103D CONGRESS
2D SESSION

S. 1996

To amend title XVIII of the Social Security Act to provide medicare beneficiaries a choice among health plans, and for other purposes.

IN THE SENATE OF THE UNITED STATES

MARCH 25 (legislative day, FEBRUARY 22), 1994

Mr. DURENBERGER introduced the following bill; which was read the first time

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A BILL

To amend title XVIII of the Social Security Act to provide medicare beneficiaries a choice among health plans, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medicare Choice Act of 1994''.

SEC. 2. PURPOSE.

The purpose of this Act is to provide better health care to medicare beneficiaries at less cost by giving such beneficiaries meaningful choices among health plans competing on the basis of price and quality.

SEC. 3. MEDICARE CHOICE.

(a) IN GENERAL.—Section 1876 of the Social Security Act (42 U.S.C. 1395mm) is amended to read as follows:

''MEDICARE CHOICE

''SEC. 1876. (a) ESTABLISHMENT OF MEDICARE MARKET AREAS.—The Secretary shall establish various medicare market areas within the United States in such manner as to—

''(1) ensure that each individual entitled to benefits under part A and enrolled under part B, or enrolled under part B only, resides in a medicare market area,

''(2) maintain all portions of each metropolitan statistical area within one medicare market area, and

''(3) maximize the number of such individuals who will have the opportunity for a meaningful choice among competing medicare health plans under contract with the Secretary under this section.

''(b) MEDICARE HEALTH PLANS.—

''(1) CONTRACTS WITH MEDICARE HEALTH PLANS.—The Secretary shall enter into a contract with any medicare health plan desiring to do business in a medicare market area and to receive payment under this section, but only if the Secretary

certifies that such plan meets the requirements of paragraph (2).

''(2) CERTIFICATION REQUIREMENTS.—Each medicare health plan must—

''(A) except as provided in paragraph (3), provide those services covered by this title (hereafter in this section referred to as 'medicare benefits') when medically necessary for a uniform monthly premium for a year;

''(B) not discriminate against beneficiaries based on their health status, claims experience, medical history, or other factors that are generally related with utilization of health care services;

''(C) demonstrate the ability to provide medicare benefits to all potential enrollees throughout the medicare market area, unless the Secretary determines it appropriate for such plan to target unique community needs within the medicare market area;

''(D) demonstrate financial solvency;

''(E) have arrangements, established in accordance with regulations prescribed by the Secretary, for an ongoing quality-assurance pro-

gram for the health care services such plan provides to such beneficiaries, which program—

''(i) stresses health outcomes, and

''(ii) provides review by physicians and other health care professionals of the process followed in the provision of such health care services;

''(F) meet the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives);

''(G) not operate any compensation arrangement between such plan and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to enrollees in such plan (hereafter in this subparagraph such arrangement shall be referred to as a 'physician incentive plan'), unless the following requirements are met:

''(i) No specific payment is made directly or indirectly under the physician incentive plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with

respect to a specific enrollee in the medicare health plan.

''(ii) If the physician incentive plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the medicare health plan—

''(I) provides stop-loss protection for the physician or physician group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk under the physician incentive plan and the number of enrollees in the medicare health plan who receive services from the physician or the physician group, and

''(II) conducts periodic surveys of both enrollees and former enrollees in the medicare health plan to determine the degree of access of such enrollees to services provided by the medicare

health plan and satisfaction with the quality of such services;

''(H) collect and provide such standard information as the Secretary shall prescribe by regulation as necessary to evaluate the performance and quality of such plan, including enrollee satisfaction, to compare such performance and quality with competing plans, and to prepare comparative materials for distribution to beneficiaries;

''(I) demonstrate the ability to integrate additional benefits into such plan for qualified medicare beneficiaries; and

''(J) offer the supplementary coverage plans established by the Secretary under subsection (g)(3)(B).

