

**PRESIDENT CLINTON'S  
BALANCED BUDGET:  
HEALTH CARE REFORMS**

**March 25, 1996**

# **President Clinton's Balanced Budget: Health Care Reforms**

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## **EXECUTIVE SUMMARY:**

### **President Clinton's Balanced Budget: Health Care Reforms**

**The President's balanced budget will protect and strengthen Medicare and Medicaid. It will:**

- Preserve our commitment to the elderly, people with disabilities, women, children and families as we make Medicare and Medicaid more efficient.
- Improve Medicare by offering new choices of high-quality health plans and delivery systems, and by providing new preventive benefits and a new respite care benefit for families coping with Alzheimer's Disease.
- Extend the life of the Medicare Hospital Insurance Trust Fund for at least a decade without imposing any new costs on Medicare beneficiaries.
- Protect the federal guarantee of coverage under Medicaid, while providing new flexibility for states to administer their programs within a targeted growth rate for spending per beneficiary.
- Establish strong new protections against fraud and abuse in the health care system.

**The President's balanced budget also includes important health initiatives that increase the availability and affordability of private health care coverage for working Americans. Specifically, it will:**

- Reform the insurance system to ensure that workers don't lose their insurance if they lose a job or change jobs, limit the use of pre-existing condition exclusions, and establish voluntary purchasing cooperatives so that small businesses can obtain more affordable health insurance coverage.
- Provide assistance for workers who are temporarily unemployed and need short-term financial support to help them keep health insurance coverage.
- Make health benefits more affordable for individuals who are self-employed by increasing the tax deductibility of health benefits.
- Simplify the administration of the health system so that fewer dollars are spent on overhead, and health professionals are freed from unnecessary paperwork.

## Preserving and Strengthening Medicare

Medicare provides health care benefits to 37 million elderly Americans and individuals with disabilities. The President's plan maintains the 30-year national commitment to this program and makes it more efficient.

The President's balanced budget proposal builds on the Administration's 1993 deficit reduction package, which strengthened the Medicare Hospital Insurance (Part A) Trust Fund, with additional Medicare reforms. It includes \$124 billion in savings over the next seven years and would assure the fiscal integrity of the Trust Fund through at least the next decade, while imposing no new cost increases on Medicare beneficiaries.

Key elements of the President's Medicare proposal are:

- **Continued Expanded Choice of Plans Under Medicare:** The President's plan retains a strong, traditional Medicare fee-for-service program while increasing choices of alternative health plans or delivery systems. It will:
  - Expand beneficiary choice among health plans and delivery system options that guarantee high quality care for reasonable costs, including preferred provider organizations (PPOs), provider networks, and point-of-service HMOs;
  - Provide beneficiaries with detailed information about the providers and health plan choices available in their area, thereby facilitating the enrollment process;
  - Improve Medicare's method for paying health plans and delivery systems;
  - Foster better quality of care provided by health plans; and
  - Enhance choice/portability through Medigap reforms.
- **A More Cost-Effective Medicare Program:** The \$124 billion in savings included in the President's plan are sound, responsible reforms that will make the program more efficient while providing sufficient funds to ensure beneficiaries have access to high-quality health care.

These changes will protect the Medicare Hospital Insurance Part A Trust Fund and maintain the Part B premium at 25 percent of program costs as under current law. The plan will:

- Reduce payments to hospitals, physicians, and other providers while ensuring that high quality health care providers continue to serve Medicare beneficiaries;

- Reform Medicare financing for graduate medical education and training provided by the nation's academic health centers and teaching hospitals;
- Assure that the Medicare Trust Fund will be sound for the short and mid-term, and place it in a much stronger position to deal with the long-term problem when the baby boom generation retires.
- **An Improved Medicare Program:** The President's plan improves Medicare program. It will:
  - Invest limited resources to expand cost-effective preventive benefits, including coverage for mammography, colorectal screening, and preventive injections for pneumonia, influenza and hepatitis B.
  - Establish a respite care benefit for families of victims of Alzheimer's Disease;
  - Redirect medical education funds from managed care payments to medical teaching and research institutions, and establish a new commission on medical education and workforce priorities.

### **Combating Fraud and Abuse**

The Clinton Administration stepped up efforts to combat fraud and abuse with remarkable results. One key has been Operation Restore Trust -- a pilot program launched earlier this year in New York, Florida, Illinois, Texas, and California. The President's plan would take Operation Restore Trust nationwide.

The President's plan would also give law enforcement officials substantial additional authority and resources to investigate, prosecute, and sanction those who defraud federal health programs; ensure adequate and dependable sources of funds to support program integrity activities; and change reimbursement policies that inadvertently may have contributed to abuse and fraud.

### **Protecting and Improving Medicaid**

Medicaid provides acute and long-term health care services to 36 million low-income women, children, families, older Americans, and people with disabilities. Nearly half of Medicaid recipients are children but approximately two-thirds of Medicaid expenditures are for care for the elderly and people with disabilities.

The President's proposal maintains the 30-year collaboration with the states to guarantee coverage for needed health services while making Medicaid more effective and efficient. It would reduce federal Medicaid spending by \$59 billion over seven years.

Key elements of the President's Medicaid proposal are:

- **Guarantee of Coverage:** People now or scheduled to be covered under current law would retain their Federal guarantee of health care coverage.
- **Cost Effectiveness:** To limit the growth in federal Medicaid expenditures, a per capita limit would be established to constrain the rate of increase in federal matching payments per beneficiary. These limits maintain the federal financial commitment to states in the event of an economic downturn that could require states to add beneficiaries. Federal payments for disproportionate share hospitals would also be tightened and states would have the flexibility to target these payments to a range of essential community providers, including federally qualified health centers and rural health centers.
- **Unprecedented State Flexibility:** States would get much greater flexibility to change how they deliver and pay for services, so that they can reduce costs, not coverage. For example, states would be authorized to implement managed care plans and provide home and community-based care without federal waivers.
- **Quality Protection:** Existing federal standards and enforcement for nursing homes and institutions for people with mental retardation and developmental disabilities would be maintained. Quality standards for managed care systems would be updated and enhanced.
- **Financial Protection:** Protections against impoverishment for spouses of nursing home residents would be retained, as would the guarantee that Medicare premiums and cost-sharing be paid for by Medicaid for low-income beneficiaries.

### **Long-Term Care**

Frail elderly Americans and younger persons with disabilities frequently require home and community-based long-term care to assist them in carrying out the routine activities of daily life. The President's plan would improve access to such services by establishing a new benefit in the Medicare program for family members of beneficiaries with Alzheimer's disease. They would be eligible for up to 32 hours of respite care each year under this new benefit.

In addition, the President's plan preserves Medicaid's guarantee of coverage for Americans who need nursing home care, as well as the protection of Federal standards and oversight of quality. Access to home and community-based care is enhanced by new flexibility the plan affords states that wish to provide this alternative to nursing home care.

## Protecting Working Americans

Today, most working Americans receive their health care insurance coverage through their employer, but the security of that coverage often depends on economic conditions and on insurance rules that can exclude coverage for some people. There has been strong, bipartisan support for taking steps to reform the health insurance market to preserve and protect the coverage of working Americans.

The President's plan includes the following insurance reforms and programs to protect workers:

- **Pre-existing Medical Conditions:** Insurers and group health plans could no longer exclude individuals from coverage because of pre-existing medical conditions. Insurers in the small group market would be required to sell coverage to small businesses regardless of the health status of the workers they employ.
- **Enhanced Portability of Coverage:** Under the President's plan, "job lock" would be eliminated by ensuring that workers who change jobs don't lose their health care coverage.
- **Ensuring Coverage for Temporarily Uninsured Workers:** Grants would be made available to the states to provide for a six-month period of private health benefits for laid-off workers who lose their coverage when they lose their jobs and receive unemployment benefits.
- **Small Business Assistance:** Grants would be provided to states to help them create voluntary small group insurance purchasing cooperatives to encourage competition and affordability in the small group market. Upon state request, the Federal Employees Health Benefits Program could require its participating health plans that serve the small group market to make themselves available through purchasing cooperatives established by the state.
- **Tax Deduction for the Self-Employed:** Self-employed individuals, including farmers, would be allowed to deduct 50 percent of the cost of their health insurance premiums from their taxable income.

## Administrative Simplification and Security of Health Information

The health care system includes a tremendous amount of red tape and paperwork that often interferes with providing care to patients. The President remains committed to reducing these burdens. Standards would be adopted to simplify the use of electronic health information transactions. New federal standards would be developed to assure the security and privacy of individual medical information contained in electronically conducted health care transactions.

## PRESERVING AND STRENGTHENING MEDICARE

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*The President's plan saves \$124 billion over seven years, extends the solvency of the Medicare Hospital Insurance Trust Fund, and does not impose new costs on beneficiaries. The plan also expands health plan choices for beneficiaries, provides new benefits, improves Medicare's health plan payment methodology, fosters continuous improvement in health plan quality, helps beneficiaries become more informed about their choices, and levels the playing field for Medicare managed care plans and Medicare supplemental coverage.*

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### I. EXPANDING MEDICARE MANAGED CARE OPTIONS

The President's plan further expands Medicare managed care options by statutorily authorizing the participation of a range of health delivery plan options, including preferred provider organizations (PPOs), provider sponsored organizations (PSOs), and other alternative delivery systems that meet strong consumer protection standards. These health delivery plans would qualify for designation as "participating" plans if they met the following criteria:

- o Benefits. At a minimum, benefits under the plan should be the benefits available under fee-for-service Medicare.
- o Quality. Beneficiaries should receive high quality care that increases the likelihood of needed and desired health outcomes.
- o Access. Beneficiaries should have timely access to all medically necessary and appropriate covered care.
- o Financial Liability. Out-of-pocket expenditures under the plan should not be greater than the cost sharing that beneficiaries would experience if they stayed in fee-for-service Medicare. This includes provisions to preclude extra balance billing for authorized plan services and to provide the same protections afforded under Medicare fee-for-service for non-authorized services. In addition, plan premiums should not vary based on health status or age.
- o Financial Soundness. Beneficiaries should be protected from the risk of interruptions to their care that could result from the insolvency of a plan or its providers.
- o Appeals, Complaints, and Grievances. Beneficiaries should have access to timely and fair resolution of any appeals, complaints, or grievances.

