106TH CONGRESS
2D SESSION

H. R. 4680

AN ACT

To amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, and for other purposes.

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To amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

2 (a) SHORT TITLE.—This Act may be cited as the
3 "Medicare Rx 2000 Act".

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

Sec. 1. Short title; table of contents.

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

Sec. 101. Establishment of a medicare prescription drug benefit.
Sec. 102. Offering of qualified prescription drug coverage under the Medicare+Choice program.
Sec. 103. Medicaid amendments.
Sec. 104. Medigap transition provisions.
Sec. 105. State Pharmaceutical Assistance Transition Commission.
Sec. 106. Demonstration project for disease management for severely chronically ill medicare beneficiaries.

TITLE II—MODERNIZATION OF ADMINISTRATION OF MEDICARE

Subtitle A—Medicare Benefits Administration

Sec. 201. Establishment of administration.
Sec. 202. Miscellaneous administrative provisions.

Subtitle B—Oversight of Financial Sustainability of the Medicare Program

Sec. 211. Additional requirements for annual financial report and oversight on medicare program.

Subtitle C—Changes in Medicare Coverage and Appeals Process

Sec. 221. Revisions to medicare appeals process.
Sec. 222. Provisions with respect to limitations on liability of beneficiaries.
Sec. 223. Waivers of liability for cost sharing amounts.
Sec. 224. Elimination of motions by the Secretary on decisions of the Provider Reimbursement Review Board.
Sec. 225. Effective date of subtitle.

TITLE III—MEDICARE+CHOICE REFORMS; PRESERVATION OF MEDICARE PART B DRUG BENEFIT

Subtitle A—Medicare+Choice Reforms

Sec. 301. Increase in national per capita Medicare+Choice growth percentage in 2001 and 2002.
Sec. 302. Permanently removing application of budget neutrality beginning in 2002.
Sec. 303. Increasing minimum payment amount.
Sec. 304. Allowing movement to 50:50 percent blend in 2002.
Sec. 305. Increased update for payment areas with only one or no Medicare+Choice contracts.

Sec. 306. Permitting higher negotiated rates in certain Medicare+Choice payment areas below national average.
Sec. 307. 10-year phase in of risk adjustment based on data from all settings.
Sec. 308. Delay from July to October, 2000 in deadline for offering and withdrawing Medicare+Choice plans for 2001.

Subtitle B—Preservation of Medicare Coverage of Drugs and Biologicals

Sec. 311. Preservation of coverage of drugs and biologicals under part B of the medicare program.
Sec. 312. GAO report on part B payment for drugs and biologicals and related services.

1 # TITLE I—MEDICARE
2 # PRESCRIPTION DRUG BENEFIT

3 **SEC. 101. ESTABLISHMENT OF A MEDICARE PRESCRIPTION**
4 **DRUG BENEFIT.**

5 (a) IN GENERAL.—Title XVIII of the Social Security
6 Act is amended—
7 (1) by redesignating part D as part E; and
8 (2) by inserting after part C the following new
9 part:

10 "PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT
11 PROGRAM

12 **"SEC. 1860A. BENEFITS; ELIGIBILITY; ENROLLMENT; AND**
13 **COVERAGE PERIOD.**

14 "(a) PROVISION OF QUALIFIED PRESCRIPTION DRUG
15 COVERAGE THROUGH ENROLLMENT IN PLANS.—Subject
16 to the succeeding provisions of this part, each individual
17 who is enrolled under part B is entitled to obtain qualified
18 prescription drug coverage (described in section
19 1860B(a)) as follows:

1 "(1) MEDICARE+CHOICE PLAN.—If the indi-
2 vidual is eligible to enroll in a Medicare+Choice plan
3 that provides qualified prescription drug coverage
4 under section 1851(j), the individual may enroll in
5 the plan and obtain coverage through such plan.

6 "(2) PRESCRIPTION DRUG PLAN.—If the indi-
7 vidual is not enrolled in a Medicare+Choice plan
8 that provides qualified prescription drug coverage,
9 the individual may enroll under this part in a pre-
10 scription drug plan (as defined in section 1860C(a)).
11 Such individuals shall have a choice of such plans under
12 section 1860E(d).

13 "(b) GENERAL ELECTION PROCEDURES.—

14 "(1) IN GENERAL.—An individual may elect to
15 enroll in a prescription drug plan under this part, or
16 elect the option of qualified prescription drug cov-
17 erage under a Medicare+Choice plan under part C,
18 and change such election only in such manner and
19 form as may be prescribed by regulations of the Ad-
20 ministrator of the Medicare Benefits Administration
21 (appointed under section 1807(b)) (in this part re-
22 ferred to as the 'Medicare Benefits Administrator')
23 and only during an election period prescribed in or
24 under this subsection.

25 "(2) ELECTION PERIODS.—

1 "(A) IN GENERAL.—Except as provided in
2 this paragraph, the election periods under this
3 subsection shall be the same as the coverage
4 election periods under the Medicare+Choice
5 program under section 1851(e), including—
6 "(i) annual coordinated election peri-
7 ods; and
8 "(ii) special election periods.
9 In applying the last sentence of section
10 1851(e)(4) (relating to discontinuance of a
11 Medicare+Choice election during the first year
12 of eligibility) under this subparagraph, in the
13 case of an election described in such section in
14 which the individual had elected or is provided
15 qualified prescription drug coverage at the time
16 of such first enrollment, the individual shall be
17 permitted to enroll in a prescription drug plan
18 under this part at the time of the election of
19 coverage under the original fee-for-service plan.
20 "(B) INITIAL ELECTION PERIODS.—
21 "(i) INDIVIDUALS CURRENTLY COV-
22 ERED.—In the case of an individual who is
23 enrolled under part B as of November 1,
24 2002, there shall be an initial election pe-
25 riod of 6 months beginning on that date.

1 "(ii) INDIVIDUAL COVERED IN FU-
2 TURE.—In the case of an individual who is
3 first enrolled under part B after November
4 1, 2002, there shall be an initial election
5 period which is the same as the initial en-
6 rollment period under section 1837(d).
7 "(C) ADDITIONAL SPECIAL ELECTION PE-
8 RIODS.—The Medicare Benefits Administrator
9 shall establish special election periods—
10 "(i) in cases of individuals who have
11 and involuntarily lose prescription drug
12 coverage described in subsection (c)(2)(C);
13 "(ii) in cases described in section
14 1837(h) (relating to errors in enrollment),
15 in the same manner as such section applies
16 to part B; and
17 "(iii) in the case of an individual who
18 meets such exceptional conditions (includ-
19 ing conditions recognized under section
20 1851(d)(4)(D)) as the Administrator may
21 provide.
22 "(D) ONE-TIME ENROLLMENT PERMITTED
23 FOR CURRENT PART A ONLY BENEFICIARIES.—
24 In the case of an individual who as of Novem-
25 ber 1, 2002—

1 "(i) is entitled to benefits under part
2 A; and
3 "(ii) is not (and has not previously
4 been) enrolled under part B,
5 the individual shall be eligible to enroll in a pre-
6 scription drug plan under this part but only
7 during the period described in subparagraph
8 (B)(i). If the individual enrolls in such a plan,
9 the individual may change such enrollment
10 under this part, but the individual may not en-
11 roll in a Medicare+Choice plan under part C
12 unless the individual enrolls under part B.
13 Nothing in this subparagraph shall be con-
14 strued as providing for coverage under a pre-
15 scription drug plan of benefits that are excluded
16 because of the application of section
17 1860B(f)(2)(B).
18 "(c) GUARANTEED ISSUE; COMMUNITY RATING; AND
19 NONDISCRIMINATION.—
20 "(1) GUARANTEED ISSUE.—
21 "(A) IN GENERAL.—An eligible individual
22 who is eligible to elect qualified prescription
23 drug coverage under a prescription drug plan or
24 Medicare+Choice plan at a time during which
25 elections are accepted under this part with re-

1 spect to the plan shall not be denied enrollment
2 based on any health status-related factor (de-
3 scribed in section 2702(a)(1) of the Public
4 Health Service Act) or any other factor.
5 "(B) MEDICARE+CHOICE LIMITATIONS
6 PERMITTED.—The provisions of paragraphs (2)
7 and (3) (other than subparagraph (C)(i), relat-
8 ing to default enrollment) of section 1851(g)
9 (relating to priority and limitation on termi-
10 nation of election) shall apply to PDP sponsors
11 under this subsection.
12 "(2) COMMUNITY-RATED PREMIUM.—
13 "(A) IN GENERAL.—In the case of an indi-
14 vidual who maintains (as determined under sub-
15 paragraph (C)) continuous prescription drug
16 coverage since first qualifying to elect prescrip-
17 tion drug coverage under this part, a PDP
18 sponsor or Medicare+Choice organization offer-
19 ing a prescription drug plan or
20 Medicare+Choice plan that provides qualified
21 prescription drug coverage and in which the in-
22 dividual is enrolled may not deny, limit, or con-
23 dition the coverage or provision of covered pre-
24 scription drug benefits or increase the premium
25 under the plan based on any health status-re-

1 lated factor described in section 2702(a)(1) of
2 the Public Health Service Act or any other fac-
3 tor.

