

104TH CONGRESS
1ST SESSION

S. 1238

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

SEPTEMBER 13 (legislative day, SEPTEMBER 5), 1995

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 established under section 7705
9 of 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
24 226(b) or 226A until such time as the Sec-

1 retary issues regulations in accordance with sec-
2 tion 1897H.

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

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

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

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

20 “(5) TRUSTEES.—The term ‘Trustees’ means
21 the Trustees of the Federal Hospital Insurance
22 Trust Fund and the Federal Supplementary Medical
23 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
25 of the individual’s enrollment or disenrollment under sub-

1 section (b) during any open enrollment period applicable
 2 to the individual, the individual shall be deemed to have
 3 reenrolled in the plan.

4 “(d) ENROLLMENT BY AN INDIVIDUAL.—

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

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

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

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

23 “(3) PERIOD OF ENROLLMENT.—

24 “(A) IN GENERAL.—An individual enroll-
 25 ing in a plan during any open enrollment period

1 under paragraph (1) shall be enrolled in the
2 plan for the calendar year following the open
3 enrollment period.

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

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

17 “(4) TERMINATIONS.—

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

23 “(B) HIGH DEDUCTIBLE PLANS.—In the
24 case of an individual enrolled in a plan de-
25 scribed in paragraph (3)(C), an individual may

1 not terminate enrollment until the open enroll-
2 ment period applicable to the individual in the
3 calendar year in which the enrollment would
4 otherwise terminate under paragraph (3)(C).

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

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

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

16 “(D) 4-YEAR PHASE-IN OF LOCK-IN.—Not-
17 withstanding subparagraph (A) or (B), an indi-
18 vidual may terminate enrollment in a choice
19 care plan prior to the next open enrollment pe-
20 riod applicable to the individual if during the 1-
21 year period beginning on—

22 “(i) January 1, 1997, such individual
23 has been enrolled in such plan for 3
24 months;

1 are substantially nonrepresentative, as deter-
2 mined in accordance with regulations of the
3 Secretary, of the population in the reimburse-
4 ment area served by the organization. The plan
5 shall not refuse or cancel coverage of eligible in-
6 dividuals except for reasons of beneficiary fraud
7 or nonpayment of amounts due the plan under
8 the coverage policy.

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

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

24 “(3) ESTABLISHMENT OF SCHEDULES.—Each
25 choice care plan shall establish premium, deductible,

1 and copayment schedules for the plan, except that in
2 the case of plans other than high deductible health
3 plans described in section 1895B(1)(C), such de-
4 ductible and copayment schedules for services de-
5 scribed in paragraph (2) may not exceed the levels
6 of deductibles and copayments established for such
7 services under the traditional medicare program.

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

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

22 “(A) insure itself against such financial
23 risk; and

1 “(B) make arrangements with other health
2 care providers to assume all or part of such fi-
3 nancial risk.

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

9 “(7) ADEQUATE CAPACITY.—The plan shall
10 adequately assure the Secretary that, with respect to
11 each reimbursement area in which it desires to par-
12 ticipate, the plan has the capacity to serve the ex-
13 pected enrollment in such reimbursement area.

14 “(8) GRIEVANCE PROCESS.—The plan shall es-
15 tablish an internal procedure for hearing and resolv-
16 ing grievances between the plan and enrollees, in-
17 cluding procedures under which an enrollee (or pro-
18 vider on behalf of such enrollee) may challenge the
19 plan’s denial of coverage of or payment for medical
20 assistance or services to the enrollee.

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

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

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

6 “(2) may provide such members with additional
7 health care services, including prescription drugs;
8 and

9 “(3) may require approval for the provision of
10 nonemergency medical assistance or services to an
11 enrollee for nonemergency services before such as-
12 sistance is provided, provided such prior approval is
13 given in a reasonably timely manner.

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

15 “(a) IN GENERAL.—The Secretary shall annually de-
16 termine, and shall announce (in a manner intended to pro-
17 vide notice to interested parties) not later than September
18 7 of 1996 and each calendar year thereafter, the choice
19 care value amount determined in accordance with this sec-
20 tion for the following calendar year for each class of eligi-
21 ble individuals in a reimbursement area enrolled under
22 this part with a choice care plan.

23 “(b) DEFINITION OF APPROPRIATE CLASSES.—The
24 Secretary shall define classes of individuals under this sec-

1 tion in the same manner as the Secretary defines classes
2 of individuals under section 1876.

