

**Calendar No. 408**

103D CONGRESS  
2D SESSION

**S. 1996**

**A BILL**

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

APRIL 11, 1994

Read the second time and placed on the calendar

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## 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

APRIL 11, 1994

Read the second time and placed on the calendar

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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.

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”.

1 **SEC. 2. PURPOSE.**

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

6 **SEC. 3. MEDICARE CHOICE.**

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

10 “MEDICARE CHOICE

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

15 “(1) ensure that each individual entitled to ben-  
16 efits under part A and enrolled under part B, or en-  
17 rolled under part B only, resides in a medicare mar-  
18 ket area,

19 “(2) maintain all portions of each metropolitan  
20 statistical area within one medicare market area,  
21 and

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

26 “(b) MEDICARE HEALTH PLANS.—

1           “(1) CONTRACTS WITH MEDICARE HEALTH  
2 PLANS.—The Secretary shall enter into a contract  
3 with any medicare health plan desiring to do busi-  
4 ness in a medicare market area and to receive pay-  
5 ment under this section, but only if the Secretary  
6 certifies that such plan meets the requirements of  
7 paragraph (2).

8           “(2) CERTIFICATION REQUIREMENTS.—Each  
9 medicare health plan must—

10           “(A) except as provided in paragraph (3),  
11 provide those services covered by this title  
12 (hereafter in this section referred to as ‘medi-  
13 care benefits’) when medically necessary for a  
14 uniform monthly premium for a year;

15           “(B) not discriminate against beneficiaries  
16 based on their health status, claims experience,  
17 medical history, or other factors that are gen-  
18 erally related with utilization of health care  
19 services;

20           “(C) demonstrate the ability to provide  
21 medicare benefits to all potential enrollees  
22 throughout the medicare market area, unless  
23 the Secretary determines it appropriate for such  
24 plan to target unique community needs within  
25 the medicare market area;

1           “(D) demonstrate financial solvency;

2           “(E) have arrangements, established in ac-  
3 cordance with regulations prescribed by the  
4 Secretary, for an ongoing quality-assurance pro-  
5 gram for the health care services such plan pro-  
6 vides to such beneficiaries, which program—

7                   “(i) stresses health outcomes, and

8                   “(ii) provides review by physicians  
9 and other health care professionals of the  
10 process followed in the provision of such  
11 health care services;

12           “(F) meet the requirement of section  
13 1866(f) (relating to maintaining written policies  
14 and procedures respecting advance directives);

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

24                   “(i) No specific payment is made di-  
25 rectly or indirectly under the physician in-

1 centive plan to a physician or physician  
2 group as an inducement to reduce or limit  
3 medically necessary services provided with  
4 respect to a specific enrollee in the medi-  
5 care health plan.

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

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

23 “(II) conducts periodic surveys of  
24 both enrollees and former enrollees in  
25 the medicare health plan to determine

1 the degree of access of such enrollees  
2 to services provided by the medicare  
3 health plan and satisfaction with the  
4 quality of such services;

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

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

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

19 “(3) COST-SHARING.—

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

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

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

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

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

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

1                   “(ii) the plan provides enrollees with  
2                   such information.

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

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

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

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

1           “(B) are available to all eligible current  
2           and former employees in the medicare market  
3           area.

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

13          “(d) MANAGING MEDICARE CHOICE.—

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

21                 “(2) ANNUAL OPEN ENROLLMENT.—

22                         “(A) IN GENERAL.—The Secretary shall  
23                         provide for an annual open enrollment period,  
24                         and may take into consideration existing em-  
25                         ployer enrollment periods, during which all indi-

1 individuals entitled to benefits under part A and  
2 enrolled under part B, or enrolled under part B  
3 only, residing in a medicare market area—

4 “(i) shall choose enrollment for the  
5 next calendar year in—

6 “(I) a medicare health plan in  
7 such area,

8 “(II) an employer-sponsored  
9 health plan, or

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

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

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

25 “(C) PERIOD OF ENROLLMENT.—

1           “(i) IN GENERAL.—Except as pro-  
2           vided in clauses (ii), (iii), and (iv), an indi-  
3           vidual may not choose another enrollment  
4           until the next annual period provided  
5           under subparagraph (A).