4 "(B) LATE ENROLLMENT PENALTY.—In
5 the case of an individual who does not maintain
6 such continuous prescription drug coverage, a
7 PDP sponsor or Medicare+Choice organization
8 may (notwithstanding any provision in this
9 title) increase the premium otherwise applicable
10 or impose a pre-existing condition exclusion
11 with respect to qualified prescription drug cov-
12 erage in a manner that reflects additional actu-
13 arial risk involved. Such a risk shall be estab-
14 lished through an appropriate actuarial opinion
15 of the type described in subparagraphs (A)
16 through (C) of section 2103(c)(4).

17 "(C) CONTINUOUS PRESCRIPTION DRUG
18 COVERAGE.—An individual is considered for
19 purposes of this part to be maintaining contin-
20 uous prescription drug coverage on and after a
21 date if the individual establishes that there is
22 no period of 63 days or longer on and after
23 such date (beginning not earlier than January
24 1, 2003) during all of which the individual did

1 not have any of the following prescription drug
2 coverage:
3 "(i) COVERAGE UNDER PRESCRIPTION
4 DRUG PLAN OR MEDICARE+CHOICE
5 PLAN.—Qualified prescription drug cov-
6 erage under a prescription drug plan or
7 under a Medicare+Choice plan.
8 "(ii) MEDICAID PRESCRIPTION DRUG
9 COVERAGE.—Prescription drug coverage
10 under a medicaid plan under title XIX, in-
11 cluding through the Program of All-inclu-
12 sive Care for the Elderly (PACE) under
13 section 1934, through a social health main-
14 tenance organization (referred to in section
15 4104(c) of the Balanced Budget Act of
16 1997), or through a Medicare+Choice
17 project that demonstrates the application
18 of capitation payment rates for frail elderly
19 medicare beneficiaries through the use of a
20 interdisciplinary team and through the
21 provision of primary care services to such
22 beneficiaries by means of such a team at
23 the nursing facility involved.
24 "(iii) PRESCRIPTION DRUG COVERAGE
25 UNDER GROUP HEALTH PLAN.—Any out-

1 patient prescription drug coverage under a
2 group health plan, including a health bene-
3 fits plan under the Federal Employees
4 Health Benefit Plan under chapter 89 of
5 title 5, United States Code, and a qualified
6 retiree prescription drug plan as defined in
7 section 1860H(f)(1).
8 ''(iv) PRESCRIPTION DRUG COVERAGE
9 UNDER CERTAIN MEDIGAP POLICIES.—
10 Coverage under a medicare supplemental
11 policy under section 1882 that provides
12 benefits for prescription drugs (whether or
13 not such coverage conforms to the stand-
14 ards for packages of benefits under section
15 1882(p)(1)), but only if the policy was in
16 effect on January 1, 2003, and only until
17 the date such coverage is terminated.
18 ''(v) STATE PHARMACEUTICAL ASSIST-
19 ANCE PROGRAM.—Coverage of prescription
20 drugs under a State pharmaceutical assist-
21 ance program.
22 ''(vi) VETERANS' COVERAGE OF PRE-
23 SCRIPTION DRUGS.—Coverage of prescrip-
24 tion drugs for veterans under chapter 17
25 of title 38, United States Code.

1 "(D) CERTIFICATION.—For purposes of
2 carrying out this paragraph, the certifications
3 of the type described in sections 2701(e) of the
4 Public Health Service Act and in section
5 9801(e) of the Internal Revenue Code shall also
6 include a statement for the period of coverage
7 of whether the individual involved had prescrip-
8 tion drug coverage described in subparagraph
9 (C).
10 "(E) CONSTRUCTION.—Nothing in this
11 section shall be construed as preventing the
12 disenrollment of an individual from a prescrip-
13 tion drug plan or a Medicare+Choice plan
14 based on the termination of an election de-
15 scribed in section 1851(g)(3), including for non-
16 payment of premiums or for other reasons spec-
17 ified in subsection (d)(3), which takes into ac-
18 count a grace period described in section
19 1851(g)(3)(B)(i).
20 "(3) NONDISCRIMINATION.—A PDP sponsor of-
21 fering a prescription drug plan shall not establish a
22 service area in a manner that would discriminate
23 based on health or economic status of potential en-
24 rollees.
25 "(d) EFFECTIVE DATE OF ELECTIONS.—

1 "(1) IN GENERAL.—Except as provided in this
2 section, the Medicare Benefits Administrator shall
3 provide that elections under subsection (b) take ef-
4 fect at the same time as the Secretary provides that
5 similar elections under section 1851(e) take effect
6 under section 1851(f).
7 "(2) NO ELECTION EFFECTIVE BEFORE 2003.—
8 In no case shall any election take effect before Janu-
9 ary 1, 2003.
10 "(3) TERMINATION.—The Medicare Benefits
11 Administrator shall provide for the termination of an
12 election in the case of—
13 "(A) termination of coverage under part B
14 (other than the case of an individual described
15 in subsection (b)(2)(D) (relating to part A only
16 individuals)); and
17 "(B) termination of elections described in
18 section 1851(g)(3) (including failure to pay re-
19 quired premiums).
20 **"SEC. 1860B. REQUIREMENTS FOR QUALIFIED PRESCRIP-**
21 **TION DRUG COVERAGE.**
22 "(a) REQUIREMENTS.—
23 "(1) IN GENERAL.—For purposes of this part
24 and part C, the term 'qualified prescription drug
25 coverage' means either of the following:

1 "(A) STANDARD COVERAGE WITH ACCESS
2 TO NEGOTIATED PRICES.—Standard coverage
3 (as defined in subsection (b)) and access to ne-
4 gotiated prices under subsection (d).
5 "(B) ACTUARIALLY EQUIVALENT COV-
6 ERAGE WITH ACCESS TO NEGOTIATED
7 PRICES.—Coverage of covered outpatient drugs
8 which meets the alternative coverage require-
9 ments of subsection (c) and access to negotiated
10 prices under subsection (d).
11 "(2) PERMITTING ADDITIONAL OUTPATIENT
12 PRESCRIPTION DRUG COVERAGE.—
13 "(A) IN GENERAL.—Subject to subpara-
14 graph (B), nothing in this part shall be con-
15 strued as preventing qualified prescription drug
16 coverage from including coverage of covered
17 outpatient drugs that exceeds the coverage re-
18 quired under paragraph (1), but any such addi-
19 tional coverage shall be limited to coverage of
20 covered outpatient drugs.
21 "(B) DISAPPROVAL AUTHORITY.—The
22 Medicare Benefits Administrator shall review
23 the offering of qualified prescription drug cov-
24 erage under this part or part C. If the Adminis-
25 trator finds that, in the case of a qualified pre-

1 scription drug coverage under a prescription
2 drug plan or a Medicare+Choice plan, that the
3 organization or sponsor offering the coverage is
4 purposefully engaged in activities intended to
5 result in favorable selection of those eligible
6 medicare beneficiaries obtaining coverage
7 through the plan, the Administrator may termi-
8 nate the contract with the sponsor or organiza-
9 tion under this part or part C.

10 "(3) APPLICATION OF SECONDARY PAYOR PRO-
11 VISIONS.—The provisions of section 1852(a)(4) shall
12 apply under this part in the same manner as they
13 apply under part C.

14 "(b) STANDARD COVERAGE.—For purposes of this
15 part, the 'standard coverage' is coverage of covered out-
16 patient drugs (as defined in subsection (f)) that meets the
17 following requirements:

18 "(1) DEDUCTIBLE.—The coverage has an an-
19 nual deductible—

20 "(A) for 2003, that is equal to $250; or

21 "(B) for a subsequent year, that is equal
22 to the amount specified under this paragraph
23 for the previous year increased by the percent-
24 age specified in paragraph (5) for the year in-
25 volved.

1 Any amount determined under subparagraph (B)
2 that is not a multiple of $5 shall be rounded to the
3 nearest multiple of $5.

4 "(2) LIMITS ON COST-SHARING.—The coverage
5 has cost-sharing (for costs above the annual deduct-
6 ible specified in paragraph (1) and up to the initial
7 coverage limit under paragraph (3)) that is equal to
8 50 percent or that is actuarially consistent (using
9 processes established under subsection (e)) with an
10 average expected payment of 50 percent of such
11 costs.

12 "(3) INITIAL COVERAGE LIMIT.—Subject to
13 paragraph (4), the coverage has an initial coverage
14 limit on the maximum costs that may be recognized
15 for payment purposes (above the annual deduct-
16 ible)—

17 "(A) for 2003, that is equal to $2,100; or

18 "(B) for a subsequent year, that is equal
19 to the amount specified in this paragraph for
20 the previous year, increased by the annual per-
21 centage increase described in paragraph (5) for
22 the year involved.

