

Carpenter

HCFE LEGISLATIVE SUMMARY

November 7, 1988

THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

On July 1, 1988, the President signed into law H.R. 2470, the Medicare Catastrophic Coverage Act of 1988 (MCCA), P.L. 100-360. This new law provides the most significant expansion of the Medicare program since its inception. It also contains numerous technical amendments to the Medicare and Medicaid programs, as well as three new Medicaid provisions. Amendments enacted to the MCCA, such as those in the Family Support Act, P.L. 100-485, will be included in summaries of the new legislation.

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THE MEDICARE CATASTROPHIC COVERAGE ACT OF 1988
(Public Law 100-360)

Table of Contents

TITLE I - PROVISIONS RELATING TO PART A OF MEDICARE PROGRAM AND SUPPLEMENTAL MEDICARE PREMIUM

Subtitle A -- Expansion of Medicare Part A Benefits

	<u>Page</u>
Sec. 101. Expanding Scope of Benefits under Part A.....	1
Sec. 102. Deductibles and Coinsurance under Part A.....	2
Sec. 103. Part A Premium for Medicare Buy-Ins.....	3
Sec. 104. Transition and Conforming Amendments.....	4

Subtitle B -- Supplemental Medicare Premium

Sec. 111. Imposition of Supplemental Medicare Premium..	5
Sec. 112. Establishment of Federal Hospital Insurance Catastrophic Coverage Reserve Fund.....	10
Sec. 113. Study of Tax Incentives for Purchase of Coverage for Long Term Care.....	10

TITLE II - PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM AND TO MEDICARE SUPPLEMENTAL HEALTH INSURANCE

Subtitle A -- Expansion of Medicare Part B Benefits

Sec. 201. Limitation on Medicare Part B Cost-Sharing...	11
Sec. 202. Coverage of Catastrophic Expenses for Prescription Drugs and Insulin.....	13
Sec. 203. Coverage of Home Intravenous Drug Therapy Services.....	22
Sec. 204. Coverage of Screening Mammography.....	23
Sec. 205. In-Home Care for Certain Chronically Dependent Individuals.....	26
Sec. 206. Extending Home Health Services.....	27
Sec. 207. Research on Long Term Care for Medicare Beneficiaries.....	28
Sec. 208. Study of Adult Day Care Services.....	29

Subtitle B -- Medicare Part B Premium and Financing

Sec. 211. Adjustments in Medicare Part B Premium.....	30
Sec. 212. Establishment of Federal Catastrophic Insurance Trust Fund; Fund Transfers.....	33
Sec. 213. Creation of Medicare Catastrophic Coverage Account.....	35

Subtitle C -- Miscellaneous Provisions

Sec. 221.	Voluntary Certification of Medical Supplemental Health Insurance Policies.....	36
Sec. 222.	Adjustment of Contracts with Prepaid Health Plans.....	38
Sec. 223.	Mailing of Notice of Medicare Benefits and Information Describing Participating Physician Program.....	39
Sec. 224.	Changes in Civil Money Penalties for Certain Practices of HMOs and CMPs.....	40

TITLE III - PROVISIONS RELATING TO THE MEDICAID PROGRAM

Sec. 301.	Requiring Medicaid Buy-In of Premiums and Cost-Sharing for Indigent Medicare Beneficiaries.....	41
Sec. 302.	Coverage and Payment for Pregnant Women and Infants with Incomes Below Poverty Line.....	43
Sec. 303.	Protection of Income and Resources of Couple for Maintenance of Community Spouse.....	45

TITLE IV - UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE, OBRA TECHNICAL CORRECTIONS, AND MISCELLANEOUS PROVISIONS

Subtitle A -- United States Bipartisan Commission on Comprehensive Health Care.....	55
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Subtitle B -- OBRA Technical Corrections

Sec. 411.	Selected Technical Corrections to Certain Health Care Provisions in OBRA 1987.....	56
(b) - Relating to Part A of Medicare		
(4) Revisions of Standards for Including a Rural County in an Urban Area.....	56	
(6) Reporting Hospital Information.....	57	
(c) - Relating to HMO Reform		
(2) Guaranteed Rates.....	58	
(3) Benefit Stabilization Fund.....	58	
(d) - Relating to Home Health Quality		
(2) Standard and Extended Survey.....	59	
(4) Home Health Agency Accreditation Results.	59	
(5) Home Health Wage Index.....	59	

(f) - Relating to Payment for Physician Services	
(4) Reduction in Prevailing Charge Level for Overpriced Procedures.....	60
(6) Customary Charges for Certain Services of New Physicians.....	60
(7) Payment for Physician Anesthesia Services	61
(9) Elimination of Markup for Certain Purchased Services.....	61
(10) Collection of National Health Service Debts	61
(11) Elimination of 1975 Floor for Prevailing Physician Charges.....	62
(g) - Relating to Payment for Other Part B Services	
(1) Payment for DME, Prosthetics, and Othotics	62
(2) Payment for Intraocular Lenses.....	63
(3) Clinical Diagnostic Laboratory Tests.....	63
(4) Payments to Hospital Outpatient Departments for Radiology and Other Diagnostic Tests	64
(h) - Relating to Part B Eligibility and Benefit Changes	
(1) Coverage of Outpatient Mental Health Services.....	64
(4) Coverage of Certified Nurse-Midwife Services.....	65
(7) Psychologist Services in Clinics.....	65
(i) - Relating to Other Part B Provisions	
(1) Submission of Claims to Supplemental Insurance Carriers.....	66
(3) Certified Registered Nurse Anesthetists..	66
(4) Unassigned Laboratory Services.....	67
(k) - Relating to Medicaid	
(6) Adjustment in Medicaid Payment for Inpatient Hospital Services Furnished by Disproportionate Share Hospitals....	67
(11) Sec. 4119 (omitted from OBRA 87 by mistake, is restored) - Report to Congress on Estate Recoveries.....	69
(12) HMO Failure to Provide Medically Necessary Items and Services.....	69
(13) Treatment of Educationally Related Services.....	70

(14)	Clarification of the Term "Institution for Mental Diseases (IMD)".....	71
(15)	Eligibility Verification for Aliens.....	71
(16)	Presumptive Eligibility Providers.....	72
(17)	Waiver for Children Infected with AIDS or Drug Dependent at Birth.....	72
(l)	- Nursing Home Reform	
(1)	Changes to the Effective Dates for Nursing Home Reform to Improve Coordination Between Medicare and Medicaid.....	73
(m)	- Rural Health.....	75
(n)	- Health-Related Provisions in Title IX	
(3)	Personal Needs Allowance for Medicaid-only Recipients.....	76
Subtitle C -- Miscellaneous Provisions		
Sec. 421.	Maintenance of Effort.....	76
Sec. 422.	Rate Reduction of Medicare Eligible Federal Annuitants.....	77
Sec. 423.	Study and Reports by the Office of Personnel Management on Offering Medicare Supplemental Plans to Federal Medicare Eligible Individuals and Other Changes.....	78
Sec. 424.	Benefits Counseling and Assistance Demonstration Project for Certain Medicare and Medicaid Beneficiaries.....	79
Sec. 425.	Case Management Demonstration Projects.....	79
Sec. 426.	Extensions of Expiring Provisions.....	81
Sec. 427.	Advisory Committee on Medicare Home Health Claims.....	81
Sec. 428.	Prohibition on Misuse of Symbols, Emblems, or Names in Reference to Social Security or Medicare.....	82
Sec. 429.	Demonstration Projects with Respect to Chronic Ventilator-Dependent Units in Hospitals.....	83

Appendices

Chart A. Catastrophic Financing and Outlays

Chart B. Catastrophic Outpatient Prescription Drug Benefit

MEDICARE CATASTROPHIC COVERAGE ACT OF 1988

TITLE I - PROVISIONS RELATING TO PART A OF THE MEDICARE PROGRAM AND THE SUPPLEMENTAL MEDICARE PREMIUM

Subtitle A - Expansion of Medicare Part A Benefits

Expanding the Scope of Benefits Under Part A (Section 101)

Current Law

- o Limit on Inpatient Hospital Days - A beneficiary is entitled to 90 days of inpatient hospital services during each spell of illness. A "spell of illness" is defined as the period of time beginning when a beneficiary enters a hospital and ending when that beneficiary is no longer receiving inpatient hospital or SNF care for 60 consecutive days. An additional 60-day lifetime reserve may be used if an individual exceeds the 90-day limit.
- o Extended Care Services - Medicare covers up to 100 days of care in a Skilled Nursing Facility (SNF) during any spell of illness. To receive payment, such care must be received within 30 days of a hospital stay of at least 3 consecutive days.
- o Hospice Care - Medicare covers two periods of 90 days each and one subsequent period of 30 days.
- o Inpatient Psychiatric Hospital Services - Medicare covers up to 190 days in an individual's lifetime. Days spent in a psychiatric hospital in the 150 days immediately prior to Medicare entitlement will be counted toward the spell of illness limit for inpatient hospital mental health services, but not towards the 190 day limit or the limit for other inpatient hospital services.

Provision

- o No Limit on Hospital Days - The spell of illness concept is dropped. Medicare now will pay for an unlimited number of hospital days for covered services.
- o Extended Care Services - The spell of illness concept is dropped. Extends Medicare coverage to 150 days of SNF care any calendar year, without the requirement for prior hospitalization.
- o Hospice Care - Permits extension of hospice care coverage beyond the 210 day cap as long as a physician certifies that

the patient is terminally ill.

- o Inpatient Psychiatric Hospital Services - Retains the spell of illness concept for the 150 day limit only. The 190 day lifetime limit is also retained.

Effective Date

- o Applies to services furnished on or after January 1, 1989.

Deductibles and Coinsurance Under Part A (Section 102)

Current Law

- o Hospital Deductible - Beneficiaries are required to pay an inpatient hospital deductible (\$540 in 1988) for each spell of illness.
- o Hospital Coinsurance - Beneficiaries are liable for daily coinsurance charges equal to one-quarter of the inpatient hospital deductible (\$135 in 1988) for days 61-90 in a spell of illness. The coinsurance for the subsequent 60 reserve days is equal to one-half the deductible (\$270 in 1988).
- o Blood Deductible - Medicare does not pay for the first three pints of whole blood or packed red cells furnished during a spell of illness. A similar deductible applies under Part B, on a calendar year basis, and may be reduced to the extent that such blood is replaced. The Part A and Part B deductibles are applied separately.
- o Coinsurance on Extended Care Services - Beneficiaries are liable for a daily coinsurance charge equal to one-eighth of the inpatient hospital deductible for days 21-100 of SNF care during a spell of illness.

Provision

- o Hospital Deductible - Individuals are responsible for paying only one hospital deductible each year. Beneficiaries who pay a deductible for hospitalizations beginning during the month of December will not be required to pay an additional deductible for hospitalizations beginning in January of the following year. However, beneficiaries will be liable for an additional deductible for hospitalizations occurring after January 31 of that following year.

Beneficiaries enrolled in HMOs or CMPs whose Medicare contracts are terminated during a year will not be charged an inpatient deductible for the remainder of the year if they can demonstrate that during that year they had an inpatient

hospital admission that was paid for by the HMO or CMP.

- o Hospital Coinsurance - Coinsurance requirements are eliminated.
- o Blood Deductible - Beneficiaries are liable for the first three pints of whole blood or packed red cells furnished each calendar year. This deductible will be reduced to the extent that individuals replace the blood. This Part A blood deductible will be reduced by any blood deductible imposed under Part B.
- o Coinsurance on Extended Care Services - Beneficiaries are liable for coinsurance equal to 20 percent of the national average per diem reasonable cost for the first eight days of SNF care. The Secretary of HHS is required to promulgate a coinsurance amount equal to the national average per diem cost during September of each year (beginning with 1988) for the following calendar year.

Effective Date

- o Applies to services furnished on or after January 1, 1989.

Part A Premium for Medicare Buy-Ins (Section 103)

Current Law

- o Individuals aged 65 and older who do not automatically qualify for Medicare part A benefits may enroll voluntarily in the program if they pay a monthly premium equal to \$33 multiplied by the ratio of the inpatient hospital deductible for the following year to the deductible in 1973. The Secretary must promulgate the premium amount in the third quarter of each calendar year.

Provision

- o The Secretary is required to promulgate the part A premium in September of each year (beginning with 1988) for the following calendar year. This monthly premium will be 1/12 of the estimated actuarial value of the average per capita amount payable from the Hospital Insurance Trust Fund for benefits and administrative costs expected to be incurred for individuals age 65 and older for the following year (including expenditures related to catastrophic coverage). Upon promulgating the premium each year, the Secretary must issue a public statement detailing the actuarial assumptions employed in calculating the actuarial rate.

Effective Date

- o Applies to premiums for January 1989 and succeeding months.

Transition and Conforming Amendments (Section 104)

Current Law

- o Adjustments in PPS Payment Rates - The Secretary is required to make adjustments annually in payment amounts to PPS and PPS-exempt hospitals. Beginning in FY 1988, the Secretary also must adjust weighting factors annually. Adjustments in outlier payments are made periodically.
- o Payment for Emergency Hospital Services - For services furnished by hospitals that do not participate in the Medicare program and that do not elect to receive Medicare payments, Medicare currently pays the beneficiary 60 percent of the hospital's reasonable charge for routine services plus 80 percent for ancillary services. If the hospital does not bill separately for these services, reimbursement is limited to two-thirds of the hospital's reasonable charge.
- o Coverage of Extended Care Services in a Christian Science Sanatorium - Individuals may receive payment for covered SNF services furnished by a Christian Science Sanatorium for 30 days during a spell of illness. Individuals receiving care in such facilities must pay coinsurance for each day equal to 1/8 of the inpatient hospital deductible.

Provision

- o Adjustments to PPS Payment Rates - When adjusting payment rates, outlier cutoff points and weighting factors for PPS hospitals and the target amounts for non-PPS hospitals (on a hospital-specific basis), the Secretary must take into account (to the extent appropriate) reductions in beneficiary payments to hospitals resulting from the elimination of a day limitation on Medicare inpatient hospital services. These payment adjustments are effective for discharges (or cost reporting periods for non-PPS hospitals) occurring on or after October 1, 1988.
- o Payment for Emergency Hospital Services - Provides for full payment to the beneficiary of the hospital's reasonable charges for routine and ancillary emergency services.
- o Coverage of Extended Care Services in Christian Science Sanatoria - Modifies the current coverage of SNF care in these facilities to 45 days per calendar year. The daily coinsurance rate will be at the same rate as the Medicare SNF

coinsurance rate (20 percent of the estimated national average per diem reasonable cost).

- o Hold Harmless Provision for Hospital and Blood Deductibles - Individuals whose spell of illness began before January 1, 1989 and ends after that date will not be liable for an inpatient hospital deductible for that spell of illness during 1989 or 1990. The Part A blood deductible for such individuals also will be reduced during 1989 or 1990 to the extent that a Part A blood deductible already was imposed during that spell of illness.

Subtitle B - Supplemental Medicare Premium

Supplemental Medicare Premium (Section 111)

Current Law

- o There is no provision for a Medicare supplemental premium under current law.
- o Pensions of Government Retirees - Currently, pensions of most government retirees are included in their taxable income while Social Security benefits are tax exempt unless they exceed a certain threshold. These differences result in larger tax liability for government retirees than for retirees receiving similar Social Security benefits.
- o Limited Medical Expense Deduction - For federal income tax purposes, individuals may deduct expenses in excess of 7.5 percent of their adjusted gross income for medical care which are not compensated for by insurance. Such expenses include insurance payments and Medicare part B premiums.

Provision

- o This provision amends the Internal Revenue Code relating to determination of tax liability.
- o Supplemental Premium - An annual supplemental premium is imposed on individuals who are eligible for Medicare part A for more than 6 months in a calendar year and whose tax liability equals or exceeds \$150 for that year. This premium is limited to a maximum annual amount per individual.

Supplemental Premium Rates for 1989-1993 - The annual supplemental premium for these years will be equal to the sum of the catastrophic coverage premium rate and the prescription drug premium rate multiplied by the number determined by dividing the individual's tax liability by \$150. The statute

specifies the catastrophic coverage premium rate and the drug premium rate. The statute also specifies a maximum supplemental premium per individual.

<u>Year</u>	<u>Cat. Coverage Premium Rates*</u>	<u>Drug Premium Rates*</u>	<u>Total Premium Rates*</u>	<u>Maximum Suppl. Premium</u>
1989	\$22.50	0	\$22.50	\$ 800
1990	\$27.14	\$10.36	\$37.50	\$ 850
1991	\$30.17	\$ 8.83	\$39.00	\$ 900
1992	\$30.55	\$ 9.95	\$40.50	\$ 950
1993	\$29.55	\$12.45	\$42.00	\$1,050

*per \$150 of adjusted Federal income tax liability.