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

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

21          “(iv) INDIVIDUAL NO LONGER IN  
22          AREA.—An individual terminating resi-  
23          dence in a medicare market area may ter-  
24          minate enrollment with the medicare  
25          health plan of such area as of the begin-

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

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

1 “(D) DEFAULT ENROLLMENT.—

2 “(i) IN GENERAL.—If an individual  
3 does not choose an enrollment option dur-  
4 ing an enrollment period under this para-  
5 graph, such individual shall be automati-  
6 cally enrolled in—

7 “(I) the same option into which  
8 such individual enrolled in the preced-  
9 ing enrollment period, or

10 “(II) if the individual was not en-  
11 rolled in such preceding period, the  
12 medicare fee-for-service.

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

19 “(3) INFORMATION REGARDING MEDICARE OP-  
20 TIONS IN MARKET AREA.—

21 “(A) IN GENERAL.—The Secretary shall  
22 provide each individual making an enrollment  
23 decision during any enrollment period described  
24 in paragraph (2) with the following information,  
25 in comparative form, regarding the medicare

1 health plans and medicare fee-for-service avail-  
2 able in the medicare market area in which such  
3 individual resides:

4 “(i) The individual’s premiums,  
5 deductibles, and copayments for medicare  
6 benefits.

7 “(ii) The individual’s premiums,  
8 deductibles, and copayments for any sup-  
9 plementary benefits.

10 “(iii) Enrollee restrictions, including  
11 provider limitations.

12 “(iv) Quality information, including  
13 enrollee satisfaction and health outcomes.

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

15 “(vi) Coverage of emergency services  
16 and urgently needed care.

17 “(vii) Appeal rights of enrollees.

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

20 “(B) MARKETING REQUIREMENTS.—The  
21 Secretary shall prescribe the procedures and  
22 conditions under which a medicare health plan  
23 that has entered into a contract with the Sec-  
24 retary under this section may inform individ-  
25 uals eligible to enroll under this section with the

1 plan about the plan. No brochures, application  
2 forms, or other promotional or informational  
3 material may be distributed by such plan to (or  
4 for the use of) individuals eligible to enroll with  
5 the plan under this section unless—

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

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

13 “(iii) the Secretary has not dis-  
14 approved the distribution of the material.

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

21 “(4) RISK ADJUSTMENTS.—

22 “(A) IN GENERAL.—The Secretary shall  
23 adjust the payments made to medicare health  
24 plans and employer-sponsored health plans  
25 under this title to reflect the relative health

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

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

25 “(5) PAYMENTS TO PLANS.—

1           “(A) IN GENERAL.—The Secretary shall  
2 forward to each medicare health plan or em-  
3 ployer-sponsored health plan the medicare per  
4 capita rate for the medicare market area, as de-  
5 termined under subsection (e), for every bene-  
6 ficiary enrolled in such plan for that month, ex-  
7 cluding any beneficiary premium but reflecting  
8 any adjustments required pursuant to para-  
9 graph (4)(A).

10           “(B) COLLECTION OF BENEFICIARY PRE-  
11 MIUMS AND REBATES.—

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

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

1           rebate to offset any premium owed by the  
2           enrollee for any supplementary benefits se-  
3           lected by the enrollee.

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

11         “(e) MEDICARE PER CAPITA RATE.—

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

18           “(2) PER CAPITA RATE.—

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

23                   “(i) the excess of—

24                           “(I) the benchmark premium for  
25                           such area, over

1 “(II) the base beneficiary pre-  
2 mium for such area; or

3 “(ii) the maximum per capita rate.