''(3) COST-SHARING.—

''(A) ACTUARIALLY EQUIVALENT MEDICARE BENEFITS.—Each medicare health plan must offer either—

''(i) medicare benefits, including the cost-sharing requirements otherwise provided in this title; or

''(ii) actuarially equivalent medicare benefits, as established by the Secretary in

regulations, which are medicare benefits, but with cost sharing requirements that are actuarially equivalent to the cost-sharing requirements otherwise provided in this title and consistent with common practices among health maintenance organizations and other managed care health plans.

In establishing actuarially equivalent medicare benefits, the Secretary shall not include in the calculation any charge in costs associated with alternative forms of health care delivery, management, or utilization control.

''(B) OUT-OF-NETWORK COST-SHARING.—Each medicare health plan may offer a point of service option for which the plan may require enrollees to pay higher cost-sharing for services than is otherwise required by this title (or required in the actuarially equivalent alternative) if—

''(i) the plan maintains relationships with affiliated providers for all medicare benefits that would not require higher cost-sharing; and

''(ii) the plan provides enrollees with such information.

''(4) CAPACITY LIMITS.—Each medicare health plan shall accept up to the limits of its capacity (as determined by the Secretary) and without restrictions (except as may be authorized by regulation) beneficiaries that may enroll in the plan on a first-come first-served basis, unless to do so would result in the enrollment of enrollees substantially nonrepresentative (as determined by regulation) of the population in the medicare market area served by such plan.

''(c) EMPLOYER-SPONSORED HEALTH PLANS.—

''(1) CRITERIA FOR CERTIFICATION.—The Secretary shall prescribe, by regulation, criteria for certifying medicare health plans sponsored by employers which will be offered only to current or former employees, including requirements that such health plans—

''(A) provide benefits that cover at least those services covered by this title at a premium for the enrollee that does not exceed the base beneficiary premium (as defined pursuant to subsection (f)); and

''(B) are available to all eligible current and former employees in the medicare market area.

''(2) SECONDARY PAYER COVERAGE.—To be certified under paragraph (1), employer-sponsored health plans shall accept, at the option of individuals eligible only for secondary coverage under this title pursuant to section 1862(b), a fixed monthly payment from the Secretary to provide such individuals coverage at least actuarially equivalent to the secondary coverage available to such individuals under this title.

''(d) MANAGING MEDICARE CHOICE.—

''(1) MEDICARE HEALTH PLAN PREMIUMS.—By August 1 of each calendar year (beginning in 1995), each medicare health plan or employer-sponsored health plan under contract pursuant to subsection (b) or (c) shall submit to the Secretary the monthly premium that such plan intends to charge in such year.

''(2) ANNUAL OPEN ENROLLMENT.—

''(A) IN GENERAL.—The Secretary shall provide for an annual open enrollment period, and may take into consideration existing employer enrollment periods, during which all individuals entitled to benefits under part A and enrolled under part B, or enrolled under part B only, residing in a medicare market area—

''(i) shall choose enrollment for the next calendar year in—

''(I) a medicare health plan in such area,

''(II) an employer-sponsored health plan, or

''(III) coverage otherwise provided under this title (hereafter in this section referred to as 'medicare fee-for-service'), and

''(ii) may choose supplementary benefits offered by such health plan or a medicare supplemental policy (certified under section 1882).

''(B) SECONDARY PAYER.—Individuals who are eligible for secondary coverage under this title pursuant to section 1862(b), may not enroll in a medicare health plan but may enroll in an employer-sponsored health plan, to which the Secretary shall make a monthly payment, pursuant to subsection (e)(2)(C).

''(C) PERIOD OF ENROLLMENT.—

''(i) IN GENERAL.—Except as provided in clauses (ii), (iii), and (iv), an individual may not choose another enrollment

until the next annual period provided under subparagraph (A).

''(ii) ENROLLMENT UPON ELIGIBILITY.—The Secretary shall provide an enrollment period of 30 days to any individual beginning 30 days before the date such individual first becomes entitled to benefits under part A or enrolled under part B only. Such enrollment shall be effective on the date of such entitlement.

