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1st Session
HOUSE OF REPRESENTATIVES
REPORT
101-378

MEDICARE CATASTROPHIC COVERAGE REPEAL ACT OF 1989

NOVEMBER 19, 1989.—Ordered to be printed

Mr. ROSTENKOWSKI, from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany H.R. 3607]

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3607) to repeal medicare provisions in the Medicare Catastrophic Coverage Act of 1988, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with the amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare Catastrophic Coverage Repeal Act of 1989".

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

SEC. 101. REPEAL OF EXPANSION OF MEDICARE PART A BENEFITS.

(a) IN GENERAL.—

(1) GENERAL RULE.—Except as provided in paragraph (2), sections 101, 102, and 104(d) (other than paragraph (7)) of the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) (in this Act referred to as "MCCA") are repealed, and the provi-

sions of law amended or repealed by such sections are restored or revived as if such section had not been enacted.

(2) EXCEPTION FOR BLOOD DEDUCTION.—The repeal of section 102(1) of MCCA (relating to deductibles and coinsurance under part A) shall not apply, but only insofar as such section amended paragraph (2) of section 1813(a) of the Social Security Act (relating to a deduction for blood).

(b) TRANSITION PROVISIONS FOR MEDICARE BENEFICIARIES.—

(1) INPATIENT HOSPITAL SERVICES AND POST-HOSPITAL EXTENDED CARE SERVICES.—In applying sections 1812 and 1813 of the Social Security Act, as restored by subsection (a)(1), with respect to inpatient hospital services and extended care services provided on or after January 1, 1990—

(A) no day before January 1, 1990, shall be counted in determining the beginning (or period) of a spell of illness;

(B) with respect to the limitation on such services provided in a spell of illness, days of such services before January 1, 1990, shall not be counted, except that days of inpatient hospital services before January 1, 1989, which were applied with respect to an individual after receiving 90 days of services in a spell of illness (commonly known as "lifetime reserve days") shall be counted;

(C) the limitation of coverage of extended care services to post-hospital extended care services shall not apply to an individual receiving such services from a skilled nursing facility during a continuous period beginning before (and including) January 1, 1990, until the end of the period of 30 consecutive days in which the individual is not provided inpatient hospital services or extended care services; and

(D) the inpatient hospital deductible under section 1813(a)(1) of such Act shall not apply—

(i) in the case of an individual who is receiving inpatient hospital services during a continuous period beginning before (and including) January 1, 1990, with respect to the spell of illness beginning on such date, if such a deductible was imposed on the individual for a period of hospitalization during 1989;

(ii) for a spell of illness beginning during January 1990, if such a deductible was imposed on the individual for a period of hospitalization that began in December 1989; and

(iii) in the case of a spell of illness of an individual that began before January 1, 1990.

(2) HOSPICE CARE.—The restoration of section 1812(a)(4) of the Social Security Act, effected by subsection (a)(1), shall not apply to hospice care provided during the subsequent period (described in such section as in effect on December 31, 1989) with respect to which an election has been made before January 1, 1990.

(3) TERMINATION OF HOLD HARMLESS PROVISIONS.—Section 104(b) of MCCA is amended by striking "or 1990" each place it appears.

(c) TERMINATION OF TRANSITIONAL ADJUSTMENTS IN PAYMENTS FOR INPATIENT HOSPITAL SERVICES.—

(1) PPS HOSPITALS.—Section 104(c)(1) of MCCA is amended by inserting "and before January 1, 1990," after "October 1, 1988,".

(2) PPS-EXEMPT HOSPITALS.—

(A) IN GENERAL.—Section 104(c)(2) of MCCA is amended—

(i) by inserting "and before January 1, 1990," after "January 1, 1989,"; and

(ii) by striking the period at the end and inserting the following: ", without regard to whether any of such beneficiaries exhausted medicare inpatient hospital insurance benefits before January 1, 1989.".

(B) TRANSITION.—The Secretary of Health and Human Services shall make an appropriate adjustment to the target amount established under section 1886(b)(3)(A) of the Social Security Act in the case of inpatient hospital services provided to an inpatient whose stay began before January 1, 1990, in order to take into account the target amount that would have applied but for the amendments made by this title.

(d) EFFECTIVE DATE.—The provisions of this section shall take effect January 1, 1990, except that the amendments made by subsection (c) shall be effective as if included in the enactment of MCCA.

SEC. 102. REPEAL OF SUPPLEMENTAL MEDICARE PREMIUM AND FEDERAL HOSPTIAL INSURANCE CATASTROPHIC COVERAGE RESERVE FUND.

(a) IN GENERAL.—Sections 111 and 112 of MCCA are repealed and the provisions of law amended by such sections are restored or revived as if such sections had not been enacted.

(b) DELAY IN STUDY DEADLINE.—Section 113(c) of MCCA is amended by striking "November 30, 1988" and inserting "May 31, 1990".

(c) DISPOSAL OF FUNDS IN FEDERAL HOSPITAL INSURANCE CATASTROPHIC COVERAGE RESERVE FUND.—Any balance in the Federal Hospital Insurance Catastrophic Coverage Reserve Fund (created under section 1817A(a) of the Social Security Act, as inserted by section 112(a) of MCCA) as of January 1, 1990, shall be transferred into the Federal Supplementary Medical Insurance Trust Fund and any amounts payable due to overpayments into such Trust Fund shall be payable from the Federal Supplementary Medical Insurance Trust Fund.

(d) EFFECTIVE DATES.—

(1) IN GENERAL.—Except as provided in this subsection, the provisions of this section shall take effect January 1, 1990.

(2) REPEAL OF SUPPLEMENTAL MEDICARE PREMIUM.—The repeal of section 111 of MCCA shall apply to taxable years beginning after December 31, 1988.

TITLE II—PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM

SEC. 201. REPEAL OF EXPANSION OF MEDICARE PART B BENEFITS.

(a) IN GENERAL.—

(1) GENERAL RULE.—Except as provided in paragraph (2), sections 201 through 208 of MCCA are repealed and the provisions of law amended or repealed by such sections are restored or revived as if such sections had not been enacted.

(2) EXCEPTION.—Paragraph (1) shall not apply to subsections (g) and (m)(4) of section 202 of MCCA.