Supplemental Premium Rates for Years After 1993 - The supplemental premium rate will be equal to the sum of the catastrophic coverage premium rate and the prescription drug premium rate for the previous year, adjusted for shortfalls in premiums and contingency margins (discussed below). Each of these rates is calculated separately. However, the total is constrained by two limits -- the new supplemental premium rate may not be less than the rate in effect for the previous year or more than \$1.50 (per \$150 of tax liability) higher than the previous rate. If the unconstrained premium rate would exceed the \$1.50 limit, the final restrained rate will be proportionally allocated between the catastrophic coverage premium rate and the drug premium rate. (Resulting reduction in revenue is made up by the flat premium; see page 31)

Catastrophic Coverage Premium Rate After 1993 - The catastrophic coverage premium rate for 1994 and after is equal to the rate for the preceding calendar year adjusted by a percentage equal to the sum of the "outlay-premium percentage" and the "reserve account percentage".

The "outlay-premium percentage" is designed to index the premium rate by the difference between the projected growth rates in outlays and premiums. Calculation: the outlay premium percentage is equal to the percentage change in per capita outlays from the third to the second preceding years minus the percentage change in per capita premium liability in this time period (calculated as if the rate in the second preceding year is the same as the rate in the third preceding year), adjusted by 50 percent of any change above or below one percent in the CPI for this period.

The "reserve account percentage" is designed to adjust the premium rate to recoup 63 percent of any shortfall (or excess) in the catastrophic coverage program

contingency reserve (the remaining 37 percent is recouped by a corresponding adjustment in the flat part B premium). The contingency reserve is 20 percent of outlays in the second preceding year. Calculation: the reserve account percentage is equal to the ratio of the change in the premium rate for the second preceding year which would have increased (or reduced) premiums by an amount equal to 63 percent of the shortfall (or excess) in the Account to the unrestrained premium rate for the preceding year.

Prescription Drug Premium Rate After 1993 - The prescription drug premium rate for 1994 and after is determined by adjusting the rate for the preceding calendar year in a manner similar to that used for the catastrophic coverage premium with two differences.

The contingency formula in the statute is based on outlays during the second preceding year. Thus, the "effective" contingency margin for the drug premium is 75 percent for 1992, 50 percent for 1993 and 25 percent for 1994 and 1995. The drug premium contingency margin is set at 20 percent in subsequent years.

The outlay-premium percentage adjustment will not be made before 1998.

Maximum Supplemental Premium After 1993 - The maximum supplemental premium for 1994 and beyond will be equal to the maximum premium in the previous year increased by the percentage by which the "Medicare part B value" for the second preceding year exceeds such value for the third preceding year. The maximum premium is rounded to the nearest \$50.

The "Medicare part B value" is an amount equal to the excess of the average per capita part B outlays for the year over the part B premiums paid by an individual for that year. Outlays and monthly premiums for covered outpatient drugs are excluded from the computation of the Medicare part B value in calendar years before 1998.

- o Exclusions - The supplemental premium does not apply to the following individuals:

--Part A Self-Pays - Individuals entitled to part A benefits solely by payment of a premium.

--Qualified Nonresidents - Individuals who are who are living in a foreign country for at least 330 days during the taxable

year and each of the four preceding taxable years and have not received a part A service and who are not entitled to part B during the taxable year or any of the four preceding taxable years. Individuals who die during a taxable year and who are present in a foreign country for at least 90 percent of the days of that year before the date of death qualify as nonresidents for the year of death.

--Residents of U.S. Commonwealths and Territories - Imposition of the supplemental premium does not apply to determining the liability of individuals residing in Puerto Rico, the Virgin Islands or possessions of the United States who do not have U.S. income tax liability.

--Part B Only - Beneficiaries receiving part B only who would not be entitled to part A upon filing an application.

- o Special Rules for Calculating Federal Income Tax Liability for Purposes of Determining the Supplemental Premium Amount - Supplemental premium payments will be made when filing income tax returns. The following special rules apply for calculating income tax liability for certain individuals:

--Individuals Filing Joint Returns - If both spouses are eligible for Part A benefits for more than 6 months during the taxable year, such spouses are treated as a single individual, except that the maximum supplemental premium is twice the amount that applies for single returns. If only one spouse is eligible for part A benefits for more than 6 months, the income tax liability of the eligible spouse will be determined by taking into account one-half of the income tax liability of the joint return.

--Individuals Filing Separate Returns - Married individuals filing separate returns who did not live apart at all times during the taxable year are treated as eligible if either spouse is eligible. The maximum supplemental premium is twice the amount that applies for single returns. A special rule applies to government retirees (see below).

--Governmental Retirees - Individuals receiving government retirement benefits will have a special adjustment to their tax liability. The formula first calculates a "government retiree exclusion amount" which is the lesser of 1) \$6,000 for singles or \$9,000 for married individuals filing a joint return when both are eligible for Medicare or 2) the amount received as a government annuity which is includable in gross income; reduced by Social security benefits received during the taxable year. In the case where only one spouse filing a joint return is eligible, only government annuities attributable to the Medicare eligible spouse are counted in

determining the "government retiree exclusion amount". For a married person filing a separate return, the individual shall receive not less than one-half of the aggregate social security benefits.

15 percent of this reduced exclusion amount is divided by the amount of credit allowed under the tax credit for the elderly and the disabled. The excess, if any, is subtracted from the income tax liability.

After 1989, the "government retiree exclusion amount" is increased by Social Security COLAs.

o Treatment of the Supplemental Premium for Tax Purposes -

--The supplemental premium may not be counted toward the individual medical expense deduction when uncompensated expenses exceed 7.5 percent of the adjusted gross income.

--The supplemental premium will not be treated as a tax for purposes of determining the amount of any tax credit or the amount of the alternative minimum tax.

--The supplemental premium is treated as an income tax for administrative purposes, such as estimated payments and collections. Estimated tax penalties do not apply with respect to the supplemental premium for the taxable year 1989.

--The supplemental premium is not treated as a change in income tax rate.

- o Premium Promulgation - The Secretary of Treasury shall determine supplemental premiums for taxable years in and after 1993 (and for periods of less than 12 months). The estimated supplemental premium rate must be announced not later than July 1 of each year and the actual rate shall be announced not later than October 1 of each year.
- o Information Reporting - The Secretary of HHS is required to include in reports to the Secretary of the Treasury related to Social Security benefits, a determination of whether individuals were eligible for Part A benefits for more than 6 months a year. The same information must be included on statements sent to Social Security and railroad retirement beneficiaries and the name of agency which determines Medicare eligibility.

Effective Date

- o Applies to taxable years beginning after December 31, 1988.

Establishment of Federal Hospital Insurance Catastrophic Coverage Reserve Fund (Section 112)

Current Law

- o Under current law, two Medicare trust funds exist: the Federal Hospital Insurance (HI) Trust Fund for part A benefits and the Federal Supplementary Medical Insurance (SMI) Trust Fund for part B benefits. The part A fund includes annual deposits of the hospital insurance taxes collected from employers, employees and the self-employed and the monthly part A premiums collected from individual who purchase these benefits. The part B fund includes deposits of the monthly premiums paid by enrollees and general revenue funds.

Provision

- o Creates a new Federal Hospital Insurance Catastrophic Coverage Reserve Fund. Amounts equal to 100 percent of outlays attributable to part A for catastrophic benefits will be transferred (at least monthly) from the general fund to the new reserve fund. These transfer payments shall come from receipts from the supplemental catastrophic premium. No transfers, authorizations, or appropriations are permitted. Rules for management of the Trust Fund are similar to those applying to the HI Trust Fund and the Board will be composed of members of the Board of Trustees of the HI Trust Fund.
- o In July 1990, the Secretary of the Treasury shall calculate the interest lost to the HI Catastrophic Coverage Reserve Fund resulting from lags between outlays in 1989 and transfers to the Reserve Fund to cover these outlays. Appropriations shall include the amount of interest.

Effective Date

- o January 1, 1989.

Study of Tax Incentives for the Purchase of Coverage for Long-Term Care (Section 113)

Current Law

- o No Provision.

Provision

- o The Secretary of the Treasury is required to conduct a study of federal tax policies to promote private financing of long-term care (LTC). The study will identify alternative methods of creating incentives, through the tax system, to encourage

individuals to purchase LTC insurance. The study should consider the cost to the Treasury and the potential benefits to consumers of such insurance and be conducted in consultation with the insurance industry, consumers and providers of LTC services.

Effective Date

- o Upon Enactment. The Secretary is required to report to Congress on the results of the study and provide recommendations for necessary statutory changes by November 30, 1988.

TITLE II - PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM AND TO MEDICARE SUPPLEMENTAL HEALTH INSURANCE

Subtitle A - Expansion of Medicare Part B Benefits

Limitation on Medicare Part B Cost-Sharing (Section 201)

Current law

- o Beneficiaries enrolled in part B are required to pay the following: a monthly premium; 20 percent of the reasonable charge for physician and other covered medical services after a \$75 deductible has been met; and the cost of the first three pints of whole blood (unless replacement blood is provided). Beneficiaries are also liable for the difference between the reasonable charge and the physician's actual charge on unassigned claims (i.e. the "balance bill amount".) There is no upper limit on the amount of cost sharing that beneficiaries must pay in connection for covered services.

Provision

- o Part B Cap - Establishes an annual limit on beneficiary out-of-pocket costs for covered part B services. The limit includes the part B deductible, the part B blood deductible, and coinsurance. The part B premium and balance bill amounts are not included. When the catastrophic limit is reached, Medicare will pay 100 percent of the reasonable charge (or cost or other reimbursement method) for covered part B services and the blood deductible would not be required. Beneficiaries will be required to continue to pay the 20 percent coinsurance for in-home services (i.e. respite care) after the catastrophic cap is met.

The catastrophic limit is established at \$1,370 in 1990 and will be set in future years at a level to ensure that 7

percent of part B beneficiaries (excluding health maintenance organization (HMO), competitive medical plan (CMP), and health care prepayment plan (HCPP) enrollees) reach the limit. Beginning in 1990, the Secretary must publish the catastrophic limit by September 1 for the subsequent year.

- o Limit on Charges - Specifies that providers may not charge beneficiaries for services for which catastrophic benefit payments are made to the provider.
- o Beneficiary Notice - The Secretary is required to provide a notice to each individual when his or her out-of-pocket costs for covered services reach the catastrophic limit.
- o Payment Adjustments for HMOs, CMPs, or HCPP Plans -

--The Secretary will adjust payment to reasonable cost HMOs and HCPPs to reflect the increases in Medicare payments as a result of the Catastrophic Coverage Act that would otherwise be made in the fee-for-service system.

--A special structure is established to assure that beneficiaries will not be penalized as a result of enrolling in a prepaid plan (defined as a HCPP, cost or risk HMO, or CMP). Two categories of plans are established--"buy-out plans" and "non-buy-out plans". "Buy-out plans" are defined as plans that impose coinsurance and deductible charges (excluding outpatient drugs) that are less than half of the national actuarial equivalent of Medicare coinsurance and deductibles.

- + For each month of enrollment in a "buy-out plan", a beneficiary is deemed to have incurred out-of-pocket costs equal to the amount that an average beneficiary would incur, except for outpatient drugs (rather than the actual amount of out-of-pocket costs they incur for services received from the plan).
- + "Non-buy-out plans" must track deductibles and coinsurance expenses imposed on part B services in coordination with carriers and agree not to charge beneficiaries for coinsurance and deductibles (other than for outpatient drugs) once they reach the catastrophic limit. The accounting will include all covered expenses for the year, whether incurred in the plan or prior to enrollment. In the case of HCPPs and cost HMOs, tracking must include services provided in and out-of-plan.

Effective Date

- o Items and services furnished after December 31, 1988.

Coverage of Catastrophic Expenses for Prescription Drugs and Insulin (Section 202)

Current Law

- o There is no general provision under current law permitting payment for outpatient prescription drugs which can be self-administered by the patient. The only outpatient drugs currently covered under Medicare are immunosuppressive drugs, which are covered for one year following an organ transplant covered by Medicare.

Provision

- o Covered Outpatient Drugs - Provides Medicare part B coverage of outpatient prescription drugs, prescription biological products and insulin which are not presently covered as part of, or as incident to, other covered services. (Note: the law includes a list of drugs specifically excluded from the definition of outpatient drugs. In general, these are situations where drugs are currently covered).

Covered drugs are defined as those dispensed only by prescription and:

- approved for safety and effectiveness under the Federal Food, Drug, and Cosmetic Act;
- marketed before 1938 (not subject to current Food and Drug Administration requirements); or
- marketed between 1938 and 1962 but not as yet the subject of a hearing to determine its effectiveness under the Drug Efficacy Study Implementation program, but for which the Secretary has determined there is justification for its medical need (currently, only nitroglycerin patches fall into this category).

Covered biological products are defined as those:

- dispensed only by prescription; and
- licensed under the Public Health Service Act, including therapeutic serum, antitoxins, vaccines, blood, blood products, and allergenic products and produced at a licensed facility.

Covered insulin is defined as:

- certified under the Federal Food, Drug, and Cosmetic Act.

Outpatient drugs that are intravenously (IV) administered in a home setting are covered only if the IV drug is administered in the individual's home. If the home IV drug is not an antibiotic, the Secretary must specifically determine that it can be generally administered safely and effectively in a home setting before payment is made. Home IV antibiotics are covered unless the Secretary specifically determines that they

are not safe and effective in a home setting. The Secretary is required to publish a list of covered home IV therapy and drugs and indications for such drugs that can be safely and effectively administered in the home by January 1, 1990 and periodically thereafter.

- o Phase-In of Drug Coverage and Coinsurance - Coverage of outpatient prescription drugs and beneficiary coinsurance amounts would be phased in, as follows:

Immunosuppressives - Effective January 1, 1990, Medicare will cover outpatient prescription drugs used in immunosuppressive therapy. Coinsurance will be set at 20 percent during the first year following a Medicare-approved transplant. After the first year, and during the first year following a transplant that was not covered by Medicare, coinsurance will be set at 50 percent in 1990 and 1991, 40 percent in 1992 and 20 percent in 1993 and thereafter.

Home Intravenous (IV) Drugs - Effective January 1, 1990, Medicare also will cover certain IV drugs which can be administered safely and effectively in the home setting. Coinsurance for these drugs will be set at 20 percent.

Other Drugs - Effective January 1, 1991, provides coverage for all other covered outpatient prescription drugs. Coinsurance will be phased in at 50 percent in 1991, 40 percent in 1992 and 20 percent in 1993 and thereafter.

Coinsurance Adjustment - The Secretary has authority to make adjustments in coinsurance in 1993 if premium revenues are insufficient to maintain contingency margins in previous years -- see page 18.

- o Outpatient Prescription Drug Deductible - Sets the deductible for outpatient prescription drugs at \$550 in 1990; \$600 in 1991; and \$652 in 1992. In succeeding years, the Secretary will determine a deductible such that an average of 16.8 percent of part B enrollees (excluding enrollees in HMOs, CMPs and HCPPs) will exceed the deductible.

The drug deductible does not apply to home IV drugs initiated while the beneficiary was an inpatient, or with respect to immunosuppressive drugs furnished within one year of an organ transplant.

The Secretary is required to publish a proposed regulation establishing the deductible before May 1 of each year beginning in 1992, and a final regulation by the last 3 days of the following September. The amount of the deductible established in the final regulation may not exceed the amount specified in the proposed regulation.

Generally, carriers will notify individuals through the electronic data system in the participating pharmacy when they meet the deductible. However, if this administrative system is not established on time, the Secretary, upon request, must notify individuals as to whether they have met the deductible.

- o Medicare Payment Amounts - After the deductible is met, Medicare will pay the lesser of the actual charge for the drug or the applicable payment limit, minus the required coinsurance.

Payment Limits - Establishes Medicare payment limits according to whether the drugs are: 1) multiple source drugs, 2) multiple source drugs with restrictive prescriptions, or 3) non-multiple source drugs. Multiple source drugs are defined as those for which there are two or more drug products which are rated as therapeutically equivalent, pharmaceutically equivalent, and bioequivalent as determined by the FDA and sold and marketed during the payment period. A restrictive prescription is one which specifies in the physician's (or other prescribing person's) handwriting that a particular drug must be dispensed. Telephone prescriptions requesting a brand name drug must be followed by a written request for the brand name drug from the physician within 30 days, or payment will be made based on the multiple source drug limit.

