The Choice in Healthcare Act

Section-by-Section

Sec. 1 -- Short Title

Sec. 2

This section requires the Secretary of Health and Human Services (HHS) to establish a demonstration program for the purpose of allowing certain Medicare and Medicaid eligible individuals to purchase qualifying private health benefits.

It further requires the Secretary to supply demonstration participants with a debit style card, known as a Medi Choice Card, to help pay for benefits.

This section requires the purchase of "qualifying health benefits"—which is defined as either the minimum coverage associated with fee-for-service Medicaid under the State Plan operating in the demonstration area or in the case of a Medicare beneficiary, fee-for-service Medicare.

Finally, this section provides guarantee issue, prevents denial of coverage based on pre-existing conditions, and requires premiums to be community rated.

Sec. 3

Section 3 details how the Medi Choice Card will be established and used. It requires the Secretary of HHS to enter into a contract with a credit card provider or financial institution for the purpose of issuing debit-style cards and limits use of the card to the purchase of qualifying health benefits, to pay copayments, deductibles, and other cost-sharing.

Sec. 4

This section defines who is eligible to participate in the demonstration program. Program participants must be legal permanent residents of the demonstration area and low income (Medicaid) or entitled to Part A benefits under the Social Security Act (Medicare). Dual eligible beneficiaries are also permitted to participate.

TRICARE participants are ineligible, as are individuals enrolled under XIX of the Social Security Act (disability). Unlawful aliens are ineligible.

Sec. 5

This section establishes the cash benefit associated with the Medi Choice Card. For Medicare beneficiaries, the annual benefit will be the U.S. average nominal dollar value of the Medicare benefit.

For beneficiaries' eligible based on low-income status, the annual benefit will be the U.S. average nominal value of the Medicaid benefit. Dual eligible beneficiaries will receive funding based on the

U.S. average nominal value of their current benefit. These funds will be made available through the debit card on a monthly pro-rata basis to pay for required coverage and are adjusted each year for inflation.

The Secretary is also required to establish a system of risk adjustment to account for the relative cost of benefits associated with program participants. Medi Choice funding will be increased or decreased based upon relative risk factors.

Finally, higher-income individuals covered by Medicare receive reduced support with a maximum reduction of 50%.

Sec. 6

This section defines the demonstration program area to be seven California Counties, including Kern, Tulare, Kings, Fresno, Madera, Merced, Stanislaus, and San Joaquin. It also specifies that the program will operate for a period of ten years and limits participation to 100,000 individuals.

Sec. 7

This section requires the Secretary to pay for the demonstration program and specifies that these expenditures are authorized expenditures under titles XIX and XVIII of the Social Security Act.

Sec. 8

This section requires the Secretary to maintain a toll free phone number to assist eligible beneficiaries with enrollment. It also specifies that demonstration participants are not required to pay any premium otherwise applicable under Medicare Part B or D.

Demonstration participants are required to maintain qualified health coverage.

Demonstration participants are not eligible to receive traditional Medicare or Medicaid benefits, with the exception of medical assistance under title XIX for services, such as long-term care, for which benefits are not provided under the demonstration.