(b) CONFORMING AMENDMENTS.—Section 1905(p) of the Social Security Act (42 U.S.C. 1396d(p)) is amended—

(1) in paragraph (3)(C)—

(A) by striking "Subject to paragraph (4), deductibles" and inserting "Deductibles", and

(B) by striking "1813, section 1833(b)" and all that follows and inserting "1813 and section 1833(b)."; and

(2) by striking paragraph (4) and redesignating paragraph (5) as paragraph (4).

(c) EFFECTIVE DATE.—The provisions of this section shall take effect January 1, 1990.

SEC. 202. REPEAL OF CHANGES IN MEDICARE PART B MONTHLY PREMIUM AND FINANCING

(a) IN GENERAL.—Sections 211 through 213 (other than sections 211(b) and 211(c)(3)(B)) of MCCA are repealed and the provisions of law amended or repealed by such sections are restored or revised as if such sections had not been enacted.

(b) EFFECTIVE DATE.—The provisions of subsection (a) shall take effect January 1, 1990, and the repeal of section 211 of MCCA shall apply to premiums for months beginning after December 31, 1989.

SEC. 203. AMENDMENT OF CERTAIN MISCELLANEOUS PROVISIONS.

(a) REVISION OF MEDIGAP REGULATIONS.—

(1) IN GENERAL.—Section 1882 of the Social Security Act (42 U.S.C. 1395ss), as amended by section 221(d) of MCCA, is amended—

(A) in the third sentence of subsection (a) and in subsection (b)(1), by striking "subsection (k)(3)" and inserting "subsections (k)(3), (k)(4), (m), and (n)";

(B) in subsection (k)—

(i) in paragraph (1)(A), by inserting "except as provided in subsection (m)," before "subsection (g)(2)(A)", and

(ii) in paragraph (3), by striking "subsection (l)" and inserting "subsections (l), (m), and (n)"; and

(C) by adding at the end the following new subsections:

"(m)(1)(A) If, within the 90-day period beginning on the date of the enactment of this subsection, the National Association of Insurance Commissioners (in this subsection and subsection (n) referred to as the 'Association') revises the amended NAIC Model Regulation (referred to in subsection (k)(1)(A) and adopted on September 20, 1988) to improve such regulation and otherwise to reflect the changes in law made by the Medicare Catastrophic Coverage Repeal Act of 1989, subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the amended NAIC Model Regulation (referred to in subsection (k)(1)(A)) as revised by the Association in accordance with this

paragraph (in this subsection and subsection (n) referred to as the 'revised NAIC Model Regulation').

"(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the revised NAIC Model Regulation or 1 year after the date the Association first adopts such revised Regulation.

"(2)(A) If the Association does not revise the amended NAIC Model Regulation, within the 90-day period specified in paragraph (1)(A), the Secretary shall promulgate, not later than 60 days after the end of such period, revised Federal model standards (in this subsection and subsection (n) referred to as 'revised Federal model standards') for medicare supplemental policies to improve such standards and otherwise to reflect the changes in law made by the Medicare Catastrophic Coverage Repeal Act of 1989, subsection (g)(2)(A) shall be applied in a State, effective on and after the date specified in subparagraph (B), as if the reference to the Model Regulation adopted on June 6, 1979, were a reference to the revised Federal model standards.

"(B) The date specified in this subparagraph for a State is the earlier of the date the State adopts standards equal to or more stringent than the revised Federal model standards or 1 year after the date the Secretary first promulgates such standards.

"(3) Notwithstanding any other provision of this section (except as provided in subsection (n))—

"(A) no medicare supplemental policy may be certified by the Secretary pursuant to subsection (a),

"(B) no certification made pursuant to subsection (a) shall remain in effect, and

"(C) no State regulatory program shall be found to meet (or to continue to meet) the requirements of subsection (b)(1)(A),

unless such policy meets (or such program provides for the application of standards equal to or more stringent than) the standards set forth in the revised NAIC Model Regulation or the revised Federal model standards (as the case may be) by the date specified in paragraph (1)(B) or (2)(B) (as the case may be).

"(n)(1) Until the date specified in paragraph (4), in the case of a qualifying medicare supplemental policy described in paragraph (3) issued in a State—

"(A) before the transition deadline, the policy is deemed to remain in compliance with the standards described in subsection (b)(1)(A) only if the insurer issuing the policy complies with the transition provision described in paragraph (2), or

"(B) on or after the transition deadline, the policy is deemed to be in compliance with the standards described in subsection (b)(1)(A) only if the insurer issuing the policy complies with the revised NAIC Model Regulation or the revised Federal model standards (as the case may be) before the date of the sale of the policy.

In this paragraph, the term 'transition deadline' means 1 year after the date the Association adopts the revised NAIC Model Regulation or 1 year after the date the Secretary promulgates revised Federal model standards (as the case may be).

"(2) The transition provision described in this paragraph is—

"(A) such transition provision as the Association provides, by not later than December 15, 1989, so as to provide for an appropriate transition (i) to restore benefit provisions which are no longer duplicative as a result of the changes in benefits under this title made by the Medicare Catastrophic Coverage Repeal Act of 1989 and (ii) to eliminate the requirement of payment for the first 8 days of coinsurance for extended care services, or

"(B) if the Association does not provide for a transition provision by the date described in subparagraph (A), such transition provision as the Secretary shall provide, by January 1, 1990, so as to provide for an appropriate transition described in subparagraph (A).

"(3) In paragraph (1), the term 'qualifying medicare supplemental policy' means a medicare supplemental policy which has been issued in compliance with this section as in effect on the date before the date of the enactment of this subsection.

"(4)(A) The date specified in this paragraph for a policy issued in a State is—

"(i) the first date a State adopts, after the date of the enactment of this subsection, standards equal to or more stringent than the revised NAIC Model Regulation (or revised Federal model standards), as the case may be, or

"(ii) the date specified in subparagraph (B),

whichever is earlier.

"(B) In the case of a State which the Secretary identifies, in consultation with the Association, as—

"(i) requiring State legislation (other than legislation appropriating funds) in order for medicare supplemental policies to meet standards described in subparagraph (A)(i), but

"(ii) having a legislature which is not scheduled to meet in 1990 in a legislative session in which such legislation may be considered,

the date specified in this subparagraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 1990. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

"(5) In the case of a medicare supplemental policy in effect on January 1, 1990, the policy shall not be deemed to meet the standards in subsection (c) unless each individual who is entitled to benefits under this title and is a policyholder or certificate holder under such policy on such date is sent a notice in an appropriate form by not later than January 31, 1990, that explains—

"(A) the changes in benefits under this title effected by the Medicare Catastrophic Coverage Repeal Act of 1989, and

"(B) how these changes may affect the benefits contained in such policy and the premium for the policy.

