105TH CONGRESS
1ST SESSION

S. 246

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

IN THE SENATE OF THE UNITED STATES

JANUARY 30, 1997

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

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A BILL

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

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medicare Improvement and Choice Care Provision Act''.

SEC. 2. PURPOSES.

The purposes of this Act are to—

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

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

(2) expand and improve the existing medicare program to provide senior citizens with a greater variety of health care options from which to choose;

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

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

(5) help preserve the immediate and long-term solvency of the medicare program by beginning to alter medicare's basic delivery structure by encouraging the provision of quality medical care at reasonable prices through enhanced competition.

TITLE I—CHOICE CARE PROGRAM

SEC. 101. CHOICE CARE PROGRAM.

Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by adding at the end the following new part:

"PART D—CHOICE CARE PROGRAM

"SEC. 1895A. ESTABLISHMENT OF CHOICE CARE PROGRAM.

''The Secretary shall establish the choice care program in accordance with this part.

"SEC. 1895B. DEFINITIONS.

''For purposes of this part:

''(1) CHOICE CARE PLAN.—The term 'choice care plan' means any of the following plans of health insurance:

''(A) INDEMNITY OR FEE-FOR-SERVICE PLANS.—Private indemnity plans that reimburse hospitals, physicians, and other providers on the basis of a privately arranged fee schedule.

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

''(i) eligible organizations with risk contracts under section 1876 or competitive medical plans having contracts under section 1833;

''(ii) qualified health maintenance organizations as defined in section 1310(d) of the Public Health Service Act; and

''(iii) preferred provider organization plans, point of service plans, or other coordinated care plans.

"(C) HIGH DEDUCTIBLE PLANS IN CONNECTION WITH MEDICARE MEDICAL SAVINGS ACCOUNTS.—Private plans that require the eligible individual to pay a minimum annual deductible for insured medical expenses equal to at least $1,500 in a calendar year and that are operated in connection with medicare medical savings accounts as defined in section 86(g) of the Internal Revenue Code of 1986.

"(D) OTHER HEALTH CARE PLANS.—Any other private plan for the delivery of health care items and services that is not described in subparagraph (A), (B), or (C).

"(2) ELIGIBLE INDIVIDUAL.—

"(A) IN GENERAL.—The term 'eligible individual' means an individual who is entitled to benefits under part A and enrolled under part B.

"(B) PHASE-IN OF DISABLED INDIVIDUALS AND INDIVIDUALS WITH ESRD.—For purposes of subparagraph (A), the term 'eligible individual' shall not include an individual who is entitled to benefits under part A under section

226(b) or 226A until such time as the Secretary issues regulations in accordance with section 1897H.

''(3) QUALIFIED PROVIDER.—The term 'qualified provider' means a provider that—

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

''(B) provides inpatient services as a choice care plan, or under a contract with a choice care plan, to individuals enrolled with a choice care plan under this part.

''(4) TRADITIONAL MEDICARE PROGRAM.—The term 'traditional medicare program' means the program of benefits available to individuals entitled to benefits under part A and enrolled under part B of this title, other than enrollment in an eligible organization with a contract under section 1876, a competitive medical plan having a contract under section 1833, or a choice care plan under this part.

''(5) TRUSTEES.—The term 'Trustees' means the Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund.

"Subpart 1—Individual Participation in Choice Care Program

"SEC. 1896A. GENERAL ELIGIBILITY.

"(a) IN GENERAL.—

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

"(2) SOLE PAYMENTS.—An eligible individual who is enrolled with a choice care plan under this part shall not be eligible for any benefits under this title other than the payment of the choice care value amount (described in section 1897C) and the rebate amount (described in section 1897F(c)) in accordance with this part.

"(b) ENROLLMENT PROCESS AND DEADLINES.—

"(1) BY MAIL.—Each eligible individual may enroll or disenroll in a choice care plan with a contract under this part by submitting a signed election and enrollment form (to be developed by the Secretary) that is postmarked prior to the close of any open enrollment period applicable to such individual.