23 Any amount determined under subparagraph (B)
24 that is not a multiple of $25 shall be rounded to the
25 nearest multiple of $25.

1 "(4) LIMITATION ON OUT-OF-POCKET EXPENDI-
2 TURES BY BENEFICIARY.—
3 "(A) IN GENERAL.—Notwithstanding para-
4 graph (3), the coverage provides benefits with-
5 out any cost-sharing after the individual has in-
6 curred costs (as described in subparagraph (C))
7 for covered outpatient drugs in a year equal to
8 the annual out-of-pocket limit specified in sub-
9 paragraph (B).
10 "(B) ANNUAL OUT-OF-POCKET LIMIT.—
11 For purposes of this part, the 'annual out-of-
12 pocket limit' specified in this subparagraph—
13 "(i) for 2003, is equal to $6,000; or
14 "(ii) for a subsequent year, is equal to
15 the amount specified in this subparagraph
16 for the previous year, increased by the an-
17 nual percentage increase described in para-
18 graph (5) for the year involved.
19 Any amount determined under clause (ii) that
20 is not a multiple of $100 shall be rounded to
21 the nearest multiple of $100.
22 "(C) APPLICATION.—In applying subpara-
23 graph (A)—
24 "(i) incurred costs shall only include
25 costs incurred for the annual deductible

1 (described in paragraph (1)), cost-sharing
2 (described in paragraph (2)), and amounts
3 for which benefits are not provided because
4 of the application of the initial coverage
5 limit described in paragraph (3); and

6 ''(ii) such costs shall be treated as in-
7 curred without regard to whether the indi-
8 vidual or another person, including a State
9 program or other third-party coverage, has
10 paid for such costs.

11 ''(5) ANNUAL PERCENTAGE INCREASE.—For
12 purposes of this part, the annual percentage increase
13 specified in this paragraph for a year is equal to the
14 annual percentage increase in average per capita ag-
15 gregate expenditures for covered outpatient drugs in
16 the United States for medicare beneficiaries, as de-
17 termined by the Medicare Benefits Administrator for
18 the 12-month period ending in July of the previous
19 year.

20 ''(c) ALTERNATIVE COVERAGE REQUIREMENTS.—A
21 prescription drug plan or Medicare+Choice plan may pro-
22 vide a different prescription drug benefit design from the
23 standard coverage described in subsection (b) so long as
24 the following requirements are met:

1 "(1) ASSURING AT LEAST ACTUARIALLY EQUIV-
2 ALENT COVERAGE.—
3 "(A) ASSURING EQUIVALENT VALUE OF
4 TOTAL COVERAGE.—The actuarial value of the
5 total coverage (as determined under subsection
6 (e)) is at least equal to the actuarial value (as
7 so determined) of standard coverage.
8 "(B) ASSURING EQUIVALENT UNSUB-
9 SIDIZED VALUE OF COVERAGE.—The unsub-
10 sidized value of the coverage is at least equal to
11 the unsubsidized value of standard coverage.
12 For purposes of this subparagraph, the unsub-
13 sidized value of coverage is the amount by
14 which the actuarial value of the coverage (as
15 determined under subsection (e)) exceeds the
16 actuarial value of the reinsurance subsidy pay-
17 ments under section 1860H with respect to
18 such coverage.
19 "(C) ASSURING STANDARD PAYMENT FOR
20 COSTS AT INITIAL COVERAGE LIMIT.—The cov-
21 erage is designed, based upon an actuarially
22 representative pattern of utilization (as deter-
23 mined under subsection (e)), to provide for the
24 payment, with respect to costs incurred that are
25 equal to the sum of the deductible under sub-

1 section (b)(1) and the initial coverage limit
2 under subsection (b)(3), of an amount equal to
3 at least such initial coverage limit multiplied by
4 the percentage specified in subsection (b)(2).
5 ''(2) LIMITATION ON OUT-OF-POCKET EXPENDI-
6 TURES BY BENEFICIARIES.—The coverage provides
7 the limitation on out-of-pocket expenditures by bene-
8 ficiaries described in subsection (b)(4).
9 ''(d) ACCESS TO NEGOTIATED PRICES.—Under
10 qualified prescription drug coverage offered by a PDP
11 sponsor or a Medicare+Choice organization, the sponsor
12 or organization shall provide beneficiaries with access to
13 negotiated prices (including applicable discounts) used for
14 payment for covered outpatient drugs, regardless of the
15 fact that no benefits may be payable under the coverage
16 with respect to such drugs because of the application of
17 cost-sharing or an initial coverage limit (described in sub-
18 section (b)(3)). Insofar as a State elects to provide medical
19 assistance under title XIX for a drug based on the prices
20 negotiated by a prescription drug plan under this part,
21 the requirements of section 1927 shall not apply to such
22 drugs.
23 ''(e) ACTUARIAL VALUATION; DETERMINATION OF
24 ANNUAL PERCENTAGE INCREASES.—

1 "(1) PROCESSES.—For purposes of this section,
2 the Medicare Benefits Administrator shall establish
3 processes and methods—
4 "(A) for determining the actuarial valu-
5 ation of prescription drug coverage, including—
6 "(i) an actuarial valuation of standard
7 coverage and of the reinsurance subsidy
8 payments under section 1860H;
9 "(ii) the use of generally accepted ac-
10 tuarial principles and methodologies; and
11 "(iii) applying the same methodology
12 for determinations of alternative coverage
13 under subsection (c) as is used with re-
14 spect to determinations of standard cov-
15 erage under subsection (b); and
16 "(B) for determining annual percentage in-
17 creases described in subsection (b)(5).
18 "(2) USE OF OUTSIDE ACTUARIES.—Under the
19 processes under paragraph (1)(A), PDP sponsors
20 and Medicare+Choice organizations may use actu-
21 arial opinions certified by independent, qualified ac-
22 tuaries to establish actuarial values.
23 "(f) COVERED OUTPATIENT DRUGS DEFINED.—

1 "(1) IN GENERAL.—Except as provided in this
2 subsection, for purposes of this part, the term 'cov-
3 ered outpatient drug' means—
4 "(A) a drug that may be dispensed only
5 upon a prescription and that is described in
6 subparagraph (A)(i) or (A)(ii) of section
7 1927(k)(2); or
8 "(B) a biological product described in
9 clauses (i) through (iii) of subparagraph (B) of
10 such section or insulin described in subpara-
11 graph (C) of such section,
12 and such term includes any use of a covered out-
13 patient drug for a medically accepted indication (as
14 defined in section 1927(k)(6)).
15 "(2) EXCLUSIONS.—
16 "(A) IN GENERAL.—Such term does not
17 include drugs or classes of drugs, or their med-
18 ical uses, which may be excluded from coverage
19 or otherwise restricted under section
20 1927(d)(2), other than subparagraph (E) there-
21 of (relating to smoking cessation agents) and
22 except to the extent otherwise specifically pro-
23 vided by the Medicare Benefits Administrator
24 with respect to a drug in any of such classes.

1 "(B) AVOIDANCE OF DUPLICATE COV-
2 ERAGE.—A drug prescribed for an individual
3 that would otherwise be a covered outpatient
4 drug under this part shall not be so considered
5 if payment for such drug is available under part
6 A or B (but shall be so considered if such pay-
7 ment is not available because benefits under
8 part A or B have been exhausted), without re-
9 gard to whether the individual is entitled to
10 benefits under part A or enrolled under part B.
11 "(3) APPLICATION OF FORMULARY RESTRIC-
12 TIONS.—A drug prescribed for an individual that
13 would otherwise be a covered outpatient drug under
14 this part shall not be so considered under a plan if
15 the plan excludes the drug under a formulary that
16 meets the requirements of section 1860C(f)(2) (in-
17 cluding providing an appeal process).
18 "(4) APPLICATION OF GENERAL EXCLUSION
19 PROVISIONS.—A prescription drug plan or
20 Medicare+Choice plan may exclude from qualified
21 prescription drug coverage any covered outpatient
22 drug—
23 "(A) for which payment would not be
24 made if section 1862(a) applied to part D; or

1 “(B) which are not prescribed in accord-
2 ance with the plan or this part.
3 Such exclusions are determinations subject to recon-
4 sideration and appeal pursuant to section 1860C(f).
5 “(5) STUDY ON INCLUSION OF DRUGS TREAT-
6 ING MORBID OBESITY.—The Medicare Policy Advi-
7 sory Board shall provide for a study on removing the
8 exclusion under paragraph (2)(A) for coverage of
9 agents used for weight loss in the case of morbidly
10 obese individuals. The Board shall report to Con-
11 gress on the results of the study not later than
12 March 1, 2002.