"(6)(A) Except as provided in subparagraph (B), in the case of an individual who had in effect, as of December 31, 1988, a medicare supplemental policy with an insurer (as a policyholder or, in the case of a group policy, as a certificate holder) and the individual terminated coverage under such policy before the date of the enact-

ment of this subsection, no medicare supplemental policy of the insurer shall be deemed to meet the standards in subsection (c) unless the insurer—

"(i) provides written notice, no earlier than December 15, 1989, and no later than January 30, 1990, to the policyholder or certificate holder (at the most recent available address) of the offer described in clause (ii), and

"(ii) offers the individual, during a period of at least 60 days beginning not later than February 1, 1990, reinstitution of coverage (with coverage effective as of January 1, 1990), under the terms which (I) do not provide for any waiting period with respect to treatment of pre-existing conditions, (II) provides for coverage which is substantially equivalent to coverage in effect before the date of such termination, and (III) provides for classification of premiums on which terms are at least as favorable to the policyholder or certificate holder as the premium classification terms that would have applied to the policyholder or certificate holder had the coverage never terminated.

"(B) An insurer is not required to make the offer under subparagraph (A)(ii) in the case of an individual who is a policyholder or certificate holder in another medicare supplemental policy as of the date of the enactment of this subsection, if (as of January 1, 1990) the individual is not subject to a waiting period with respect to treatment of a pre-existing condition under such other policy.".

(b) ADJUSTMENT OF CONTRACTS WITH PREPAID HEALTH PLANS.—Notwithstanding any other provision of this Act, the amendments made by this Act (other than the repeal of sections 1833(c)(5) and 1834(c)(6) of the Social Security Act) shall not apply to risk-sharing contracts, for contract year 1990—

(1) with eligible organizations under section 1876 of the Social Security Act, or

(2) with health maintenance organizations under section 1876(i)(2)(A) of such Act (as in effect before February 1, 1985), under section 402(a) of the Social Security Amendments of 1967, or under section 222(a) of the Social Security Amendments of 1972.

(c) NOTICE OF CHANGES.—The Secretary of Health and Human Services shall provide, in the notice of medicare benefits provided under section 1804 of the Social Security Act for 1990, for a description of the changes in benefits under title XVIII of such Act made by the amendments made by this Act.

(d) MISCELLANEOUS TECHNICAL CORRECTION.—Section 221(g)(3) of MCCA is amended by striking "subsection (f)" and inserting "subsection (e)".

(e) EFFECTIVE DATE.—The provisions of this section shall take effect January 1, 1990, except that the amendment made by subsection (d) shall be effective as if included in the enactment of MCCA.

TITLE III—MISCELLANEOUS AMENDMENTS

SEC. 301. MISCELLANEOUS MCCA AMENDMENTS.

(a) IN GENERAL.—Sections 421 through 425 and 427 of MCCA are repealed and any provision of law amended or repealed by such sections is restored or revived as if such sections had not been enacted.

(b) MISCELLANEOUS TECHNICAL CORRECTIONS.—

(1) Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, section 1834(b)(4)(A) of the Social Security Act, as added by section 4049(a)(2) of the Omnibus Budget Reconciliation Act of 1987, is amended by striking "insurance and deductibles under section 1835(a)(1)(I)" and inserting "coinsurance and deductibles under sections 1833(a)(1)(J)".

(2) Section 1842(j)(1)(C)(vii) of the Social Security Act, as added by section 4085(i)(7)(C) of the Omnibus Budget Reconciliation Act of 1987, is amended by striking "accordingly" and inserting "according".

(3) Section 1886(g)(3)(A)(iv) of the Social Security Act, as added by section 4006(a)(2) of the Omnibus Budget Reconciliation Act of 1987, is amended by striking "may) be" and inserting "may be)"

(4) Section 1866(a)(1)(F)(i)(III) of the Social Security Act is amended by striking "fiscal year))" and inserting "fiscal year)".

(5) Section 1875(c)(7) of the Social Security Act, as added by section 9316(a) of the Omnibus Budget Reconciliation Act of 1986, is amended by striking "date of the enactment of this Act" and inserting "date of the enactment of this section".

(6) Section 1842(j)(2)(B) of the Social Security Act, as amended by section 8(c)(2)(A) of the Medicare and Medicaid Fraud and Abuse Patient Protection Act of 1987, is amended by striking "paragraphs" and inserting "subsections".

(c) MISCELLANEOUS CORRECTIONS RELATING TO THE OMNIBUS BUDGET RECONCILIATION ACT OF 1987.—

(1) Effective as if included in the enactment of the Omnibus Budget Reconciliation Act of 1987, section 1834(b)(4)(A) of the Social Security Act (42 U.S.C. 1395m(b)(4)(A)), as added by section 4049(a)(2) of the Omnibus Budget Reconciliation Act of 1987, is amended by striking "insurance and deductibles under section 1835(a)(1)(I)" and inserting "coinsurance and deductibles under sections 1833(a)(1)(J)".

(2) Section 1842(j)(1)(C)(vii) of the Social Security Act (42 U.S.C. 1395u(j)(1)(C)(viii)), as added by section 4085(i)(7)(C) of the Omnibus Budget Reconciliation Act of 1987, is amended by striking "accordingly" and inserting "according".

(3) Section 1886(g)(3)(A)(iv) of the Social Security Act (42 U.S.C. 1395ww(g)(3)(A)(iv)), as added by section 4006(a)(2) of the Omnibus Budget Reconciliation Act of 1987, is amended by striking "may) be" and inserting "may be)".

(d) OTHER CORRECTIONS.—

(1) Section 1866(a)(1)(F)(i)(III) of the Social Security Act (42 U.S.C. 1395cc(a)(1)(F)(i)(III)) is amended by striking "fiscal year))" and inserting "fiscal year)".

(2) Section 1875(c)(7) of the Social Security Act (42 U.S.C. 1395ll(c)(7)), as added by section 9316(a) of the Omnibus Budget Reconciliation Act of 1986, is amended by striking "date of the enactment of this Act" and inserting "date of the enactment of this section".

(3) Section 1842(j)(2)(B) of the Social Security Act (42 U.S.C. 1395u(j)(2)(B)), as amended by section 8(c)(2)(A) of the Medicare and Medicaid Fraud and Abuse Patient Protection Act of 1987, is amended by striking "paragraphs" and inserting "subsections".