"(2) BY TELEPHONE OR THROUGH PLAN NOTIFICATION.—The Secretary, in consultation with the

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

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

"(B) a choice care plan with a contract under this part may directly accept enrollment and disenrollment information by an eligible individual and provide the Secretary with notice of such enrollment or disenrollment.

"(3) USE OF AGENTS.—The Secretary, in consultation with the Trustees, shall implement the enrollment process in a manner that ensures that eligible individuals may utilize the services of, and enroll in the selected choice care plan through, independent insurance agents. Any plan salesperson or agent, whether independent or employed by a plan, that meets personally and directly with one or more eligible individuals to assist in their choice and enrollment in a plan, shall be required to be accredited and licensed in the State in which they operate.

"(c) DEFAULT ENROLLMENT.—If an eligible individual is enrolled in a choice care plan under this part and such individual fails to provide the Secretary with notice

of the individual's enrollment or disenrollment under subsection (b) during any open enrollment period applicable to the individual, the individual shall be deemed to have reenrolled in the plan.

''(d) ENROLLMENT BY AN INDIVIDUAL.—

''(1) ANNUAL 45-DAY PERIOD.—Each choice care plan with a contract under this section shall offer an annual open enrollment period between November 1 and December 15 of each year for the enrollment and termination of enrollment of individuals.

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

''(A) INITIAL MEDICARE ELIGIBILITY.—An open enrollment period to each eligible individual during any enrollment period specified by section 1837 that applies to that individual (effective as specified by section 1838).

''(B) NONENROLLED INDIVIDUALS.—A continuous open enrollment period to each eligible individual who is not enrolled in a choice care plan.

''(3) PERIOD OF ENROLLMENT.—

''(A) IN GENERAL.—An individual enrolling in a plan during any open enrollment period under paragraph (1) shall be enrolled in the plan for the calendar year following the open enrollment period.

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

''(C) HIGH DEDUCTIBLE PLANS.—An individual enrolling during any open enrollment period in a choice care plan which is a high deductible plan health plan described in section 1895B(1)(C), shall be enrolled until the close of the calendar year following the calendar year referred to in subparagraph (A) or (B).

''(4) TERMINATIONS.—

''(A) LOCK-IN.—Except as otherwise provided in this paragraph, an individual may not terminate enrollment in a choice care plan before the next open enrollment period applicable to the individual.

"(B) HIGH DEDUCTIBLE PLANS.—In the case of an individual enrolled in a plan described in paragraph (3)(C), an individual may not terminate enrollment until the open enrollment period applicable to the individual in the calendar year in which the enrollment would otherwise terminate under paragraph (3)(C).

"(C) TERMINATION FOR CAUSE.—Notwithstanding subparagraph (A) or (B), an individual may terminate enrollment in a choice care plan if—

"(i) the individual moves to a new reimbursement area; or

"(ii) the choice care plan in which the individual is enrolled fails to meet the plan's service or capacity requirements under section 1897B(a)(7), as determined by the Secretary.

"(D) PHASE-IN OF LOCK-IN.—Notwithstanding subparagraph (A) or (B), an individual may terminate enrollment in a choice care plan prior to the next open enrollment period applicable to the individual—

"(i) at any time during calendar year 1998; or

''(ii) if, during the 1-year period beginning on—

''(I) January 1, 1999, such individual has been enrolled in such plan for 4 months; and

''(II) January 1, 2000, such individual has been enrolled in such plan for 8 months.

"Subpart 2—Contracting and Choice Care Plans

"SEC. 1897A. AUTHORITY TO CONTRACT.

''The Secretary shall enter into a 1-year contract with each choice care plan in a reimbursement area if the plan meets the requirements of this section with respect to eligible individuals enrolled under this section.

"SEC. 1897B. CHOICE CARE PLAN REQUIREMENTS.