- o Information. Beneficiaries should have timely access to comprehensive, understandable information about plans, including: basic policies and procedures, consumer satisfaction, and plan performance.
- o Marketing and Enrollment. Beneficiaries should not be coerced to enroll in a plan, prevented from enrolling in a plan of their choice due to health status, or encouraged to disenroll from a plan.
- o Accountability. Beneficiaries should be assured that those purchasing services on their behalf will establish, monitor, and enforce beneficiary protections.

## II. IMPROVING MEDICARE'S MANAGED CARE PAYMENT METHODOLOGY

The plan phases in a series of improvements in Medicare payment methods, while testing alternatives. Under the plan, the Administration would:

- o Reduce extreme regional variation in the capitated payments to plans contracting with Medicare and immediately increase rates in rural areas by: delinking payments to plans from fee-for-service expenditures at the local level; adopting a blended payment methodology; and creating a minimum payment amount.
- o Maintain linkage and equity with the fee-for-service program at the national level by updating payment rates based on projected growth in per capita Medicare spending.
- o Test new risk adjusters for capitated payments in order to improve the accuracy of rates and to reduce the impact of selection on Medicare payments.
- o Conduct demonstrations on a competitive pricing methodology, under which Medicare's payments to plans would be based on plan bids.
- o Create a partial-risk payment alternative to the current inefficient cost payment option. Under the partial-risk payment methodology, plans would be paid on a fee-for-service basis subject to an annual limit. Plans would share in savings achieved below the limit.

Specific savings proposals are discussed in Section VII under "Medicare Managed Care."

### **III. FOSTERING CONTINUOUS IMPROVEMENT IN HEALTH PLAN QUALITY**

The plan would enhance quality assurance by building on existing mechanisms and cooperative efforts with national organizations. Under the plan, the Administration would:

- o Create partnerships with public and private purchasers, consumer groups, and managed care plans to focus on developing population-based outcome measures and encounter data systems that could assure quality of care.
- o Collaborate with national quality assurance organizations to develop plan performance indicators relevant to the Medicare population.
- o Expedite the process for terminating non-compliant plans and expand authority for intermediate sanctions (e.g., freezing new enrollment).
- o Develop a proposed regulation (to be released in August 1997) establishing consistent standards for quality assurance and performance measurement. These standards, when implemented, would replace the "50/50" rule, which requires Medicare and Medicaid membership not to exceed 50 percent of total plan enrollment. As an interim measure, they would give the HHS Secretary authority to waive the "50/50" rule in specified circumstances.
- o Give plans the option of contracting with an independent organization, approved by the HHS Secretary, to certify that the plan has met internal quality assurance requirements.

### **IV. BENEFICIARY INFORMATION/LEVEL PLAYING FIELD**

The plan would develop information to help Medicare beneficiaries become more informed about their choices, and level the playing field for Medicare managed care plans and Medicare supplemental coverage. The plan would:

- o Authorize the HHS Secretary to (1) develop standardized comparative materials for beneficiaries about managed care and Medigap plans, and (2) contract out to a third-party to provide enrollment and disenrollment activities for Medicare managed care plans. To assure adequate funding, all plans would contribute to the costs of these activities.
- o Work with the National Association of Insurance Commissioners to develop an approach to standardize additional benefits offered by managed care plans and to move to community rating of Medigap policies.

- o Eliminate barriers to beneficiaries enrolling in the managed care or Medigap plan of their choice by: (1) establishing an annual 30-day simultaneous open enrollment period for all managed care and Medigap plans; (2) giving newly-entitled beneficiaries a special open enrollment period; and (3) allowing beneficiaries leaving managed care to re-enroll in Medigap plans, without prejudice.
- o Strengthen current safeguards for managed care enrollees by protecting enrollees who go outside their plans to receive services without plan authorization.

## **V. EXPANDED BENEFITS**

The plan strengthens the Medicare benefit package by expanding coverage for important preventive care, and it takes steps to encourage families to keep beneficiaries in the community and simultaneously avoid institutional costs for Medicare and Medicaid. The new preventive benefits include: annual mammograms for beneficiaries age 50 and over; waiver of cost-sharing for mammography; several procedures for the early detection of colorectal cancer (including barium enemas); blood glucose monitors and associated supplies and professional assistance for managing diabetes; and increasing Medicare payments for preventive injections.

The plan also establishes a new respite care benefit for beneficiaries with Alzheimer's disease or other irreversible dementia. Under this benefit, Medicare beneficiaries with cognitive impairment would be eligible to receive up to 32 hours per year of non-medical care, giving the beneficiary's informal care givers (e.g., children, spouse) a break from the constant demands of caring for these beneficiaries.

## **VI. STRENGTHENING MEDICARE**

The President's plan saves \$124 billion over seven years (FY 1996-2002)<sup>1</sup> and ensures the solvency of the Hospital Insurance, or Part A, Trust Fund through at least the next decade.

To achieve these savings, the plan modifies Medicare payments in a number of ways. The plan ensures that Medicare acts as a prudent purchaser and provides incentives to hospitals for efficiency by constraining updates for hospital operating costs, reimbursing reasonable levels for capital costs, reforming medical education payments, reforming add-on payments for extremely costly (i.e., outlier) cases, and reforming the rules governing transfers from a hospital to a post-acute care facility.

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<sup>1</sup>All savings and cost estimates for Medicare are from preliminary CBO scoring dated February 28, 1996.

The plan also changes Medicare physician payments by (1) tying allowable volume growth, which in turn affects fee increases, to the growth in real gross domestic product (GDP) per capita (plus an additional factor), and (2) implementing proposals that create incentives for physicians to deliver quality care efficiently. In addition, the plan reforms payments to home health agencies and skilled nursing facilities by establishing interim payment systems in preparation for rapid implementation of a new prospective payment system.

The plan achieves savings from managed care by tying growth in managed care payments to overall Medicare growth per person. It also removes payments for graduate medical education and disproportionate share hospitals from the AAPCC and redistributes all of the savings to ensure that teaching hospitals caring for Medicare managed care enrollees are compensated directly for the cost of training physicians. Finally, the plan maintains the Part B premium at 25 percent of program costs, reduces payments for durable medical equipment and ambulatory service center services, ensures that Medicare pays for services only after a beneficiary's primary insurance has paid appropriately, reduces the regulatory burden on clinical labs under the Clinical Laboratory Amendments Act (CLIA), and employs a wide variety of strong new initiatives to combat fraud and abuse.

## VII. MEDICARE SAVINGS PROPOSALS

### Part A -- Hospital Insurance Trust Fund

Medicare Part A provides insurance coverage for hospital, home health, skilled nursing facility (SNF), and hospice care. Most Americans age 65 or older are entitled to Part A coverage. This coverage is financed primarily through a payroll tax of 2.9 percent, paid equally by the individual and employer. Reductions in Part A expenditures, combined with reform of the home health benefit, will extend the solvency of the Part A Trust Fund through at least the next decade.

Under Medicare, hospitals are paid in one of two ways. Most are paid under a prospective payment system (PPS), under which fixed hospital payments per admission are established based on a patient's diagnosis before services are provided. Certain specialty hospitals (i.e., rehabilitation, childrens, long-term care, and psychiatric care hospitals) are paid based on their costs in a base year.

#### Hospital Proposals

- Reduce the "Market Basket" Payment Update for Inpatient Hospital Services. Under current law, inpatient hospital prospective payment rates are updated annually by a "market basket index" that reflects inflation in the prices of operating an inpatient facility. The update has often been reduced in past budget reconciliation acts -- in OBRA 1993, it was reduced by between 0.5 and 2.5 percentage points in FY 1994-1997. An update of

less than the full market basket is given to reflect anticipated productivity gains and provide an incentive for hospitals to increase efficiency. **This proposal would reduce the hospital market basket index update for prospectively paid hospitals by 1.5 percentage points for each year between FY 1997 and FY 2002.** For 1997, a hospital paid under the prospective payment system would receive about a 2.1 percent increase rather than about a 3.1 percent increase (which reflects the current law reduction of .5 percentage point for that year). The proposal would continue the OBRA 1993 reductions, thereby eliminating a sudden increase in baseline spending that would occur under current law. The Prospective Payment Assessment Commission (ProPAC), created by Congress to offer advice on policies affecting Medicare payments to hospitals and other facilities, recommends a market basket reduction of 1.5 to 2.0 percentage points for the short term.

**This proposal also would reduce the update by 1.5 percentage points in FY 1997-2002 for hospitals that are exempt from Medicare's hospital prospective payment system (i.e., psychiatric, rehabilitation, long-term care, cancer, and children's hospitals).** This proposal also would reform the methodology for paying PPS-exempt facilities. Exempt hospitals would continue to be reimbursed based on their costs in a base year, subject to limits, but the base year would be updated to use more recent data. Cost limits would be subject to a ceiling of 150 percent of the national average and a floor of 70 percent of the national average (specific to each type of facility). Facilities still would be eligible for payments above their limits under certain conditions, but incentive payments for facilities whose costs are below their targets would be ended.

**Seven-year savings from reducing the hospital market basket index update are \$19.7 billion. Seven-year savings from reducing the PPS-exempt hospital market basket index update are \$1.1 billion.**

- Extend OBRA 1990 Reductions for Hospital Capital Payments. Hospitals receive payments for their capital-related costs (e.g., construction, maintenance) based on the number of Medicare patients they treat. **This proposal would set future hospital capital payments by updating 1995 capital rates for inflation. In effect, this proposal permanently captures the savings from the OBRA 1990 capital provision, which limited payments for capital under PPS to 90 percent of what they would have been under a reasonable cost system.** Without this extension, capital payments to hospitals increased about 16 percent in FY 1996. This proposal could be considered an efficiency adjustment to recoup excessive Medicare capital reimbursement of the late 1980s. In addition, the current base amount reflects overestimated capital costs, and should be modified to reflect more accurate data. The Office of Inspector General recommends that capital payments be reduced to prevent overpayment to hospitals.

In addition, this proposal would pay 85 percent of capital costs for PPS-exempt hospitals and units for FY 1997-2002.

