105TH CONGRESS
1ST SESSION

S. 904

To amend title XVIII of the Social Security Act to provide medicare beneficiaries with choices, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 16, 1997

Mr. BREAUX (for himself, Mr. MACK, and Mr. KERREY) 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 medicare beneficiaries with choices, and for other purposes.

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

SECTION 1. SHORT TITLE; AMENDMENTS; REFERENCES; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Comprehensive Medicare Reform and Improvement Act of 1997''.

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment

to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) REFERENCES TO OBRA.—In this Act, the terms ''OBRA–1986'', ''OBRA–1987'', ''OBRA–1990'', and ''OBRA–1993'' refer to the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509), the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203), the Omnibus Budget Reconciliation Act of 1989 (Public Law 101–239), the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508), and the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66), respectively.

(d) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

SEC. 2. PURPOSES.

The purposes of this Act are—

(1) to improve the existing medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) by adopting a competitive model to provide medicare beneficiaries with better and broader health care coverage and a greater variety of health care options from which to choose;

(2) to increase the flexibility of the medicare program to allow health care items and services to be delivered in a progressive, efficient fashion;

(3) to enable the medicare program to take swift advantage of future market improvements in the means of health care delivery;

(4) to provide medicare beneficiaries with practical information they and their families can use to make the best health care choices possible;

(5) to promote high quality, comprehensive, integrated care geared to the needs of beneficiaries within a system that is focused on preventing and ameliorating disease;

(6) to encourage good health through the efficient delivery of care to an aging population in a va-

riety of settings best suited to the needs of the individual; and

(7) to develop a medicare plan that will provide quality medical care to medicare beneficiaries while addressing the need to ensure the immediate and long-term viability by developing a competitively based program based on the Federal Employees Health Benefits Plan, a proven model of health care delivery.

TITLE I—ESTABLISHMENT OF MEDIHEALTH PLANS

SEC. 101. MEDIHEALTH PLANS.

(a) IN GENERAL.—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—MEDIHEALTH PLANS

''Subpart 1—Definitions

''SEC. 1895A. DEFINITIONS.

''(a) MEDIHEALTH PLAN.—In this part—

''(1) IN GENERAL.—The term 'MediHealth plan' means an eligible health plan with respect to which there is a contract in effect under this part to provide health benefits coverage to MediHealth eligible individuals.

''(2) MEDIHEALTH PLAN SPONSOR.—The terms 'MediHealth plan sponsor' and 'plan sponsor' mean a public or private entity which establishes or maintains a MediHealth plan.

''(b) ELIGIBLE HEALTH PLAN.—In this part:

''(1) IN GENERAL.—The term 'eligible health plan' means a policy, contract, or plan which is capable of providing health benefits coverage of items and services provided under the traditional medicare program to MediHealth eligible individuals.

''(2) TYPES OF INSURANCE.—The term 'eligible health plan' shall include private managed or coordinated care plans which provide health care services through an integrated network of providers, including—

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

''(B) preferred provider organization plans, point of service plans, provider-sponsored network plans, or other coordinated care plans.

''(c) OTHER DEFINITIONS.—In this part:

''(1) AREAS.—

''(A) MEDICARE PAYMENT AREA.—

''(i) IN GENERAL.—Except as provided in clause (ii), the term 'medicare payment area' means—

''(I) a metropolitan statistical area (whether or not such area is in a single State) or in the case of a consolidated metropolitan statistical area, each primary metropolitan statistical area within the consolidated area; or

"(II) one area within each State composed of all areas that do not fall within a metropolitan statistical area.

"(ii) GEOGRAPHIC ADJUSTMENT.—Upon request of the chief executive officer of a State, the Secretary may make a geographic adjustment to a medicare payment area otherwise determined under clause (i).

"(iii) AREAS.—In this subparagraph, the terms 'metropolitan statistical area', 'consolidated metropolitan statistical area', and 'primary metropolitan statistical area' mean any area designated as such by the Secretary of Commerce.

"(B) MEDICARE SERVICE AREA.—

"(i) IN GENERAL.—Except as provided in clause (ii), the term 'medicare service area' means a medicare payment area.

"(ii) GEOGRAPHIC ADJUSTMENT.—The Secretary may designate a medicare service area other than a medicare payment area for a MediHealth plan if the Secretary determines that such designation

is nondiscriminatory and consistent with the effective implementation of this part.

''(2) DIRECTOR.—The term 'Director' means the Director of the Office of Competition within the Department of Health and Human Services as established under section 1895M.

''(3) MEDIHEALTH ELIGIBLE INDIVIDUAL.—

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

''(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—Such term shall not include an individual medically determined to have end-stage renal disease, except that an individual who develops end-stage renal disease while enrolled in a MediHealth plan may continue to be enrolled in that plan. Not later than December 31, 1999, the Secretary shall submit to the Congress recommendations on expanding the definition of 'MediHealth eligible individual' to include individuals with end-stage renal disease and the enrollment of such individuals in MediHealth plans.

''(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 a MediHealth plan under this part.

"Subpart 2—Entitlement of MediHealth Eligible Individuals to Health Care Choices

"SEC. 1895B. ENTITLEMENT TO MEDICARE CHOICES.

''Each MediHealth eligible individual is entitled to choose to receive health care items and services covered under parts A and B—

''(1) through the traditional medicare program; or

''(2) by receiving payments toward the individual's enrollment in a MediHealth plan under this part.

"SEC. 1895C. ENROLLMENT PROCEDURES.

''(a) IN GENERAL.—Except as provided in section 1895G(a)(2), each MediHealth eligible individual shall be entitled to enroll in any MediHealth plan with a medicare service area including the geographic area in which the individual resides during—

''(1) the annual open enrollment period described in section 1895G(b)(1); or

''(2) any other enrollment period described in section 1895G(b)(2) applicable to the individual.

''(b) METHOD OF ENROLLMENT AND DISENROLLMENT.—

''(1) NOTICE PROVIDED TO THE SECRETARY.—Each MediHealth eligible individual desiring to enroll or terminate enrollment in a MediHealth plan shall provide the Secretary with notice of such enrollment or disenrollment during any enrollment period applicable to the individual. The Secretary shall, to the extent feasible, provide for the receipt of such notice by telephone, through the mail, and in person at local social security offices.

''(2) INFORMATION FORWARDED TO THE PLAN.—The Secretary shall promptly provide each MediHealth plan with notice of an individual's enrollment or disenrollment with the plan.

''(c) NOTICES TO INDIVIDUALS TO ASSIST IN ENROLLMENT.—

''(1) OPEN SEASON NOTIFICATION.—

''(A) MAILING OF NOTICE.—By September 30 of each year beginning after 2001, the Secretary shall mail a notice of eligibility to each MediHealth eligible individual and each individual entitled to benefits under part A prior to

the end of the annual open enrollment period described in section 1895G(b)(1).

"(B) NOTICE DESCRIBED.—The notice described in subparagraph (A) shall include an informational brochure that includes the information described in this section, and any other information that the Secretary determines will assist the individual's enrollment decision.

"(2) NOTIFICATION TO NEWLY MEDIHEALTH ELIGIBLE INDIVIDUALS.—With respect to an individual who becomes eligible to enroll in a MediHealth plan during the period described in section 1895G(b)(2)(A) and to whom paragraph (1) does not apply, the Secretary shall, not later than 2 months before the date on which the individual becomes eligible, mail to the individual the notice of eligibility described in paragraph (1).

"(d) SECRETARY'S MATERIALS; CONTENTS.—The notice and informational materials mailed by the Secretary under subsection (c) shall be written and formatted in the most easily understandable manner possible, and shall include, at a minimum, the following:

"(1) GENERAL INFORMATION.—General information with respect to coverage under this part during the next calendar year, including—

"(A) the part B premium rates that will be charged for part B coverage, and a statement of the fact that enrollees in MediHealth plans are not required to pay such premium,

"(B) the deductible, copayment, and coinsurance amounts for coverage under the traditional medicare program,

"(C) a description of the coverage under the traditional medicare program and any changes in coverage under the program from the prior year,

"(D) a description of the individual's medicare payment area, and the standardized medicare payment amount available with respect to such individual,

"(E) information and instructions on how to enroll in a MediHealth plan,

"(F) the right of each MediHealth plan sponsor by law to terminate or refuse to renew its contract and the effect the termination or nonrenewal of its contract may have on individuals enrolled with the MediHealth plan under this part,

''(G) appeal rights of enrollees, including the right to address grievances to the Secretary or the applicable external review entity, and

''(H) the benefits offered by plans in basic benefit plans under section 1895H(a), and how those benefits differ from the benefits offered under parts A and B.

''(2) COMPARATIVE REPORT.—A copy of the most recent comparative report (as established by the Secretary under subsection (e)) for the MediHealth plans in the individual's medicare payment area.

''(e) COMPARATIVE REPORT.—

''(1) IN GENERAL.—The Secretary shall develop an understandable standardized comparative report on the MediHealth plans offered by MediHealth plan sponsors, that will assist MediHealth eligible individuals in their decisionmaking regarding medical care and treatment by allowing such individuals to compare the MediHealth plans that such individuals are eligible to enroll with. In developing such report the Secretary shall consult with outside organizations, including groups representing the elderly, MediHealth plan sponsors, providers of services, and physicians and other health care professionals, in

order to assist the Secretary in developing the report.