''(iii) TERMINATION OF PLAN.—If a contract for a medicare health plan under this section is terminated during any calendar year, the Secretary shall provide for an enrollment period of 30 days to any individual enrolled in such plan beginning on the date of such termination.

''(iv) INDIVIDUAL NO LONGER IN AREA.—An individual terminating residence in a medicare market area may terminate enrollment with the medicare health plan of such area as of the beginning of the first calendar month following the date on which the request is made for such termination, and the Secretary shall

provide for an open enrollment period of 30 days to such individual for enrollment in the new medicare market area in which such individual resides beginning on the date of such termination. In the case of an individual's termination of enrollment, the medicare health plan shall provide the individual with a copy of the written request for termination of enrollment and a written explanation of the period (ending on the effective date of the termination) during which the individual continues to be enrolled with the plan and may not receive medicare benefits other than through such plan.

''(v) EFFECTIVE DATE OF NEW ENROLLMENT.—Enrollment under clause (iii) or (iv) shall be effective 30 days after the end of the enrollment period, or, if the Secretary determines that such date is not feasible, such other date as the Secretary specifies.

''(D) DEFAULT ENROLLMENT.—

''(i) IN GENERAL.—If an individual does not choose an enrollment option dur-

ing an enrollment period under this paragraph, such individual shall be automatically enrolled in—

''(I) the same option into which such individual enrolled in the preceding enrollment period, or

''(II) if the individual was not enrolled in such preceding period, the medicare fee-for-service.

''(ii) NO MEDICARE HEALTH PLANS IN AREA.—If there are no medicare health plans in the medicare market area in which the individual resides, such individual shall be automatically enrolled in the medicare fee-for-service.

''(3) INFORMATION REGARDING MEDICARE OPTIONS IN MARKET AREA.—

''(A) IN GENERAL.—The Secretary shall provide each individual making an enrollment decision during any enrollment period described in paragraph (2) with the following information, in comparative form, regarding the medicare health plans and medicare fee-for-service available in the medicare market area in which such individual resides:

''(i) The individual's premiums, deductibles, and copayments for medicare benefits.

''(ii) The individual's premiums, deductibles, and copayments for any supplementary benefits.

''(iii) Enrollee restrictions, including provider limitations.

''(iv) Quality information, including enrollee satisfaction and health outcomes.

''(v) Out-of-area coverage provided.

''(vi) Coverage of emergency services and urgently needed care.

''(vii) Appeal rights of enrollees.

''(viii) Any other necessary information as determined by the Secretary.

''(B) MARKETING REQUIREMENTS.—The Secretary shall prescribe the procedures and conditions under which a medicare health plan that has entered into a contract with the Secretary under this section may inform individuals eligible to enroll under this section with the plan about the plan. No brochures, application forms, or other promotional or informational material may be distributed by such plan to (or

for the use of) individuals eligible to enroll with the plan under this section unless—

''(i) at least 45 days before its distribution, the plan has submitted the material to the Secretary for review,

''(ii) the material is made available to all individuals eligible to enroll in the medicare health plan in the medicare market area, and

''(iii) the Secretary has not disapproved the distribution of the material.

The Secretary shall review all such material submitted and shall disapprove such material if the Secretary determines, in the Secretary's discretion, that the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.

''(4) RISK ADJUSTMENTS.—

''(A) IN GENERAL.—The Secretary shall adjust the payments made to medicare health plans and employer-sponsored health plans under this title to reflect the relative health risks of classes of beneficiaries enrolled in such plans in the medicare market area. The Secretary shall, at a minimum, define appropriate

classes of beneficiaries, based on age, sex, disability status, eligibility under title XIX, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence and the efficient delivery of health care. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence. The Secretary may enter into risk sharing arrangements in a medicare market area, if the Secretary determines it to be appropriate.