13 **“SEC. 1860C. BENEFICIARY PROTECTIONS FOR QUALIFIED**
14 **PRESCRIPTION DRUG COVERAGE.**

15 “(a) GUARANTEED ISSUE COMMUNITY-RELATED
16 PREMIUMS AND NONDISCRIMINATION.—For provisions re-
17 quiring guaranteed issue, community-rated premiums, and
18 nondiscrimination, see sections 1860A(c)(1), 1860A(c)(2),
19 and 1860F(b).
20 “(b) DISSEMINATION OF INFORMATION.—
21 “(1) GENERAL INFORMATION.—A PDP sponsor
22 shall disclose, in a clear, accurate, and standardized
23 form to each enrollee with a prescription drug plan
24 offered by the sponsor under this part at the time
25 of enrollment and at least annually thereafter, the

1 information described in section 1852(c)(1) relating
2 to such plan. Such information includes the fol-
3 lowing:

4 ‘‘(A) Access to covered outpatient drugs,
5 including access through pharmacy networks.

6 ‘‘(B) How any formulary used by the spon-
7 sor functions.

8 ‘‘(C) Co-payments and deductible require-
9 ments.

10 ‘‘(D) Grievance and appeals procedures.

11 ‘‘(2) DISCLOSURE UPON REQUEST OF GENERAL
12 COVERAGE, UTILIZATION, AND GRIEVANCE INFORMA-
13 TION.—Upon request of an individual eligible to en-
14 roll under a prescription drug plan, the PDP spon-
15 sor shall provide the information described in section
16 1852(c)(2) (other than subparagraph (D)) to such
17 individual.

18 ‘‘(3) RESPONSE TO BENEFICIARY QUESTIONS.—
19 Each PDP sponsor offering a prescription drug plan
20 shall have a mechanism for providing specific infor-
21 mation to enrollees upon request. The sponsor shall
22 make available, through an Internet website and in
23 writing upon request, information on specific
24 changes in its formulary.

1 "(4) CLAIMS INFORMATION.—Each PDP spon-
2 sor offering a prescription drug plan must furnish to
3 enrolled individuals in a form easily understandable
4 to such individuals an explanation of benefits (in ac-
5 cordance with section 1806(a) or in a comparable
6 manner) and a notice of the benefits in relation to
7 initial coverage limit and annual out-of-pocket limit
8 for the current year, whenever prescription drug
9 benefits are provided under this part (except that
10 such notice need not be provided more often than
11 monthly).
12 "(c) ACCESS TO COVERED BENEFITS.—
13 "(1) ASSURING PHARMACY ACCESS.—The PDP
14 sponsor of the prescription drug plan shall secure
15 the participation of sufficient numbers of pharmacies
16 (which may include mail order pharmacies) to en-
17 sure convenient access (including adequate emer-
18 gency access) for enrolled beneficiaries, in accord-
19 ance with standards established under section
20 1860D(e) that ensure such convenient access. Noth-
21 ing in this paragraph shall be construed as requiring
22 the participation of (or permitting the exclusion of)
23 all pharmacies in any area under a plan.
24 "(2) ACCESS TO NEGOTIATED PRICES FOR PRE-
25 SCRIPTION DRUGS.—The PDP sponsor of a prescrip-

1 tion drug plan shall issue such a card that may be
2 used by an enrolled beneficiary to assure access to
3 negotiated prices under section 1860B(d) for the
4 purchase of prescription drugs for which coverage is
5 not otherwise provided under the prescription drug
6 plan.

7 ‘‘(3) REQUIREMENTS ON DEVELOPMENT AND
8 APPLICATION OF FORMULARIES.—Insofar as a PDP
9 sponsor of a prescription drug plan uses a for-
10 mulary, the following requirements must be met:

11 ‘‘(A) FORMULARY COMMITTEE.—The spon-
12 sor must establish a pharmaceutical and thera-
13 peutic committee that develops the formulary.
14 Such committee shall include at least one physi-
15 cian and at least one pharmacist.

16 ‘‘(B) INCLUSION OF DRUGS IN ALL THERA-
17 PEUTIC CATEGORIES.—The formulary must in-
18 clude drugs within all therapeutic categories
19 and classes of covered outpatient drugs (al-
20 though not necessarily for all drugs within such
21 categories and classes).

22 ‘‘(C) APPEALS AND EXCEPTIONS TO APPLI-
23 CATION.—The PDP sponsor must have, as part
24 of the appeals process under subsection (f)(2),

1 a process for appeals for denials of coverage
2 based on such application of the formulary.
3 "(d) COST AND UTILIZATION MANAGEMENT; QUAL-
4 ITY ASSURANCE; MEDICATION THERAPY MANAGEMENT
5 PROGRAM.—
6 "(1) IN GENERAL.—The PDP sponsor shall
7 have in place—
8 "(A) an effective cost and drug utilization
9 management program, including appropriate in-
10 centives to use generic drugs, when appropriate;
11 "(B) quality assurance measures and sys-
12 tems to reduce medical errors and adverse drug
13 interactions, including a medication therapy
14 management program described in paragraph
15 (2); and
16 "(C) a program to control fraud, abuse,
17 and waste.
18 "(2) MEDICATION THERAPY MANAGEMENT PRO-
19 GRAM.—
20 "(A) IN GENERAL.—A medication therapy
21 management program described in this para-
22 graph is a program of drug therapy manage-
23 ment and medication administration that is de-
24 signed to assure that covered outpatient drugs
25 under the prescription drug plan are appro-

1 priately used to achieve therapeutic goals and
2 reduce the risk of adverse events, including ad-
3 verse drug interactions.
4 ‘‘(B) ELEMENTS.—Such program may
5 include—
6 ‘‘(i) enhanced beneficiary under-
7 standing of such appropriate use through
8 beneficiary education, counseling, and
9 other appropriate means; and
10 ‘‘(ii) increased beneficiary adherence
11 with prescription medication regimens
12 through medication refill reminders, special
13 packaging, and other appropriate means.
14 ‘‘(C) DEVELOPMENT OF PROGRAM IN CO-
15 OPERATION WITH LICENSED PHARMACISTS.—
16 The program shall be developed in cooperation
17 with licensed pharmacists and physicians.
18 ‘‘(D) CONSIDERATIONS IN PHARMACY
19 FEES.—The PDP sponsor of a prescription
20 drug program shall take into account, in estab-
21 lishing fees for pharmacists and others pro-
22 viding services under the medication therapy
23 management program, the resources and time
24 used in implementing the program.

1 "(3) TREATMENT OF ACCREDITATION.—Section
2 1852(e)(4) (relating to treatment of accreditation)
3 shall apply to prescription drug plans under this
4 part with respect to the following requirements, in
5 the same manner as they apply to Medicare+Choice
6 plans under part C with respect to the requirements
7 described in a clause of section 1852(e)(4)(B):
8 "(A) Paragraph (1) (including quality as-
9 surance), including medication therapy manage-
10 ment program under paragraph (2).
11 "(B) Subsection (c)(1) (relating to access
12 to covered benefits).
13 "(C) Subsection (g) (relating to confiden-
14 tiality and accuracy of enrollee records).
15 "(4) PUBLIC DISCLOSURE OF PHARMACEUTICAL
16 PRICES FOR GENERIC EQUIVALENT DRUGS.—Each
17 PDP sponsor shall provide that each pharmacy or
18 other dispenser that arranges for the dispensing of
19 a covered outpatient drug shall inform the bene-
20 ficiary at the time of purchase of the drug of any
21 differential between the price of the prescribed drug
22 to the enrollee and the price of the lowest cost ge-
23 neric drug that is therapeutically and pharmaceuti-
24 cally equivalent and bioequivalent.

1 "(e) GRIEVANCE MECHANISM.—Each PDP sponsor
2 shall provide meaningful procedures for hearing and re-
3 solving grievances between the organization (including any
4 entity or individual through which the sponsor provides
5 covered benefits) and enrollees with prescription drug
6 plans of the sponsor under this part in accordance with
7 section 1852(f).

8 "(f) COVERAGE DETERMINATIONS, RECONSIDER-
9 ATIONS, AND APPEALS.—

10 "(1) IN GENERAL.—A PDP sponsor shall meet
11 the requirements of section 1852(g) with respect to
12 covered benefits under the prescription drug plan it
13 offers under this part in the same manner as such
14 requirements apply to a Medicare+Choice organiza-
15 tion with respect to benefits it offers under a
16 Medicare+Choice plan under part C.

17 "(2) APPEALS OF FORMULARY DETERMINA-
18 TIONS.—Under the appeals process under paragraph
19 (1) an individual who is enrolled in a prescription
20 drug plan offered by a PDP sponsor may appeal to
21 obtain coverage for a covered outpatient drug that
22 is not on the formulary of the sponsor (established
23 under subsection (c)) if the prescribing physician de-
24 termines that the therapeutically similar drug that is

1 on the formulary is not as effective for the enrollee
2 or has significant adverse effects for the enrollee.
3 ''(g) CONFIDENTIALITY AND ACCURACY OF EN-
4 ROLLEE RECORDS.—A PDP sponsor shall meet the re-
5 quirements of section 1852(h) with respect to enrollees
6 under this part in the same manner as such requirements
7 apply to a Medicare+Choice organization with respect to
8 enrollees under part C.