''(2) REPORT.—The report described in paragraph (1) shall include a comparison for each MediHealth plan of—

''(A) the plan's medicare service area;

''(B) coverage by the plan of emergency services and urgently needed care;

''(C) the amount of any deductibles, coinsurance, or any monetary limits on benefits;

''(D) the number of individuals who disenrolled from the plan within 3 months of enrollment during the previous fiscal year (excluding individuals whose disenrollment was due to death or moving outside of the plan's service area) stated as percentages of the total number of individuals in the plan;

''(E) process, outcome, and enrollee satisfaction measures, as recommended by the Quality Advisory Institute (as established under section 302 of the Comprehensive Medicare Reform and Improvement Act of 1997);

''(F) information on access and quality of services obtained from the analysis described in section 302(c)(4) of such Act;

''(G) the procedures used by the plan to control utilization of services and expenditures, including any financial incentives;

''(H) the number of applications during the previous fiscal year requesting that the plan cover or pay for certain medical services that were denied by the plan (and the number of such denials that were subsequently reversed by the plan), stated as a percentage of the total number of applications during such period requesting that the plan cover such services;

''(I) the number of times during the previous fiscal year (after an appeal was filed with the Secretary) that the Secretary upheld or reversed a denial of a request that the plan cover certain medical services;

''(J) the restrictions (if any) on payment for services provided outside the plan's health care provider network;

''(K) the process by which services may be obtained through the plan's health care provider network;

''(L) coverage for out-of-area services;

"(M) any exclusions in the types of health care providers participating in the plan's health care provider network;

"(N) whether the plan is, or has within the past two years been, out-of-compliance with any requirements of this part (as determined by the Secretary);

"(O) the plan's premium price for the basic benefit plan submitted under section 1895N(a)(1), an indication of the difference between such premium price and the standardized medicare payment amount, and the portion of the premium an individual must pay out of pocket;

"(P) whether the plan offers any of the optional supplemental benefit plans described in section 1895H(b), and if so, the plan's premium price for the plan submitted under section 1895N(a)(1); and

"(Q) any additional information that the Secretary determines would be helpful for MediHealth eligible individuals to compare the MediHealth plans that such individuals are eligible to enroll with.

''(3) ADDITIONAL INFORMATION.—The comparative report shall also include—

''(A) a comparison of each MediHealth plan to the fee-for-service program under parts A and B;

''(B) an explanation of medicare supplemental policies under section 1882 and how to obtain specific information regarding such policies; and

''(C) a phone number for each MediHealth plan that will enable MediHealth eligible individuals to call to receive a printed listing of all health care providers participating in the plan's health care provider network.

''(4) UPDATE.—The Secretary shall, not less than annually, update each comparative report.

''(5) DEFINITIONS.—In this subsection—

''(A) HEALTH CARE PROVIDER.—The term 'health care provider' means anyone licensed under State law to provide health care services under part A or B.

''(B) NETWORK.—The term 'network' means, with respect to a MediHealth plan sponsor, the health care providers who have entered into a contract or agreement with the plan

sponsor under which such providers are obligated to provide items, treatment, and services under this section to individuals enrolled with the plan sponsor under this part.

''(C) OUT-OF-NETWORK.—The term 'out-of-network' means services provided by health care providers who have not entered into a contract agreement with the MediHealth plan sponsor under which such providers are obligated to provide items, treatment, and services under this section to individuals enrolled with the plan sponsor under this part.

''(6) COST SHARING.—Each MediHealth plan sponsor shall pay to the Secretary its pro rata share of the estimated costs incurred by the Secretary in carrying out the requirements of this section and section 4360 of the Omnibus Reconciliation Act of 1990. There are hereby appropriated to the Secretary the amount of the payments under this paragraph for purposes of defraying the cost described in the preceding sentence. Such amounts shall remain available until expended.

''(f) AGREEMENTS WITH COMMISSIONER OF SOCIAL SECURITY.—In order to promote the efficient administration of this section and this part, the Secretary may enter

into an agreement with the Commissioner of Social Security under which the Commissioner performs administrative responsibilities relating to enrollment and disenrollment under this section.

"SEC. 1895D. EFFECT OF ENROLLMENT.

"(a) PREMIUM DIFFERENTIALS.—If a MediHealth eligible individual enrolls in a MediHealth plan, the individual shall be required to pay—

"(1) 10 percent of the plan's premium;

"(2) if the premium of the plan is higher than the standardized payment amount (as determined under section 1895M), 100 percent of such difference; and

"(3) an amount equal to cost-sharing under the medicare fee-for-service program, except that such amount shall not exceed the actuarial value of the deductibles and coinsurance under such program less the actual value of nominal copayments for benefits under such plan for basic benefits described in section 1895H(a)(1).

"(b) PERIOD OF ENROLLMENT.—

"(1) ANNUAL ENROLLMENT PERIOD.—An individual enrolling in a MediHealth plan during the annual open enrollment period under section

1895G(b)(1) shall be enrolled in the plan for the calendar year following the open enrollment period.

''(2) SPECIAL ENROLLMENT PERIODS.—An individual enrolling in a plan under section 1895G(b)(2) shall be enrolled in the plan for the portion of the calender year on and after the date on which the enrollment becomes effective (as specified by the Secretary).

''(3) TERMINATIONS.—

''(A) IN GENERAL.—Except as otherwise provided in this subsection, an individual may not terminate enrollment in a MediHealth plan before the next annual open enrollment period applicable to the individual.

''(B) QUALIFYING EVENTS.—Notwithstanding subparagraph (A), an individual may terminate enrollment in a MediHealth plan if—

''(i) the individual moves to a new medicare service area, or

''(ii) the individual has experienced a qualifying event (as determined by the Secretary).

''(C) FOR CAUSE.—Notwithstanding subparagraph (A), an individual may terminate enrollment in a MediHealth plan if the plan fails

to meet quality or capacity standards or for other cause as determined by the Secretary.

''(D) TERMINATION AFTER INITIAL ENROLLMENT.—An individual may terminate enrollment in a MediHealth plan within 90 days of the individual's initial enrollment in such MediHealth plan and enroll in another MediHealth plan or the traditional medicare program.

''(4) SEAMLESS ENROLLMENT.—If a MediHealth eligible individual is enrolled in a MediHealth plan under this part and such individual fails to provide the Secretary with notice of the individual's enrollment or disenrollment under section 1895C(b)(1) during any open enrollment period applicable to the individual, the individual shall be deemed to have reenrolled in the plan.

''(c) SOLE PAYMENTS.—Subject to subsections (d)(2) and (e) of section 1895H, payments under a contract to a MediHealth plan under section 1895O shall be instead of the amounts which (in the absence of the contract) would be otherwise payable under the traditional medicare program for items or services furnished to individuals enrolled with the plan under this section.

''(d) PART B PREMIUM.—An individual enrolled in a MediHealth plan under this part shall not be required to pay the premium amount (determined under section 1839) under part B for so long as such individual is so enrolled.

"Subpart 3—MediHealth Plan Requirements

"SEC. 1895G. AVAILABILITY AND ENROLLMENT.

''(a) GENERAL AVAILABILITY.—

''(1) IN GENERAL.—Except as provided in paragraph (2), each MediHealth plan sponsor shall provide that each MediHealth eligible individual shall be eligible to enroll under this part in a MediHealth plan of the sponsor during an enrollment period applicable to such individual if the plan's medicare service area includes the geographic area in which the individual resides.

''(2) EXCEPTIONS.—Each MediHealth plan sponsor shall provide that, at any time during which enrollments are accepted, the plan sponsor will accept MediHealth eligible individuals in the order in which they apply for enrollment up to the limits of the MediHealth plan's certified capacity (as determined by the Secretary) and without restrictions, except as may be authorized in regulations. The preceding sentence shall not apply if it would result in

the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the medicare population in the medicare service area of the plan.

''(b) ENROLLMENT PERIODS.—

''(1) ANNUAL OPEN ENROLLMENT PERIOD.—Each MediHealth plan sponsor shall offer an annual open enrollment period in November of each year for the enrollment and termination of enrollment of MediHealth eligible individuals for the next year.

''(2) ADDITIONAL PERIODS.—Each MediHealth plan sponsor shall accept the enrollment of an individual in the MediHealth plan—

''(A) during the initial medicare enrollment period specified by section 1837 that applies to the individual (effective as specified by section 1838), and

''(B) during the period specified by the Secretary following any termination of the enrollment of the individual in a MediHealth plan under subparagraph (B), (C), or (D) of section 1895D(b)(3).

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

''(1) IN GENERAL.—In addition to any informational materials distributed by the Secretary under section 1895C(c), a MediHealth plan sponsor 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 MediHealth plan sponsor and any marketing strategy developed by such plan sponsor—

''(A) shall accurately describe differences between health care coverage available under the plan and the health care coverage available under the traditional medicare program,

''(B) shall be pursued in a manner not intended to violate the nondiscrimination requirement of section 1895J(e)(1),

''(C) 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, and

''(D) shall, for any written marketing materials, contain an explanation of the

MediHealth eligible individual's rights and responsibilities under this part and a copy of the most recent comparative report (as established by the Secretary under section 1895C) for any MediHealth plan offered by the plan sponsor in the individual's medicare payment area.

''(3) PRIOR APPROVAL BY SECRETARY.—

''(A) IN GENERAL.—No marketing materials may be distributed by a MediHealth plan sponsor to (or for the use of) individuals eligible to enroll with the plan under this part unless—

''(i) at least 45 days before its distribution, the plan has submitted the material to the Secretary for review, and

''(ii) the Secretary has not disapproved the distribution of the material.

''(B) REVIEW.—The Secretary shall review all marketing materials submitted under guidelines established by the Secretary and shall disapprove such material if the Secretary determines, in the Secretary's discretion, that the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.