''(B) PENALTIES FOR DISCRIMINATION.—The Secretary shall prescribe the procedures and conditions under which the Secretary shall impose financial penalties on medicare health plans or employer-sponsored health plans that knowingly violate the prohibition against discrimination against potential enrollees based on their health status, claims experience, medical history, or other factors that are generally related with utilization of health care services.

''(5) PAYMENTS TO PLANS.—

''(A) IN GENERAL.—The Secretary shall forward to each medicare health plan or employer-sponsored health plan the medicare per

capita rate for the medicare market area, as determined under subsection (e), for every beneficiary enrolled in such plan for that month, excluding any beneficiary premium but reflecting any adjustments required pursuant to paragraph (4)(A).

''(B) COLLECTION OF BENEFICIARY PREMIUMS AND REBATES.—

''(i) PREMIUMS.—Each medicare health plan or employer-sponsored plan shall be responsible for collecting premiums owed by beneficiaries for enrolling in such plan, including premiums for medicare benefits and any supplementary benefits.

''(ii) REBATES.—Any medicare health plan or employer-sponsored plan which charges a monthly premium which is less than the medicare per capita rate for an enrollee shall be responsible for paying to such enrollee a rebate equal to the excess medicare per capita rate or may use such rebate to offset any premium owed by the enrollee for any supplementary benefits selected by the enrollee.

''(C) SOURCE OF PAYMENT.—The amounts paid to medicare health plans and employer-sponsored health plans shall be made from the Federal Hospital Insurance Trust Fund and the Supplementary Insurance Trust Fund based on an allocation determined by the Secretary.

''(e) MEDICARE PER CAPITA RATE.—

''(1) ANNOUNCEMENT.—With respect to each medicare market area, the Secretary shall announce, not later than October 1 (beginning with 1995) the per capita rate that will apply to such market area beginning with the enrollment year (which coincides with the next calendar year).

''(2) PER CAPITA RATE.—

''(A) IN GENERAL.—Except as provided in subparagraphs (B), (C), and (D), the per capita rate for a medicare market area shall be equal to the lesser of—

''(i) the excess of—

''(I) the benchmark premium for such area, over

''(II) the base beneficiary premium for such area; or

''(ii) the maximum per capita rate.

''(B) EXCEPTION.—For individuals eligible for medicare benefits prior to January 1, 1999, the per capita rate for a medicare market area shall be equal to the lesser of the maximum per capita rate or the sum of—

''(i) the excess of—

''(I) the benchmark premium for such area, over

''(II) the base beneficiary premium for such area, and

''(ii) the applicable percentage of the excess of—

''(I) the fee-for-service per capita costs (hereafter in this section referred to as 'FFSPCC') for such area, over—

''(II) such benchmark premium.

For purposes of the preceding sentence, the applicable percentage shall be determined by the following table:

"Enrollment year:	Applicable Percentage:
1996	90
1997	80
1998	70
1999	60
2000 and thereafter	50.

''(C) SECONDARY PAYER PER CAPITA RATE.—For individuals who are eligible for sec-

ondary coverage under this title pursuant to section 1862(b) and elect to enroll in an employer-sponsored health plan, the Secretary shall determine a per capita rate for each medicare market area equal to the costs of providing secondary coverage to all individuals in such market area divided by the number of individuals eligible for such coverage in such market area.

''(D) RURAL ENROLLEES.—

''(i) FIVE-YEAR BONUS.—For enrollment periods beginning in 1996 through 2000, the per capita rate in each medicare market area (otherwise determined under this paragraph) shall be increased by 10 percent with respect to each individual enrolling in a medicare health plan or employer-sponsored health plan who resides in an underserved rural area within such market area, as determined by the Secretary.

''(ii) IMPROVE ACCESS.—The bonus amount paid under this subparagraph shall be used by such health plans to improve access and coordinated service delivery in

the underserved rural area in which the enrollee resides. The bonus amount shall not reduce the premiums owed by the enrollee for medicare benefits or any supplementary coverage.