3 “(c) CALCULATION OF CHOICE CARE VALUE
4 AMOUNT.—

5 “(1) 1996.—For purposes of subsection (a), the
6 choice care value amount for 1996 shall be—

7 “(A) for a reimbursement area described
8 in subsection (d)(1), an amount equal to the av-
9 erage of the sum of the adjusted average per
10 capita costs determined for parts A and B of all
11 reimbursement areas described in subsection
12 (d)(1) in the State in which the area is located;
13 and

14 “(B) for a reimbursement area described
15 in paragraph (2) or (3) of subsection (d), the
16 average of the sum of the adjusted average per
17 capita costs determined for parts A and part B
18 of all of the counties within such reimburse-
19 ment area.

20 “(2) SUBSEQUENT YEAR AMOUNTS.—For pur-
21 poses of subsection (a), the choice care value amount
22 for a reimbursement area for years after 1996 shall
23 be an amount equal to the choice care value amount
24 determined for the preceding year, increased—

1 “(A) by 11 percent if, during the preceding
2 year, the choice care value amounts determined
3 for such reimbursement area were equal to or
4 less than 85 percent of the average of all choice
5 care value amounts in all reimbursement areas
6 for such preceding year;

7 “(B) by 7.5 percent if, during the preced-
8 ing year, the choice care value amounts deter-
9 mined for such reimbursement area were equal
10 to or greater than 85 percent of the average of
11 all choice care value amounts in all reimburse-
12 ment areas, but equal to or less than 95 per-
13 cent of such average for such preceding year;

14 “(C) by 2.5 percent if, during the preced-
15 ing year, the choice care value amounts deter-
16 mined for such reimbursement area were equal
17 to or greater than 105 percent of the average
18 of all choice care value amounts in all reim-
19 bursement areas for such preceding year, but
20 equal to or less than 120 percent of such aver-
21 age;

22 “(D) by 0.5 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 120 percent of the average

1 of all choice care value amounts in all reim-
2 bursement areas for such preceding year; and

3 “(E) in all reimbursement areas not de-
4 scribed in subparagraph (A), (B), (C), and (D),
5 by a percentage determined by the Secretary
6 which is greater than 2.5 percent and less than
7 7.5 percent and which ensures that the average
8 amount of the increase for all such areas is 5
9 percent.

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

11 For purposes of this subsection—

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

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

19 “(i) IME.—Any payments attributable
20 to section 1886(d)(5)(B) relating to indi-
21 rect medical education.

22 “(ii) DIRECT GME.—Any payments at-
23 tributable to section 1886(h) relating to di-
24 rect graduate medical education.

1 “(iii) DISPROPORTIONATE SHARE
2 HOSPITALS.—Any payments attributable to
3 section 1886(d)(5)(F) relating to direct
4 graduate medical education.

5 “(4) DISTRIBUTION OF IME, DME, AND DISH.—
6 “(A) IN GENERAL.—

7 “(i) ANNUAL DETERMINATION.—The
8 Secretary shall estimate, based on enroll-
9 ment in choice care plans under this part,
10 the aggregate amount of payments that
11 would have been made under this title to
12 providers for each category of payment de-
13 scribed in clause (i), (ii), and (iii) of para-
14 graph (3)(B) with respect to individuals
15 enrolled in choice care plans if such indi-
16 viduals had not been enrolled in such
17 plans.

18 “(ii) ALLOCATION OF AMOUNTS.—For
19 each year, the Secretary shall allocate each
20 of the aggregate amounts determined
21 under clause (i) to qualified providers on a
22 per patient basis in accordance with sub-
23 paragraph (B) and based on the Sec-
24 retary’s best estimation of whether such

1 amount will fully deplete each such aggregate amount for the year.

2
3 “(iii) END OF YEAR RECONCILIATION.—The Secretary shall develop a
4 process that permits the Secretary to—
5

6 “(I) recoup from qualified providers
7 an amount equal to the difference
8 (if any) between the allocations made
9 under clause (ii) for a category of
10 payment described in clause (i), (ii),
11 or (iii) of paragraph (3)(B) and the
12 Secretary’s estimate for such category
13 under clause (i); and

14 “(II) provide additional payments
15 to qualified providers if the allocations
16 made under clause (ii) for a category
17 of payments described in clause (i),
18 (ii), or (iii) of paragraph (3)(B) are
19 less than the Secretary’s estimate for
20 such category under clause (i).

21 “(B) DISTRIBUTION.—The amounts that
22 are excluded from the adjusted average per capita
23 cost in accordance with paragraph (3)(B)
24 shall be distributed to qualified providers as follows:
25

1 “(i) For any provider that would qual-
2 ify for the indirect medical education ad-
3 justment under section 1886(d)(5)(B) or
4 the disproportionate share adjustment
5 under section 1886(d)(5)(F), payment
6 shall be made on a per discharge basis for
7 each individual enrolled in a choice care
8 plan with a contract under this part who
9 receives inpatient care at that provider as
10 though the traditional medicare program
11 was making payment to such provider on
12 the basis of a diagnostic related group.