"(C) DEEMED APPROVAL.—If marketing material has been submitted under subparagraph (A) to the Secretary or a regional office of the Department of Health and Human Services and the Secretary or the office has not disapproved the distribution of the materials under subparagraph (B) with respect to an area, the Secretary is deemed not to have disapproved such distribution in all areas covered by the plan, except for information specific to the service area.

"(d) RESTRICTION ON ENROLLMENT FOR CERTAIN MEDICARE CHOICE PLANS.—

"(1) IN GENERAL.—In the case of a Medicare Choice religious fraternal benefit society plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the society offering the plan may restrict the enrollment of individuals under this part to individuals who are members of the church, convention, or group described in paragraph (3)(B) with which the society is affiliated.

"(2) MEDICAREPLUS RELIGIOUS FRATERNAL BENEFIT SOCIETY PLAN DESCRIBED.—For purposes of this subsection, a Medicare Choice religious fra-

ternal benefit society plan described in this paragraph is a Medicare Choice plan described in section 1895A(b) that—

"(A) is offered by a religious fraternal benefit society described in paragraph (3) only to members of the church, convention, or group described in paragraph (3)(B); and

"(B) permits all such members to enroll under the plan without regard to health status-related factors.

Nothing in this subsection shall be construed as waiving any plan requirements relating to financial solvency. In developing solvency standards under section 1895I(c), the Secretary shall take into account open contract and assessment features characteristic of fraternal insurance certificates.

"(3) RELIGIOUS FRATERNAL BENEFIT SOCIETY DEFINED.—For purposes of paragraph (2)(A), a 'religious fraternal benefit society' described in this section is an organization that—

"(A) is exempt from Federal income taxation under section 501(c)(8) of the Internal Revenue Code of 1986;

"(B) is affiliated with, carries out the tenets of, and shares a religious bond with, a

church or convention or association of churches or an affiliated group of churches;

"(C) offers, in addition to a Medicare Choice religious fraternal benefit society plan, at least the same level of health coverage to individuals not entitled to benefits under this title who are members of such church, convention, or group; and

"(D) does not impose any limitation on membership in the society based on any health status-related factor.

"(4) PAYMENT ADJUSTMENT.—Under regulations of the Secretary, in the case of individuals enrolled under this part under a Medicare Choice religious fraternal benefit society plan described in paragraph (2), the Secretary shall provide for such adjustment to the payment amounts otherwise established under section 1895N as may be appropriate to assure an appropriate payment level, taking into account the actuarial characteristics and experience of such individuals.

"SEC. 1895H. BENEFITS PROVIDED TO INDIVIDUALS.

"(a) BASIC BENEFIT PLAN.—Each MediHealth plan shall provide to members enrolled under this part, through

providers and other persons that meet the applicable requirements of this title and part A of title XI—

''(1) those items and services covered under parts A and B of this title which are available to individuals residing in the medicare service area of the plan, subject to nominal copayments as determined by the Secretary,

''(2) prescription drugs, subject to such limits as established by the Secretary, and

''(3) additional health services as the Secretary may approve.

''(b) SUPPLEMENTAL BENEFITS.—

''(1) IN GENERAL.—Each MediHealth plan may offer any of the optional supplemental benefit plans described in paragraph (2) to an individual enrolled in the basic benefit plan offered by such organization under this part for an additional premium amount. If the supplemental benefits are offered only to individuals enrolled in the sponsor's plan under this part, the additional premium amount shall be the same for all enrolled individuals in the medicare payment area. Such benefits may be marketed and sold by the MediHealth plan sponsor outside of the enrollment process described in section 1895D(b).

''(2) OPTIONAL SUPPLEMENTAL BENEFIT PLANS DESCRIBED.—The Secretary shall provide for 2 optional supplemental benefit plans. Such plans shall include such standardized items and services that the Secretary determines must be provided to enrollees of such plans described in order to offer the plans to MediHealth eligible individuals.

''(3) LIMITATION.—A MediHealth plan sponsor may not offer an optional benefit plan to a MediHealth eligible individual unless such individual is enrolled in a basic benefit plan offered by such organization.

''(4) LIMITATION ON PREMIUM.—If a MediHealth plan sponsor provides to individuals enrolled in a MediHealth plan supplemental benefits described in paragraph (1), the sum of—

''(A) the annual premiums for such benefits, plus

''(B) the actuarial value of any deductibles, coinsurance, and copayments charged with respect to such benefits for the year,

shall not exceed the amount that would have been charged for a plan in the MediHealth payment area which is not a MediHealth plan (adjusted in such manner as the Secretary may prescribe to reflect

that only medicare beneficiaries are enrolled in such plan). The Secretary shall negotiate the limitation under this paragraph with each plan to which this paragraph applies.

''(c) NATIONAL COVERAGE DETERMINATION.—If there is a national coverage determination made in the period beginning on the date of an announcement under section 1895N(b) and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to the MediHealth plan of providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the determination of the medicare payment amount included in the announcement made at the beginning of such period—

''(1) such determination shall not apply to contracts under this part until the first contract year that begins after the end of such period, and

''(2) if such coverage determination provides for coverage of additional benefits or coverage under additional circumstances, section 1895I(b)(2) shall not apply to payment for such additional benefits or benefits provided under such additional cir-

cumstances until the first contract year that begins after the end of such period,

unless otherwise required by law.

''(d) OVERLAPPING PERIODS OF COVERAGE.—A contract under this part shall provide that in the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual's—

''(1) enrollment with a MediHealth plan under this part—

''(A) payment for such services until the date of the individual's discharge shall be made under this title as if the individual were not enrolled with the plan,

''(B) the plan sponsor shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

''(C) the plan sponsor shall nonetheless be paid the full amount otherwise payable to the plan under this part, or

''(2) termination of enrollment with a MediHealth plan under this part—

''(A) the plan sponsor shall be financially responsible for payment for such services after such date and until the date of the individual's discharge,

''(B) payment for such services during the stay shall not be made under section 1886(d), and

''(C) the plan sponsor shall not receive any payment with respect to the individual under this part during the period the individual is not enrolled.

''(e) ORGANIZATION AS SECONDARY PAYER.—Notwithstanding any other provision of law, a MediHealth plan sponsor may (in the case of the provision of services to an individual under this part under circumstances in which payment is made secondary pursuant to section 1862(b)(2)) charge or authorize the provider of such services to charge, in accordance with the charges allowed under the law, plan, or policy which is the primary payer under such circumstances—

''(1) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

''(2) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

''SEC. 1895I. LICENSING AND FINANCIAL REQUIREMENTS.

''(a) LICENSING REQUIREMENT.—

''(1) IN GENERAL.—A MediHealth plan sponsor shall be organized and licensed under applicable State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which the MediHealth plan enrolls individuals under this part.

''(2) COORDINATED CARE PLANS.—Paragraph (1) shall apply to a coordinated care plan except to the extent provided in section 1895R.

''(b) ASSUMPTION OF FULL FINANCIAL RISK.—A MediHealth plan sponsor shall assume full financial risk on a prospective basis for the provision of health care services for which benefits are required to be provided under paragraphs (1) and (2) of section 1895H(a)(1), except that such plan sponsor may—

''(1) obtain insurance or make other arrangements for the cost of such health care services the aggregate value of which exceeds $5,000 per person in any year,

''(2) obtain insurance or make other arrangements for the cost of such health care services provided to its enrolled members other than through the plan sponsor because medical necessity required their provision before they could be secured through the plan sponsor,

''(3) obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and

''(4) make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions.

''(c) PROTECTION AGAINST RISK OF INSOLVENCY.—

''(1) IN GENERAL.—A MediHealth plan sponsor shall make adequate provision against the risk of insolvency (including provision to prevent enrollees from being held liable to any person or entity for the plan sponsor's debts in the event of the plan sponsor's insolvency)—

''(A) as determined by the Secretary, or

"(B) as determined by a State which the Secretary determines requires solvency standards at least as stringent as the standards under subparagraph (A).

"(2) FACTORS TO CONSIDER.—In establishing standards under paragraph (1) for coordinated care plans described in section 1895A(b)(1)(B)(i), the Secretary shall consult with interested parties and shall take into account—

"(A) a coordinated care plan sponsor's delivery system assets and its ability to provide services directly to enrollees through affiliated providers, and

"(B) alternative means of protecting against insolvency, including reinsurance, unrestricted surplus, letters of credit, guarantees, organizational insurance coverage, and partnerships with other licensed entities.

The Secretary is not required to include alternative means described in subparagraph (B) in the standards but may consider such alternatives where consistent with the standards.

"(d) PAYMENTS TO THE PLAN.—

"(1) PREPAID PAYMENT.—A MediHealth plan sponsor shall be compensated (except for

deductibles, coinsurance, and copayments) for the provision of health care services to individuals enrolled under this part by a payment by the Secretary (and if applicable, the individual) which is paid on a periodic basis without regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided to a member.

''(2) SOLE PAYMENTS.—Subject to subsections (d)(2) and (e) of section 1895H, if an individual is enrolled under this part with a MediHealth plan, only the plan sponsor shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.

''SEC. 1895J. HEALTH PLAN STANDARDS.

''(a) IN GENERAL.—Each MediHealth plan sponsor shall meet the requirements of this section.

''(b) QUALITY ASSURANCE AND ACCREDITATION.—

''(1) CERTIFICATION.—Each MediHealth plan offered by a MediHealth plan sponsor shall be certified pursuant to title IV of the Comprehensive Medicare Reform and Improvement Act of 1997.

''(2) EXTERNAL REVIEW.—

''(A) IN GENERAL.—Each MediHealth plan sponsor shall, for each MediHealth plan it

operates, have an agreement with an independent quality review and improvement organization approved by the Secretary.

