

105TH CONGRESS
1ST SESSION

S. 246

To amend title XVIII of the Social Security Act to provide greater flexibility and choice under the medicare program.

IN THE SENATE OF THE UNITED STATES

JANUARY 30, 1997

Mr. GREGG introduced the following bill; which was read twice and referred to the Committee on Finance

A BILL

To amend title XVIII of the Social Security Act to provide greater flexibility and choice under the medicare program.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Medicare Improvement
5 and Choice Care Provision Act”.

6 **SEC. 2. PURPOSES.**

7 The purposes of this Act are to—

8 (1) improve the quality of medical care provided
9 to America’s senior citizens, by making the medicare

1 program more responsive to the special health care
2 needs of senior citizens;

3 (2) expand and improve the existing medicare
4 program to provide senior citizens with a greater va-
5 riety of health care options from which to choose;

6 (3) increase the flexibility of the medicare pro-
7 gram to allow health care services to be delivered in
8 a modern fashion, and to enable the program to take
9 swift advantage of future market improvements in
10 the means of health care delivery;

11 (4) provide senior citizens with the information
12 they need to make for themselves the best health
13 care choices possible; and

14 (5) help preserve the immediate and long-term
15 solvency of the medicare program by beginning to
16 alter medicare's basic delivery structure by encour-
17 aging the provision of quality medical care at rea-
18 sonable prices through enhanced competition.

19 **TITLE I—CHOICE CARE** 20 **PROGRAM**

21 **SEC. 101. CHOICE CARE PROGRAM.**

22 Title XVIII of the Social Security Act (42 U.S.C.
23 1395 et seq.) is amended by adding at the end the follow-
24 ing new part:

1 **“PART D—CHOICE CARE PROGRAM**

2 **“SEC. 1895A. ESTABLISHMENT OF CHOICE CARE PROGRAM.**

3 “The Secretary shall establish the choice care pro-
4 gram in accordance with this part.

5 **“SEC. 1895B. DEFINITIONS.**

6 “For purposes of this part:

7 “(1) CHOICE CARE PLAN.—The term ‘choice
8 care plan’ means any of the following plans of health
9 insurance:

10 “(A) INDEMNITY OR FEE-FOR-SERVICE
11 PLANS.—Private indemnity plans that reim-
12 burse hospitals, physicians, and other providers
13 on the basis of a privately arranged fee sched-
14 ule.

15 “(B) COORDINATED CARE PLANS.—Private
16 managed or coordinated care plans, including—

17 “(i) eligible organizations with risk
18 contracts under section 1876 or competi-
19 tive medical plans having contracts under
20 section 1833;

21 “(ii) qualified health maintenance or-
22 ganizations as defined in section 1310(d)
23 of the Public Health Service Act; and

24 “(iii) preferred provider organization
25 plans, point of service plans, or other co-
26 ordinated care plans.

1 “(C) HIGH DEDUCTIBLE PLANS IN CON-
2 NECTION WITH MEDICARE MEDICAL SAVINGS
3 ACCOUNTS.—Private plans that require the eli-
4 gible individual to pay a minimum annual de-
5 ductible for insured medical expenses equal to
6 at least \$1,500 in a calendar year and that are
7 operated in connection with medicare medical
8 savings accounts as defined in section 86(g) of
9 the Internal Revenue Code of 1986.

10 “(D) OTHER HEALTH CARE PLANS.—Any
11 other private plan for the delivery of health care
12 items and services that is not described in sub-
13 paragraph (A), (B), or (C).

14 “(2) ELIGIBLE INDIVIDUAL.—

15 “(A) IN GENERAL.—The term ‘eligible in-
16 dividual’ means an individual who is entitled to
17 benefits under part A and enrolled under part
18 B.

19 “(B) PHASE-IN OF DISABLED INDIVIDUALS
20 AND INDIVIDUALS WITH ESRD.—For purposes
21 of subparagraph (A), the term ‘eligible individ-
22 ual’ shall not include an individual who is enti-
23 tled to benefits under part A under section

1 226(b) or 226A until such time as the Sec-
2 retary issues regulations in accordance with sec-
3 tion 1897H.

4 “(3) QUALIFIED PROVIDER.—The term ‘quali-
5 fied provider’ means a provider that—

6 “(A) qualifies for any or all payments
7 under subsection (d)(5)(B), (d)(5)(F), or (h) of
8 section 1886; and

9 “(B) provides inpatient services as a choice
10 care plan, or under a contract with a choice
11 care plan, to individuals enrolled with a choice
12 care plan under this part.

13 “(4) TRADITIONAL MEDICARE PROGRAM.—The
14 term ‘traditional medicare program’ means the pro-
15 gram of benefits available to individuals entitled to
16 benefits under part A and enrolled under part B of
17 this title, other than enrollment in an eligible organi-
18 zation with a contract under section 1876, a com-
19 petitive medical plan having a contract under section
20 1833, or a choice care plan under this part.

21 “(5) TRUSTEES.—The term ‘Trustees’ means
22 the Trustees of the Federal Hospital Insurance
23 Trust Fund and the Federal Supplementary Medical
24 Insurance Trust Fund.

1 **“Subpart 1—Individual Participation in**
2 **Choice Care Program**

3 **“SEC. 1896A. GENERAL ELIGIBILITY.**

4 “(a) IN GENERAL.—

5 “(1) ELIGIBILITY TO ENROLL.—Each eligible
6 individual shall be eligible to enroll under this part
7 with any choice care plan with a contract under this
8 part which services the reimbursement area in which
9 the individual resides.

10 “(2) SOLE PAYMENTS.—An eligible individual
11 who is enrolled with a choice care plan under this
12 part shall not be eligible for any benefits under this
13 title other than the payment of the choice care value
14 amount (described in section 1897C) and the rebate
15 amount (described in section 1897F(c)) in accord-
16 ance with this part.

17 “(b) ENROLLMENT PROCESS AND DEADLINES.—

18 “(1) BY MAIL.—Each eligible individual may
19 enroll or disenroll in a choice care plan with a con-
20 tract under this part by submitting a signed election
21 and enrollment form (to be developed by the Sec-
22 retary) that is postmarked prior to the close of any
23 open enrollment period applicable to such individual.

