They would be covered only if the physician who is managing the individual's diabetic condition certifies that the services are needed under a comprehensive plan of care to provide the individual with necessary skills and knowledge (including skills related to the self-administration of injectable drugs) to participate in the management of the individual's condition. Certified providers for these purposes would be defined as physicians or other individuals or entities that, in addition to providing diabetes outpatient self-management training services, provide other items or services reimbursed by Medicare. Providers would have to meet quality standards established by the Secretary. They would be deemed to have met the Secretary's standards if they meet standards originally established by the National Diabetes Advisory Board and subsequently revised by organizations who participated in the establishment of standards of the Board, or if they are recognized by an organization representing persons with diabetes as meeting standards for furnishing such services. In establishing payment amounts for diabetes outpatient self-management training provided by physicians and determining the relative value for these services, the Secretary would be required to consult with appropriate organizations, including organizations representing persons or Medicare beneficiaries with diabetes.

In addition, beginning January 1, 1998, the provision would extend Medicare coverage of blood glucose monitors and testing strips to Type II diabetics and without regard to a person's use of insulin (as determined under standards established by the Secretary in consultation with appropriate organization). The provision would also reduce the national payment limit for testing strips by 10% beginning in 1998.

The Secretary, in consultation with appropriate organizations, would be required

to establish outcome measures, including glycosylated hemoglobin (past 90-day average blood sugar levels), for purposes of evaluating the improvement of the health status of Medicare beneficiaries with diabetes. The Secretary would also be required to submit recommendations to Congress from time to time on modifications to coverage of services for these beneficiaries.

Section 10106. Vaccines Outreach Expansion

Current Law. The Health Care Financing Administration, in conjunction with the Centers for Disease Control and the National Coalition for Adult Immunization, conducts an Influenza and Pneumococcal Vaccination Campaign. The Campaign is scheduled to cease operations in 2000.

Explanation of Provision. The provision would extend the campaign through the end of FY 2002. The provision would appropriate \$8 million for each fiscal year 1998 - 2002 to the Campaign; 60 percent of the appropriation would come from the Federal Hospital Insurance Trust Fund and 40 percent from the Federal Supplementary Medical Insurance Trust Fund.

Section 10107. Study on Preventive Benefits

Current Law. No provision

Explanation of Provision. The provision would require the Secretary to request the National Academy of Sciences, in conjunction with the United States Preventive Services Task Force, to analyze the expansion or modification of preventive services covered under Medicare. The study would consider both the short term and long term benefits and costs to Medicare. The study would have to include specific findings with respect to the following: (1) nutrition therapy, including parenteral and enteral nutrition; (2) standardization of coverage for bone mass measurement; (3) medically necessary dental care; (4) routine patient care costs for beneficiaries enrolled in approved clinical trial programs; and (5) elimination of time limitation for coverage of immunosuppressive drugs for transplant patients. The Secretary would be required to provide such funding as may be necessary in FY 1998 and FY 1999.

SUBTITLE C - RURAL INITIATIVES

Section 10201. Rural Primary Care Hospital Program

Current Law. Under the Essential Access Community Hospital (EACH) demonstration program seven states received grants to develop rural health networks consisting of essential access community hospitals (EACHs) and rural primary care hospitals (RPCHs). In order to have been designated by a State as a RPCH, a facility was required to meet certain criteria, including a requirement that inpatient stays not exceed 72 hours.

Montana also has a limited hospital program called the Medical Assistance Facility (MAF).

Explanation of Provision. The provision would expand the Medicare Rural Primary Care Hospital Program under which a state could designate one or more facilities as a rural primary care hospital (RPCH). A facility could be designated as an RPCH if it was a nonprofit or public hospital located in a county in a rural area that is located at a distance that corresponds to travel time of more than 30 minutes from another hospital or RPCH, or is certified by the state as being a necessary provider of health care services. An RPCH would be required to provide 24-hour emergency care services, provide not more than 15 acute care inpatient beds for providing inpatient care for a period not to exceed 96 hours (except under certain conditions), and would not have to meet all the staffing requirements that apply to hospitals under Medicare.