''(B) FUNCTIONS OF ORGANIZATION.—Each independent quality review and improvement organization with an agreement under subparagraph (A) shall—

''(i) provide an alternative mechanism for addressing enrollee grievances,

''(ii) review plan performance based on accepted quality performance criteria,

''(iii) promote and make plans accountable for improved plan performance,

''(iv) integrate into ongoing external quality assurance activities a new set of quality indicators and standards appropriate for the medicare population that would be used to determine whether a plan is providing quality care and appropriate continuity and coordination of care, and

''(v) report to the Secretary on those plans that have demonstrated unwillingness or inability to improve their performance.

''(c) ACCESS.—Each MediHealth plan sponsor shall—

''(1) make the services described in section 1895H(a) (and such other health care services as such individuals have contracted for) either directly or indirectly through providers and other persons that meet the applicable requirements of this title and part A of title XI—

''(A) available and accessible to each such individual, within the medicare service area of the plan, with reasonable promptness, and in a manner which assures continuity, and

''(B) when medically necessary, available and accessible 24 hours a day and 7 days a week,

''(2) provide for reimbursement with respect to such services which are provided to such an individual other than through the plan's providers, if—

''(A) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition, and

''(B) it was not reasonable given the circumstances to obtain the services through the plan's providers,

''(3) provide access to appropriate providers, including credentialed specialists, for all medically necessary treatment and services, and

''(4) except as provided by the Secretary on a case-by-case basis, in the case of a coordinated care plan described in section 1895A(b)(1)(B)(i), provide primary care services within 30 minutes or 30 miles from an enrollee's place of residence if the enrollee resides in a rural area.

''(d) CAPACITY.—Each MediHealth plan sponsor shall provide the Secretary with a demonstration of the plan's capacity to adequately service the plan's expected enrollment of individuals under this part.

''(e) CONSUMER PROTECTIONS.—

''(1) NONDISCRIMINATION.—Each MediHealth plan sponsor shall provide assurances to the Secretary that it will not deny enrollment to, expel, or refuse to reenroll any such 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. A MediHealth plan sponsor may not cancel or refuse to renew a beneficiary except in the case of fraud or nonpayment of premium amounts due

the plan, or other circumstances specified by the Secretary.

''(2) GRIEVANCE PROCEDURES.—

''(A) IN GENERAL.—Each MediHealth plan sponsor shall provide meaningful procedures for hearing and resolving grievances between the plan (including any entity or individual through which the plan provides health care services) and members enrolled with the plan under this part.

''(B) COVERAGE DETERMINATIONS AND APPEALS.—

''(i) DETERMINATION BY ORGANIZATION.—A MediHealth plan sponsor shall have a procedure for determining whether an individual enrolled with the organization under this part is entitled to receive a benefit described in section 1851H and the amount (if any) that the individual is required to pay for that benefit, which includes the following elements:

''(I) RECONSIDERATION.—The organization shall provide for reconsideration of an initial adverse determination.

"(II) EXPEDITED DETERMINATIONS IN URGENT CASES.—The organization shall have an expedited process for determinations and reconsiderations in cases in which delayed treatment could seriously jeopardize the life or health of the individual, or the individual's ability to regain maximum function.

"(III) TIME LIMITS.—The Secretary may establish time limitations for determinations and reconsiderations under this clause.

"(ii) REVIEW BY EXTERNAL CONTRACTOR.—The Secretary shall establish procedures for the independent review of reconsiderations under clause (i) that are adverse to the individual.

"(iii) APPEAL TO SECRETARY.—An individual dissatisfied with a determination under clause (ii) concerning the individual's coverage under a plan under this part is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in

section 205(b), and in such a hearing the Secretary shall make the MediHealth plan sponsor a party. If the amount in controversy is $1,000 or more, the individual or sponsor, upon notifying the other party, shall be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the sponsor shall be entitled to be parties to that judicial review. In applying sections 205(b) and 205(g) as provided in this paragraph, and in applying section 205(l) thereto, any reference to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

''(3) SUPPLEMENTAL COVERAGE IF PLAN TERMINATES THE CONTRACT.—Each MediHealth plan sponsor that provides items and services pursuant to a contract under this part shall provide assurances to the Secretary that in the event the contract is terminated, the sponsor shall provide or arrange for supplemental coverage of benefits under this title re-

lated to a preexisting condition with respect to any exclusion period, to all individuals enrolled with the entity who receive benefits under this title, for the lesser of 6 months or the duration of such period.

''(f) PROMPT PAYMENT.—

''(1) IN GENERAL.—Each MediHealth plan sponsor shall provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for services and supplies furnished to individuals pursuant to such contract, if the services or supplies are not furnished under a contract between the plan and the provider or supplier.

''(2) DIRECT PAYMENT.—In the case of a MediHealth plan sponsor which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with paragraph (1), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for such covered services furnished to individuals enrolled under this part under the contract. If the Secretary provides for such direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the plan sponsor under this part to reflect

the amount of the Secretary's payments (and costs incurred by the Secretary in making such payments).

''(g) MINIMUM PRIVATE ENROLLMENT.—The MediHealth plan sponsor shall have at least 5,000 enrollees that are not eligible for benefits under this title or under title XIX, except that the Secretary may waive such requirement—

''(1) if the MediHealth plan sponsor primarily serves enrollees residing outside urban areas; or

''(2) in situations and under conditions that the Secretary determines are in the best interest of individuals entitled to benefits under this title.

''SEC. 1895K. MEDIHEALTH PLANS IN RURAL AREAS.

''(a) IN GENERAL.—The Secretary may waive or modify any requirement of a MediHealth plan under this part for a MediHealth plan that is offered in a rural area (as defined in section 1886(d)(2)(D)) to—

''(1) reflect any differences between the provision of health care items and services in rural and nonrural areas; and

''(2) encourage organizations to offer MediHealth plans in rural areas.

''(b) QUALITY.—If the Secretary waives or modifies any requirement of a MediHealth plan pursuant to sub-

section (a), the Secretary shall ensure that such waiver or modification does not undermine the quality of the health care items and services provided under such plan.

"Subpart 4—Office of Competition; Determination of Medicare Payment Amounts

"SEC. 1895M. OFFICE OF COMPETITION.

''(a) ESTABLISHMENT.—There is established within the Department of Health and Human Services an office to be known as the 'Office of Competition'.

''(b) DIRECTOR.—The Secretary shall appoint the Director of the Office of Competition.

''(c) DUTIES.—

''(1) IN GENERAL.—The Director shall administer this part and section 1876.

''(2) TRANSFER AUTHORITY.—The Secretary shall transfer such personnel, administrative support systems, assets, records, funds, and other resources in the Health Care Financing Administration to the Office of Competition as are used in the administration of section 1876 and as may be required to implement the provisions of this part promptly and efficiently.

''(d) USE OF NON-FEDERAL ENTITIES.—The Secretary shall, to the maximum extent feasible, enter into

contracts with appropriate non-Federal entities to carry out activities under this part.

"SEC. 1895N. STANDARDIZED MEDICARE PAYMENT AMOUNTS.

"(a) SUBMISSION AND CHARGING OF PREMIUMS.—

"(1) IN GENERAL.—Not later than June 1 of each calendar year, each MediHealth plan sponsor shall file with the Secretary, in a form and manner and at a time specified by the Secretary, a bid which contains the amount of the monthly premium for coverage under each MediHealth plan it offers under this part in each medicare payment area in which the plan is being offered.

"(2) UNIFORM PREMIUM.—The premiums charged by a MediHealth plan sponsor under this part may not vary among individuals who reside in the same medicare payment area.

"(3) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each MediHealth plan sponsor shall permit the payment of premiums on a monthly basis.

"(b) ANNOUNCEMENT OF STANDARDIZED MEDICARE PAYMENT AMOUNTS.—

"(1) AUTHORITY TO NEGOTIATE.—After bids are submitted under subsection (a), the Secretary

may negotiate with MediHealth plan sponsors in order to modify such bids if the Secretary determined that the bids do not provide enough revenues to ensure the plan's actuarial soundness, are too high relative to the medicare payment area, foster adverse selection, or otherwise require renegotiation under this paragraph.

''(2) IN GENERAL.—Not later than July 31 of each calendar year (beginning with 2002), the Secretary shall determine, and announce in a manner intended to provide notice to interested parties, a standardized medicare payment amount determined in accordance with this section for the following calendar year for each medicare payment area.

''(c) CALCULATION OF STANDARDIZED MEDICARE PAYMENT AMOUNTS.—

''(1) IN GENERAL.—The standardized medicare payment amount for a calendar year after 2002 for any medicare payment area shall be equal to the maximum premium determined for such area under paragraph (2).

''(2) MAXIMUM PREMIUM.—The maximum premium for any medicare payment area shall be equal to the amount determined under paragraph (3) for

the payment area, but in no case shall such amount be greater than the sum of—

''(A) the average per capita amount, as determined by the Secretary as appropriate for the population eligible to enroll in MediHealth plans in such payment area, for such calendar year that the Secretary would have expended for an individual in such payment area enrolled under the medicare fee-for-service program under parts A and B, plus

''(B) the amount equal to the actuarial value of deductibles, coinsurance, and copayments charged an individual for services provided under the medicare fee-for-service program (as determined by the Secretary).

''(3) DETERMINATION OF AMOUNT.—

''(A) IN GENERAL.—The Secretary shall determine for each medicare payment area for each calendar year an amount equal to the average of the bids (weighted based on capacity) submitted to the Secretary under subsection (a)(1) for that payment area.