''(a) GENERAL REQUIREMENTS.—Each choice care plan with a contract under this part shall meet the following requirements:

''(1) NONDISCRIMINATION.—

''(A) ENROLLMENT.—The plan shall accept on a first-come-first-served basis, up to the limits of its capacity (as determined by the Secretary) and without restrictions, all eligible individuals within the plan's reimbursement area

who elect to enroll in such plan, unless to do so would result in the enrollment of enrollees who are substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the reimbursement area served by the organization. The plan shall not refuse or cancel coverage of eligible individuals except for reasons of beneficiary fraud or nonpayment of amounts due the plan under the coverage policy.

''(B) CONTINUED ENROLLMENT PROTECTED.—The plan shall provide assurances to the Secretary that it will not expel, or refuse to re-enroll any eligible individual because of the individual's health status or requirements for health care services, and that it will notify each such individual of such fact at the time of the individual's enrollment.

''(2) PARTS A AND B SERVICES.—The plan shall provide those services covered under parts A and B of this title through providers and other persons that meet the applicable requirements of this title and part A of title XI. The Secretary may not require any additional benefits to be provided other than those described in the previous sentence.

''(3) ESTABLISHMENT OF SCHEDULES.—

''(A) IN GENERAL.—Each choice care plan shall establish premium, deductible, and copayment schedules for the plan, except that in the case of plans other than high deductible health plans described in section 1895B(1)(C) and as provided in subparagraph (B) and subsection (b)(2), such premium, deductible, and copayment schedules for services described in paragraph (2) may not exceed the levels of the premiums, deductibles and copayments established for such services under the traditional medicare program.

''(B) ADDITIONAL DEDUCTIBLES AND COPAYMENTS.—A coordinated care choice care plan may establish schedules for copayments and deductibles which exceed the level established under the traditional medicare program for services purchased from a provider who is not part of such coordinated care plan network.

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

''(5) AT-RISK BASIS.—The plan shall agree to provide all coverage described in paragraph (2) to eligible individuals who enroll with the plan for not more than the sum of the choice care value amount determined with respect to such individual and any additional premiums paid by such individual (pursuant to section 1897F(a)), and to assume the full financial risk of the cost of furnishing such coverage on a prospective basis regardless of whether such cost exceeds such fixed payment, except that the plan may—

''(A) insure itself against such financial risk; and

''(B) make arrangements with other health care providers to assume all or part of such financial risk.

''(6) SOLVENCY.—The plan shall make adequate provision against the risk of insolvency, including provisions to prevent the plan's enrollees from being held liable to any person or entity for the plan's debts in the event of the plan's insolvency.

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

each reimbursement area in which it desires to participate, the plan has the capacity to serve the expected enrollment in such reimbursement area.

''(8) GRIEVANCE PROCESS.—The plan shall establish an internal procedure for hearing and resolving grievances between the plan and enrollees, including procedures under which an enrollee (or provider on behalf of such enrollee) may challenge the plan's denial of coverage of or payment for medical assistance or services to the enrollee.

''(9) RATE TABLE.—The plan shall submit to the Secretary a table of its rates for all actuarial categories of eligible individuals prior to contract approval by the Secretary.

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

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

''(2) may provide such members with additional health care services, including prescription drugs, and may establish a premium schedule for such additional services which exceeds the levels established under the traditional medicare program; and

''(3) may require approval for the provision of nonemergency medical assistance or services to an enrollee for nonemergency services before such assistance is provided, provided such prior approval is given in a reasonably timely manner.

''SEC. 1897C. CHOICE CARE VALUE AMOUNTS.

''(a) IN GENERAL.—The Secretary shall annually determine, and shall announce (in a manner intended to provide notice to interested parties) not later than September 7 of 1997 and each calendar year thereafter, the choice care value amount determined in accordance with this section for the following calendar year for each class of eligible individuals in a reimbursement area enrolled under this part with a choice care plan.

''(b) DEFINITION OF APPROPRIATE CLASSES.—The Secretary shall define classes of individuals under this section in the same manner as the Secretary defines classes of individuals under section 1876.

''(c) CALCULATION OF CHOICE CARE VALUE AMOUNT.—

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

''(A) for a reimbursement area described in subsection (d)(1), an amount equal to the average of the sum of the adjusted average per

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

''(B) for a reimbursement area described in paragraph (2) or (3) of subsection (d), the average of the sum of the adjusted average per capita costs determined for parts A and part B of all of the counties within such reimbursement area.