Payment limits are established as follows:

- Non-multiple source drugs and multiple source drugs with restrictive prescriptions - Prior to January 1, 1992, the number of tablets or units dispensed multiplied by the per tablet or unit average wholesale price for the drug plus the administrative allowance. Beginning January 1, 1992, the lesser of the number of tablets or units dispensed multiplied by the average wholesale price per tablet or unit plus the administrative allowance or the 90th percentile of the actual charge per tablet computed on a geographic area basis (as determined by the Secretary) for the second previous payment calculation period, adjusted to reflect the number of tablets or units dispensed.
- multiple source drugs without restrictive prescriptions - the number of tablets or units dispensed multiplied by the unweighted median average wholesale price per tablet or unit plus the administrative allowance.

Determination of Average Wholesale Price - The Secretary is required to determine the per tablet or unit average wholesale price for an outpatient drug in a payment calculation period beginning on or after January 1, 1990. The determinations are based on prices for a reasonable quantity of drugs on the first day of the first month of the previous calculation

period.

--non-multiple source drugs - requires the Secretary to conduct a biannual survey of a sample of direct sellers, wholesalers or pharmacies to determine the average wholesale (or comparable direct) price of a drug (excluding discounts). If the sales volume of the drug is low, or for covered outpatient drugs in 1990, or for other appropriate reasons, the Secretary may make the determination of the unit price based on published average wholesale (or comparable direct) prices.

--multiple-source drugs - the Secretary may base the unit price of a covered drug on the published average wholesale (or the comparable direct) price of the drug, or on the biannual survey.

If a wholesaler or direct seller refuses to provide information required by the survey, or deliberately provides false information, the Secretary may impose civil monetary penalties of up to \$10,000 for each instance. Information gathered during the survey is not disclosable except as necessary to implement this provision.

Administrative Allowance - The administrative allowance for 1990 and 1991 is \$4.50 for drugs dispensed by a participating pharmacy, and \$2.50 for drugs dispensed by a non-participating pharmacy. The Secretary may reduce the administrative allowance for mail service pharmacies. After 1991, the allowances are adjusted annually by the percent increase in the GNP deflator for the twelve month period ending in August of the previous year.

Geographic Basis - Payment limits generally will be national, but the Secretary may take into account regional availability and regional variations in average wholesale prices.

Supply - Generally limits payment to a 30 day supply of any given drug. The Secretary may authorize payment for a supply not to exceed 90 days, except in "exceptional circumstances".

Calculation Period - Payments are calculated for six month periods beginning in January and July of each year.

- Appropriate Utilization - Requires the Secretary to establish a program to identify and educate physicians and pharmacists concerning instances of unnecessary or inappropriate prescribing and dispensing practices, substandard care and potential adverse drug reactions. Requires the Secretary to establish standards for prescribing covered drugs based on accepted medical practice.

Prohibits the Secretary from establishing a formulary to exclude from coverage or deny payment for any covered outpatient drugs or a specific use of such drug unless the Secretary determines that such drug is not safe or effective.

- o Prepaid Organizations - Expenses incurred by beneficiaries enrolled in "drug buy-out plans" (plans offering a drug benefit where the deductible is less than 50 percent of the catastrophic drug deductible) will not be counted toward the catastrophic drug deductible, unless the individual disenrolls during the year. In such cases, the beneficiary is deemed to have incurred expenses for covered outpatient drugs in an amount equal to the monthly average actuarial value of the drug deductible for each month of enrollment. The Secretary may not enter into a contract with a prepaid organization other than a drug buy-out plan, unless the organization assures the Secretary that it will maintain records of expenses incurred for outpatient prescription drugs for each enrollee; and that the plan count toward any drug deductible it establishes any beneficiary expense for covered outpatient drugs that would have otherwise counted towards the catastrophic drug deductible.

Requires the Secretary to adjust payments to cost-based pre-paid plans providing outpatient prescription drug coverage.

- o Physician Guide - Requires the Secretary to develop and update an annual physician guide listing the average wholesale prices, by therapeutic categories, for a day's supply of at least 500 of the most commonly prescribed outpatient drugs. The guide will be mailed annually beginning January 1991 to participating hospitals, physicians who routinely provide part B services, Social Security offices, senior citizens' centers and to other appropriate locations.
- o Contingency Margins - Establishes a special procedure if minimum contingency margins for 1993 (50 percent) and 1994 (25 percent), determined based on total outlays from the Trust Fund at the close of the calendar year, are not met. The Secretary will publish a proposed regulation by May of each year describing how outlays will be reduced by an amount necessary to provide the contingency margin in the succeeding year. In taking action to provide the necessary contingency margin, the Secretary may not implement a formulary, change the methodology for calculating whether the drug deductible has been met, or increase the coinsurance above the level in effect during the previous year. The Secretary may increase the amount of the drug deductible.

The final regulation will be published during the last 3 days of September and become effective for one year beginning the following January 1. The final regulation cannot decrease

outlays by an amount greater than the amount in the proposed regulation.

- o Budgetary Information - Requires the Secretary to compile information on manufacturers' prices, pharmacists' charges, and the use of outpatient drugs by beneficiaries for 6 month periods beginning January 1987 and compare this data with the semiannual increase in such prices and charges during the 6 years beginning with 1981. The Secretary will report such information to Medicare's Congressional Committees of jurisdiction in May and November of 1989 and 1990, and in May of each succeeding year.

After 1991, the report shall include an explanation of the extent to which outlay increases are due to increases in charges and utilization and projections on:

- budgetary status of the Trust Fund for the succeeding year;
- increases in manufacturers' prices and pharmacists' charges for covered drugs;
- level of utilization by beneficiaries; and
- administrative costs of the benefit.

Reports provided in 1992 and 1993 will include information on whether the Trust Fund will maintain minimum contingency margins, describe reasons for anticipated increases or unanticipated outlays for covered outpatient drugs, and describe any necessary changes to assure that the contingency margins in the succeeding year are met.

Requires the Secretary to submit monthly reports to Congress, from October 1991 through April 1993, showing outlays and receipts of the Federal Catastrophic Drug Insurance Trust Fund.

- o Participating Pharmacies - On or after January 1, 1991, an entity which is authorized under state law to dispense covered outpatient drugs and enters into an agreement with the Secretary which meets the following conditions may become a participating pharmacy.

- accept assignment for beneficiaries meeting the drug deductible;
- agree not to refuse to dispense covered outpatient drugs in stock to any Medicare beneficiary; (clarifies that pharmacies operated by HMOs/CMPs/HCPPs are not required to dispense covered drugs to non-enrollees)
- keep beneficiary records, including expenses, for all drugs dispensed;
- offer counseling and information on drug usage and potential interactions;
- advise beneficiaries on the availability of generic drugs;
- do not charge Medicare beneficiaries more than the amount

- charged to the general public;
- provide price information requested by the Secretary during a survey; and
- submit information necessary to administer this benefit.

Special Services - Requires the Secretary to publish a directory of participating pharmacies (separate from participating physician directories, if appropriate). Participating pharmacies also will receive a distinctive emblem for public display. If the Secretary determines that participating pharmacies need assistance in using electronic systems to submit required claims information, he must provide electronic equipment (other than expanded telephone service) and technical assistance. (Note: participating pharmacies also receive a higher administrative allowance -- see page 17).

Only participating pharmacies can accept assignment of claims.

Audits - Requires the Secretary to conduct periodic audits of participating pharmacies to assure compliance with the requirements of participation and to assure the accuracy of submitted information.

- o Penalties - Authorizes the Secretary to impose civil monetary penalties on participating pharmacies who violate a participation agreement; participating and non-participating pharmacies which charge Medicare beneficiaries more than the general public and/or fail to provide information requested by the Secretary in a survey.
- o Electronic Point-of-Sale System - Requires the Secretary to establish by January 1, 1991 a point-of-sale electronic system for use by participating pharmacies and carriers in submitting required information.
- o Administration - Authorizes the Secretary to contract with qualified entities (i.e. voluntary associations, corporations, partnerships, or other nongovernment organizations, including non-health insuring organizations) to assist in the implementation and operation of the electronic system. The Secretary may contract with such organizations on a regional basis, or on other than a cost basis. The Secretary is also required to establish performance standards for these organizations.

These new "limited carriers" will be responsible for receiving electronic information and responding to requests from pharmacies and individuals regarding deductible status. Toll-free telephone lines are not required. This provision is effective on enactment.

Adds additional functions to the carrier authority to receive information transmitted under the electronic system and respond to deductible status, and authority to contract with limited carriers as the Secretary determines necessary to implement the electronic system.

- o Medigap - Where outpatient drugs are concerned, delays until January 1, 1993 the requirement that carriers coordinate benefits with Medicare supplemental insurers for participating physician and supplier claims.
- o Payments To Pharmacies and Individuals - Payments will be made for approved claims once a month according to a payment schedule. If payment is not made within 5 days of the requisite payment date, interest will accrue until payment is made. This provision is effective January 1, 1991, but payment will not be required before February 1, 1991.
- o Separate Test of Actuarial Equivalence for Drug Benefits in HMOs/CMPs - The requirement that an organization's cost-sharing requirements not exceed the actuarial value of cost-sharing in the fee-for service setting will be applied separately with respect to covered outpatient drugs effective January 1, 1990.
- o Report - Requires the Secretary to use data from the 1987 National Medical Expenditures Survey 1) to report to Congress, by April 1, 1989 on expenses incurred by Medicare beneficiaries for outpatient prescription drugs, and 2) to provide data to the Congressional Budget Office (CBO) as necessary to estimate outlays and revenues for FY 1990 through FY 1993. The Director of CBO is required to submit outlay and revenue estimates to Congress for fiscal years 1990 - 1993 within 60 days after receiving this data from the Secretary.
- o Standard Claims Form - Requires development of a standard Medicare prescription drug claim form and an electronic claims format. The electronic claims format is to be distributed by October 1, 1989 and the claims form by October 1, 1990.
- o Prescription Drug Payment Review Commission - Requires the establishment of the Prescription Drug Payment Review Commission. The eleven Commission members will be named by the Director of the Congressional Office of Technology Assessment, and will be appointed by January 1, 1989 for a three-year term (except for staggered terms of initial members). An annual report concerning the payment methodology for outpatient drugs will be due to Congress annually beginning May 1, 1990.

Beginning in 1992, the report will include information on the previous year's increases in manufacturers' prices,

pharmacists' charges, utilization and administrative costs, as well as comments on the budgetary status of the Federal Catastrophic Drug Insurance Trust Fund and recommendations for outlay reductions necessary to achieve the contingency margin in the following year.

o HHS Studies:

- by January 1, 1990, a study on possible Medicare coverage of experimental cancer and immunosuppressive drugs and other experimental drugs and biologicals;
- by January 1, 1990, a study on the potential of mail order pharmacies to reduce program costs;
- by January 1, 1993, a study of methods to improve utilization review of covered outpatient drugs; and
- by January 1, 1993, a longitudinal study on the medical necessity, potential for adverse drug interactions, cost and patient waste of outpatient prescription drugs by Medicare beneficiaries.

- o GAO Studies - By May 1, 1991, a study comparing wholesale drug prices with actual pharmacy acquisition costs; an analysis of retail pharmacy overhead costs; and an analysis of discounts offered by pharmacies to other third party insurers. Pharmacies failing to provide information necessary for these studies may be excluded from the Medicare and Medicaid programs.

In addition to the catastrophic drug benefit, this section includes another provision impacting part B benefits:

- o Diagnostic Coding - Beginning April 1, 1989, requires physicians to submit an appropriate diagnostic code, as established by the Secretary, with each request for payment under part B. Assigned claims which do not include the code may be denied. For unassigned claims, a \$2,000 civil monetary penalty may be imposed on a physician who knowingly and willfully fails to provide such codes. If a physician repeatedly fails to provide diagnostic codes on unassigned claims, the physician may be barred from participation in the program for a period of up to five years.

Effective Date

- o Generally applies to items dispensed on or after January 1, 1990 unless otherwise noted.

**Coverage of Home Intravenous (IV) Drug Therapy Services
(Section 203)**

Current Law

- o Drugs which cannot be self-administered are covered under part B, unless provided incident to professional services.

Provision

- o Provides part B coverage for home IV drug therapy services including nursing, pharmacy, and related items and services necessary for the safe and effective administration of home IV drugs. Prescription drugs used for home IV therapy are not covered under this provision but are covered under the catastrophic drug benefit provision.
- o Home IV drug therapy must be furnished by a qualified, licensed provider, defined as an entity which:
 - is capable of providing or arranging for the provision of home IV drug therapy;
 - maintains clinical records on all patients;
 - adheres to written protocols and policies;
 - makes services available 24 hours a day, seven days a week;
 - coordinates all services with the patient's physician;
 - conducts a quality assessment and assurance program, including drug regimen review and coordination of patient care;
 - assures that only trained personnel provide patient care;
 - assumes responsibility for the quality of services provided by others under arrangement;
 - is licensed or approved under State or local law; and
 - meets other health and safety requirements as prescribed by the Secretary.
- o Home IV drug therapy services will not be subject to part B deductible or coinsurance.
- o Requires the Secretary to develop a fee schedule by January 1, 1990 (and for each year thereafter) on a per diem basis. Payment will be the lesser of the provider's actual charge or the fee schedule amount.
- o Prohibits payment for home IV therapy based on a referral from a physician who (or whose immediate family member) has an ownership interest in, or receives compensation from, the provider. Civil monetary penalties of up to \$15,000 for each item or service may be imposed on providers or physicians who knowingly are party to such referrals. Exceptions are made for the following individuals: sole community providers; physicians who have ownership through publicly traded stock

and are not receiving kickbacks from the provider, those related to the provider only as an uncompensated officer or director; or in cases where ownership or compensation does not pose a substantial risk of program abuse.

- o Requires the Secretary to establish criteria to be used by professional review organizations (PROs) in reviewing all home IV therapy services for medical necessity and quality during 1990-1992. All therapy initiated on an outpatient basis must be pre-approved by the PROs within one working day.
- o Requires the Inspector General to report to Congress by May 1, 1989 on physician ownership of, and compensation by, providers to whom they make referrals; the extent to which this practice encourages inappropriate utilization; and the difficulties involved in enforcing anti-kickback provisions.
- o By March 1, 1991, requires the Prospective Payment Assessment Commission (ProPAC) to study and make recommendations concerning prospective payment system (PPS) rate adjustments to account for hospital savings resulting from IV drug therapy being performed more often at home than in an inpatient setting.
- o Requires the Secretary to develop and implement intermediate sanctions for home IV therapy providers who fail to meet Medicare conditions of participation.
- o Allows the Secretary to contract with fiscal intermediaries for the administration of the home IV drug benefit on a regional basis.

Effective Date

- o Applies to services furnished on or after January 1, 1990.

Coverage of Screening Mammography (Section 204)

Current Law

- o Routine mammography screenings are not covered under the Medicare program. Mammographies are covered only as a diagnostic tool in cases in which breast cancer is suspected.

Provision

- o Definition - Defines screening mammography as a radiologic procedure provided to a woman for early detection of breast cancer, including a physician's interpretation of the results of the procedure.

- Payments and Standards - Payments may be made only for screening mammographies consistent with the frequency limitations, quality standards, and special payment rules described below. The amount of the payment will be subject to the part B deductible and be equal to 80 percent of the lesser of the actual charge or the fee schedule amount established by the Secretary; or a payment limit (set at \$50 in 1990).
- Frequency Limitations
 - Women under 35 years of age are not covered under this provision.
 - Women between the ages of 35 and 39 may receive payment for only one screening mammography.
 - Women between the ages of 40 and 49 who are at high risk of developing breast cancer, may receive payment for annual screenings; for those who are not at high risk, payment may be for biennial screenings.
 - Women between the ages of 50 and 64 may receive payment for annual screenings
 - Women over 64 years of age may receive payment for biennial screenings.
- Revision of Frequency - Directs the Secretary, in consultation with the Director of the National Cancer Institute, to review periodically the appropriate frequency for performing screening mammography, based on age and other pertinent factors. The Secretary, on the basis of this review, may revise the mammography frequency limitations on or after January 1, 1992.
- Quality Standards - Requires the Secretary to establish quality standards, in consultation with State agencies and other organizations, to assure the safety and accuracy of screening mammographies. The standards must include the following requirements:
 - the equipment must be specifically designed for mammography and must meet radiologic standards established by the Secretary;
 - the procedure must be performed by an individual who is either licensed by a State to perform radiologic procedures or is certified to perform such procedures by an organization specified in regulations;
 - the results of the mammography must be interpreted by a physician who is certified by a board or program specified

in regulations as assuring the qualifications of the physician to interpret the mammography; and

-- there must be assurances that the results of the first screening paid for by Medicare will be placed in the permanent medical records of the woman.

o Certification - Requires the Secretary to utilize State agencies to determine compliance of providers of services with the conditions of participation regarding mammography screening. Authorizes the Secretary to find that all institutions accredited by the Joint Commission on Accreditation of Health Care Organizations, or any other national accreditation body comply with the statutory requirements of mammography screening.

o Payment Limits - Establishes a payment limit of \$50 for screening mammography performed in 1990. In a subsequent year, the limit will be indexed by the percentage increase in the Medicare Economic Index. The Secretary may reduce the amount of the limit nationwide or for selected areas after 1991, if such action maintains convenient access to quality screening services.

