

# CRS Report for Congress

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## **Medicare Managed Care Provisions of Title II of S. 1, as Passed by the Senate, and H.R. 1, as Passed by the House**

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# Medicare Managed Care Provisions of Title II of S. 1, as Passed by the Senate, and H.R. 1, as Passed by the House

## Summary

On June 27, 2003, the Senate passed the Prescription Drug and Medicare Improvement Act of 2003 (S. 1) and the House passed the Medicare Prescription Drug and Modernization Act of 2003 (H.R. 1).

Title II of each bill would establish a new Medicare managed care program to replace the current Medicare+Choice program. Under S. 1, Title II would establish the Medicare Advantage (MA) program to replace the M+C program. The MA program would continue to offer coordinated care and other plans on a county-wide basis as under current law. The bill would also establish regional Preferred Provider Organizations (PPOs), to be offered in regions. Beginning in 2008, the bill would establish a limited competition program, in designated highly competitive areas. Under H.R. 1, Title II would establish the Medicare Advantage (MA) program to replace the M+C program, which would also continue to offer coordinated care and other plans on a county-wide basis as under current law. The bill would establish the Medicare Enhanced Fee-for-Service (EFFS) program, under which Medicare beneficiaries would be provided access to a range of regional EFFS plans that could include preferred provider networks. Beginning in 2010, it would also use competitive bidding, in the same style of the Federal Employees Health Benefits program (FEHBP) for certain EFFS plans and MA plans.

There are considerable differences in the specifics of the MA provisions in S. 1 and H.R. 1. These differences are at issue in a pending conference between the two Houses.

This report provides a side-by-side comparison of the Title II provisions of both bills, and will be updated as necessary.

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# Medicare Managed Care Provisions of Title II of S. 1, as Passed by the Senate, and H.R. 1, as Passed by the House

## Introduction

On June 27, 2003, the Senate passed the Prescription Drug and Medicare Improvement Act of 2003 (S. 1) and the House passed the Medicare Prescription Drug and Modernization Act of 2003 (H.R. 1).

Title II of each bill would establish a new Medicare managed care program to replace the current Medicare+Choice program. Under S. 1, Title II would establish the Medicare Advantage (MA) program to replace the M+C program. The MA program would continue to offer coordinated care and other plans on a county-wide basis as under current law. The bill would also establish regional Preferred Provider Organizations (PPOs), to be offered in regions. Beginning in 2008, the bill would establish a limited competition program, in designated “highly competitive” areas. Under H.R. 1, Title II would establish the Medicare Advantage (MA) program to replace the M+C program, which would also continue to offer coordinated care and other plans on a county-wide basis as under current law. The bill would establish the Medicare Enhanced Fee-for-Service (EFFS) program, under which Medicare beneficiaries would be provided access to a regional EFFS plans that could include preferred provider networks. Beginning in 2010, it would also use competitive bidding, similar to the Federal Employees Health Benefits program (FEHBP), for certain EFFS plans and MA plans.

The Congressional Budget Office (CBO) has estimated the costs of Title II, for both the House and Senate bills. Title II of H.R. 1 is estimated to cost \$7.5 billion over the 10-year period (2004-2013) and Title II of S. 1 is estimated to cost \$18.3 billion over the same time period.

There are considerable differences in the specifics of the MA provisions in S. 1 and H.R. 1. These differences are at issue in a pending conference between the two Houses.

This report provides a side-by-side comparison of the Title II provisions of both bills, and will be updated as necessary.

## Side by Side Comparison of S. 1 and H.R. 1, Title II MedicareAdvantage (S. 1) or Medicare Advantage (H.R. 1)

### Overview of Title II Provisions

Provisions	Current Law	S. 1	H.R. 1
<i>Summary</i>	Health maintenance organizations (HMOs) and other types of managed care plans have participated in the Medicare program, beginning with private health plan contracts in the 1970s and the Medicare risk contract program in the 1980s. In 1997, Congress passed the Balanced Budget Act of 1997 (BBA 1997, P.L. 105-33), which replaced the risk contract program with the Medicare+Choice (M+C) program. M+C plans include coordinated care plans (HMOs, preferred provider organizations or PPOs, and provider-sponsored organizations or PSOs), private fee for service (PFFS) plans, and, on a temporary basis, medical savings accounts (MSAs).	Title II would establish the MedicareAdvantage (MA) program which would replace the M+C program, beginning in 2006. The MA program would continue to offer coordinated care and other plans on a county-wide basis as under current law. It would also establish regional PPOs, to be offered in regions. Beginning in 2008, it would establish a limited competition program, in areas designated as “highly competitive”.	Title II would establish, upon enactment, the Medicare Advantage (MA) program to replace the M+C program, which would continue to offer coordinated care and other plans on a county-wide basis as under current law. It would establish the Medicare Enhanced Fee-for-Service (EFFS) program, under which Medicare beneficiaries would be provided access to a range of regional EFFS plans that could include preferred provider networks, beginning in 2006. Beginning in 2010, it would also use competitive bidding, in the same style as the Federal Employees Health Benefits program (FEHBP) for certain EFFS plans and MA plans.

### Medicare Advantage or MedicareAdvantage

Provisions	Current Law	S. 1	H.R. 1
<b>Beneficiary Eligibility, Information Requirements, Beneficiary Elections and Enrollment Periods</b>			
<i>Beneficiary eligibility</i>	Medicare beneficiaries who are entitled to Part A of Medicare and enrolled in Part B may receive Medicare benefits through the original Medicare fee-for-service (FFS) program or they may enroll in a Medicare+Choice (M+C) plan.	<b>Section 201. [1851(a)(3)]</b> of the Social Security Act]. In addition to current law requirements, Medicare beneficiaries would also be required to be enrolled in the new Part D (drug program) in order to enroll in MA (except for PFFS).	Current law would not change. Enrollment in Part D would not be mandatory in order to enroll in MA or EFFS, as long as there was at least one MA plan with prescription drug coverage or at least one EFFS plan with prescription drug coverage available to the beneficiary.
<i>Provision of information on coverage options and open season</i>	The Secretary must provide information to Medicare beneficiaries and prospective beneficiaries on the coverage options provided under the M+C program, including open season	<b>Section 201. [1851(d)]</b> . In addition to the information dissemination required under current law, the Secretary would be required to provide: (1) the MA monthly basic beneficiary premium,	<b>Section 231(d)</b> . In addition to the information dissemination required under current law, the Secretary would be required to provide beneficiaries with a list of plans that are or would

Provisions	Current Law	S. 1	H.R. 1
	<p>notification, a list of plans and other general information.</p>	<p>(2) the monthly beneficiary premium for any enhanced medical benefits, (3) the MA monthly beneficiary obligation for qualified prescription drug coverage, (4) the catastrophic coverage amount (including the maximum limitation on out-of-pocket expenses) and unified deductible for the plan, (5) the outpatient prescription drug coverage benefits, (6) any beneficiary cost-sharing, including information on the unified deductible, (7) comparative information relating to prescription drug coverage, (8) if applicable, any reduction in the Medicare Part B premium, (9) whether the MA monthly premium for enhanced benefits was optional or mandatory, and (10) quality and performance indicators for prescription drug coverage, including a comparison with FFS Medicare.</p> <p><b>[§851(e)(3)].</b> Additionally, the Secretary would conduct a special information campaign to inform MA eligible beneficiaries about plans beginning on November 15, 2005 and ending on December 31, 2005.</p>	<p>be available in an area, to the extent the information was available at the time the materials were prepared for mailing.</p>
<p><i>Beneficiary elections and enrollment periods</i></p>	<p>Since the beginning of the M+C program, beneficiaries have been able to make and change election to an M+C plan on an ongoing basis. Beginning in 2005, elections and changes to elections will be available on a more limited basis. Beneficiaries can make or change elections during the annual coordinated election period (November 15 through December 31 for 2003 and 2004, and the month of November, thereafter). Current Medicare beneficiaries may also change their election at any time during the first 6 months of 2005 (or first 3 months of any subsequent year). Additionally, there are special enrollment rules for newly eligible aged beneficiaries as well as special</p>	<p><b>Section 201. [§1851(e)].</b> Medicare beneficiaries would retain their ability to make and change elections to an M+C plan through 2005. The current law limitation on changing elections that begins in 2005, would be delayed until 2006. Further, the annual coordinated election period for 2003 through 2006 would begin on November 15 and end on December 31. Beginning in 2007, the annual coordinated election period would be during the month of November.</p>	<p><b>Section 231(b).</b> H.R. 1 would retain the current law schedule for making and changing elections to plans. The annual coordinated election period would be permanently changed to November 15 through December 31.</p>