''(iii) STUDY AND RECOMMENDATIONS.—The Secretary shall report to the Congress at the end of the 5-year period described in clause (ii) on the status of health care access in underserved rural areas and shall make recommendations regarding continuation of bonus per capita payments.

''(E) CALCULATION REQUIREMENTS.—The FFSPCC shall be calculated directly to accurately reflect the costs of providing care in the fee-for-service system. The FFSPCC shall not be derived from the removal of medicare health plan payments and enrollees from total payments and enrollees.

''(3) MAXIMUM PER CAPITA RATE.—

''(A) IN GENERAL.—Except as provided in subparagraph (E), the maximum per capita rate in any medicare market area shall be the excess of—

''(i) the product of—

''(I) FFSPCC in all medicare market areas, and

''(II) an adjustment factor for such market area, over

''(ii) the base beneficiary premium in such market area.

''(B) ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(i)(II), and except as provided in subparagraph (D):

''(i) FFSPCC RATIO LESS THAN .8.—For medicare market areas with a FFSPCC ratio less than or equal to .8, the adjustment factor shall be .8.

''(ii) FFSPCC RATIO BETWEEN .8 AND .95.—For medicare market areas with a FFSPCC ratio less than .95 but greater than .8, the adjustment factor shall be the sum of .85, plus—

''(I) .1, multiplied by

''(II) the ratio of the excess of the FFSPCC ratio over .8, to .15.

''(iii) FFSPCC RATIO BETWEEN .95 AND 1.05.—For medicare market areas with a FFSPCC ratio of at least .95 but

less than 1.05, the adjustment factor shall be the FFSPCC ratio.

''(iv) FFSPCC RATIO BETWEEN 1.05 AND 1.2.—For medicare market areas with a FFSPCC ratio of at least 1.05 but less than 1.2, the adjustment factor shall be the sum of 1.05, plus—

''(I) .1, multiplied by

''(II) the ratio of the excess of the FFSPCC ratio over 1.05, to .15.

''(v) FFSPCC RATIO GREATER THAN 1.2.—For medicare market areas with a FFSPCC ratio greater than or equal to 1.2, the adjustment factor shall be 1.2.

''(C) FFSPCC RATIO.—For purposes of subparagraph (B), for each medicare market area, the Secretary shall determine a FFSPCC ratio by dividing FFSPCC in such market area by FFSPCC for all medicare market areas.

''(D) BUDGET NEUTRALITY.—The Secretary shall change the adjustment factors as necessary to ensure that total spending under this title shall not exceed the level of spending that would occur if the maximum per capita

rate in each medicare market area were equal to the FFSPCC in each such market area.

''(E) ALTERNATIVE FORMULA.—The Secretary may substitute an alternative formula for determining the maximum rate in each medicare market area. Such an alternative formula shall generally conform to the pattern of adjustment factors specified in subparagraph (B), except that such formula shall maintain a consistent mathematical relationship between the adjustment factor and the FFSPCC ratio in each such market area in a manner that achieves budget neutrality.

''(F) STUDY AND RECOMMENDATIONS.—The Secretary and the Physician Payment Review Commission shall report to the Congress every 2 years (beginning in 1997) on the method for determining the maximum per capita rate and the experience of each medicare market area with the formula. The Secretary and the Physician Payment Review Commission shall make recommendations regarding the appropriateness of basing the maximum per capita rate formula on fee-for-service per capita costs. The Secretary and the Physician Pay-

ment Review Commission shall also examine the appropriateness of implementing urban and rural adjusters to the maximum per capita rate formula.

''(4) DEFINITIONS.—For purposes of this subsection:

''(A) BENCHMARK PREMIUM.—The benchmark premium for a medicare market area shall be equal to the sum of—

''(i) the lowest health plan monthly premium submitted by a medicare health plan in such area for the enrollment year, and

''(ii) the applicable percentage of the excess of—

''(I) the average of all medicare health plan premiums submitted in such area, over

''(II) the lowest health plan premium in such area.