Application of Limit in Hospital Outpatient Setting - The Secretary will provide an appropriate allocation of the payment limit between professional and technical components for hospital outpatient screening mammographies (and comparable situations) where there is a claim for professional services separate from the claim for the radiologic procedure.

o Limiting Charges of Non-participating Physicians - Beginning January 1, 1990, nonparticipating physicians or suppliers may not charge an individual more than the limiting charge (similar to the maximum allowable actual charge, or MAAC, for non-participating physicians) or, if less and if applicable, the MAAC allowed for radiologists as established or revised by the Secretary. This "limiting charge" is 125 percent of the payment limit (\$62.50) in 1990, 120 percent of the payment limit in 1991, and 115 percent of the payment limit in subsequent years.

Enforcement - Authorizes the Secretary to apply the same sanctions available for MAAC violations against a physician or supplier who knowingly and willfully violates the limiting charge requirements.

o Reports - Directs the Physician Payment Review Commission to study and report, by July 1, 1989, to the Congress concerning the cost of providing screening mammography in a variety of settings and at different volume levels. Directs the General Accounting Office to study and report, by July 1, 1989, to the

Congress concerning the quality of care of screening mammography in a variety of settings.

Effective Date

- o For services performed on or after January 1, 1990, except for the provision dealing with "limiting charges of nonparticipating physicians" which will apply only until such time as the Secretary implements the physician fee schedules based on a relative value scale developed by the Secretary.

In-Home Care for Certain Chronically Dependent Individuals (Section 205)

Current Law

- o Home care is provided only to beneficiaries requiring skilled health care services. Services available include part-time or intermittent nursing or home health aide care; speech, occupational or physical therapy; medical social services and medical supplies and equipment.

Provision

- o Coverage - Adds a new benefit to part B of Medicare -- in-home care for a chronically dependent individual for a total of up to 80 hours in any 12-month period, but not to exceed 80 hours in any calendar year. Care provided for less than 3 hours will be counted as 3 hours of care in determining the 12-month or calendar year limit.

In-home care includes the services of a trained homemaker/home health aide; personal care services; and nursing care provided by a licensed professional nurse.

These services must be furnished under the supervision of a registered professional nurse, by a home health agency or others under arrangements with an agency.

- o Eligibility - In-home services will be available to chronically dependent individuals who are certified by a physician as having been chronically dependent for at least 3 months. A "chronically dependent individual" is defined as a person who cannot perform at least 2 activities of daily living (ADLs) without the assistance of an unpaid primary caregiver who is living with the individual. These ADLs are eating, bathing, dressing, toileting and transferring in and out of a bed or a chair.

These in-home services may be provided during a 1-year period beginning on the date that a chronically dependent individual

either has been determined to have met the catastrophic expense cap or have met the outpatient prescription drug expense cap.

If a Medicare beneficiary meets a second cap within 12 months after meeting a prior cap, a new 12-month period of eligibility begins.

Requires the Secretary to establish procedures to identify individuals in a "buy-out" prepaid health plan or a drug "buy-out plan" (where the plan is not required to track expenses) to assure that individuals are provided in-home care services.

- o Payment - Payment for in-home care services will be made per hour of care provided, on a reasonable cost (or similar cost-related) basis.

Requires the Secretary to provide an appropriate adjustment to payment rates for prepaid health plans to reflect this additional Medicare benefit.

- o Standards for Utilization - Specifies that payment cannot be made unless care is reasonable and necessary to maintain the health and condition of individuals in their homes. Requires the Secretary to assure the quality and provide for appropriate utilization of in-home care for chronically dependent individuals.
- o Study of Alternative Out-of-Home Services - Requires the Secretary to study and report to the Congress, not later than 18 months after enactment, on the advisability of providing eligible individuals with out-of-home services such as adult day care services or nursing facility services as an alternative to in-home care.

Effective Date

- o Services furnished on or after January 1, 1990.

Extending Home Health Services (Section 206)

Current Law

- o To qualify for home health services under current law, a Medicare beneficiary must be confined to the home (but does not need to be bedridden), be under the care of a physician, and require skilled nursing care on an intermittent basis, or physical or speech therapy, or in certain circumstances, occupational therapy. Intermittent is defined in administrative guidelines as no more than four days per week. Daily skilled nursing visits are permitted for up to eight

hours a day for up to three weeks if medically reasonable and necessary. Daily care can be extended beyond three weeks for extraordinary circumstances, provided the need for such care is not indefinite.

Provision

- o Defines "intermittent" care as less than seven days a week. Daily care may be provided for up to 38 consecutive days.

Effective Date

- o Services furnished on or after January 1, 1990.

Research on Long-Term Care Services For Medicare Beneficiaries (Section 207)

Current Law

- o Medicare does not cover services required for individuals whose chronic conditions require long-term nursing home or home and community-based services. There is no current requirement that the Secretary conduct research relating to long-term care services.

Provision

- o Requires the Secretary to provide for research on the delivery and financing of long-term care services for Medicare beneficiaries, including at least:
 - the financial characteristics of Medicare beneficiaries who receive or need long-term care services, including their eligibility for Medicaid benefits;
 - how the financial and other characteristics of Medicare beneficiaries affect their utilization of institutional and noninstitutional long-term care services;
 - how relatives of Medicare beneficiaries are affected financially and in other ways because the beneficiaries require or receive long-term care services;
 - the quality of long-term care services (in community-based and custodial settings) and how the provision of such services may reduce expenditures for acute health care services;
 - the effectiveness of and need for State and Federal consumer protections which assure adequate access to and protect the rights of Medicare beneficiaries receiving

long-term care in settings other than nursing facilities.

- o Requires the Secretary to submit to Congress interim reports by December 1, 1990 and December 1, 1992 and a final report by June 1, 1994.
- o Authorizes \$5 million to be appropriated in equal parts from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, for each of fiscal years 1989 through 1992.

Effective Date

- o Upon enactment.

Study of Adult Day Care Services (Section 208)

Current Law

- o No provision.

Provision

- o Requires the Secretary to conduct a national survey of adult day care services to collect information on:
 - the scope and availability of such services;
 - the characteristics of entities providing such services;
 - licensure, certification, and other quality standards applied to those providing such services;
 - the cost and financing of such services; and
 - the characteristics of the people who use such services.
- o Defines adult day care services as medical or social services provided in an organized nonresidential setting to chronically impaired persons who are not inpatients in a medical institution.
- o Requires the Secretary to report to Congress by one year after enactment. The report must provide recommendations on appropriate standards for adult day care services under Medicare, including defining chronically dependent individuals, defining services included in adult day care, establishing qualifications of providers of adult day care services, and establishing a reimbursement mechanism.

Effective Date

- o Upon enactment.

Subtitle B - Medicare Part B Monthly Premium Financing

Adjustment to Medicare Part B Premium (Section 211)

Current Law

- o Premiums for Medicare part B are charged to Medicare enrollees on a monthly basis according to an amount established in advance for each calendar year. The statute provides that the amount of the premium be established to support 25 percent of part B program costs. For 1986-1989, beneficiaries' Social Security checks cannot be reduced because of part B premium increases (i.e., beneficiaries are "held harmless").
- o Medicare beneficiaries who reside in a U.S. Commonwealth or Territory or who are not entitled to part A benefits and are enrolled in part B pay the same premiums and receive the same benefits as beneficiaries residing in the U.S.

Provision

- o Financing for catastrophic and drug coverage under this Act comes from both the supplemental premium described in section 111 (page 5) and from increases in the monthly part B premium. Revenues from the monthly part B premium increase are estimated to provide about 37 percent of the necessary financing while the supplemental premium is estimated to provide the remaining financing. Indexing of these premiums is established to maintain the proportion of program costs financed by each premium.
- o The monthly part B premium (termed the "flat premium") is increased by the sum of the catastrophic coverage monthly premium and the prescription drug monthly premium. This amount is specified in law for years 1989 - 1993.

<u>Year</u>	<u>Catastrophic Coverage Monthly Premium</u>	<u>Prescription Drug Monthly Premium</u>	<u>Total Increase</u>
1989	\$4.00	0	\$ 4.00
1990	\$4.90	0	\$ 4.90
1991	\$5.46	\$1.94	\$ 7.40
1992	\$6.75	\$2.45	\$ 9.20
1993	\$7.18	\$3.02	\$10.20

After 1993, the flat part B premium will be increased by the sum of the catastrophic coverage monthly premium and the prescription drug monthly premium, adjusted for shortfalls in the premiums and contingency margins. Each of these is calculated separately (described below).

The total monthly premium increase is then adjusted for shortfalls or excesses in annual supplemental premium rates resulting from the requirement in section 111 that the annual supplemental premium rate may not increase by more than \$1.50 or be lower than the prior year increase (see page 6).

Calculation: a) The Secretary of Treasury determines the "excess or shortfall rate" by subtracting the current year actual supplemental premium rate from what the supplemental premium rate would have been if it had not been adjusted by the limits; b) The "excess or shortfall" is then determined by dividing the total supplemental premiums imposed in the second preceding year by the total amount of such premiums adjusted by the "excess or shortfall rate"; c) 1/12th this excess or shortfall amount is increased by the percentage by which the per capita catastrophic coverage premium liability for the fourth preceding year exceeds such liability for the fourth preceding year (calculated as if the catastrophic coverage premium rate for the second and fourth preceding calendar year were the same); d) The adjusted monthly excess or shortfall is divided by the average number of individuals covered during the preceding year.

In no case could the monthly premium increase be less than the increase in effect in the preceding year. If these adjustments change the total monthly premium increase, the increase in the monthly premium would be allocated proportionately between the catastrophic monthly premium and the prescription drug monthly premium on the basis of the respective amounts of such premiums.

Catastrophic Coverage Monthly Premiums After 1993: After 1993, the catastrophic coverage monthly premium will be the premium in effect for months in the preceding year adjusted by the sum of the outlay-premium percentage and the reserve account percentage.

The "outlay premium percentage" is the percent by which the per capita catastrophic outlays in the second preceding year exceeds (or are less than) such outlays in the third preceding year. An adjustment is provided for changes in the Consumer Price Index.

The "reserve account percentage" is designed to adjust the premium rate to recoup 37 percent of any shortfall (or excess) in the catastrophic coverage program contingency reserve. The remaining 63 percent is recouped by a corresponding adjustment in the supplemental premium. The contingency reserve is 20 percent of outlays in the second preceding year. Calculation: the reserve account percentage is equal to the ratio of the change in the

catastrophic monthly premium for the second preceding year which would have increased (or reduced) premiums by an amount equal to 63 percent of the shortfall (or excess) in the Account to the unrestrained catastrophic monthly premium for the preceding year.

Prescription Drug Monthly Premium After 1993: Premiums after 1993 will be determined using the same rules described above with two differences:

The contingency margin is different. The amounts in the law are based on outlays during the second preceding year. Thus, the "effective" contingency margin for the monthly drug premium is 75 percent for 1992, 50 percent for 1993, and 25 percent for 1994 and 1995.

No adjustment for the outlay-premium percentage shall be made for years before 1998.

- o Premiums for Residents of Puerto Rico or other U.S. Territories or Commonwealths: The monthly premium for these individuals shall be increased by the sum of a special catastrophic coverage monthly premium and the prescription drug monthly premium for the year, as follows:

<u>Year</u>	<u>Catastrophic Monthly Premium</u>		<u>Drug Monthly Premium</u>	
	<u>Puerto Rico</u>	<u>Other Terr.</u>	<u>Puerto Rico</u>	<u>Other Terr.</u>
1989	\$1.30	\$2.10	0	0
1990	\$3.56	\$5.78	\$0.14	\$0.22
1991	(see below)	(see below)	\$1.21	\$1.93

For years after 1990, the catastrophic monthly premium will be increased with respect to such residents by the percentage by which per capita catastrophic outlays for the year will exceed per capita outlays for the preceding year. A similar calculation with regard to outlays for prescription drugs will be used to establish future prescription drug premium increases.

- o Part B Only Beneficiaries - The basic part B premium for these individuals will be increased by the sum of a special catastrophic coverage monthly premium and the prescription drug monthly premium for the year. The catastrophic monthly premium is set at \$8.57 in 1990. In subsequent years, the monthly premium will be equal to 1/12 of the estimated average actuarial expenses incurred during the year for benefits and administrative costs for catastrophic benefits (other than benefits and costs attributable to part A).

The prescription drug monthly premium is set at \$0.53 in 1990

and \$4.61 in 1991. In later years, the monthly premium will be equal to 1/12 of the average actuarial expenses estimated to be incurred for benefits and administrative costs for drugs under this program.

- Regulations - The Secretaries of HHS and Treasury will jointly publish a proposed regulation by July 1 of each year (beginning with 1993) to establish premium increases for the following year. The Secretaries shall report to Congress by September 1 of such year on the final premiums and publish those premiums as a final regulation in the Federal Register during the last 3 days of September of each year.

The Secretary of HHS will report to Congress in 1993 regarding the appropriateness of the level of premium increases for residents of Puerto Rico and other U.S. Commonwealths and Territories.

- Hold Harmless Provision - For 1989 and beyond, beneficiaries entitled to Social Security or Railroad Retirement benefits for November and December of the preceding year and who have their part B premiums deducted from their Social Security or Railroad Retirement checks for December and January, may not have their Social Security and Railroad Retirement benefits decreased due to an increase in the part B premium (including the drug and catastrophic premiums) in any year.
- Payments to HMOs and CMPs - For risk-sharing organizations, the Secretary will determine the portion of the payment from each trust fund based on the relative weight that benefits from each fund contribute to the adjusted average per capita cost. For cost-contracting organizations, initial allocations will be based on the Plan's most recent budget, adjusted (if necessary) to reflect actual expenditures.

Effective Date

- Applies to monthly premiums beginning with January 1989.

Establishment of Federal Catastrophic Drug Insurance Trust Fund; Fund Transfers (Section 212)

Current Law

- Under current law, there are two Medicare trust funds: the Federal Hospital Insurance (HI) Trust Fund for part A benefits and the Federal Supplementary Medical Insurance (SMI) Trust Fund for part B benefits.

- o Authorizes the Secretary to appoint state members of the Supplemental Health Insurance Panel.

Effective Date

- o The new model standards must be issued 90 days after enactment by NAIC (or 60 days thereafter by the federal government, if necessary). States have up to one year to adopt equivalent standards. If state legislation is required and the legislature does not meet in 1989, the State will have until the first day of the first calendar quarter after the close of the first legislative session beginning after January 1, 1989 to adopt new standards.

Beneficiaries must receive a notice by January 1, 1989 for deemed policies and by January 31, 1989 for policies that do not meet the deeming requirements.

- o Review of advertisements applies as of January 1, 1989.
- o The Secretary shall reappoint members to the Supplemental Health Panel no later than 90 days after enactment.
- o The 30 day cancellation provision and the provision requiring reporting of loss ratios are effective when the state adopts amended standards.
- o The reports to Congress are due in March 1989 and July 1990.

Adjustment of Contracts with Prepaid Health Plans (Section 222)

Current law

- o The Secretary is authorized to contract with HCPPs, HMOs and CMPs to provide Medicare covered services.

Provision

- o This provision requires the Secretary to modify contracts with all prepaid plans (including HCPPs, cost- and risk-contracting HMOs and CMPs, and prepaid plans under demonstration projects) to reflect the new catastrophic requirements.
- o The prepaid plans are required to adjust their agreements with beneficiaries, including appropriate adjustments in premiums and covered benefits.

Effective Date

- o Portions of contract years occurring after December 31, 1988.

Mailing of Notice of Medicare Benefits and Information Describing Participating Physician Program (Section 223)

Current law

- o There is no current requirement for an annual notice to beneficiaries on the scope of Medicare benefits, although the Medicare Handbook is frequently updated and is made available to beneficiaries.
- o Physicians and suppliers may "participate" by accepting assignment (Medicare payment as payment in full with the exception of coinsurance) on all claims. Directories of participating physicians and suppliers are published and made available through Social Security Offices, hospitals, aging and consumer groups. The Explanation of Benefits for unassigned claims includes a reminder of the participating physician and supplier program and a toll-free number where information can be obtained.