Provisions	Current Law	S. 1	H.R. 1
	enrollment periods for all enrollees under limited situations, such as an enrollee who changes place of residence.		
<b>Required Benefits and Beneficiary Protections</b>			
<i>Required additional benefits</i>	<p>M+C plans are required to include all Medicare-covered services ( Parts A and B benefits, except hospice care). In some circumstances, plans may also be required to offer additional benefits or reduced cost-sharing to their beneficiaries. The <i>basic</i> benefit package includes all of the Medicare-covered benefits (except hospice services) as well as the additional benefits, as determined by a formula which is set in law. The adjusted community rate (ACR) mechanism is the process through which health plans determine the minimum amount of additional benefits, if any, they are required to provide to Medicare enrollees and the cost-sharing they are permitted to charge for those benefits. Medicare does not have a catastrophic limit on beneficiary out-of-pocket expenses although some plans offer an out-of-pocket limit as an added benefit. Also there is a Part B deductible and a separate Part A deductible for inpatient hospital stays.</p>	<p><b>Section 202. [§1852(a)].</b> In addition to offering Medicare Parts A and B benefits (except hospice) and any additional required benefits, each MA plan (except an MSA, and in the case of prescription drug coverage, PFFS plans) would be required to offer: 1) qualified prescription drug coverage under Part D to beneficiaries residing in the area, and 2) a maximum limitation on out-of-pocket expenses and a unified deductible.</p> <p>[§1852(a)(7)]. The unified deductible would be defined as an annual deductible amount applied in lieu of the inpatient hospital deductible and the Part B deductible. This would not prevent an MA organization from requiring coinsurance or a copayment for inpatient hospital services, after the unified deductible was satisfied, subject to statutory limitations.</p> <p>[§1852(a)(2)(D)]. A PFFS plan could choose not to offer qualified prescription drug coverage under part D. Beneficiaries enrolling in such a PFFS plan could choose to enroll in an eligible entity under part D to receive their prescription drug coverage. [§1852(d)(4)]. A PFFS plan entirely meeting the access requirement for a category of providers through contracts or agreements (other than deemed contracts) could require higher beneficiary co-payments for providers who did not have such contracts or agreements.</p>	<p><b>Title I, Section 102.</b> In addition to offering Medicare Parts A and B benefits (except hospice), at least one plan offered by each MA organization in an MA area would be required to offer qualified drug coverage under Part D. MA plans would be required to pay rebates to beneficiaries to the extent that program payments to MA plans exceeded bid amounts. MA plans would also be able to offer supplemental benefits for additional premiums. [Plans would no longer be required to offer additional benefits, as these would be replaced by the rebates discussed below.]</p> <p>Also under <b>Title I, Section 102 (a)</b>, there would be exceptions for the prescription drug coverage offered by PFFS plans. PFFS plans would not be required to negotiate prices or discounts; however, to the extent a plan did so, it would be required to meet related Part D requirements.</p>

Provisions	Current Law	S. 1	H.R. 1
<i>Enhanced benefits</i>	M+C plans may offer supplemental benefits in addition to any required benefits under Parts A and B of Medicare and any additional required benefits.	<b>Section 202.</b> [§1852(a)(3)]. MA plans could choose to provide beneficiaries with enhanced medical benefits that the Secretary could approve. The Secretary could deny any submission for enhanced benefits believed to discourage enrollment by MA eligible individuals. The Secretary could not approve any enhanced medical benefit that provided for the coverage of any prescription drug, other than those relating to covered prescription drugs under Part D.	<b>Section 221 (a).</b> Plans could include supplemental benefits in their bids. The Secretary's authority to negotiate bids would include these supplemental benefits.
<i>Plan disclosure requirements</i>	An M+C organization must disclose, in clear, accurate and standardized form to each new enrollee and at least annually thereafter, certain information regarding the plan. The information includes service area, benefits, access, out-of-area coverage, emergency coverage, supplemental benefits, prior authorization rules, grievance and appeals procedures, a description of the quality assurance program, and other information upon request.	<b>Section 202.</b> [§1852(c)]. In addition to information that plans must disseminate under current law, they would also be required to provide the following information: (1) the maximum limitation on out-of-pocket expenses and the unified deductible, (2) qualified prescription drug coverage under Part D, and (3) benefits under FFS Medicare.	<b>Title VII, Section 722.</b> In addition to information that plans must disseminate under current law, plans would also be required to disseminate information about their chronic care improvement program.
<i>Quality assurance requirements</i>	M+C plans must have a quality assurance program that: (1) stresses health outcomes and provides data permitting measurement of outcomes and other indices of quality; (2) monitors and evaluates high volume and high risk services and the care of acute and chronic conditions; (3) evaluates the continuity and coordination of care that enrollees receive; (4) is evaluated on an ongoing basis as to its effectiveness; (5) includes measures of consumer satisfaction, and (6) provides the Secretary with certain information to monitor and evaluate the plan's quality.  Only certain coordinated care plans (not PFFS or PPO plans) have to comply with other quality assurance requirements, such as providing for internal peer review, establishing written protocols	<b>Section 202.</b> [§1852(e)]. In addition to current law requirements for quality assurance, the quality assurance programs of an organization would also be required to provide access to disease management and chronic care services and to provide access to preventive benefits and information for enrollees on such benefits.	<b>Section 234(a).</b> The requirement that MSAs have an ongoing quality assurance program would be eliminated.  <b>Title VII, Section 722.</b> One year after enactment, the quality assurance program requirement would be replaced with a requirement for chronic care improvement programs designed to manage the needs of enrollees with multiple severe chronic conditions.



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	for utilization review, establishing mechanisms to detect under and over utilization, establishing or altering practice patterns based on identified areas for improvement, taking action to improve quality, and making quality information available to beneficiaries.		
<b>Payments to MA Organizations</b>			
<i>General</i>	In general, the Secretary makes monthly payments to each M+C organization for enrollees, based on 1/12 of the annual capitation rate, reduced by any Part B premium reduction, and adjusted for risk. The Secretary will announce the M+C payment rates no later than the 2 <sup>nd</sup> Monday in May through 2004, and by March 1, thereafter.	<p><b>Section 203. [§1853(a)].</b> Each MA organization would receive a separate monthly payment for: (1) benefits under FFS Medicare Parts A and B, and (2) benefits under the prescription drug program, Part D. The Secretary would ensure that payments for each enrollee would equal the MA benchmark amount for the payment area, as adjusted. The adjustments would include both a risk adjustment and an adjustment based on the ratio of the payment amount to the weighted service area benchmark.</p> <p>Beginning April 15, 2005 (at the same time as risk adjusters for prescription drug coverage were announced), the Secretary would annually announce the benchmark for each MA payment area, and the risk adjustment factors.</p>	<p><b>Section 221(c).</b> For payments before 2006, the monthly payment amount would equal 1/12 of the annual MA capitation rate, for an enrollee for that area, reduced by any Part B premium reduction and adjusted for demographics including an adjustment for health status.</p> <p><b>Section 221(e).</b> Beginning in 2006, the Secretary would also announce yearly and no later than the 2<sup>nd</sup> Monday in May, the MA area-specific non-drug benchmark and the adjustment factors relating to demographics, end stage renal disease (ESRD), and health status in each MA plan in the area.</p> <p><b>Section 241(b).</b> Beginning in 2010, the Secretary would also announce, as applicable: (1) the competitive MA non-drug benchmark for the year and the competitive MA area involved, (2) the national FFS market share, (3) the FFS area-specific non drug amount, (4) the MA area-wide non-drug amount, and (5) the number of enrollees in each MA plan in the area.</p>
<i>Payment rate modifications</i>	Under current law, Medicare+Choice (M+C) plans are paid an administered monthly payment, called the M+C payment rate, for each enrollee. The per capita rate for a payment area is set at the highest of one of three amounts: (1) a minimum payment (or floor) rate, (2) a rate calculated as a blend of an	<b>Section 203. [§1853(c)].</b> For payments before 2006, the payment would be calculated in the same manner as under current law — the highest of the blend, minimum amount (floor), or minimum update. However the calculation of the minimum percentage increase would change for	<b>Section 212(a).</b> For 2004, a 4 <sup>th</sup> payment mechanism would be added and plans would receive the highest of the four payment calculations (the floor, minimum percentage increase, blend or the new amount). The new payment amount would be 100% of fee-for-

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	<p>area-specific (local) rate and a national rate, or (3) a rate reflecting a minimum increase from the previous year's rate (currently 2%).</p> <p>A budget neutrality adjustment is made so that estimated total M+C payments in a given year will be equal to the total payments that would be made if payments were based solely on area-specific rates. The budget neutrality adjustment may only be applied to the blended rates because rates cannot be reduced below the floor or minimum increase amounts. The blend payment is also adjusted to remove the direct and indirect costs of graduate medical education. The blend payment amount is based on a weighted average of local and national rates for all Medicare beneficiaries. Each year, the three payment amounts are updated by formulas set in statute. Both the floor and the blend are updated each year by a measure of growth in program spending, the national growth percentage. The minimum increase provides for an increase of at least 2% over the previous year's amount.</p>	<p>2005. The minimum percentage increase for 2005 would be a 3% increase over the rate for the area for 2003. For 2006 and subsequent years, it would be a 2% increase over the previous year (but calculated as though the increase in 2005 was 2%). Additionally, beginning in 2014, the minimum amount (floor) would be increased by the percentage increase in the CPI for all consumers, for the 12-month period ending in June of the previous year.</p> <p><b>Section 210.</b> The costs of DOD and VA military facility services would be included in the area specific M+C payment and the local fee for service rates beginning in 2006.</p>	<p>service (FFS). The FFS payment would be based on the adjusted average per capita cost for the year, for an MA payment area, for services covered under Parts A and B for beneficiaries entitled to benefits under Part A, enrolled under Part B and not enrolled in an MA plan. This payment would be adjusted to remove payments for direct medical education costs and to include the additional payments that would have been made if Medicare beneficiaries entitled to benefits from facilities of the Department of Veteran Affairs (VA) and the Department of Defense (DOD) had not used those services (VA/DOD adjustment).</p> <p><b>Section 212.</b> Additionally, changes would be made to the blend calculations for 2004. <b>Section 212(b).</b> No adjustment would be made for budget neutrality, which would fund the blend for 2004. <b>Section 212(d).</b> The area-specific MA capitation rate (the local component of the blend) would be adjusted to include the VA/DOD adjustment.</p> <p><b>Section 212(c).</b> The calculation of the minimum percentage increase would also be revised. For 2004 and beyond, the <i>minimum percentage increase</i> would be the <i>greater</i> of: (1) a 2% increase over the previous year's payment rate (as under current law); or (2) the previous year's payment increased by the national per capita MA growth percentage. For purposes of calculating the minimum percentage increase, there would be no adjustment to the national growth percentage for prior years errors before 2004.</p>