13 “(ii) For any provider that would
14 qualify for the direct graduate medical
15 education payment under section 1886(h),
16 payment shall be made to such provider by
17 counting as medicare inpatient days those
18 days attributable to individuals enrolled in
19 a choice care contract in determining the
20 provider’s medicare patient load.

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

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

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

4 “(3) for a county that falls within a Metropoli-
5 tan Statistical Area but not within a Primary Metro-
6 politan Statistical Area, the Metropolitan Statistical
7 Area.

8 “(e) REPORTS BY PROPAC.—Not later than January
9 1, 1997, the Prospective Payment Assessment Commis-
10 sion shall submit reports to the Congress on the impact
11 of the indirect medical education adjustment, direct grad-
12 uate medical education payment, and the disproportionate
13 share hospital adjustment distribution system established
14 under subsection (c), and on the impact of the reimburse-
15 ment areas established under subsection (d). Each report
16 shall include any recommendations for appropriate modi-
17 fications.

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

19 “(a) NOTIFICATION.—

20 “(1) GENERAL NOTIFICATION.—Each choice
21 care plan that desires to enter into a contract under
22 this part with the Secretary in 1 or more reimburse-
23 ment areas for the next calendar year shall submit
24 a notification in accordance with subsection (b) to
25 the Secretary not later than 21 days after the date

1 of the announcement of the choice care value
2 amounts described in section 1897C(a).

3 “(2) LATE NOTIFICATION.—A choice care plan
4 may submit a notification for a calendar year in ac-
5 cordance with subsection (b) to the Secretary after
6 the date described in paragraph (1) but such plan
7 shall not be eligible to enroll an eligible individual
8 during the annual open enrollment period described
9 in section 1896A(d)(1)(A) for such calendar year
10 unless the Secretary determines it is otherwise fair
11 and administratively feasible.

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

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

19 “(2) A schedule of benefits and services that
20 will be available (including those subject to prior au-
21 thorization by the plan as a condition of coverage),
22 including the amounts of premiums, copayments,
23 and deductibles to be assessed.

1 “(A) By October 15 of each year beginning
2 after 1995, the Trustees shall mail a notice of
3 eligibility to participate in the choice care pro-
4 gram to each eligible individual and each indi-
5 vidual who is eligible to become entitled to ben-
6 efits under part A prior to the end of the an-
7 nual open season enrollment period described in
8 section 1896A(d)(1).

9 “(B) The notice described in subparagraph
10 (A) shall include an informational brochure that
11 includes the information described this section,
12 and any other information that the Trustees de-
13 termine will facilitate the individual’s enroll-
14 ment decisions under the choice care program.

15 “(2) NOTIFICATION TO NEWLY MEDICARE-ELI-
16 GIBLE INDIVIDUALS.—With respect to an individual
17 who becomes an eligible individual after the close of
18 the annual open enrollment period described in sec-
19 tion 1896A(d)(1), the Trustees shall, not later than
20 3 months before the date on which the individual be-
21 comes an eligible individual, mail to each such indi-
22 vidual the notice of eligibility described in paragraph
23 (1).

24 “(b) TRUSTEES’ MATERIALS; CONTENTS.—The no-
25 tice and informational materials mailed by the Trustees

1 under subsection (a)(1)(A) shall be written and formatted
2 in the most easily understandable manner possible, and
3 shall include, at a minimum, the following information
4 with respect to coverage under this part during the next
5 calendar year:

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

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

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

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

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

22 “(6) For each choice care plan with a contract
23 under this part in the eligible individual’s reimburse-
24 ment area, information on the amount of cash re-
25 bates that may be received by such eligible individ-

1 ual, or additional premium amounts, deductibles or
2 copayments that must be paid by such eligible indi-
3 vidual.

4 “(7) For each participating plan, any restric-
5 tions on coverage for services furnished other than
6 through the plan, any restrictions on services fur-
7 nished through the plan, such as preauthorization
8 review, concurrent review, post-service review, or
9 post-payment review, and any financial incentives
10 that might limit treatment or restrict referrals, such
11 as economic profiling or capitation.

12 “(8) Information on enrollee satisfaction with
13 each participating plan in the eligible individual’s re-
14 imbursement area, including enrollment and
15 disenrollment rates from previous years (excluding
16 disenrollment by death).

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

21 “(10) A simplified chart that presents and com-
22 pares the benefits provided and services covered of
23 each plan participating in the eligible individual’s re-
24 imbursement area.

1 “(11) Any other information that choice care
2 plans provide to the Secretary under section 1897D
3 or otherwise, that the Trustees determine will be of
4 assistance to informed decisionmaking by eligible in-
5 dividuals.