(e) EFFECTIVE DATE.—The provisions of this section (other than subsections (c) and (d)) shall take effect January 1, 1990, except that—

(1) the repeal of section 421 of MCCA shall not apply to duplicative part A benefits for periods before January 1, 1990, and

(2) the amendments made by subsection (b) shall take effect on the date of the enactment of this Act.

And the Senate agree to the same.

From the Committee on Ways and Means, for consideration of the House bill, and the Senate amendment, and modifications committed to conference:

BRIAN DONNELLY,
BEN CARDIN,
MARTY RUSSO,
BILL ARCHER,
GUY VANDER JAGT,
PHILIP M. CRANE,
BILL FRENZEL,
R.T. SCHULZE,

From the Committee on Energy and Commerce, for consideration of the House bill, and the Senate amendment, and modifications committed to conference:

JOHN D. DINGELL,
HENRY A. WAXMAN,
DOUG WALGREN,
RON WYDEN,
TERRY L. BRUCE,
J. ROY ROWLAND,
CARDISS COLLINS,
RALPH M. HALL,
NORMAN F. LENT,
EDWARD R. MADIGAN,
BILL DANNEMEYER,
MIKE BILIRAKIS,

Managers on the Part of the House.

LLOYD BENTSEN,
SPARK M. MATSUNAGA,
DANIEL PATRICK MOYNIHAN,
MAX BAUCUS,
GEORGE J. MITCHELL,
BOB PACKWOOD,
W.V. ROTH, Jr.,
JOHN C. DANFORTH,

Managers on the Part of the Senate.

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 3607) to repeal medicare provisions in the Medicare Catastrophic Coverage Act of 1988, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

The Senate amendment struck out all of the House bill after the enacting clause and inserted a substitute text.

The House recedes from its disagreement to the amendment of the Senate with an amendment which is a substitute for the House bill and the Senate amendment. The differences between the House bill, the Senate amendment, and the substitute agreed to in conference are noted below, except for clerical corrections, conforming changes made necessary by agreements reached by the conferees, and minor drafting and clarifying changes.

CATASTROPHIC HEALTH INSURANCE

1. PROVISIONS RELATING TO PART A OF MEDICARE PROGRAM AND SUPPLEMENTAL PREMIUM

Present law

(a) Part A benefits

(1) *Hospital Benefits.*—The Medicare Catastrophic Coverage Act of 1988 (MCCA) provided coverage for an unlimited number of hospital days subject to one annual deductible.

Previously, coverage was linked to a spell of illness. A spell of illness began when a beneficiary entered a hospital and ended when he or she had not been an inpatient for a hospital or skilled nursing facility (SNF) for 60 days. For each spell of illness, one deductible was imposed for the first 60 days of care. Days in excess of 60 were subject to coinsurance charges; a beneficiary could potentially have exhausted all inpatient hospital benefits.

(2) *Skilled Nursing Facility Benefits.*—The SNF benefit as modified by MCCA authorizes coverage for up to 150 days of care per calendar year; no prior hospitalization is required. Daily coinsurance charges are imposed for the first 8 days per year equal to 20 percent of the national average Medicare reasonable cost for SNF care (estimated at $25.50/day in 1989).

Prior to MCCA, Medicare covered 100 days of post-hospital SNF care per spell of illness. (See definition under (1)). Beneficiaries were subject to daily cost-sharing charges (equal to one-eighth of the inpatient hospital deductible on days 21–100).

(3) *Home Health Benefits.*—Home health benefits are covered under Medicare if the beneficiary is homebound and requires skilled nursing care on an intermittent basis or physical or speech therapy. Program guidelines have defined intermittent as permitting daily care for 5 days a week for up to 2 or 3 weeks. MCCA, effective January 1, 1990 expands the intermittent definition so that daily care is defined as up to 7 days a week for 38 days.

(4) *Hospice Benefits.*—MCCA provided for an extension beyond the 210-day limit if the beneficiary is rectified as terminally ill.

(5) *Transition Provisions.*—No provision.

(6) *Hold Harmless.*—MCCA applied a special provision in the case of a beneficiary whose spell of illness (for which a deductible was imposed) began before Jan. 1, 1989 and had not ended on that date. No deductible could be applied for that spell of illness in 1989 or 1990.

(7) *PPS Payments.*—MCCA provided for transitional adjustments in PPS payments to take into account the new law.

In the case of a hospital exempt from PPS, MCCA provided for an adjustment in the target amount (the annual limit on total Medicare payment to such a hospital) to take into account the additional days of care that Medicare would be covering. In computing this adjustment, the Secretary has excluded days of care that will be provided to beneficiaries who had exhausted their Medicare inpatient benefit before January 1, 1989.

(b) *Supplemental Medicare Premium and Federal Hospital Insurance Catastrophic Coverage Reserve Fund.*—All persons entitled to Medicare Part A who have a Federal tax liability of $150 or more are required to pay the supplemental premium. The supplemental premium is collected in conjunction with income tax payments. An estimated 41 percent of enrollees will pay the supplemental premium in 1989.

The Internal Revenue Code specifies the following supplemental premium rates per $150 of tax liability for 1989 through 1993: 1989, $22.50; 1990, $37.50; 1991, $39.00; 1992, $40.50; 1993, $42.00. The maximum supplemental premium amount is $800 in 1989, $850 in 1990, $900 in 1991, $950 in 1992, and $1,050 in 1993.

MCCA created a Federal Hospital Insurance Catastrophic Coverage Reserve Fund on the books of the Treasury, to which is appropriated amounts received from the supplemental catastrophic coverage premiums equal to 100 percent of Part A catastrophic benefit outlays.

(c) *Study.*—MCCA required the Secretary of the Treasury to study and report to Congress by November 30, 1988, on Federal tax policies to promote the private financing of long-term care.

House bill

(a) Part A benefits

(1) *Hospital Benefits.*—Repeals expanded benefits and restores pre-MCCA provisions.

(2) *Skilled Nursing Facility Benefits.*—Repeals expanded benefits and restores pre-MCCA provisions.

(3) *Home Health Benefits.*—Repeals the MCCA expansion.

(4) *Hospice Benefits.*—Repeals the MCCA extension.

(5) *Transition Provisions.*—Provides transition provisions for beneficiaries using inpatient hospital and extended care services after January 1, 1990:

(A) No period before January 1, 1990 is to be counted in determining the beginning or period of a spell of illness.

