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2^D 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

A BILL

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

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 Choice Act
5 of 1994”.

6 **SEC. 2. PURPOSE.**

7 The purpose of this Act is to provide better health
8 care to medicare beneficiaries at less cost by giving such
9 beneficiaries meaningful choices among health plans com-
10 peting on the basis of price and quality.

1 **SEC. 3. MEDICARE CHOICE.**

2 (a) IN GENERAL.—Section 1876 of the Social Secu-
3 rity Act (42 U.S.C. 1395mm) is amended to read as
4 follows:

5 “MEDICARE CHOICE

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

10 “(1) ensure that each individual entitled to ben-
11 efits under part A and enrolled under part B, or en-
12 rolled under part B only, resides in a medicare mar-
13 ket area,

14 “(2) maintain all portions of each metropolitan
15 statistical area within one medicare market area,
16 and

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

21 “(b) MEDICARE HEALTH PLANS.—

22 “(1) CONTRACTS WITH MEDICARE HEALTH
23 PLANS.—The Secretary shall enter into a contract
24 with any medicare health plan desiring to do busi-
25 ness in a medicare market area and to receive pay-
26 ment under this section, but only if the Secretary

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

3 “(2) CERTIFICATION REQUIREMENTS.—Each
4 medicare health plan must—

5 “(A) except as provided in paragraph (3),
6 provide those services covered by this title
7 (hereafter in this section referred to as ‘medi-
8 care benefits’) when medically necessary for a
9 uniform monthly premium for a year;

10 “(B) not discriminate against beneficiaries
11 based on their health status, claims experience,
12 medical history, or other factors that are gen-
13 erally related with utilization of health care
14 services;

15 “(C) demonstrate the ability to provide
16 medicare benefits to all potential enrollees
17 throughout the medicare market area, unless
18 the Secretary determines it appropriate for such
19 plan to target unique community needs within
20 the medicare market area;

21 “(D) demonstrate financial solvency;

22 “(E) have arrangements, established in ac-
23 cordance with regulations prescribed by the
24 Secretary, for an ongoing quality-assurance pro-

1 gram for the health care services such plan pro-
2 vides to such beneficiaries, which program—

3 “(i) stresses health outcomes, and

4 “(ii) provides review by physicians
5 and other health care professionals of the
6 process followed in the provision of such
7 health care services;

8 “(F) meet the requirement of section
9 1866(f) (relating to maintaining written policies
10 and procedures respecting advance directives);

11 “(G) not operate any compensation ar-
12 rangement between such plan and a physician
13 or physician group that may directly or indi-
14 rectly have the effect of reducing or limiting
15 services provided with respect to enrollees in
16 such plan (hereafter in this subparagraph such
17 arrangement shall be referred to as a ‘physician
18 incentive plan’), unless the following require-
19 ments are met:

20 “(i) No specific payment is made di-
21 rectly or indirectly under the physician in-
22 centive plan to a physician or physician
23 group as an inducement to reduce or limit
24 medically necessary services provided with

1 respect to a specific enrollee in the medi-
2 care health plan.

3 “(ii) If the physician incentive plan
4 places a physician or physician group at
5 substantial financial risk (as determined by
6 the Secretary) for services not provided by
7 the physician or physician group, the medi-
8 care health plan—

9 “(I) provides stop-loss protection
10 for the physician or physician group
11 that is adequate and appropriate,
12 based on standards developed by the
13 Secretary that take into account the
14 number of physicians placed at such
15 substantial financial risk under the
16 physician incentive plan and the num-
17 ber of enrollees in the medicare health
18 plan who receive services from the
19 physician or the physician group, and

20 “(II) conducts periodic surveys of
21 both enrollees and former enrollees in
22 the medicare health plan to determine
23 the degree of access of such enrollees
24 to services provided by the medicare

1 health plan and satisfaction with the
2 quality of such services;

3 “(H) collect and provide such standard in-
4 formation as the Secretary shall prescribe by
5 regulation as necessary to evaluate the perform-
6 ance and quality of such plan, including en-
7 rollee satisfaction, to compare such performance
8 and quality with competing plans, and to pre-
9 pare comparative materials for distribution to
10 beneficiaries;

11 “(I) demonstrate the ability to integrate
12 additional benefits into such plan for qualified
13 medicare beneficiaries; and

14 “(J) offer the supplementary coverage
15 plans established by the Secretary under sub-
16 section (g)(3)(B).