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

10 “(13) A separate notice which—

11 “(A) identifies expenses that are generally
12 considered long-term care expenses,

13 “(B) clearly explains to eligible individuals
14 that long-term care expenses are not covered by
15 the traditional medicare program or choice care
16 plans, and

17 “(C) provides a list of long-term care in-
18 surers which have notified the Trustees of their
19 availability within a particular reimbursement
20 area.

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

24 “(d) PLAN PARTICIPATION IN ENROLLMENT PROC-
25 ESS.—

1 “(1) IN GENERAL.—In addition to any informa-
2 tional materials distributed by the Trustees under
3 subsection (a), a choice care plan with a contract
4 under this part may develop and distribute market-
5 ing materials and engage in marketing strategies in
6 accordance with this subsection.

7 “(2) PLAN MARKETING AND ADVERTISING
8 STANDARDS.—Any marketing material developed or
9 distributed by a choice care plan with a contract
10 under this part and any marketing strategy devel-
11 oped by such plan—

12 “(A) shall compare—

13 “(i) health care coverage available
14 under the plan with the health care cov-
15 erage available under the traditional medi-
16 care program, and

17 “(ii) any rebates that may be avail-
18 able, or additional premium, deductibles,
19 or copayments that may be required under
20 the plan with the deductibles and
21 copayments required under the traditional
22 medicare program,

23 “(B) shall be provided in a form and man-
24 ner that is easily understood by a typical eligi-
25 ble individual, and that contains accurate and

1 sufficient information for an individual to make
2 an informed decision on whether to enroll in the
3 plan, or to seek additional information,

4 “(C) shall include a telephone number that
5 may be called to receive information equivalent
6 to the information provided by the plan to the
7 Trustees under section 1897D,

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

11 “(E) shall not contain false or materially
12 misleading information, and shall conform to
13 any other fair marketing and advertising stand-
14 ards and requirements applicable to such plans
15 under law.

16 “(e) PLAN NOTIFICATION TO ENROLLEES.—Each
17 choice care plan with a contract under this part shall pro-
18 vide to each individual who has elected to enroll in the
19 plan, at the time of enrollment and at least annually there-
20 after, an explanation of the enrollee’s rights under the
21 plan and this part, including an explanation of the follow-
22 ing:

23 “(1) The enrollee’s rights to benefits from the
24 plan.

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

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

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

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

7 **“SEC. 1897F. PREMIUMS, PLAN PAYMENTS, AND CASH-BACK**
8 **AWARDS.**

9 “(a) ADDITIONAL PREMIUMS PAID TO THE PLAN.—

10 An eligible individual who enrolls in a choice care plan
11 with a contract under this part shall pay any premium
12 amounts that may be required by the plan in excess of
13 the choice care value amount determined with respect to
14 such individual directly to the plan in a manner mutually
15 arranged between the individual and the plan.

16 “(b) PAYMENTS TO PLANS.—

17 “(1) MONTHLY PAYMENTS IN ADVANCE.—For
18 each eligible individual enrolled with the plan under
19 this part, the Secretary shall make monthly pay-
20 ments in advance to a choice care plan with a con-
21 tract under this part in an amount equal to the less-
22 er of the monthly choice care value amount deter-
23 mined with respect to such individual under section
24 1897C or the monthly premium determined for such
25 individual.

1 “(2) RETROACTIVE ADJUSTMENTS.—The
2 amount of payment under this paragraph may be
3 retroactively adjusted to take into account any dif-
4 ference between the actual number of individuals en-
5 rolled in the plan under this section and the number
6 of such individuals estimated to be so enrolled in de-
7 termining the amount of the advance payment.

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

21 “(c) REBATES.—

22 “(1) IN GENERAL.—If the weighted average of
23 the choice care value amounts with respect to all in-
24 dividuals in a reimbursement area exceeds the pre-

1 mium of the plan in which an eligible individual is
2 enrolled, the Secretary shall—

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

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

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

8 “(A) ELIGIBILITY.—An individual shall be
9 eligible for a payment under paragraph (1) only
10 if the individual enrolls in the plan during the
11 annual open enrollment period described in sec-
12 tion 1896A(d)(1).

13 “(B) TIME FOR PAYMENT.—A rebate
14 under paragraph (1) shall be paid as of the
15 close of the calendar year to which the enroll-
16 ment applied.

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

21 “(i) subparagraph (B) shall not apply,
22 and

23 “(ii) the Secretary shall, within 30
24 days of enrollment of the individual in the
25 plan, deposit the rebate into the medicare

1 medical savings account (as defined in sec-
2 tion 7705 of the Internal Revenue Code of
3 1986) of the individual specified in the en-
4 rollment.