''(2) SUBSEQUENT YEAR AMOUNTS.—For purposes of subsection (a), the choice care value amount for a reimbursement area for years after 1998 shall be an amount equal to the choice care value amount determined for the preceding year, increased—

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

''(B) by 7.5 percent if, during the preceding year, the choice care value amounts determined for such reimbursement area were equal to or greater than 85 percent of the average of

all choice care value amounts in all reimbursement areas, but equal to or less than 95 percent of such average for such preceding year;

''(C) by 2.5 percent if, during the preceding year, the choice care value amounts determined for such reimbursement area were equal to or greater than 105 percent of the average of all choice care value amounts in all reimbursement areas for such preceding year, but equal to or less than 120 percent of such average;

''(D) by 0.5 percent if, during the preceding year, the choice care value amounts determined for such reimbursement area were equal to or greater than 120 percent of the average of all choice care value amounts in all reimbursement areas for such preceding year; and

''(E) in all reimbursement areas not described in subparagraph (A), (B), (C), and (D), by a percentage determined by the Secretary which is greater than 2.5 percent and less than 7.5 percent and which ensures that the average amount of the increase for all such areas is 5 percent.

''(3) ADJUSTED AVERAGE PER CAPITA COST.—For purposes of this subsection—

''(A) IN GENERAL.—the term 'adjusted average per capita cost' has the meaning given such term by section 1876(a)(4).

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

''(i) IME.—Any payments attributable to section 1886(d)(5)(B) relating to indirect medical education.

''(ii) DIRECT GME.—Any payments attributable to section 1886(h) relating to direct graduate medical education.

''(iii) DISPROPORTIONATE SHARE HOSPITALS.—Any payments attributable to section 1886(d)(5)(F) relating to direct graduate medical education.

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

''(A) IN GENERAL.—

''(i) ANNUAL DETERMINATION.—The Secretary shall estimate, based on enrollment in choice care plans under this part, the aggregate amount of payments that

would have been made under this title to providers for each category of payment described in clause (i), (ii), and (iii) of paragraph (3)(B) with respect to individuals enrolled in choice care plans if such individuals had not been enrolled in such plans.

''(ii) ALLOCATION OF AMOUNTS.—For each year, the Secretary shall allocate each of the aggregate amounts determined under clause (i) to qualified providers on a per patient basis in accordance with subparagraph (B) and based on the Secretary's best estimation of whether such amount will fully deplete each such aggregate amount for the year.

''(iii) END OF YEAR RECONCILIATION.—The Secretary shall develop a process that permits the Secretary to—

''(I) recoup from qualified providers an amount equal to the difference (if any) between the allocations made under clause (ii) for a category of payment described in clause (i), (ii), or (iii) of paragraph (3)(B) and the

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

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

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

"(i) For any provider that would qualify for the indirect medical education adjustment under section 1886(d)(5)(B) or the disproportionate share adjustment under section 1886(d)(5)(F), payment shall be made on a per discharge basis for each individual enrolled in a choice care plan with a contract under this part who receives inpatient care at that provider as though the traditional medicare program

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

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

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

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

''(2) for a county that falls within a Primary Metropolitan Statistical Area, the Primary Metropolitan Statistical Area, and

''(3) for a county that falls within a Metropolitan Statistical Area but not within a Primary Metropolitan Statistical Area, the Metropolitan Statistical Area.

''(e) REPORTS BY PROPAC.—Not later then January 1, 1999, the Prospective Payment Assessment Commission shall submit reports to the Congress on the impact

of the indirect medical education adjustment, direct graduate medical education payment, and the disproportionate share hospital adjustment distribution system established under subsection (c), and on the impact of the reimbursement areas established under subsection (d). Each report shall include any recommendations for appropriate modifications.

"SEC. 1897D. PLAN NOTIFICATION TO THE SECRETARY.