**Seven-year savings from limiting capital payments to prospective payment hospitals are \$6.1 billion. Seven-year savings from limiting capital payments for non-prospective payment hospitals are \$1.4 billion.**

- Reform of Long-term Care Hospital Reimbursement. Hospitals with average stays of more than 25 days by all patients are considered long-term care hospitals. These hospitals are currently exempt from the prospective payment system. **This proposal would make new long-term care hospitals subject to the PPS, effective upon enactment.** PPS has proven to be an effective mechanism for increasing efficiency and controlling costs in other inpatient hospitals.

**Seven-year savings are \$0.7 billion.**

- Graduate Medical Education (GME) Reform. Medicare pays teaching hospitals for a share of the direct (i.e., resident salaries and fringe benefits, teaching costs, and institutional overhead) and indirect costs they incur in providing graduate medical education. The indirect costs are reimbursed through the IME adjustment to the diagnosis related groups (DRGs). But direct costs are based on Medicare's share of hospital-specific, per resident amounts that reflect a hospital's 1984 cost per resident, indexed for increases in the level of consumer prices.

**This proposal actually contains three individual proposals, including two program expansions.<sup>2</sup> Most experts agree that the current GME and IME payment methodology is flawed. ProPAC analysis suggests that teaching hospitals are overcompensated, especially in terms of the IME adjustment, and there is general consensus (e.g., Council of Graduate Medical Education, the Physician Payment Review Commission) that GME/IME payments encourage hospital-based specialty training at the expense of primary care training. This proposal is designed to slow the growth in Medicare spending on graduate medical education while encouraging more primary care training.**

**Seven-year savings are \$7.4 billion.**

- **Establish National Commission on Medical Education and Workforce Priorities. This proposal would establish the National Commission on Medical Education and Workforce Priorities within the Department of Health and Human Services. The Commission would: (1) develop and recommend policies to address the preservation of academic health centers' research and educational capacity and the supply, composition, and support of the future health care workforce; and (2) make recommendations concerning the most effective allocation of training resources to ensure that the numbers and competencies of health care professionals are responsive to national needs.**

**There are no Medicare savings or costs associated with this proposal.**

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<sup>2</sup>The three proposals would: (1) cap the total number and the number of non-primary care residency positions reimbursed under Medicare at the current level; (2) count work in non-hospital settings for IME; and (3) allow GME payments to non-hospitals (e.g., Federally Qualified Health Centers) for primary care residents in those settings, when a hospital is not paying for the resident's salary in that setting.

- Reduce Indirect Medical Education (IME) Adjustment to 6 percent. Through the IME adjustment, Medicare recognizes the higher indirect costs that teaching hospitals incur in running a teaching program (e.g., additional tests and procedures that residents may order as part of their training). Currently, the IME adjustment is based on a teaching hospital's ratio of interns and residents to beds (IRB), with payments increasing by about 7.7 percent for each 10 percent increase in a hospital's IRB. ProPAC analysis suggests that the current IME adjustment overcompensates hospitals. It recommends initially reducing the adjustment to 7 percent and, in the future, further reducing it to a level that corresponds more closely with the actual relationship between teaching intensity and costs. Health Care Financing Administration (HCFA) data also suggest that a lower IME adjustment would more accurately reflect what teaching hospitals actually experience. **This proposal would reduce the IME adjustment to 6.5 percent in FY 1997, 6.3 percent in FY 1998, and 6 percent in FY 1999 and thereafter.**

Seven-year savings are \$6.3 billion.

- Refine Outlier Payment Methodology. Currently, hospitals are eligible for additional payments, called outlier payments, when they serve long-term patients or those who require exceptionally costly care. When the outlier amount is paid, teaching and disproportionate share (DSH) hospitals also receive additional IME and DSH payments added to the outlier payments. **This proposal would eliminate increased IME and DSH payments that are attributable to the outlier payments, but would allow hospitals to count IME and DSH as part of costs that trigger outlier payments, effective FY 1997.** Consequently, teaching and DSH hospitals would receive a greater portion of outlier payments. ProPAC supports this change as being consistent with the intent of the PPS.

Seven-year savings are \$3.2 billion.

- Redefine Hospital "Transfer." Currently, hospitals that move patients to PPS-exempt facilities and SNFs "discharge" the patient and receive a full DRG payment. This policy overpays hospitals and contributes to higher post-acute expenditure growth rates, because these sites end up caring for more acutely ill patients. **Under this proposal, moving a patient from a PPS hospital to a non-PPS hospital or SNF would be considered a hospital "transfer" rather than a discharge. Reimbursement for each transfer reimbursements would be made on a per diem basis, subject to a cap equivalent to the DRG payment.**

Seven-year savings are \$5 billion.

- Expand "Centers of Excellence" Demonstration. Currently, HCFA is conducting a demonstration that pays 10 facilities, considered "centers of excellence," a flat fee to provide cataract or coronary artery bypass graft (CABG) surgery. The facilities were selected on the basis of their outstanding experience, outcomes, and efficiency in performing these procedures. **This proposal would expand centers of excellence demonstrations to all urban areas by allowing Medicare to pay select facilities a single rate for all services associated with CABG surgery or other heart procedures, knee surgery, hip surgery, and other procedures that the HHS Secretary determines appropriate.** This approach gives hospitals incentives to provide high quality care more efficiently. Beneficiaries would not be required to receive services at these centers.

**Seven-year savings are \$0.2 billion.**

- Sole Community Hospitals (SCH). SCHs are the sole source of inpatient services reasonably available in a geographic area. Payments for SCH services are currently based on FY 1982 or FY 1987 costs (updated annually) or a standard federal amount. **This proposal would base SCH payments on FY 1992 and 1993 costs, although SCHs could still be paid based on updated 1982 or 1987 costs or the federal rate if it would yield higher payments.**

**Seven-year investment is \$0.3 billion.**

- Rural Referral Centers. The Rural Referral Center designation is a special classification for large rural hospitals that provide a large amount of specialized hospital services. **This proposal would allow hospitals designated as rural referral centers as of FY 1994 to continue to be treated as rural referral centers. This proposal also would increase the wage adjustment for rural referral centers whose wages are between 100 percent and 108 percent of the average wage in their area.**

**Seven-year investment is \$0.1 billion.**

- Telemedicine. Telemedicine uses telecommunications technology to provide patients with real-time interactive examination and consultation from medical professionals who are at a remote site. **This proposal would establish a grant program to support the development of telemedicine networks in rural areas.**
- Rural Health Outreach Grant Program. This proposal would establish a grant program to demonstrate the effectiveness of outreach to populations in rural areas that do not normally seek, or have access to, health or mental health services.

**Seven-year investment for both telemedicine and the rural health outreach grant program is \$0.2 billion.**

- Medicare Dependent Hospitals. OBRA 1989 established a Medicare Dependent Hospitals classification, which allowed small rural hospitals with more than 60 percent of their utilization from Medicare patients to receive higher payments based on the method Sole Community Hospitals. **This classification was discontinued as of FY 1995. This provision would once again reinstate the classification and allow Medicare Dependent Hospitals to receive higher payments.**

**Seven-year investment is \$0.1 billion.**

- Rural Primary Care Hospitals (RPCH). The RPCH program seeks to preserve rural residents' access to hospital care by allowing certain hospitals to convert to limited service, short-stay hospitals and receive reasonable cost reimbursement. The program is currently authorized in only seven states. **This proposal would make several improvements to the RPCH program, including: extending the program to all states, expanding the allowable number of beds, extending the allowable length of stay and establishing a minimum separation distance between RPCHs. This proposal also would eliminate the Essential Access Community Hospital (EACH) designation for new hospitals, while allowing existing EACHs to continue to be paid on a reasonable cost basis.**

**Seven-year investment is \$0.2 billion.**

#### Home Health Agencies

- Extend Savings from OBRA 1993 Home Health Cost Limits Freeze. Medicare pays for covered home health services on a cost basis, subject to limits that are updated annually. OBRA 1993 eliminated the update for home health cost limits from July 1, 1994 to July 1, 1996. **Although this proposal would not extend the freeze, it would permanently**

**extend the savings realized from setting future home health limits by not allowing for the inflation that occurred during the freeze. Without new legislation, spending would revert to pre-freeze levels.**

- **Reform Home Health Payment:** Home health services are one of the fastest growing areas of Medicare expenditures, and there is widespread consensus that the high rate of growth in home health expenditures must be addressed. This proposal combines three individual proposals designed to reform the reimbursement system for home health services, improve financial management, and control fraud and abuse:

1. Establish a Prospective Payment System (PPS) for Home Health Services -- Medicare reimburses home health agencies on a cost basis, subject to limits. However, Medicare's retrospective reimbursement rates often contribute to increased expenditures by failing to control volume. **This proposal would constrain growth in expenditures through lower cost limits over the short run and implement a per-episode PPS for home health in 1999.** Budget-neutral rates under the PPS would be calculated after first reducing, by 15 percent, expenditures that exist on the last day prior to implementation. HCFA is currently running a demonstration to test a per-episode home health PPS.

**This proposal would take the following interim steps to help reduce home health costs and control volume:**

- ▶ **Beginning October 1, 1996, reduce the current cost limits from 112 percent of the mean to 105 percent of the median.**
- ▶ **Beginning October 1, 1996, implement an additional limit, based upon aggregate per beneficiary costs in a base year.** Payment would be the lesser of: (1) the actual costs (defined as Medicare allowable costs paid on a reasonable cost basis); (2) the per visit cost limits; or (3) a new agency-specific per beneficiary annual limit calculated from 1994 reasonable costs. Effective January 1, 1997, or as soon as feasible, the agency-specific per beneficiary limit would be modified to provide for regional or national variations in utilization by calculating the limit through a blend of 75 percent of the agency-specific cost or utilization in 1994 with 25 percent of the national or regional cost or utilization in 1994.

Home health agencies (HHAs) with costs or utilization experience less than 125 percent of the mean national or regional aggregate per beneficiary cost or utilization experience for 1994, and with year-end costs below the agency-specific per beneficiary limit, would share 50 percent of the savings for FYs 1997-1999. The shared savings, however, could not exceed 5 percent of an agency's aggregate Medicare reasonable cost in a year. The interim reimbursement mechanism

would be in effect until a full per-episode home health PPS is implemented in 1999.