5 “(D) DISENROLLMENT.—

6 “(i) IN GENERAL.—No rebate shall be
7 paid under paragraph (1) if an individual
8 terminates enrollment in the choice care
9 plan before the close of the calendar year
10 to which the enrollment applied.

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

20 “(iii) HIGH DEDUCTIBLE PLANS.—If
21 clause (i) applies to a plan described in
22 subparagraph (C), the Secretary shall pro-
23 vide for the repayment of any amount paid
24 under subparagraph (C).

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

5 **“SEC. 1897G. QUALITY ASSURANCE, PLAN COVERAGE, AND**
6 **PARTICIPATION STANDARDS.**

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

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

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

16 “(b) INTERNAL QUALITY ASSURANCE.—

17 “(1) ACCESS.—Each choice care plan with a
18 contract under this part shall provide or arrange for
19 the provision of all medically necessary health care
20 services required under this Act and under a con-
21 tract under this part.

22 “(2) TIMELY DELIVERY OF SERVICES.—Each
23 choice care plan with a contract under this part
24 shall deliver, upon request, to eligible individuals en-
25 rolled with the plan upon request health care serv-

1 ices in a manner that is reasonably prompt and,
2 when medically necessary, that is available and ac-
3 cessible 24 hours a day and 7 days a week.

4 “(c) PERFORMANCE MEASURES.—Each plan shall
5 undertake to measure and maintain data on the plan’s ac-
6 tual performance in delivering of health care services to
7 eligible individuals. Such measures shall incorporate the
8 following information:

9 “(1) PATIENT ENCOUNTER DATA.—Sufficient
10 patient encounter data, including data to identify
11 the health care provider that delivers services to
12 each patient and the type of service provided, as de-
13 termined by the Secretary or Trustees to be of as-
14 sistance in the performance of their duties under
15 this part.

16 “(2) PERFORMANCE-BASED INFORMATION.—
17 Data that are continuously or periodically gathered,
18 and that—

19 “(A) are sufficient to reflect the care pro-
20 vided for the prevalent clinical conditions
21 among the enrollees served, including data on
22 health or functional status, clinical perform-
23 ance, functional improvement, and prevention
24 or early detection, and

1 “(B) provide information on compliance
2 with performance-based standards that reflect a
3 minimum set of comparable performance-based
4 data, that are selected in consultation with an
5 advisory body of outside experts in order to de-
6 velop a standardized set of measures that can
7 produce comparable and consistent information,
8 and that are updated periodically.

9 “(3) PLAN SATISFACTION DATA.—Data that
10 are periodically gathered to measure the perception
11 of patients, providers, and purchasers, including
12 data on the level of satisfaction associated with, at
13 a minimum, the responsiveness, access to services,
14 quality of services, and continuity of care of a par-
15 ticular plan.

16 “(d) INDEPENDENT ACCREDITATION.—

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

21 “(2) ACCREDITING ORGANIZATION.—The inde-
22 pendent review and accreditation shall be performed
23 by an accrediting organization that—

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

1 “(B) maintains an accreditation program
2 for accrediting managed care plans or other
3 health care plans that are offered under the
4 choice care program, and

5 “(C) is independent of the control of
6 health care providers, health care plans, or
7 trade associations of health care providers.

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

14 “(4) DISQUALIFICATION.—A choice care plan
15 that fails to receive accreditation under this sub-
16 section shall be disqualified from participation in the
17 choice care program, unless the plan meets the fol-
18 lowing:

19 “(A) PROVISIONAL ACCREDITATION.—The
20 plan is a new plan (as determined by the Sec-
21 retary) and such plan is making reasonable
22 progress toward receiving accreditation, to the
23 satisfaction of the accrediting organization.

24 “(B) PRIOR ACCREDITATION.—The plan
25 received prior accreditation and such plan is

1 making reasonable progress toward correcting
2 the flaws that led to the failure to receive ac-
3 creditation, to the satisfaction of the accrediting
4 organization, and such plan does in fact correct
5 such flaws within 6 months.

6 “(e) ASSISTED SUICIDE.—No choice care plan may
7 provide any services, the purpose of which is to cause, or
8 to assist in the causing of, the death, suicide, euthanasia,
9 or mercy killing of an individual.

10 **“SEC. 1897H. SPECIAL RULE FOR DISABLED AND ESRD POP-**
11 **ULATIONS.**

12 “Not later than 5 years after the date of the enact-
13 ment of this part and after the Secretary obtains appro-
14 priate experience in administering this part, the Secretary
15 shall develop regulations to integrate individuals described
16 in section 1895B(2)(B) in the choice care program estab-
17 lished under this part.