''(a) NOTIFICATION.—

''(1) GENERAL NOTIFICATION.—Each choice care plan that desires to enter into a contract under this part with the Secretary in 1 or more reimbursement areas for the next calendar year shall submit a notification in accordance with subsection (b) to the Secretary not later than 21 days after the date of the announcement of the choice care value amounts described in section 1897C(a).

''(2) LATE NOTIFICATION.—A choice care plan may submit a notification for a calendar year in accordance with subsection (b) to the Secretary after the date described in paragraph (1) but such plan shall not be eligible to enroll an eligible individual during the annual open enrollment period described in section 1896A(d)(1)(A) for such calendar year

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

''(b) PLAN NOTIFICATION DESCRIBED.—A plan notification described in this subsection shall be in a form and manner prescribed by the Secretary and shall include the following information with respect to each reimbursement area that the plan seeks to serve:

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

''(2) A schedule of benefits and services that will be available (including those subject to prior authorization by the plan as a condition of coverage), including the amounts of premiums, copayments, and deductibles to be assessed.

''(3) The identity, locations, qualifications, and availability of the health care providers participating in the plan.

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

''(5) The rights and responsibilities of enrollees under the plan.

''(6) The results of the plan's independent reviews or accreditation process (as described in section 1897G(d)).

''(7) Historical performance and satisfaction information (described in section 1897G(c)); and

''(8) Historical enrollment and disenrollment data of the plan (excluding disenrollment by death).

''(c) SECRETARY TRANSMISSION OF INFORMATION TO TRUSTEES.—Upon receipt of the notifications described in subsection (b), the Secretary shall promptly transmit the information contained in such notifications to the Trustees. The Secretary shall also provide any other information requested by the Trustees, in order for the Trustees to carry out their duties under section 1897E.

''SEC. 1897E. INFORMATION DUTIES OF THE TRUSTEES AND PLANS.

''(a) IN GENERAL.—

''(1) OPEN SEASON NOTIFICATION.—

''(A) By October 15 of each year beginning after 1997, the Trustees shall mail a notice of eligibility to participate in the choice care program to each eligible individual and each individual who is eligible to become entitled to benefits under part A prior to the end of the annual open season enrollment period described in section 1896A(d)(1).

''(B) The notice described in subparagraph (A) shall include an informational brochure that

includes the information described this section, and any other information that the Trustees determine will facilitate the individual's enrollment decisions under the choice care program.

''(2) NOTIFICATION TO NEWLY MEDICARE-ELIGIBLE INDIVIDUALS.—With respect to an individual who becomes an eligible individual after the close of the annual open enrollment period described in section 1896A(d)(1), the Trustees shall, not later than 3 months before the date on which the individual becomes an eligible individual, mail to each such individual the notice of eligibility described in paragraph (1).

''(b) TRUSTEES' MATERIALS; CONTENTS.—The notice and informational materials mailed by the Trustees under subsection (a)(1)(A) shall be written and formatted in the most easily understandable manner possible, and shall include, at a minimum, the following information with respect to coverage under this part during the next calendar year:

''(1) The part B (and part A, if applicable) premium rates that will be charged for coverage under the traditional medicare program.

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

''(3) A description of any changes in coverage that will occur under the traditional medicare program.

''(4) A description of the eligible individual's reimbursement area, and the choice care value amount available with respect to such individual within the reimbursement area.

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

''(6) For each choice care plan with a contract under this part in the eligible individual's reimbursement area, information on the amount of cash rebates that may be received by such eligible individual, or additional premium amounts, deductibles or copayments that must be paid by such eligible individual.

''(7) For each participating plan, any restrictions on coverage for services furnished other than through the plan, any restrictions on services furnished through the plan, such as preauthorization review, concurrent review, post-service review, or post-payment review, and any financial incentives

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

''(8) Information on enrollee satisfaction with each participating plan in the eligible individual's reimbursement area, including enrollment and disenrollment rates from previous years (excluding disenrollment by death).

''(9) Performance and outcome-based information and reports, with respect to each of the plans with a contract under this part in the eligible individual's reimbursement area.

''(10) A simplified chart that presents and compares the benefits provided and services covered of each plan participating in the eligible individual's reimbursement area.