(B) With respect to the spell of illness day limitation, days of services provided before January 1, 1990, are not to be counted except that any lifetime reserve days used before January 1, 1989 are to be counted.

(C) The limitation on coverage of extended care services to post-hospital extended care services shall not apply to an individual receiving such services from a SNF during a continuous period beginning before (and including) January 1, 1990, until the end of the 30 consecutive day period in which the individual is not provided inpatient hospital or extended care services.

(D) The inpatient deductible does not apply:

(i) in the case of an individual who is receiving inpatient hospital services during a continuous period beginning before (and including) January 1, 1990 with respect to the spell of illness beginning on that date, if a deductible was imposed during 1989.

(ii) for a spell of illness beginning during January 1, 1990, if such a deductible was imposed on the individual for a period of hospitalization that began in Dec. 1989.

(iii) in the case of a spell of illness of an individual that began before January 1, 1989 and has not ended as of January 1, 1990.

Specifies that the pre-MCCA hospice provisions shall not apply to hospice care provided during the subsequent extension period (beyond 210 days) for which an election was made prior to January 1, 1990.

(6) *Holds Harmless.*—Deletes application of the provision in 1990.

(7) *PPS Payments.*—Terminates the transitional adjustments for payments to PPS and PPS-exempt hospitals January 1, 1990.

Requires the Secretary to include, in computing adjustments to the target amounts for PPS-exempt hospitals, days of care for persons who had exhausted their inpatient benefit before 1989.

(b) *Supplemental Medicare Premium and Federal Hospital Insurance Catastrophic Coverage Reserve Fund.*—Repeals the supplemental Medicare premium and the Federal Hospice Insurance Catastrophic Coverage Reserve Fund. Provides that any balance in the Reserve Fund as of January 1, 1990 must be transferred to the HI Trust Fund, and any amounts payable due to overpayments into such Trust Fund must be payable from the HI Trust Fund.

(c) *Study.*—Delays reporting date to May 31, 1990.

Effective date.—(a) Effective January 1, 1990, except termination of transitional PPS adjustments effective as if included in the enactment of MCCA. (b) Effective January 1, 1990, except premium repeal applies to taxable years beginning after December 31, 1988. (c) Effective January 1, 1990.

Senate amendment

(a) Part A benefits

(1) *Hospital Benefits.*—No provision.

(2) *Skilled Nursing Facility Benefits.*—Provides post-hospital extended care services coverage for up to 100 days during any spell of SNF care. Restores post-hospital requirements in effect prior to MCCA and makes conforming changes.

Defines the term "spell of SNF care". It is a period of consecutive days. It begins with the first day (not included in a previous spell of SNF care) on which the individual is furnished extended care services and which occurs in a month the individual is entitled to Part A. It ends with the close of the first 60 consecutive days thereafter on which he is not an inpatient of a SNF.

Restores pre-MCCA coinsurance requirements. The daily coinsurance, equal to one eigth of the inpatient hospital deductible, is imposed on days 21–100.

Requires the GAO to study the reasons for the unexpected increase in cost estimates of the Medicare extended care benefit. GAO is to report to Congress by February 1, 1990 on the results of the study.

Provides that the Secretary may provide coverage for extended care services that are not post-hospital. Such coverage is available at such time and for so long as the Secretary determines that inclusion of such services will not (A) result in any increase in the total SNF payments, and (B) will not alter the acute nature of the SNF benefit. The Secretary is required to provide to the extent necessary: (A) for limitations on the scope and extent of such services and on the categories of individuals who may be eligible for such services; and (B) notwithstanding relevant payment provisions, such restrictions and alternatives on the amount and method of payment that may be necessary.

(3) *Home Health Benefits.*—No provision.

(4) *Hospice Benefits.*—No provision.

(5) *Transition Provisions.*—Provides a transition provision for an individual who is in a current spell of SNF care. The number of days of coverage of extended care services (furnished during such spell and on or after December 1, 1989) to which the individual is entitled under Part A cannot exceed 150 less the number of days for which such benefits were payable for such individual in 1989 before December 1. Further, in applying the copayment provisions (as in effect before enactment of this Act) extended care services furnished during such spell during 1990 shall be considered to have been furnished during 1989. For purposes of this provision, the term "current spell of SNF care" means a spell of SNF care which began before December 1, 1989, which includes such date, and for which benefits for extended care services were payable before such date.

Provides that in no case shall the establishment of the definition of the spell of SNF care result in an individual being entitled to benefits for extended care services for more than 150 days during 1989. Provides that if an individual would otherwise be entitled to benefits in excess of 150 days in 1989, such unpaid days in 1989 do not count in determining the number of days of benefits for such

services in 1990 during a spell of SNF care. Further they do not count in the determination of coinsurance.

Specifies that for purposes of the transition provisions, the term "spell of SNF care" has the same meaning as defined under (2) above. Days before December 1, 1989 are included in the determination of spells of SNF care.

(6) *Hold Harmless.*—No provision.

(7) *PPS Payments.*—Includes identical provisions with respect to clarification of transition for PPS-exempt hospitals.

(b) *Supplemental Medicare Premium and the Federal Hospital Insurance Catastrophic Coverage Reserve Fund.*—Similar provision except disposal of funds applies to balance as of the date of enactment.

(c) *Study.*—No provision.

Effective date.—(a) applies to extended care services furnished in a spell of SNF care beginning on or after December 1, 1989 except as provided in transition provision. PPS-exempt payment adjustment effective as if included in the enactment of MCCA. (b) enactment, except premium repeal applies to taxable years beginning after December 31, 1988.

Conference agreement

(a) *Part A Benefits.*—(1) Hospital Benefits. The conference agreement includes the House provision.

(ii) *Skilled Nursing facility Benefits.*—The Conference agreement includes the House provision.

(iii) *Home Health Benefits.*—The Conference agreement includes the House provision.

(iv) *Hospice.*—The Conference agreement includes the House provision.

(v) *Transition Provisions.*—The Conference agreement includes the House provision.

(vi) *Hold Harmless.*—The Conference agreement includes the House provision.

(vii) *PPS Payments.*—The Conference agreement includes the Senate amendment, with an amendment to terminate the transitional adjustments for payments to PPS and PPS-exempt hospitals January 1, 1990. The Secretary of Health and Human Services is required to make appropriate adjustments to the inpatient hospital services provided to an inpatient whose stay began before January 1, 1990. This adjustment shall take into account the target amount that would have been applied prior to the enactment of this Act.