18 **“SEC. 1897J. DEMONSTRATION PROJECT ON MARKET-**
19 **BASED REIMBURSEMENT AND COMPETITIVE**
20 **PRICING.**

21 “After the Secretary has obtained appropriate experi-
22 ence in operating the choice care program under this part,
23 the Secretary may establish 1 or more demonstration
24 projects to determine the choice care value amount de-
25 scribed in section 1897C through competitive bidding by

1 choice care plans in reimbursement areas in which at least
2 3 choice care plans (including national indemnity plans)
3 participate in the competitive bidding. The Secretary may
4 conduct a demonstration project under this section only
5 if the Secretary determines that the choice care plans de-
6 siring to participate in the competitive bidding have ade-
7 quate aggregate capacity to service all eligible individuals
8 in the reimbursement area.”

9 **SEC. 102. MAXIMUM FLEXIBILITY IN IMPLEMENTATION.**

10 In promulgating regulations to implement this Act,
11 the Secretary of Health and Human Services shall—

12 (1) promulgate regulations to govern, and ad-
13 minister, the choice care program established under
14 part D of title XVIII of the Social Security Act in
15 a manner that maximizes program efficiency and
16 flexibility, and that avoids having burdensome regu-
17 latory requirements or overly bureaucratic program
18 administration undermine the purposes of the choice
19 care program; and

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

23 **SEC. 103. CONFORMING AMENDMENTS.**

24 (a) IN GENERAL.—Not later than 90 days after the
25 date of the enactment of this Act, the Secretary of Health

1 and Human Services shall submit to the appropriate com-
 2 mittees of Congress a legislative proposal providing for
 3 such technical and conforming amendments in the law as
 4 are required by the provisions of this Act.

5 (b) MEDICARE PATIENT LOAD.—Section
 6 1886(h)(3)(C) (42 U.S.C. 1395ww(h)(3)(C)) is amended
 7 by inserting “including all days attributable to patients
 8 enrolled in a choice care plan under part D” before the
 9 period at the end.

10 (c) 1876 CONTRACTS.—Section 1876 (42 U.S.C.
 11 1395mm) is amended by adding at the end the following
 12 new subsection:

13 “(k) This section shall not apply to risk contracts for
 14 contract years beginning on or after January 1, 1997.”.

15 **SEC. 104. EFFECTIVE DATE.**

16 The amendments made by section 101 shall apply
 17 with respect to contracts effective on or after 1996.

18 **TITLE II—TAX PROVISIONS RE-**
 19 **LATING TO CHOICE CARE**
 20 **PLANS**

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

22 (a) IN GENERAL.—Chapter 79 of the Internal Reve-
 23 nue Code of 1986 is amended by adding at the end the
 24 following new section:

1 **“SEC. 7705. MEDICARE MEDICAL SAVINGS ACCOUNTS.**

2 “(a) GENERAL RULE.—The term ‘medicare medical
3 savings account’ means a trust created or organized in the
4 United States for the exclusive benefit of the account ben-
5 efiary, but only if the written governing instrument cre-
6 ating the trust meets the following requirements:

7 “(1) Except in the case of a rollover contribu-
8 tion described in subsection (c)(3), the only con-
9 tributions to the account are—

10 “(A) payments made by the Secretary of
11 Health and Human Services under section
12 1897F(c)(2) of the Social Security Act on be-
13 half of the account beneficiary, or

14 “(B) deposits in cash to the account not in
15 excess of the amount of the rebate received for
16 the calendar year under section 1897F(c)(1).

17 “(2) The trustee is a bank (as defined in sec-
18 tion 408(n)), insurance company (as defined in sec-
19 tion 816), or another person who demonstrates to
20 the satisfaction of the Secretary that the manner in
21 which such person will administer the trust will be
22 consistent with the requirements of this section.

23 “(3) The assets of the trust will not be commin-
24 gled with other property except in a common trust
25 fund or common investment fund.

1 “(4) No part of the trust assets will be invested
2 in life insurance contracts.

3 “(5) The interest of an individual in the bal-
4 ance in the individual’s account is nonforfeitable.

5 “(b) TAX TREATMENT OF ACCOUNTS.—

6 “(1) EXEMPTION FROM TAX.—A medicare med-
7 ical savings account is exempt from taxation under
8 this title unless it ceases to be such an account
9 under paragraph (2). Notwithstanding the preceding
10 sentence, a medicare medical savings account is sub-
11 ject to the taxes imposed by section 511 (relating to
12 imposition of tax on unrelated business income of
13 charitable, etc. organizations).