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

9 “(i) the excess of—

10 “(I) the benchmark premium for  
11 such area, over

12 “(II) the base beneficiary pre-  
13 mium for such area, and

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

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

20 “(II) such benchmark premium.

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

<b>“Enrollment year:</b>	<b>Applicable Percentage:</b>
1996 .....	90
1997 .....	80
1998 .....	70

1999 .....	60
2000 and thereafter .....	50.

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

12          “(D) RURAL ENROLLEES.—

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

1           “(ii) IMPROVE ACCESS.—The bonus  
2           amount paid under this subparagraph shall  
3           be used by such health plans to improve  
4           access and coordinated service delivery in  
5           the underserved rural area in which the  
6           enrollee resides. The bonus amount shall  
7           not reduce the premiums owed by the en-  
8           rollee for medicare benefits or any supple-  
9           mentary coverage.

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

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

25           “(3) MAXIMUM PER CAPITA RATE.—

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

5                   “(i) the product of—

6                           “(I) FFSPCC in all medicare  
7                           market areas, and

8                           “(II) an adjustment factor for  
9                           such market area, over

10                   “(ii) the base beneficiary premium in  
11                   such market area.

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

15                   “(i) FFSPCC RATIO LESS THAN .8.—

16                   For medicare market areas with a  
17                   FFSPCC ratio less than or equal to .8, the  
18                   adjustment factor shall be .8.

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

24                           “(I) .1, multiplied by

1                   “(II) the ratio of the excess of  
2                   the FFSPCC ratio over .8, to .15.

3                   “(iii) FFSPCC RATIO BETWEEN .95  
4                   AND 1.05.—For medicare market areas  
5                   with a FFSPCC ratio of at least .95 but  
6                   less than 1.05, the adjustment factor shall  
7                   be the FFSPCC ratio.

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

13                   “(I) .1, multiplied by

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

16                   “(v) FFSPCC RATIO GREATER THAN  
17                   1.2.—For medicare market areas with a  
18                   FFSPCC ratio greater than or equal to  
19                   1.2, the adjustment factor shall be 1.2.

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

1           “(D) BUDGET NEUTRALITY.—The Sec-  
2           retary shall change the adjustment factors as  
3           necessary to ensure that total spending under  
4           this title shall not exceed the level of spending  
5           that would occur if the maximum per capita  
6           rate in each medicare market area were equal  
7           to the FFSPCC in each such market area.

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

19          “(F) STUDY AND RECOMMENDATIONS.—  
20          The Secretary and the Physician Payment Re-  
21          view Commission shall report to the Congress  
22          every 2 years (beginning in 1997) on the meth-  
23          od for determining the maximum per capita  
24          rate and the experience of each medicare mar-  
25          ket area with the formula. The Secretary and

1 the Physician Payment Review Commission  
2 shall make recommendations regarding the ap-  
3 propriateness of basing the maximum per cap-  
4 ita rate formula on fee-for-service per capita  
5 costs. The Secretary and the Physician Pay-  
6 ment Review Commission shall also examine the  
7 appropriateness of implementing urban and  
8 rural adjusters to the maximum per capita rate  
9 formula.

10 “(4) DEFINITIONS.—For purposes of this sub-  
11 section:

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

15 “(i) the lowest health plan monthly  
16 premium submitted by a medicare health  
17 plan in such area for the enrollment year,  
18 and

19 “(ii) the applicable percentage of the  
20 excess of—

21 “(I) the average of all medicare  
22 health plan premiums submitted in  
23 such area, over

24 “(II) the lowest health plan pre-  
25 mium in such area.

1 For purposes of the preceding sentence, the ap-  
 2 plicable percentage shall be determined by the  
 3 following table:

<b>“Enrollment year:</b>	<b>Applicable Percentage:</b>
1996 .....	80
1997 .....	60
1998 .....	40
1999 and thereafter .....	20.

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

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

15 “(ii) the number of such individuals.  
 16 The Secretary shall make such other adjust-  
 17 ments as may be necessary to allow an accurate  
 18 comparison of FFSPCC for the medicare mar-  
 19 ket area with premiums charged by medicare  
 20 health plans in such area.