For purposes of the preceding sentence, the applicable percentage shall be determined by the following table:

"Enrollment year:	**Applicable Percentage:**
1996	80
1997	60
1998	40

1999 and thereafter ..... 20.

''(B) FEE-FOR-SERVICE PER CAPITA COSTS.—The Secretary shall determine FFSPCC for a medicare market area by dividing—

''(i) the total spending for medicare benefits (not including beneficiary cost sharing) for individuals who reside in such area, who are not enrolled in a medicare health plan or employer-sponsored health plan, and who are not in secondary payer status, by

''(ii) the number of such individuals.

The Secretary shall make such other adjustments as may be necessary to allow an accurate comparison of FFSPCC for the medicare market area with premiums charged by medicare health plans in such area.

''(f) BENEFICIARY PREMIUMS.—For purposes of this section:

''(1) BASE BENEFICIARY PREMIUM.—The base beneficiary premium for each medicare market area shall be equal to the product of—

''(A) the premium determined under section 1839, and

''(B) the FFSPCC for such area divided by the average national FFSPCC, as determined by the Secretary.

''(2) MONTHLY PREMIUMS.—

''(A) IN GENERAL.—To be enrolled for coverage in a medicare health plan or medicare fee-for-service during an enrollment year for medicare benefits, each beneficiary shall pay a monthly premium equal to the excess of—

''(i) the premium charged by the plan (determined under subsection (d)(1)) or the fee-for-service (determined under subparagraph (B)), over

''(ii) the medicare per capita rate in the medicare market area in which the beneficiary resides.

''(B) FEE-FOR-SERVICE BENEFICIARY PREMIUM.—

''(i) IN GENERAL.—For beneficiaries selecting medicare fee-for-service in a medicare market area, the monthly premium shall be equal to the excess of—

''(I) the FFSPCC for such area, over

''(II) the medicare per capita rate for such area.

''(ii) EXCEPTION.—For individuals eligible for medicare benefits prior to January 1, 1999, who select medicare fee-for-service for coverage, the beneficiary premium shall equal—

''(I) the base beneficiary premium, plus

''(II) any additional premium required pursuant to section 1893.

''(g) SUPPLEMENTARY COVERAGE PLANS.—

''(1) IN GENERAL.—The Secretary shall ensure that all supplementary coverage plans meet the requirements of this subsection, in addition to any requirements that may be applicable under section 1882.

''(2) COORDINATION WITH MEDICARE CHOICE.—Supplementary coverage plans may only be offered to beneficiaries during the same annual open enrollment period during which beneficiaries select medicare coverage and must be offered to all beneficiaries in the same medicare market area for the same, uniform monthly premium during the enrollment period.

''(3) STANDARD BENEFITS.—

''(A) IN GENERAL.—Medicare health plans may only offer standardized supplementary coverage plans as the Secretary shall prescribe by regulation.

''(B) REQUIRED OPTIONS.—Among the standardized plans, the Secretary shall include a plan—

''(i) covering only outpatient prescription drugs, and

''(ii) which, together with medicare benefits, would resemble coverage typically offered by health maintenance organizations to employer groups, including an annual out-of-pocket maximum beneficiary liability (covering coinsurance, copayments, and deductibles).

''(4) ONE SPONSOR.—A sponsor of supplementary coverage may not offer such coverage to a beneficiary selecting a medicare health plan from a different sponsor, except that sponsors of supplementary coverage may offer such coverage to any individual selecting medicare fee-for-service.

''(5) SURCHARGE ON CERTAIN PLANS.—Notwithstanding any other provision of this section, if

an individual chooses to purchase a medicare supplemental policy certified pursuant to section 1882 and the coverage under such policy results in increased costs to the program under this title, the monthly premium otherwise applicable under this section shall be increased by a surcharge actuarially equivalent to such increased costs.