14 “(2) ACCOUNT TERMINATES IF INDIVIDUAL EN-
15 GAGES IN PROHIBITED TRANSACTION.—

16 “(A) IN GENERAL.—If, during any taxable
17 year of the account beneficiary, such beneficiary
18 engages in any transaction prohibited by section
19 4975 with respect to the account, the account
20 shall cease to be a medicare medical savings ac-
21 count as of the first day of such taxable year.

22 “(B) ACCOUNT TREATED AS DISTRIBUTING
23 ALL ITS ASSETS.—In any case in which any ac-
24 count ceases to be a medicare medical savings
25 account by reason of subparagraph (A) on the

1 first day of any taxable year, subsection (c)
2 shall be applied as if—

3 “(i) there were a distribution on such
4 first day in an amount equal to the fair
5 market value (on such first day) of all as-
6 sets in the account (on such first day), and

7 “(ii) no portion of such distribution
8 were used to pay qualified medical ex-
9 penses.

10 “(3) EFFECT OF PLEDGING ACCOUNT AS SECUR-
11 RITY.—If, during any taxable year, the account ben-
12 eficiary uses the account or any portion thereof as
13 security for a loan, the portion so used is treated as
14 distributed and not used to pay qualified medical ex-
15 penses.

16 “(c) TAX TREATMENT OF DISTRIBUTIONS.—

17 “(1) AMOUNTS USED FOR QUALIFIED MEDICAL
18 EXPENSES.—Any amount paid or distributed out of
19 a medicare medical savings account which is used
20 exclusively to pay qualified medical expenses of any
21 account beneficiary shall not be includible in gross
22 income.

23 “(2) INCLUSION OF AMOUNTS NOT USED FOR
24 QUALIFIED MEDICAL EXPENSES.—

1 “(A) IN GENERAL.—Any amount paid or
2 distributed out of a medicare medical savings
3 account which is not used exclusively to pay the
4 qualified medical expenses of the account bene-
5 ficiary shall be included in the gross income of
6 such beneficiary.

7 “(B) SPECIAL RULE.—For purposes of
8 subparagraph (A), any distribution of property
9 shall be taken into account at its fair market
10 value on the date of the distribution.

11 “(3) ROLLOVER CONTRIBUTION.—

12 “(A) IN GENERAL.—If any amount paid or
13 distributed from a medicare medical savings ac-
14 count to the account beneficiary is paid into a
15 medicare medical savings account for the bene-
16 fit of such beneficiary not later than the 60th
17 day after the day on which the beneficiary re-
18 ceives the payment or distribution—

19 “(i) paragraph (2) shall not apply to
20 such amount, and

21 “(ii) such amount shall be treated as
22 a rollover contribution described in this
23 paragraph.

24 “(B) INHERITED ACCOUNTS.—If an ac-
25 count beneficiary dies, the medicare medical

1 savings account shall be treated in the same
2 manner as an individual retirement plan.

3 “(4) COORDINATION WITH MEDICAL EXPENSE
4 DEDUCTION.—For purposes of section 213, any pay-
5 ment or distribution out of a medicare medical sav-
6 ings account for qualified medical expenses shall not
7 be treated as an expense paid for medical care.

8 “(d) DEFINITIONS.—For purposes of this section—

9 “(1) QUALIFIED MEDICAL EXPENSES.—

10 “(A) IN GENERAL.—The term ‘qualified
11 medical expenses’ means any expense—

12 “(i) for medical care (as defined in
13 section 213(d)), or

14 “(ii) for qualified long-term care serv-
15 ices (including coverage under an insur-
16 ance contract for payment of such serv-
17 ices).

18 “(B) QUALIFIED LONG-TERM CARE SERV-
19 ICES.—The term ‘qualified long-term care serv-
20 ices’ means necessary diagnostic, preventive,
21 therapeutic, rehabilitative, and maintenance (in-
22 cluding personal care) services which are re-
23 quired by an individual during any period dur-
24 ing which such individual is a functionally im-

1 paired individual (as determined in the manner
2 prescribed by the Secretary).

3 “(2) ACCOUNT BENEFICIARY.—

4 “(A) IN GENERAL.—The term ‘account
5 beneficiary’ means an individual—

6 “(i) who is entitled to benefits under
7 part A of title XVIII of the Social Security
8 Act and enrolled under part B of such
9 title, and

10 “(ii) for whose benefit the medicare
11 medical savings account is maintained.

12 “(B) JOINT ACCOUNTS.—If married indi-
13 viduals are both described in subparagraph
14 (A)(i), they may establish a joint account and
15 each spouse shall be treated as an account ben-
16 eficiary.