9 **''SEC. 1860D. REQUIREMENTS FOR PRESCRIPTION DRUG**
10 **PLAN (PDP) SPONSORS; CONTRACTS; ESTAB-**
11 **LISHMENT OF STANDARDS.**

12 ''(a) GENERAL REQUIREMENTS.—Each PDP sponsor
13 of a prescription drug plan shall meet the following re-
14 quirements:
15 ''(1) LICENSURE.—Subject to subsection (c),
16 the sponsor is organized and licensed under State
17 law as a risk-bearing entity eligible to offer health
18 insurance or health benefits coverage in each State
19 in which it offers a prescription drug plan.
20 ''(2) ASSUMPTION OF FULL FINANCIAL RISK.—
21 ''(A) IN GENERAL.—Subject to subpara-
22 graph (B) and section 1860E(d)(2), the entity
23 assumes full financial risk on a prospective
24 basis for qualified prescription drug coverage
25 that it offers under a prescription drug plan

1 and that is not covered under reinsurance
2 under section 1860H.
3 ‘‘(B) REINSURANCE PERMITTED.—The en-
4 tity may obtain insurance or make other ar-
5 rangements for the cost of coverage provided to
6 any enrolled member under this part.
7 ‘‘(3) SOLVENCY FOR UNLICENSED SPONSORS.—
8 In the case of a sponsor that is not described in
9 paragraph (1), the sponsor shall meet solvency
10 standards established by the Medicare Benefits Ad-
11 ministrator under subsection (d).
12 ‘‘(b) CONTRACT REQUIREMENTS.—
13 ‘‘(1) IN GENERAL.—The Medicare Benefits Ad-
14 ministrator shall not permit the election under sec-
15 tion 1860A of a prescription drug plan offered by a
16 PDP sponsor under this part, and the sponsor shall
17 not be eligible for payments under section 1860G or
18 1860H, unless the Administrator has entered into a
19 contract under this subsection with the sponsor with
20 respect to the offering of such plan. Such a contract
21 with a sponsor may cover more than one prescrip-
22 tion drug plan. Such contract shall provide that the
23 sponsor agrees to comply with the applicable require-
24 ments and standards of this part and the terms and
25 conditions of payment as provided for in this part.

1 "(2) NEGOTIATION REGARDING TERMS AND
2 CONDITIONS.—The Medicare Benefits Administrator
3 shall have the same authority to negotiate the terms
4 and conditions of prescription drug plans under this
5 part as the Director of the Office of Personnel Man-
6 agement has with respect to health benefits plans
7 under chapter 89 of title 5, United States Code. In
8 negotiating the terms and conditions regarding pre-
9 miums for which information is submitted under sec-
10 tion 1860F(a)(2), the Administrator shall take into
11 account the reinsurance subsidy payments under
12 section 1860H and the adjusted community rate (as
13 defined in section 1854(f)(3)) for the benefits cov-
14 ered.
15 "(3) INCORPORATION OF CERTAIN
16 MEDICARE+CHOICE CONTRACT REQUIREMENTS.—
17 The following provisions of section 1857 shall apply,
18 subject to subsection (c)(5), to contracts under this
19 section in the same manner as they apply to con-
20 tracts under section 1857(a):
21 "(A) MINIMUM ENROLLMENT.—Para-
22 graphs (1) and (3) of section 1857(b).
23 "(B) CONTRACT PERIOD AND EFFECTIVE-
24 NESS.—Paragraphs (1) through (3) and (5) of
25 section 1857(c).

1 "(C) PROTECTIONS AGAINST FRAUD AND
2 BENEFICIARY PROTECTIONS.—Section 1857(d).
3 "(D) ADDITIONAL CONTRACT TERMS.—
4 Section 1857(e); except that in applying section
5 1857(e)(2) under this part—
6 "(i) such section shall be applied sepa-
7 rately to costs relating to this part (from
8 costs under part C);
9 "(ii) in no case shall the amount of
10 the fee established under this subpara-
11 graph for a plan exceed 20 percent of the
12 maximum amount of the fee that may be
13 established under subparagraph (B) of
14 such section; and
15 "(iii) no fees shall be applied under
16 this subparagraph with respect to
17 Medicare+Choice plans.
18 "(E) INTERMEDIATE SANCTIONS.—Section
19 1857(g).
20 "(F) PROCEDURES FOR TERMINATION.—
21 Section 1857(h).
22 "(4) RULES OF APPLICATION FOR INTER-
23 MEDIATE SANCTIONS.—In applying paragraph
24 (3)(E)—

1 "(A) the reference in section
2 1857(g)(1)(B) to section 1854 is deemed a ref-
3 erence to this part; and
4 "(B) the reference in section
5 1857(g)(1)(F) to section 1852(k)(2)(A)(ii) shall
6 not be applied.
7 "(c) WAIVER OF CERTAIN REQUIREMENTS TO EX-
8 PAND CHOICE.—
9 "(1) IN GENERAL.—In the case of an entity
10 that seeks to offer a prescription drug plan in a
11 State, the Medicare Benefits Administrator shall
12 waive the requirement of subsection (a)(1) that the
13 entity be licensed in that State if the Administrator
14 determines, based on the application and other evi-
15 dence presented to the Administrator, that any of
16 the grounds for approval of the application described
17 in paragraph (2) has been met.
18 "(2) GROUNDS FOR APPROVAL.—The grounds
19 for approval under this paragraph are the grounds
20 for approval described in subparagraph (B), (C),
21 and (D) of section 1855(a)(2), and also include the
22 application by a State of any grounds other than
23 those required under Federal law.
24 "(3) APPLICATION OF WAIVER PROCEDURES.—
25 With respect to an application for a waiver (or a

1 waiver granted) under this subsection, the provisions
2 of subparagraphs (E), (F), and (G) of section
3 1855(a)(2) shall apply.

4 "(4) LICENSURE DOES NOT SUBSTITUTE FOR
5 OR CONSTITUTE CERTIFICATION.—The fact that an
6 entity is licensed in accordance with subsection
7 (a)(1) does not deem the entity to meet other re-
8 quirements imposed under this part for a PDP spon-
9 sor.

10 "(5) REFERENCES TO CERTAIN PROVISIONS.—
11 For purposes of this subsection, in applying provi-
12 sions of section 1855(a)(2) under this subsection to
13 prescription drug plans and PDP sponsors—

14 "(A) any reference to a waiver application
15 under section 1855 shall be treated as a ref-
16 erence to a waiver application under paragraph
17 (1); and

18 "(B) any reference to solvency standards
19 shall be treated as a reference to solvency
20 standards established under subsection (d).

21 "(d) SOLVENCY STANDARDS FOR NON-LICENSED
22 SPONSORS.—

23 "(1) ESTABLISHMENT.—The Medicare Benefits
24 Administrator shall establish, by not later than Oc-
25 tober 1, 2001, financial solvency and capital ade-

1 quacy standards that an entity that does not meet
2 the requirements of subsection (a)(1) must meet to
3 qualify as a PDP sponsor under this part.
4 ‘‘(2) COMPLIANCE WITH STANDARDS.—Each
5 PDP sponsor that is not licensed by a State under
6 subsection (a)(1) and for which a waiver application
7 has been approved under subsection (c) shall meet
8 solvency and capital adequacy standards established
9 under paragraph (1). The Medicare Benefits Admin-
10 istrator shall establish certification procedures for
11 such PDP sponsors with respect to such solvency
12 standards in the manner described in section
13 1855(c)(2).
14 ‘‘(e) OTHER STANDARDS.—The Medicare Benefits
15 Administrator shall establish by regulation other stand-
16 ards (not described in subsection (d)) for PDP sponsors
17 and plans consistent with, and to carry out, this part. The
18 Administrator shall publish such regulations by October
19 1, 2001. In order to carry out this requirement in a timely
20 manner, the Administrator may promulgate regulations
21 that take effect on an interim basis, after notice and pend-
22 ing opportunity for public comment.
23 ‘‘(f) RELATION TO STATE LAWS.—
24 ‘‘(1) IN GENERAL.—The standards established
25 under this section shall supersede any State law or

1 regulation (including standards described in para-
2 graph (2)) with respect to prescription drug plans
3 which are offered by PDP sponsors under this part
4 to the extent such law or regulation is inconsistent
5 with such standards.

6 "(2) STANDARDS SPECIFICALLY SUPER-
7 SEDED.—State standards relating to the following
8 are superseded under this subsection:

9 "(A) Benefit requirements.

10 "(B) Requirements relating to inclusion or
11 treatment of providers.

12 "(C) Coverage determinations (including
13 related appeals and grievance processes).

14 "(D) Establishment and regulation of pre-
15 miums.