2. Eliminate Periodic Interim Payments (PIP) for HHAs -- PIP was established to help simplify cash flow for new home health providers by paying them a set amount on a bi-weekly basis. Then, at the end of the year, PIP is reconciled with actual expenditures. But, with about 100 new HHAs joining Medicare each month, access to home health care is no longer a problem, and new providers no longer need PIP to encourage them to participate in Medicare. Further, the Office of Inspector General has found that Medicare tends to overpay providers who receive PIP, and has a hard time recovering the money. **This proposal would eliminate PIP for home health agencies simultaneous with PPS implementation.**

3. Base Payments on Location of Service Delivery -- HHAs are often established with a home office in an urban area and branches in rural areas. When HHAs bill Medicare, payment is based on the higher wage rate for the urban area, even though the service delivery occurred in a rural area. **Under this proposal, payments would be based on the location where the services are rendered, not where the services are billed, beginning January 1, 1997.**

**Total seven-year savings from home health reforms are \$9.1 billion.**

- **Shift Financing of a Part of the Home Health Benefit to Part B.** This proposal divides the financing of the Medicare home health benefit between Part A and Part B -- without changing general coverage and eligibility rules or imposing any beneficiary cost sharing. Under this proposal, effective in FY 1997, the first 100 visits following a three-day hospital stay would be reimbursed under Part A. All other visits, including those not following hospitalization, would be reimbursed under Part B. (Part B visits would not be subject to the Part B coinsurance or deductible; this shift also would not impact the Part B premium.) For those beneficiaries who are eligible for only Part A or Part B, the benefit would be financed completely by the part for which they are eligible. This proposal also would clarify current policy on the definitions of "intermittent" and "part-time or intermittent" skilled nursing and home health aide services. By creating a post-hospital home health benefit under Part A, this proposal would recognize that Part A covers only acute care services. It allows Part B to finance the longer-term, and more expensive, portion of home health services. And by restructuring the home health benefit so that Part B bears more of the costs, this proposal would extend the solvency of the Part A Trust Fund.

**Medicare spending shifted from Part A to Part B over seven years is \$62.1 billion.**

## Skilled Nursing Facilities

- **Extend Savings from OBRA 1993 SNF Cost Limits Freeze.** Payments for SNF routine services are made on a reasonable cost basis, subject to certain SNF cost limits that are updated annually. OBRA 1993 eliminated the update for FY 1994 and FY 1995. Beginning in FY 1997, SNF routine payments would not reflect the effects of the freeze. **Although this proposal would not extend the freeze, it would permanently extend the savings realized from setting future limits by not allowing for the inflation that occurred during the freeze.**
- **Reform the SNF Reimbursement System.** Within Medicare, the SNF program is one of the fastest growing benefits, with both increased volume and costs driving the overall increase in SNF expenditures. SNFs provide daily skilled nursing care to Medicare beneficiaries for conditions related to a prior hospitalization. Medicare reimburses SNFs on a cost basis, subject to certain limits. For SNFs, limits are applied only to the routine services (i.e., room and board, nursing, administration, and other overhead); ancillary (e.g., drugs, physical therapy, speech therapy) and capital-related costs are not subject to any limits. Medicare's current retrospective reimbursement rates contribute to rising expenditures by providing incentives to increase costs.

### **This proposal would make the following changes in SNF reimbursement:**

- ▶ **Establish an interim prospective rate for routine costs, beginning in FY 1997. These rates would be based on facility-specific costs, subject to regional limits.** The regional limits would be based on data from freestanding SNFs only. Freestanding SNFs tend to have lower costs than hospital-based SNFs. SNFs would be reimbursed under this system until a full SNF PPS is implemented in FY 1998.
- ▶ **Eliminate new provider exemptions and new exceptions to the cost limits, beginning in FY 1997.** Currently, new Medicare SNF providers are exempted from the cost limits for three to four years. These exemptions allow SNFs to be reimbursed for inflated costs for several years. An exception currently is provided for SNFs that provide atypical care (e.g., sub-acute care) or are forced to operate under extraordinary circumstances (e.g., earthquakes, hurricanes). In the case of exceptions, an upward adjustment to the cost limit is determined. Exceptions effectively allow SNFs to fully bill Medicare for more costly sub-acute care services, which Medicare reimbursement would not completely cover. SNFs that had exceptions in the base year would be protected under a hold harmless provision, because the limit plus the exception amount would be included in the

base year cost. The HHS Secretary may also make future adjustments, based on case mix, to the routine payment rates.

- ▶ **Establish limits on ancillary services.** Ancillary services would be subject to limits based on amounts payable for similar services on a fee-for-service basis under Part B.
  
- ▶ **Require consolidated billing, beginning in FY 1997.** The HHS Office of Inspector General and others have reported that some Part B suppliers bill Medicare for supplies that were never delivered to nursing home residents. **This proposal would require SNFs to bill Medicare for all services its residents receive (except the services of physicians, certified nurse midwives, psychologists, hospice services, and nurse anesthetists), prohibiting payment to any entity other than the SNF for services or supplies furnished to Medicare-covered inpatients. SNFs also would be required to include HCFA Common Procedure Codes on their Part B bills.** This proposal will reduce double billing for some supplies and services and reduce beneficiary Part B copayments for services covered under Part A. It also will provide data necessary to construct a SNF PPS rate that covers ancillary services. (This proposal is discussed in the "Eliminating Waste, Fraud, and Abuse" section.)
  
- ▶ **Establish a full SNF PPS, beginning in FY 1998.** The prospective rate would be designed to cover all three (i.e., routine, ancillary, and capital-related) SNF costs. Budget-neutral rates under the new system would be calculated after first reducing, by 7 percent, rates that exist on the last day of FY 1997.

- **Establish Therapy Guidelines.** As part of their SNF care, Medicare beneficiaries are eligible for occupational (OT), physical (PT), speech, and respiratory therapies. While some SNFs employ their own therapists; many use contractors to provide these services. In the latter case, either the SNF or the contractors can bill Medicare. Medicare spending on therapy services has risen significantly over the last several years, and Medicare has established salary equivalency guidelines for PT and respiratory therapy. These guidelines determine the maximum Medicare payment for this service. However, similar guidelines have not been developed for OT and speech-language pathology. In a March 1995 General Accounting Office (GAO) report, GAO found that Medicare needs tighter rules to curtail overcharges for nursing home therapy and recommended that HCFA set limits to ensure that Medicare does not pay more for therapy services than other health care purchasers. **This proposal would apply salary equivalency guidelines for OT and speech language therapy and update the existing PT and respiratory therapy guidelines, effective October 1, 1996.**

**Total seven-year savings from SNF reforms are \$8.3 billion.** (Note: Some savings from the consolidated billing and therapy guidelines provisions are attributable to Part B.)

#### Medicare Managed Care

- **Reform Medicare Managed Care.** While managed care appears to have reduced private health care costs, studies indicate that it does not reduce Medicare costs, due to a flawed payment methodology and favorable selection. Under current law, Medicare is required to pay HMOs a capitated rate equal to 95 percent of fee-for-service costs.

**This proposal includes several policies to improve the current payment methodology. It would:**

- ▶ **Reduce current geographic variations in managed care payment rates.** This proposal would raise payment levels for certain counties, encouraging HMOs to enter new markets and provide more beneficiaries with a choice of plans. It also would limit payments for counties whose rates have been inflated by high service utilization in the fee-for-service sector.
- ▶ **Tie managed care payment growth to overall Medicare expenditure growth per person.** This growth rate allows for a fair and reasonable increase in managed care payments.
- ▶ **Eliminate the GME, IME and DSH payments included in HMO rates; redistribute these funds to teaching hospitals and managed care plans with teaching programs.** These payments would be distributed directly to academic

medical centers, and to HMOs that run their own residency programs (i.e., incur most of the costs of an approved residency program).

- ▶ **Conduct a competitive pricing demonstration to test a market-based alternative payment methodology.** Under the demonstration, rates to all HMOs in an area would be established using a competitive pricing methodology. It is part of a long-range strategy to improve the payment methodology for managed care products.

**Seven-year savings from revising the Medicare managed care payment methodology are \$23.7 billion.** (Note: Some savings from this provision are attributable to Part B.)

## **Part B -- Supplementary Medical Insurance Trust Fund**

Medicare Part B provides insurance coverage for physician services, hospital outpatient services (including diagnostic testing and ambulatory surgery), clinical laboratory services, durable medical equipment (e.g, wheelchairs, oxygen services, medical supplies), and other medical services. Payments for physician fees, clinical laboratory services, and durable medical equipment are based on fee schedules. Payments for other services reasonable costs or reasonable charges. The program provides for annual updates of based on payment amounts to reflect inflation and other factors.

Part B coverage is voluntary; almost all of those who are eligible for Part A coverage choose to buy Part B coverage. Part B is financed through (1) beneficiaries' monthly premiums which will continue to cover 25 percent of program costs under the Administration's proposal, and (2) general Federal revenue.

### Physicians

- Establish Single Conversion Factor and Reform Method for Updating Physician Fees. Each year, the fees paid to doctors who serve Medicare beneficiaries are updated to account for medical inflation. In addition, the update is adjusted according to a formula that compares actual spending on physicians' services to a spending "standard" established each year according to a complex statutory formula. For purposes of updating fees, Medicare divides doctors' services into three categories: surgical services, primary care, and all other services (e.g., diagnostic tests). Because of different growth rates and spending standards, the three categories have received different updates each year since 1992, when a major payment reform was implemented.

Between 1992 and 1995, the basic payments increased as follows: 29.7 percent for surgical services, 19.6 percent for primary care services, and 13.8 percent for medical services. The Physician Payment Review Commission (PPRC) has stated repeatedly that these different rates of increase are inconsistent with the basic principle of physician payment reform -- i.e., physician fees should vary only according to the relative amount of resources used to provide services.

**This proposal would implement several PPRC recommendations to improve the physician payment system.** First, a single conversion factor would go into effect in 1997 (the conversion factors for 1996 will be at the levels established by the HHS Secretary under current law). Second, the single conversion factor for 1997 will be based on the 1996 conversion factor for primary care services (\$35.42), updated for 1997 based on performance relative to the overall Medicare Volume Performance Standards (MVPS) for FY 1995. Third, to set spending growth targets beginning with FY 1996, the MVPS would be replaced with a sustainable growth rate based on growth in real GDP per capita plus one percentage point (rather than historical volume and intensity growth). This policy would affect updates to the single conversion factor beginning in 1998. Fourth, an upper limit on fee increases of 3 percentage points above medical inflation would be set. And fifth, the lower limit on fee increases would be increased from 5 percentage points to 8.25 percentage points.