17 “(3) COST-SHARING.—

18 “(A) ACTUARIALLY EQUIVALENT MEDI-
19 CARE BENEFITS.—Each medicare health plan
20 must offer either—

21 “(i) medicare benefits, including the
22 cost-sharing requirements otherwise pro-
23 vided in this title; or

24 “(ii) actuarially equivalent medicare
25 benefits, as established by the Secretary in

1 regulations, which are medicare benefits,
2 but with cost sharing requirements that
3 are actuarially equivalent to the cost-shar-
4 ing requirements otherwise provided in this
5 title and consistent with common practices
6 among health maintenance organizations
7 and other managed care health plans.

8 In establishing actuarially equivalent medicare
9 benefits, the Secretary shall not include in the
10 calculation any charge in costs associated with
11 alternative forms of health care delivery, man-
12 agement, or utilization control.

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

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

24 “(ii) the plan provides enrollees with
25 such information.

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

11 “(c) EMPLOYER-SPONSORED HEALTH PLANS.—

12 “(1) CRITERIA FOR CERTIFICATION.—The Sec-
13 retary shall prescribe, by regulation, criteria for cer-
14 tifying medicare health plans sponsored by employ-
15 ers which will be offered only to current or former
16 employees, including requirements that such health
17 plans—

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

23 “(B) are available to all eligible current
24 and former employees in the medicare market
25 area.

1 “(2) SECONDARY PAYER COVERAGE.—To be
2 certified under paragraph (1), employer-sponsored
3 health plans shall accept, at the option of individuals
4 eligible only for secondary coverage under this title
5 pursuant to section 1862(b), a fixed monthly pay-
6 ment from the Secretary to provide such individuals
7 coverage at least actuarially equivalent to the sec-
8 ondary coverage available to such individuals under
9 this title.

10 “(d) MANAGING MEDICARE CHOICE.—

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

18 “(2) ANNUAL OPEN ENROLLMENT.—

19 “(A) IN GENERAL.—The Secretary shall
20 provide for an annual open enrollment period,
21 and may take into consideration existing em-
22 ployer enrollment periods, during which all indi-
23 viduals entitled to benefits under part A and
24 enrolled under part B, or enrolled under part B
25 only, residing in a medicare market area—

1 “(i) shall choose enrollment for the
2 next calendar year in—

3 “(I) a medicare health plan in
4 such area,

5 “(II) an employer-sponsored
6 health plan, or

7 “(III) coverage otherwise pro-
8 vided under this title (hereafter in this
9 section referred to as ‘medicare fee-
10 for-service’), and

11 “(ii) may choose supplementary bene-
12 fits offered by such health plan or a medi-
13 care supplemental policy (certified under
14 section 1882).

15 “(B) SECONDARY PAYER.—Individuals who
16 are eligible for secondary coverage under this
17 title pursuant to section 1862(b), may not en-
18 roll in a medicare health plan but may enroll in
19 an employer-sponsored health plan, to which the
20 Secretary shall make a monthly payment, pur-
21 suant to subsection (e)(2)(C).

22 “(C) PERIOD OF ENROLLMENT.—

23 “(i) IN GENERAL.—Except as pro-
24 vided in clauses (ii), (iii), and (iv), an indi-
25 vidual may not choose another enrollment

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

3 “(ii) ENROLLMENT UPON ELIGI-
4 BILITY.—The Secretary shall provide an
5 enrollment period of 30 days to any indi-
6 vidual beginning 30 days before the date
7 such individual first becomes entitled to
8 benefits under part A or enrolled under
9 part B only. Such enrollment shall be ef-
10 fective on the date of such entitlement.