16 "(3) PROHIBITION OF STATE IMPOSITION OF
17 PREMIUM TAXES.—No State may impose a premium
18 tax or similar tax with respect to premiums paid to
19 PDP sponsors for prescription drug plans under this
20 part, or with respect to any payments made to such
21 a sponsor by the Medicare Benefits Administrator
22 under this part.

1 **"SEC. 1860E. PROCESS FOR BENEFICIARIES TO SELECT**
2 **QUALIFIED PRESCRIPTION DRUG COVERAGE.**

3 "(a) IN GENERAL.—The Medicare Benefits Adminis-
4 trator, through the Office of Beneficiary Assistance, shall
5 establish, based upon and consistent with the procedures
6 used under part C (including section 1851), a process for
7 the selection of the prescription drug plan or
8 Medicare+Choice plan which offer qualified prescription
9 drug coverage through which eligible individuals elect
10 qualified prescription drug coverage under this part.

11 "(b) ELEMENTS.—Such process shall include the fol-
12 lowing:

13 "(1) Annual, coordinated election periods, in
14 which such individuals can change the qualifying
15 plans through which they obtain coverage, in accord-
16 ance with section 1860A(b)(2).

17 "(2) Active dissemination of information to pro-
18 mote an informed selection among qualifying plans
19 based upon price, quality, and other features, in the
20 manner described in (and in coordination with) sec-
21 tion 1851(d), including the provision of annual com-
22 parative information, maintenance of a toll-free hot-
23 line, and the use of non-Federal entities.

24 "(3) Coordination of elections through filing
25 with a Medicare+Choice organization or a PDP

1 sponsor, in the manner described in (and in coordi-
2 nation with) section 1851(c)(2).
3 "(c) MEDICARE+CHOICE ENROLLEE IN PLAN OF-
4 FERING PRESCRIPTION DRUG COVERAGE MAY ONLY OB-
5 TAIN BENEFITS THROUGH THE PLAN.—An individual
6 who is enrolled under a Medicare+Choice plan that offers
7 qualified prescription drug coverage may only elect to re-
8 ceive qualified prescription drug coverage under this part
9 through such plan.
10 "(d) ASSURING ACCESS TO A CHOICE OF QUALIFIED
11 PRESCRIPTION DRUG COVERAGE.—
12 "(1) CHOICE OF AT LEAST TWO PLANS IN EACH
13 AREA.—
14 "(A) IN GENERAL.—The Medicare Bene-
15 fits Administrator shall assure that each indi-
16 vidual who is enrolled under part B and who is
17 residing in an area has available, consistent
18 with subparagraph (B), a choice of enrollment
19 in at least two qualifying plans (as defined in
20 paragraph (5)) in the area in which the indi-
21 vidual resides, at least one of which is a pre-
22 scription drug plan.
23 "(B) REQUIREMENT FOR DIFFERENT
24 PLAN SPONSORS.—The requirement in subpara-
25 graph (A) is not satisfied with respect to an

1 area if only one PDP sponsor or
2 Medicare+Choice organization offers all the
3 qualifying plans in the area.

4 ''(2) GUARANTEEING ACCESS TO COVERAGE.—
5 In order to assure access under paragraph (1) and
6 consistent with paragraph (3), the Medicare Benefits
7 Administrator may provide financial incentives (in-
8 cluding partial underwriting of risk) for a PDP
9 sponsor to expand the service area under an existing
10 prescription drug plan to adjoining or additional
11 areas or to establish such a plan (including offering
12 such a plan on a regional or nationwide basis), but
13 only so long as (and to the extent) necessary to as-
14 sure the access guaranteed under paragraph (1).

15 ''(3) LIMITATION ON AUTHORITY.—In exer-
16 cising authority under this subsection, the Medicare
17 Benefits Administrator—

18 ''(A) shall not provide for the full under-
19 writing of financial risk for any PDP sponsor;

20 ''(B) shall not provide for any under-
21 writing of financial risk for a public PDP spon-
22 sor with respect to the offering of a nationwide
23 prescription drug plan; and

1 "(C) shall seek to maximize the assumption of financial risk by PDP sponsors or Medicare+Choice organizations.

4 "(4) REPORTS.—The Medicare Benefits Administrator shall, in each annual report to Congress under section 1807(f), include information on the exercise of authority under this subsection. The Administrator also shall include such recommendations as may be appropriate to minimize the exercise of such authority, including minimizing the assumption of financial risk.

12 "(5) QUALIFYING PLAN DEFINED.—For purposes of this subsection, the term 'qualifying plan' means a prescription drug plan or a Medicare+Choice plan that includes qualified prescription drug coverage.

17 **"SEC. 1860F. PREMIUMS.**

18 "(a) SUBMISSION OF PREMIUMS AND RELATED INFORMATION.—

20 "(1) IN GENERAL.—Each PDP sponsor shall submit to the Medicare Benefits Administrator information of the type described in paragraph (2) in the same manner as information is submitted by a Medicare+Choice organization under section 1854(a)(1).

1 "(2) TYPE OF INFORMATION.—The information
2 described in this paragraph is the following:
3 "(A) Information on the qualified prescrip-
4 tion drug coverage to be provided.
5 "(B) Information on the actuarial value of
6 the coverage.
7 "(C) Information on the monthly premium
8 to be charged for the coverage, including an ac-
9 tuarial certification of—
10 "(i) the actuarial basis for such pre-
11 mium;
12 "(ii) the portion of such premium at-
13 tributable to benefits in excess of standard
14 coverage; and
15 "(iii) the reduction in such premium
16 resulting from the reinsurance subsidy
17 payments provided under section 1860H.
18 "(D) Such other information as the Medi-
19 care Benefits Administrator may require to
20 carry out this part.
21 "(3) REVIEW.—The Medicare Benefits Admin-
22 istrator shall review the information filed under
23 paragraph (2) for the purpose of conducting negotia-
24 tions under section 1860D(b)(2).

1 "(b) UNIFORM PREMIUM.—The premium for a pre-
2 scription drug plan charged under this section may not
3 vary among individuals enrolled in the plan in the same
4 service area, except as is permitted under section
5 1860A(c)(2)(B) (relating to late enrollment penalties).

6 "(c) TERMS AND CONDITIONS FOR IMPOSING PRE-
7 MIUMS.—The provisions of section 1854(d) shall apply
8 under this part in the same manner as they apply under
9 part C, and, for this purpose, the reference in such section
10 to section 1851(g)(3)(B)(i) is deemed a reference to sec-
11 tion 1860A(d)(3)(B) (relating to failure to pay premiums
12 required under this part).

13 "(d) ACCEPTANCE OF REFERENCE PREMIUM AS
14 FULL PREMIUM IF NO STANDARD (OR EQUIVALENT) COV-
15 ERAGE IN AN AREA.—

16 "(1) IN GENERAL.—If there is no standard pre-
17 scription drug coverage (as defined in paragraph
18 (2)) offered in an area, in the case of an individual
19 who is eligible for a premium subsidy under section
20 1860G and resides in the area, the PDP sponsor of
21 any prescription drug plan offered in the area (and
22 any Medicare+Choice organization that offers quali-
23 fied prescription drug coverage in the area) shall ac-
24 cept the reference premium under section

1860G(b)(2) as payment in full for the premium charge for qualified prescription drug coverage.

"(2) STANDARD PRESCRIPTION DRUG COVERAGE DEFINED.—For purposes of this subsection, the term 'standard prescription drug coverage' means qualified prescription drug coverage that is standard coverage or that has an actuarial value equivalent to the actuarial value for standard coverage.

"SEC. 1860G. PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS.

"(a) IN GENERAL.—

"(1) FULL PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR INDIVIDUALS WITH INCOME BELOW 135 PERCENT OF FEDERAL POVERTY LEVEL.—In the case of a subsidy eligible individual (as defined in paragraph (3)) who is determined to have income that does not exceed 135 percent of the Federal poverty level, the individual is entitled under this section—

"(A) to a premium subsidy equal to 100 percent of the amount described in subsection (b)(1); and

"(B) subject to subsection (c), to the substitution for the beneficiary cost-sharing de-

1 scribed in paragraphs (1) and (2) of section
2 1860B(b) (up to the initial coverage limit speci-
3 fied in paragraph (3) of such section) of
4 amounts that are nominal.

5 "(2) SLIDING SCALE PREMIUM SUBSIDY FOR
6 INDIVIDUALS WITH INCOME ABOVE 135, BUT BELOW
7 150 PERCENT, OF FEDERAL POVERTY LEVEL.—In
8 the case of a subsidy eligible individual who is deter-
9 mined to have income that exceeds 135 percent, but
10 does not exceed 150 percent, of the Federal poverty
11 level, the individual is entitled under this section to
12 a premium subsidy determined on a linear sliding
13 scale ranging from 100 percent of the amount de-
14 scribed in subsection (b)(1) for individuals with in-
15 comes at 135 percent of such level to 0 percent of
16 such amount for individuals with incomes at 150
17 percent of such level.