RPCHs would be required to have agreements with at least one hospital for patient referral and transfer, the development and use of communication systems including telemetry systems and systems for electronic sharing of patient data, and the provision of emergency and non-emergency transportation between the facility and the hospital. Each RPCH would also be required to have an agreement concerning credentialing and quality assurance with at least one hospital, peer review organization or equivalent entity, or other appropriate and qualified entity identified by the state.

Payment for inpatient and outpatient services provided at RPCHs would be made on the basis of reasonable costs of providing such services. Such payment would also continue for designated EACH and RPCH hospitals in effect on September 30, 1997, as well as for the MAF demonstration program.

Section 10202. Prohibiting Denial of Request By Rural Referral Centers For Reclassification on Basis of Comparability of Wages

Current Law. Referral centers are defined as:

- (1) rural hospitals having 275 or more beds;
- (2) hospitals having at least 50 percent of their Medicare patients referred from other hospitals or from physicians not on the hospital's staff, at least 60 percent of their Medicare patients residing more than 25 miles from the hospital, and at least 60 percent of the services furnished to Medicare beneficiaries living 25 miles or more from the hospital; or
- (3) rural hospitals meeting the following criteria for hospital cost reporting periods beginning on or after October 1, 1985:
 - (a) a case mix index equal to or greater than the median case mix for all urban hospital (the national standard), or the median case mix for urban hospitals located in the same census region, excluding hospitals with approved teaching programs;
 - (b) a minimum of 5,000 discharges, the national discharge

criterion (3,000 in the case of osteopathic hospitals), or the median number of discharges in urban hospitals for the region in which the hospital is located; and

© at least one of the following three criteria: more than 50 percent of the hospital's medical staff are specialists, at least 60 percent of discharges are for inpatients who reside more than 25 miles from the hospital, or at least 40 percent of inpatients treated at the hospital have been referred either from physicians not on the hospital's staff or from other hospitals.

RRCs were paid prospective payments based on the applicable urban payment amount rather than the rural payment amount, as adjusted by the hospital's area wage index, until FY1995 when the standardized payment amount for "other urban" and "rural" were combined into a single payment category, "other areas."

OBRA 93 extended the classification through FY1994 for those referral centers classified as of September 30, 1992.

Explanation of Provision. The provision would prohibit the Medicare Geographic Classification Review Board (MGCRCB) from rejecting a hospital's request for reclassification on the basis of any comparison between the average hourly wage of the hospital and the average hourly wage of hospitals in the area in which it is located if the hospital was ever classified as an RRC.

Section 10203. Hospital Geographic Reclassification Permitted for Purposes of Disproportionate Share Payment Adjustments

Current Law. The Medicare Geographic Classification Review Board is required to consider the applications from PPS hospitals requesting that the Secretary change the hospital's geographic classification for purposes of determining for a fiscal year the hospital's average standardized amount and the wage index used to adjust the DRG payment to reflect area differences in hospital wage levels.

Explanation of the Provision. The provision would permit hospitals to request geographic reclassification for the purposes of receiving additional disproportionate share hospital (DSH) payment amounts provided to hospitals that treat a disproportionate share of low-income patients. The provision would require the Board to apply the guidelines established for reclassification for the standardized amount to applications for DSH payments until the Secretary promulgates separate guidelines for reclassification for DSH.

Section 10204. Medicare-Dependent Small Rural Hospital Payment Extension

Current Law. Medicare-dependent small rural hospitals are hospitals located in

a rural area, with 100 beds or less, that are not classified as a sole community provider, and for which not less than 60 percent of inpatient days or discharges in the hospital cost reporting period are attributable to Medicare. These hospitals are reimbursed on the same basis as sole community hospitals. The designation for Medicare-dependent small rural hospitals expired on July 30, 1994.

Explanation of Provision. The provision would reinstate and extend the classification through October 1, 2001. The provision would extend the target amount for cost reporting periods beginning on or after October 1, 1997, and before October 1, 2001. The provision would also permit hospitals to decline reclassification.