''(6) DEFINITIONS.—The term 'supplementary coverage plan' means any health insurance coverage offered by a medicare health plan or medicare supplemental policy (as defined in section 1882) that covers health care costs not covered under as medicare benefits and for which the enrollee must pay a premium.''.

(b) CONFORMING AMENDMENTS.—

(1) Section 1882(c) of the Social Security Act (42 U.S.C. 1395ss(c)) is amended—

(A) by striking ''with respect to paragraph (3)'' and inserting ''with respect to paragraphs (3) and (6)'',

(B) by striking ''and'' at the end of paragraph (4),

(C) by striking the period at the end of paragraph (5) and inserting ''; and'', and

(D) by adding at the end the following new paragraph:

''(6) agrees—

''(A) to offer such policy during the annual open enrollment period specified in section 1876(c)(2) at a uniform monthly premium to all beneficiaries in a medicare market area established under section 1876(a); and

''(B) not to discriminate against beneficiaries based on their health status, claims experience, medical history, or other factors that are generally related with utilization of health care services.''.

(2) Section 1882(s) of such Act (42 U.S.C. 1395ss(s)) is amended—

(A) by striking paragraph (2),

(B) by striking ''paragraphs (1) and (2)'' in paragraph (3) and inserting ''paragraph (1)'', and

(C) by redesignating paragraph (3) as paragraph (2).

(3) Section 1839(e) of such Act (42 U.S.C. 1395r(e)) is amended to read as follows:

''(e) Notwithstanding the provisions of subsection (a), the monthly premium for each individual enrolled under this part for each month—

''(1) in 1994 shall be $41.10,

''(2) in 1995 shall be $46.10, and

''(3) after December 1995 shall be an amount equal to 25 percent of the monthly actuarial rate for enrollees age 65 and over, as determined under subsection (a)(1) and applicable to such month.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to contracts entered into with respect to calendar years beginning after December 31, 1995.

SEC. 4. FEE-FOR-SERVICE COST CONTAINMENT.

(a) IN GENERAL.—Part C of title XVIII of the Social Security Act (42 U.S.C. 1395x et seq.) is amended by adding at the end thereof the following new section:

''FEE-FOR-SERVICE COST CONTAINMENT

''SEC. 1893. (a) IN GENERAL.—Unless Congress otherwise provides, notwithstanding any other provision of this title, payment for services provided to individuals entitled to benefits under part A and enrolled under part B, or enrolled under part B only (other than to individuals enrolled in medicare health plans or employer-sponsored health plans) (hereafter in this section referred to as 'service payments') shall be subject to an aggregate fee-for-

service spending limit in each market area for each calendar year, beginning with 1997.

''(b) SETTING AGGREGATE FEE-FOR-SERVICE SPENDING LIMITS.—

''(1) LIMITS FOR EACH MARKET AREA.—By not later than October 1 of each year (beginning with 1996), and subject to paragraph (2), the Secretary shall determine and publish in the Federal Register, the fee-for-service spending limits for each medicare market area for the succeeding calendar year.

''(2) FORMULA FOR DETERMINING LIMITS.—The Secretary shall calculate such limits by allowing aggregate fee-for-service spending in each medicare market area to increase for—

''(A) inflation, as measured by the consumer price index,

''(B) changes in the numbers of enrollees described in subsection (a), and

''(C) an additional growth allowance of—

''(i) 4.0 percent in 1997,

''(ii) 3.5 percent in 1998,

''(iii) 3.0 percent in 1999, and

''(iv) 2.5 percent in 2000 and thereafter.

''(c) DETERMINING EXCESS SPENDING.—

''(1) IN GENERAL.—The Secretary shall determine the amount of excess spending (if any) for each medicare market area by subtracting the limit determined by the Secretary for such market area under subsection (b) from baseline spending for such market area.

''(2) BASELINE SPENDING.—The Secretary shall measure baseline spending for each medicare market area as the aggregate amount of service payments that would be made in such a market area on behalf of individuals in fee-for-service (as defined in subsection (a)) under the provisions of this title without regard to this section.