18 "(3) DETERMINATION OF ELIGIBILITY.—

19 "(A) SUBSIDY ELIGIBLE INDIVIDUAL DE-
20 FINED.—For purposes of this section, subject
21 to subparagraph (D), the term 'subsidy eligible
22 individual' means an individual who—

23 "(i) is eligible to elect, and has elect-
24 ed, to obtain qualified prescription drug
25 coverage under this part;

1 "(ii) has income below 150 percent of
2 the Federal poverty line; and
3 "(iii) meets the resources requirement
4 described in section 1905(p)(1)(C).
5 "(B) DETERMINATIONS.—The determina-
6 tion of whether an individual residing in a State
7 is a subsidy eligible individual and the amount
8 of such individual's income shall be determined
9 under the State medicaid plan for the State
10 under section 1935(a). In the case of a State
11 that does not operate such a medicaid plan (ei-
12 ther under title XIX or under a statewide waiv-
13 er granted under section 1115), such deter-
14 mination shall be made under arrangements
15 made by the Medicare Benefits Administrator.
16 "(C) INCOME DETERMINATIONS.—For pur-
17 poses of applying this section—
18 "(i) income shall be determined in the
19 manner described in section
20 1905(p)(1)(B); and
21 "(ii) the term 'Federal poverty line'
22 means the official poverty line (as defined
23 by the Office of Management and Budget,
24 and revised annually in accordance with
25 section 673(2) of the Omnibus Budget

1 Reconciliation Act of 1981) applicable to a
2 family of the size involved.
3 "(D) TREATMENT OF TERRITORIAL RESI-
4 DENTS.—In the case of an individual who is not
5 a resident of the 50 States or the District of
6 Columbia, the individual is not eligible to be a
7 subsidy eligible individual but may be eligible
8 for financial assistance with prescription drug
9 expenses under section 1935(e).
10 "(b) PREMIUM SUBSIDY AMOUNT.—
11 "(1) IN GENERAL.—The premium subsidy
12 amount described in this subsection for an individual
13 residing in an area is the reference premium (as de-
14 fined in paragraph (2)) for qualified prescription
15 drug coverage offered by the prescription drug plan
16 or the Medicare+Choice plan in which the individual
17 is enrolled.
18 "(2) REFERENCE PREMIUM DEFINED.—For
19 purposes of this subsection, the term 'reference pre-
20 mium' means, with respect to qualified prescription
21 drug coverage offered under—
22 "(A) a prescription drug plan that—
23 "(i) provides standard coverage (or al-
24 ternative prescription drug coverage the
25 actuarial value is equivalent to that of

1 standard coverage), the premium imposed
2 for enrollment under the plan under this
3 part (determined without regard to any
4 subsidy under this section or any late en-
5 rollment penalty under section
6 1860A(c)(2)(B)); or

7 ''(ii) provides alternative prescription
8 drug coverage the actuarial value of which
9 is greater than that of standard coverage,
10 the premium described in clause (i) multi-
11 plied by the ratio of (I) the actuarial value
12 of standard coverage, to (II) the actuarial
13 value of the alternative coverage; or

14 ''(B) a Medicare+Choice plan, the stand-
15 ard premium computed under section
16 1851(j)(5)(A)(iii), determined without regard to
17 any reduction effected under section
18 1851(j)(5)(B).

19 ''(c) RULES IN APPLYING COST-SHARING SUB-
20 SIDIES.—

21 ''(1) IN GENERAL.—In applying subsection
22 (a)(1)(B)—

23 ''(A) the maximum amount of subsidy that
24 may be provided with respect to an enrollee for
25 a year may not exceed 95 percent of the max-

1 imum cost-sharing described in such subsection
2 that may be incurred for standard coverage;
3 ''(B) the Medicare Benefits Administrator
4 shall determine what is 'nominal' taking into
5 account the rules applied under section
6 1916(a)(3); and
7 ''(C) nothing in this part shall be con-
8 strued as preventing a plan or provider from
9 waiving or reducing the amount of cost-sharing
10 otherwise applicable.
11 ''(2) LIMITATION ON CHARGES.—In the case of
12 an individual receiving cost-sharing subsidies under
13 subsection (a)(1)(B), the PDP sponsor may not
14 charge more than a nominal amount in cases in
15 which the cost-sharing subsidy is provided under
16 such subsection.
17 ''(d) ADMINISTRATION OF SUBSIDY PROGRAM.—The
18 Medicare Benefits Administrator shall provide a process
19 whereby, in the case of an individual who is determined
20 to be a subsidy eligible individual and who is enrolled in
21 prescription drug plan or is enrolled in a Medicare+Choice
22 plan under which qualified prescription drug coverage is
23 provided—
24 ''(1) the Administrator provides for a notifica-
25 tion of the PDP sponsor or Medicare+Choice orga-

1 nization involved that the individual is eligible for a
2 subsidy and the amount of the subsidy under sub-
3 section (a);

4 ''(2) the sponsor or organization involved re-
5 duces the premiums or cost-sharing otherwise im-
6 posed by the amount of the applicable subsidy and
7 submits to the Administrator information on the
8 amount of such reduction; and

9 ''(3) the Administrator periodically and on a
10 timely basis reimburses the sponsor or organization
11 for the amount of such reductions.

12 The reimbursement under paragraph (3) with respect to
13 cost-sharing subsidies may be computed on a capitated
14 basis, taking into account the actuarial value of the sub-
15 sidies and with appropriate adjustments to reflect dif-
16 ferences in the risks actually involved.

17 ''(e) RELATION TO MEDICAID PROGRAM.—

18 ''(1) IN GENERAL.—For provisions providing
19 for eligibility determinations, and additional financ-
20 ing, under the medicaid program, see section 1935.

21 ''(2) MEDICAID PROVIDING WRAP AROUND BEN-
22 EFITS.—The coverage provided under this part is
23 primary payor to benefits for prescribed drugs pro-
24 vided under the medicaid program under title XIX.

1 **"SEC. 1860H. SUBSIDIES FOR ALL MEDICARE BENE-**
2 **FICIARIES THROUGH REINSURANCE FOR**
3 **QUALIFIED PRESCRIPTION DRUG COVERAGE.**

4 ''(a) REINSURANCE SUBSIDY PAYMENT.—In order to
5 reduce premium levels applicable to qualified prescription
6 drug coverage for all medicare beneficiaries, to reduce ad-
7 verse selection among prescription drug plans and
8 Medicare+Choice plans that provide qualified prescription
9 drug coverage, and to promote the participation of PDP
10 sponsors under this part, the Medicare Benefits Adminis-
11 trator shall provide in accordance with this section for
12 payment to a qualifying entity (as defined in subsection
13 (b)) of the reinsurance payment amount (as defined in
14 subsection (c)) for excess costs incurred in providing quali-
15 fied prescription drug coverage—

16 ''(1) for individuals enrolled with a prescription
17 drug plan under this part;

18 ''(2) for individuals enrolled with a
19 Medicare+Choice plan that provides qualified pre-
20 scription drug coverage under part C; and

21 ''(3) for medicare primary individuals (de-
22 scribed in subsection (f)(3)(D)) who are enrolled in
23 a qualified retiree prescription drug plan.

24 This section constitutes budget authority in advance of ap-
25 propriations Acts and represents the obligation of the Ad-

1 ministrator to provide for the payment of amounts pro-
2 vided under this section.

3 ‘‘(b) QUALIFYING ENTITY DEFINED.—For purposes
4 of this section, the term ‘qualifying entity’ means any of
5 the following that has entered into an agreement with the
6 Administrator to provide the Administrator with such in-
7 formation as may be required to carry out this section:

8 ‘‘(1) A PDP sponsor offering a prescription
9 drug plan under this part.

10 ‘‘(2) A Medicare+Choice organization that pro-
11 vides qualified prescription drug coverage under a
12 Medicare+Choice plan under part C.

13 ‘‘(3) The sponsor of a qualified retiree prescrip-
14 tion drug plan (as defined in subsection (f)).