Section 10205. Floor on Area Wage Index

Current Law. As part of the methodology for determining prospective payments to hospitals under PPS, the Secretary is required to adjust a portion of the standardized amounts for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

Explanation of Provision. For discharges occurring on or after October 1, 1997, the area wage index applicable for any hospital which was not located in a rural area could not be less than the average of the area wage indices applicable to hospitals located in rural areas in the state in which the hospital was located. The Secretary would be required to make any adjustments in the wage index in a budget neutral manner.

Section 10206. Informatics, Telemedicine, and Education Demonstration Project

Current Law. No provision.

Explanation of Provision. The provision would require the Secretary to conduct, no later than 9 months after enactment, a 4-year demonstration project designed to use eligible health care provider telemedicine networks to apply high-capacity computing and advanced networks for the provision of health care to Medicare beneficiaries who are residents of medically underserved rural and inner-city areas. The project would focus on improvements in primary care and prevention of complications for those residents with diabetes mellitus. The objectives of the project would include: 1) improving patient access to and compliance with appropriate care guidelines for chronic diseases through direct telecommunications links with information networks; 2) developing a curriculum to train, and provide standards for credentialing and licensure of, health professionals (particularly primary care) in the use of medical informatics and telecommunications; 3) demonstrating the application of advanced technologies to assist primary care providers in assisting patients with chronic illnesses in a home setting; 4) applying medical informatics to residents with limited English language skills; 5) developing standards in the application of telemedicine and medical informatics; and 6) developing a model for the cost-effective delivery of primary and related care both in a managed care and fee-for-service environment.

The provision defines an eligible health care provider telemedicine network as a consortium that includes at least one tertiary care hospital, at least one medical school (but no more than two such hospitals), and at least one regional telecommunications provider, no more than four facilities in rural or urban areas, and meets certain additional requirements. The provision would define those services to be covered under Part B for the purposes of this demonstration project. Medicare payment for covered Part B services would be made at a rate of 50% of the reasonable costs of providing such services. The Secretary would be required to recognize the following project costs as permissible costs for covered under Part B: (1) the acquisition of telemedicine equipment for use in patient homes; (2) curriculum development and training of health professionals in medical informatics and telemedicine, (3) payment of certain telecommunications costs, including costs of telecommunications between patients' homes and the eligible network and between the network and other entities under the arrangements described in the bill; and (4) payments to practitioners and providers under Medicare. Costs not covered under Part B would include: (1) purchase or installation of transmission equipment, (2) the establishment or operation of a telecommunications common carrier network, (3) the costs of construction (except for minor renovations related to the installation of reimbursable equipment), or (4) the acquisition or building of real property.

The total amount of Medicare payments permitted under the project would be \$30 million. The project would be prohibited from imposing cost sharing on a Medicare beneficiary for the receipt of services under the project of more than 20% of the recognized costs of the project attributable to these services. The Secretary would be required to submit to the House Committees on Ways and Means and Commerce and the Senate Committee on Finance interim reports on the project and a final report on the project within 6 months of the conclusion of the project. The final report would be required to include an evaluation of the impact of the use of telemedicine and medical informatics on improving the access of Medicare beneficiaries to health care services, on reducing the costs of such services, and on improving the quality of life of such beneficiaries.

**SUBTITLE D - ANTI-FRAUD AND ABUSE PROVISIONS AND
ADMINISTRATIVE
EFFICIENCIES**

CHAPTER 1. - FRAUD AND ABUSE RELATED PROVISIONS

Section 10301. Permanent Exclusion for Those Convicted of 3 Health Care Related Crimes

Current Law. Section 1128(a) of the Social Security Act directs the Secretary of Health and Human Services to mandatorily exclude individuals and entities from participation in the Medicare program and state health care programs (Medicaid, Title V Maternal and Child Health Block Grants, and Title XX Social Services Block Grants) upon conviction of certain criminal offenses including Medicare and Medicaid program-related crimes, patient abuse crimes, health care fraud felonies, and felonies relating to controlled substances. Such mandatory exclusions are, in most cases, for a minimum period of 5 years.