24 “(2) BY TELEPHONE OR THROUGH PLAN NOTI-
25 FICATION.—The Secretary, in consultation with the

1 Trustees, shall develop a process by which, during
2 enrollment periods—

3 “(A) an eligible individual may enroll or
4 disenroll in a choice care plan under this part
5 by telephone; and

6 “(B) a choice care plan with a contract
7 under this part may directly accept enrollment
8 and disenrollment information by an eligible in-
9 dividual and provide the Secretary with notice
10 of such enrollment or disenrollment.

11 “(3) USE OF AGENTS.—The Secretary, in con-
12 sultation with the Trustees, shall implement the en-
13 rollment process in a manner that ensures that eligi-
14 ble individuals may utilize the services of, and enroll
15 in the selected choice care plan through, independent
16 insurance agents. Any plan salesperson or agent,
17 whether independent or employed by a plan, that
18 meets personally and directly with one or more eligi-
19 ble individuals to assist in their choice and enroll-
20 ment in a plan, shall be required to be accredited
21 and licensed in the State in which they operate.

22 “(c) DEFAULT ENROLLMENT.—If an eligible individ-
23 ual is enrolled in a choice care plan under this part and
24 such individual fails to provide the Secretary with notice

1 of the individual's enrollment or disenrollment under sub-
 2 section (b) during any open enrollment period applicable
 3 to the individual, the individual shall be deemed to have
 4 reenrolled in the plan.

5 “(d) ENROLLMENT BY AN INDIVIDUAL.—

6 “(1) ANNUAL 45-DAY PERIOD.—Each choice
 7 care plan with a contract under this section shall
 8 offer an annual open enrollment period between No-
 9 vember 1 and December 15 of each year for the en-
 10 rollment and termination of enrollment of individ-
 11 uals.

12 “(2) ADDITIONAL PERIODS.—Each choice care
 13 plan with a contract under this section shall offer
 14 the following:

15 “(A) INITIAL MEDICARE ELIGIBILITY.—An
 16 open enrollment period to each eligible individ-
 17 ual during any enrollment period specified by
 18 section 1837 that applies to that individual (ef-
 19 fective as specified by section 1838).

20 “(B) NONENROLLED INDIVIDUALS.—A
 21 continuous open enrollment period to each eligi-
 22 ble individual who is not enrolled in a choice
 23 care plan.

24 “(3) PERIOD OF ENROLLMENT.—

1 “(A) IN GENERAL.—An individual enroll-
2 ing in a plan during any open enrollment period
3 under paragraph (1) shall be enrolled in the
4 plan for the calendar year following the open
5 enrollment period.

6 “(B) SPECIAL ENROLLMENT PERIODS.—
7 An individual enrolling in a plan during any
8 open enrollment period under paragraph (2)
9 shall be enrolled in the plan for the portion of
10 the calendar year on and after the date on
11 which the enrollment becomes effective.

12 “(C) HIGH DEDUCTIBLE PLANS.—An indi-
13 vidual enrolling during any open enrollment pe-
14 riod in a choice care plan which is a high de-
15 ductible plan health plan described in section
16 1895B(1)(C), shall be enrolled until the close of
17 the calendar year following the calendar year
18 referred to in subparagraph (A) or (B).

19 “(4) TERMINATIONS.—

20 “(A) LOCK-IN.—Except as otherwise pro-
21 vided in this paragraph, an individual may not
22 terminate enrollment in a choice care plan be-
23 fore the next open enrollment period applicable
24 to the individual.

1 “(B) HIGH DEDUCTIBLE PLANS.—In the
2 case of an individual enrolled in a plan de-
3 scribed in paragraph (3)(C), an individual may
4 not terminate enrollment until the open enroll-
5 ment period applicable to the individual in the
6 calendar year in which the enrollment would
7 otherwise terminate under paragraph (3)(C).

8 “(C) TERMINATION FOR CAUSE.—Notwith-
9 standing subparagraph (A) or (B), an individ-
10 ual may terminate enrollment in a choice care
11 plan if—

12 “(i) the individual moves to a new re-
13 imbursement area; or

14 “(ii) the choice care plan in which the
15 individual is enrolled fails to meet the
16 plan’s service or capacity requirements
17 under section 1897B(a)(7), as determined
18 by the Secretary.

19 “(D) PHASE-IN OF LOCK-IN.—Notwith-
20 standing subparagraph (A) or (B), an individ-
21 ual may terminate enrollment in a choice care
22 plan prior to the next open enrollment period
23 applicable to the individual—

24 “(i) at any time during calendar year
25 1998; or

1 “(ii) if, during the 1-year period be-
2 ginning on—

3 “(I) January 1, 1999, such indi-
4 vidual has been enrolled in such plan
5 for 4 months; and

6 “(II) January 1, 2000, such indi-
7 vidual has been enrolled in such plan
8 for 8 months.

9 **“Subpart 2—Contracting and Choice Care**
10 **Plans**

11 **“SEC. 1897A. AUTHORITY TO CONTRACT.**

12 “The Secretary shall enter into a 1-year contract with
13 each choice care plan in a reimbursement area if the plan
14 meets the requirements of this section with respect to eli-
15 gible individuals enrolled under this section.

16 **“SEC. 1897B. CHOICE CARE PLAN REQUIREMENTS.**

17 “(a) GENERAL REQUIREMENTS.—Each choice care
18 plan with a contract under this part shall meet the follow-
19 ing requirements:

20 “(1) NONDISCRIMINATION.—

21 “(A) ENROLLMENT.—The plan shall ac-
22 cept on a first-come-first-served basis, up to the
23 limits of its capacity (as determined by the Sec-
24 retary) and without restrictions, all eligible indi-
25 viduals within the plan’s reimbursement area

1 who elect to enroll in such plan, unless to do so
2 would result in the enrollment of enrollees who
3 are substantially nonrepresentative, as deter-
4 mined in accordance with regulations of the
5 Secretary, of the population in the reimburse-
6 ment area served by the organization. The plan
7 shall not refuse or cancel coverage of eligible in-
8 dividuals except for reasons of beneficiary fraud
9 or nonpayment of amounts due the plan under
10 the coverage policy.