(b) *Supplemental Medicare Premium and Federal Hospital Insurance Catastrophic Coverage Reserve Fund.*—The Conference agreement includes the House provision with an amendment to transfer the balance in the Reserve Fund to the Supplementary Medical Insurance Trust Fund, and any amounts payable due to overpayments must be payable from the Supplementary Medical Insurance Trust Fund.

(c) *Study.*—The Conference agreement includes the House provision.

2. PROVISIONS RELATING TO PART B OF THE MEDICARE PROGRAM

Present law

(a) Part B benefits.—MCCA provided coverage for the following new Part B benefits effective January 1, 1990: a limit on beneficiary Part B deductible and coinsurance charges ($1,370 in 1990); biennial screening mammograms, subject to a payment limit and Part B coinsurance charges; 80 hours of respite care per year if the beneficiary reaches either the catastrophic or prescription drug deductibles; and coverage for home intravenous drug therapy services.

(b) Outpatient Prescription Drug Benefits.—MCCA authorized catastrophic coverage for outpatient prescription drugs. Effective January 1, 1990, a limited prescription drug benefit is established for home IV drugs and immunosuppressive drugs furnished after the first year following a transplant (they were already covered in the first year). The deductible is $550 in 1990; the coinsurance is 20 percent for home IV drugs and 50 percent for immunosuppressives. The deductible does not apply in the case of home IV drugs dispensed in connection with home IV therapy services initiated during a hospital stay.

Coverage for all outpatient prescription drugs begins in 1991, subject to specified deductable and coinsurance anounts.

Payments for single-source drugs is the lowest of the pharmacy's actual charge, the 90th percentile of pharmacy charges (beginning in 1992) or the average wholesale price plus an administrative allowance.

(c) Part B Premium.—MCCA provided a fixed dollar increase in the monthly Part B premium for all Part B enrollees to finance a portion of the catastrophic benefits added by MCCA. The add-on to the Part B premium was $4.00 for 1989; $4.90 for 1990; $7.40 for 1991; $9.20 for 1992; and $10.20 for 1993. Amounts for future years were based on actual program experience during prior time periods. MCCA extended indefinitely a hold harmless provision, which provides that beneficiaries who have their Part B premiums deducted from their social security or railroad retirement checks cannot have the amount of the social security benefits drop because of a Part B premium increase.

MCCA established a Federal Catastrophic Drug Insurance Trust Fund, to which is transferred amounts from the supplemental premium and the new prescription drug monthly premium (a component of the additional Part B monthly premium amount) to pay for the prescription drug benefit. MCCA also established a Medicare Catastrophic Coverage Account which is credited with receipts and debited for outlays for all new catastrophic benefits except prescription drugs.

House bill

(a) Part B Benefits.—Repeals the following new Part B benefits provided in MCCA: the limit on beneficiary Part B liability, mammograms, respite care coverage, and home intraveneous (IV) drug therapy services. Also repealed are the provisions requiring research on long-term care services and that requiring the study of adult day care services.

(b) Outpatient Prescription Drug Benefits.—Deletes MCCA coverage for outpatient prescription drugs. Retains the MCCA requirement that physicians include the appropriate diagnosis code when requesting Medicare payment, effective March 31, 1989.

(c) Part B Premium.—Repeals the MCCA increase to the Medicare Part B premium for catastrophic benefits, the Federal Catastrophic Drug Insurance Trust Fund, and the Medicare Catastrophic Coverage Account. Retains the hold harmless provision.

Provides for a one-time transfer, as of January 1, 1990, from the Supplementary Medical Insurance (SMI) Trust Fund to the Hospital Insurance (HI) Trust Fund an amount equal to (1) the amount of the add-on to the Part B premiums collected for catastrophic coverage, minus (2) Part B administrative expenses incurred for implementation of MCCA, plus (3) interest accrued to the SMI Trust Fund attributable to the balance of (1) minus (2).

Effective date.—(a) and (b) effective January 1, 1990. (c) applies January 1, 1990, except that the repeal of the provision adjusting Part B premiums applies to premiums for months beginning after December 31, 1989.

Senate Amendment

(a) Part B Benefits.—Repeals the Part B cap. Delays implementation of the mammogram and home IV drug therapy services provisions until 1991 (and delays other reference dates in those provisions by one year).

Delays implementation of the respite provision until 1991. The payment threshold provision is modified to provide that the 12-month coverage period begins on the date that the Secretary determines that a chronically dependent individual has incurred out-of-pocket Part B cost-sharing equal to the Part B catastrophic limit. The catastrophic limit is $1,780 in 1991. This threshold is increased each year by an amount estimated by the Secretary to reflect the amount of such charges which will be incurred by only 5.5 percent of beneficiaries (other than HMO enrollees) in the following year. The Secretary is required to promulgate a new limit each year. The Secretary is required to submit a report to Congress by June 1, 1990 on alternative eligibility standards for respite benefits.

(b) Outpatient Prescription Drug Benefits.—Limits coverage for outpatient prescription drugs to immunosuppressives and home IV drugs provided in 1991 and thereafter. The deductible is $550 in 1991, increased in future years by the percentage increase in the MEI applicable to physicians services. Specifies that the coinsurance is 20 percent.

Provides that payment for single-source drugs on the basis of the 90th percentile of pharmacy charges is delayed until 1993. Specifies that the administrative dispensing allowance is $4.50.

Deletes provisions relating to prepaid organizations, physician guide, definition of outlays, participating pharmacies, administrative provisions, modification of HMO/CMP contracts, requirement for reestimation of costs, requirement for a series of additional studies, and development of a standard claims form. Modifies requirement for report on outlays and receipts. An annual report is required each May, beginning in 1990.

Deletes provision requiring establishing the Prescription Drug Payment Review Commission; however, the Commission is authorized to continue its activities for 30 days after enactment.

(c) *Part B Premium.*—Combines current catastrophic coverage monthly premium and prescription drug monthly premium into a single catastrophic coverage monthly premium. Specifies that this premium is the same as the total of the two premiums under current law for 1989–1993. Requires the Secretary to determine during September 1990, 1991, and 1992, the monthly actuarial rate for months in the succeeding year which if substituted for the specified amounts would assure (taking into account potential contingencies) a positive balance in the Medicare Catastrophic Coverage Account at the end of the succeeding year. If this rate is lower, it is to be substituted for the amount otherwise specified for that year.