Explanation of Provision. The provision would specify that if an individual has been mandatorily excluded by the Secretary of Health and Human Services from participation in federal health care programs, as defined in Section 1128b(f) of the Social Security Act (see Section X309© of this title), and state health care programs, because of a conviction relating to Medicare and Medicaid program-related crimes, patient abuse, or felonies related to health care fraud or controlled substances, that the exclusion be either for a period of 10 years if the individual has been convicted on only one previous occasion of one or more offenses for which such an exclusion may be imposed, or that the exclusion be permanent if the individual has been convicted on two or more previous occasions of one or more offenses for which such an exclusion may be imposed. The provision would apply to exclusions based on a conviction occurring on or after the date of enactment of this section where the individual has had prior convictions occurring before, on, or after the date of enactment of this section.

Section 10302. Authority to Refuse to Enter into Medicare Agreements with Individuals or Entities Convicted of Felonies

Current Law. Section 1866 of the Social Security Act sets forth certain conditions under which providers may become qualified to participate in the Medicare program. The Secretary may refuse to enter into an agreement with a provider, or may refuse to renew or may terminate such an agreement, if the Secretary determines that the provider has failed to comply with provisions of the agreement, other applicable Medicare requirements and regulations, or if the provider has been excluded from participation in a health care program under section 1128 or 1128A of the Social Security Act. Section 1842 of the Social Security Act permits physicians and suppliers to enter into agreements with the Secretary under which they become "participating" physicians or suppliers under

the Medicare program.

Explanation of Provision. The provision would add a new section giving the Secretary authority to refuse to enter into an agreement, or refuse to renew or terminate an agreement with a provider if the provider has been convicted of a felony under federal or state law for an offense which the Secretary determines is inconsistent with the best interests of program beneficiaries. This authority would extend to the Secretary's agreements with physicians or suppliers who become "participating" physicians or suppliers under the Medicare program. Similar provisions would apply to the Medicaid program. This section would take effect as of the date of enactment of this Act, and apply to new and renewed contracts on or after that date.

Section 10303. Liability of Medicare Carriers and Fiscal Intermediaries for Claims Submitted by Excluded Persons

Current Law. Carriers and fiscal intermediaries are the entities which process claims for Medicare. Intermediaries process claims submitted by Part A providers of services and carriers process claims submitted by Part B providers.

Explanation of Provision. The provision would specify that agreements with fiscal intermediaries or carriers require that such organizations reimburse the Secretary for any amounts paid for services under Medicare which have been furnished, directed, or prescribed by an individual or entity during any period in which the individual or entity has been excluded from participation under Medicare, if the amounts have been paid after the fiscal intermediary or carrier has received notice of the exclusion. Similar restrictions would be imposed upon states under the Medicaid program. These provisions would apply to contracts and agreements entered into, renewed, or extended after the date of enactment of this Act, but only with respect to claims submitted on or after either January 1, 1998, or the effective date of the contract, whichever is later.

Section 10304. Exclusion of Entity Controlled by Family Member of a Sanctioned Individual

Current Law. Section 1128 of the Social Security act authorizes the Secretary of HHS to impose mandatory and permissive exclusions of individuals and entities from participation in the Medicare program, Medicaid program and programs receiving funds under the Title V Maternal and Child Health Services Block Grant, or the Title XX Social Services Block Grant. The Secretary may exclude any entity which the Secretary determines has a person with a direct or indirect ownership or control interest of 5 percent or more in the entity or who is an officer, director, agent, or managing employee of the entity, where that person has been convicted of a specified criminal offense, or against whom a civil monetary penalty has been assessed, or who has been excluded from participation under Medicare or a state health care program.

Explanation of Provision. The provision would specify that if a person transfers an ownership or control interest in an entity to an immediate family member or to a member of the household of the person in anticipation of, or following, a conviction, assessment or exclusion against the person, that the entity may be excluded from participation in Federal health care programs (see Section X309 of this bill) on the basis of that transfer. The terms "immediate family member" and "member of the household" are defined in this section.