Provision

- o Requires the Secretary to send an annual notice to beneficiaries (and a notice to new eligibles) that describes benefits covered and not covered under Medicare (including long-term care services covered under Medicare and Medicaid) and the limitations on Medicare payments (including deductibles and coinsurance). The Secretary will consult with groups representing the elderly and health insurers when preparing this notice.
- o Requires the Secretary to send an annual mailing to beneficiaries that will describe the advantages of the participation program and an explanation of carrier assistance in obtaining the name of a participating physician or supplier, including a toll-free line and free directory.
- o Requires the "Explanation of Benefits" sent to the beneficiary to include a "prominent" reminder of the participating physician and supplier program, an offer of assistance in obtaining the name of a participating physician specialist, and a free copy of the participating physician and supplier directory. Requires the "Explanation of Benefits" to include a clear statement of charges for services on a particular claim which are above the Medicare approved amount.

Effective Date

- o The first annual notice of Medicare benefits is to be distributed by January 31, 1989; the annual notice on the participating physician program will begin in 1989; and the revised explanation of benefits applies to items or services

furnished on or after January 1, 1989.

**Changes in Civil Money Penalties for Certain Practices of Health Maintenance Organizations and Competitive Medical Plans
(Section 224)**

Current law

- o Risk-sharing HMOs and CMPs that fail to furnish medically necessary services are subject to civil monetary penalties of \$25,000 for each failure.
- o The Secretary may impose civil money penalties up to \$25,000 on HMOs or CMPs that impose premiums on enrollees in excess of those permitted by law; violate provisions that relate to expulsion of or refusal to re-enroll individuals because of health status; misrepresent or falsify information provided to an individual or another entity; fail to pay promptly for services and supplies.

Civil money penalties of up to \$100,000 can be imposed on HMOs or CMPs that deny or discourage enrollment on the basis of health status, or that misrepresent or falsify information to the Secretary.

- o In addition to civil money penalties, the Secretary may impose intermediate sanctions (suspend new enrollments or payments) until corrections have been made.

Provision

- o If the Secretary assesses a civil money penalty against an HMO or CMP for charging a premium in excess of that permitted by law, the penalty will be double the excess premium amount. The amount of the excess premium will be deducted from the civil money penalty paid by the HMO or CMP and paid to the beneficiary.
- o If an HMO or CMP denies or discourages enrollment on the basis of health status, the Secretary may assess an additional penalty of \$15,000 for each individual not enrolled.

Effective Date

- o Enactment.

TITLE III - PROVISIONS RELATING TO THE MEDICAID PROGRAM

Requiring Medicaid Buy-In of Premiums and Cost-Sharing for Indigent Medicare Beneficiaries (Section 301)

Current Law

- o Under a "buy-in" agreement, most States pay Medicare part B premiums for Medicaid eligibles who are also eligible for Medicare.
- o Prior to OBRA 86, federal matching funds for premium payments were available only for cash assistance recipients. States could use State-only funds to buy in for non-cash assistance persons.
- o OBRA 86 made a number of changes, effective July 1, 1987:
 - Medicare Part A beneficiaries not otherwise eligible for Medicaid were established as a new optional coverage group. If a State chooses this option:
 - + It may set an income eligibility level up to a maximum of 100% of the federal poverty level; and
 - + It must use the Supplemental Security Income (SSI) resource standard, except if the State has a medically needy program using a higher resource standard it may apply this higher standard to this group;
 - + It must cover "some or all" newly pregnant women and children up to 100% of the federal poverty line (see Section 302 below).
 - Covered benefits for the new optional coverage group of Medicare beneficiaries, for which federal Medicaid matching funds are available, are limited to Medicare cost-sharing. This term is defined as: part B premiums, part A premiums (if applicable), part A deductibles and coinsurance, and part B deductibles and coinsurance. The definition may also include, at State option, premiums for enrollment of an eligible beneficiary with a Medicare-qualified risk-sharing HMO.

Provision

- o For the elderly and disabled whose incomes are at or below the specified percentage of the federal poverty level and who, except for 1902(a)(10)(E), would not be Medicaid eligible, Medicaid buy-in of Medicare coverage is changed from State option to mandatory. This will be phased in as follows.

- For all States (except the 5 specified 209(b) States listed below):
 - + 1/1/89 - 85% of poverty
 - + 1/1/90 - 90% of poverty
 - + 1/1/91 - 95% of poverty
 - + 1/1/92 - 100% of poverty
- For a specified 5 of the 14 209(b) States (HI, IL, NC, OH, and UT):
 - + 1/1/89 - 80% of poverty
 - + 1/1/90 - 85% of poverty
 - + 1/1/91 - 90% of poverty
 - + 1/1/92 - 95% of poverty
 - + 1/1/93 - 100% of poverty
- Mandatory coverage is optional for the Commonwealths and Territories. If they choose to offer such coverage, they also may choose the income level (percent of poverty).
- States retain the option to offer coverage (and receive federal matching funds) at higher income levels than the mandatory phase-in schedule (up to a maximum of 100 percent of poverty).
- o The resource standard for qualified Medicare beneficiaries (QMBs) is changed to twice the SSI resource standard.
- o Medicare cost-sharing for QMBs is revised to include coverage of catastrophic premiums, coinsurance, and deductibles (subject to the drug deductible option described below).
- o The new Medicare prescription drug catastrophic benefit (added by provisions elsewhere in the law) is also available to QMBs.
- Mandatory coverage is phased in on the same income schedules described above for the buy-in. Therefore, when the prescription drug benefit becomes fully operational on January 1, 1991, it will be provided from that point forward under the buy-in to individuals at or below 95 percent of poverty in non-209(b) States and to individuals at or below 90 percent of poverty in the 5 specified 209(b) States.

-- Medicare cost-sharing for QMBs will now include State use of Medicaid funds to pay the catastrophic prescription drug benefit deductible. Alternatively, if the State provides a prescription drug benefit under its Medicaid State plan, it may opt to provide QMBs (before the catastrophic drug deductible amount is reached) with prescription drug benefits of the same amount, duration, and scope as is provided to mandatory Medicaid eligibles.

Effective Date

- o These provisions apply for monthly Medicare premiums and for items and services furnished on or after January 1, 1989 (without regard to whether or not final regulations have been promulgated).

Coverage and Payment for Pregnant Women and Infants with Incomes Below Poverty Line (Section 302)

Current Law

- o A State choosing the OBRA 86 option to buy into Medicare for qualified Medicare beneficiaries must provide Medicaid coverage for "some or all" pregnant women and children at or below 100 percent of the federal poverty line.
- o States may continue the eligibility of a qualified pregnant woman (through the end of the month in which the 60-day period, beginning on the last day of her pregnancy, ends) without regard to changes in family income.
- o Any State which chooses the OBRA 87 option to cover pregnant women and infants up to age one with incomes up to 185 percent of poverty cannot reduce Aid to Families with Dependent Children (AFDC) cash assistance levels below the levels in effect as of July 1, 1987.

Provision

- o Optional Medicaid coverage of pregnant women and infants up to age 1 is made mandatory in the 50 States and Washington, D.C.
 - Infants will be covered for all Medicaid benefits offered by the States to cash assistance recipients.
 - Mandatory coverage will be phased in. Individuals and families with incomes at or below 75 percent of the federal poverty level for a family of that size must be covered, beginning July 1, 1989. Those with incomes at or below 100 percent of the poverty level must be covered beginning July 1, 1990.

- For the Commonwealths and Territories, coverage under these provisions is optional. If they choose to provide coverage under this option, they may also choose the income level (percentage of poverty).
- States have the option to continue the eligibility of pregnant women, without regard to income changes, through the end of the month in which the 60-day post-partum period ends.
- There are several State maintenance of effort requirements:
 - + Any State that, as of July 1, 1988, offered Medicaid coverage to optional categorically needy poverty level pregnant women (or had enacted legislation to offer such coverage before July 1, 1989) must continue this coverage for at least the same income level (or at 100 percent of the poverty level) until the new mandatory rates exceed the State's current optional rate.
 - + If a State had chosen to provide medical assistance to pregnant women and children with incomes below 185 percent of the poverty level, federal financial participation is now prohibited for such medical assistance if the State reduced its AFDC cash assistance levels below those which were in effect on July 1, 1987. In addition, the Secretary may not approve State Medicaid plans for States that reduce their AFDC cash assistance levels below the levels in effect on May 1, 1988.
- o Exceptions are required to inpatient hospital service limits for infants up to age one in disproportionate share hospitals.
 - If a State has durational limits on Medicaid payments, it must provide an exception in the Medicaid State plan for medically necessary inpatient hospital services for infants up to age one for disproportionate share hospitals.
 - Any State that pays for inpatient hospital services on a prospective basis must develop an outlier payment policy to provide reasonable adjustments to disproportionate share hospitals for medically necessary inpatient services delivered on or after July 1, 1989 for infants up to age one. State plan amendments governing disproportionate share hospitals must be submitted to the Secretary no later than April 1, 1989.

Effective Date

- o The new mandatory coverage provision is effective for medical assistance furnished in calendar quarters beginning on or

after July 1, 1989 (without regard to promulgation of final regulations). If the Secretary determines that State legislation is needed to implement these provisions, State plan amendments may be delayed until the first day of the first calendar quarter beginning after the close of the first regular session (the close of the first year of a two-year session) of the State legislature that begins after July 1, 1988.

- o The disproportionate share provisions are effective July 1, 1988.

Protection of Income and Resources of Couple for Maintenance of Community Spouse (Section 303)

Current Law

- o General - The linkage of Medicaid eligibility to actual or potential receipt of SSI cash assistance leads to certain financial difficulties for recipients or their spouses when one individual in a married couple is institutionalized while the other remains in the community. This is particularly evident when most of the couple's income and resources are in the name of the institutionalized spouse.
- o Attribution of Income - When spouses live together in the community, the income of each is considered to be available to the other and is considered in determining SSI and Medicaid eligibility. When one member of the married couple is institutionalized for longer than one month in a Medicaid-certified facility, only the income of the institutionalized individual is considered in determining his or her Medicaid eligibility. Most States follow the "name on the check" rule, where income is considered to belong to the individual named on the check or other financial instrument (court decisions in some States direct that community property principles will be applied). The institutionalized individual is allowed to keep an amount for the maintenance of his or her spouse in the community, if that spouse has little or no income of his or her own. However, the permissible amount is so low that a community spouse without substantial independent income and resources is likely to be left impoverished because income and resources above the protected level must be spent to pay for institutional care, both before and after Medicaid eligibility is established.
- o Resources - Resources must be considered mutually available for 6 months after institutionalization if both spouses are SSI eligible and for 1 month if only one spouse is SSI eligible. After that time, the following rules apply:

- If resources are held solely by the institutionalized spouse, they are attributed to him or her.
- If they are held jointly by the institutionalized spouse and the noninstitutionalized spouse, each spouse is considered to own 100 percent of the resources in determining their eligibility as individuals.
- If they are held solely by the noninstitutionalized spouse, they are not attributed to the institutionalized spouse.
- After excluding the couple's home and limited amounts for a car, household goods and personal effects, resources above specified amounts (\$1,900 in liquid resources for an individual and \$2,850 for a couple in 1988) that are attributed to the institutionalized person must be used to pay for the costs of the institutionalized spouse's care.
- o Protecting Income for Community Spouse - After an institutionalized individual has established Medicaid eligibility, all income in excess of specified deductions must be applied to the cost of his or her institutional care. The deductions apply in the order shown below:
 - A monthly personal needs allowance for the institutionalized individual (at least \$30 as of July 1, 1988).
 - A monthly maintenance needs allowance for an individual with a spouse at home which may not exceed:
 - + the SSI standard for an individual residing in his or her own home, or
 - + the highest income standard for State optional supplementary payments, or
 - + the medically needy standard for one person.
 - An additional allowance for an individual with a family at home.
 - Amounts for medical expenses not covered by a third party, subject to reasonable limits (regulations make this a State option, effective April 8, 1988).
- o Notice and Hearing - No provision.
- o Court Ordered Support - The income of an institutionalized spouse is available to him or her for contributing to the cost of care, notwithstanding State or local court orders requiring monthly payments to the community spouse.

- o Transfer of Assets - In most States, Medicaid excludes items from countable assets before determining eligibility (the same items that SSI excludes). States have the option to impose certain restrictions on transfers of assets. If an individual disposes of a countable asset for less than fair market value, the uncompensated value of the asset is considered still available to the individual, and may, when added to the amount of other non-excludable resources, result in ineligibility for a period of time after the date of transfer. At State option, this time period may be 24 months (the same as SSI), or a longer or shorter period which is reasonably related to the amount of uncompensated value. This penalty may be waived in cases of undue hardship.

States may also deny Medicaid eligibility for at least 24 months to an individual who is an inpatient in a medical institution and who, within 24 months prior to application for Medicaid or thereafter, disposes of a home (an excluded resource for both SSI and Medicaid purposes) for less than fair market value. This penalty must be waived: if the individual is expected to return to the home; if title was transferred to a spouse or to a child who is under age 21, blind or disabled; if the individual intended to transfer the home for fair market value; or if undue hardship would result.

- o Income and Resource Eligibility Methodologies - Some States use less restrictive income and resource methods for determining eligibility than are used under the SSI or AFDC programs, despite the statutory requirement that States use the same methods as AFDC or SSI. There is a statutory moratorium on adverse actions that would otherwise be taken in cases where State policies or practices covered by the moratorium do not conform to this requirement.

Provision

- o New Provision for Institutionalized Spouses - A new provision supercedes other Medicaid eligibility provisions as they apply to institutionalized spouses. Comparable treatment is not required for other groups of eligibles. The new section does not apply to determinations of what constitutes income or resources for other Medicaid purposes or to the methodology and standards to be used for determining and evaluating income and resources. The provisions are applicable to the 50 States and Washington, D.C., including States with a Section 1115 waiver, but not to the Commonwealths and Territories.

-- Attribution of Income - During any month in which a spouse is institutionalized, no income belonging to the community spouse is considered to be available to the institutionalized spouse in determining the eligibility of

either spouse.

Once Medicaid eligibility is established for the institutionalized spouse, the following rules apply, regardless of State community property laws to the contrary. They apply to both trust and non-trust income unless the trust or other instrument provides otherwise.

- + Income paid solely in the name of one spouse is considered to belong only to that individual.
- + If income is paid in the names of both spouses, half is considered to be available to each spouse.
- + If income is paid in the names of either or both spouses and another individual or individuals, income is considered to be available to each spouse in proportion to that spouse's interest.
- + If a division of interest between the two spouses is not specified--regardless of whether from a trust, nontrust instrument, or from no instrument establishing ownership--half of the income is considered to be available to each spouse.

An institutionalized spouse can rebut the above income attribution rules for non-trust income or for income from property without an instrument by establishing by a preponderance of the evidence that ownership interests are other than those specified in the new provisions.

- Resources - The State must compute the total value of a couple's resources as of the start of a continuous period of institutionalization. Each spouse's share is considered to be one-half of the total.

At the beginning of a continuous period of institutionalization of one spouse, if either spouse so requests, the State must provide to each spouse an assessment and copies of documentation of total joint resources promptly upon receipt of such documentation. If the request is not part of an application for Medicaid, the State may charge a reasonable fee for the assessment.

When the State provides the copy of the assessment, it must provide notice that either spouse may request a fair hearing as to whether the community spouse resource allowance is adequate to generate sufficient money to raise the community spouse's income to the minimum monthly maintenance needs allowance.

At the time of application for Medicaid (which in many

cases lags behind the time of admission), determination of countable resources is to be made, regardless of State laws relating to community property or division of marital property. All the couple's resources, except for the home and all household goods, are considered to be available to the institutionalized spouse except for a resource allowance for the community spouse.

The resource allowance protected for the community spouse is the greater of \$12,000 (indexed for inflation) or the spouse's share (half) of the couple's total resources as calculated at the start of the period of institutionalization.

- + The State may elect to set a minimum amount that is higher than \$12,000.
- + Higher amounts can be protected to the extent that the community spouse demonstrates in a fair hearing that additional amounts of resources are necessary to generate enough income to assure that the community spouse has the minimum protected amount of monthly income, or if a court orders an additional amount to be transferred for the support of the community spouse.
- + However, in all cases the maximum amount of the couple's resources that is protected for the community spouse is \$60,000 (also indexed for inflation).

If resources available to the community spouse are less than the community resource allowance described above, then the institutionalized spouse is permitted to transfer resources to the community spouse in an amount which, when added to the community spouse's own resources, equal the community spouse resource allowance.

An institutionalized spouse will not be considered ineligible because of resources determined to be available if:

- + Such individual has assigned to the State any rights of support from the community spouse;
- + Such individual lacks the ability to execute an assignment due to physical or mental impairment but the State has a right to bring a support proceeding against the community spouse without such assignment; or
- + The State determines that denial of eligibility would work an undue hardship.

During the continuous period of institutionalization, after

an institutionalized spouse has established eligibility for Medicaid, no resources of the community spouse shall be considered to be available to the institutionalized spouse.

-- Protecting Income for Community Spouse - After an institutionalized spouse is determined to be eligible for Medicaid, in determining the amount of that spouse's income that is to be applied monthly to the costs of institutional care, deductions from that spouse's income are to be made in the following order:

- + A monthly personal needs allowance of not less than \$30 for the institutionalized spouse.