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			<p>In 2005, the payments to all plans would be based on their 2004 rate increased each subsequent year by the revised minimum percentage increase.</p> <p><b>Section 212(e).</b> Beginning January 1, 2004, the payment rule for beneficiaries in a short-term general hospital at the time they either elected to enroll in or to terminate their enrollment in an M+C plan, would be extended to a beneficiary in an inpatient rehabilitation facility.</p> <p><b>Section 212(h).</b> The Secretary would calculate and announce the new MA capitation rates within 6 weeks of enactment of this legislation.</p>
<p><i>Payments to MA organizations beginning in 2006 — Payment calculations</i></p>	<p>See description of payments under <i>Payment modifications</i>.</p>	<p><b>Section 203. [§1853(c&amp;d)].</b> Beginning in 2006, payments to MA plans would be determined differently, based on a comparison between plan bids and the weighted service area benchmark. The Secretary would however, continue to calculate the annual M+C capitation rates.</p> <p>Plans would submit bids to the Secretary by the second Monday in September.</p> <p>The Secretary would calculate the benchmark amounts as the greater of the minimum amount (floor) or the local FFS rate for the area. The local FFS rate would be calculated similarly to the adjusted average per capita cost (AAPCC), adjusted to remove the costs of indirect and direct graduate medical education.</p> <p>The Secretary would calculate the weighted service area benchmark amount equal to the weighted average of the benchmark amounts for</p>	<p><b>Section 221.</b> Beginning in 2006, MA payment rates would be determined by the Administrator by comparing plan bids to the benchmark. Bids would be submitted by the plans, reflecting the dollar amount and actuarial basis for the provision of: (1) all statutory Part A and B services, (2) statutory prescription drug services, and (3) any non-statutory benefits. Benchmarks would equal one-twelfth of the annual MA capitation rate for an enrollee in that area, and would be calculated by updating the previous year's capitation rate by the annual increase in the minimum percentage increase (as defined above).</p> <p><b>Section 221 (c).</b> For plans with bids below the benchmark (for the provision of non-drug benefits), the payment would equal the unadjusted MA statutory non-drug monthly bid amount, with adjustments for demographic factors (including age, disability, gender, and health status) and the monthly rebate.</p>

Provisions	Current Law	S. 1	H.R. 1
		<p>required services for the payment areas included in the service area of the plan.</p> <p>The Secretary would determine the difference between each plan's bid and the weighted service area benchmark amount. For plan bids that equal or exceed the weighted service area benchmark, the MA organization would be paid the weighted service area benchmark amount. For plan bids below the weighted service area benchmark, the plan would be paid the weighted service area benchmark reduced by the amount of any premium reduction elected by the plan. The Secretary would adjust payments using the comprehensive risk adjustment methodology.</p> <p><b>Section 205.</b> This provision would establish the additional payments that would be made to the MA plans for the prescription drug coverage under Part D.</p> <p><b>Section 204.</b> The provision would establish the requirement that the MA monthly basic beneficiary premium, the MA monthly beneficiary obligation for qualified prescription drug coverage, and the MA monthly beneficiary premium for enhanced medical benefits could not vary among beneficiaries enrolled in the plan. Also, the MA MSA premium would not vary among beneficiaries enrolled in the MSA plan.</p>	<p>Conversely, for plans with bids at or above the benchmark, the payment amount would equal the MA area-specific non-drug monthly benchmark amount, with the demographic and health status adjustments.</p> <p>Additionally, for an MA enrollee who enrolled in Part D and elected prescription drug coverage through the plan, the plan's payment would include a direct and a reinsurance subsidy payment and reimbursement for premiums and cost-sharing reductions for certain low-income beneficiaries.</p> <p>The MA monthly bid amount, the MA monthly basic, prescription drug, and the supplemental beneficiary premium would not vary among enrollees in the plan. Additionally, the MA monthly MSA premium would not vary within an MSA plan.</p>
<p><i>Risk adjustment</i></p>	<p>M+C payments are risk-adjusted to reflect variations in the cost of providing health care among Medicare beneficiaries. Currently a risk adjustment system is being phased-in that adjusts payments based on inpatient data using the 15 principal inpatient diagnostic cost groups (PIP-DCGs) adjuster and demographic factors, so that</p>	<p><b>Section 203. [§1853(a)].</b> The Secretary would apply the comprehensive risk adjustment methodology to 100% of the amount of payments to plans beginning in 2006. This would apply to all types of plans. Organizations would be required to submit data and other information, in order to carry out risk adjustment. The Secretary</p>	<p>In addition to the current law requirements for risk adjustments for individual enrollees, both bids and benchmarks would also be risk adjusted, based on the following methodology.</p> <p><b>Section 221.</b> Beginning in 2006 (at the same time the payment rates are promulgated), the</p>

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Provisions	Current Law	S. 1	H.R. 1
	<p>this system accounts for both demographic and health-status variations. Under this mechanism, the per capita payment made to a plan for an enrollee is adjusted if that enrollee had an inpatient stay during the previous year. Separate demographically-based payments are used for enrollees without a prior hospitalization, newly eligible aged persons, newly eligible disabled Medicare enrollees, and others without a medical history. This system will be replaced with a more comprehensive risk adjustment methodology that uses data from inpatient hospitals and ambulatory settings, beginning in 2004. Capitation rates will be risk-adjusted using this new method, on a phased-in basis, at the rate of 30% in 2004, 50% in 2005, and 75% in 2006. Beginning in 2007, capitation rates will be 100% risk adjusted.</p>	<p>could revise the comprehensive risk adjustment methodology from time to time to improve payment accuracy.</p>	<p>Administrator would determine, for each state, the average of the risk adjustment factors (including age, disability status, gender, institutional status, health status, and other factors the Administrator determines to be appropriate) to be applied to enrollees in that state. In the case of a state in which a plan was offered in the previous year, the Administrator could compute the average based on factors used in the previous year. If no MA plan was offered in a state in the previous year, the Administrator would estimate the average and could use average risk adjustment factors applied to comparable states or applied on a national basis.</p> <p>The Administrator would apply the average risk adjustors to the MA area-specific non-drug monthly benchmark amount and the unadjusted MA statutory non-drug monthly bid amount. The Administrator could determine and apply risk adjustment factors on the basis of areas other than states.</p>
<b>Bids and Premiums</b>			
<p><i>Submission of bids and associated deadlines</i></p>	<p>The Public Health Security and Bioterrorism Preparedness and Response Act of 2002, P.L. 107-188, made temporary changes to reporting dates and deadlines including the plan deadline for submitting ACRs and other information. This deadline moved from no later than July 1 to no later than the second Monday in September for 2002, 2003, and 2004.</p>	<p><b>Section 204. [§1854(a)].</b> Each MA organization would be required to submit information by the second Monday in September, including: (1) notice of intent and information on the service area of the plan, (2) the plan type for each plan, (3) specific information for coordinated care and PFFS plans, (4) enrollment capacity, (5) the expected mix of enrollees, by health status, and (6) other information specified by the Secretary. For coordinated care plans and PFFS plans, the plans would be required to submit the plan bid (the total amount that the plan was willing to accept for required Parts A and B benefits not taking into</p>	<p><b>Section 231.</b> This provision would permanently move the plan deadline for submitting information to no later than the second Monday in September.</p> <p><b>Section 221(a)(3).</b> Each year, beginning in 2006, an MA organization would be required to provide the following information: (1) the bid amount for the provision of all required items and services, based on average costs for a typical enrollee residing in the area and the actuarial bases for determining such amount; (2) the proportion of the bid attributed to the provision</p>

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Provisions	Current Law	S. 1	H.R. 1
		<p>account the application of comprehensive risk adjustment), the assumptions used in preparing the bid with respect to the number of enrollees in each payment area and the mix by health status, and any required information for prescription drug coverage. The plan bid would also have to be based on actuarial equivalence (see description below in <i>Limitation on Enrollee Liability</i>).</p> <p>For any enhanced medical benefit package a plan chooses to offer, it would be required to provide the following information: 1) the ACR, 2) the portion of the actuarial value of such benefits package (if any) that would be applied toward satisfying the requirement for additional benefits, 3) the MA monthly beneficiary premium for enhanced benefits, 4) cost-sharing requirements, 5) the description of whether the unified deductible had been lowered or if the maximum out-of-pocket limitation had been decreased, and 6) other information required by the Secretary.</p> <p>[§1854(a)(5)]. Each plan bid would be required to reasonably and equitably reflect the cost of benefits provided under that plan.</p>	<p>of statutory non-drug benefits, and non-statutory benefits (including the actuarial basis for determining these proportions); and (3) additional information as the Administrator may require.</p>
<p><i>Authority to negotiate and reject bid submissions</i></p>	<p>Each year an M+C organization submits an adjusted community rate (ACR) proposal, estimating their proposed cost of serving Medicare beneficiaries for the following contract year. The ACR process is a mechanism through which health plans determine the minimum amount of additional benefits they are required to provide to Medicare enrollees and the cost-sharing they are planning to charge for those benefits, within statutory limitations. Under Medicare's rules, a plan may not earn a higher return from its</p>	<p><b>Section 204.</b> [§1854(a)]. The Secretary could disapprove a plan bid if he or she determined that the deductibles, coinsurance or copayments discouraged access to covered services or were likely to result in favorable selection of MA eligible beneficiaries.</p>	<p><b>Section 221(a)(3)(C).</b> The Administrator would have the same authority to negotiate bid amounts that the Director of the Office of Personnel Management has with respect to the Federal Employee Health Benefits Plan. The Administrator could negotiate the bid amount and could also reject a bid amount or proportion of the bid, if it was not supported by the actuarial basis. PFFS plans would be exempt from this negotiation. <b>Section 221(d).</b> The Administrator would not approve a plan if benefits were</p>