Section 10305. Imposition of Civil Money Penalties

Current Law. Section 1128A of the Social Security Act sets forth a list of fraudulent activities relating to claims submitted for payments for items of services under a Federal health care program. Civil money penalties of up to \$10,000 for each item or service may be assessed. In addition, the Secretary of HHS (or head of the department or agency for the Federal health care program involved) may also exclude the person involved in the fraudulent activity from participation in a Federal health care program, defined as any program providing health benefits, whether directly or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program).

Explanation of Provision. The provision would add a new civil money penalty for cases in which a person contracts with an excluded provider for the provision of health care items or services, where the person knows or should know that the provider has been excluded from participation in a Federal health care program. A civil money penalty is also added for cases in which a person provides a service ordered or prescribed by an excluded provider, where that person knows or should know that the provider has been excluded from participation in a Federal health care program.

Section 10306. Disclosure of Information and Surety Bonds

Current Law. Section 1834(a) of the Social Security Act establishes requirements for payments under Medicare for covered items defined as durable medical equipment. Home health agencies are required, under Section 1861(o) of the Social Security Act, to meet specified conditions in order to provide health care services under Medicare, including requirements, set by the Secretary, relating to bonding or establishing of escrow accounts, as the Secretary finds necessary for the effective and efficient operation of the Medicare program.

Explanation of Provision. The provision would require that suppliers of durable medical equipment provide the Secretary with full and complete information as to persons with an ownership or control interest in the supplier, or in any subcontractor in which the

supplier has a direct or indirect 5 percent or more ownership interest, other information concerning such ownership or control, and a surety bond for at least \$50,000. Home health agencies, comprehensive outpatient rehabilitation facilities, and rehabilitation agencies would also be required to provide a surety bond for at least \$50,000. The Secretary may impose the surety bond requirement which applies to durable medical equipment suppliers to suppliers of ambulance services and certain clinics that furnish medical and other health services (other than physicians' services).

The amendments with respect to suppliers of durable medical equipment would apply to equipment furnished on or after January 1, 1998. The amendments with respect to home health agencies would apply to services furnished on or after such date, and the Secretary of HHS is directed to modify participation agreements with home health agencies to provide for implementation of these amendments on a timely basis. The amendments with respect to ambulance services, certain clinics, comprehensive outpatient rehabilitation facilities and rehabilitation agencies would take effect on the date of enactment of this Act.

Section 10307. Provision of Certain Identification Numbers

Current Law. Section 1124 of the Social Security Act requires that entities participating in Medicare, Medicaid and the Maternal and Child Health Block Grant programs (including providers, clinical laboratories, renal disease facilities, health maintenance organizations, carriers and fiscal intermediaries), provide certain information regarding the identity of each person with an ownership or control interest in the entity, or in any subcontractor in which the entity has a direct or indirect 5 percent or more ownership interest. Section 1124A of the Social Security Act requires that providers under Part B of Medicare also provide information regarding persons with ownership or control interest in a provider, or in any subcontractor in which the provider has a direct or indirect 5 percent or more ownership interest.

Explanation of Provision. The provision would require that all Medicare providers supply the Secretary with both the employer identification number and social security account number of each disclosing entity, each person with an ownership or control interest, and any subcontractor in which the entity has a direct or indirect 5 percent or more ownership interest. The Secretary of HHS is directed to transmit to the Commissioner of Social Security information concerning each social security account number and to the Secretary of the Treasury information concerning each employer identification number supplied to the Secretary for verification of such information. The Secretary would reimburse the Commissioner and the Secretary of the Treasury for costs incurred in performing the verification services required by this provision. The Secretary of HHS would report to Congress on the steps taken to assure confidentiality of social security numbers to be provided to the Secretary under this section. This section's reporting requirements would then become effective 90 days after submission of the Secretary's report to Congress on confidentiality of social security numbers.

