the tribe's reservation. The rest of the property will be sold to the city of Scottsdale. This legislation, which is the result of months of negotiation between the city of Scottsdale and the Salt River Pima-Maricopa Indian community, will serve to ratify and authorize the agreement and will provide that the property purchased by the tribe will be taken into trust reservation status. It does not authorize any expenditure of funds by the United States.

The Saddleback Mountain-Arizona Settlement Act of 1995 is noncontroversial and I urge my colleagues to support this important legislation.

THE DEMOCRATIC SUBSTITUTE FOR H.R. 2425

HON. SAM GIBBONS

OF FLORIDA

IN THE HOUSE OF REPRESENTATIVES

Tuesday, October 17, 1995

Mr. GIBBONS. Mr. Speaker, during the debate on H.R. 2425, the so-called Medicare Preservation Act, later this week, Representative JOHN DINGELL and I plan, along with Representative JIM MCDERMOTT, and others, to offer a substitute that takes the steps needed to assure solvency for Medicare for the next decade—through 2006. Instead of cutting $270 billion out of Medicare as the Republicans have proposed to finance their tax breaks for the wealthy, our Democratic plan reduces Medicare by $90 billion—and achieves solvency through 2006.

To assure an informed debate, I want to share a copy of the summary of the Gibbons-Dingell substitute. The legislative language of the substitute is published in the amendments section of today's RECORD. The summary follows:

A DEMOCRATIC MEDICARE REFORM PLAN

A BALANCED PACKAGE OF REFORMS TO MAKE MEDICARE SOLVENT FOR THE NEXT DECADE (2006)

The Gibbons-Dingell substitute

Peace of Mind for Medicare Beneficiaries

Assurance that Medicare—as you know it now—will be there when you need it.

Expanded choice of providers and plans.

A freeze in the part B premium.

Reduced copayments for outpatient services.

New preventive benefits—payment for more frequent mammographies, colorectal screening, pap smears, and diabetes screening.

Quality standards for nursing homes.

Reasonable Provider Reductions and Reforms

Modest reductions in hospital payments.

Protection for hospitals that serve the uninsured in urban and rural areas.

Reduced funds for hospital construction.

A new graduate medical education trust fund.

Limits on physician reimbursement.

Other ''Good Government'' Reforms

A prospective payment system for home health services.

Reformed nursing home reimbursement.

Tough fraud and abuse prevention.

Aggressive pursuit of payment by private insurers, to assure Medicare is the payer of last resort.

A commission on the long-term solvency of Medicare.

Total savings: $90 billion.

DETAILED SPECIFICATIONS

Subtitle A. Provisions relating to Medicare part A

A. Reasonable Hospital Reductions and Reforms

Medicare is the single largest insurer in the United States today. Reductions in payments to providers under Medicare must be carefully planned and implemented to avoid severe negative consequences for Medicare beneficiaries and the American taxpayer. Excessive reductions in hospital costs—like those proposed by the Republican majority—could be counter-productive, negatively affecting the quality of care, reducing access to care, and resulting in higher costs for the private sector. Little would be accomplished by unnecessarily blunt reductions in Medicare payments to hospitals. Our most vulnerable hospitals—those who serve a large share of the 40 million Americans who are uninsured—would carry an unfair burden.

Under this Democratic plan, reasonable reductions would be made in hospital payments. Furthermore, there would be no reductions in payments made to compensate hospitals that care for a disproportionate share (DSH) of the uninsured. In addition, funding for DSH hospitals, now paid to HMO's, would be paid directly to these high-indigent care hospitals.

Specifically, the substitute would:

1. Make modest hospital payment reductions with special protections for vulnerable rural hospitals.—Hospital payments would be limited to market basket minus one in FY '96 through FY '02 except that the rural hospital update would be set at 0.5 percent in each of these years.