Deletes current requirements for calculation of the premium after 1993. Specifies that each September (beginning in 1993), the Secretary is required to determine the monthly acturial rate for months in the succeeding year which would assure a balance in the Account at the end of the year equal to 20 percent of the total debits to the Account in the year. This rate is the catastrophic monthly premium for the year.

Specifies premiums applicable for residents of Puerto Rico and the territories. For Puerto Rico, it is $1.30 per month for 1989 and $1.40 per month for 1990. For other commonwealths and territories, it is $2.10 in 1989 and $2.30 in 1990. In subsequent years, a rate is determined for Puerto Rico and another rate is determined for other commonwealths and territories, each of which is a fraction of the rate determined for the States and DC. The fraction is to reflect the relative per capita outlays which are accounted for under the Account for residents in such respective areas compared to those for residents of the States and DC.

Specifies that, for Part B only individuals, the Part B premium (otherwise determined without regard to the catastrophic calculation) is to be increased (beginning January 1991) by a fraction of the increase otherwise determined. The Secretary is required from time to time to establish a fraction that reflects the relative per capita outlays accounted for under the Account by Part B only individuals compared to individuals entitled to benefits under both Parts A and B.

Includes a one-time transfer of funds provision similar to the House bill.

Provides for appropriation from the SMI trust fund to the HI trust fund from such amounts as are attributable to catastrophic coverage monthly premiums imposed after December 1989. The appropriation equals the amount by which HI outlays attributable to catastrophic expenses exceeds the amounts transferred under the one-time transfer of funds provision. The amounts shall be transferred from time to time (not less frequently than monthly) based on estimates made by the Secretary. Periodic adjustments are to be made.

Repeals the Federal Catastrophic Drug Insurance Trust Fund and makes conforming changes to provisions relating to the Medicare Catastrophic Coverage Account.

Effective date.—(a) enactment except the repeal of the Part B cap effective as if included in MCCA; (b) enactment; (c) enactment.

Conference agreement

(a) *Part B Benefits.*—The Conference agreement includes the House provision.

(b) *Outpatient Prescription Drug Benefits.*—The Conference agreement includes the House provision.

(c) *Part B Premium.*—The Conference agreement includes the House provision, with an amendment to strike the provisions pertaining to the transfer of funds from the Federal Supplementary Medical Insurance Trust Fund to the Hospital Insurance Trust Fund.

3. OTHER MISCELLANEOUS AMENDMENTS

Present law

(a) *Revision of Medigap Regulations.*—Individually purchased private health insurance policies which are designed to supplement Medicare's coverage are known as medigap plans. Law, prior to passage of MCCA established a voluntary certification program for such policies. To be certified under the program, the plan must meet or exceed standards set forth in a model regulation approved by the National Association of Insurance Commissioners (NAIC). The voluntary program applies only in States which fail to establish equivalent or more stringent programs; almost all States have established their own programs.

MCCA amended procedures for Federal certification of medigap policies. New NAIC model standards, designed to eliminate duplication between medigap policies and Medicare's new catastrophic coverage, were adopted Sept. 20, 1989 and replaced prior law standards for new medigap policies. Policies sold before enactment of MCCA and in effect on January 1, 1989 were deemed not to duplicate Medicare's new benefits if they complied with NAIC model transition rules. These rules required insurers to notify beneficiaries of policy and premium changes and to make appropriate premium adjustments in their policies.

(b) *Contracts with Prepaid Health Plans.*—MCCA required the Secretary to modify contracts with prepaid health plans, for portions of contract years occurring after December 31, 1988, to take into account the MCCA provisions. The plans are required to make appropriate adjustments in the terms of their agreements with beneficiaries, including adjustments in benefits and premiums.

The Secretary announced the average per capita rate payment for prepaid health plans on September 7, 1989.

(c) *Notice of Changes.*—MCCA provided that the Secretary must provide to new beneficiaries and annually distribute to current beneficiaries notices containing an explanation of Medicare's benefits, Medicare's limits on payments, and the limited benefits for long-term care services available under Medicare and under State Medicaid plans.

(d) *Other Miscellaneous Amendments.*—MCCA provided for a "maintenance of effort" provision requiring certain employers to provide additional benefits or refunds to beneficiaries equal to the

value of the benefits in their plans which duplicated Medicare's new catastrophic coverage. Federal Employees Health Benefits (FEHB) plans are required to provide a rebate equal to the duplicative benefits. MCCA required the Office of Personnel Management (OPM) to conduct a study of changes to the FEHB program that may be required to incorporate plans designed specifically for Medicare-eligible individuals; OPM issued the study in April 1989.

MCCA required the Secretary to establish a 3-year demonstration project to train volunteers to provide benefits counseling and assistance concerning the Medicare and Medicaid programs to elderly persons.

MCCA required the Secretary to establish by July 1, 1989, four demonstration projects to provide case management services to Medicare beneficiaries with selected high cost illnesses.

MCCA required the HCFA Administrator to appoint, within 90 days of enactment, an Advisory Committee on Medicare Home Health Claims to study the reasons for the increase in the denial rate for home health claims, the ramifications of such denials, and the need for reform. The Committee is to report its findings within 1 year of enactment.

House bill

(a) *Revision of Medigap Regulations.*—Provides a period of 90 days, beginning with enactment, for the NAIC to amend their model medigap regulation to reflect the Medicare benefit changes made by this provision. Provides that the amended regulation would apply in a State effective on the date the State adopts medigap standards equal to or more stringent than the revised regulation, or 1 year after the date the NAIC first adopts such revised regulation. Provides that if the NAIC does not amend the model regulation within 90 days, the Secretary must promulgate revised Federal model standards within the subsequent 60 day period. These standards would become effective on the earlier of the date the State adopts the standards, equal or more stringent than the revised standards, or one year after the date the Secretary promulgates the standards. After either of these dates, no medigap policy may be certified by the Secretary and no Secretarial certification may remain in effect unless the policy meets the revised NAIC model standards (or the revised Federal model standards.)

Provides that medigap policies issued after July 1, 1990 must comply with the revised NAIC model regulation or Federal model standards to be in compliance. Provides that medigap policies issued before July 1, 1990 are deemed to be in compliance with the new standards if they comply with a transition provision to be issued by the NAIC no later than December 15, 1989 (or failing that, by the Secretary by Jan. 1, 1990). The transition regulation ceases to apply on the earlier (sic) of the date the State adopts the NAIC model regulation or Federal model standard or the date established for States requiring legislative action.