''(11) Any other information that choice care plans provide to the Secretary under section 1897D or otherwise, that the Trustees determine will be of assistance to informed decisionmaking by eligible individuals.

''(12) The phone numbers that an eligible individual may use to enroll in a choice care plan with a contract under this part in the eligible individual's reimbursement area.

''(13) A separate notice which—

''(A) identifies expenses that are generally considered long-term care expenses,

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

''(C) provides a list of long-term care insurers which have notified the Trustees of their availability within a particular reimbursement area.

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

''(d) PLAN PARTICIPATION IN ENROLLMENT PROCESS.—

''(1) IN GENERAL.—In addition to any informational materials distributed by the Trustees under subsection (a), a choice care plan with a contract under this part may develop and distribute marketing materials and engage in marketing strategies in accordance with this subsection.

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

under this part and any marketing strategy developed by such plan—

"(A) shall compare—

"(i) health care coverage available under the plan with the health care coverage available under the traditional medicare program, and

"(ii) any rebates that may be available, or additional premium, deductibles, or copayments that may be required under the plan with the deductibles and copayments required under the traditional medicare program,

"(B) shall be provided in a form and manner that is easily understood by a typical eligible individual, and that contains accurate and sufficient information for an individual to make an informed decision on whether to enroll in the plan, or to seek additional information,

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

''(D) shall be pursued in a manner not intended to violate the anti-discrimination requirement of section 1897B(a)(1), and

''(E) shall not contain false or materially misleading information, and shall conform to any other fair marketing and advertising standards and requirements applicable to such plans under law.

''(e) PLAN NOTIFICATION TO ENROLLEES.—Each choice care plan with a contract under this part shall provide to each individual who has elected to enroll in the plan, at the time of enrollment and at least annually thereafter, an explanation of the enrollee's rights under the plan and this part, including an explanation of the following:

''(1) The enrollee's rights to benefits from the plan.

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

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

''(4) The plan's coverage of urgently needed care and emergency services.

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

"SEC. 1897F. PREMIUMS, PLAN PAYMENTS, AND CASH-BACK AWARDS.

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

"(b) PAYMENTS TO PLANS.—

"(1) MONTHLY PAYMENTS IN ADVANCE.—For each eligible individual enrolled with the plan under this part, the Secretary shall make monthly payments in advance to a choice care plan with a contract under this part in an amount equal to the lesser of the monthly choice care value amount determined with respect to such individual under section 1897C or the monthly premium determined for such individual.

"(2) RETROACTIVE ADJUSTMENTS.—The amount of payment under this paragraph may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled in the plan under this section and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

''(3) TRUST FUND WITHDRAWALS.—The payment to a choice care plan under this section for eligible individuals enrolled under this part with the organization and entitled to benefits under part A and enrolled under part B shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The portion of the payment to the plan for a month to be paid by each trust fund shall be determined each year by the Secretary based on the relative weight that benefits from each fund contribute to the determination of the choice care value amount determined under section 1897C, as estimated by the Secretary.

''(c) REBATES.—

''(1) IN GENERAL.—If the weighted average of the choice care value amounts with respect to all individuals in a reimbursement area exceeds the premium of the plan in which an eligible individual is enrolled, the Secretary shall—

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

''(B) deposit the remainder of the excess in the Federal Hospital Insurance Trust Fund.

''(2) ELIGIBILITY AND TIME FOR PAYMENT.—

"(A) ELIGIBILITY.—An individual shall be eligible for a payment under paragraph (1) only if the individual enrolls in the plan during the annual open enrollment period described in section 1896A(d)(1).

"(B) TIME FOR PAYMENT.—A rebate under paragraph (1) shall be paid as of the close of the calendar year to which the enrollment applied.

"(C) SPECIAL RULE FOR HIGH DEDUCTIBLE PLANS.—In the case of an individual in a choice care plan which is a high deductible health plan described in section 1895B(1)(C)—

"(i) subparagraph (B) shall not apply, and

"(ii) the Secretary shall, within 30 days of enrollment of the individual in the plan, deposit the rebate into the medicare medical savings account (as defined in section 86(g) of the Internal Revenue Code of 1986) of the individual specified in the enrollment.