11 “(B) CONTINUED ENROLLMENT PRO-
12 TECTED.—The plan shall provide assurances to
13 the Secretary that it will not expel, or refuse to
14 re-enroll any eligible individual because of the
15 individual’s health status or requirements for
16 health care services, and that it will notify each
17 such individual of such fact at the time of the
18 individual’s enrollment.

19 “(2) PARTS A AND B SERVICES.—The plan
20 shall provide those services covered under parts A
21 and B of this title through providers and other per-
22 sons that meet the applicable requirements of this
23 title and part A of title XI. The Secretary may not
24 require any additional benefits to be provided other
25 than those described in the previous sentence.

1 “(3) ESTABLISHMENT OF SCHEDULES.—

2 “(A) IN GENERAL.—Each choice care plan
3 shall establish premium, deductible, and copay-
4 ment schedules for the plan, except that in the
5 case of plans other than high deductible health
6 plans described in section 1895B(1)(C) and as
7 provided in subparagraph (B) and subsection
8 (b)(2), such premium, deductible, and copay-
9 ment schedules for services described in para-
10 graph (2) may not exceed the levels of the pre-
11 miums, deductibles and copayments established
12 for such services under the traditional medicare
13 program.

14 “(B) ADDITIONAL DEDUCTIBLES AND CO-
15 PAYMENTS.—A coordinated care choice care
16 plan may establish schedules for copayments
17 and deductibles which exceed the level estab-
18 lished under the traditional medicare program
19 for services purchased from a provider who is
20 not part of such coordinated care plan network.

21 “(4) OUT-OF-AREA COVERAGE.—The plan shall
22 provide for coverage for its enrollees if an enrollee
23 requires medical care out of the plan’s service area.

1 “(5) AT-RISK BASIS.—The plan shall agree to
2 provide all coverage described in paragraph (2) to el-
3 igible individuals who enroll with the plan for not
4 more than the sum of the choice care value amount
5 determined with respect to such individual and any
6 additional premiums paid by such individual (pursu-
7 ant to section 1897F(a)), and to assume the full fi-
8 nancial risk of the cost of furnishing such coverage
9 on a prospective basis regardless of whether such
10 cost exceeds such fixed payment, except that the
11 plan may—

12 “(A) insure itself against such financial
13 risk; and

14 “(B) make arrangements with other health
15 care providers to assume all or part of such fi-
16 nancial risk.

17 “(6) SOLVENCY.—The plan shall make ade-
18 quate provision against the risk of insolvency, in-
19 cluding provisions to prevent the plan’s enrollees
20 from being held liable to any person or entity for the
21 plan’s debts in the event of the plan’s insolvency.

22 “(7) ADEQUATE CAPACITY.—The plan shall
23 adequately assure the Secretary that, with respect to

1 each reimbursement area in which it desires to par-
2 ticipate, the plan has the capacity to serve the ex-
3 pected enrollment in such reimbursement area.

4 “(8) GRIEVANCE PROCESS.—The plan shall es-
5 tablish an internal procedure for hearing and resolv-
6 ing grievances between the plan and enrollees, in-
7 cluding procedures under which an enrollee (or pro-
8 vider on behalf of such enrollee) may challenge the
9 plan’s denial of coverage of or payment for medical
10 assistance or services to the enrollee.

11 “(9) RATE TABLE.—The plan shall submit to
12 the Secretary a table of its rates for all actuarial
13 categories of eligible individuals prior to contract ap-
14 proval by the Secretary.

15 “(b) PLAN PARTICIPATION OPTIONS.—Each choice
16 care plan with a contract under this part—

17 “(1) may, subject to paragraphs (2) and (3) of
18 subsection (a), offer any combination or structure of
19 benefits, covered items, services, and coverage limits;

20 “(2) may provide such members with additional
21 health care services, including prescription drugs,
22 and may establish a premium schedule for such ad-
23 ditional services which exceeds the levels established
24 under the traditional medicare program; and

1 “(3) may require approval for the provision of
 2 nonemergency medical assistance or services to an
 3 enrollee for nonemergency services before such as-
 4 sistance is provided, provided such prior approval is
 5 given in a reasonably timely manner.

6 **“SEC. 1897C. CHOICE CARE VALUE AMOUNTS.**

7 “(a) IN GENERAL.—The Secretary shall annually de-
 8 termine, and shall announce (in a manner intended to pro-
 9 vide notice to interested parties) not later than September
 10 7 of 1997 and each calendar year thereafter, the choice
 11 care value amount determined in accordance with this sec-
 12 tion for the following calendar year for each class of eligi-
 13 ble individuals in a reimbursement area enrolled under
 14 this part with a choice care plan.

15 “(b) DEFINITION OF APPROPRIATE CLASSES.—The
 16 Secretary shall define classes of individuals under this sec-
 17 tion in the same manner as the Secretary defines classes
 18 of individuals under section 1876.

19 “(c) CALCULATION OF CHOICE CARE VALUE
 20 AMOUNT.—

21 “(1) 1998.—For purposes of subsection (a), the
 22 choice care value amount for 1998 shall be—

23 “(A) for a reimbursement area described
 24 in subsection (d)(1), an amount equal to the av-
 25 erage of the sum of the adjusted average per

1 capita costs determined for parts A and B of
2 all reimbursement areas described in subsection
3 (d)(1) in the State in which the area is located;
4 and

5 “(B) for a reimbursement area described
6 in paragraph (2) or (3) of subsection (d), the
7 average of the sum of the adjusted average per
8 capita costs determined for parts A and part B
9 of all of the counties within such reimburse-
10 ment area.