- + A minimum monthly maintenance needs allowance for the community spouse sufficient to bring the community spouse's monthly income (from all sources) up to a level between the minimum and maximum amounts specified, plus an excess shelter allowance (see below):
 - Minimum 9/30/89 1/12 of 122% of Federal poverty level for 2-person household
 - 7/1/91 1/12 of 133% of Federal poverty level for 2-person household
 - 7/1/92 1/12 of 150% of Federal poverty level for 2-person household

 - Maximum not to exceed \$1,500 (indexed for inflation), except where a higher level is set through a fair hearing or court order.

 - Excess shelter allowance in the amount (if any) that the sum of the following exceeds 30 percent of the minimum monthly maintenance needs allowance: the rent or mortgage, plus taxes and insurance, plus the required maintenance charge (for condominiums and cooperatives), plus the standard utility allowance used by the State under the Food Stamp Act (or the spouse's actual utility expenses if the State does not use this allowance).

- + A monthly family allowance for each family member (minor or dependent child, dependent parent or dependent sibling of the institutionalized or community spouse residing with the community spouse) equal to at least one-third of the amount by which one-twelfth of 122 percent of the federal poverty level for a family of two exceeds the amount of monthly income of that family member. The percentage will rise from one-twelfth of 122 percent to one-twelfth of 133 percent on July 1,

1991, and to one twelfth of 150 percent on July 1, 1992.

- + Incurred expenses of the institutionalized spouse for medical or remedial care not subject to payment by a third party (which are further described below).

- Notice and Hearing - Requires the State to notify both spouses at the time of the eligibility determination, or to notify either spouse upon request: of the amount of the community spouse minimum monthly maintenance needs allowance and any family allowance; of the method for computing the amount of the community spouse resource allowance; and of each spouse's right to a fair hearing on ownership or availability of income or resources, and on the determination of the community spouse minimum monthly maintenance needs or resource allowances. Hearings must be held within 30 days of the date a request is made.

If either spouse establishes at a fair hearing that, due to exceptional circumstances resulting in significant financial hardship, the community spouse needs income above the level of the minimum monthly maintenance needs allowance, the State is required to increase the allowance to provide this amount, even if it exceeds the \$1,500 statutory maximum.

If either spouse establishes in a fair hearing that the community spouse resource allowance (in terms of the amount of income it generates) is inadequate to raise the income of the community spouse to the level of the minimum monthly maintenance needs allowance (taking into account other income attributed to the community spouse), the State must provide for a resource allowance sufficient to generate that level of income for the community spouse.

- Court Ordered Support - If a court has entered an order against an institutionalized spouse, the following provisions will apply:

- + If the order specifies monthly income support for the community spouse, the community spouse monthly maintenance needs allowance must be at least as much as the court-ordered amount.

- + If the order requires the institutionalized spouse to transfer countable resources to the community spouse, such transfer will not be considered to be a violation of the transfer of assets prohibitions.

- + If the order requires the transfer of resources from the institutionalized spouse to the community spouse, the community spouse resource allowance will be the amount

specified in the order or the statutory ceiling amount, whichever is greater.

- o Transfer of Assets - The Medicaid transfer of assets provisions are amended to require all States, including those that have used more restrictive State-defined rules on transfer of assets (209(b) States), to determine whether an individual institutionalized in a nursing facility or other medical institution has disposed of countable assets for less than fair market value within the 30 months prior to application for Medicaid.
 - If the State determines that this has occurred, the Medicaid State plan must provide for a period of ineligibility. The period will begin with the month in which the resources were transferred. It will last for the lesser of 30 months or the number of months that the uncompensated value of the transferred resources would have paid, at the average cost to a private patient at the time of application for Medicaid, in a nursing facility in the State (or, at the option of the State, in the community) where the individual is institutionalized.
 - The period of ineligibility would not apply in cases where:
 - + The resource transferred is the home and it is transferred to the individual's spouse;
 - + The home is transferred to the individual's child, who is under age 21, or blind, or disabled;
 - + The home is transferred to a sibling who has an equity interest in the home and was residing in the home for at least a year prior to the individual's admission to a nursing home or medical facility;
 - + The home is transferred to the individual's child who was residing in the home for at least two years prior to the admission and was providing care which permitted the individual to reside at home;
 - + The resource is transferred to (or is transferred to another for the benefit of) the community spouse, or the individual's child who is blind or is permanently and totally disabled;
 - + A satisfactory showing can be made to the State that: the individual intended to dispose of the resources for fair market value or for other valuable consideration; or the resources were transferred exclusively for a purpose other than to qualify for Medicaid;

+ The State determines that denial of eligibility would work an undue hardship.

- o Transfer of Resources - Current SSI law requires that the uncompensated value of non-excludable resources transferred at less than fair market value by an SSI applicant or recipient be counted toward the SSI resource limit. This provision is repealed. However, such a transfer by an SSI applicant or recipient will still be considered in determining the individual's Medicaid eligibility, if and when the individual enters a nursing facility or other medical institution.

The Secretary will be required to inform individuals of these provisions in writing at the time of application for SSI and at the time of SSI redetermination of eligibility.

The Secretary is also required to request information from individuals about transfers, to inform the individual at that time that such information will be made available to the State Medicaid agency, and to make such information available to the State Medicaid agency upon request.

- o Income of Institutionalized Individuals and Incurred expenses for Medical and Remedial Care not Subject to Third Party Payment - Post-eligibility income treatment for an institutionalized individual (whether or not he or she has a spouse in the community) and for persons receiving services under a home and community-based waiver must take into account incurred expenses for medical or remedial care that are not subject to payment by a third party, including Medicare, as well as health insurance premiums, deductibles, and coinsurance.

This new provision is intended to retroactively reinstate the rule used prior to the recent regulation (which was effective April 8, 1988 and which permitted States to substantially limit or eliminate this deduction). As before, the intention is that States may set "reasonable limits" so that nursing facility residents are able to use their own funds to purchase necessary medical or remedial care not covered by the State Medicaid program, while minimizing opportunities for providers to take advantage of either the program or the residents.

- o Conforming Amendment on Income and Resource Standards - A State's methodology for determining income and resource eligibility for the medically needy, and qualified pregnant women and children, and mandatory poverty level women and infants, and the optional categorically needy may be less restrictive, but no more restrictive, than that under the relevant cash assistance program. The methodology is considered to be no more restrictive if, in using it, additional individuals may be eligible and no otherwise

eligible individuals are made ineligible. Income and resource eligibility methodologies in 209(b) States may be both less restrictive and more restrictive than SSI.

- o Homestead Exemption in Missouri - The Missouri Medicaid State plan must be amended to provide that the State will not consider the home of any aged, blind, or disabled individual in the State who applies for Medicaid in determining resources, regardless of the value of the home.

Effective Date

- o Unless otherwise specified, these changes apply to Medicaid payments for calendar quarters beginning on or after September 30, 1989, regardless of the promulgation of final regulations.
- o The new provisions on eligibility regarding institutionalized spouses applies only to institutionalized individuals who begin continuous periods of institutionalization on or after September 30, 1989, except that the provisions dealing with income, shall apply as of September 30, 1989 to individuals who are institutionalized on or after that date.
- o The amendments regarding Medicaid transfer of assets requirements apply to Medicaid payments for calendar quarters beginning on or after July 1, 1988.
 - An exception is permitted if the Secretary determines that State legislation is required, in which case the effective date is delayed until the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature (or the first year in States with two-year legislative sessions) after the date of enactment.
 - The amendments apply to applications for Medicaid on or after July 1, 1988 and to assets transferred on or after that date. They also apply on or after that date in 209(b) States that had elected the option to use more restrictive eligibility standards than SSI. However, the State may continue to apply transfer of assets policies which were contained in the Medicaid State plan as of June 30, 1988 with respect to resources disposed of before July 1, 1988, even when application for Medicaid is made on or after that date.
- o Repeal of the SSI transfer of resources provision applies to transfers on or after July 1, 1988 regardless of the promulgation of final regulations.
- o Disregard of payment for medical or remedial expenses not subject to third party payments is effective on or after April

8, 1988 and the regulation on this subject is superceded to the extent that it is inconsistent with the legislation.

- o The conforming amendment regarding income and resources is effective retroactively for medical assistance furnished on or after October 1, 1982.
- o The Missouri homestead exemption provision requires the Missouri Medicaid State plan to be amended by October 1, 1989.

TITLE IV - UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE, OBRA TECHNICAL CORRECTIONS, AND MISCELLANEOUS PROVISIONS

Subtitle A --United States Bipartisan Commission on Comprehensive Health Care

Current Law

- o No provision.

Provision

- o Establishes a commission to examine shortcomings in the current health care delivery and financing mechanisms that limit or prevent access of all individuals in the United States to comprehensive health care.
- o Requires that the Commission make specific recommendations to Congress with respect to Federal programs, policies, and financing needed to assure the availability of comprehensive long-term care and overall health care services for the elderly, disabled and the total U.S. population.
- o Members of the Commission are to be appointed by the President, the President Pro Tempore of the Senate and the Speaker of the House.
- o The Commission may secure technical assistance and any information necessary to carry out its duties from any Federal agency.
- o Reports due to Congress no later than:
 - 1/1/89 Report on Comprehensive Long-Term Care Services for the Elderly and Disabled
 - 7/1/89 Report on Comprehensive Health Care Services.

-- The reports are to contain detailed recommendations for appropriate legislative initiatives.

- o \$1,500,000 is authorized to be appropriated to carry out this title.

Effective date

- o July 1, 1988

Subtitle B - OBRA Technical Corrections

Selected Technical Corrections to Certain Health Care Provisions in the Omnibus Budget Reconciliation Act of 1987 (Section 411)

NOTE: Subsections of Section 411 are summarized below only if the corrections substantially change the intent or application of such provisions as originally drafted. Hence, textual changes intended to conform statute more closely to original intent, as well as corrections of punctuation and printing, are not described.

EFFECTIVE DATES: Unless otherwise noted, the technical corrections are effective as if they were included in the OBRA 87 provisions.

Corrections Relating to Part 1 of Subtitle A of Title IV (Part A of the Medicare Program) (Section 411(b))

Revision of Standards for Including a Rural County in an Urban Area (Section 411(b)(4))

Current Law

- o Treats hospitals located in rural counties adjacent to one or more urban area as being located in the urban area to which the greatest number of workers in the community commute, if:
 - the rural county would otherwise be considered urban, except that it does not meet the commuting rate standard;
AND
 - rural residents who commute to the central county or counties of all adjacent MSAs equal 15 percent of the number of employed residents OR
 - the sum of rural residents who commute to the central county or counties of an adjacent MSA plus the residents of

the adjacent urban area who commute to the rural county must equal at least 20 percent of the number of employed rural residents.

Provision

- o Narrows the number of rural counties which will qualify for the urban rate by redefining the standards that hospitals located in rural areas must meet, as follows:
 - rural counties which otherwise would be considered part of an urban area under the standards for designating MSAs, if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable, from) the central county or counties of all contiguous MSAs.

Reporting Hospital Information (Section 411(b)(6))

Current Law

- o OBRA requires the Secretary to conduct a project demonstrating the costs and benefits of establishing a uniform system for reporting hospital cost, charge, and revenue information. A list of data items hospitals would be required to report was specified, as well as project duration -- 3 years -- and funding -- a minimum of \$3 million over 3 years, not to exceed \$15 million.

Provision

- o Eliminates or modifies information requirements. Information is no longer required to be reported by "category of service." Information concerning outpatient visits is no longer required, although the Secretary is required to develop a definition of "outpatient visits" for purposes of reporting hospital information.
- o Loosens specific constraints on the timing and funding for the project, without changing overall totals, in order to accommodate time lags in the submission of cost report information.
- o Permits the Secretary to delay or waive the standardized electronic cost reporting format for hospitals where implementation would result in financial hardship for hospital cost reporting periods beginning on or after October 1, 1989.

Corrections Relating to Subpart A of Part 2 of Subtitle A of Title IV (Health Maintenance Organization Reforms) (Section 411(c))

Guaranteed Rates (Section 411(c)(2))

Current Law

- o OBRA imposed a requirement that hospitals and SNFs accept the Medicare rates or limits as payment in full for services they furnish to Medicare beneficiaries enrolled in TEFRA risk plans.

Provision

- o Extends the OBRA provision to pre-TEFRA risk plans, including demonstration projects, and also clarifies that the provision applies only in the case of hospitals and SNFs with which a plan does not have a contract establishing payment amounts. That is, a hospital or SNF may negotiate with a prepaid health plan to determine the specific rates to be paid for services provided to plan members. However, in the absence of a contract specifying such rates for services furnished to Medicare beneficiaries, the hospital or SNF will have to accept the amount which would otherwise be paid under Medicare.

Effective Date

- o Admissions on or after November 1, 1988.

Benefit Stabilization Fund (Section 411(c)(3))

Current Law

- o Prior to OBRA, a plan could, during a four-year period, establish a benefit stabilization fund that could be maintained for up to four years. OBRA extended by two years the period of time plans can maintain benefit stabilization funds.

Provision

- o Amends the provision so that, consistent with Congressional intent, the two-year extension applies to the period during which plans can establish benefit stabilization funds, and not to the period for which they can maintain them. Thus, the Secretary may not approve use of the benefit stabilization fund for any period beginning later than September 30, 1990.

Corrections Relating to Subpart B of Part 2 of Subtitle A of Title IV (Home Health Quality) (Section 411(d))

Home Health Agency Standard and Extended Survey (Section 411(d)(2)(B))

Current Law

- o Provides for new survey requirements, including unannounced standard surveys with home visit assessments and extended surveys, and requires the Secretary to evaluate and report to Congress on the assessment process by January 1, 1991.

Provision

- o Delays the date on which the Secretary must report to Congress to January 1, 1992.

Home Health Agency Accreditation Survey Results (Section 411(d)(4)(B))

Current Law

- o OBRA requires State survey agencies to collect, maintain, and make available to the public through a toll-free hotline data on recent survey findings in home health agencies. The Social Security Act, however, prohibits the Secretary from disclosing the results of any accreditation survey done by a national accrediting body, such as the Joint Commission for Accreditation of Health Care Organizations.

Provision

- o This amendment excludes home health agency survey results from the prohibition on disclosing survey results from private accrediting agencies. As a result, if a private accrediting body surveys a home health agency for Medicare, State survey agencies will have access to the survey data and will be able to make it available to the public in compliance with the OBRA requirement.

Home Health Agency Wage Index (Section 411(d)(5))

Current Law

- o OBRA requires the Secretary to use a wage index based on audited wage data from home health agencies in establishing the home health agency cost limits. OBRA required this wage index to apply to cost reporting periods beginning on July 1, 1988 and to report to Congress on urban/rural issues by June

1, 1988.

Provision

- o Extends by one year (until July 1, 1989) the date by which the Secretary must develop a wage index based on wage data from home health agencies. The report to Congress is also delayed one year.
- o Allows the Secretary to withhold up to 5 percent of payments from any home health agency that refuses to submit the required wage information (or provides false wage data) to the Secretary for the purpose of constructing the home health wage index. Payments would be returned when the data are satisfactorily provided.
- o Changes references from "audited data" to "verified data".

Corrections Relating to Subpart A of Part 3 of Subtitle A of Title IV (Payments for Physicians' Services) (Section 411(f))

Reduction in Prevailing Charge Level for Overpriced Procedures (Section 411(f)(4))

Current Law

- o OBRA reduced prevailing charges for a list of 12 procedures, including cataract surgery, by up to fifteen percent for the nine months starting April 1, 1988.

Provision

- o Clarifies that cataract surgery includes subsequent insertion of intraocular lenses. A conforming amendment makes the same clarification to a provision that precludes payment for an assistant at surgery in a cataract operation without pre-procedure review by the PRO.
- o Clarifies that the reduced prevailing charges serve as the basis for calculating prevailing charges for these procedures in future years.

Customary Charges for Certain Services of New Physicians (Section 411(f)(6))

Current Law

- o OBRA provided that the Secretary is to set the customary charges for services (other than primary care services or services in a rural area designated as a health manpower

shortage area) of new physicians at 80 percent of the prevailing charge.

Provision

- o Clarifies that customary charges set according to this method for those procedures identified as "overpriced" will be established based on the reductions in prevailing charges imposed by the overpriced procedure sections of the statute.

Payment for Physician Anesthesia Services (Section 411(f)(7))

Current Law

- o OBRA reduced physicians' reasonable charges for concurrent medical direction of two or more nurse anesthetists.

Provision

- o Clarifies that the reductions in reasonable charges for concurrent medical direction also reduce the maximum allowable actual charge (MAAC) limits that constrain the amounts nonparticipating physicians can bill.