11 “(iii) TERMINATION OF PLAN.—If a
12 contract for a medicare health plan under
13 this section is terminated during any cal-
14 endar year, the Secretary shall provide for
15 an enrollment period of 30 days to any in-
16 dividual enrolled in such plan beginning on
17 the date of such termination.

18 “(iv) INDIVIDUAL NO LONGER IN
19 AREA.—An individual terminating resi-
20 dence in a medicare market area may ter-
21 minate enrollment with the medicare
22 health plan of such area as of the begin-
23 ning of the first calendar month following
24 the date on which the request is made for
25 such termination, and the Secretary shall

1 provide for an open enrollment period of
2 30 days to such individual for enrollment
3 in the new medicare market area in which
4 such individual resides beginning on the
5 date of such termination. In the case of an
6 individual's termination of enrollment, the
7 medicare health plan shall provide the indi-
8 vidual with a copy of the written request
9 for termination of enrollment and a written
10 explanation of the period (ending on the
11 effective date of the termination) during
12 which the individual continues to be en-
13 rolled with the plan and may not receive
14 medicare benefits other than through such
15 plan.

16 “(v) EFFECTIVE DATE OF NEW EN-
17 ROLLMENT.—Enrollment under clause (iii)
18 or (iv) shall be effective 30 days after the
19 end of the enrollment period, or, if the
20 Secretary determines that such date is not
21 feasible, such other date as the Secretary
22 specifies.

23 “(D) DEFAULT ENROLLMENT.—

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

1 ing an enrollment period under this para-
2 graph, such individual shall be automati-
3 cally enrolled in—

4 “(I) the same option into which
5 such individual enrolled in the preced-
6 ing enrollment period, or

7 “(II) if the individual was not en-
8 rolled in such preceding period, the
9 medicare fee-for-service.

10 “(ii) NO MEDICARE HEALTH PLANS IN
11 AREA.—If there are no medicare health
12 plans in the medicare market area in
13 which the individual resides, such individ-
14 ual shall be automatically enrolled in the
15 medicare fee-for-service.

16 “(3) INFORMATION REGARDING MEDICARE OP-
17 TIONS IN MARKET AREA.—

18 “(A) IN GENERAL.—The Secretary shall
19 provide each individual making an enrollment
20 decision during any enrollment period described
21 in paragraph (2) with the following information,
22 in comparative form, regarding the medicare
23 health plans and medicare fee-for-service avail-
24 able in the medicare market area in which such
25 individual resides:

1 “(i) The individual’s premiums,
2 deductibles, and copayments for medicare
3 benefits.

4 “(ii) The individual’s premiums,
5 deductibles, and copayments for any sup-
6 plementary benefits.

7 “(iii) Enrollee restrictions, including
8 provider limitations.

9 “(iv) Quality information, including
10 enrollee satisfaction and health outcomes.

11 “(v) Out-of-area coverage provided.

12 “(vi) Coverage of emergency services
13 and urgently needed care.

14 “(vii) Appeal rights of enrollees.

15 “(viii) Any other necessary informa-
16 tion as determined by the Secretary.

17 “(B) MARKETING REQUIREMENTS.—The
18 Secretary shall prescribe the procedures and
19 conditions under which a medicare health plan
20 that has entered into a contract with the Sec-
21 retary under this section may inform individ-
22 uals eligible to enroll under this section with the
23 plan about the plan. No brochures, application
24 forms, or other promotional or informational
25 material may be distributed by such plan to (or

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

3 “(i) at least 45 days before its dis-
4 tribution, the plan has submitted the mate-
5 rial to the Secretary for review,

6 “(ii) the material is made available to
7 all individuals eligible to enroll in the medi-
8 care health plan in the medicare market
9 area, and

10 “(iii) the Secretary has not dis-
11 approved the distribution of the material.

12 The Secretary shall review all such material
13 submitted and shall disapprove such material if
14 the Secretary determines, in the Secretary’s dis-
15 cretion, that the material is materially inac-
16 curate or misleading or otherwise makes a ma-
17 terial misrepresentation.