**Seven-year savings are \$13.5 billion.**

- Make Single Payment for Surgery. Under certain conditions, Medicare will make an extra payment for each physician or other practitioner who assists the primary surgeon during an operation. These "assistants-at-surgery" are paid a percentage of the fee paid to the primary surgeon. Both the Rand Corporation and the PPRC have reported that there is substantial geographic variation in the use of assistants for the same surgical procedure. This evidence suggests a lack of medical consensus on the use of assistants, which suggests that, in some cases, the use of an assistant-at-surgery may not meet the criteria for medical necessity.

**This proposal would make the same payment to primary surgeons, regardless of whether they use an assistant-at-surgery for whom Medicare makes a separate payment.** In effect, Medicare's payment to the primary surgeon would be reduced by the amount of the payment for the surgeon's assistant-at-surgery. The HHS Secretary would specify exceptions for specific procedures or special situations.

**Seven-year savings are \$0.6 billion.**

- Extend OBRA 1993 Reduction in Payments for Physician Overhead Expenses.

Medicare's fee schedule payment for each physician service is made up of three parts: payment for the physician's work, payment for overhead costs or "practice expenses" (e.g., office rent, employee wages), and payment for malpractice insurance costs. On average, about 41 percent of each payment is for overhead costs. Unlike the payment for the physician's work, which is based on an estimate of the actual resources involved in providing a service, practice expense payments are based on historical charges. In some cases, this distorts the fee schedule, because the resulting practice expense payment is inappropriately large relative to the work payment.

In 1993, Congress considered legislation to implement a permanent, resource-based payment system for practice expenses. To address the existing payment distortion and begin the transition to the new system, OBRA 1993 reduced practice expense payments for certain services. For services meeting certain conditions, the excess practice expense payment is reduced by 25 percent of the difference in 1994, 1995, and 1996, subject to a limit on the total reduction. Because it intended to have a permanent solution to the payment distortions in place by 1997, Congress limited the cut to three years (through 1996). However, legislation mandating the permanent solution was not passed until late 1994, delaying the new payment system until 1998. **This proposal would extend the OBRA 1993 practice expense payment cut for one more year (i.e., through 1997) and reduce the limit on the reduction from 128 percent to 115 percent of the physician work payment.**

**Seven-year savings are \$0.7 billion.**

- Create Incentives to Control High-Volume Inpatient Physician Services. Urban Institute research has found wide variation among hospitals in the volume of physician services per admission, even after adjusting for case severity, teaching hospital status, and disproportionate-share status. Given a limited consensus on clinical practice guidelines and regional differences in practice styles, some amount of variation in volume and intensity is inevitable. But this variation in the volume of physician services suggests there is room for efficiency improvements. This proposal would create incentives to encourage physicians with high-volume inpatient practice styles to become more efficient.

**This proposal would limit payments to groups of physicians practicing in hospitals whose volume and intensity of services per admission exceeded 120 percent of the national median for urban hospitals (125 percent in 1999 and 2000) and 140 percent for rural hospitals. For each physician practicing in hospitals above those limits, 15 percent of each payment would be withheld during the year. If the physicians collaborate in order to efficiently manage the volume and intensity of the services they provide during the year, the physicians would receive the withheld payments, plus interest at the end of the year. The policy would not be implemented until 1999, to give physicians**

time to organize themselves to control volume and intensity while maintaining the delivery of high-quality care.

**Seven-year savings are \$2.3 billion.**

- Direct Payment to Physician Assistants, Nurse Practitioners, and Clinical Nurse Specialists in Home and Ambulatory Care Settings. Medicare currently pays for services provided by physician assistants, nurse practitioners and clinical nurse specialists -- but only in limited settings (primarily rural areas and nursing facilities). **This proposal would expand coverage to include home and ambulatory care settings in which a separate facility or provider fee is not charged.** Further, these providers would have the option of billing Medicare directly for covered services (as opposed to receiving the payments through their employer).

**Seven-year investment is \$0.7 billion.**

#### Hospital Outpatient Departments (OPDs)

- Extend OBRA 1993 Reduction in Payments to Outpatient Departments Made on a "Reasonable Cost" Basis. Although there are several payment methodologies for services delivered in the hospital outpatient setting, some outpatient department services are still made on a reasonable cost basis. OBRA 1990 reduced payment for these services by 5.8 percent for FY 1991-1995. OBRA 1993 extended this reduction through FY 1998. In both cases, sole community hospitals and rural primary care hospitals are exempt from this reduction. **This proposal would permanently extend the 5.8 percent reduction.**

- Extend OBRA 1993 Reduction in Payments to Outpatient Departments for Capital Costs. Hospital outpatient departments receive payments for their capital-related costs (e.g., construction, maintenance) based on the number of Medicare patients they treat. OBRA 1990 reduced payments for outpatient department capital costs by 10 percent for FY 1992-1995. OBRA 1993 extended this reduction through FY 1998. In both cases, sole community hospitals and rural primary care hospitals are exempt from this reduction. **This proposal would permanently extend the 10 percent reduction.**

- Correct the "Formula-Driven Overpayment." Current law requires Medicare to use a flawed formula to calculate payments for most ambulatory surgeries, radiology procedures, and diagnostic services performed in hospital outpatient departments. For these services, Medicare's payments are not reduced by the full amount of beneficiary coinsurance. Thus, the Medicare payment is higher than it should be, and hospitals have an incentive to increase charges, which also increases costs to beneficiaries. **This proposal would correct this so-called "formula-driven overpayment" by allowing**

**Medicare to fully deduct beneficiary coinsurance payments received by the hospital before the program makes its payments.**

**Seven-year savings from the three OPD proposals are \$15.0 billion.**

- **Establish a Prospective Payment System for Outpatient Department Services. Medicare's current outpatient payment methodologies do not create incentives for providers to operate efficiently, and allow beneficiary coinsurance to grow as a percentage of total outpatient payments. This proposal would implement a PPS for outpatient department services, starting in 2002. The new PPS would be designed to limit growth in Medicare outpatient expenditures by providing incentives for providers to operate efficiently, and gradually reduce beneficiary coinsurance as a percentage of total outpatient payments.**

**This proposal would be implemented in a budget-neutral manner.**

#### Medicare Managed Care

- **Reform Medicare Managed Care Payments. See discussion on page 16.**

#### Other Providers

- **Freeze Durable Medical Payments and Reduce Oxygen Payments. Durable medical equipment covered by Medicare includes items ranging from electric heat pads and wheelchairs to oxygen equipment and hospital beds. Medicare also covers artificial limbs and other prosthetic and orthotic devices. Medicare's fees for these items are based on fee schedules that are updated annually by the consumer price index for urban consumers (CPI-U). Durable medical equipment is one of the fastest growing areas of Medicare spending; CBO's most recent projections (December 1995) show Medicare spending for these medical items growing by over 13 percent per year from 1996-2002. This proposal would freeze updates for durable medical equipment, and orthotics, and prosthetics from 1997-2002. It would also reduce overpriced payments for oxygen and oxygen equipment by 10 percent beginning in 1997.**

**Seven-year savings are \$2.3 billion.**

- **Reduce Updates for Ambulatory Surgical Center Fees Through 2002. Medicare pays for ambulatory surgical center (ASC) services on the basis of prospectively determined rates. These rates are updated annually for inflation using the CPI-U. OBRA 1993 eliminated updates for ASCs for FY 1994 and FY 1995. Utilization of ASC services has escalated rapidly since the mid-1980s. In addition, the number of ASC facilities has increased**

dramatically over the same period, suggesting that Medicare's payment rates are more than adequate to cover facility costs. In 1984, there were 155 ASCs participating in Medicare; by 1993, over 1,600 ASCs were participating.

**This proposal would reduce the annual CPI update for ASC fees by 2 percentage points for each year between FY 1997 and 2002.**

**Seven-year savings are \$0.8 billion.**

- Expand Centers of Excellence. See description on page 10.
- Extend Part B Premium at 25 percent of Program Costs. Premiums for 1991-1995 under the Supplementary Medical Insurance (SMI) program are specified in the Medicare law. OBRA 1993 set the Part B premium at 25 percent of SMI program costs for 1996-1998. Beginning in 1999, the percentage increase in the premium will be limited to the Social Security cost of living adjustment (COLA). **This provision would permanently set Part B premiums at 25 percent of SMI program costs.** The monthly premium in calendar year 2002 under this proposal would be \$67.50 (preliminary CBO estimate).

**Seven-year savings (net of interactions with Part B program savings) are \$6.9 billion.**

#### **Preventive Services Benefit Expansions (all in Part B)**

- Waive Cost-Sharing for Mammography Services. Although Medicare's coverage of mammography services began in 1991, only 14 percent of eligible beneficiaries without supplemental insurance received mammograms during the first two years of the benefit. One factor is the required 20 percent coinsurance. To remove financial barriers to women seeking preventive mammograms, **this proposal waives the Medicare coinsurance and the deductible, effective January 1, 1998.**
- Cover Annual Screening Mammograms for Beneficiaries Age 50 and Over. OBRA 1990 mandated coverage of biannual screening mammography for Medicare beneficiaries over age 65. **This proposal would cover annual screening mammograms for beneficiaries age 50 and over, without coinsurance or a deductible, effective January 1, 1998.**

**Seven-year investment for both mammography benefits is \$4.8 billion.**

- **Cover Colorectal Screening. Effective January 1, 1998, this proposal would cover four common preventive screening procedures -- barium enema, colonoscopy, sigmoidoscopy, fecal-occult blood test -- for detection of colorectal cancers. Current law provides for these procedures only as diagnostic services.**

**Seven-year investment is \$0.8 billion.**

- **Increase Payments to Providers for Preventive Injections. Effective January 1, 1998, this proposal would increase the payment for administration of Medicare-covered preventive injections, which include pneumonia, influenza, and hepatitis B vaccines. It is expected that enhanced payment will increase utilization of these vital preventive services. The proposal would waive the Part B deductible and coinsurance for all of these injections.**

**Seven-year investment is \$0.5 billion.**

- **Establish Diabetes Self-Management Benefit. Effective January 1, 1998, this proposal would provide Medicare coverage of diabetes outpatient self-management training services rendered by a certified provider in an outpatient setting. The proposal would also allow Medicare to cover blood-glucose monitors and associated testing strips as durable medical equipment for both Type II and Type I diabetics.**

**Seven-year investment is \$0.5 billion.**

- **Establish Respite Benefit. This proposal would establish a Medicare respite benefit for beneficiaries with Alzheimer's disease or other irreversible dementia, beginning in FY 2002. The benefit would cover up to 32 hours of care per year and would be administered through home health agencies or other entities, as determined by the HHS Secretary. The benefit would apply to home-based services as well.**

**Seven-year investment is \$1.1 billion.**

**Medicare Parts A and B (proposals that affect outlays from both the HI and SMI Trust Funds)**

**Medicare as Secondary Payer (MSP)**

Some Medicare beneficiaries have health coverage through an employer group health plan, workers' compensation, or automobile and liability insurance. In these cases, Medicare pays after a beneficiary's primary insurer, subject to certain restrictions and conditions.