Provisions	Current Law	S. 1	H.R. 1
	<p>Medicare business than it does in the commercial market. The Secretary reviews this information and approves or disapproves the premiums, cost-sharing amounts, and benefits. The Secretary does not have the authority to review the premiums for either MSA plans or PFFS plans.</p>		<p>designed to substantially discourage enrollment by certain MA eligible individuals.</p>
<p><i>Beneficiary premiums and rebates</i></p>	<p>Beneficiaries share in any projected cost savings between Medicare’s per capita payment to a plan and what it would cost the plan to provide Medicare benefits to its commercial enrollees. To accomplish this, plans must provide either reduced cost-sharing or additional benefits to their Medicare enrollees that are valued at 100% of the difference between the projected cost of providing Medicare-covered services and the expected revenue for Medicare enrollees. Additionally, beginning in 2003, plans may also reduce the Medicare Part B premium. Plans can choose which additional benefits to offer, however, the total cost of these benefits must at least equal the “savings” from Medicare-covered services. Plans may also place the additional funds in a stabilization fund or return funds to the Treasury.</p> <p>Alternatively, under the ACR process, plans may also charge a premium if they demonstrate higher costs rather than savings for providing the basic benefit package.</p>	<p><b>Section 204. [§1854(b)].</b> The monthly amount of the premium, if any, charged to an MA enrollee would be the sum of any MA monthly basic beneficiary premium, any premium for enhanced medical benefits and any obligation for prescription drug coverage.</p> <p><b>[§1854(c)].</b> If the weighted service area benchmark exceeded the plan bid, the Secretary would require the plan to provide additional benefits, and if the plan bid exceeded the weighted service area benchmark, the plan could charge an MA monthly basic beneficiary premium equal to the amount the bid exceeded the benchmark.</p> <p><b>Section 204. [§1854(g)].</b> If the plan bid was lower than the weighted service area benchmark, the plan could, in addition to benefits allowed under current law, also lower the amount of the unified deductible and decrease the maximum limitation on out-of-pocket expenses. However, plans would be restricted from specifying any additional benefits that provided for the coverage of any prescription drug, other than that relating to covered drugs under Part D.</p>	<p><b>Section 221(d).</b> For plans with a bid amount below the benchmark, the basic premium would be zero. For plans with bids above the benchmark, the basic premium would be equal to the amount the bid exceeded the benchmark.</p> <p><b>Section 221(b).</b> An MA plan would be required to provide an enrollee a monthly rebate that equaled 75% of any average per capita savings (the amount by which the risk-adjusted benchmark exceeded the risk adjusted bid). The rebate could be credited toward the MA monthly supplemental beneficiary premium or the prescription drug premium; could be paid directly to the beneficiary; could be provided by another means approved by the Administrator; or any combination of the above. The remaining 25% of the average per capita savings would be retained by the federal government.</p> <p><b>Section 221(e).</b> This provision would repeal §1854(e) - relating to required additional benefits and ACRs. [Required beneficiary rebates would replace the requirement for additional benefits.]</p>

Provisions	Current Law	S. 1	H.R. 1
<i>Limitation on enrollee liability</i>	The actuarial value of deductibles, coinsurance, and copayments applicable on average to enrollees in an M+C plan for required services may not exceed the actuarial value of deductibles, coinsurance, and copayments on average for beneficiaries in traditional Medicare. However, this average may be achieved by having higher copayments for some M+C services and lower for other services.	<p><b>Section 204. [§1854(f)].</b> The monthly basic beneficiary premium and the actuarial value of the deductibles, coinsurance and copayments, (calculated in the same manner as the plan bid and applicable on average to enrollees in an MA plan), would have to be equal to the actuarial value of the deductibles, coinsurance and copayments applicable on average to FFS beneficiaries (adjusted to account for geographic differences and for the plan cost and utilization differences).</p> <p>Similarly, for enhanced medical benefits, the sum of the MA monthly beneficiary premium for enhanced medical benefits and the actuarial value of the deductibles, coinsurance, and copayments, must equal the ACR for such benefits for the year minus the actuarial value of any required additional benefits.</p>	<b>Section 221(e).</b> This provision would repeal §1854(e) — relating to the limitation on enrollee liability. [The information collected by the Secretary in <b>Section 221(a)(3)</b> would require the MA organization to submit the actuarial basis for determining the bid, as well as the proportion of the bid attributed to the provision of statutory non-drug benefits, statutory prescription drug benefits, and non-statutory benefits.]
<i>Premium payment</i>	Under current law, Medicare beneficiaries can have their Part B premium deducted from their monthly Social Security benefit.	No provision.	<b>Section 221(b).</b> Enrollees would be permitted to have their MA premiums deducted directly from their Social Security benefits or through an electronic funds transfer. The Administrator would be required to provide a mechanism whereby a beneficiary who joined an MA plan and elected Part D coverage through the plan would be able to pay one consolidated premium amount.
<i>Adjusted community rates (ACR)</i>	Each year an M+C organization submits an ACR proposal, estimating their proposed cost of serving Medicare beneficiaries for the following contract year. The ACR process is a mechanism through which health plans determine the minimum amount of additional benefits they are required to provide to Medicare enrollees and the cost-sharing they are permitted to charge for those benefits.	No provision, thus no change in the ACR process.	<b>Section 221.</b> This provision would repeal §1854(e) - relating to required additional benefits and ACRs. Plans would not be required to submit ACRs beginning in 2006. [Plan bids would replace ACRs.]



Provisions	Current Law	S. 1	H.R. 1
<p><i>Required studies/reports beneficiary cost-sharing</i></p>	<p>No provision.</p>	<p><b>Section 204(b).</b> The Secretary would conduct a study to determine the extent to which M+C cost-sharing discourages access to covered services or discriminates based on the health status of M+C eligible beneficiaries. The Secretary would submit a report to Congress, providing recommendations for legislation and administrative action, no later than December 31, 2004.</p>	<p><b>Section 212(f).</b> No later than 18 months after enactment of this legislation, the Medicare Payment Advisory Commission would report to Congress providing an assessment of the method used for determining the adjusted average per capita cost (AAPCC). The report would examine the variation in costs between different areas, including differences in input prices, utilization and practice patterns; the appropriate geographic area for payment; and the accuracy of the risk adjustment methods in reflecting differences in the cost of providing care.</p> <p><b>Section 212(g).</b> No later than July 1, 2006, the Administrator would submit a report to Congress that described the impact of additional financing provided under the Act and other Acts, (including the Balanced Budget Refinement Act of 1999 — BBRA and Benefits Improvement and Protection Act of 2000 -BIPA) on the availability of MA plans in different areas and the impact on lowering premiums and increasing benefits under such plans.</p>
<p><b>Other MA Provisions</b></p>			
<p><i>Special rules for prescription drug benefits</i></p>	<p>No provision.</p>	<p><b>Section 205.</b> Beginning on January 1, 2006, MA plans, other than PFFS and MSA plans, would be required to offer each enrollee qualified prescription drug coverage that met the requirements for such coverage under the MA program and under Part D of Medicare. An MA plan could offer qualified prescription drug coverage that exceeded the coverage required under Part D, as long as it also offered an MA plan in the area that provided only the required coverage. This provision would also establish payments to each MA organization offering an</p>	<p><b>Title I, Section 102.</b> Beginning January 1, 2006, at least one MA plan offered by an MA organization in an area would be required to offer qualified drug coverage under Part D; meet the beneficiary protections outlined in the new Section 1860D-3, including requirements relating to information dissemination as well as grievance and appeals; and provide the same information required from prescription drug plan sponsors when submitting a bid unless waived by the Administrator. MA organizations providing qualified drug coverage would receive low-</p>

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Provisions	Current Law	S. 1	H.R. 1
		MA plan that provided qualified prescription drug coverage, including a low-income drug subsidy.	income subsidy payments and direct and reinsurance subsidies. A single premium would be established for drug and non-drug coverage.
<i>Facilitating employer participation</i>	Employers may sponsor an M+C plan or pay premiums for retirees who enroll in an M+C plan. If an M+C plan contracts with an employer group health plan (EGHP) that covers enrollees in an M+C plan, the enrollees must be provided the same benefits as all other enrollees in the M+C plan, with the EGHP benefits supplementing the M+C plan benefits. The Secretary may waive or modify requirements that hinder the ability of employer or union group health plans from offering a M+C plan option.	<b>Section 206.</b> The Administrator could permit an MA plan to establish a separate premium amount for enrollees in an employer or other group health plan that provides employment-based retiree health coverage. This provision would also apply the current law requirements to regional PPOs.	No provision.
<i>Administration</i>	The M+C program is currently administered by the Centers for Medicare and Medicaid Services (CMS).	<b>Section 207.</b> Beginning January 1, 2006, the MA program and the Part D prescription drug program would be administered by the Center for Medicare Choices, and each reference to the Secretary would be deemed to be a reference to the Administrator of the Center for Medicare Choices. [Related program administration provisions are in <b>Title III</b> addressing the Center for Medicare Choices.]	<b>Title VIII.</b> The Medicare Benefits Administration (MBA), would be established to administer MA, ERF, and the new Medicare prescription drug benefit.
<b>Conforming Amendments</b>			
<i>Cause for intermediate sanctions</i>	The Secretary is authorized to carry out specific remedies in the event that an M+C organization: (1) fails substantially to provide medically necessary items and services required to be provided, if the failure adversely affects the Medicare enrollee; (2) imposes premiums on enrollees that are in excess of those allowed; (3) acts to expel or refuses to reenroll an enrollee in violation of Federal requirements; (4) engages in any practice that would have the effect of denying or discouraging enrollment (except as permitted by law) of eligible beneficiaries whose medical	<b>Section 208.</b> In addition to specifications included in current law, the Secretary could also carry out remedies if an organization charged any Medicare enrollee an amount in excess of the MA monthly beneficiary obligation for qualified prescription drug coverage, provided coverage that was not qualified prescription drug coverage, offered prescription drug coverage but did not make standard prescription drug coverage available, or provided coverage for drugs other than that relating to prescription drugs covered under Part D, as an enhanced or additional benefit.	No comparable provision.