"(D) DISENROLLMENT.—

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

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

''(ii) TERMINATIONS FOR CAUSE.—Clause (i) and subparagraph (A) shall not apply in the case of a termination described in section 1896A(d)(4)(C), but the Secretary shall adjust the amount of the rebate for the terminated plan and any other choice care plan the individual enrolls in for the remainder of the calendar year.

''(iii) HIGH DEDUCTIBLE PLANS.—If clause (i) applies to a plan described in subparagraph (C), the Secretary shall provide for the repayment of any amount paid under subparagraph (C).

''(3) SOURCE OF REBATES.—The payment amount described in paragraph (1) shall be made in the same manner as payments are made under subsection (b)(3).

''SEC. 1897G. QUALITY ASSURANCE, PLAN COVERAGE, AND PARTICIPATION STANDARDS.

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

''(1) have an ongoing quality assurance system or program with respect to services the plan provides to eligible individuals under this part which ensures that the plan meets, at a minimum, the requirements of this section; and

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

''(b) INTERNAL QUALITY ASSURANCE.—

''(1) ACCESS.—Each choice care plan with a contract under this part shall provide or arrange for the provision of all medically necessary health care services required under this Act and under a contract under this part.

''(2) TIMELY DELIVERY OF SERVICES.—Each choice care plan with a contract under this part shall deliver, upon request, to eligible individuals enrolled with the plan upon request health care services in a manner that is reasonably prompt and, when medically necessary, that is available and accessible 24 hours a day and 7 days a week.

''(c) PERFORMANCE MEASURES.—Each plan shall undertake to measure and maintain data on the plan's actual performance in delivering of health care services to eligible individuals. Such measures shall incorporate the following information:

''(1) PATIENT ENCOUNTER DATA.—Sufficient patient encounter data, including data to identify the health care provider that delivers services to each patient and the type of service provided, as determined by the Secretary or Trustees to be of assistance in the performance of their duties under this part.

''(2) PERFORMANCE-BASED INFORMATION.—Data that are continuously or periodically gathered, and that—

''(A) are sufficient to reflect the care provided for the prevalent clinical conditions among the enrollees served, including data on health or functional status, clinical performance, functional improvement, and prevention or early detection, and

''(B) provide information on compliance with performance-based standards that reflect a minimum set of comparable performance-based data, that are selected in consultation with an advisory body of outside experts in order to develop a standardized set of measures that can produce comparable and consistent information, and that are updated periodically.

''(3) PLAN SATISFACTION DATA.—Data that are periodically gathered to measure the perception of patients, providers, and purchasers, including data on the level of satisfaction associated with, at a minimum, the responsiveness, access to services, quality of services, and continuity of care of a particular plan.

''(d) INDEPENDENT ACCREDITATION.—

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

''(2) ACCREDITING ORGANIZATION.—The independent review and accreditation shall be performed by an accrediting organization that—

''(A) is a private, nonprofit organization,

''(B) maintains an accreditation program for accrediting managed care plans or other health care plans that are offered under the choice care program, and

''(C) is independent of the control of health care providers, health care plans, or trade associations of health care providers.

''(3) PUBLIC AVAILABILITY.—The results of reviews described in paragraph (2) shall be made publicly available upon request, and specifically made available to the plan's enrollees and potential enrollees, in a manner that does not disclose the identity of any particular patient.

''(4) DISQUALIFICATION.—A choice care plan that fails to receive accreditation under this subsection shall be disqualified from participation in the choice care program, unless the plan meets the following:

''(A) PROVISIONAL ACCREDITATION.—The plan is a new plan (as determined by the Secretary) and such plan is making reasonable progress toward receiving accreditation, to the satisfaction of the accrediting organization.

''(B) PRIOR ACCREDITATION.—The plan received prior accreditation and such plan is making reasonable progress toward correcting the flaws that led to the failure to receive accreditation, to the satisfaction of the accrediting organization, and such plan does in fact correct such flaws within 6 months.