18 “(4) RISK ADJUSTMENTS.—

19 “(A) IN GENERAL.—The Secretary shall
20 adjust the payments made to medicare health
21 plans and employer-sponsored health plans
22 under this title to reflect the relative health
23 risks of classes of beneficiaries enrolled in such
24 plans in the medicare market area. The Sec-
25 retary shall, at a minimum, define appropriate

1 classes of beneficiaries, based on age, sex, dis-
2 ability status, eligibility under title XIX, and
3 such other factors as the Secretary determines
4 to be appropriate, so as to ensure actuarial
5 equivalence and the efficient delivery of health
6 care. The Secretary may add to, modify, or sub-
7 stitute for such classes, if such changes will im-
8 prove the determination of actuarial equiva-
9 lence. The Secretary may enter into risk shar-
10 ing arrangements in a medicare market area, if
11 the Secretary determines it to be appropriate.

12 “(B) PENALTIES FOR DISCRIMINATION.—
13 The Secretary shall prescribe the procedures
14 and conditions under which the Secretary shall
15 impose financial penalties on medicare health
16 plans or employer-sponsored health plans that
17 knowingly violate the prohibition against dis-
18 crimination against potential enrollees based on
19 their health status, claims experience, medical
20 history, or other factors that are generally re-
21 lated with utilization of health care services.

22 “(5) PAYMENTS TO PLANS.—

23 “(A) IN GENERAL.—The Secretary shall
24 forward to each medicare health plan or em-
25 ployer-sponsored health plan the medicare per

1 capita rate for the medicare market area, as de-
2 termined under subsection (e), for every bene-
3 ficiary enrolled in such plan for that month, ex-
4 cluding any beneficiary premium but reflecting
5 any adjustments required pursuant to para-
6 graph (4)(A).

7 “(B) COLLECTION OF BENEFICIARY PRE-
8 MIUMS AND REBATES.—

9 “(i) PREMIUMS.—Each medicare
10 health plan or employer-sponsored plan
11 shall be responsible for collecting pre-
12 miums owed by beneficiaries for enrolling
13 in such plan, including premiums for medi-
14 care benefits and any supplementary bene-
15 fits.

16 “(ii) REBATES.—Any medicare health
17 plan or employer-sponsored plan which
18 charges a monthly premium which is less
19 than the medicare per capita rate for an
20 enrollee shall be responsible for paying to
21 such enrollee a rebate equal to the excess
22 medicare per capita rate or may use such
23 rebate to offset any premium owed by the
24 enrollee for any supplementary benefits se-
25 lected by the enrollee.

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

8 “(e) MEDICARE PER CAPITA RATE.—

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

15 “(2) PER CAPITA RATE.—

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

20 “(i) the excess of—

21 “(I) the benchmark premium for
22 such area, over

23 “(II) the base beneficiary pre-
24 mium for such area; or

25 “(ii) the maximum per capita rate.

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

6 “(i) the excess of—

7 “(I) the benchmark premium for
 8 such area, over

9 “(II) the base beneficiary pre-
 10 mium for such area, and

11 “(ii) the applicable percentage of the
 12 excess of—

13 “(I) the fee-for-service per capita
 14 costs (hereafter in this section re-
 15 ferred to as ‘FFSPCC’) for such area,
 16 over—

17 “(II) such benchmark premium.

18 For purposes of the preceding sentence, the ap-
 19 plicable percentage shall be determined by the
 20 following table:

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

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

1 ondary coverage under this title pursuant to
2 section 1862(b) and elect to enroll in an em-
3 ployer-sponsored health plan, the Secretary
4 shall determine a per capita rate for each medi-
5 care market area equal to the costs of providing
6 secondary coverage to all individuals in such
7 market area divided by the number of individ-
8 uals eligible for such coverage in such market
9 area.