Provisions	Current Law	S. 1	H.R. 1
	condition or history indicates a need for substantial future medical services; (5) misrepresents or falsifies information to the Secretary or others; (6) fails to comply with rules regarding physician participation; or (7) employs or contracts with any individual or entity that has been excluded from participation in Medicare.		
<i>Medicare Medical Savings Accounts (MSAs)</i>	BBA1997 authorized a demonstration for M+C MSAs. The M+C option combined a high-deductible health insurance plan with an M+C MSA. New enrollment is not allowed after January 1, 2003 or after the number of enrollees reaches 390,000. No private plans have established an M+C MSA for Medicare beneficiaries. M+C plans (including MSAs) must have an ongoing quality assurance program for health care services provided to Medicare beneficiaries. The required elements of the program are specified in statute.	<b>Section 201.</b> The deadline for enrollment in an MSA would be extended until December 31, 2003.	<b>Section 234.</b> The Medicare MSA demonstration would be made a permanent option, the capacity limit would be removed and the deadline for enrollment would be eliminated. For enrollees in MSA plans, physicians or other entities (other than providers of services, such as hospitals) would be required to accept the Medicare fee-for service payment as a payment in full (no balance billing would be permitted). The quality assurance requirements for MSAs would be removed.
<i>Effective date</i>	No provision.	<b>Section 209.</b> Generally effective January 1, 2006. However, the Secretary would apply payment and other rules for MSA plans, as if this title had not been enacted.	<b>Section 211(e).</b> The MA program would be effective January 1, 2004. <b>Section 221 (g).</b> The competition program would be effective January 1, 2006.

## Regional Preferred Provider Organizations/FFS

Provisions	Current Law	S. 1	H.R. 1
<i>General</i>	PPOs are permitted to be offered as coordinated care plans under the Medicare+Choice program.	<p><b>Section 211. [§1858(a)].</b> Beginning January 1, 2006, a preferred provider organization (PPO) plan would be offered to MA eligible individuals in preferred provider regions. A PPO would be an entity with a contract that met other requirements of this Act. A PPO would have a network of providers that agreed to contractually specified reimbursements for covered benefits under Parts A and B. The PPO would pay for all covered services an enrollee received, whether provided in or out of network.</p> <p>Each plan would be offered to any MA eligible individual residing in the service area.</p>	<p><b>Section 201(a).</b> Beginning January 1, 2006, the Administrator would establish the EFFE program offering plans on a regional basis. <b>[§1860E-1(b)(2)].</b> EFFE plans would be required to provide either FFS or preferred provider coverage. Under FFS coverage, plans would: (1) pay hospitals, physicians and other providers at a rate determined by the plan on a FFS basis, without placing providers at risk, (2) not vary rates based on the provider's utilization, and (3) not restrict the selection of providers from among those who were lawfully authorized to provide covered services and agreed to accept the plan's terms and conditions. Under preferred provider coverage, plans would: (1) have a network of providers who agreed to a contractually-specified payment for covered benefits with the organization, and (2) provide for payment for all covered benefits regardless of whether they were provided within the network.</p> <p>Each plan would be offered to any EFFE eligible beneficiary residing in the EFFE region.</p>
<i>Establishing regions</i>	Enrollment in any individual M+C plan is open only to those beneficiaries living in a specific service area. Plans define a service area as a set of counties and county parts, identified at the zip code level. At a state's option, the service area could be defined as the entire state; however, to date, no state has done so.	<p><b>Section 211. [§1858(a)(3)].</b> There would be at least 10 regions. Each region would have to include at least one state, and could be the entire United States. The Secretary could not divide states so that portions of the state were in different regions. To the extent possible, the Secretary would include multi-state metropolitan statistical areas (MSAs) in a single region, except that he or she could divide an MSA where necessary to</p>	<p><b>Section 201(a). [§1860E-1(a)(1 and 2)].</b> Plans would be offered on a regional basis, in at least 10 regions established by the Administrator. Before establishing the regions, the Administrator would conduct a market survey and analysis, including an examination of current insurance markets, to determine how the regions should be established. Regions would be established to take into consideration</p>

Provisions	Current Law	S. 1	H.R. 1
		<p>establish a region of such size and geography to maximize the participation of PPOs. The Secretary could use the same regions established for the prescription drug program, under Part D. The service area of a PPO would be the region.</p>	<p>maximizing full access for all EFFE-eligible individuals, especially those residing in rural areas.</p>
<p><i>Required number of plans and benefits in each region</i></p>	<p>No provision.</p>	<p><b>Section 211. [§1858(d)].</b> If there were bids for more than three plans in a preferred provider region, the Secretary would limit the number of plans to the three lowest-cost credible plans that met or exceeded the quality or minimum standards.</p>	<p><b>Section 201(a). [§1860E-3(a)(3)(D)].</b> The Administrator could enter into contracts for up to 3 EFFE organizations in any region. <b>[§1860E-2].</b> EFFE plans could only be offered in a region, if the plan: (1) was available to all EFFE eligible individuals in an entire region, (2) complied with statutory access requirements, (3) uniformly provided all required Parts A and B benefits, (4) included a single deductible for benefits under Parts A and B, and a catastrophic limit on out-of-pocket expenses, and (5) provided prescription drug coverage for each enrollee electing Part D drug coverage. An EFFE would also be able to offer supplemental benefits.</p> <p><b>Title VII, Section 722(b).</b> EFFE plans would have to offer chronic care management plans to enrollees with multiple or sufficiently severe chronic conditions.</p>
<p><i>Access</i></p>	<p>Both M+C and PFFE plans must demonstrate to the Secretary a sufficient number and range of health care providers who agree to the plan’s terms. For PFFE plans this requirement is considered to be met if the plan establishes payment rates for covered services that are not less than Medicare’s fee-for-service rates, or if the plan has contracts or agreements with a sufficient number and range of providers. These requirements do not restrict enrollees access to other providers for covered services.</p>	<p><b>Section 211. [§1858(b)].</b> PPOs would be required to establish a sufficient number and range of health care professionals and providers willing to provide services under the plan’s terms. The Secretary would consider this requirement to be met if the organization had a sufficient number of contracts and agreements with a sufficient number and range of providers. These arrangements would not restrict enrollee access to other providers for covered services. Additionally, if the plan was in a state where 25% or more of the</p>	<p><b>Section 201(a). [§1860E-2(b)(2)].</b> EFFE plans would have to comply with the statutory requirements in §1852(d)(4) that currently apply only to PFFE plans. The requirement for establishing a sufficient number of contracts, and not restricting enrollee access to other providers is similar to provisions in S. 1.</p>

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Provisions	Current Law	S. 1	H.R. 1
		population resided in a health professional shortage area, these arrangements would also not restrict the categories of licensed health professionals or providers from whom the enrollee could obtain covered benefits.	
<i>Prescription drug benefits</i>	No provision.	Same requirements as under the MA program.	<b>Title I, Section 102.</b> An EFFS organization in a region would have to offer a least one plan that included qualified prescription drug coverage under Part D (i.e., if the organization offered several plans, only one would have to include Part D). An EFFS organization could not offer prescription drug coverage (other than the existing drug benefit under Parts A and B) to an enrollee unless such coverage was qualified prescription drug coverage under Part D.
<b>Payments to Regional Organizations</b>			
<i>Monthly payments</i>	See similar description under Payments to MA organization section above ( <i>Payment rate modifications</i> ).	<b>Section 211. [§1858(c)].</b> The Secretary would make separate monthly payments with respect to required benefits under Parts A and B and benefits under the voluntary prescription drug program under Part D. The Secretary would also establish a methodology for adjusting spending variations within a region, similar to the method for equalizing the federal contribution under Section 203 of this legislation.	<b>Section 201. [§1860E-3(c)].</b> The Administrator would make monthly payments to each EFFS organization with respect to coverage of an enrollee in an EFFS region.