21 “(f) BENEFICIARY PREMIUMS.—For purposes of this  
 22 section:

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

4           “(A) the premium determined under sec-  
5 tion 1839, and

6           “(B) the FFSPCC for such area divided  
7 by the average national FFSPCC, as deter-  
8 mined by the Secretary.

9           “(2) MONTHLY PREMIUMS.—

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

15           “(i) the premium charged by the plan  
16 (determined under subsection (d)(1)) or  
17 the fee-for-service (determined under sub-  
18 paragraph (B)), over

19           “(ii) the medicare per capita rate in  
20 the medicare market area in which the  
21 beneficiary resides.

22           “(B) FEE-FOR-SERVICE BENEFICIARY PRE-  
23 MIUM.—

24           “(i) IN GENERAL.—For beneficiaries  
25 selecting medicare fee-for-service in a med-

1           icare market area, the monthly premium  
2           shall be equal to the excess of—

3                   “(I) the FFSPCC for such area,  
4                   over

5                   “(II) the medicare per capita  
6                   rate for such area.

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

12                   “(I) the base beneficiary pre-  
13                   mium, plus

14                   “(II) any additional premium re-  
15                   quired pursuant to section 1893.

16           “(g) SUPPLEMENTARY COVERAGE PLANS.—

17                   “(1) IN GENERAL.—The Secretary shall ensure  
18                   that all supplementary coverage plans meet the re-  
19                   quirements of this subsection, in addition to any re-  
20                   quirements that may be applicable under section  
21                   1882.

22                   “(2) COORDINATION WITH MEDICARE  
23                   CHOICE.—Supplementary coverage plans may only  
24                   be offered to beneficiaries during the same annual  
25                   open enrollment period during which beneficiaries

1 select medicare coverage and must be offered to all  
2 beneficiaries in the same medicare market area for  
3 the same, uniform monthly premium during the  
4 enrollment period.

5 “(3) STANDARD BENEFITS.—

6 “(A) IN GENERAL.—Medicare health plans  
7 may only offer standardized supplementary cov-  
8 erage plans as the Secretary shall prescribe by  
9 regulation.

10 “(B) REQUIRED OPTIONS.—Among the  
11 standardized plans, the Secretary shall include  
12 a plan—

13 “(i) covering only outpatient prescrip-  
14 tion drugs, and

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

22 “(4) ONE SPONSOR.—A sponsor of supple-  
23 mentary coverage may not offer such coverage to a  
24 beneficiary selecting a medicare health plan from a  
25 different sponsor, except that sponsors of supple-

1       mentary coverage may offer such coverage to any in-  
2       dividual selecting medicare fee-for-service.

3           “(5) SURCHARGE ON CERTAIN PLANS.—Not-  
4       withstanding any other provision of this section, if  
5       an individual chooses to purchase a medicare supple-  
6       mental policy certified pursuant to section 1882 and  
7       the coverage under such policy results in increased  
8       costs to the program under this title, the monthly  
9       premium otherwise applicable under this section  
10      shall be increased by a surcharge actuarially equiva-  
11      lent to such increased costs.

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

19      (b) CONFORMING AMENDMENTS.—

20          (1) Section 1882(c) of the Social Security Act  
21      (42 U.S.C. 1395ss(c)) is amended—

22              (A) by striking “with respect to paragraph  
23              (3)” and inserting “with respect to paragraphs  
24              (3) and (6)”,

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

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

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

7 “(6) agrees—

8 “(A) to offer such policy during the annual  
9 open enrollment period specified in section  
10 1876(c)(2) at a uniform monthly premium to  
11 all beneficiaries in a medicare market area es-  
12 tablished under section 1876(a); and

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

18 (2) Section 1882(s) of such Act (42 U.S.C.  
19 1395ss(s)) is amended—

20 (A) by striking paragraph (2),

21 (B) by striking “paragraphs (1) and (2)”  
22 in paragraph (3) and inserting “paragraph  
23 (1)”, and

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

1           (3) Section 1839(e) of such Act (42 U.S.C.  
2           1395r(e)) is amended to read as follows:

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

6                   “(1) in 1994 shall be \$41.10,

7                   “(2) in 1995 shall be \$46.10, and

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

12          (c) EFFECTIVE DATE.—The amendments made by  
13          this section shall apply to contracts entered into with re-  
14          spect to calendar years beginning after December 31,  
15          1995.