2. Reduce payments for hospital capital (construction) expenses, given excess capacity.—All hospital capital payments would be reduced by 10 percent (including PPS-exempt hospitals) through 2002.

3. Retarget outlier payments.—The indirect medical education and disproportionate share hospital add-on payment would be eliminated for outlier cases.

B. Nursing Home Reforms

The Republican majority has proposed to reduce payments for skilled nursing facilities by $10 billion over seven years, through untested limits on payments that could place patients with complex needs at risk of inadequate services or, even worse, encourage facilities to avoid patients with greater resource needs.

The Republican majority also proposes to eliminate the current nursing home reform standards, leaving elderly nursing home patients and their families without protections that have improved the quality of life for millions of nursing home residents. The regulations—which the Republican majority wants to repeal—have resulted in fewer hospital visits and healthier nursing home residents, more complete and reliable medical records, a significant improvement in patient well-being, and savings to Medicare of $2 billion since the regulations took effect.

This Democratic plan would retain these essential protections for Medicare beneficiaries in nursing homes. In addition, this substitute would revamp the nursing facility reimbursement system by taking the following steps:

1. Extend the skilled nursing facility (SNF) cost limits.—The OBRA '93 SNF cost limits would be extended.

2. Establish a prospective payment system to control costs.—Beginning in FY 1997, routine costs would be paid in accordance with a prospective payment system established by the Secretary. Payments under the system would be determined on a per diem basis and would equal 112 percent of the mean per diem routine costs in a base year for freestanding skilled nursing facilities located in the same region. These limits would be determined separately for urban and rural facilities; hospital-based facilities would be held harmless. Beginning in FY 1998, all costs for skilled nursing facilities would be paid based upon the prospective payment system.

3. Reform SNF transfer policies.—End gaming of discharge status by hospitals who also have their own nursing home unit. Patients transferred from a hospital to a SNF unit of the hospital would be classified as a transfer and not as a discharge. Patients discharged to home health services would still be classified as a discharge.

Subtitle B. Provisions relating to Medicare part B

A. Physician Payment Reforms

Efforts to control Medicare spending require that limits be placed on reimbursements to all providers, including physicians. Since the nation's doctors have been supportive of the reforms included in HR 2425, this substitute includes those reforms with very slight modifications.

To control Medicare spending on physician payments, this Democratic plan adopts the recommendations of the Physician Payment Review Commission. This means that on January 1, 1996, the fee schedule conversion factor for all three categories of service—primary care, surgery, and all other services—would be set to a uniform $34.60. Three separate expenditure targets are retained, however, for determining updates in future years for each category.

In addition, the upward bias in the current Medicare Volume Performance System (MVPS) is corrected by assuring that the targets are cumulative—the MVPS bonuses and penalties apply for only one year, and are not built into the base-year spending target. Adjustments to the annual updates are also limited.

B. Reforms in Payments for Other Health Services

The Republican majority has proposed an unprecedented seven-year freeze on payments for clinical laboratory services, durable medical equipment, and ambulatory surgery, raising questions about whether these providers will, in the future, continue to serve Medicare beneficiaries. In addition, the Republican majority curtails the steady progress Democrats have made, over the past decade, in improving preventive benefits; under the Republican plan, no new preventive benefits are offered, despite strong evidence that the basic Medicare benefit package needs improvement in this area.

This Democratic substitute offers a package of shared sacrifice combined with modest program improvements. It would:

1. Impose a two-year freeze.—Fee schedules for clinical labs, durable medical equipment, and ambulatory surgery would be frozen for two years.

2. Eliminate excessive beneficiary copayments for outpatient services by correcting the payment formula.—The hospital outpatient department formula driven overpayment would be eliminated, on a budget-neutral basis, as the savings would be returned to the beneficiaries to reduce the effective beneficiary co-payment.