- Extend Medicare as Secondary Payer (MSP) Provisions from OBRA 1993. Under current law, Medicare is a secondary payer under specified circumstances when beneficiaries are covered by other third-party payers. Medicare is secondary payer to workers' compensation, automobile, medical, no-fault, and liability insurance. To identify primary payers, OBRA 1993 extended, through FY 1998, the data match among HCFA, the Social Security Administration (SSA), and the Internal Revenue Service (IRS). In addition, OBRA 1993 extended, through FY 1998, an OBRA 1990 provision making Medicare the secondary payor for ESRD beneficiaries who are enrolled in employer group health plans for 18 months after they become eligible for Medicare benefits. Finally, OBRA 1993 also extended, through FY 1998, an OBRA 1990 provision making Medicare the secondary payor for disabled beneficiaries with employer-based health insurance. **This proposal would permanently extend these three MSP provisions.**

**Seven-year savings (Part A and B combined) are \$5.6 billion.**

- Establish Better Coordination of Insurance Coverage. **This proposal would require a beneficiary's other insurance plan to tell Medicare when that beneficiary is covered.** Currently, Medicare has problems getting this information, resulting in billions of dollars in Medicare payments made on behalf of beneficiaries whose private insurance should have covered the service.
- Clarify Medicare Secondary Payer Authority. The Supreme Court recently invalidated long-standing Medicare rules on MSP, limiting Medicare's ability to make collections in certain situations. **This proposal would clarify Medicare's authority.**
- Eliminate Fraud and Abuse. **This proposal (described in the following section entitled "Combating Fraud and Abuse") would eliminate fraud and abuse in the Medicare by: providing Medicare with modern administrative tools to detect fraud, ensuring that individuals and entities who defraud Medicare are penalized or banned from the program; preventing participation by individuals and entities seeking to defraud the program; and by maintaining necessary resources for eliminating fraud and waste in Medicare.**

**Seven-year savings from the three proposals (Part A and B combined) are \$3.4 billion.**

- **Physician Self-Referral Prohibitions.** Medicare law prohibits physicians from making referrals to medical facilities in which they have a financial interest. This "self-referral" ban covers certain "designated health services" (e.g., laboratory tests, MRI procedures) that are specified in the law. Some general exceptions to the ban are provided in current law. **This proposal would expand the current exceptions to include services that are furnished in a "shared facility" (defined in the legislation), in ambulatory surgical**

**centers, and by hospice programs. The proposal also clarifies the requirements for permissible compensation arrangements.**

**Seven-year cost is \$0.3 billion.**

**Note: Because of rounding, savings estimates for individual proposals may not equal the total savings.**

## COMBATING FRAUD AND ABUSE

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*This President's plan combats fraud and abuse in the Medicare program by: (1) ensuring that Medicare has the necessary resources to prevent and to eliminate fraud and abuse, (2) providing Medicare with modern administrative tools to detect fraud, and (3) ensuring that individuals and entities who defraud Medicare are penalized, or even banned from the program, and that individuals and entities seeking to defraud the program are not allowed to participate.*

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### I. EXPAND OPERATION RESTORE TRUST

The initial phase of Operation Restore Trust, which was limited to five states (New York, Florida, Illinois, Texas and California), has proven that a concentrated and collaborative effort among law enforcement and program policy agencies can reverse the growing trend of Medicare fraud and abuse. The plan would expand Operation Restore Trust nationwide. The cost of these efforts will be offset by even greater savings to the Medicare Trust Funds.

Furthermore, the President's plan to attack fraud and abuse would:

- o Establish a Fraud and Abuse Control Program to coordinate HHS and Department of Justice anti-fraud activities. The program would be funded through mandatory general fund and Medicare Trust Fund appropriations.
- o Establish the Medicare Integrity System program (previously named the Benefit Quality Assurance Program) to provide a stable and increased source of funding for Medicare payment safeguards activities and ensure that claims are paid properly.
- o Establish mechanisms for tracking savings that result from Medicare payment safeguards and anti-fraud and abuse activities.

### II. UTILIZE MODERN TOOLS TO FIGHT FRAUD AND ABUSE

The plan would:

- o Allow Medicare to contract competitively with private entities that want to perform administrative activities.

### **III. ESTABLISH PROVIDER QUALIFICATIONS AND PENALTIES**

The plan would broaden HHS' authority to eliminate fraud and abuse and provide new tools to ensure stringent enforcement by:

- o Establishing new conditions to exclude from Medicare individuals and entities with a history of abuse.
- o Authorizing Medicare to require Social Security, tax identification, and employer identification numbers from entities wishing to bill Medicare. These added requirements would help the program administrators determine if employers or other individuals have a history of defrauding Medicare.
- o Creating a national data base with names of those who have a history of health care fraud, to facilitate coordination among various organizations at the state and Federal levels.
- o Extending current civil monetary penalty authority.
- o Extending the Medicare/Medicaid Anti-kickback Statute.

**Seven-year savings from our efforts to combat fraud and abuse are \$3.4 billion.**

## PROTECTING AND IMPROVING MEDICAID

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*The President's Medicaid plan saves \$59 billion in Federal expenditures over seven years. The plan has three components: unprecedented, new flexibility for states to administer the program, a per capita cap, and reduced and re-targeted disproportionate share hospital (DSH) spending. Under a per capita cap, the federal guarantee of coverage would be retained, and spending per beneficiary would be federally matched up to a set level. The cap would be set using spending per beneficiary in a base year, increased by an annual growth limit. The plan also would re-target, and limit the size of, DSH payments.*

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### I. STATE FLEXIBILITY PROVISIONS:

The President's plan would give states substantially increased flexibility in managing their Medicaid programs.

#### A. Provider Payment

The plan would:

- o Repeal the Boren Amendment.
- o Repeal other special federal payment requirements. Federal requirements related to payment for obstetrical and pediatric services would be repealed. Federal requirements that most FQHCs/RHCs be paid based on costs also would be repealed (starting in FY 1999).
- o Repeal the requirement that forces States to pay for private insurance when it is cost-effective. The plan would give States the option of purchasing group insurance and negotiating their own payment rate.

## **B. Delivery Systems**

The plan would:

- o No longer require States to seek and be granted a federal waiver to establish managed care delivery systems (e.g., primary care case management, HMOs). States would continue to offer Medicaid enrollees a choice of plan or delivery system, but they would not be required to do so in rural areas. Choice of providers within plans would be maintained in rural areas. Special provisions would be made for including Indian health providers and Native Americans in managed care systems.
- o Modify managed care requirements by repealing (1) the upper payment limit for managed care contracts and (2) federal prior approval of HMO contracts over \$100,000. States would be allowed to offer managed care in one part of the state without making available in all parts of the state. The plan also would extend the state option for a six-month lock-in and guaranteed extension of eligibility to all managed care enrollees.
- o Modify managed care quality-of-care requirements by repealing both the requirement that 25 percent of every plan's enrollees be non-Medicaid and the independent external review requirement, while adding a provision requiring states to develop a quality improvement strategy, consistent with federal standards, to ensure that managed care providers maintain reasonable access and quality health care.
- o Allow States to provide home and community-based services at state option, without federal waivers.
- o Allow States to establish programs enabling non-profit organizations to receive capitated payments for providing comprehensive acute and long-term care services to frail elderly who are eligible for institutional care.

## **C. Administration**

The plan would:

- o Repeal special minimum qualification standards for certain physicians who serve pregnant women and children.

- o Repeal federally-mandated administrative requirements. Instead, the plan would give authority to establish similar requirements for:
  - Personnel (e.g., merit personnel standards, training of sub-professional staff); and
  - Cooperative agreement requirements.
- o Re-engineer Medicaid Management Information System (MMIS) requirements to retain the required use of standardized claims formats and standardized HCFA reporting requirements.
- o Repeal the duplicative annual resident review for people with mental illness or mental retardation in nursing homes under Pre-Admission Screening and Annual Resident Review (PASARR).
- o Allow nurse-aide training to be conducted in certain rural nursing homes that are currently not allowed to conduct nurse-aide training..

#### **D. Eligibility Expansions and Simplification**

The plan would:

- o Enable states to expand or simplify eligibility for individuals up to 150 percent of the federal poverty level through a simplified and expedited procedure. The plan would continue to limit federal matching by the aggregate limit, which would be based on current law eligibility and be constrained to the lower of the aggregate cap for current eligibles or projected state spending below the cap.
- o Allow States to modify the eligibility levels under which they provide coverage for optionally-eligible groups of pregnant women and children, so long as they continue to meet the minimum mandatory federal eligibility requirements.

## **II. FEDERAL OVERSIGHT PROVISIONS**

### **A. Eligibility**

The plan would:

- o Retain current mandatory and optional eligibility groups, including welfare and SSI cash and non-cash groups, poverty level children and pregnant women, so-called “medically needy” (individuals that qualify for Medicaid by spending much of their income on high medical expenditures), qualified Medicare beneficiaries, and specified low-income Medicare beneficiaries.
- o Retain current protection against spousal impoverishment.

### **B. Services**

The plan would:

- o Retain the requirement that states continue to offer all Medicaid mandatory services.

### **C. Payment**

The plan would:

- o Allow States to impose nominal copayments on HMO enrollees. The plan would continue all other current law restrictions on copayments.
- o Retain requirement for federal matching and DSH payment requirements from the 1987 and 1991 laws, and per hospital limits included in OBRA 93. The plan would also retain the prohibition on using so-called “provider taxes and donations” as state spending in order to get Federal matching payments.