''(B) DISREGARD CERTAIN PLANS.—In determining the amount under subparagraph (A), the Secretary may disregard any plan that the

Director determines would unreasonably distort the amount determined under such subparagraph.

''(d) ADJUSTMENTS FOR PAYMENTS TO PLAN SPONSORS.—

''(1) IN GENERAL.—For purposes of determining the amount of payment under section 1895O to a MediHealth plan sponsor with respect to any MediHealth eligible individual enrolled in a MediHealth plan of the sponsor, the standardized medicare payment amount for the medicare payment area and the premium charged by the plan sponsor shall be adjusted with respect to such individual for such risk factors as age, disability status, gender, institutional status, health status, and such other factors as the Secretary determines to be appropriate, so as to ensure actuarial equivalence. The Secretary may add to, modify, or substitute for such classes, if such changes will improve the determination of actuarial equivalence.

''(2) RECOMMENDATIONS.—

''(A) IN GENERAL.—In addition to any other duties required by law, the Physician Payment Review Commission and the Prospec-

tive Payment Assessment Commission shall each develop recommendations on—

"(i) the risk factors that the Secretary should use in adjusting the standardized medicare payment amount and premium under paragraph (1), and

"(ii) the methodology that the Secretary should use in determining the risk factors to be used in adjusting the standardized medicare payment amount and premium under paragraph (1).

"(B) TIME.—The recommendations described in subparagraph (A) shall be developed not later than January 1, 1999.

"(C) ANNUAL REPORT.—The Physician Payment Review Commission and the Prospective Payment Assessment Commission shall include the recommendations described in subparagraph (A) in their respective annual reports to Congress.

"SEC. 1895O. PAYMENTS TO PLAN SPONSORS.

"(a) MONTHLY PAYMENTS.—

"(1) IN GENERAL.—Subject to subsection (d), for each individual enrolled with a plan under this part, the Secretary shall make monthly payments in

advance to the MediHealth plan sponsor of the MediHealth plan with which the individual is enrolled in an amount equal to 1/12 of the amount determined under subsection (b).

''(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.

''(b) AMOUNT OF PAYMENT TO MEDIHEALTH PLANS.—The amount determined under this subsection with respect to any individual shall be equal to the sum of—

''(1) the lesser of—

''(A) the standardized medicare payment amount for the medicare payment area, as adjusted for such individual under section 1895N(d), or

''(B) the premium charged by the plan for such individual, as adjusted for such individual under section 1895N(d), minus

''(2) the amount such individual paid to the plan pursuant to section 1895D(a)(1) (relating to 10 percent of the premium).

''(c) PAYMENTS FROM TRUST FUNDS.—The payment to a MediHealth plan sponsor or to a MediHealth account under this section for a medicare-eligible individual shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under parts A and B are representative of the actuarial value of the total benefits under this part.

''(d) LIMITATION ON AMOUNTS AN OUT-OF-PLAN PHYSICIAN OR OTHER ENTITY MAY COLLECT.—

''(1) IN GENERAL.—A physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with an eligible organization shall accept as payment in full for services that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this title (but

not enrolled with an eligible organization under this part) also applies with respect to an individual so enrolled.

''(2) CROSS REFERENCE.—For similar requirements applicable to providers of services, see section 1866(a)(1)(O).

''Subpart 5—Contractual Authority; Temporary Licensing; Regulations

''SEC. 1895P. GENERAL PERMISSION TO CONTRACT.

''The Secretary shall enter into a contract with any MediHealth plan sponsor in a medicare payment area if the requirements of this part are met with respect to the MediHealth plan and the plan sponsor.

''SEC. 1895Q. RENEWAL AND TERMINATION OF CONTRACT.

''(a) IN GENERAL.—Except as provided in subsection (b), each contract under this part may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term.

''(b) TERMINATION FOR CAUSE.—

''(1) IN GENERAL.—In accordance with procedures established under paragraph (2), the Secretary may terminate any contact with a MediHealth plan sponsor at any time or may impose the intermediate sanctions described in paragraph (2) or (3) or sub-

section (f) (whichever is applicable) on the plan sponsor, if the Secretary finds that the plan sponsor—

"(A) has failed substantially to carry out the contract,

"(B) is carrying out the contract in a manner substantially inconsistent with the efficient and effective administration of this part, or

"(C) no longer substantially meets the applicable conditions of this part.

"(2) PROCEDURES.—The Secretary may terminate a contract with a MediHealth plan sponsor under this part in accordance with formal investigation and compliance procedures established by the Secretary under which—

"(A) the Secretary first provides the MediHealth plan sponsor with the reasonable opportunity to develop and implement a corrective action plan to correct the deficiencies that were the basis of the Secretary's determination under paragraph (1) and the MediHealth plan sponsor fails to develop or implement such a corrective action plan, and

"(B) the Secretary provides the plan sponsor with reasonable notice and opportunity for

hearing (including the right to appeal an initial decision) before imposing any sanction or terminating the contract.

''(c) TERMS OF CONTRACT.—Each contract under this part shall—

''(1) provide that the Secretary, or any person or organization designated by the Secretary—

''(A) shall have the right to inspect or otherwise evaluate—

''(i) the quality, appropriateness, and timeliness of services performed under the contract, and

''(ii) the facilities of the plan sponsor when there is reasonable evidence of some need for such inspection,

''(B) shall have the right to audit and inspect any books and records of the plan sponsor that pertain to the ability of the plan sponsor to bear the risk of potential financial losses,

''(2) require the plan sponsor with a contract to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled under this part with the plan sponsor,

''(3) except as provided by the Secretary, require the plan sponsor to comply with requirements similar to the requirements of subsections (a) and (c) of section 1318 of the Public Health Service Act (relating to disclosure of certain financial information) and section 1301(c)(8) of such Act (relating to liability arrangements to protect members),

''(4) require the plan sponsor to provide and supply information (described in section 1866(b)(2)(C)(ii)) in the manner such information is required to be provided or supplied under that section,

''(5) require the plan sponsor to notify the Secretary of loans and other special financial arrangements which are made between the plan sponsor and subcontractors, affiliates, and related parties, and

''(6) contain such other terms and conditions not inconsistent with this part (including requiring the plan sponsor to provide the Secretary with such information) as the Secretary may find necessary and appropriate.

''(d) 5-YEAR LOCKOUT.—The Secretary may not enter into a contract under this part with a MediHealth plan sponsor if a previous contract with that plan sponsor under this part was terminated at the request of the plan

sponsor within the preceding 5-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

''(e) APPLICATION OF OTHER FEDERAL LAWS.—The authority vested in the Secretary by this part may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

''(f) REMEDIES FOR FAILURE TO COMPLY.—

''(1) FAILURE OF PLAN SPONSOR TO COMPLY WITH CONTRACT.—If the Secretary determines that a MediHealth plan sponsor—

''(A) fails substantially to provide medically necessary items and services that are required (under law or under the contract) to be provided to an individual covered under the contract, and the failure has adversely affected (or has substantial likelihood of adversely affecting) the individual,

''(B) imposes cost-sharing on individuals enrolled under this part in excess of the cost-sharing permitted,

''(C) acts to expel or to refuse to reenroll an individual in violation of the provisions of this part,

''(D) engages in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment (except as permitted by this part) by eligible individuals with the plan whose medical condition or history indicates a need for substantial future medical services,

''(E) misrepresents or falsifies information that is furnished—

''(i) to the Secretary under this section, or

''(ii) to an individual or to any other entity under this section,

''(F) fails to comply with the requirements of section 1895J(f), or

''(G) employs or contracts with any individual or entity that is excluded from participation under this title under section 1128 or 1128A for the provision of health care, utilization review, medical social work, or administrative services or employs or contracts with any entity for the provision (directly or indirectly)

through such an excluded individual or entity of such services,

the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2).

''(2) REMEDIES.—The remedies described in this paragraph are—

''(A) civil money penalties of not more than $25,000 for each determination under paragraph (1) or, with respect to a determination under subparagraph (D) or (E)(i) of such paragraph, of not more than $100,000 for each such determination, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such subparagraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(D), $15,000 for each individual not enrolled as a result of the practice involved,

''(B) suspension of enrollment of individuals under this section after the date the Secretary notifies the plan sponsor of a determination under paragraph (1) and until the Sec-

retary is satisfied that the basis for such determination has been corrected and is not likely to recur, or

''(C) suspension of payment to the plan sponsor under this section for individuals enrolled after the date the Secretary notifies the plan sponsor of a determination under paragraph (1) and until the Secretary is satisfied that the basis for such determination has been corrected and is not likely to recur.

''(3) INTERMEDIATE SANCTIONS.—In the case of a MediHealth plan sponsor for which the Secretary makes a determination under subsection (b)(1) the basis of which is not described in subparagraph (A) thereof, the Secretary may apply the following intermediate sanctions:

''(A) Civil money penalties of not more than $25,000 for each determination under subsection (b)(1) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the plan's contract.

''(B) Civil money penalties of not more than $10,000 for each week beginning after the

initiation of procedures by the Secretary under subsection (b)(2) during which the deficiency that is the basis of a determination under subsection (b)(1) exists.

''(C) Suspension of enrollment of individuals under this section after the date the Secretary notifies the plan sponsor of a determination under subsection (b)(1) and until the Secretary is satisfied that the deficiency that is the basis for the determination has been corrected and is not likely to recur.

''(4) PROCEEDINGS.—The provisions of section 1128A (other than subsections (a), (b), and (m)) shall apply to a civil money penalty under paragraph (2)(A) or (3)(A) in the same manner as they apply to a civil money penalty or proceeding under section 1128A(a).