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

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

"SEC. 1897H. SPECIAL RULE FOR DISABLED AND ESRD POPULATIONS.

"Not later than 5 years after the date of the enactment of this part and after the Secretary obtains appropriate experience in administering this part, the Secretary shall develop regulations to integrate individuals described in section 1895B(2)(B) in the choice care program established under this part.".

SEC. 102. MAXIMUM FLEXIBILITY IN IMPLEMENTATION, INCLUDING USE OF NEGOTIATED RULEMAKING.

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

(1) promulgate regulations to govern, and administer, the choice care program established under part D of title XVIII of the Social Security Act, as added by section 102, in a manner that maximizes program efficiency and flexibility, and that avoids having burdensome regulatory requirements or overly bureaucratic program administration undermine the purposes of the choice care program; and

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

SEC. 103. CONFORMING AMENDMENTS.

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

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

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

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

SEC. 104. EFFECTIVE DATE.

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

TITLE II—MEDICARE MEDICAL SAVINGS ACCOUNTS

SEC. 201. MEDICARE MEDICAL SAVINGS ACCOUNTS.

(a) EXCLUSION FROM GROSS INCOME OF CONTRIBUTIONS TO ACCOUNTS.—Subsection (a) of section 86 of the Internal Revenue Code of 1986 (relating to taxation of social security and tier 1 railroad retirement benefits) is amended by adding at the end the following new paragraph:

''(3) MEDICARE CHOICE CARE REBATES.—Gross income shall include any choice care rebate amount received under section 1897F(c) of the Social Security Act to the extent such amount is not deposited into a medicare medical savings account (as defined in subsection (g)).''

(b) MEDICARE MEDICAL SAVINGS ACCOUNTS.—Section 86 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

''(g) MEDICARE MEDICAL SAVINGS ACCOUNTS.—

''(1) IN GENERAL.—The term 'medicare medical savings account' means a medical savings account (as defined in section 220(d))—

''(A) which is designated as a medicare medical savings account, and

''(B) with respect to which no contribution may be made other than—

''(i) a contribution made by the Secretary of Health and Human Services under section 1897F(c)(2) of the Social Security Act on behalf of the account holder,

''(ii) contributions made by or on behalf of the account holder for a calendar year not in excess of the amount of the rebate received by the holder under section 1897F(c)(1) of the Social Security Act for the calendar year, or

''(iii) rollover contributions described in section 220(f)(5).

''(2) SPECIAL RULES FOR DISTRIBUTIONS.—

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

''(B) WITHDRAWAL OF ERRONEOUS CONTRIBUTIONS.—Section 220(f)(2) shall not apply to any payment or distribution from a medicare medical savings account to the Secretary of Health and Human Services of an erroneous

contribution to the account and of the net income attributable to such account.

''(3) SPECIAL RULES FOR TREATMENT OF ACCOUNT AFTER DEATH OF ACCOUNT HOLDER.—Notwithstanding section 220(f)(1)(A), if, as of the date of the death of the account holder, the spouse of such holder is not entitled to benefits under title XVIII of the Social Security Act, then after the date of such death—

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

''(B) such account shall be treated as a medical savings account which is not a medicare medical savings account.

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

''(A) shall include the fair market value of the assets in such medicare medical savings account as of the close of each calendar year, and

''(B) shall be furnished to the account holder—

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

''(ii) in such manner as the Secretary prescribes in such regulations.

''(5) COORDINATION WITH MEDICAL SAVINGS ACCOUNT.—Any account designated as a medicare medical savings account shall not be taken into account for purposes of subsection (i) or (j) of section 220.''

(c) CLERICAL AMENDMENTS.—

(1) The heading for section 86 of the Internal Revenue Code of 1986 is amended by inserting ''**; MEDICARE CHOICE REBATES**'' after ''**BENEFITS**''.

(2) The table of sections for part II of subchapter B of chapter 1 of such Code is amended by inserting ''; medicare choice rebates'' after ''benefits'' in the item relating to section 86.

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

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