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Provisions	Current Law	S. 1	H.R. 1
<i>Region-specific benchmarks</i>	See similar description under Payments to MA organization section above ( <i>Payment rate modifications</i> ).	<b>Section 211. [§1858(c)(2)].</b> Beginning in 2006, the Secretary would calculate a benchmark amount for required services for each region equal to the average of each benchmark amount for each MA payment area within the region, weighted by the number of MA eligible individuals residing in the payment area for the year. Each year, beginning in 2005, the Secretary would publish (at the time of publication of the risk adjustors under Part D — no later than April 15) the benchmark amount for each region, factors to be used for adjusting payments under the comprehensive risk adjustment methodology and methodology used for adjustments for geographic variations within a region.	<b>Section 201. [§1860E-3(b)(3)].</b> Similar to S. 1. The EFFE region-specific non-drug monthly benchmark amount would be an amount equal to one-twelfth of the average (weighted by the number of EFFE eligible individuals in each payment area) of the annual MA capitation rate calculated for that area. The capitation rate would be calculated by increasing the previous year payment rate by the revised minimum percentage increase. (See <b>Section 212.</b> )  <b>Section 231.</b> The announcement of payment rates, including rates for EFFE plans, would be permanently moved to no later than the second Monday in May.
<i>Payments to plans based on bids</i>	No provision.	<b>Section 211. [§1858(c)(4)].</b> The Secretary would pay plans as follows. <b>Non-drug benefits:</b> For plans with bids <i>below</i> the regional benchmark, the plan would receive the regional benchmark reduced by the amount of any Part B premium reduction elected by the plan. For bids <i>at or above</i> the regional benchmark (adjusted using the plan’s assumptions with respect to the numbers of enrollees), the plan would receive the regional benchmark amount. Payments would be adjusted for risk and geographic variation.  <b>Drug benefits:</b> The same methodology for calculating prescription drug payments for MA plans would be used for regional PPOs.	<b>Section 201(a). [§1860E-3(c)].</b> The Administrator would pay plans as follows. <b>Non-drug benefits:</b> For plans with bids <i>below</i> the benchmark, the payment would equal the unadjusted EFFE statutory non-drug monthly bid amount, with adjustments for demographics (including health status) as well as intra-regional geographic variations and the monthly rebate. For plans with bids <i>at or above</i> the benchmark, the payment amount would equal the EFFE region-specific non-drug monthly benchmark amount, with the demographic (including health status) as well as intra-regional geographic adjustments.  <b>Drug benefits:</b> Additionally, for an EFFE enrollee who enrolled in Part D and elected prescription drug coverage through the plan, the plan’s payment would include a direct and a reinsurance subsidy payment and reimbursement for premiums and cost-sharing reductions for certain low-income beneficiaries.

Provisions	Current Law	S. 1	H.R. 1
<p><i>Risk adjustment</i></p>	<p>See similar description under Payments to MA organizations section above (<i>Risk Adjustment</i>).</p>	<p><b>Section 211.</b> [§1858(c)]. The Secretary would apply the comprehensive risk adjustment methodology to 100% of the plan payment.</p>	<p>In addition to the current law requirements for risk adjustments for individual enrollees, both bids and benchmarks would also be risk adjusted, based on the following methodology.</p> <p>[§1860E-4]. Beginning in 2006, the Administrator would determine (no later than the second Monday in September), for each EFFE region, the average of the risk adjustment factors (including age, disability status, gender, institutional status, health status, and other factors the Administrator determined to be appropriate) to be applied to enrollees in that region. In the case of an EFFE region in which a plan was offered in the previous year, the Administrator could compute the average based on factors used in the previous year. In a case of a region in which no EFFE plan was offered in the previous year, the Administrator would estimate the average and could use average risk adjustment factors applied to comparable regions or applied on a national basis.</p> <p>The Administrator would apply the average risk adjustors to the EFFE region-specific non-drug monthly benchmark amount and the unadjusted EFFE statutory non-drug monthly bid amount.</p>
<p><b>Bids, Premiums and Risk Sharing</b></p>			
<p><i>Submission of bids and associated deadlines</i></p>	<p>See similar description under Bids and Premiums in the MA section above (<i>Submission of bids and associated deadlines</i>).</p>	<p><b>Section 211.</b>[§1858(d)]. Each plan would submit a bid for coverage of required benefits, with assumptions about the number of enrollees. No later than the second Monday in September, a PPO would have to submit notice of intent, information on which region the plan is bidding, and information similarly required for other MA plans.</p>	<p><b>Section 201(a).</b> [§1860E-3(a)]. Each year, beginning in 2006, an EFFE organization would submit a monthly bid amount for each plan in each region, referred to as the “EFFE monthly bid amount,” in a form, manner, and time specified by the Administrator. The bid could not vary among EFFE eligible individuals in the EFFE region involved. The EFFE organization</p>



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Provisions	Current Law	S. 1	H.R. 1
		<p>The same rules for providing additional benefits in MA plans would also apply to the PPOs. If the regional benchmark exceeded the bid, the PPO plan would be required to provide additional benefits in the same manner as required in the MA program.</p> <p>Unlike other MA plans, PPOs would not be permitted to segment a region.</p>	<p>would be required to provide the following information: (1) the bid amount for the provision of all required items and services, based on average costs for a typical beneficiary residing in the region and the actuarial basis for determining such amount; (2) the proportion of the bid attributed to the provision of statutory non-drug benefits (the “unadjusted EFFS statutory non-drug monthly bid amount”), statutory prescription drug benefits, and non-statutory benefits (including the actuarial basis for determining these proportions); and (3) additional information as the Administrator may require.</p>
<p><i>Authority to negotiate and reject bid submissions</i></p>	<p>See similar description under Bids and Premiums in the MA section above (<i>Authority to negotiate and reject bid submission</i>).</p>	<p><b>Section 211. [§1858(d)].</b> The Secretary would review the adjusted community rates, the amounts of the MA monthly basic premium and the MA monthly beneficiary premium for enhanced medical benefits and could approve or disapprove these amounts.</p> <p><b>[§1858(b)].</b> The Secretary could disapprove any PPO believed to attract a population that is healthier than the average population of the region serviced by the plan.</p>	<p><b>Section 201(a). [§1860E-2(c)(2)].</b> The Administrator would not approve an EFFS plan if benefits were designed to substantially discourage enrollment by certain eligible individuals.</p> <p><b>Section 201(a). [§1860E-3(a)].</b> The Administrator would have the authority to negotiate bid amounts that the Director of the Office of Personnel Management has with respect to the Federal Employee Health Benefits Plan. The Administrator could negotiate the bid amount and could also reject a bid amount or proportion, if it was not supported by the actuarial basis.</p>

Provisions	Current Law	S. 1	H.R. 1
<i>Beneficiary premiums and rebates</i>	See similar description under Bids and Premiums in the MA section above ( <i>Beneficiary premiums and rebates</i> ).	<b>Section 211. [§1858(d)].</b> The monthly premium charged to an enrollee would equal the sum of any MA monthly basic beneficiary premium, any MA monthly beneficiary premium for enhanced medical benefits, and any MA monthly obligation for qualified prescription drug coverage. Premiums could not vary among MA eligibles in a region.	<p><b>Section 201(a). [§1860E-4(a)].</b> The beneficiary monthly premium would be zero for plans providing rebates (explained below). For other plans it would be the amount, if any, by which the unadjusted EFFE statutory non-drug monthly bid amount exceeded the EFFE region-specific non-drug monthly benchmark amount.</p> <p><b>[§1860E-3(b)].</b> The EFFE plan would provide the enrollee a monthly rebate equal to 75% of the average per capita saving, if any. The average per capita monthly savings would equal the amount by which the risk-adjusted benchmark exceeded the risk-adjusted bid. The remaining 25% of the average per capita savings would be retained by the federal government.</p> <p>The rebate could be in the form of any combination of a credit towards the EFFE monthly prescription drug premium, the EFFE monthly supplemental beneficiary premium, a direct monthly payment, or other means approved by the Administrator, or a combination of the above.</p>
<i>Risk-sharing arrangements</i>	No provision.	<p><b>Section 211. [§1858(e)].</b> The PPO would notify the Secretary of the total amount of costs incurred during 2007 and 2008 in providing covered benefits under Part A and B of Medicare, except that certain expenses would not be included (administrative expenses over the amount determined appropriate by the Administrator and amounts expended for enhanced medical benefits).</p> <p>The Secretary would be required to establish risk corridors for the regional PPO plans for 2006 and</p>	No provision.

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Provisions	Current Law	S. 1	H.R. 1
		<p>2007. Medicare would share risk with PPO organizations after costs fell above or below a risk corridor of 5% as follows: 1) Medicare would share 50% of the losses or profits between 105% and 110% of a target which consists of Medicare's MA payment plus the beneficiaries' contributions; and 2) Medicare would share 90% of the losses or profits above 110% of the target. PPOs would be at full risk for all enhanced medical benefits. A beneficiary's liability would not be affected by these risk corridors in the given years.</p>	
<p><i>Beneficiary incentives</i></p>	<p>M+C plans cannot offer cash or monetary rebates as an inducement for enrollment.</p>	<p>No provision.</p>	<p><b>Section 201(a).</b> [§1860-1(c)]. EFSF plans would have to comply with existing eligibility, election, and enrollment provisions (under §1851) including guaranteed issue and renewal, but could offer cash or monetary rebates as an inducement for enrollment.</p> <p><b>Section 221(e).</b> For MA plans, the ability to offer cash or monetary rebates would be limited to the rebates (based on the calculation of average per capita monthly savings) established under this bill.</p>

## Other Managed Care Reforms

Provisions	Current Law	S. 1	H.R. 1
<p><i>Extend reasonable cost contracts</i></p>	<p>Cost-based plans are those plans that are reimbursed by Medicare for the actual cost of furnishing covered services to Medicare beneficiaries, less the estimated value of beneficiary cost-sharing. The Secretary can not extend or renew a reasonable cost reimbursement contract for any period beyond December 31, 2004.</p>	<p><b>Section 221.</b> Reasonable cost contracts could be extended or renewed until December 31, 2009. Beginning in 2004, these plans would have to comply with certain requirements of the M+C program (and beginning in 2006 the MA program), including ongoing quality assurance programs, physician incentive plan limitations, uniform premium amount requirements, premium tax restrictions, federal preemption, authority of an organization to include supplemental health care benefits, benefit filling deadlines, contract renewals and beneficiary notifications, and proposed cost-sharing subject to the Secretary's review.</p> <p>The Secretary would be required to approve a new application for a group practice HMO to enter into a reasonable cost contract if the group met certain requirements of the Public Health Service Act. The requirements would be that the group practice HMO, as of January 1, 2004, provided at least 85% of the services of a physician (which are provided as basic health services) through a medical group (or groups), and met other requirements for such entities specified in statute.</p>	<p><b>Section 235.</b> Reasonable cost contracts could be extended or renewed through 2007. Beginning January 1, 2008, cost contracts could continue unless during the entire previous year, the service area had two or more coordinated care MA plans or two or more EFFEFS plans, each of which met the following minimum enrollment requirements: 1) at least 5,000 enrollees for the portion of the area that is within a metropolitan statistical area having more than 250,000 people and counties contiguous to such an area, and 2) at least 1,500 enrollees for any other portion of such area.</p>