''SEC. 1895R. TEMPORARY LICENSING PROCESS FOR COORDINATED CARE PLANS.

''(a) FEDERAL ACTION ON LICENSING.—

''(1) IN GENERAL.—If—

''(A) a State fails to substantially complete action on a licensing application of a coordinated care plan sponsor within 120 days of receipt of the completed application, or

''(B) a State denies a licensing application and the Secretary determines that the State's licensing standards or review process create an unreasonable barrier to market entry,

the Secretary shall evaluate such application pursuant to the procedures established under subsection (b).

''(2) UNREASONABLE BARRIERS TO MARKET ENTRY.—A State's licensing standards and review process shall not be treated as unreasonable barriers to market entry under paragraph (1) if they—

''(A) are applied on a nondiscriminatory basis to all coordinated care MediHealth plan applications, and

''(B) are not directly in conflict, or inconsistent with, the Federal standards.

''(b) FEDERAL LICENSING PROCEDURES.—

''(1) IN GENERAL.—The Secretary shall establish a process for the licensing of a coordinated care plan and its sponsor as meeting the requirements of this part in cases described in subsection (a)(1).

''(2) REQUIREMENTS.—Such process shall—

''(A) set forth the standards for the licensing,

''(B) provide that final action will be taken on an application for licensing within 120 business days of receipt of the completed application,

''(C) provide that State law and regulations shall apply to the extent they have not been found to be an unreasonable barrier to market entry under subsection (a)(1)(B), and

''(D) require any person receiving a license to provide the Secretary with all reasonable information in order to ensure compliance with the licensing.

''(3) EFFECT OF LICENSING.—

''(A) IN GENERAL.—A license under this section shall be issued for not more than 36 months and may not be renewed.

''(B) COORDINATION WITH STATE.—A person receiving a license under this section shall continue to seek State licensure under subsection (a) during the period the license is in effect.

''(C) SUNSET.—No license shall be issued under this section after December 31, 2006, and no license under this section shall remain in effect after December 31, 2007.

''(c) REPORT.—Not later than December 31, 2004, the Secretary shall report to Congress on the temporary Federal licensing system under subsection (b), including an analysis of State efforts to adopt licensing standards and review processes that take into account the fact that coordinated care plan sponsors provide services directly to enrollees through affiliated providers.

''(d) COORDINATED CARE PLAN.—In this section, the term 'coordinated care plan' means a plan described in section 1895A(b)(1)(B)(i).

''(e) TRANSITION RULE FOR CERTAIN RISK CONTRACTORS.—A MediHealth plan sponsor that is an eligible organization (as defined in section 1876(b)) and that—

''(1) has a risk-sharing contract in effect under section 1876 as of the date of enactment of this part, or

''(2) has an application for such a contract filed before such date and the contract is entered into before July 1, 2002,

shall be treated as meeting the Federal standards in effect under this section for any contract year beginning before January 1, 2006.

''SEC. 1895S. REGULATIONS.

''(a) IN GENERAL.—The Secretary shall establish such regulations as may be necessary to carry out the pur-

poses of this part, including regulations setting forth the requirements to meet all quality, access, and solvency standards specified in sections 1895I and 1895J.

''(b) USE OF INTERIM, FINAL REGULATIONS.—In order to carry out the provisions of this part in a timely manner, the Secretary may, within 120 days after the date of enactment of this part, promulgate regulations described in subsection (a) that take effect on an interim basis, after notice and opportunity for public comment.''.

(b) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—Not later than 90 days after the date of 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 chapter.

(2) OTHER AMENDMENTS.—(A) Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended—

(i) in the matter preceding clause (i), by inserting ''or MediHealth plan under part D'' after ''eligible organization'', and

(ii) in clause (i), by inserting ''or under a contract under part D,'' after ''1972,''.

(B) Section 1882(g)(1) (42 U.S.C. 1395ww(g)(1)) is amended in the first sentence by inserting ", or under a MediHealth plan under part D" before the end period.

(C) Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following:

"(h) An individual enrolled in a MediHealth plan under part D shall not be required to pay the premium (determined under this section) under this part for so long as the individual is so enrolled.".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to contracts effective on and after January 1, 2003.

SEC. 102. TREATMENT OF 1876 ORGANIZATIONS.

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

"(k)(1) Except as provided in paragraph (2), this section shall not apply to risk-sharing contracts effective for contract years beginning on or after January 1, 2003.

"(2) An individual who is enrolled in part B only and is enrolled in an eligible organization with a risk-sharing contract under this section on December 31, 2002, may continue enrollment in such organization. Not later than July 1, 2002, the Secretary shall issue regulations relating to such individuals and such organizations.".

SEC. 103. MEDIHEALTH DEMONSTRATION PROJECTS.

(a) DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—The Secretary shall conduct demonstration projects in applicable areas, as defined in paragraph (2), for the purpose of conducting a demonstration project as described in paragraph (3). Such projects shall provide for payments under the projects to begin on January 1, 1999.

(2) APPLICABLE AREA DEFINED.—In paragraph (1), the term ''applicable area'' means, as determined by the Secretary of Health and Human Services—

(A) 10 urban areas with respect to which less than 25 percent of medicare beneficiaries are enrolled with an eligible organization under section 1876 of the Social Security Act (42 U.S.C. 1395mm); and

(B) 3 rural areas not described in subparagraph (A).

(3) DEMONSTRATION PROJECT.—A demonstration project described in this paragraph is a demonstration project that implements the amendments made to title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) by this Act, as if such amendments had become effective on the date of enactment of this Act.

(b) REPORT TO CONGRESS.—

(1) IN GENERAL.—Not later than December 31, 2000, the Secretary shall submit to the President a report regarding the demonstration projects conducted under this section.

(2) CONTENTS OF REPORT.—The report described in paragraph (1) shall include the following:

(A) A description of the demonstration projects conducted under this section.

(B) An evaluation of the effectiveness of the demonstration projects conducted under this section and any legislative recommendations determined appropriate by the Secretary.

(C) Any other information regarding the demonstration projects conducted under this section that the Secretary determines to be appropriate.

(D) An evaluation as to whether the method of payment under section 1895N of the Social Security Act (as added by section 101) which was used in the demonstration projects for payment to MediHealth plans should be extended to the entire medicare population and if such evaluation determines that such method should not be extended, legislative recommenda-

tions to modify such method so that it may be applied to the entire medicare population.

(3) SUBMISSION TO CONGRESS.—The President shall submit the report under paragraph (2) to the Congress and if the President determines appropriate, an implementing bill with respect to any legislative recommendations under paragraph (2) (B) or (D).

(4) EXPEDITED CONGRESSIONAL CONSIDERATION OF LEGISLATION.—

(A) IN GENERAL.—An implementing bill submitted under paragraph (3) shall—

(i) not later than 3 days after it is submitted, be introduced (by request) in the House of Representatives by the Majority Leader of the House and shall be introduced (by request) in the Senate by the Majority Leader of the Senate; and

(ii) be given expedited consideration under the same provisions and in the same way, subject to subparagraph (B), as a joint resolution under section 2908 of the Defense Base Closure and Realignment Act of 1990 (10 U.S.C. 2678 note).

(B) SPECIAL RULES.—For purposes of applying subparagraph (A) with respect to such provisions, the following rules shall apply:

(i) Section 2908(a) of the Defense Base Closure and Realignment Act of 1990 (10 U.S.C. 2678 note) shall not apply.

(ii) Any reference to the resolution described in subparagraph (A) shall be deemed to be a reference to the bill submitted under paragraph (3).

(iii) Any reference to the Committee on National Security of the House of Representatives shall be deemed to be a reference to the Committee on Ways and Means of the House of Representatives and any reference to the Committee on Armed Services of the Senate shall be deemed to be a reference to the Committee on Finance of the Senate.

(iv) Any reference to the date on which the President transmits a report shall be deemed to be a reference to the date on which the implementing bill is submitted under paragraph (3).

(v) Notwithstanding section 2908(d)(2) of the Act—

(I) debate on the bill in the House of Representatives, and on all debatable motions and appeals in connection with the bill, shall be limited to not more than 10 hours, divided equally between those favoring and those opposing the bill;

(II) debate on the bill in the Senate, and on all debatable motions and appeals in connection with the bill, shall be limited to not more than 10 hours, divided equally between those favoring and those opposing the bill; and

(III) debate in the Senate on any single debatable motion and appeal in connection with the bill shall be limited to not more than 1 hour, divided equally between the proponent of the motion and the manager of the bill, except that if the manager of the bill is in favor of the motion or appeal, the time in opposition to the motion

or appeal shall be controlled by the Minority Leader or the Leader's designee, and the Majority and Minority Leader may each allot additional time from time under such Leader's control to any Senator during the consideration of any debatable motion or appeal.

(c) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of titles XI, XVIII, and XIX of the Social Security Act (42 U.S.C. 1301 et seq., 1395 et seq., 1396 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects under this section.

(d) DURATION.—A demonstration project under this section shall be conducted for a period to be determined by the Secretary of Health and Human Services except that the demonstration project shall not be conducted after December 31, 2002. The Secretary may terminate a project if the Secretary determines that the consortium conducting the project is not in substantial compliance with the terms of the application approved by the Secretary.

(e) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund

and the Federal Supplementary Insurance Trust Fund under title XVIII of the Social Security Act (42 U.S.C. 1395i, 1395t), in such proportions as the Secretary determines to be appropriate, of such funds as are necessary for the costs of carrying out the demonstration projects under this section.

TITLE II—INCREASE IN FLEXIBILITY UNDER MEDICARE

SEC. 201. COMPETITIVE BIDDING.