Elimination of Markup for Certain Purchased Services (Section 411(f)(9))

Current Law

- o OBRA limited payment for diagnostic tests (other than clinical laboratory tests) purchased by a physician from a supplier to the net acquisition cost or, if lower, the supplier's reasonable charge. The physician is thus prevented from adding a markup. The provision prohibited the physician from billing the patient directly for such tests, except for applicable deductible and coinsurance.

Provision

- o Permits the physician to bill the patient directly for these diagnostic tests. The limitations precluding markups, however, apply to such bills.

Collection of National Health Service Debts (Section 411(f)(10))

Current Law

- o OBRA directed the Secretary to enter into agreements with physicians who breach their National Health Service Corps

Scholarship contracts, providing for offset of Medicare payments to them until their past-due obligations (plus accrued interest) have been repaid. Also, Medicare payment to these physicians will be made only on an assignment-related basis.

Provision

- o Extends these provisions to non-physicians as well, and also expands them to apply to breach of contracts with the Physician Shortage Area Scholarship Program or the Health Education Assistance Loan Program as well as the National Health Service Corps Scholarship Program.

Elimination of 1975 Floor for Prevailing Physician Charges (Section 411(f)(11))

Current Law

- o Year-to-year increases in the prevailing charges for physician services are limited by application of an economic index. OBRA eliminated a provision that prevented prevailing charges from falling below the levels in place before introduction of the limits, that is, for the year ending June 30, 1975.

Provision

- o Clarifies that the 1975 floor is to be retained in all cases where it affects the level of physician payment, but is phased out where it is no longer needed.

Corrections Relating to Subpart B of Part 3 of Subtitle A of Title IV (Payments for Other Part B Services) (Section 411(g))

Payment for Durable Medical Equipment, Prosthetics, and Orthotics (Section 411(g)(1))

Current Law

- o OBRA establishes a fee schedule as the basis for payment for each of six categories of durable medical equipment (DME), prosthetics, and orthotics.
- o The Secretary is permitted to apply the inherent reasonableness provisions of the statute to covered items furnished on or after January 1, 1991.
- o The Secretary is required to provide, upon written request, data and information used in determining the payment amounts for covered items of DME, prosthetics, and orthotics.

Provision

- o Clarifies that the fee schedule also applies to items covered by this section furnished by all home health agencies.
- o Clarifies that fees for "other items of durable medical equipment" will be set by the Secretary, not by the carriers.
- o Clarifies definition of "customized items," which has the effect of classifying orthotics as "other covered items."
- o Clarifies that the same inherent reasonableness policies as apply for physicians' services must also be followed in this area.
- o Requires any individual or organization requesting data or information related to the determination of the payment amounts for DME, prosthetics, and orthotics to pay a reasonable copying fee established by the Secretary. In addition, the provision states that the data provided by the Secretary will be in a form that does not identify individual suppliers.

Payment for Intraocular Lenses (Section 411(g)(2))

Current Law

- o OBRA required that payment for an intraocular lens inserted during cataract surgery in an ambulatory surgical center must be incorporated into the facility fee.

Provision

- o Establishes a civil money penalty for separate billing for an intraocular lens inserted during cataract surgery in an ambulatory surgical center.

Clinical Diagnostic Laboratory Tests (Section 411(g)(3))

Current Law

- o OBRA froze for three months the fee schedule amounts paid for clinical laboratory services and provided for a zero CPI increase in the fee schedules for the balance of 1988. It reduced the fee schedules otherwise established for certain tests by 8.3 percent and set national payment limits at the median fee schedule amount for each test.
- o OBRA limited the two percent differential paid to certain hospital labs to those in sole community hospitals.

Provision

- o Provides that the reduced fee schedules shall serve as the base for calculating fee schedules for 1989 and subsequent years.
- o Clarifies that the effective date for the elimination of the two percent hospital differential is April 1, 1988.

Payments to Hospital Outpatient Departments for Radiology and Other Diagnostic Tests (Section 411(g)(4))

Current Law

- o OBRA limited the aggregate payment for hospital outpatient radiology and diagnostic services by use of a "blended" amount that combines hospital payments -- the "cost portion" -- and physician payments -- the "charge portion."
- o The limits for radiology services become effective in FY 1989, but the limits for diagnostic services do not apply until FY 1990.
- o For FY 1989, the blended amount is 65 percent "cost portion" and 35 percent "charge portion." For FY 1990 and beyond, the blend is 50-50.

Provision

- o Amends the blend for the limit for diagnostic services to 65-35 for FY 1990, the first year diagnostic services are subject to the limit. Thereafter, the blend for both radiology and diagnostic services will be 50-50.
- o Clarifies that calculation of the "charge portion" for radiology services after January 1, 1989, will be based on the fee schedule for radiologist services established by OBRA, rather than on prevailing charges.

Corrections Relating to Subpart C of Part 3 of Subtitle A of Title IV (Part B Eligibility and Benefits Changes) (Section 411(h))

Coverage of Outpatient Mental Health Services (Section 411(h)(1))

Current Law

- o OBRA increased the limit on recognized charges for the outpatient treatment of mental disorders and provided that,

starting in calendar year 1989, brief office visits for the sole purpose of prescribing or monitoring prescription drugs for the treatment of these disorders will not count against the limit.

- o OBRA provided for partial hospitalization services for treatment of mental disorders provided by a "hospital-based or hospital-affiliated" program (as defined by the Secretary).

Provision

- o Modifies the standard of which visits will be excluded from the limit from visits for the sole purpose of "prescribing or monitoring prescription drugs" to visits for the sole purpose of "monitoring or changing drug prescriptions."
- o Narrows the definition of a program of partial hospitalization services to one "furnished by a hospital to its outpatients."

Coverage of Certified Nurse-Midwife Services (Section 411(h)(4))

Current Law

- o OBRA provided for part B coverage of and direct payment for certified nurse-midwife services (to the extent these services are authorized under State law) that would be covered if performed by a physician (or as incident to a physician's service). Payments will be made only under assignment on the basis of a fee schedule established by the Secretary.

Provision

- o Extends the standard 20 percent coinsurance to these services, and adopts the standard practice of limiting payment to the lesser of the actual charge or the fee schedule amount. A conforming amendment applies the same penalty for improper unassigned billing as applies to services of nurse anesthetists and physician assistants.

Psychologist Services in Clinics (Section 411(h)(7))

Current Law

- o OBRA provided for part B coverage of and direct payment for clinical psychologists' services in rural health clinics and community mental health centers that would be covered if performed by a physician (or as incident to a physician's service). Payment will be made only under assignment on the basis of a fee schedule established by the Secretary.

Medicare or set a minimum additional payment amount or percentage related to the ratio of Medicaid inpatient days to total inpatient days (the first definitional formula).

- o Hospitals offering non-emergency obstetrical services must have at least two obstetricians with staff privileges who have agreed to provide services to Medicaid beneficiaries. This requirement does not apply to children's hospitals or to rural hospitals which do not offer nonemergency obstetrical services to the general population as of the OBRA 87 enactment date (December 22, 1987). In the case of a rural hospital, an "obstetrician" is defined to include any physician with staff privileges who performs nonemergency obstetrical services.
- o The plan requirements may not be waived under 1915(b)(4) (permitting States to implement programs that restrict freedom of choice).
- o New York State's payment plan for disproportionate share hospitals, which was in effect as of January 1, 1984, was given a special exemption from the requirements of this section.

Provision

- o The entire Section 4112 of OBRA 87 regarding disproportionate share hospitals, which was enacted as a freestanding statutory provision, is now incorporated into title XIX of the Social Security Act as a new Section 1923, with the modifications below.
- o If a State does not choose to use the Medicare disproportionate share hospital payment adjustment methodology, its plan amendment must include a detailed description of the methodology to be used and it must publish, at least annually, the name of each hospital qualifying for a payment adjustment.
- o The payment adjustment is phased in, with at least one-third of the required payment adjustment amount by July 1, 1988, at least two-thirds by July 1, 1989, and 100 percent by July 1, 1990.
- o When computing the disproportionate share payment adjustment percentage for children's hospitals, the low income utilization rate is twice the percentage of inpatient hospital days attributable to Medicaid patients.
- o In determining the low-income utilization rate, hospital charges for inpatient hospital services which are attributable to charity care may not include cash subsidies received by the hospital for inpatient hospital services.

- o When paying for inpatient hospital services out-of-State, States must use the out-of-State definition of a disproportionate share hospital when calculating the Medicaid inpatient utilization rate for these hospitals.
- o Texas is permitted (for three years beginning July 1, 1988) to apply its own disproportionate share hospital definition and payment adjustment methodology as long as the aggregate payment adjustment is not less than the aggregate payment adjustment that would have been made under the law. Texas is also allowed to use the same definition of "obstetrician" for hospitals in urban as well as rural areas.

Omitted Section - Study on Recovering Costs from Estates of Medicaid Beneficiaries (Section 411(k)(11))

Current Law

- o OBRA 87 inadvertently omitted a requirement regarding a study that had been agreed to in conference.

Provision

- o Requires the Secretary to study means of recovering the costs of nursing facility services from the estates of Medicaid beneficiaries. The Secretary's report to Congress, which is to include recommendations for legislative changes, is due not later than December 31, 1988.

Penalties for HMO Failure to Provide Medically Necessary Items and Services (Section 411(k)(12))

Current Law

- o Any entity failing to provide medically necessary services and adversely affecting its enrollees is subject to a civil money penalty of up to \$10,000 per failure to provide such services.

Provision

- o In addition to other remedies, the Secretary may assess the following civil money penalties for each determination of:
 - Substantial failure to provide medically necessary services as required by law or by the contract which adversely affects an individual -- \$25,000 each;
 - Imposition of premiums in excess of those allowable under law -- up to \$100,000 each plus two times the amount of excess charged;

- Discrimination against an individual whose medical condition indicates a need for substantial future medical services -- up to \$100,000 each plus \$15,000 for each individual discriminated against; or
- Misrepresentation of information to the Secretary, or to any individual or entity governed under the Social Security Act -- up to \$100,000 each.
- o Additional penalties of up to \$100,000 per determination of failure to provide service are permitted in some cases.
- o The Secretary may deny payment to the State for an entity in violation of this provision. The Secretary may resume payments when the violation has been corrected and is determined unlikely to recur.

Effective Date

- o July 1, 1988

Treatment of Educationally Related Services (Section 411(k)(13))

Current Law

- o No statutory provision. Medicaid regulations provide that payments to ICFs/MR may not include reimbursement for vocational training and educational activities. Guidance in the State Medicaid Manual states that Medicaid payment may not be made for services covered as educational services under Public Law 94-142, The Education for All Handicapped Children Act.

Provision

- o Prohibits Medicaid from denying payment for services that are otherwise covered under the State plan to handicapped children solely because such services are included in the child's individualized education program or individualized family service plan (under Public Law 94-142).

Effective Date

- o July 1, 1988

Clarification of the Term "Institution for Mental Diseases (IMD)"
(Section 411(k)(14))

Current Law

- o Payments for services to certain residents of IMDs who are under age 65 are prohibited. An IMD is not defined.
- o Medicaid regulations define an "institution" as an establishment that furnishes food, shelter, and some treatment or services to four or more persons unrelated to the proprietor. Further, an institution for mental diseases is defined as an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases.

Provision

- o Defines "institution for mental diseases" in statute as a hospital, nursing facility or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care, and related services.

Effective Date

- o July 1, 1988

Eligibility Verification for Aliens (Section (411(k)(15))

Current Law

- o Aliens are required to furnish their Social Security numbers to States as input to the States' income and eligibility verification systems. The statute describes the requirements and workings of a State verification system, including a written declaration by the individual of his citizenship status and procedures and time limits for the verification of such status.

Provision

- o Provides that aliens seeking medical assistance for emergency medical conditions are not subject to the State's income eligibility verification system, and do not have to provide their Social Security numbers.

Effective Date

- o For medical assistance furnished to aliens on or after January 1, 1987.

Presumptive Eligibility Providers (Section 411(k)(16))

Current Law

- o Services to presumptively eligible pregnant women may only be provided by a qualified provider, a very restrictive group which must be funded under one of several Public Health (excepting Indian Health Service), Nutrition or State perinatal programs. During the period of presumptive eligibility preceding verification of regular Medicaid eligibility, Medicaid payments are not available for referrals to specialists and certain other services that may be needed for effective prenatal care, unless they are "qualified providers."

Provision

- o Services furnished during the presumptive eligibility period by a "provider that is eligible for payments under the State plan" are allowed to be included as medical assistance.
- o In addition, Indian Health Service and health programs or facilities operated by tribes under the Indian Self-Determination Act are established as potential "qualified providers."
- o PHS' primary care research and demonstration projects are added to the list of those who may become "qualified providers."

Effective Date

- o Applies to ambulatory prenatal care furnished in calendar quarters beginning on or after April 1, 1987.

Waiver for Children Infected with AIDS or Drug Dependent at Birth (Section 411(k)(17))

Current Law

- o Medicaid waivers permit the provision of home and community-based services to individuals who would otherwise require care in a nursing facility. Through the waivers, a State can provide medical and certain non-medical services not covered under its Medicaid plan.

Provision

- o A separate waiver authority is established for the provision of home and community-based services to children under the age of five:

- who either were infected with or test positive for the etiologic agent for acquired immunodeficiency syndrome at birth, have such syndrome, or were dependent on heroin, cocaine, or phencyclidine at the time of birth;
 - to whom adoption or foster care assistance is (or will be) made available under Part E of Title IV of the Social Security Act; and
 - for whom a determination has been made that, but for the provision of waiver services, the child would likely require the level of care provided in a hospital or nursing facility, the cost of which would be paid by Medicaid.
- o States may be granted a waiver of statewideness and comparability.
 - o Waivers are for an initial term of three years, with possible extensions of five-year periods.
 - o Medicaid payment will be made for part or all of the cost of services provided pursuant to a plan of care, which may include nursing care, respite care, physicians' services, prescribed drugs, medical devices and supplies, transportation services, and such other services requested by the State and approved by the Secretary.
 - o States must assure necessary safeguards to protect the health and welfare of the children covered under the waiver and financial accountability for funds expended for waiver services. Average per capita expenditures under the waiver may not exceed 100 percent of the expected average per capita amount for the same children if the waiver had not been granted.
 - o The State must report annually on the impact of the waiver granted on the type and amount of medical assistance provided under the State plan and on the health and welfare of the waiver recipients.

Effective Date

- o July 1, 1988.

Changes to Section 4201 Effective Dates for Nursing Home Reform to Improve Coordination Between Medicare and Medicaid (Section 411(1)(1))

Current Law

- o Effective dates for several of the nursing home reform

provisions are inconsistent between Medicare and Medicaid.

- o Additionally, certain dates create logistical problems for effective implementation of the reform provisions.

Provision

- o Changes effective dates for nursing home reform below.

<u>Provision/Section</u>	<u>OBRA 87 Date</u>	<u>New Eff. Date</u>
<u>MEDICARE NURSING FACILITIES</u>		
Resident assessment required for each resident by such date	10/1/90	1/1/91
Required training of nurse aides	10/1/89	1/1/90
State specification of nurse aide training and competency evaluation programs	3/1/89	1/1/89
State review and reapproval of nurse aide training and competency evaluation programs	3/1/90	1/1/90
Nurse Aide Registry	3/1/89	1/1/89
State appeals process for transfers	10/1/90	10/1/89
State specification of resident assessment instrument	7/1/89	7/1/90
Federal guidelines for State appeals process for transfers	10/1/89	10/1/88
Secretary's specification of minimum data set for resident assessment	7/1/89	1/1/89
Secretary's specification of resident assessment instruments	10/1/90	4/1/90
Secretary establishes protocols for standard and extended surveys	10/1/90	1/1/90
<u>MEDICAID NURSING FACILITIES</u>		
State specification of nurse aide training and competency evaluation programs	9/1/88	1/1/89

<u>Provision/Section</u>	<u>OBRA 87 Date</u>	<u>New Eff.Date</u>
State review and reapproval of nurse aide training and competency evaluation programs	9/1/90	1/1/90
Permitting alternative disposition plans for mentally retarded or mentally ill residents	10/1/88	4/1/89
Secretary's responsibilities for setting nurse aide training and competency evaluation program requirements	7/1/88	9/1/88

- o Conference report language in the catastrophic legislation includes the following two clarifications of OBRA 87.
 - Nursing facilities with more than 120 beds must have at least one professional, full-time social worker.
 - Requirements regarding consultation and supervision of social work services, and requirements for dietary services are considered to be at least as stringent as those in effect prior to enactment of OBRA 87.