### **D. Administration**

The plan would:

- o Expand the Medicaid Eligibility Quality Control sample size to a level necessary to ensure statistically valid findings. The number of beneficiaries used to calculate the cap would be adjusted if the eligibility error rate exceeded the current law standard of three percent of total eligibles. Error rates would be determined for each of the four groups.

- o Refine current reporting requirements to develop an enforcement mechanism for the per capita cap.

## E. Quality

The plan would:

- o Retain quality-of-care provisions, such as OBRA 87 nursing home reform provisions and the regulation of intermediate care facilities for people with mental retardation, as well as uncapped funding for the state survey and certification activities, and peer review organization (PRO) utilization review provisions.
- o Continue beneficiary protection requirements and administrative provisions that require states to ensure quality of care:
  - Use a single state agency to administer or supervise the administration of the plan;
  - Provide reasonable opportunities for all citizens to appeal and obtain a hearing on State actions;
  - Submit proposed program changes for public review and comment;
  - Make post-decisional records publicly available (e.g., policy guidelines, correspondence, court filings);
  - Consult with medical experts and establish procedures regarding medical appropriateness and standards of care paid for under Medicaid;
  - Safeguard information about recipients.
- o Conduct a study to investigate the relationship among quality, access and provider payments to address the need for adequate access to Medicaid.
- o Require public notice and comment when determining nursing home payment rates.
- o Retain current fraud and abuse provisions and uncapped funding for the State fraud control units.

- o Change requirements related to State contracts with health plans:
  - States must develop an overall quality improvement strategy, including plan standards, monitoring strategies, and data analysis;
  - States may require plans to report certain information from the plan's patient data;
  - Health plans must demonstrate the capacity to deliver all contracted services for all populations; and
  - Health plans must maintain an internal quality assurance program and grievance process.

#### **F. Current Demonstration Waivers**

The plan would subject all States to the per capita limits, including those with statewide demonstration programs. The same per capita growth rates would apply to all states.

- o Enrollment Base: The plan would permit states that have implemented demonstration programs to choose between two approaches for maintaining their eligibility expansion: (1) including demonstration eligibles in their enrollment base for calculating their aggregate limit, or (2) calculating their aggregate limit off of current law eligibles, and expanding enrollment in a budget-neutral manner within this cap.
- o Interaction with DSH Changes: The plan would not redefine DSH expenditures that had been re-directed to capitation payments.

### **III. PER CAPITA GROWTH LIMITS POLICY**

A "per capita cap" policy limits federal spending without risking the loss of health coverage. It sets, for each state, a federal spending "cap" per beneficiary, which adapts automatically to the size and type of each state's Medicaid beneficiary population.

Under the President's plan, the cap would limit per beneficiary spending growth to a specified index. If a state's actual spending exceeded the cap, the federal government would match only up to the cap, using the current federal medical assistance percentage (FMAP) for the State.

The cap would be coupled with enhanced flexibility, enabling each state to use individual strategies to control Medicaid costs.

## **A. Calculation of the Cap**

Under the plan, the cap would be the product of three components:

- o total state and federal spending per beneficiary (annualized) in 1995, the base year;
- o an index (for years between the base year and the current year);
- o the number of beneficiaries (annualized) in the current year.

To allow for a change in the mix of Medicaid beneficiaries over time, the plan would calculate the cap by using the specific spending per beneficiary and number of beneficiaries in four subgroups: the aged, individuals with disabilities, non-disabled adults, and non-disabled children. Once the cap is calculated, it would be multiplied by the FMAP to calculate the maximum federal spending in each state.

The per capita cap would become effective in FY 1997.

## **B. Spending**

The plan would:

- o Exclude from the cap, payments for DSH, state fraud control units, survey and certification, and Medicare premiums and cost-sharing. Also excluded from the cap are payments to the Indian Health Service and other Indian health providers and the Vaccines for Children Program.
- o Include most administrative costs in the base year calculation.
- o Adjust the base year for disallowances and prior period adjustments.
- o Make Section 1115 demonstrations subject to the per capita limits. States would continue to be able to expand and simplify eligibility in a budget-neutral manner.

## **C. Beneficiaries**

The plan would:

- o Make all beneficiaries, except qualified Medicare beneficiaries and any new groups covered under state eligibility expansions, subject to the cap.

## D. Index

The plan would:

- o Index growth in spending per beneficiary using an inflation-based index -- a five-year rolling average of historical growth in nominal GDP per capita -- adjusted with a plus or minus factor to meet budgetary targets. Using CBO's December 1995 baseline and assumptions, the growth index would be slightly different. The same index would be used for each eligibility category and state.

## IV. ENFORCEMENT

The plan would:

- o Enforce the cap on an aggregate state level, based on the sum of subgroup caps for each of the beneficiary enrollment categories. This allows states to invest savings from one group to offset the costs of another.
- o Modify the current reporting requirements to implement the per capita cap.
  - Disaggregate, by beneficiary group, spending projections for upcoming quarters.
  - Change expenditure reports to include enrollment data and to reference expenditure and beneficiary categories. The plan would require states to submit monthly beneficiary data on a quarterly basis. This data would be used to determine final aggregate spending limits for states. All categories would be comparable to the categories used in the cap calculation.
  - Continue and expand audits of the financial data on the expenditure reports to examine spending by beneficiary group. The plan would subject enrollment information to a review based primarily on a trend/outlier analysis.
- o Continue the current system for reconciling actual and allowed spending and adjust quarterly grants to reflect updated information as it becomes available. The final reconciliation would occur after the actual data from the full fiscal year were reported.

The plan would use a quarterly grant process similar to that used to announce DSH allotments. HCFA would use a specified set of information submitted by States and its own review to set preliminary and final allotments for states. HCFA would publish these allotments in the Federal Register, and they would be used to adjust quarterly grant awards.

## V. REDUCING AND RETARGETING MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

The President's plan would reduce and retarget the amount of Federal Medicaid Disproportionate Share Hospital (DSH) payments made by states to hospitals serving large low-income and uninsured populations.

### o Reducing payments

Beginning in FY 1997, the plan would phase out States' Federal DSH payments by FY 2000, and phase in a new, optional DSH program by FY 2000. This transition would occur in 25 percent increments and result in approximately \$39 billion in savings by FY 2002.<sup>3</sup>

### o State allotments

**Transition:** Between FY 1997 and FY 1999, each state's allotment, or limit on Federal matching payments, would be the sum of the phased-out current payments and phased-in new allotment. In FY 1997, this amount would be equal to 75 percent of the FY 1995 Federal DSH payments to the state, plus 25 percent of the FY 2000 state allotment. In FY 1998, the amount would be equal to 50 percent of the FY 1995 Federal DSH payments to the state, plus 50 percent of the FY 2000 state allotment. And in FY 1999, the amount would be equal to 25 percent of the FY 1995 Federal DSH payments and 75 percent of the FY 2000 state allotment. By FY 2000, the allotments would be based solely on the allotment formula of the new DSH program.

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<sup>3</sup>All savings are staff estimates using CBO December 1995 baseline.

**New Program:** In FY 2000 and subsequent years, state allotments would be based on each state's share of low-income patient days for a core set of providers. A "low-income patient day" would be defined as either an inpatient day or a day with one or more outpatient visits for uninsured and Medicaid patients. These days would be summed for a core set of providers in each state. Each state's allotment would be determined by multiplying the total Federal limit in the year by the state's days divided by the nation's days. Federal funding for this new program would be limited to \$5.0 billion in FY 2000, \$4.5 billion in FY 2001, and \$4.0 billion for subsequent fiscal years.

o Program Design:

**Transition Period:** Before FY 2000, the plan would continue current laws regarding DSH (with the exception of the allotment structure). New program rules would begin on October 1, 1999.

**Optional Program:** The DSH program would be optional, beginning in FY 2000. States choosing to participate could do so throughout the current state plan amendment process and would have an additional requirement to produce an annual report describing which providers in their state received funds and how much they received.

**Eligible Providers:** A "core provider" would be (1) a hospital whose low-income utilization rate exceeds 25 percent and (2) children's hospitals whose low-income utilization rate exceeds 25 percent or whose Medicaid inpatient utilization rate exceeds 20 percent or is one standard deviation above the mean receiving Medicaid payments in the state. The plan also would give States the option of designating other hospitals that serve a disproportionate number of low-income patients with special needs.

**Provider Payments:** The plan would require States with DSH program to pay core providers and give them the option of paying additional providers that meet the core provider standard. The plan would retain limits on maximum payments to facilities and rules about payment proportionality.

o Annual State report: The plan would require States to submit an annual report to the HHS Secretary and make it available to the general public. The report would include:

- a list of DSH providers and their uncompensated care amount;
- the amount of DSH payments to each provider;
- an explanation of how state payments (including payments based on uncompensated care and undocumented persons pools) related to the state plan; and

-- a demonstration of how the allocation affected uncompensated care.

o Transition Pools.

The plan would designate three capped pools of Federal funds for payments to specific states and providers to help them transition to the new Medicaid program.

1. **Undocumented Persons Pool**

The plan would create this temporary pool for states with high numbers of undocumented persons to help pay for emergency health services. State matching payments would not be required. The pool would be funded at \$700 million per year for fiscal years 1997 through 2001.

The 15 states with the highest number of undocumented persons, according to Immigration and Naturalization Service data (October 1992), would be eligible. Each state would receive an allotment from the pool, according to its share of the total number of undocumented persons in the 15 states.

2. **Pool for Federally-Qualified Health Centers & Rural Health Clinics**

The plan would create a pool for supplemental payments limited to \$500 million annually to federally-qualified health centers (FQHCs) and rural health clinics (RHCs).

3. **Transition Pool**

The plan would create a pool for payments to states to assist in the transition to the new Medicaid program. Federal funding amounts of \$3.1 billion in fiscal years 1997 and 1998 and \$2.5 billion in fiscal years 1999 and 2000 would be authorized.

## VI. COMMISSION ON FEDERAL AND STATE EQUITY IN MEDICAID

- The plan would establish a two-year commission to study the need for, and methods for, changing federal Medicaid matching payments to the states to better reflect the differing effects of demographics, health care utilization, and economic variation. The commission would be expected to examine differential growth in the population below poverty, as well as for those eligible for Medicaid within states and across states. The commission would also investigate trends in health utilization and spending within states and among different population groups. Finally, the commission would examine differences due to economic factors such as wages, per capita income, state tax capacity, and state tax efforts.
  