(a) GENERAL RULE.—Part B of title XVIII (42 U.S.C. 1395j et seq.) is amended by inserting after section 1846 the following:

"SEC. 1847. COMPETITIVE ACQUISITION OF ITEMS AND SERVICES.

''(a) ESTABLISHMENT OF BIDDING AREAS.—

''(1) IN GENERAL.—The Secretary shall establish competitive acquisition areas for contract award purposes for the furnishing under this part of the items and services described in subsection (c). The Secretary may establish different competitive acquisition areas under this subsection for different classes of items and services.

''(2) CRITERIA FOR ESTABLISHMENT.—The competitive acquisition areas established under paragraph (1) shall be chosen based on the availability

and accessibility of entities able to furnish items and services, and the probable savings to be realized by the medicare program established under this title from the use of competitive bidding in the furnishing of items and services in the area.

''(b) AWARDING OF CONTRACTS IN AREAS.—

''(1) IN GENERAL.—The Secretary shall conduct a competition among individuals and entities supplying items and services described in subsection (c) for each competitive acquisition area established under subsection (a) for each class of items and services.

''(2) CONDITIONS FOR AWARDING CONTRACT.—The Secretary may not award a contract to any entity under the competition conducted pursuant to paragraph (1) to furnish an item or service unless the Secretary finds that the entity meets quality standards specified by the Secretary, and that the total amounts to be paid under the contract are expected to be less than the total amounts that would otherwise be paid.

''(3) CONTENTS OF CONTRACT.—A contract entered into with an individual or an entity under the competition conducted pursuant to paragraph (1) is

subject to terms and conditions that the Secretary may specify.

''(4) LIMIT ON NUMBER OF CONTRACTORS.—The Secretary may limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for items and services covered under the contracts.

''(c) SERVICES DESCRIBED.—The items and services to which this section applies are all items and services covered under this part (except for physician services as defined in section 1861(r)) that the Secretary may specify.''.

(b) ITEMS AND SERVICES TO BE FURNISHED ONLY THROUGH COMPETITIVE ACQUISITION.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) by striking ''or'' at the end of paragraph (15),

(2) by striking the period at the end of paragraph (16) and inserting ''; or'', and

(3) by inserting after paragraph (16) the following:

''(17) where the expenses are for an item or service furnished in a competitive acquisition area (as established by the Secretary under section 1847(a)) by an entity other than an entity with which the Secretary has entered into a contract

under section 1847(b) for the furnishing of such an item or service in that area, unless the Secretary finds that the expenses were incurred in a case of urgent need, or in other circumstances specified by the Secretary.''.

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) shall apply to items and services furnished on and after October 1, 1997.

SEC. 202. FLEXIBLE PURCHASING.

Title XVIII (42 U.S.C. 1395 et seq.) is amended by adding at the end the following:

''FLEXIBLE PURCHASING

''SEC. 1894. (a) IN GENERAL.—The Secretary may enter into contracts with providers of services, physicians, and other entities and individuals that furnish items or services under the medicare program established under this title under which the Secretary may utilize—

''(1) alternative claims processing, administrative, and related procedures; and

''(2) reduced payment rates or alternative payment methodologies.

''(b) SAVINGS TO BENEFICIARIES.—Contracts under this section may provide for reductions in payments required from individuals entitled to benefits under this title.

''(c) REQUIREMENTS UNDER A CONTRACT UNDER THIS SECTION.—The following requirements shall apply to any contract entered into pursuant to this section:

''(1) The provisions of subtitle B of title XI, other provisions concerned with quality of care, and conditions of participation shall apply unchanged.

''(2) The Secretary shall certify that the amounts to be paid under such a contract are less than the amounts that otherwise would be paid under this title.

''(3) Individuals entitled to benefits under this title may not be required to pay more for services provided pursuant to such a contract than the amounts that such individuals would otherwise be required to pay under this title.

''(4) The contract shall be for a fixed term (but may be renewed).

''(5) The terms of the contract shall be subject to periodic review by the Secretary.

''(d) WAIVER OF COMPETITION REQUIREMENTS.—The Secretary may waive the applicability of any otherwise applicable competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5)) to any contract entered into under this section.''.

SEC. 203. REPORT ON USE OF NEW AUTHORITIES.

(a) IN GENERAL.—Not later than 2 years after the date of enactment of this Act, and biennially thereafter for 6 years, the Secretary of Health and Human Services shall report to Congress on the implementation and results of the amendments made to title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) by this title.

(b) CONTENTS OF REPORT.—Each report described in subsection (a) shall contain a detailed description of the impact of such amendments on expenditures for, access to, and quality of items and services provided under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

TITLE III—QUALITY IN MEDIHEALTH PLANS

SEC. 301. DEFINITIONS.

In this title:

(1) COMPARATIVE REPORT.—The term ''comparative report'' means the comparative report developed under section 1895C(e) of the Social Security Act (as added by section 101 of this Act).

(2) DIRECTOR.—The term ''Director'' means the Director of the Office of Competition within the Department of Health and Human Services as established under section 1895M(a) of the Social Security Act (as added by section 101 of this Act).

(3) MEDICARE PROGRAM.—The term ''medicare program'' means the program of health care benefits provided under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(4) MEDIHEALTH PLAN.—The term ''MediHealth plan'' has the meaning given the term in section 1895A(a)(1) of the Social Security Act (as added by section 101 of this Act).

(5) MEDIHEALTH PLAN SPONSOR.—The term ''MediHealth plan sponsor'' has the meaning given the term in section 1895A(a)(2) of the Social Security Act (as added by section 101 of this Act).

SEC. 302. QUALITY ADVISORY INSTITUTE.

(a) ESTABLISHMENT.—There is established an Institute to be known as the ''Quality Advisory Institute'' (in this title referred to as the ''Institute'') to make recommendations to the Director concerning licensing and certification criteria and comparative measurement methods under this title.

(b) MEMBERSHIP.—

(1) COMPOSITION.—The Institute shall be composed of 5 members to be appointed by the Director from among individuals who have demonstrable expertise in—

(A) health care quality measurement;

(B) health plan certification criteria setting;

(C) the analysis of information that is useful to consumers in making choices regarding health coverage options, health plans, health care providers, and decisions regarding health treatments; and

(D) the analysis of health plan operations.

(2) TERMS AND VACANCIES.—The members of the Institute shall be appointed for 5-year terms with the terms of the initial members staggered as determined appropriate by the Director. Vacancies shall be filled in a manner provided for by the Director.

(c) DUTIES.—The Institute shall—

(1) not later than 1 year after the date on which all members of the Institute are appointed under subsection (b)(2), provide advice to the Director concerning the initial set of criteria for the certification of MediHealth plans;

(2) analyze the use of the criteria for the certification of MediHealth plans implemented by the Director under this title and recommend modifications in such criteria as needed;

(3) analyze the use of the comparative measurements implemented by the Director in developing comparative reports and recommend modifications in such measurements as needed;

(4) perform, or enter into contracts with other entities for the performance of, an analysis of access to services and clinical outcomes based on patient encounter data;

(5) enter into contracts with other entities for the development of such criteria and measurements and to otherwise carry out its duties under this section; and

(6) carry out any other activities determined appropriate by the Institute to carry out its duties under this section.

The analysis described in paragraph (4) should focus on conditions and procedures of significance to beneficiaries under the medicare program, as determined by the Institute, and should be designed, and the results summarized, in a manner that facilitates comparisons across health plans.

(d) COMPENSATION OF MEMBERS.—Section 5315 of title 5, United States Code, is amended by adding at the end the following:

''Member, Quality Advisory Institute''.

(e) CONFLICT OF INTEREST.—No member of the Institute shall engage in any other business, vocation, or employment than that of serving as a member of the Institute, nor shall any such member participate, directly or indirectly, in any operations or transactions of a character subject to regulation by the Institute pursuant to this title.

(f) STAFF.—The Institute may appoint and fix the compensation of such officers and other experts and employees as may be necessary for carrying out the functions of the Institute under this title and shall fix the salaries of such officers, experts, and employees in accordance with chapter 51 and subchapter III of chapter 53 of title 5, United States Code.

(g) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Institute without reimbursement (other than the regular compensation of the employee), and such detail shall be without interruption or loss of civil service status or privilege.

(h) CONTRACTING AUTHORITY.—Notwithstanding any other provision of law, the Institute may enter directly into contracts with entities as the Institute determines necessary to carry out the functions of the Institute under this title.

(i) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The members of the Institute may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

(j) LEASING AUTHORITY.—Notwithstanding any other provision of law, the Institute may enter directly into leases for real property for office, meeting, storage, and such other space as may be necessary to carry out the functions of the Institute under this title, and shall be exempt from any General Services Administration space management regulations or directives.

(k) ACCEPTANCE OF PAYMENTS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, in accordance with regulations which the Institute shall prescribe to prevent conflicts of interest, the Institute may accept payment and reimbursement, in cash or in kind, from non-Federal agencies, organizations, and individuals for travel, subsistence, and other necessary expenses incurred by members of the Institute in attending meetings and conferences concerning the functions or activities of the Institute.

(2) CREDIT OF ACCOUNT.—Any payment or reimbursement accepted shall be credited to the appropriated funds of the Institute.

(3) AMOUNT.—The amount of travel, subsistence, and other necessary expenses for members and employees paid or reimbursed under this subsection may exceed per diem amounts established in official travel regulations, but the Institute may include in its regulations under this subsection a limitation on such amounts.

SEC. 303. DUTIES OF DIRECTOR.