10 “(D) RURAL ENROLLEES.—

11 “(i) FIVE-YEAR BONUS.—For enroll-
12 ment periods beginning in 1996 through
13 2000, the per capita rate in each medicare
14 market area (otherwise determined under
15 this paragraph) shall be increased by 10
16 percent with respect to each individual en-
17 rolling in a medicare health plan or em-
18 ployer-sponsored health plan who resides in
19 an underserved rural area within such
20 market area, as determined by the Sec-
21 retary.

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

1 the underserved rural area in which the
2 enrollee resides. The bonus amount shall
3 not reduce the premiums owed by the en-
4 rollee for medicare benefits or any supple-
5 mentary coverage.

6 “(iii) STUDY AND RECOMMENDA-
7 TIONS.—The Secretary shall report to the
8 Congress at the end of the 5-year period
9 described in clause (ii) on the status of
10 health care access in underserved rural
11 areas and shall make recommendations re-
12 garding continuation of bonus per capita
13 payments.

14 “(E) CALCULATION REQUIREMENTS.—The
15 FFSPCC shall be calculated directly to accu-
16 rately reflect the costs of providing care in the
17 fee-for-service system. The FFSPCC shall not
18 be derived from the removal of medicare health
19 plan payments and enrollees from total pay-
20 ments and enrollees.

21 “(3) MAXIMUM PER CAPITA RATE.—

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

1 “(i) the product of—

2 “(I) FFSPCC in all medicare
3 market areas, and

4 “(II) an adjustment factor for
5 such market area, over

6 “(ii) the base beneficiary premium in
7 such market area.

8 “(B) ADJUSTMENT FACTOR.—For pur-
9 poses of subparagraph (A)(i)(II), and except as
10 provided in subparagraph (D):

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

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

20 “(I) .1, multiplied by

21 “(II) the ratio of the excess of
22 the FFSPCC ratio over .8, to .15.

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

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

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

8 “(I) .1, multiplied by

9 “(II) the ratio of the excess of
10 the FFSPCC ratio over 1.05, to .15.

11 “(v) FFSPCC RATIO GREATER THAN
12 1.2.—For medicare market areas with a
13 FFSPCC ratio greater than or equal to
14 1.2, the adjustment factor shall be 1.2.

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

20 “(D) BUDGET NEUTRALITY.—The Sec-
21 retary shall change the adjustment factors as
22 necessary to ensure that total spending under
23 this title shall not exceed the level of spending
24 that would occur if the maximum per capita

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

3 “(E) ALTERNATIVE FORMULA.—The Sec-
4 retary may substitute an alternative formula for
5 determining the maximum rate in each medi-
6 care market area. Such an alternative formula
7 shall generally conform to the pattern of adjust-
8 ment factors specified in subparagraph (B), ex-
9 cept that such formula shall maintain a consist-
10 ent mathematical relationship between the ad-
11 justment factor and the FFSPCC ratio in each
12 such market area in a manner that achieves
13 budget neutrality.

14 “(F) STUDY AND RECOMMENDATIONS.—
15 The Secretary and the Physician Payment Re-
16 view Commission shall report to the Congress
17 every 2 years (beginning in 1997) on the meth-
18 od for determining the maximum per capita
19 rate and the experience of each medicare mar-
20 ket area with the formula. The Secretary and
21 the Physician Payment Review Commission
22 shall make recommendations regarding the ap-
23 propriateness of basing the maximum per cap-
24 ita rate formula on fee-for-service per capita
25 costs. The Secretary and the Physician Pay-

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

5 “(4) DEFINITIONS.—For purposes of this sub-
 6 section:

7 “(A) BENCHMARK PREMIUM.—The bench-
 8 mark premium for a medicare market area shall
 9 be equal to the sum of—

10 “(i) the lowest health plan monthly
 11 premium submitted by a medicare health
 12 plan in such area for the enrollment year,
 13 and

14 “(ii) the applicable percentage of the
 15 excess of—

16 “(I) the average of all medicare
 17 health plan premiums submitted in
 18 such area, over

19 “(II) the lowest health plan pre-
 20 mium in such area.