Corrections Relating to Subtitle E of Title IV (Relating to Rural Health) (Section 411(m))

Set-Aside of Funds for Experiments and Demonstration Projects (Section 411(m)(2))

Current Law

- o OBRA requires that, beginning in FY 1989, HCFA set aside 10 percent of amounts expended each year for experiments and demonstration projects for projects exclusively or substantially related to rural health care issues.

Provision

- o The amendment requires that, for each of the three years beginning in FY 1988, HCFA will set aside, from total amounts appropriated and expended for research and demonstration projects in each year, 10 percent for projects exclusively or substantially related to rural health care issues and 10 percent for projects exclusively or substantially related to inner city health care issues.

Corrections to Certain Health-Related Provisions in Title IX

Personal Needs Allowance for Medicaid-only Recipients (Section 411 (n))

Current Law

- o No provision in statute, but regulations require States to establish an allowance for clothing and other personal needs for Medicaid-only recipients.

Provision

- o Establishes a minimum monthly personal needs allowance for clothing and other personal needs for Medicaid-eligible individuals who are inpatients in a Medicaid institution or nursing facility for which Medicaid payments are made throughout a month. The allowance must be a reasonable amount for clothing and other personal needs of the individual (or couple) while in an institution and must be at least \$30 for individuals and \$60 for couples, the maximum amount paid by SSI to individuals and couples in Medicaid institutions.

Effective Date

- o Applies to Medicaid payments for calendar quarters beginning on or after July 1, 1988 whether or not regulations have been promulgated.

Subtitle C - Miscellaneous Provisions

Maintenance of Effort (Section 421)

Current Law

- o Employer-sponsored group health insurance plans that provide benefits to Medicare beneficiaries generally are coordinated to supplement Medicare benefits although there are no Federal requirements that employer plans provide specific benefits to participants.

Provision

- o Any employer who provides health benefits to an employee or retired employee (other than Federal employees or retired Federal employees) that duplicate Medicare benefits as a result of the catastrophic legislation (excluding outpatient drugs) by at least 50 percent of the national average actuarial value of the catastrophic benefit, is required to

provide additional benefits or refunds that are at least equal to the actuarial value of the duplicative benefits (net of any employee premiums) for one year.

- o Employers have the option of calculating the value of the duplicative benefits by using average actuarial values promulgated by the Secretary or the actuarial values with respect to that employer based on the Secretary's guidelines. The Secretary is required to calculate and publish the national average actuarial values and guidelines for computing actuarial values of duplicative benefits for each of four years beginning with 1989 for part A and 1990 for part B benefits.
- o This provision will not apply to duplicative benefits provided under plans to which more than one employer contributes, and which are maintained pursuant to multi-employer collective bargaining agreements.

Effective Date

- o The requirements with respect to duplicative part A benefits will be effective during CY 1989 and requirements for duplicative part B benefits will be effective during CY 1990.
- o If duplicative benefits are provided under a collective bargaining agreement in effect when the catastrophic legislation was enacted, those requirements are extended beyond the end of the calendar year until the expiration of that collective bargaining agreement.

Rate Reduction For Medicare Eligible Federal Annuitants (Section 422)

Current Law

- o The Federal Employees Health Benefits (FEHB) Program offers no plans that only supplement Medicare coverage, and certain Federal employee health benefits duplicate Medicare benefits. Premiums are shared by the Federal government and the enrollee and are deposited in the Employees Health Benefit Fund, from which benefit and administrative costs are paid.

Provision

- o Requires the Office or Personnel Management to reduce the rates charged to Medicare-eligible individuals participating in FEHB plans by the amount of the estimated cost of medical services and supplies that duplicate benefits added under this legislation.

- o Makes available funds in Employees Health Benefits Funds for costs incurred in making rate reductions without fiscal year limitations.

Effective Date

- o Reductions are effective January 1, 1989 for duplicative part A benefits and January 1, 1990 for duplicative part B benefits.

Study and Reports by the Office of Personnel Management on Offering Medicare Supplemental Plans to Federal Medicare Eligible Individuals and Other Changes (Section 423)

Current Law

- o The Federal Employees Health Benefits Program offers no Medicare supplemental policies. The Secretary is required to establish a procedure for certifying that Medicare supplemental policies meet standards developed by the National Association of Insurance Commissioners (NAIC) and certain loss ratio requirements.

Provision

- o Requires the Director of the Office of Personnel Management (OPM) to conduct a study and report by April 1, 1989 to the Senate Committee on Governmental Affairs and the House Committee on Post Office and Civil Service regarding any changes to the FEHB Plan necessary to incorporate Medicare supplemental plans.
- o Prohibits any Medicare supplemental plan recommended by the Director of OPM from duplicating Medicare benefits. Requires such plans to cover Medicare coinsurance or deductibles, and allows supplemental plans to provide additional reimbursement for Medicare benefits limited by fee schedules and for benefits not covered by Medicare.
- o Requires the Director of OPM to report to Congress by April 1, 1989 on the feasibility of adopting standards for these plans similar to Medigap standards issued by the NAIC.

Effective Date

- o Upon enactment.

**Benefits Counseling And Assistance Demonstration Project for
Certain Medicare And Medicaid Beneficiaries (Section 424)**

Current Law

- o No comparable provision exists in current law.

Provision

- o Requires the Secretary to establish a three-year demonstration project with a public or private nonprofit agency or organization to train volunteers and provide counseling to the elderly (age 60 and above) on their eligibility for Medicare and Medicaid benefits and to assist them in preparing documents that may be required to receive such benefits.
- o The Secretary may reimburse volunteers (through the agency or organization) for expenses incurred in training or assisting the elderly. The Secretary may provide for the use of services, personnel, and facilities of Federal, State, and local agencies, with their consent, with or without reimbursement. The Secretary also may provide materials for making the elderly aware of this volunteer assistance and in educating the elderly regarding the availability of this assistance.
- o Provides that volunteers will not be considered federal employees, except that volunteers are subject to federal employee prohibitions against unauthorized disclosures of confidential information. Amounts received by volunteers as expense reimbursements are tax exempt.
- o Authorizes appropriations from the HI and SMI trust funds for fiscal years 1989, 1990, and 1991 sums necessary to conduct the demonstration project.

Effective Date

- o Upon enactment.

Case Management Demonstration Projects (Section 425)

Current Law

- o There are no requirements for Medicare beneficiaries to receive case management services, and case management is not a covered service under Medicare, except as it is provided by HMOs and CMPs.

Provision

- o Requires the Secretary to establish four demonstration projects to provide case management services to Medicare beneficiaries with selected catastrophic illnesses, especially those associated with high health care costs. At least one demonstration will be conducted by a peer review organization (PRO).
- o Specifies that the purpose of the demonstration is to provide the Secretary and the Congress with information necessary to evaluate the appropriateness of providing case management services to beneficiaries with high medical expenses and to determine the most effective approach to implementing a Medicare case management system.
- o Requires the agreement between the Secretary and the demonstration to specify the high cost cases for which case management services will be provided, the payments to be made for conducting the demonstration, and other necessary terms and conditions. The demonstration projects are required to provide information necessary to evaluate the results of the demonstration.
- o Requires the Secretary to waive any PRO requirements that would be applicable and any Medicare limitations or restrictions on benefits necessary to conduct the demonstration.
- o Provides a two-year duration of the demonstration and allows the Secretary to terminate a project earlier if it is not in compliance with the terms of the agreement.
- o Requires the Secretary to submit to Congress an interim report after the first year of project operations and a final report with findings, recommendations and conclusions.
- o Requires the Secretary to transfer amounts from the HI and SMI trust funds not to exceed \$2 million in each of two years for administrative costs in carrying out these demonstration projects. The amounts will be transferred without regard to amounts appropriated in advance in Appropriation Acts.

Effective Date

- o The Secretary is required to establish the demonstration projects within 12 months of enactment.

Extension of Expiring Provisions (Section 426)

Current Law

- o The "favorable presumption" waiver of liability for certain providers is an administrative mechanism established to avoid determining on a case-by-case basis whether the provider knew or could have been expected to know that services would not be covered because they were not medically necessary, or because the patient needed custodial care. Providers are presumed to meet this test and are paid for noncovered care if their denial rates are under a particular percentage.
- o The Secretary is prohibited from issuing any regulation, instruction or other policy in final form prior to October 15, 1988 which would result in a net reduction in expenditures during FY 89 of \$50 million for hospital or physician services provided under Medicare.

Provision

- o Extends to November 1, 1990 the favorable presumption to waive payment liability for hospices which have 2.5 percent or fewer days of care denied on the basis of medical necessity.
- o Extends the favorable presumption waiver of liability for SNFs until October 31, 1990.
- o Extends to November 1, 1990 the favorable presumption waiver of liability for HHAs, including the provision of services that would not be covered because they did not meet the homebound or intermittent care requirements.
- o Extends the prohibition on issuing any final cost-saving regulation, instruction or other policy to October 15, 1989 for net reductions in FY 1990 Medicare expenditures.

Effective Date

- o Upon enactment.

Advisory Committee on Medicare Home Health Claims (Section 427)

Current Law

- o No provision.

Provision

- o Requires the HCFA Administrator to establish an Advisory Committee on Medicare Home Health Claims. The eleven-member

Committee will be composed of at least 5 representatives of home health or visiting nurse services agencies. The remaining members shall be representative of fiscal intermediaries, physician groups, and senior citizen groups, but no more than 3 members shall be representative of fiscal intermediaries. Members will represent all geographic areas of the United States.

- o The Advisory Committee will study the increase in the denial of claims for home health services during 1986 and 1987, the ramifications of such increase, and the need to reform the process involved in such denials.
- o Requires the Committee to report to the Administrator and to appropriate Congressional committees on the results of the study and recommendations for regulatory changes not later than one year after enactment.
- o Provides for the conduct of the Advisory Committee, including authorizing the Committee to hold hearings and to secure necessary data from any Federal agency. The GSA will provide administrative and support services to the Committee upon request.
- o Authorizes the appropriation of the necessary sums for the Advisory committee.

Effective Date

- o The Advisory Committee must be established within 90 days of enactment.

Prohibition of Misuse of Symbols, Emblems, of Names in Reference to Social Security or Medicare and Civil Monetary Penalties for Medigap Violations (Section 428)

Current Law

- o No comparable provisions exists in current law.

Provision

- o Authorizes the Secretary to take action against entities which use the emblem or name of Social Security or Medicare programs in a manner that would convey a false impression of official authorization. Violations would be subject to civil monetary penalties.
- o Authorizes the Secretary to impose civil money penalties not to exceed \$5,000 for each violation of this prohibition and in the case of broadcast or telecast a penalty not to exceed

\$25,000. Limits the total amount of penalties in one year to \$100,000. Those who are assessed penalties may request a hearing before an Administrative Law Judge and appeal thereafter to the U.S. District Court of Appeals. The Secretary has the discretion to impose lesser penalties. Amounts recovered will be paid to the Secretary and deposited as miscellaneous receipts in the Treasury. The Secretary must coordinate his/her actions with the Justice Department.

- o Authorizes civil monetary penalties of up to \$5,000 for each act and up to 5 years imprisonment for violations of Medigap requirements.

Effective Date

- o Upon enactment.

Demonstration Projects with Respect to Chronic Ventilator-Dependent units in Hospitals (Section 429)

Current Law

- o No comparable provision exists under current law.

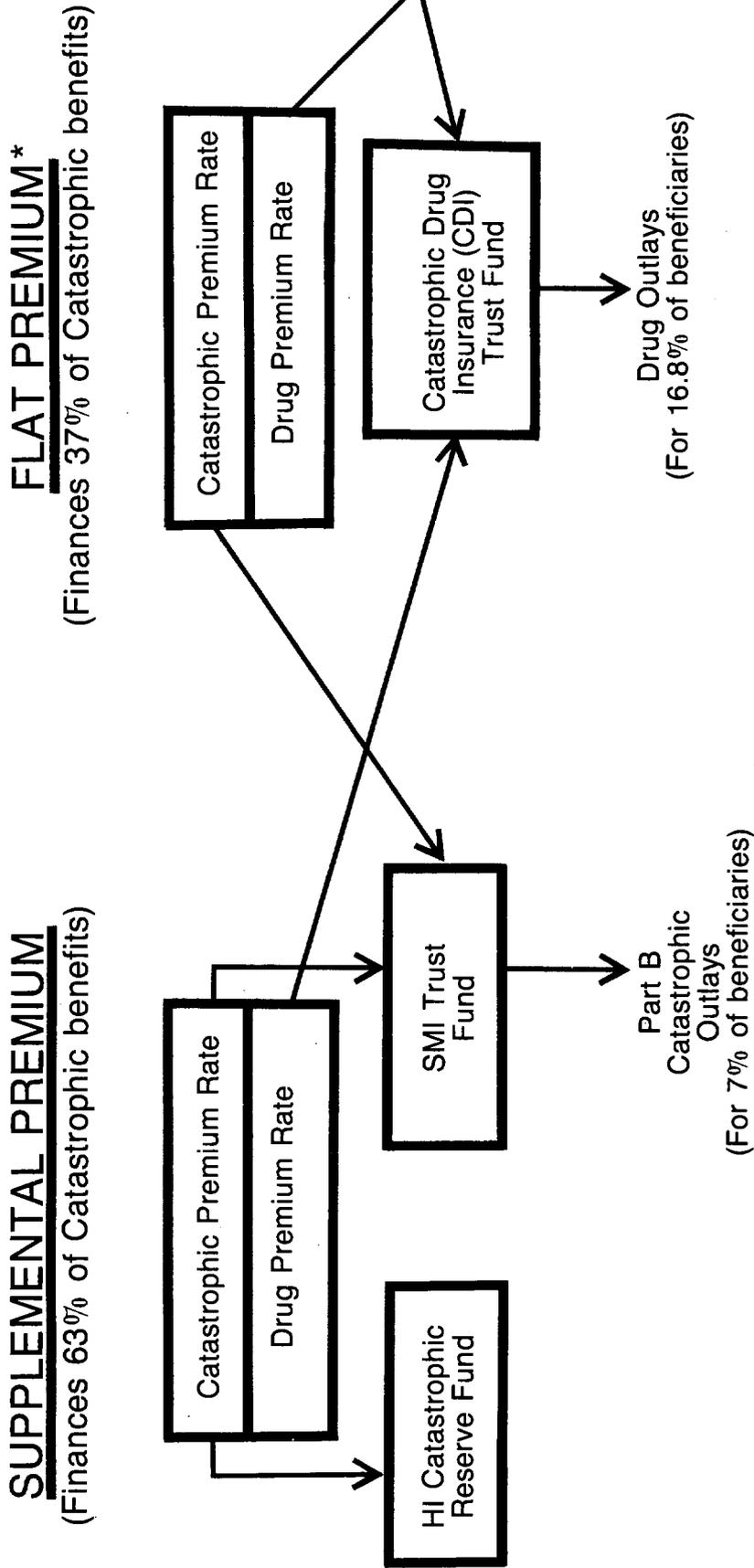
Provision

- o Requires the Secretary in consultation with the Prospective Payment Assessment Commission to initiate up to five three-year projects to demonstrate the feasibility of including chronic ventilator services under the Medicare program.
- o The services would be reimbursed on a cost basis as are rehabilitation hospitals.

Effective Date

- o Upon enactment.

CATASTROPHIC FINANCING AND OUTLAYS



* Added on to Part B premium

** Accounting Mechanism—Keeps track of Catastrophic receipts, outlays, and interest.

Catastrophic Outpatient Prescription Drug Benefit

Taxable Year	Premium Rate Per \$150 Tax Liability	Annual Deductible	Coinsurance	Trust Fund Contingency Margin
1990	\$10.36	\$550	20% for HIV and immunosuppressives ¹	-0-
1991	\$ 8.83	\$600	50%	-0-
1992	\$ 9.95	\$652	40%	75%
1993	\$12.45	16.8% will qualify	20% ²	50%
1994	based on previous calendar year premium indexed by projected growth rates in outlays and premiums	16.8% will qualify	20%	25%
1995	based on previous calendar year premium indexed by projected growth rates in outlays and premiums	16.8% will qualify	20%	25% hereafter)

¹ Regardless of coinsurance amounts for other covered outpatient drugs, the coinsurance for covered home IV and immunosuppressive drugs for 1 year following a Medicare covered transplant will always be 20 percent. For immunosuppressive drugs following a transplant not covered by Medicare, the coinsurance amounts will be the same as other covered outpatient drugs.

² Beginning in 1993 and thereafter, the Secretary may adjust the coinsurance to ensure that the contingency margin is met. However, the coinsurance may not be set at an amount higher than the amount of the previous year (for example, in 1993 the coinsurance may not be more than 40%). If the contingency margin is met, the coinsurance will be 20%.

³ The Secretary may adjust the deductible for 1993 and thereafter to assure that 16.8% of beneficiaries (excluding those covered by pre-paid plans) meet the deductible.