11 “(2) SUBSEQUENT YEAR AMOUNTS.—For pur-
12 poses of subsection (a), the choice care value amount
13 for a reimbursement area for years after 1998 shall
14 be an amount equal to the choice care value amount
15 determined for the preceding year, increased—

16 “(A) by 11 percent if, during the preceding
17 year, the choice care value amounts determined
18 for such reimbursement area were equal to or
19 less than 85 percent of the average of all choice
20 care value amounts in all reimbursement areas
21 for such preceding year;

22 “(B) by 7.5 percent if, during the preced-
23 ing year, the choice care value amounts deter-
24 mined for such reimbursement area were equal
25 to or greater than 85 percent of the average of

1 all choice care value amounts in all reimburse-
2 ment areas, but equal to or less than 95 per-
3 cent of such average for such preceding year;

4 “(C) by 2.5 percent if, during the preced-
5 ing year, the choice care value amounts deter-
6 mined for such reimbursement area were equal
7 to or greater than 105 percent of the average
8 of all choice care value amounts in all reim-
9 bursement areas for such preceding year, but
10 equal to or less than 120 percent of such aver-
11 age;

12 “(D) by 0.5 percent if, during the preced-
13 ing year, the choice care value amounts deter-
14 mined for such reimbursement area were equal
15 to or greater than 120 percent of the average
16 of all choice care value amounts in all reim-
17 bursement areas for such preceding year; and

18 “(E) in all reimbursement areas not de-
19 scribed in subparagraph (A), (B), (C), and (D),
20 by a percentage determined by the Secretary
21 which is greater than 2.5 percent and less than
22 7.5 percent and which ensures that the average
23 amount of the increase for all such areas is 5
24 percent.

1 “(3) ADJUSTED AVERAGE PER CAPITA COST.—

2 For purposes of this subsection—

3 “(A) IN GENERAL.—the term ‘adjusted av-
4 erage per capita cost’ has the meaning given
5 such term by section 1876(a)(4).

6 “(B) REDUCTION FOR IME, DME, AND DSH
7 PAYMENTS.—The following shall not be taken
8 into account in computing the adjusted average
9 per capita cost under subparagraph (A):

10 “(i) IME.—Any payments attributable
11 to section 1886(d)(5)(B) relating to indi-
12 rect medical education.

13 “(ii) DIRECT GME.—Any payments at-
14 tributable to section 1886(h) relating to di-
15 rect graduate medical education.

16 “(iii) DISPROPORTIONATE SHARE
17 HOSPITALS.—Any payments attributable to
18 section 1886(d)(5)(F) relating to direct
19 graduate medical education.

20 “(4) DISTRIBUTION OF IME, DME, AND DISH.—

21 “(A) IN GENERAL.—

22 “(i) ANNUAL DETERMINATION.—The
23 Secretary shall estimate, based on enroll-
24 ment in choice care plans under this part,
25 the aggregate amount of payments that

1 would have been made under this title to
2 providers for each category of payment de-
3 scribed in clause (i), (ii), and (iii) of para-
4 graph (3)(B) with respect to individuals
5 enrolled in choice care plans if such indi-
6 viduals had not been enrolled in such
7 plans.

8 “(ii) ALLOCATION OF AMOUNTS.—For
9 each year, the Secretary shall allocate each
10 of the aggregate amounts determined
11 under clause (i) to qualified providers on a
12 per patient basis in accordance with sub-
13 paragraph (B) and based on the Sec-
14 retary’s best estimation of whether such
15 amount will fully deplete each such aggre-
16 gate amount for the year.

17 “(iii) END OF YEAR RECONCILI-
18 ATION.—The Secretary shall develop a
19 process that permits the Secretary to—

20 “(I) recoup from qualified provid-
21 ers an amount equal to the difference
22 (if any) between the allocations made
23 under clause (ii) for a category of
24 payment described in clause (i), (ii),
25 or (iii) of paragraph (3)(B) and the

1 Secretary's estimate for such category
2 under clause (i); and

3 “(II) provide additional payments
4 to qualified providers if the allocations
5 made under clause (ii) for a category
6 of payments described in clause (i),
7 (ii), or (iii) of paragraph (3)(B) are
8 less than the Secretary's estimate for
9 such category under clause (i).

10 “(B) DISTRIBUTION.—The amounts that
11 are excluded from the adjusted average per cap-
12 ita cost in accordance with paragraph (3)(B)
13 shall be distributed to qualified providers as fol-
14 lows:

15 “(i) For any provider that would qual-
16 ify for the indirect medical education ad-
17 justment under section 1886(d)(5)(B) or
18 the disproportionate share adjustment
19 under section 1886(d)(5)(F), payment
20 shall be made on a per discharge basis for
21 each individual enrolled in a choice care
22 plan with a contract under this part who
23 receives inpatient care at that provider as
24 though the traditional medicare program

1 was making payment to such provider on
2 the basis of a diagnostic related group.

3 “(ii) For any provider that would
4 qualify for the direct graduate medical
5 education payment under section 1886(h),
6 payment shall be made to such provider by
7 counting as medicare inpatient days those
8 days attributable to individuals enrolled in
9 a choice care contract in determining the
10 provider’s medicare patient load.

11 “(d) REIMBURSEMENT AREA.—For purposes of this
12 part, a reimbursement area is—

13 “(1) for a county that does not fall within a
14 Metropolitan Statistical Area, the county,

15 “(2) for a county that falls within a Primary
16 Metropolitan Statistical Area, the Primary Metro-
17 politan Statistical Area, and

18 “(3) for a county that falls within a Metropoli-
19 tan Statistical Area but not within a Primary Metro-
20 politan Statistical Area, the Metropolitan Statistical
21 Area.

22 “(e) REPORTS BY PROPAC.—Not later than January
23 1, 1999, the Prospective Payment Assessment Commis-
24 sion shall submit reports to the Congress on the impact

1 of the indirect medical education adjustment, direct grad-
2 uate medical education payment, and the disproportionate
3 share hospital adjustment distribution system established
4 under subsection (c), and on the impact of the reimburse-
5 ment areas established under subsection (d). Each report
6 shall include any recommendations for appropriate modi-
7 fications.

8 **“SEC. 1897D. PLAN NOTIFICATION TO THE SECRETARY.**

9 “(a) NOTIFICATION.—

10 “(1) GENERAL NOTIFICATION.—Each choice
11 care plan that desires to enter into a contract under
12 this part with the Secretary in 1 or more reimburse-
13 ment areas for the next calendar year shall submit
14 a notification in accordance with subsection (b) to
15 the Secretary not later than 21 days after the date
16 of the announcement of the choice care value
17 amounts described in section 1897C(a).