3. Add new services to prevent cancer and complications from diabetes.—Medicare's preventive benefits would be improved to more quickly detect breast, cervical and colon cancer by increasing the mammography scheudle and providing payment for colorectal screening, pap smears, and pelvic examinations. In addition, payment would be authorized for diabetes outpatient self-management services and for blood-testing strips for individuals with diabetes.

4. Extend limits on payments for outpatient capital expenses.—The current 10 percent capital reduction for hospital outpatient services would be extended.

c. Freeze the Beneficiary Premium

Fully 83 percent of Medicare expenditures are for beneficiaries with incomes of less than $25,000 per year. Clearly, beneficiary premiums and copayments should be increased only as a very last resort. These senior citizens can ill-afford to pay any increase in the part B premium, however small. Under this Democratic plan, Medicare beneficiaries are protected.

Under current law, the part B beneficiary premium is $46.10 for 1995. Under the Democratic plan, the premium will remain the same for 1996. Subsequent premiums would be determined without regard to home health services transferred from Part A to Part B as a result of this proposal. The following chart shows the premium amounts under current law, the Republican proposal (HR 2425), and the Democratic plan:

	1995	1996	1997	1998	1999	2000	2001	2002
Current law	$46	$43	$48	$53	$55	$57	$59	$61
Republican plan	46	53	57	60	64	72	79	88
Democratic substitute	46	46	47	51	53	54	56	58

D. Anesthesiology Payments

Payment for anesthesia services would be clarified such that when services are provided jointly by anesthesiologists and by nurse anesthetists, both providers would be reimbursed.

Subtitle C. Provisions relating to parts A and B

A. Continue Medicare as the Payer of Last Resort

When a Medicare beneficiary also has private insurance, Medicare pays only after the other insurer has met its obligations. The authority for this policy is temporary, however, expiring in 1998. This Democratic plan extends the so-called Medicare secondary payer provisions through 2002. In addition, insurers would be required to report on secondary payer status and current rules would be clarified, given recent judicial action.

B. Expand Beneficiary Choice

Medicare beneficiaries currently select either traditional fee-for-service or an HMO for the delivery of their health care. Under this democratic plan, additional managed care choices would be provided, including preferred provider organizations (PPOs), point-of-service (POS) plans, and provider service organizations. Plans could not bar any professional from participating in a plan solely on the basis of their license or certification under State law.

C. Improve Graduate Medical Education

Prudent reforms are needed in Medicare's policies for reimbursing the costs of graduate medical education. Instead, the Republican majority has chosen to slash support for hospitals dedicated to training the next generation of health professionals. Under this Democratic substitute, only the needed reforms would be made. Specifically, the plan would:

1. Establish a graduate medical education trust fund.—Funds would be targeted to teaching hospitals by creating a graduate medical education trust fund. Funds for teaching hospitals, now paid to HMO's, would be deposited into the new graduate medical education trust fund. A commission on graduate medical education would also be established to develop a method for assuring that academic medical centers train the types of physicians that will be required to meet the nation's health needs.

2. Reform Medicare payments for graduate medical education.—A number of needed improvements would be made in Medicare policies for reimbursing the costs of graduate medical education. Specifically:

The total number and number of non-primary care residency positions reimbursed under Medicare would be frozen.

The OBRA '93 freeze on updates for nonprimary care residents would be extended for an additional two years.

Residents in training beyond their initial residency period would be counted less, for purposes of the indirect medical education adjustment.

Reimbursement would be made for work performed in non-hospital settings for indirect medical education.

Payments would be authorized for non-hospital settings for residents receiving primary care training when a hospital is not paying the resident's salary.

D. Home Health Reforms

Payments for home health services have been one of the fastest growing components of Medicare since the late 1980's. In fact, outlays for home health services more than quintupled between 1987 and 1994. This increase is, in large part, due to a 1989 court decision—Duggan v. Bowen—which liberalized the Medicare benefit and made the denial of home health claims difficult. Clearly, reforms are needed to control the growth in expenditures.