(a) IN GENERAL.—The Director shall—

(1) adopt, adapt, or develop criteria in accordance with sections 306 through 309 to be used in the licensing of certifying entities and in the certification of MediHealth plans, including any minimum criteria needed for the operation of MediHealth plans during the transition period described in section 306(c);

(2) issue licenses to certifying entities that meet the criteria developed under paragraph (1) for the purpose of enabling such entities to certify MediHealth plans in accordance with this title;

(3) develop comparative health care measures in addition to those implemented by the Director in de-

veloping comparative reports in order to guide consumer choice under the medicare program and to improve the delivery of quality health care under such program;

(4) develop procedures, consistent with part D of the Social Security Act (as added by section 101 of this Act), for the dissemination of certification and comparative quality information provided to the Director;

(5) contract with an independent entity for the conduct of audits concerning certification and quality measurement and require that as part of the certification process performed by licensed certification entities that there include an onsite evaluation, using performance-based standards, of the providers of items and services under a MediHealth plan;

(6) at least quarterly, meet jointly with the Agency for Health Care Policy and Research to review innovative health outcomes measures, new measurement processes, and other matters determined appropriate by the Director;

(7) at least annually, meet with the Institute concerning certification criteria;

(8) not later than January 1, 1999, and each January 1 thereafter, prepare and submit to

MediHealth plan sponsors and to Congress, a report concerning the activities of the Director for the previous year;

(9) advise the President and Congress concerning health insurance and health care provided under MediHealth plans and make recommendations concerning measures that may be implemented to protect the health of all enrollees in MediHealth plans; and

(10) carry out other activities determined appropriate by the Director.

(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed to limit the authority of the Director or the Secretary of Health and Human Services with respect to requirements other than those applied under this title with respect to MediHealth plans.

SEC. 304. COMPLIANCE.

(a) IN GENERAL.—Not later than January 1, 1999, the Director shall ensure that a MediHealth plan may not be offered unless it has been certified in accordance with this title.

(b) CONTRACTS OR REIMBURSEMENTS.—In carrying out subsection (a), the Director—

(1) may not enter into a contract with a MediHealth plan sponsor for the provision of a

MediHealth plan unless the MediHealth plan is certified in accordance with this title;

(2) may not reimburse a MediHealth plan sponsor for items and services provided under a MediHealth plan unless the MediHealth plan is certified in accordance with this title; and

(3) shall, after providing notice to the MediHealth plan sponsor operating a MediHealth plan and an opportunity for such MediHealth plan to be certified, and in accordance with any applicable grievance and appeals procedures under section 309, terminate any contract with a MediHealth plan sponsor for the operation of a MediHealth plan if such MediHealth plan is not certified in accordance with this title.

SEC. 305. PAYMENTS FOR VALUE.

(a) ESTABLISHMENT OF PROGRAM.—The Director shall establish a program under which payments are made to various MediHealth plans to reward such plans for meeting or exceeding quality targets.

(b) PERFORMANCE MEASURES.—In carrying out the program under subsection (a), the Director shall establish broad categories of quality targets and performance measures. Such targets and measures shall be designed to per-

mit the Director to determine whether a MediHealth plan is being operated in a manner consistent with this title.

(c) USE OF FUNDS.—The Director shall use amounts allocated under section 1895M(k) of the Social Security Act (as added by subsection (e)) to make annual payments to those MediHealth plans that have been determined by the Director to meet or exceed the quality targets and performance measures established under subsection (b). Any amounts allocated under such section for a fiscal year and remaining available after payments are made under subsection (d), shall be used for deficit reduction.

(d) AMOUNT OF PAYMENT.—

(1) FORMULA.—The amount of any payment made to a MediHealth plan under this section shall be determined in accordance with a formula to be developed by the Director. The formula shall ensure that a payment made to a MediHealth plan under this section be in an amount equal to—

(A) with respect to a MediHealth plan that is determined to be in the first quintile, 1 percent of the amount allocated by the plan under section 1895M(k) of the Social Security Act (as added by subsection (e));

(B) with respect to a MediHealth plan that is determined to be in the second quintile, 0.75

percent of the amount allocated by the plan under such section;

(C) with respect to a MediHealth plan that is determined to be in the third quintile, 0.50 percent of the amount allocated by the plan under such section; and

(D) with respect to a MediHealth plan that is determined to be in the fourth quintile, 0.25 percent of the amount allocated by the plan under such section.

(2) NO PAYMENT.—A MediHealth plan that is determined by the Director to be in the fifth quintile shall not be eligible to receive a payment under this section.

(3) DETERMINATION OF QUINTILES.—Not later than April 30 of each calendar year, the Director shall rank each MediHealth plan based on the performance of the plan during the preceding year as determined using the quality targets and performance measures established under subsection (b). Such rankings shall be divided into quintiles with the first quintile containing the highest ranking plans and the fifth quintile containing the lowest ranking plans. Each such quintile shall contain plans

that in the aggregate cover an equal number of beneficiaries as compared to another quintile.

(e) MEDIHEALTH PLANS.—Section 1895O of the Social Security Act (as added by section 101 of this Act) is amended by adding at the end the following:

''(d) WITHHOLDING OF PAYMENTS TO ENCOURAGE QUALITY PERFORMANCE.—

''(1) WITHHOLDING.—For each MediHealth plan, the Secretary shall withhold 0.50 percent from any payment that a MediHealth plan sponsor under this part receives with respect to an individual enrolled with such plan with the plan sponsor.

''(2) DISBURSEMENT.—From the total amount withheld under paragraph (1), the Secretary shall make payments to MediHealth plan sponsors under this part in accordance with the formula established by the Director of the Office of Competition within the Department of Health and Human Services under section 305(d) of the Comprehensive Medicare Reform and Improvement Act of 1997.''.

SEC. 306. CERTIFICATION REQUIREMENT.

(a) IN GENERAL.—To be eligible to enter into a contract with the Director to enroll individuals in a MediHealth plan, a MediHealth plan sponsor shall participate in the certification process and have the MediHealth

plans offered by such plan sponsor certified in accordance with this title.

(b) EFFECT OF MERGERS OR PURCHASE.—

(1) CERTIFIED PLANS.—Where 2 or more MediHealth plan sponsors offering certified MediHealth plans are merged or where 1 such plan sponsor is purchased by another plan sponsor, the resulting plan sponsor may continue to operate and enroll individuals for coverage under the MediHealth plan as if the MediHealth plan involved were certified. The certification of any resulting MediHealth plan shall be reviewed by the applicable certifying entity to ensure the continued compliance of the contract with the certification criteria.

(2) NONCERTIFIED PLANS.—The certification of a MediHealth plan shall be terminated upon the merger of the MediHealth plan sponsor involved or the purchase of the plan sponsor by another entity that does not offer any certified MediHealth plans. Any MediHealth plans offered through the resulting plan sponsor may reapply for certification after the completion of the merger or purchase.

(c) TRANSITION FOR NEW PLANS.—

(1) IN GENERAL.—A MediHealth plan that has not provided health insurance coverage to individuals

prior to the effective date of this Act shall be permitted to contract with the Director and operate and enroll individuals under a MediHealth plan without being certified for the 2-year period beginning on the date on which such MediHealth plan sponsor enrolls the first individual in the MediHealth plan. Such MediHealth plan must be certified in order to continue to provide coverage under the contract after such period.

(2) LIMITATION.—A new MediHealth plan described in paragraph (1) shall, during the period referred to in paragraph (1) prior to certification, comply with the minimum criteria developed by the Director under section 306(a)(1).

SEC. 307. LICENSING OF CERTIFICATION ENTITIES.

(a) IN GENERAL.—The Director shall develop procedures for the licensing of entities to certify MediHealth plans under this title.

(b) REQUIREMENTS.—The procedures developed under subsection (a) shall ensure that—

(1) to be licensed under this section a certification entity shall apply the requirements of this title to MediHealth plans seeking certification;

(2) a certification entity has procedures in place to suspend or revoke the certification of a

MediHealth plan that is failing to comply with the certification requirements; and

(3) the Director will give priority to licensing entities that are accrediting health plans that contract with the Director on the date of enactment of this Act.

SEC. 308. CERTIFICATION CRITERIA.

(a) ESTABLISHMENT.—The Director shall establish minimum criteria under this section to be used by licensed certifying entities in the certification of MediHealth plans under this title.

(b) REQUIREMENTS.—Criteria established by the Director under subsection (a) shall require that, in order to be certified, a MediHealth plan shall comply at a minimum with the following:

(1) QUALITY IMPROVEMENT PLAN.—The MediHealth plan shall implement a total quality improvement plan that is designed to improve the clinical and administrative processes of the MediHealth plan on an ongoing basis and demonstrate that improvements in the quality of items and services provided under the MediHealth plan have occurred as a result of such improvement plan.

(2) PROVIDER CREDENTIALS.—The MediHealth plan shall compile and annually provide to the li-

censed certifying entity documentation concerning the credentials of the hospitals, physicians, and other health care professionals reimbursed under the MediHealth plan.

(3) COMPARATIVE INFORMATION.—The MediHealth plan shall compile and provide, as requested by the Secretary of Health and Human Services, to the such Secretary the information necessary to develop a comparative report.

(4) ENCOUNTER DATA.—The MediHealth plan shall maintain patient encounter data in accordance with standards established by the Institute, and shall provide these data, as requested by the Institute, to the Institute in support of conducting the analysis described in section 302(c)(4).

(5) OTHER REQUIREMENTS.—The MediHealth plan shall comply with other requirements authorized under this title and implemented by the Director.

SEC. 309. GRIEVANCE AND APPEALS.

The Director shall develop grievance and appeals procedures under which a MediHealth plan that is denied certification under this title may appeal such denial to the Director.

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