18 “(2) LATE NOTIFICATION.—A choice care plan
19 may submit a notification for a calendar year in ac-
20 cordance with subsection (b) to the Secretary after
21 the date described in paragraph (1) but such plan
22 shall not be eligible to enroll an eligible individual
23 during the annual open enrollment period described
24 in section 1896A(d)(1)(A) for such calendar year

1 unless the Secretary determines it is otherwise fair
2 and administratively feasible.

3 “(b) PLAN NOTIFICATION DESCRIBED.—A plan noti-
4 fication described in this subsection shall be in a form and
5 manner prescribed by the Secretary and shall include the
6 following information with respect to each reimbursement
7 area that the plan seeks to serve:

8 “(1) The type of health care plan, by category
9 described in section 1895B(1).

10 “(2) A schedule of benefits and services that
11 will be available (including those subject to prior au-
12 thorization by the plan as a condition of coverage),
13 including the amounts of premiums, copayments,
14 and deductibles to be assessed.

15 “(3) The identity, locations, qualifications, and
16 availability of the health care providers participating
17 in the plan.

18 “(4) The appeals procedures provided by the
19 plan in accordance with section 1897I(b).

20 “(5) The rights and responsibilities of enrollees
21 under the plan.

22 “(6) The results of the plan’s independent re-
23 views or accreditation process (as described in sec-
24 tion 1897G(d)).

1 “(7) Historical performance and satisfaction in-
2 formation (described in section 1897G(e)); and

3 “(8) Historical enrollment and disenrollment
4 data of the plan (excluding disenrollment by death).

5 “(c) SECRETARY TRANSMISSION OF INFORMATION
6 TO TRUSTEES.—Upon receipt of the notifications de-
7 scribed in subsection (b), the Secretary shall promptly
8 transmit the information contained in such notifications
9 to the Trustees. The Secretary shall also provide any other
10 information requested by the Trustees, in order for the
11 Trustees to carry out their duties under section 1897E.

12 **“SEC. 1897E. INFORMATION DUTIES OF THE TRUSTEES AND**
13 **PLANS.**

14 “(a) IN GENERAL.—

15 “(1) OPEN SEASON NOTIFICATION.—

16 “(A) By October 15 of each year beginning
17 after 1997, the Trustees shall mail a notice of
18 eligibility to participate in the choice care pro-
19 gram to each eligible individual and each indi-
20 vidual who is eligible to become entitled to ben-
21 efits under part A prior to the end of the an-
22 nual open season enrollment period described in
23 section 1896A(d)(1).

24 “(B) The notice described in subparagraph
25 (A) shall include an informational brochure that

1 includes the information described this section,
2 and any other information that the Trustees de-
3 termine will facilitate the individual's enroll-
4 ment decisions under the choice care program.

5 “(2) NOTIFICATION TO NEWLY MEDICARE-ELI-
6 GIBLE INDIVIDUALS.—With respect to an individual
7 who becomes an eligible individual after the close of
8 the annual open enrollment period described in sec-
9 tion 1896A(d)(1), the Trustees shall, not later than
10 3 months before the date on which the individual
11 becomes an eligible individual, mail to each such in-
12 dividual the notice of eligibility described in para-
13 graph (1).

14 “(b) TRUSTEES’ MATERIALS; CONTENTS.—The no-
15 tice and informational materials mailed by the Trustees
16 under subsection (a)(1)(A) shall be written and formatted
17 in the most easily understandable manner possible, and
18 shall include, at a minimum, the following information
19 with respect to coverage under this part during the next
20 calendar year:

21 “(1) The part B (and part A, if applicable) pre-
22 mium rates that will be charged for coverage under
23 the traditional medicare program.

24 “(2) The deductible and copayment amounts
25 for coverage under the traditional medicare program.

1 “(3) A description of any changes in coverage
2 that will occur under the traditional medicare pro-
3 gram.

4 “(4) A description of the eligible individual’s re-
5 imbursement area, and the choice care value amount
6 available with respect to such individual within the
7 reimbursement area.

8 “(5) Information on the choice care plans with
9 a contract under this part in the eligible individual’s
10 reimbursement area, including the premiums that
11 will be charged by such plans.

12 “(6) For each choice care plan with a contract
13 under this part in the eligible individual’s reimburse-
14 ment area, information on the amount of cash re-
15 bates that may be received by such eligible individ-
16 ual, or additional premium amounts, deductibles or
17 copayments that must be paid by such eligible indi-
18 vidual.

19 “(7) For each participating plan, any restric-
20 tions on coverage for services furnished other than
21 through the plan, any restrictions on services fur-
22 nished through the plan, such as preauthorization
23 review, concurrent review, post-service review, or
24 post-payment review, and any financial incentives

1 that might limit treatment or restrict referrals, such
2 as economic profiling or capitation.

3 “(8) Information on enrollee satisfaction with
4 each participating plan in the eligible individual’s re-
5 imbursement area, including enrollment and
6 disenrollment rates from previous years (excluding
7 disenrollment by death).

8 “(9) Performance and outcome-based informa-
9 tion and reports, with respect to each of the plans
10 with a contract under this part in the eligible indi-
11 vidual’s reimbursement area.

12 “(10) A simplified chart that presents and com-
13 pares the benefits provided and services covered of
14 each plan participating in the eligible individual’s re-
15 imbursement area.

16 “(11) Any other information that choice care
17 plans provide to the Secretary under section 1897D
18 or otherwise, that the Trustees determine will be of
19 assistance to informed decisionmaking by eligible in-
20 dividuals.

21 “(12) The phone numbers that an eligible indi-
22 vidual may use to enroll in a choice care plan with
23 a contract under this part in the eligible individual’s
24 reimbursement area.

25 “(13) A separate notice which—

1 “(A) identifies expenses that are generally
2 considered long-term care expenses,

3 “(B) clearly explains to eligible individuals
4 that long-term care expenses are not covered by
5 the traditional medicare program or choice care
6 plans, and

7 “(C) provides a list of long-term care in-
8 surers which have notified the Trustees of their
9 availability within a particular reimbursement
10 area.