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

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

20                   “FEE-FOR-SERVICE COST CONTAINMENT

21                   “SEC. 1893. (a) IN GENERAL.—Unless Congress oth-  
22          erwise provides, notwithstanding any other provision of  
23          this title, payment for services provided to individuals enti-  
24          tled to benefits under part A and enrolled under part B,  
25          or enrolled under part B only (other than to individuals  
26          enrolled in medicare health plans or employer-sponsored

1 health plans) (hereafter in this section referred to as ‘serv-  
2 ice payments’) shall be subject to an aggregate fee-for-  
3 service spending limit in each market area for each cal-  
4 endar year, beginning with 1997.

5 “(b) SETTING AGGREGATE FEE-FOR-SERVICE  
6 SPENDING LIMITS.—

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

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

17 “(A) inflation, as measured by the  
18 consumer price index,

19 “(B) changes in the numbers of enrollees  
20 described in subsection (a), and

21 “(C) an additional growth allowance of—

22 “(i) 4.0 percent in 1997,

23 “(ii) 3.5 percent in 1998,

24 “(iii) 3.0 percent in 1999, and

1                   “(iv) 2.5 percent in 2000 and there-  
2                   after.

3                   “(c) DETERMINING EXCESS SPENDING.—

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

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

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

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

1           “(B) the Secretary shall increase the  
2           amount of excess spending for the succeeding  
3           year by the amounts in the current or prior  
4           years by which aggregate spending exceeded the  
5           aggregate spending limit for the medicare mar-  
6           ket area.

7           “(d) ENFORCING MARKET AREA AGGREGATE  
8           SPENDING LIMITS.—

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

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

23          “(3) PREMIUM ADD-ON.—The Secretary shall  
24          increase the monthly part B premium that would  
25          otherwise apply under this title for the succeeding

1 calendar year by an amount that is sufficient to in-  
2 crease aggregate part B premium payments from in-  
3 dividuals (as defined in subsection (a)) by an  
4 amount equal to one-half of the estimated excess  
5 spending in the succeeding calendar year.

6 “(e) EXEMPTING LOW-COST AREAS.—

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

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

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

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

1 **SEC. 5. MEDICARE ADMINISTRATIVE SIMPLIFICATION.**

2 (a) CONSOLIDATION OF PARTS A AND B.—By not  
3 later than October 1, 1995, the Secretary shall submit to  
4 the Congress a proposal to consolidate entitlement for part  
5 A of the title XVIII of the Social Security Act and enroll-  
6 ment in part B of such title into eligibility or enrollment  
7 into the entire medicare program under such title. In pre-  
8 paring such a proposal, the Secretary shall consider phas-  
9 ing in such a consolidation, and shall ensure that no bene-  
10 ficiary shall pay higher premiums for coverage under such  
11 program than under such program as of the date of the  
12 enactment of this Act.

13 (b) CONSOLIDATION OF FEE-FOR-SERVICE ADMINIS-  
14 TRATION.—

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

21 (2) COMBINATION OF INTERMEDIARY AND CAR-  
22 RIER FUNCTIONS.—In taking such steps, the Sec-  
23 retary may contract with a single entity that com-  
24 bines the fiscal intermediary and carrier functions in  
25 an area. No medicare market area (established

1 under section 1876(a)) may be subject to more than  
2 1 entity.

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

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

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

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

S 1996 PCS—2

S 1996 PCS—3