21 For purposes of the preceding sentence, the ap-
 22 plicable percentage shall be determined by the
 23 following table:

“Enrollment year:	Applicable Percentage:
1996	80
1997	60
1998	40

1999 and thereafter 20.

1 “(B) FEE-FOR-SERVICE PER CAPITA
2 COSTS.—The Secretary shall determine
3 FFSPCC for a medicare market area by divid-
4 ing—

5 “(i) the total spending for medicare
6 benefits (not including beneficiary cost
7 sharing) for individuals who reside in such
8 area, who are not enrolled in a medicare
9 health plan or employer-sponsored health
10 plan, and who are not in secondary payer
11 status, by

12 “(ii) the number of such individuals.

13 The Secretary shall make such other adjust-
14 ments as may be necessary to allow an accurate
15 comparison of FFSPCC for the medicare mar-
16 ket area with premiums charged by medicare
17 health plans in such area.

18 “(f) BENEFICIARY PREMIUMS.—For purposes of this
19 section:

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

23 “(A) the premium determined under sec-
24 tion 1839, and

1 “(B) the FFSPCC for such area divided
2 by the average national FFSPCC, as deter-
3 mined by the Secretary.

4 “(2) MONTHLY PREMIUMS.—

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

10 “(i) the premium charged by the plan
11 (determined under subsection (d)(1)) or
12 the fee-for-service (determined under sub-
13 paragraph (B)), over

14 “(ii) the medicare per capita rate in
15 the medicare market area in which the
16 beneficiary resides.

17 “(B) FEE-FOR-SERVICE BENEFICIARY PRE-
18 MIUM.—

19 “(i) IN GENERAL.—For beneficiaries
20 selecting medicare fee-for-service in a med-
21 icare market area, the monthly premium
22 shall be equal to the excess of—

23 “(I) the FFSPCC for such area,
24 over

1 “(II) the medicare per capita
2 rate for such area.

3 “(ii) EXCEPTION.—For individuals el-
4 igible for medicare benefits prior to Janu-
5 ary 1, 1999, who select medicare fee-for-
6 service for coverage, the beneficiary pre-
7 mium shall equal—

8 “(I) the base beneficiary pre-
9 mium, plus

10 “(II) any additional premium re-
11 quired pursuant to section 1893.

12 “(g) SUPPLEMENTARY COVERAGE PLANS.—

13 “(1) IN GENERAL.—The Secretary shall ensure
14 that all supplementary coverage plans meet the re-
15 quirements of this subsection, in addition to any re-
16 quirements that may be applicable under section
17 1882.

18 “(2) COORDINATION WITH MEDICARE
19 CHOICE.—Supplementary coverage plans may only
20 be offered to beneficiaries during the same annual
21 open enrollment period during which beneficiaries
22 select medicare coverage and must be offered to all
23 beneficiaries in the same medicare market area for
24 the same, uniform monthly premium during the
25 enrollment period.

1 “(3) STANDARD BENEFITS.—

2 “(A) IN GENERAL.—Medicare health plans
3 may only offer standardized supplementary cov-
4 erage plans as the Secretary shall prescribe by
5 regulation.

6 “(B) REQUIRED OPTIONS.—Among the
7 standardized plans, the Secretary shall include
8 a plan—

9 “(i) covering only outpatient prescrip-
10 tion drugs, and

11 “(ii) which, together with medicare
12 benefits, would resemble coverage typically
13 offered by health maintenance organiza-
14 tions to employer groups, including an an-
15 nual out-of-pocket maximum beneficiary li-
16 ability (covering coinsurance, copayments,
17 and deductibles).

18 “(4) ONE SPONSOR.—A sponsor of supple-
19 mentary coverage may not offer such coverage to a
20 beneficiary selecting a medicare health plan from a
21 different sponsor, except that sponsors of supple-
22 mentary coverage may offer such coverage to any in-
23 dividual selecting medicare fee-for-service.