11 “(c) USE OF PRIVATE ENTITIES.—The Trustees may
12 contract with private entities to undertake, in whole or in
13 part, the informational duties described in this section.

14 “(d) PLAN PARTICIPATION IN ENROLLMENT PROC-
15 ESS.—

16 “(1) IN GENERAL.—In addition to any informa-
17 tional materials distributed by the Trustees under
18 subsection (a), a choice care plan with a contract
19 under this part may develop and distribute market-
20 ing materials and engage in marketing strategies in
21 accordance with this subsection.

22 “(2) PLAN MARKETING AND ADVERTISING
23 STANDARDS.—Any marketing material developed or
24 distributed by a choice care plan with a contract

1 under this part and any marketing strategy devel-
2 oped by such plan—

3 “(A) shall compare—

4 “(i) health care coverage available
5 under the plan with the health care cov-
6 erage available under the traditional medi-
7 care program, and

8 “(ii) any rebates that may be avail-
9 able, or additional premium, deductibles,
10 or copayments that may be required under
11 the plan with the deductibles and copay-
12 ments required under the traditional medi-
13 care program,

14 “(B) shall be provided in a form and man-
15 ner that is easily understood by a typical eligi-
16 ble individual, and that contains accurate and
17 sufficient information for an individual to make
18 an informed decision on whether to enroll in the
19 plan, or to seek additional information,

20 “(C) shall include a telephone number that
21 may be called to receive information equivalent
22 to the information provided by the plan to the
23 Trustees under section 1897D,

1 “(D) shall be pursued in a manner not in-
2 tended to violate the anti-discrimination re-
3 quirement of section 1897B(a)(1), and

4 “(E) shall not contain false or materially
5 misleading information, and shall conform to
6 any other fair marketing and advertising stand-
7 ards and requirements applicable to such plans
8 under law.

9 “(e) PLAN NOTIFICATION TO ENROLLEES.—Each
10 choice care plan with a contract under this part shall pro-
11 vide to each individual who has elected to enroll in the
12 plan, at the time of enrollment and at least annually there-
13 after, an explanation of the enrollee’s rights under the
14 plan and this part, including an explanation of the follow-
15 ing:

16 “(1) The enrollee’s rights to benefits from the
17 plan.

18 “(2) The restrictions on coverage for services
19 furnished other than through the plan.

20 “(3) Out-of-area coverage provided by the plan.

21 “(4) The plan’s coverage of urgently needed
22 care and emergency services.

23 “(5) The appeal rights of enrollees in the plan.

1 **“SEC. 1897F. PREMIUMS, PLAN PAYMENTS, AND CASH-BACK**
2 **AWARDS.**

3 “(a) **ADDITIONAL PREMIUMS PAID TO THE PLAN.—**
4 An eligible individual who enrolls in a choice care plan
5 with a contract under this part shall pay any premium
6 amounts that may be required by the plan in excess of
7 the choice care value amount determined with respect to
8 such individual directly to the plan in a manner mutually
9 arranged between the individual and the plan.

10 “(b) **PAYMENTS TO PLANS.—**

11 “(1) **MONTHLY PAYMENTS IN ADVANCE.—**For
12 each eligible individual enrolled with the plan under
13 this part, the Secretary shall make monthly pay-
14 ments in advance to a choice care plan with a con-
15 tract under this part in an amount equal to the less-
16 er of the monthly choice care value amount deter-
17 mined with respect to such individual under section
18 1897C or the monthly premium determined for such
19 individual.

20 “(2) **RETROACTIVE ADJUSTMENTS.—**The
21 amount of payment under this paragraph may be
22 retroactively adjusted to take into account any dif-
23 ference between the actual number of individuals en-
24 rolled in the plan under this section and the number
25 of such individuals estimated to be so enrolled in de-
26 termining the amount of the advance payment.

1 “(3) TRUST FUND WITHDRAWALS.—The pay-
2 ment to a choice care plan under this section for eli-
3 gible individuals enrolled under this part with the or-
4 ganization and entitled to benefits under part A and
5 enrolled under part B shall be made from the Fed-
6 eral Hospital Insurance Trust Fund and the Federal
7 Supplementary Medical Insurance Trust Fund. The
8 portion of the payment to the plan for a month to
9 be paid by each trust fund shall be determined each
10 year by the Secretary based on the relative weight
11 that benefits from each fund contribute to the deter-
12 mination of the choice care value amount determined
13 under section 1897C, as estimated by the Secretary.

14 “(c) REBATES.—

15 “(1) IN GENERAL.—If the weighted average of
16 the choice care value amounts with respect to all in-
17 dividuals in a reimbursement area exceeds the pre-
18 mium of the plan in which an eligible individual is
19 enrolled, the Secretary shall—

20 “(A) pay to such individual an amount
21 equal to 75 percent of the excess, and

22 “(B) deposit the remainder of the excess in
23 the Federal Hospital Insurance Trust Fund.

24 “(2) ELIGIBILITY AND TIME FOR PAYMENT.—

1 “(A) ELIGIBILITY.—An individual shall be
2 eligible for a payment under paragraph (1) only
3 if the individual enrolls in the plan during the
4 annual open enrollment period described in sec-
5 tion 1896A(d)(1).

6 “(B) TIME FOR PAYMENT.—A rebate
7 under paragraph (1) shall be paid as of the
8 close of the calendar year to which the enroll-
9 ment applied.

10 “(C) SPECIAL RULE FOR HIGH DEDUCT-
11 IBLE PLANS.—In the case of an individual in a
12 choice care plan which is a high deductible
13 health plan described in section 1895B(1)(C)—

14 “(i) subparagraph (B) shall not apply,

15 and

16 “(ii) the Secretary shall, within 30
17 days of enrollment of the individual in the
18 plan, deposit the rebate into the medicare
19 medical savings account (as defined in sec-
20 tion 86(g) of the Internal Revenue Code of
21 1986) of the individual specified in the en-
22 rollment.

23 “(D) DISENROLLMENT.—

24 “(i) IN GENERAL.—No rebate shall be
25 paid under paragraph (1) if an individual

1 terminates enrollment in the choice care
2 plan before the close of the calendar year
3 to which the enrollment applied.