''(3) LOOK BACK.—In determining excess spending for a medicare market area—

''(A) the Secretary shall reduce the amount of excess spending for the succeeding year by the amounts in the current or prior years by which aggregate spending fell below the aggregate spending limit for the medicare market area, and

''(B) the Secretary shall increase the amount of excess spending for the succeeding year by the amounts in the current or prior years by which aggregate spending exceeded the

aggregate spending limit for the medicare market area.

''(d) ENFORCING MARKET AREA AGGREGATE SPENDING LIMITS.—

''(1) IN GENERAL.—By not later than October 1 of each year (beginning with 1996), the Secretary shall determine and publish in the Federal Register adjustments (if any) in service payment rates and beneficiary premiums that are required to eliminate excess spending in the succeeding calendar year in each medicare market area.

''(2) SERVICE PAYMENT RATES.—The Secretary shall reduce service payments that would otherwise apply under this title by the percentage that is necessary to reduce aggregate service payments in the medicare market area by an amount equal to one-half of the estimated excess spending in the succeeding calendar year.

''(3) PREMIUM ADD-ON.—The Secretary shall increase the monthly part B premium that would otherwise apply under this title for the succeeding calendar year by an amount that is sufficient to increase aggregate part B premium payments from individuals (as defined in subsection (a)) by an

amount equal to one-half of the estimated excess spending in the succeeding calendar year.

''(e) EXEMPTING LOW-COST AREAS.—

''(1) IN GENERAL.—Any medicare market area in which fee-for-service spending per individual is below 90 percent of the national average shall be exempt from enforcement of the aggregate spending limit for such market area.

''(2) BUDGET NEUTRALITY.—The Secretary shall increase the amount of excessive spending in medicare market areas with fee-for-service spending per individual to ensure the application of paragraph (1) does not increase total spending under this title.

''(3) HIGH FEE-FOR-SERVICE SPENDING.—Medicare market areas with high fee-for-service spending per individual are those areas where spending per individual is higher than 120 percent of all other medicare market areas.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to payments under title XVIII of the Social Security Act in calendar years beginning after December 31, 1995.

SEC. 5. MEDICARE ADMINISTRATIVE SIMPLIFICATION.

(a) CONSOLIDATION OF PARTS A AND B.—By not later than October 1, 1995, the Secretary shall submit to

the Congress a proposal to consolidate entitlement for part A of the title XVIII of the Social Security Act and enrollment in part B of such title into eligibility or enrollment into the entire medicare program under such title. In preparing such a proposal, the Secretary shall consider phasing in such a consolidation, and shall ensure that no beneficiary shall pay higher premiums for coverage under such program than under such program as of the date of the enactment of this Act.

(b) CONSOLIDATION OF FEE-FOR-SERVICE ADMINISTRATION.—

(1) IN GENERAL.—The Secretary shall take such steps as may be necessary to consolidate the administration (including processing systems) of parts A and B of the medicare program (under title XVIII of the Social Security Act), including medicare supplemental policies, over a 5-year period.

(2) COMBINATION OF INTERMEDIARY AND CARRIER FUNCTIONS.—In taking such steps, the Secretary may contract with a single entity that combines the fiscal intermediary and carrier functions in an area. No medicare market area (established under section 1876(a)) may be subject to more than 1 entity.

(3) STREAMLINED PROCESSING SYSTEMS.—In carrying out this subsection, the Secretary may ensure—

(A) a streamlined, standardized, and paperless process for handling all fee-for-service claims, and

(B) that payments under title XVIII of the Social Security Act are made first by the medicare program and medicare supplemental policies before providers can bill beneficiaries for services using standardized forms.

(4) SUPERSEDING CONFLICTING REQUIREMENTS.—The provisions of sections 1816 and 1842 of the Social Security Act (including provider nominating provisions in such section 1816) are superseded to the extent required to carry out this subsection.

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