24 “(5) SURCHARGE ON CERTAIN PLANS.—Not-
25 withstanding any other provision of this section, if

1 an individual chooses to purchase a medicare supple-
2 mental policy certified pursuant to section 1882 and
3 the coverage under such policy results in increased
4 costs to the program under this title, the monthly
5 premium otherwise applicable under this section
6 shall be increased by a surcharge actuarially equiva-
7 lent to such increased costs.

8 “(6) DEFINITIONS.—The term ‘supplementary
9 coverage plan’ means any health insurance coverage
10 offered by a medicare health plan or medicare sup-
11 plemental policy (as defined in section 1882) that
12 covers health care costs not covered under as medi-
13 care benefits and for which the enrollee must pay a
14 premium.”.

15 (b) CONFORMING AMENDMENTS.—

16 (1) Section 1882(c) of the Social Security Act
17 (42 U.S.C. 1395ss(c)) is amended—

18 (A) by striking “with respect to paragraph
19 (3)” and inserting “with respect to paragraphs
20 (3) and (6)”,

21 (B) by striking “and” at the end of para-
22 graph (4),

23 (C) by striking the period at the end of
24 paragraph (5) and inserting “; and”, and

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

3 “(6) agrees—

4 “(A) to offer such policy during the annual
5 open enrollment period specified in section
6 1876(c)(2) at a uniform monthly premium to
7 all beneficiaries in a medicare market area es-
8 tablished under section 1876(a); and

9 “(B) not to discriminate against bene-
10 ficiaries based on their health status, claims ex-
11 perience, medical history, or other factors that
12 are generally related with utilization of health
13 care services.”.

14 (2) Section 1882(s) of such Act (42 U.S.C.
15 1395ss(s)) is amended—

16 (A) by striking paragraph (2),

17 (B) by striking “paragraphs (1) and (2)”
18 in paragraph (3) and inserting “paragraph
19 (1)”, and

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

22 (3) Section 1839(e) of such Act (42 U.S.C.
23 1395r(e)) is amended to read as follows:

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

4 “(1) in 1994 shall be \$41.10,

5 “(2) in 1995 shall be \$46.10, and

6 “(3) after December 1995 shall be an amount
 7 equal to 25 percent of the monthly actuarial rate for
 8 enrollees age 65 and over, as determined under sub-
 9 section (a)(1) and applicable to such month.”.

10 (c) EFFECTIVE DATE.—The amendments made by
 11 this section shall apply to contracts entered into with re-
 12 spect to calendar years beginning after December 31,
 13 1995.

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

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

18 “FEE-FOR-SERVICE COST CONTAINMENT

19 “SEC. 1893. (a) IN GENERAL.—Unless Congress oth-
 20 erwise provides, notwithstanding any other provision of
 21 this title, payment for services provided to individuals enti-
 22 tled to benefits under part A and enrolled under part B,
 23 or enrolled under part B only (other than to individuals
 24 enrolled in medicare health plans or employer-sponsored
 25 health plans) (hereafter in this section referred to as ‘serv-
 26 ice payments’) shall be subject to an aggregate fee-for-

1 service spending limit in each market area for each cal-
2 endar year, beginning with 1997.

3 “(b) SETTING AGGREGATE FEE-FOR-SERVICE
4 SPENDING LIMITS.—

5 “(1) LIMITS FOR EACH MARKET AREA.—By not
6 later than October 1 of each year (beginning with
7 1996), and subject to paragraph (2), the Secretary
8 shall determine and publish in the Federal Register,
9 the fee-for-service spending limits for each medicare
10 market area for the succeeding calendar year.

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

15 “(A) inflation, as measured by the
16 consumer price index,

17 “(B) changes in the numbers of enrollees
18 described in subsection (a), and

19 “(C) an additional growth allowance of—

20 “(i) 4.0 percent in 1997,

21 “(ii) 3.5 percent in 1998,

22 “(iii) 3.0 percent in 1999, and

23 “(iv) 2.5 percent in 2000 and there-
24 after.

25 “(c) DETERMINING EXCESS SPENDING.—

1 “(1) IN GENERAL.—The Secretary shall deter-
2 mine the amount of excess spending (if any) for
3 each medicare market area by subtracting the limit
4 determined by the Secretary for such market area
5 under subsection (b) from baseline spending for such
6 market area.