4 “(ii) TERMINATIONS FOR CAUSE.—
5 Clause (i) and subparagraph (A) shall not
6 apply in the case of a termination de-
7 scribed in section 1896A(d)(4)(C), but the
8 Secretary shall adjust the amount of the
9 rebate for the terminated plan and any
10 other choice care plan the individual en-
11 rolls in for the remainder of the calendar
12 year.

13 “(iii) HIGH DEDUCTIBLE PLANS.—If
14 clause (i) applies to a plan described in
15 subparagraph (C), the Secretary shall pro-
16 vide for the repayment of any amount paid
17 under subparagraph (C).

18 “(3) SOURCE OF REBATES.—The payment
19 amount described in paragraph (1) shall be made in
20 the same manner as payments are made under sub-
21 section (b)(3).

22 **“SEC. 1897G. QUALITY ASSURANCE, PLAN COVERAGE, AND**
23 **PARTICIPATION STANDARDS.**

24 “(a) IN GENERAL.—Each choice care plan with a
25 contract under this part shall—

1 “(1) have an ongoing quality assurance system
2 or program with respect to services the plan provides
3 to eligible individuals under this part which ensures
4 that the plan meets, at a minimum, the require-
5 ments of this section; and

6 “(2) be required to have received independent
7 accreditation, as described in this section.

8 “(b) INTERNAL QUALITY ASSURANCE.—

9 “(1) ACCESS.—Each choice care plan with a
10 contract under this part shall provide or arrange for
11 the provision of all medically necessary health care
12 services required under this Act and under a con-
13 tract under this part.

14 “(2) TIMELY DELIVERY OF SERVICES.—Each
15 choice care plan with a contract under this part
16 shall deliver, upon request, to eligible individuals en-
17 rolled with the plan upon request health care serv-
18 ices in a manner that is reasonably prompt and,
19 when medically necessary, that is available and ac-
20 cessible 24 hours a day and 7 days a week.

21 “(c) PERFORMANCE MEASURES.—Each plan shall
22 undertake to measure and maintain data on the plan’s ac-
23 tual performance in delivering of health care services to
24 eligible individuals. Such measures shall incorporate the
25 following information:

1 “(1) PATIENT ENCOUNTER DATA.—Sufficient
2 patient encounter data, including data to identify
3 the health care provider that delivers services to
4 each patient and the type of service provided, as de-
5 termined by the Secretary or Trustees to be of as-
6 sistance in the performance of their duties under
7 this part.

8 “(2) PERFORMANCE-BASED INFORMATION.—
9 Data that are continuously or periodically gathered,
10 and that—

11 “(A) are sufficient to reflect the care pro-
12 vided for the prevalent clinical conditions
13 among the enrollees served, including data on
14 health or functional status, clinical perform-
15 ance, functional improvement, and prevention
16 or early detection, and

17 “(B) provide information on compliance
18 with performance-based standards that reflect a
19 minimum set of comparable performance-based
20 data, that are selected in consultation with an
21 advisory body of outside experts in order to de-
22 velop a standardized set of measures that can
23 produce comparable and consistent information,
24 and that are updated periodically.

1 “(3) PLAN SATISFACTION DATA.—Data that
2 are periodically gathered to measure the perception
3 of patients, providers, and purchasers, including
4 data on the level of satisfaction associated with, at
5 a minimum, the responsiveness, access to services,
6 quality of services, and continuity of care of a par-
7 ticular plan.

8 “(d) INDEPENDENT ACCREDITATION.—

9 “(1) IN GENERAL.—Each plan shall arrange for
10 an annual external independent accreditation of the
11 plan, which includes a review of the plan’s quality
12 assurance and improvement systems.

13 “(2) ACCREDITING ORGANIZATION.—The inde-
14 pendent review and accreditation shall be performed
15 by an accrediting organization that—

16 “(A) is a private, nonprofit organization,

17 “(B) maintains an accreditation program
18 for accrediting managed care plans or other
19 health care plans that are offered under the
20 choice care program, and

21 “(C) is independent of the control of
22 health care providers, health care plans, or
23 trade associations of health care providers.

1 “(3) PUBLIC AVAILABILITY.—The results of re-
2 views described in paragraph (2) shall be made pub-
3 licly available upon request, and specifically made
4 available to the plan’s enrollees and potential enroll-
5 ees, in a manner that does not disclose the identity
6 of any particular patient.

7 “(4) DISQUALIFICATION.—A choice care plan
8 that fails to receive accreditation under this sub-
9 section shall be disqualified from participation in the
10 choice care program, unless the plan meets the fol-
11 lowing:

12 “(A) PROVISIONAL ACCREDITATION.—The
13 plan is a new plan (as determined by the Sec-
14 retary) and such plan is making reasonable
15 progress toward receiving accreditation, to the
16 satisfaction of the accrediting organization.

17 “(B) PRIOR ACCREDITATION.—The plan
18 received prior accreditation and such plan is
19 making reasonable progress toward correcting
20 the flaws that led to the failure to receive ac-
21 creditation, to the satisfaction of the accrediting
22 organization, and such plan does in fact correct
23 such flaws within 6 months.

24 “(e) ASSISTED SUICIDE.—No choice care plan may
25 provide any services, the purpose of which is to cause, or

1 to assist in the causing of, the death, suicide, euthanasia,
2 or mercy killing of an individual.

3 **“SEC. 1897H. SPECIAL RULE FOR DISABLED AND ESRD POP-**
4 **ULATIONS.**

5 “Not later than 5 years after the date of the enact-
6 ment of this part and after the Secretary obtains appro-
7 priate experience in administering this part, the Secretary
8 shall develop regulations to integrate individuals described
9 in section 1895B(2)(B) in the choice care program estab-
10 lished under this part.”.