- The commission would be composed of 18 members -- six would be appointed by the President, six appointed by the President pro tempore of the Senate, and six appointed by the Speaker of the House. These appointees would include representatives of state governments, beneficiaries, and the general public. The commission would submit recommendations and report on its work to the Secretary of Health and Human Services and the Congress two years after its first meeting.

## **PROTECTING WORKING AMERICANS: INSURANCE REFORMS**

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*The President's plan contains insurance reforms to make health coverage more accessible, portable, and affordable. The plan would restrict pre-existing condition exclusions; require insurers to issue, renew and, ultimately, rate group coverage without regard to health status; and prohibit insurers from imposing lifetime benefit maximums, or caps, on benefits for specific conditions. In addition, the plan would provide financial assistance to states to help promote the establishment of health insurance purchasing cooperatives.*

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### **I. ACCESS AND COVERAGE PROTECTION: Measures to improve working Americans' ability to obtain and maintain coverage.**

#### **A. Group Market**

The plan would:

- o Define the "small group" market as 1-50 employees (i.e., self-employed individuals and sole proprietors would be covered) and limit the use of health status in setting small group premium rates.
- o Limit pre-existing condition exclusions to 12 months, and ensure that they are imposed only for conditions diagnosed or treated within the six months prior to health plan enrollment. This proposal would apply to plans of all sizes.
- o Reduce, by one month for each month of coverage a new enrollee had under a prior plan, the period of exclusion for pre-existing conditions. This proposal would apply to all plans.
- o Require insurers to renew coverage to employer groups, regardless of any group member's health status.
- o Require insurers to make coverage available to all eligible groups, regardless of any group member's health status (generally referred to as "guaranteed issue").
- o Require insurers to provide an open enrollment period of at least 30 days for new employees.

- o Prohibit insurers from individually rating new enrollees in an existing group health plan (i.e., new enrollee premiums must be the same as other enrollees with similar demographic characteristics). Although this proposal would apply to plans of all sizes, it would primarily benefit small businesses.
- o Prohibit insurers and self-insured employer plans from imposing (1) caps on benefits for specific diseases or medical conditions (e.g., AIDS) and (2) lifetime maximums on total benefit payments. This proposal would apply to all plans.

## **B. Individual Market**

The plan would:

- o Require insurers in the individual market to offer coverage to persons who: (1) had health insurance over the previous 12 months, (2) lost the coverage under certain circumstances (e.g., loss of employment, death of a spouse, divorce, change of residence), and (3) applied for individual coverage within 60 days of losing their previous coverage.
  - The plan also would require insurers to offer coverage at the average price for someone with the same characteristics and without pre-existing condition exclusions.
- o Limit the ability of insurers to impose pre-existing conditions.
- o Require insurers to renew coverage for all individual policyholders at the same rate as people with similar demographic characteristics, without regard to health status.

## **II. AFFORDABILITY: Measures to make coverage more affordable for the self-employed and to limit variations in small group premiums.**

The plan would:

- o Increase gradually, to 50 percent, the tax deduction for self-employed individuals.
- o Limit premium variations for small businesses by phasing out, over a four-year period, the use of claims experience, duration of coverage, and health status in determining rates. Other factors, such as age and family composition, could be used in rating, but they would have to be actuarially justifiable.

**III. ENCOURAGE COMPETITION: Measures to restructure the market to promote competition among insurers based on efficiency and service.**

The plan would:

- o Provide grants to States to establish purchasing coops. Certain conditions would be imposed (e.g., not bearing any insurance risk; being geographically based; offering multiple plans; etc.). The assistance would total \$25 million the first year.
- o Permit the Federal Employees Health Benefit Program (FEHBP) to require its local commercial carriers to participate in purchasing cooperatives at state request.

**IV. ENFORCEMENT OF INSURANCE REFORMS**

The plan would:

- o Codify reforms into Federal law.
- o Ensure that states enforce requirements that affect insurance carriers, and require states to submit an enforcement plan to the HHS Secretary.
- o Enforce, through the Labor Secretary, requirements affecting self-insured plans. Plans that fail to comply would be subject to civil penalties under the Employee Retirement Income Security Act of 1974 (ERISA).

## ENSURING COVERAGE FOR TEMPORARILY UNEMPLOYED FAMILIES

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*Building on the insurance reform provisions, the President's plan would establish a demonstration program to make funds available for states to finance up to six months of coverage for unemployed workers and their families. The program would be available to unemployment recipients with incomes below a certain threshold, who had employer-based coverage in their prior jobs. The plan would give states substantial flexibility to administer the demonstration program. A Presidential Commission would study and provide recommendations as to whether the program should be made permanent.*

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### I. FEDERAL FUNDING FOR STATES

The President's plan would:

- o Provide annual grants under a four year demonstration program to participating states. HHS would operate a program in a state that chooses not to participate.

### II. ELIGIBILITY FOR COVERAGE

- o Recipients would be required to have made an unemployment insurance claim and to be in active status.
- o Coverage would not exceed six months.
- o Individuals would have to have had health insurance coverage through their last employer for at least the six previous months (including plans where the employee paid the full cost).
- o A full subsidy would be provided up to 100 percent of the poverty level for family income and phased out at 240 percent of the poverty level.
- o An employed spouse could not have health insurance coverage or, if covered, the employer could contribute no more than 50 percent of the premium.
- o The individual/family could not be eligible for Medicaid or Medicare.
- o Individuals would be eligible based on their place of residence.

- o No reduction could be made in the duration or amount of unemployment benefits as the result of an individual participating in the health care coverage program.

### **III. BENEFITS**

- o States would have flexibility in how to use funds to assure access to an insurance product:
  - COBRA coverage from their prior employer;
  - an insurance product in the private market (with the general standard being a product equivalent to the Blue Cross/Blue Shield standard option plan);
  - alternative means of coverage (e.g., state high risk pools, Medicaid buy-in, special plan for the temporarily unemployed).
- o States would have the option of extending eligibility periods or providing a more generous package using state funds.
- o Any reduction in either the duration or extent of health coverage benefits would have to be approved by the HHS Secretary.

### **IV. ADMINISTRATION**

- o A Presidential Commission would study and provide recommendations as to whether the program should be made permanent.

## ADMINISTRATIVE SIMPLIFICATION AND SECURITY OF HEALTH INFORMATION

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*Under the President's plan, the HHS Secretary would be required to adopt standards from among those already approved by private standards developing organizations for certain electronic health transactions, including: claims, enrollment, eligibility, payment, and coordination of benefits. These standards must address the security and privacy of health information on the electronic network. The plan would require health plans to use the approved standards if requested by a provider or other health plan. The plan would not allow private health plans to require providers to change their current procedures.*

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### I. GENERAL REQUIREMENTS TO PROMOTE DEVELOPMENT OF AN ELECTRONIC HEALTH INFORMATION NETWORK

The plan would require the HHS Secretary to adopt standards developed by a private standards developing organization, or standards in common use, for electronic health information transactions. The HHS Secretary also would have to establish standards for the security and privacy of electronic transmission and storage of health information.

Under the President's plan, health plans (i.e., any public or private entity which provides or pays for the cost of health benefits) could conduct the specified electronic transactions using such standards, and must use such standards if requested to do so by a provider, employer, or another plan.

- o Health plans could meet this requirement either directly or through a "health information network service" -- an entity that processes nonstandard data elements of health information into standard data elements. The HHS Secretary could establish criteria for voluntary certification of "health information network services;" such certification would indicate that the entity meets the requirements established under the President's plan.
- o The HHS Secretary could develop standards only if the adoption or modification of existing standards were inadequate.
- o The HHS Secretary would be required to adopt such standards within 18 months of enactment. Health plans could be required to use the standards 24 months after the HHS Secretary adopts them (36 months for small plans).
- o The plan would not limit any public health authority or reporting requirements.

- o The plan would not require the disclosure of health information or expand access to health information.

## II. STANDARDS FOR INFORMATION TRANSACTIONS AND DATA ELEMENTS

Under the plan, the HHS Secretary must adopt standards for electronic transactions and data elements relating to financial and administrative matters, specifically:

- o Claims or equivalent encounter information, claims status, and claims attachments;
- o Enrollment and disenrollment;
- o Eligibility;
- o Health care payment and remittance advice;
- o Premium payments;
- o First report of injury; and
- o Referral certification and authorization.

The HHS Secretary could set standards for other financial and administrative transactions. But the standards shall not require disclosure of trade secrets or confidential commercial information.

The HHS Secretary would also be required to:

- o Adopt standards for providing unique identifiers for individuals, employers, plans, and providers for use in the health care system.
- o Select code sets for appropriate data elements.
- o Specify procedures for the electronic transmission and authentication of signatures; these will preempt state laws (such as "quill pen" laws that require paper records) and satisfy Federal and state requirements for written signatures.
- o Develop rules and procedures for determining a health plan's financial liability when benefits are payable under two or more plans (coordination of benefits).

- o Recommend to Congress (no earlier than two years and not later than six years after enactment) a plan for implementing uniform data and electronic exchange standards for patient medical record information.

### **III. STANDARDS FOR SECURITY AND PRIVACY OF HEALTH INFORMATION**

The HHS Secretary's security standards would:

- o Require reasonable and appropriate administrative, technical, and physical safeguards to protect and ensure the integrity and confidentiality of the information.
- o Take into account the technical capabilities of existing systems, implementation costs, the needs of small and rural health care providers, the need for training, the value of audit trails, and the needs of law enforcement agencies to investigate health care fraud and abuse.

The HHS Secretary's privacy standards would address:

- o The rights of an individual who is the subject of such information;
- o The procedures to be established for the exercise of such rights;
- o The authorized uses and disclosures of such information;
- o Adequate security practices; and
- o Reasonable access for law enforcement agencies to investigate health care fraud and abuse.

### **IV. PENALTIES**

General: Under the plan, people who do not comply could face a civil penalty of not more than \$1000 per violation, with an annual limit of \$250,000. The HHS Secretary would be able to waive or reduce penalties and could not impose penalties if the failure to comply were due to reasonable cause and was corrected.