Provisions	Current Law	S. 1	H.R. 1
<i>Establish specialized Medicare Advantage plans for beneficiaries with special needs</i>	One model for providing a specialized M+C plan, EverCare, operates as a demonstration program. EverCare is designed to study the effectiveness of managing acute-care needs of nursing home residents by pairing physicians and geriatric nurse practitioners. EverCare receives a fixed capitated payment, based on a percentage of the AAPCC, for all nursing home resident Medicare enrollees.	<b>Section 222.</b> A new M+C option would be established — specialized M+C plans for special needs beneficiaries (such as the EverCare demonstration). Special needs beneficiaries are defined as those M+C eligible beneficiaries who were institutionalized, entitled to Medicaid, or met requirements determined by the Secretary. Enrollment in specialized M+C plans could be limited to special needs beneficiaries until January 1, 2008. No later than December 31, 2006, the Secretary would be required to submit a report to Congress that assessed the impact of specialized M+C plans for special needs beneficiaries on the cost and quality of services provided to enrollees. No later than 1 year after enactment of this Act, the Secretary would be required to issue final regulations to establish requirements for special needs beneficiaries.	<b>Section 233.</b> Substantially the same provision, but these specialized plans would be established as new MA plans. Also, the Secretary would be permitted to offer specialized MA plans for plans that disproportionately serve beneficiaries with special needs who are the frail elderly. Enrollment could be limited to special needs beneficiaries until January 1, 2007. Interim regulations would be required within 6 months of enactment. The required study would be due no later than December 31, 2005.
<i>Payment by Program of All-Inclusive Care for the Elderly (PACE) providers for Medicare and Medicaid services furnished by non-contract providers</i>	PACE was created as a demonstration project in the Omnibus Budget Reconciliation Act (OBRA 86). The Secretary was required to grant waivers of certain Medicare and Medicaid requirements to a maximum of 10 (expanded to 15 in OBRA90) community-based organizations to provide health and long-term care services on a capitated basis to frail elderly persons at risk of being institutionalized. Balanced Budget Act 97 (BBA97) made PACE a permanent part of Medicare and a state option for the Medicaid program.	<b>Section 223.</b> For the Medicare program, protections against balance billing to PACE providers and beneficiaries enrolled with such PACE providers would apply in the same manner as applies to M+C. For the Medicaid program, with respect to services covered under the State plan (but not under Medicare) that were furnished to beneficiary enrolled in a PACE program, the PACE program would not be required to pay a provider an amount greater than required under the state plan.	No provision.
<i>Require Institute of Medicine (IOM) study on health care performance measures</i>	No provision.	<b>Section 224.</b> Within 2 months of enactment, the Secretary would be required to enter into an arrangement with IOM to evaluate leading health care performance measures and options to implement policies that align performance with payment under the Medicare program. The information that would be catalogued, reviewed	<b>Section 237.</b> The Secretary would request that the IOM conduct a study to review and evaluate public and private sector experiences in: 1) establishing performance measures and payment incentives under the Medicare program, and 2) linking performance to payment. The Secretary would also request that no later than 18 months

Provisions	Current Law	S. 1	H.R. 1
		and evaluated by IOM would be specified in statute. A report would be due to the Secretary and the congressional committees of jurisdiction within 18 months of enactment. There would be \$1 million authorized to be appropriated to conduct the evaluation and prepare the report.	after enactment, the Institute submit a report to the Secretary and the Congress that included a review and evaluation of incentives to encourage quality performance, as specified in the statute. The study would also examine how these measures and incentives might be applied in the Medicare MA, EFS, and FFS programs. The report would include recommendations regarding appropriate performance measures for use in assessing and paying for quality and would identify options for updating performance measures.
<i>Expand the work of Medicare Quality Improvement Organizations (QIOs) to include Parts C and D</i>	QIOs, formerly known as Peer Review Organizations (PROs), are responsible for working with consumers, physicians, hospitals, and other care-givers to refine care delivery .	<b>Section 225.</b> The responsibilities of the QIOs would be expanded to include M+C and MA organizations, prescription drug card sponsors, and eligible entities beginning January 1, 2004. Quality improvement assistance relating to prescription drug therapy would be provided to providers, practitioners, prescription drug card sponsors, eligible entities under Part D, M+C plans, and MA plans beginning January 1, 2004.	No provision.
<i>Extend demonstration project for end-stage renal disease (ESRD) managed care</i>	Medicare beneficiaries with ESRD cannot enroll in a managed care plan. If they develop ESRD while a member of a plan they can continue their enrollment in the plan. The Deficit Reduction Act of 1984 established a demonstration project for ESRD managed care, which was subsequently extended by the Omnibus Budget Reconciliation Act of 1993.	<b>Section 226.</b> The Secretary would be required to extend the demonstration project for ESRD managed care through December 31, 2007. The terms and conditions in place during 2002 would apply. The monthly capitation rate for enrollees would be set based on the reasonable medical and direct administrative costs of providing the benefits to participants.	No provision.
<i>Avoid duplicative state regulations</i>	Medicare law currently preempts state law or regulation from applying to M+C plans to the extent they are inconsistent with federal requirements imposed on M+C plans, and specifically, relating to benefit requirements, the inclusion or treatment of providers, and coverage determinations (including related appeals and grievance processes).	No provision.	<b>Section 232.</b> Federal standards established by this legislation would supersede any state law or regulation (other than state licensure laws and state laws relating to plan solvency), with respect to MA plans offered by MA organizations.

Provisions	Current Law	S. 1	H.R. 1
<i>Extend Municipal Health Service demonstration project</i>	Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, the Municipal Health Service demonstration project will expire on December 31, 2004. The project is a multi-site demonstration intended to improve access to primary care services in underserved urban areas and to reduce the cost of health care. BBA97 authorized the Secretary to extend the project through December 31, 2000, but only with respect to persons who had received at least one service for the period of January 1, 1996-August 7, 1997 (the enactment date of BBA97). Sites that wanted the demonstration project extended were required to submit plans for the orderly transition of participants to a non-demonstration health care delivery system. Subsequent legislation extended the project through December 31, 2004.	<b>Section 618.</b> Demonstration projects would be extended through December 31, 2006, for beneficiaries who reside in the city in which the project is operated.	<b>Section 236.</b> Same provision but would extend the demonstration through December 31, 2009.
<i>Evaluate fee-for-service modernization projects</i>	No provision.	<b>Section 232.</b> The Secretary would be required to review the results of the demonstrations required under Sections 442, 443, and 444 of this bill and report to Congress by January 1, 2008. [These demonstrations are the Medicare health care quality demonstration, the Medicare complex clinical care management payment demonstration, and the Medicare fee-for-service care coordination demonstration.] Beginning in 2009, the Secretary would be required to establish projects to provide Medicare beneficiaries in traditional Medicare coverage of enhanced benefits or services (preventive services not already covered under Medicare, chronic care coordination services, disease management services or other benefits determined by the Secretary). The purpose of the projects would be to evaluate whether the enhanced benefits or services improved the quality of care, improved	No explicit provision. H.R. 1 would establish chronic care improvement benefits under fee-for-service (Section 721) and under MA and EFS (Section 722).

Provisions	Current Law	S. 1	H.R. 1
		health care delivery systems, and reduced expenditures under the Medicare program. The projects would be conducted in regions comparable to the regions designated as “highly competitive.” The Secretary would be required to submit annual reports to Congress and the GAO beginning no later than April 1, 2010. The GAO would be required to report by January 1, 2011 and biennially thereafter for as long as the projects were being conducted.	
<i>Establish MA enrollment goal</i>	No provision.	<b>Section 241.</b> This provision would establish an MA enrollment goal of at least 15% of Medicare beneficiaries by January 1, 2010. If the goal were not met, a bipartisan commission would be established as provided for in Section 242.	No provision.
<i>Establish national bipartisan commission on Medicare reform</i>	No provision.	<b>Section 242.</b> If the enrollment goal described in Section 241 were not met, the National Bipartisan Commission on Medicare Reform would be established. The Commission would review and analyze the long-term financial condition of the Medicare program; identify problems that threaten the financial integrity of the Medicare Trust Funds; and analyze potential solutions to the identified problems. The Commission would be required to make recommendations, including issues facing Medicare, such as solvency, financing of the Medicare Trust Funds, and benefits. The Commission would have 17 members — four appointed by the President, 12 appointed by Congressional leaders, and one appointed jointly by the President and Congressional leaders to serve as Chairperson. The Commission would be required to submit a report and an implementation bill to the President and Congress no later than April 1, 2014.	No provision.



Provisions	Current Law	S. 1	H.R. 1
<i>Establish congressional consideration of reform proposals</i>	No provision.	<b>Section 243.</b> Congressional leaders would be required to introduce the implementation bill required by Section 242. Hearings would be required by appropriate committees as well as floor consideration.	No provision.
<i>Authorize appropriations</i>	No provision.	<b>Section 244.</b> Appropriations would be authorized for such sums as necessary to carry out the provisions regarding the National Bipartisan Commission on Medicare Reform for fiscal years 2012 through 2013.	No provision.