11 **SEC. 102. MAXIMUM FLEXIBILITY IN IMPLEMENTATION, IN-**
12 **CLUDING USE OF NEGOTIATED RULEMAKING.**

13 In promulgating regulations, pursuant to negotiated
14 rulemaking under subchapter III of chapter 5 of title 5,
15 United States Code (but without making the determina-
16 tion under section 563(a) of such title), to implement this
17 Act, the Secretary of Health and Human Services shall—

18 (1) promulgate regulations to govern, and ad-
19 minister, the choice care program established under
20 part D of title XVIII of the Social Security Act, as
21 added by section 102, in a manner that maximizes
22 program efficiency and flexibility, and that avoids
23 having burdensome regulatory requirements or over-
24 ly bureaucratic program administration undermine
25 the purposes of the choice care program; and

1 (2) avoid (expressly or effectively) duplicating
2 or incorporating by reference the regulations relating
3 to section 1876 of the Social Security Act.

4 **SEC. 103. CONFORMING AMENDMENTS.**

5 (a) IN GENERAL.—Not later than 90 days after the
6 date of the enactment of this Act, the Secretary of Health
7 and Human Services shall submit to the appropriate com-
8 mittees of Congress a legislative proposal providing for
9 such technical and conforming amendments in the law as
10 are required by the provisions of this Act.

11 (b) MEDICARE PATIENT LOAD.—Section
12 1886(h)(3)(C) (42 U.S.C. 1395ww(h)(3)(C)) is amended
13 by inserting “including all days attributable to patients
14 enrolled in a choice care plan under part D” before the
15 period at the end.

16 (c) 1876 CONTRACTS.—Section 1876 (42 U.S.C.
17 1395mm) is amended by adding at the end the following
18 new subsection:

19 “(k) This section shall not apply to risk contracts for
20 contract years beginning on or after January 1, 1999.”.

21 **SEC. 104. EFFECTIVE DATE.**

22 The amendments made by section 101 shall apply
23 with respect to contracts effective on or after January 1,
24 1998.

1 **TITLE II—MEDICARE MEDICAL**
 2 **SAVINGS ACCOUNTS**

3 **SEC. 201. MEDICARE MEDICAL SAVINGS ACCOUNTS.**

4 (a) EXCLUSION FROM GROSS INCOME OF CONTRIBU-
 5 TIONS TO ACCOUNTS.—Subsection (a) of section 86 of the
 6 Internal Revenue Code of 1986 (relating to taxation of
 7 social security and tier 1 railroad retirement benefits) is
 8 amended by adding at the end the following new para-
 9 graph:

10 “(3) MEDICARE CHOICE CARE REBATES.—
 11 Gross income shall include any choice care rebate
 12 amount received under section 1897F(c) of the So-
 13 cial Security Act to the extent such amount is not
 14 deposited into a medicare medical savings account
 15 (as defined in subsection (g)).”

16 (b) MEDICARE MEDICAL SAVINGS ACCOUNTS.—Sec-
 17 tion 86 of the Internal Revenue Code of 1986 is amended
 18 by adding at the end the following new subsection:

19 “(g) MEDICARE MEDICAL SAVINGS ACCOUNTS.—
 20 “(1) IN GENERAL.—The term ‘medicare medi-
 21 cal savings account’ means a medical savings ac-
 22 count (as defined in section 220(d))—

23 “(A) which is designated as a medicare
 24 medical savings account, and

1 “(B) with respect to which no contribution
2 may be made other than—

3 “(i) a contribution made by the Sec-
4 retary of Health and Human Services
5 under section 1897F(e)(2) of the Social
6 Security Act on behalf of the account hold-
7 er,

8 “(ii) contributions made by or on be-
9 half of the account holder for a calendar
10 year not in excess of the amount of the re-
11 bate received by the holder under section
12 1897F(e)(1) of the Social Security Act for
13 the calendar year, or

14 “(iii) rollover contributions described
15 in section 220(f)(5).

16 “(2) SPECIAL RULES FOR DISTRIBUTIONS.—

17 “(A) QUALIFIED MEDICAL EXPENSES.—In
18 applying section 220, qualified medical expenses
19 shall include only expenses for medical care of
20 the account holder.

21 “(B) WITHDRAWAL OF ERRONEOUS CON-
22 TRIBUTIONS.—Section 220(f)(2) shall not apply
23 to any payment or distribution from a medicare
24 medical savings account to the Secretary of
25 Health and Human Services of an erroneous

1 contribution to the account and of the net in-
2 come attributable to such account.

3 “(3) SPECIAL RULES FOR TREATMENT OF AC-
4 COUNT AFTER DEATH OF ACCOUNT HOLDER.—Not-
5 withstanding section 220(f)(1)(A), if, as of the date
6 of the death of the account holder, the spouse of
7 such holder is not entitled to benefits under title
8 XVIII of the Social Security Act, then after the date
9 of such death—

10 “(A) the Secretary of Health and Human
11 Services may not make any payments to such
12 account, other than payments attributable to
13 periods before such date, and

14 “(B) such account shall be treated as a
15 medical savings account which is not a medi-
16 care medical savings account.

17 “(4) REPORTS.—In the case of a medicare
18 medical savings account, the report under section
19 220(h)—

20 “(A) shall include the fair market value of
21 the assets in such medicare medical savings ac-
22 count as of the close of each calendar year, and

23 “(B) shall be furnished to the account
24 holder—

1 “(i) not later than January 31 of the
2 calendar year following the calendar year
3 to which such reports relate, and

4 “(ii) in such manner as the Secretary
5 prescribes in such regulations.

6 “(5) COORDINATION WITH MEDICAL SAVINGS
7 ACCOUNT.—Any account designated as a medicare
8 medical savings account shall not be taken into ac-
9 count for purposes of subsection (i) or (j) of section
10 220.”

11 (c) CLERICAL AMENDMENTS.—

12 (1) The heading for section 86 of the Internal
13 Revenue Code of 1986 is amended by inserting “;
14 **MEDICARE CHOICE REBATES**” after “**BENE-**
15 **FITS**”.

16 (2) The table of sections for part II of sub-
17 chapter B of chapter 1 of such Code is amended by
18 inserting “; medicare choice rebates” after “bene-
19 fits” in the item relating to section 86.

20 (d) EFFECTIVE DATE.— The amendments made by
21 this section shall apply to taxable years beginning after
22 December 31, 1996.

○