Provides that medigap policies in effect on January 1, 1990 would not meet the standards unless each policy holder who is eligible for Medicare is sent a notice by Jan. 31, 1990 explaining the change in Medicare's benefits resulting from this provision, and how these changes affect the policy's benefits and premium.

Provides that if an insurer had a medigap policy in effect as of December 31, 1988 which was terminated by the policyholder as of January 1, 1989 (or at the earliest renewal date thereafter), then the insurer must offer the policyholder (through written notice by January 15, 1990) continuation of coverage from January 1, 1990 to March 1, 1990. Provides that such continuation coverage be under the terms respecting treatment of preexisting conditions and group ratings of premiums which are at least as favorable to the individual as such terms which existed with respect to the policy as of December 31, 1988.

Expresses the sense of Congress that States should respond at the earliest practicable date after the enactment to requests by insurers for review and approval of riders and premium adjustments for Medigap policies in order to comply with the changed requirements.

(b) *Contracts with Prepaid Health Plans.*—Provides that the requirement for contract adjustments ends January 1, 1990.

(c) *Notice of Changes.*—Provides that the Secretary must provide in the 1990 beneficiary notices a description of the changes in Medicare benefits made by this provision.

(d) *Other Miscellaneous Amendments.*—Repeals MCCA provisions related to maintenance of effort, FEHBP rebates, the OPM study of plans for Medicare-eligible individuals, benefits counseling and assistance demonstration project for certain Medicare and Medicaid beneficiaries, case management demonstration projects, and the Advisory Committee on Medicare Home Health Claims.

Makes other miscellaneous technical corrections.

Effective date.—(a), (b), and effective January 1, 1990, except the repeal of the maintenance of effort provision would not apply to duplicative Part A benefits for periods before January 1, 1990. (d) effective on enactment.

Senate amendment

(a) *Revision of Medigap Regulations.*—Similar provision relating to NAIC or Federal actions except refers to revised (rather than amended) NAIC Model Regulation.

Similar provision relating to policies issued after a particular date except that the date is the transition deadline (rather than July 1, 1990). The transition deadline is defined as one year after NAIC adopts the revised Model Regulation or one year after the Secretary promulgates revised Federal model standards, as the case may be. Further, the NAIC transition provision is to provide (1) for the restoration of benefits which are no longer duplicative, and (2) elimination of coinsurance for the first 8 days of SNF care.

Similar notice provision except applies to policyholder or certificate holder.

Provides that if an individual had a Medigap supplemental policy in effect as of December 31, 1988 with an insurer (as a policyholder, or in the case of a group policy, a certificate holder) and the individual terminated the policy before enactment of this Act, the insurer must offer the policyholder or certificate holder (through written notice between December 15, 1989 and January 30, 1990) reinstitution coverage. The individual must be offered during a period of at least 60 days (beginning not later than February 1,

1990) reinstitution coverage (with coverage effective as of January 1, 1990). The offering must be under the terms which: (1) do not provide for any waiting period with respect to treatment of pre-existing conditions; (2) provides for coverage which is substantially equivalent to coverage in effect before the date of such termination, and (3) provides for classification of premiums on which terms are at least as favorable to the policyholder or certificate holder as the premium classification that would have applied to that person had the coverage never been terminated. An insurer is not required to make this offer in the case of a policyholder or certificate holder in another Medigap policy as of the date of enactment of this Act if (as of January 1, 1990) the policy under which the individual was provided coverage provides for no waiting period with respect to a pre-existing condition.

Modifies sense of Congress provision to include the sense that premium adjustments be effective January 1, 1990.

(b) *Contracts with Prepaid Health Plans.*—Requires, for calendar year 1990 only, prepaid health plans with risk-sharing contracts to provide the additional Part B benefits otherwise repealed and retains the adjustment in 1990 premium rates to cover the costs of these benefits.

(c) *Notice of Changes.*—Identical provision.

(d) *Other Miscellaneous Amendments.*—Specifies that any refund under the maintenance of effort provision is not to be considered as wages or compensation (as appropriate) and is therefore not subject to taxation for purposes of social security, railroad retirement, or Federal unemployment programs.

Includes miscellaneous corrections included in House bill as well as additional technical corrections to portions of MCCA which are retained.

Effective date.—Enactment, except that provision relating to treatment of refunds under the maintenance of effort provision applies with respect to refunds provided on or after January 1, 1989.

Conference agreement

(a) *Revision of Medigap Regulations.*—The Conference agreement includes the Senate amendment, with an amendment to strike the sense of the Congress provisions. The Conferees intend that States should respond, at the earliest practicable date after the date of enactment of this Act, to requests by insurers for review of riders and premium adjustments for medicare supplemental policies in order to comply with the amendments pertaining to the revision of Medigap regulations, and that all such premium adjustments be effective January 1, 1990.

(b) *Contracts with Prepaid Health Plans.*—The Conference agreement includes the Senate amendment with an amendment to repeal sections 1833(c)(5) and 1834(c)(6).

(c) *Notice of changes.*—The Conference agreement includes the House provision.

(d) *Other Miscellaneous Amendments*—The Conference agreement includes the House provision.

From the Committee on Ways and Means, for consideration of the House bill, and the Senate amendment, and modifications committed to conference:

BRIAN DONNELLY,
BEN CARDIN,
MARTY RUSSO,
BILL ARCHER,
GUY VANDER JAGT,
PHILIP M. CRANE,
BILL FRENZEL,
R.T. SCHULZE,

From the Committee on Energy and Commerce, for consideration of the House bill, and the Senate amendment, and modifications committed to conference:

JOHN D. DINGELL,
HENRY A. WAXMAN,
DOUG WALGREN,
RON WYDEN,
TERRY L. BRUCE,
J. ROY ROWLAND,
CARDISS COLLINS,
RALPH M. HALL,
NORMAN F. LENT,
EDWARD R. MADIGAN,
BILL DANNEMEYER,
MIKE BILIRAKIS,

Managers on the Part of the House.

LLOYD BENTSEN,
SPARK M. MATSUNAGA,
DANIEL PATRICK MOYNIHAN,
MAX BAUCUS,
GEORGE J. MITCHELL,
BOB PACKWOOD,
W.V. ROTH, Jr.,
JOHN C. DANFORTH,

Managers on the Part of the Senate.

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