### Alternative Payment or Competition Reforms

Provisions	Current Law	S. 1	H.R. 1
<i>General</i>	No provision.	<b>Section 231.</b> [§1851 (i)]. Beginning in 2008, the Secretary would establish a limited program in highly competitive areas, in which payments to plans is based on bids in place of benchmarks.	<b>Section 241.</b> Beginning in 2010, competitive bidding would be introduced for designated highly competitive areas or regions. All Medicare beneficiaries residing in competitive areas, including those remaining in FFS, could have their Part B premium payment adjusted, either up or down.
<i>Eligible areas</i>	Under existing minimum enrollment requirements, an M+C organization must provide health care benefits to at least 5,000 individuals; a provider-sponsored organization (PSO) must provide health care benefits to 1,500 individuals. M+C organizations that primarily serve individuals residing outside of urban areas must provide health care benefits to 1,500 individuals; such a PSO must provide benefits to 500 individuals.	<b>Section 231.</b> In 2008, the Secretary would be required to designate a limited number, but not less than 1, of preferred provider regions as “highly competitive.” For each subsequent year, the Secretary could designate a limited number of additional regions as highly competitive.  In determining which regions to designate as highly competitive, the Secretary would consider whether: (1) the designation would enhance participation of PPO plans in the region, (2) three bids would be likely, (3) MA eligible individuals would elect PPO plans if the area was designated, and	<b>Section 241.</b> Beginning in 2010, this provision would provide for a new payment in a “competitive EFFE region” and in a “competitive MA area” (CMA) defined as a region (or in the case of a MA, an area) that, during open season, offered at least 2 EFFE plans (or in the case of a CMA, at least 2 MA plans) by different organizations, each meeting the current law minimum enrollment requirements for a plan, as of March of the previous year. Additionally, there would be a minimum percentage enrollment requirement for EFFE eligible individuals (or MA eligible

Provisions	Current Law	S. 1	H.R. 1
		<p>(4)designation would permit compliance with the funding limitation (\$6 billion in addition to what would have been expended under this Title if this subsection had not been enacted, for 2009 through 2013). Beginning in 2014, there would be no additional funding, beyond the total amount that would have been expended if this subsection of the bill were not enacted.</p> <p>The Secretary would be required to give special consideration to regions where no bids had been submitted in the previous year.</p>	<p>individuals) in the region (or area) — the lessor of 20% enrollment or the percentage enrolled for EFFS and MA plans nationwide, as of March of the previous year. For an EFFS region (or for a MA area) that was competitive in the previous year, the Administrator could continue to treat the region or area as meeting the requirement for being competitive if there was only a de minimis reduction.</p>
<p><i>Benchmark rate for competitive regions</i></p>	<p>No provision.</p>	<p><b>Section 231.</b> If an area was designated as highly competitive, benchmarks would not apply. Instead, a plan would bid the total payment it was willing to accept (not taking into account risk adjustment) for providing required Parts A and B benefits to plan enrollees residing in the service area. The Secretary would substitute the second lowest bid for the benchmark. If there were fewer than three bids, the Secretary would be required to substitute the lowest bid for the benchmark.</p>	<p><b>Section 241(a)(2).</b> For EFFS regions, the competitive EFFS non-drug monthly benchmark amount would be equal to the sum of the <b>EFFS component</b> and the FFS component.</p> <p>The <b>EFFS component</b> would be based on the weighted average of the EFFS plan bids, multiplied by one minus the FFS market percentage. (The weighted average of plan bids would equal the unadjusted EFFS statutory non-drug monthly bid multiplied by percentage enrollment of EFFS enrollees in the plan during March of the previous year. The one minus the FFS market share component of this calculation would be the proportion of EFFS eligible individuals enrolled in an EFFS or MA plan in the region, or nationwide, if greater.)</p> <p>The <b>FFS component</b> would be based on the adjusted average per capita cost (AAPCC) multiplied by the FFS market share percentage. (The AAPCC would include services covered under Parts A and B of Medicare for individuals entitled to Part A, enrolled in Part B, who were not enrolled in an EFFS or MA plan. This</p>

Provisions	Current Law	S. 1	H.R. 1
			<p>amount would be adjusted to: (1)exclude direct graduate medical education costs, (2) fully take into account demographic and health status risk factors to reflect average costs for a typical beneficiary residing in the region, and (3) include the VA/DOD adjustment. The FFS market percentage would equal the percent of beneficiaries not enrolled in MA or EFFS plans in the region, or nationwide if higher.)</p>
<p><i>Benchmark rate for competitive areas</i></p>	<p>No provision.</p>	<p>No provision, because an alternative payment system is used for these plans.</p>	<p><b>Section 241(b)(1).</b> For CMAs, the CMA non-drug benchmark amount would be equal to the sum of the <b>MA component and the FFS component.</b></p> <p>The <b>MA component</b> would be based on the weighted average of the MA plan bids for the area and year multiplied by one minus the FFS market percentage. (The weighted average of plan bids would equal the unadjusted MA statutory non-drug monthly bid multiplied by percentage enrollment of MA enrollees in the plan during March of the previous year. The one minus the FFS market share component of this calculation would be the proportion of MA eligible individuals enrolled in an EFFS or MA plan, or nationwide, if greater.)</p> <p>The <b>FFS component</b> would be based on the AAPCC (adjusted in the same manner as the AAPCC is adjusted for the EFFS FFS component), multiplied by the FFS market share percentage. The FFS market percentage would equal the percent of MA eligible individuals who were not enrolled in MA or EFFS plans in the region, or nationwide if higher.)</p>

Provisions	Current Law	S. 1	H.R. 1
<i>Beneficiary premiums and rebates</i>	M+C enrollees share in any projected cost savings between Medicare's per capita payment to a plan and what it would cost the plan to provide Medicare benefits to its commercial enrollees. To accomplish this, plans must provide either reduced cost-sharing or additional benefits to their Medicare enrollees that are valued at 100% of the difference between the projected cost of providing Medicare-covered services and the expected revenue for Medicare enrollees. Additionally, beginning in 2003, plans may also reduce the Medicare Part B premium. Plans can choose which additional benefits to offer, however, the total cost of these benefits must at least equal the "savings" from Medicare-covered services. Plans may also place the additional funds in a stabilization fund or return funds to the Treasury.	No specific provision, so that current law calculation of premiums (or rebates) would continue to remain in effect.	<p><b>Section 241.</b> For plans with a bid below the benchmark, the beneficiary premium would be zero. Similar to the premium rebate under the MA or EFS programs for non-competitive areas/regions, enrollees in competitive areas/regions would receive a rebate equal to 75% of the average per capita monthly savings if the plan bid were below the benchmark. The remaining 25% of the average per capita savings would be retained by the federal government. For plans with bids above the benchmark, the premium would be equal to the full amount the bid exceeded the benchmark.</p> <p>A beneficiary residing in a competitive area or region who was covered under FFS Medicare, could also have an adjustment to their Part B premium, either as an increase or a decrease. For competitive areas or regions, if the FFS area/region-specific non-drug amount for the month <i>did not exceed</i> the benchmark for the competitive area/region, the Part B premium would be reduced by 75% of the difference. If the FFS area/region specific non-drug amount for the month <i>exceeded</i> the benchmark for the competitive area/region, the Medicare beneficiary's Medicare Part B premium would increase by the full amount of the difference.</p>
<i>Phase-in of competitive program</i>	No provision.	No provision.	<p><b>Section 241.</b> The competitive programs would be phased-in so that if an area (or region) had not been designated as competitive for each of the last 4 years, the benchmark for plans would be calculated based on a phased-in benchmark. During the first year of the phase-in, the benchmark would be one-fifth competitive benchmark and four-fifth non-competitive, benchmark, increasing the competitive share by</p>

Provisions	Current Law	S. 1	H.R. 1
			<p>another one-fifth each year until the benchmark was 100% competitive.</p> <p>Part B premium adjustments for Medicare beneficiaries covered under FFS would also be phased-in similarly over a 5-year period.</p>
<i>Other requirements</i>	No provision.	No provision.	The Administrator would transmit the name, Social Security number and Part B premium adjustment to the Commissioner of Social Security at the beginning of each year and periodically throughout the year, effective January 1, 2010.
<i>Reports</i>	No provision.	<p><b>Section 231.</b> The Secretary would be required to report to Congress and the Comptroller General no later than April 1 of each year, beginning 2010. The report would include a description of (and certification of reasonableness and accuracy by the Chief Actuary for CMS) of the total amount expended under this provision compared with what otherwise would have been expended, the projection of the total amount that will be expended compared to the total that would otherwise be expended, the amounts remaining of the \$6 billion limitation, and the steps the Secretary would take to ensure expenditures would not exceed the amount specified.</p> <p>The GAO would be required to submit to the Secretary and the Congress a report on the designation of highly competitive regions no later than January 1, 2011 and biennially thereafter. The report would be required to include an evaluation of: the quality of care provided to beneficiaries enrolled in an MA plan in a highly competitive region; the satisfaction of beneficiaries with benefits under the plan; the costs to the Medicare</p>	No provision.

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Provisions	Current Law	S. 1	H.R. 1
		<p>program for payments made to the plans; any improvement in the delivery of health care services under a plan; and other information.</p>	
		<p>The Secretary would be required to report to Congress if she or he intends to designate one or more regions as highly competitive in 2014 or subsequent years. The report would be required by April 1 of the year prior to the designation, and would include the steps the Secretary would take to ensure that funding would not exceed the amount specified and would contain a certification from the Chief Actuary of CMS that the steps described would meet statutory requirements.</p>	

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