Under this Democratic substitute, payments for home health would, over time, shift from cost-based retrospective reimbursement, to a prospective payment system. Specifically, the plan would:

1. Establish a prospective payment system for home health services effective in FY 2000 with the following steps.—

Impose interim cost limits.—Through the end of FY 1996, the cost limits on home health services would equal to 112 percent of the mean labor-related and nonlabor costs per visit of free standing home health agencies.

Effective October 1, 1996, the cost limits would be reduced to 105 percent of the median costs.

Effective October 1, 1996, the Secretary would be authorized to establish a TEFRA-limits type system under which each home health agency would be subject to a total dollar cap for each beneficiary per year, based on the lesser of (1) actual costs per visit times the average number of visits per beneficiary in calendar year 1995 (the base year); or (2) the agency-specific per beneficiary limit.

Extend, through FY 1996, the OBRA '93 freeze on updates.

Modify payment rules.—Effective for FY 1996, payment to home health agencies would be based on the site where service is rendered, as opposed to the location of the site where the service is billed.

Establish a prospective payment system.—The Secretary would be authorized to impose a full per episode home health prospective payment system in FY 2000.

2. Establish a 160-visit limit.—A 160-visit limit would be imposed on home health services under part A of Medicare. Visits beyond the limit would be reimbursed under part B, as in current law.

E. Commission on the Future of Medicare and the Protection of the Health of Senior Citizens

A commission would be established to analyze the health status of the Medicare-eligible population, make recommendations on actions to improve the health of that population, analyze the effects of changes in Medicare on the private health financing system, examine the impact of the increase in the eligible population occurring after 2010, and make recommendations to the Congress on actions to preserve the program during that period.

F. Miscellaneous

Under this Democratic plan, Medicare law could not be construed to prohibit coverage of items and services associated with the use of a medical device in the furnishing of inpatient or outpatient hospital services (including outpatient diagnostic imaging services) on the grounds that the device is not an approved device if it is an investigational device or is used instead of an approved device or a covered procedure.

Subtitle D. Preventing fraud and abuse

A. Tough Anti-fraud Measures

This Democratic plan would fill the holes in the Republican fraud detection proposal by strengthening Federal anti-fraud and abuse provisions, requiring HHS to offer interpretive rulings on kick-back and self-referral legislation, and pre-emption of State corporate practice laws.

B. Mandatory Funding for the Inspector General

The HHS Inspector General (IG) is responsible for Medicare fraud detection, yet this year the Republican majority has proposed to reduce funding for the IG by 6 percent. And, given limited funds, the IG doesn't even maintain a field office in 23 States. Simply put, rhetoric alone won't result in fraud detection—and prosecution. We need an aggressive IG who has the manpower to carry out the threat.

For that reason, this Democratic plan mandates appropriation of funds from the Medicare trust funds to the HHS Office of the Inspector General. This will assure adequate funds for the IG and a field office in every State. Funding would total $130 million in FY 96, $181 million in FY 97, and $204 million in FY 98 with future amounts indexed to total increases in Medicare expenditures.

C. Enhanced Payment Safeguards

This Democratic substitute also mandates appropriation of funds from the Medicare trust funds for enhanced payment safeguard activities by the Health Care Financing Administration and its contractors to crack down on double billing, overcharging, and other abuses. Funding for these payment safeguards would total $430 million in FY 96, $490 million in FY 97, $550 million in FY 98, $620 million in FY 99, $670 million in FY 00, $690 million in FY 01, and $710 million in FY 02.

D. Commission to Prevent Medicare Fraud and Abuse

Finally, this Democratic substitute established a temporary ''blue ribbon panel'' to examine the full scope of waste, fraud and abuse in the Medicare system and recommend cost effective remedies. The Commission would hold hearings, take testimony, receive evidence with full subpoena power, and report to Congress within 18 months. The Commission would terminate within 90 days after submission of its report to Congress.