17 “(e) CUSTODIAL ACCOUNTS.—For purposes of this
18 section, a custodial account shall be treated as a trust if—

19 “(1) the assets of such account are held by a
20 bank (as defined in section 408(n)), insurance com-
21 pany (as defined in section 816), or another person
22 who demonstrates to the satisfaction of the Sec-
23 retary that the manner in which such person will ad-
24 minister the account will be consistent with the re-
25 quirements of this section, and

1 “(2) the custodial account would, except for the
2 fact that it is not a trust, constitute a medicare
3 medical savings account described in subsection (a).
4 For purposes of this title, in the case of a custodial ac-
5 count treated as a trust by reason of the preceding sen-
6 tence, the custodian of such account shall be treated as
7 the trustee thereof.

8 “(f) REPORTS.—The trustee of a medicare medical
9 savings account shall make such reports regarding such
10 account to the Secretary and to the individual for whose
11 benefit the account is maintained with respect to contribu-
12 tions, distributions, and such other matters as the Sec-
13 retary may require under regulations. The reports re-
14 quired by this subsection shall be filed at such time and
15 in such manner and furnished to such individuals at such
16 time and in such manner as may be required by those reg-
17 ulations.

18 “(g) TRANSFER OF ACCOUNT INCIDENT TO DI-
19 VORCE.—The transfer of an individual’s interest in a med-
20 icare medical savings account to an individual’s spouse or
21 former spouse under a divorce or separation instrument
22 described in subparagraph (A) of section 71(b)(2) shall
23 not be considered a taxable transfer made by such individ-
24 ual notwithstanding any other provision of this subtitle,
25 and such interest at the time of the transfer shall be treat-

1 ed as a medicare medical savings account of such spouse,
2 and not of such individual. Any such account or annuity
3 shall, for purposes of this subtitle, be treated as main-
4 tained for the benefit of the spouse to whom the interest
5 was transferred.”

6 (b) TAX ON PROHIBITED TRANSACTIONS.—Section
7 4975 of the Internal Revenue Code of 1986 (relating to
8 prohibited transactions) is amended—

9 (1) by adding at the end of subsection (c) the
10 following new paragraph:

11 “(4) SPECIAL RULE FOR MEDICARE MEDICAL
12 SAVINGS ACCOUNTS.—An individual for whose bene-
13 fit a medicare medical savings account (within the
14 meaning of section 7705(a)) is established shall be
15 exempt from the tax imposed by this section with re-
16 spect to any transaction concerning such account
17 (which would otherwise be taxable under this sec-
18 tion) if, with respect to such transaction, the ac-
19 count ceases to be a medicare savings account by
20 reason of the application of section 7705(b)(2)(A) to
21 such account.”, and

22 (2) by inserting “or a medicare medical savings
23 account described in section 7705(a)” in subsection
24 (e)(1) after “described in section 408(a)”.

1 (c) FAILURE TO PROVIDE REPORTS ON MEDICARE
2 MEDICAL SAVINGS ACCOUNTS.—Section 6693 of the In-
3 ternal Revenue Code of 1986 (relating to failure to provide
4 reports on individual retirement accounts or annuities) is
5 amended—

6 (1) by inserting “**OR ON MEDICARE MEDI-**
7 **CAL SAVINGS ACCOUNTS**” after “**ANNUITIES**” in
8 the heading of such section, and

9 (2) by adding at the end of subsection (a) the
10 following: “The person required by section 7705(f)
11 to file a report regarding a medicare medical savings
12 account at the time and in the manner required by
13 such section shall pay a penalty of \$50 for each fail-
14 ure unless it is shown that such failure is due to rea-
15 sonable cause.”

16 (d) CLERICAL AMENDMENTS.—

17 (1) The table of sections for subchapter B of
18 chapter 68 of such Code is amended by inserting “or
19 on medicare medical savings accounts” after “annu-
20 ities” in the item relating to section 6693.

21 (2) The table of sections for chapter 79 of such
22 Code is amended by adding at the end the following
23 new item:

“Sec. 7705. Medicare medical savings accounts.”

1 **SEC. 202. TAXATION OF CHOICE CARE REBATES.**

2 (a) IN GENERAL.—Subsection (a) of section 86 of the
 3 Internal Revenue Code of 1986 (relating to taxation of
 4 social security and tier 1 railroad retirement benefits) is
 5 amended by adding at the end the following new para-
 6 graph:

7 “(3) MEDICARE CHOICE CARE REBATES.—
 8 Gross income shall include any choice care rebate
 9 amount received under section 1897F(c) of the So-
 10 cial Security Act to the extent such amount is not
 11 deposited into a medicare medical savings account
 12 established under section 7705.”

13 (b) EFFECTIVE DATE.—The amendment made by
 14 this section shall apply to amounts received after the date
 15 of the enactment of this Act.

○

S 1238 IS—2

S 1238 IS—3

S 1238 IS—4

S 1238 IS—5