7 “(2) BASELINE SPENDING.—The Secretary
8 shall measure baseline spending for each medicare
9 market area as the aggregate amount of service pay-
10 ments that would be made in such a market area on
11 behalf of individuals in fee-for-service (as defined in
12 subsection (a)) under the provisions of this title
13 without regard to this section.

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

16 “(A) the Secretary shall reduce the amount
17 of excess spending for the succeeding year by
18 the amounts in the current or prior years by
19 which aggregate spending fell below the aggre-
20 gate spending limit for the medicare market
21 area, and

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

1 aggregate spending limit for the medicare mar-
2 ket area.

3 “(d) ENFORCING MARKET AREA AGGREGATE
4 SPENDING LIMITS.—

5 “(1) IN GENERAL.—By not later than October
6 1 of each year (beginning with 1996), the Secretary
7 shall determine and publish in the Federal Register
8 adjustments (if any) in service payment rates and
9 beneficiary premiums that are required to eliminate
10 excess spending in the succeeding calendar year in
11 each medicare market area.

12 “(2) SERVICE PAYMENT RATES.—The Secretary
13 shall reduce service payments that would otherwise
14 apply under this title by the percentage that is nec-
15 essary to reduce aggregate service payments in the
16 medicare market area by an amount equal to one-
17 half of the estimated excess spending in the succeed-
18 ing calendar year.

19 “(3) PREMIUM ADD-ON.—The Secretary shall
20 increase the monthly part B premium that would
21 otherwise apply under this title for the succeeding
22 calendar year by an amount that is sufficient to in-
23 crease aggregate part B premium payments from in-
24 dividuals (as defined in subsection (a)) by an

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

3 “(e) EXEMPTING LOW-COST AREAS.—

4 “(1) IN GENERAL.—Any medicare market area
5 in which fee-for-service spending per individual is
6 below 90 percent of the national average shall be ex-
7 empt from enforcement of the aggregate spending
8 limit for such market area.

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

14 “(3) HIGH FEE-FOR-SERVICE SPENDING.—Med-
15 icare market areas with high fee-for-service spending
16 per individual are those areas where spending per in-
17 dividual is higher than 120 percent of all other med-
18 icare market areas.”.

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

23 **SEC. 5. MEDICARE ADMINISTRATIVE SIMPLIFICATION.**

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

1 the Congress a proposal to consolidate entitlement for part
2 A of the title XVIII of the Social Security Act and enroll-
3 ment in part B of such title into eligibility or enrollment
4 into the entire medicare program under such title. In pre-
5 paring such a proposal, the Secretary shall consider phas-
6 ing in such a consolidation, and shall ensure that no bene-
7 ficiary shall pay higher premiums for coverage under such
8 program than under such program as of the date of the
9 enactment of this Act.

10 (b) CONSOLIDATION OF FEE-FOR-SERVICE ADMINIS-
11 TRATION.—

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

18 (2) COMBINATION OF INTERMEDIARY AND CAR-
19 RIER FUNCTIONS.—In taking such steps, the Sec-
20 retary may contract with a single entity that com-
21 bines the fiscal intermediary and carrier functions in
22 an area. No medicare market area (established
23 under section 1876(a)) may be subject to more than
24 1 entity.

1 (3) STREAMLINED PROCESSING SYSTEMS.—In
 2 carrying out this subsection, the Secretary may en-
 3 sure—

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

7 (B) that payments under title XVIII of the
 8 Social Security Act are made first by the medi-
 9 care program and medicare supplemental poli-
 10 cies before providers can bill beneficiaries for
 11 services using standardized forms.

12 (4) SUPERSEDING CONFLICTING REQUIRE-
 13 MENTS.—The provisions of sections 1816 and 1842
 14 of the Social Security Act (including provider nomi-
 15 nating provisions in such section 1816) are super-
 16 seded to the extent required to carry out this sub-
 17 section.

○

S 1996 IS—2

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