15 ‘‘(c) REINSURANCE PAYMENT AMOUNT.—

16 ‘‘(1) IN GENERAL.—Subject to subsection
17 (d)(2) and paragraph (4), the reinsurance payment
18 amount under this subsection for a qualifying cov-
19 ered individual (as defined in subsection (g)(1)) for
20 a coverage year (as defined in subsection (g)(2)) is
21 equal to the sum of the following:

22 ‘‘(A) For the portion of the individual’s
23 gross covered prescription drug costs (as de-
24 fined in paragraph (3)) for the year that ex-
25 ceeds $1,250, but does not exceed $1,350, an

1 amount equal to 30 percent of the allowable
2 costs (as defined in paragraph (2)) attributable
3 to such gross covered prescription drug costs.
4 ''(B) For the portion of the individual's
5 gross covered prescription drug costs for the
6 year that exceeds $1,350, but does not exceed
7 $1,450, an amount equal to 50 percent of the
8 allowable costs attributable to such gross cov-
9 ered prescription drug costs.
10 ''(C) For the portion of the individual's
11 gross covered prescription drug costs for the
12 year that exceeds $1,450, but does not exceed
13 $1,550, an amount equal to 70 percent of the
14 allowable costs attributable to such gross cov-
15 ered prescription drug costs.
16 ''(D) For the portion of the individual's
17 gross covered prescription drug costs for the
18 year that exceeds $1,550, but does not exceed
19 $2,350, an amount equal to 90 percent of the
20 allowable costs attributable to such gross cov-
21 ered prescription drug costs.
22 ''(E) For the portion of the individual's
23 gross covered prescription drug costs for the
24 year that exceeds $7,050, an amount equal to

1 90 percent of the allowable costs attributable to
2 such gross covered prescription drug costs.
3 "(2) ALLOWABLE COSTS.—For purposes of this
4 section, the term 'allowable costs' means, with re-
5 spect to gross covered prescription drug costs under
6 a plan described in subsection (b) offered by a quali-
7 fying entity, the part of such costs that are actually
8 paid under the plan, but in no case more than the
9 part of such costs that would have been paid under
10 the plan if the prescription drug coverage under the
11 plan were standard coverage.
12 "(3) GROSS COVERED PRESCRIPTION DRUG
13 COSTS.—For purposes of this section, the term
14 'gross covered prescription drug costs' means, with
15 respect to an enrollee with a qualifying entity under
16 a plan described in subsection (b) during a coverage
17 year, the costs incurred under the plan for covered
18 prescription drugs dispensed during the year, includ-
19 ing costs relating to the deductible, whether paid by
20 the enrollee or under the plan, regardless of whether
21 the coverage under the plan exceeds standard cov-
22 erage and regardless of when the payment for such
23 drugs is made.
24 "(4) INDEXING DOLLAR AMOUNTS.—

1 "(A) AMOUNTS FOR 2003.—The dollar
2 amounts applied under paragraph (1) for 2003
3 shall be the dollar amounts specified in such
4 paragraph.

5 "(B) FOR 2004.—The dollar amounts ap-
6 plied under paragraph (1) for 2004 shall be the
7 dollar amounts specified in such paragraph in-
8 creased by the annual percentage increase de-
9 scribed in section 1860B(b)(5) for 2004.

10 "(C) FOR SUBSEQUENT YEARS.—The dol-
11 lar amounts applied under paragraph (1) for a
12 year after 2004 shall be the amounts (under
13 this paragraph) applied under paragraph (1)
14 for the preceding year increased by the annual
15 percentage increase described in section
16 1860B(b)(5) for the year involved.

17 "(D) ROUNDING.—Any amount, deter-
18 mined under the preceding provisions of this
19 paragraph for a year, which is not a multiple of
20 $5 shall be rounded to the nearest multiple of
21 $5.

22 "(d) ADJUSTMENT OF PAYMENTS.—

23 "(1) IN GENERAL.—The Medicare Benefits Ad-
24 ministrator shall estimate—

1 "(A) the total payments to be made (with-
2 out regard to this subsection) during a year
3 under this section; and
4 "(B) the total payments to be made by
5 qualifying entities for standard coverage under
6 plans described in subsection (b) during the
7 year.
8 "(2) ADJUSTMENT OF PAYMENTS.—The Ad-
9 ministrator shall proportionally adjust the payments
10 made under this section for a coverage year in such
11 manner so that the total of the payments made for
12 the year under this section is equal to 35 percent of
13 the total payments described in paragraph (1)(B)
14 during the year.
15 "(e) PAYMENT METHODS.—
16 "(1) IN GENERAL.—Payments under this sec-
17 tion shall be based on such a method as the Medi-
18 care Benefits Administrator determines. The Admin-
19 istrator may establish a payment method by which
20 interim payments of amounts under this section are
21 made during a year based on the Administrator's
22 best estimate of amounts that will be payable after
23 obtaining all of the information.

1 "(2) SOURCE OF PAYMENTS.—Payments under
2 this section shall be made from the Medicare Pre-
3 scription Drug Account.

4 "(f) QUALIFIED RETIREE PRESCRIPTION DRUG
5 PLAN DEFINED.—

6 "(1) IN GENERAL.—For purposes of this sec-
7 tion, the term 'qualified retiree prescription drug
8 plan' means employment-based retiree health cov-
9 erage (as defined in paragraph (3)(A)) if, with re-
10 spect to an individual enrolled (or eligible to be en-
11 rolled) under this part who is covered under the
12 plan, the following requirements are met:

13 "(A) ASSURANCE.—The sponsor of the
14 plan shall annually attest, and provide such as-
15 surances as the Medicare Benefits Adminis-
16 trator may require, that the coverage meets the
17 requirements for qualified prescription drug
18 coverage.

19 "(B) AUDITS.—The sponsor (and the plan)
20 shall maintain, and afford the Medicare Bene-
21 fits Administrator access to, such records as the
22 Administrator may require for purposes of au-
23 dits and other oversight activities necessary to
24 ensure the adequacy of prescription drug cov-

1 erage, the accuracy of payments made, and
2 such other matters as may be appropriate.
3 "(C) PROVISION OF CERTIFICATION OF
4 PRESCRIPTION DRUG COVERAGE.—The sponsor
5 of the plan shall provide for issuance of certifi-
6 cations of the type described in section
7 1860A(c)(2)(D).
8 "(D) OTHER REQUIREMENTS.—The spon-
9 sor of the plan shall comply with such other re-
10 quirements as the Medicare Benefits Adminis-
11 trator finds necessary to administer the pro-
12 gram under this section.
13 "(2) LIMITATION ON BENEFIT ELIGIBILITY.—
14 No payment shall be provided under this section
15 with respect to an individual who is enrolled under
16 a qualified retiree prescription drug plan unless the
17 individual is a medicare primary individual who—
18 "(A) is covered under the plan; and
19 "(B) is eligible to obtain qualified prescrip-
20 tion drug coverage under section 1860A but did
21 not elect such coverage under this part (either
22 through a prescription drug plan or through a
23 Medicare+Choice plan).
24 "(3) DEFINITIONS.—As used in this section:

1 "(A) EMPLOYMENT-BASED RETIREE
2 HEALTH COVERAGE.—The term 'employment-
3 based retiree health coverage' means health in-
4 surance or other coverage of health care costs
5 for medicare primary individuals (or for such
6 individuals and their spouses and dependents)
7 based on their status as former employees or
8 labor union members.

9 "(B) EMPLOYER.—The term 'employer'
10 has the meaning given such term by section
11 3(5) of the Employee Retirement Income Secu-
12 rity Act of 1974 (except that such term shall
13 include only employers of two or more employ-
14 ees).

15 "(C) SPONSOR.—The term 'sponsor'
16 means a plan sponsor, as defined in section
17 3(16)(B) of the Employee Retirement Income
18 Security Act of 1974.

19 "(D) MEDICARE PRIMARY INDIVIDUAL.—
20 The term 'medicare primary individual' means,
21 with respect to a plan, an individual who is cov-
22 ered under the plan and with respect to whom
23 the plan is not a primary plan (as defined in
24 section 1862(b)(2)(A)).

1 "(g) GENERAL DEFINITIONS.—For purposes of this
2 section:
3 "(1) QUALIFYING COVERED INDIVIDUAL.—The
4 term 'qualifying covered individual' means an indi-
5 vidual who—
6 "(A) is enrolled with a prescription drug
7 plan under this part;
8 "(B) is enrolled with a Medicare+Choice
9 plan that provides qualified prescription drug
10 coverage under part C; or
11 "(C) is covered as a medicare primary in-
12 dividual under a qualified retiree prescription
13 drug plan.
14 "(2) COVERAGE YEAR.—The term 'coverage
15 year' means a calendar year in which covered out-
16 patient drugs are dispensed if a claim for payment
17 is made under the plan for such drugs, regardless of
18 when the claim is paid.

19 **"SEC. 1860I. MEDICARE PRESCRIPTION DRUG ACCOUNT IN**
20 **FEDERAL SUPPLEMENTARY MEDICAL INSUR-**
21 **ANCE TRUST FUND.**

22 "(a) IN GENERAL.—There is created within the Fed-
23 eral Supplementary Medical Insurance Trust Fund estab-
24 lished by section 1841 an account to be known as the
25 'Medicare Prescription Drug Account' (in this section re-

1 ferred to as the 'Account'). The Account shall consist of
2 such gifts and bequests as may be made as provided in
3 section 201(i)(1), and such amounts as may be deposited
4 in, or appropriated to, such fund as provided in this part.
5 Funds provided under this part to the Account shall be
6 kept separate from all other funds within the Federal Sup-
7 plementary Medical Insurance Trust Fund.

8 ''(b) PAYMENTS FROM ACCOUNT.—

9 ''(1) IN GENERAL.—The Managing Trustee
10 shall pay from time to time from the Account such
11 amounts as the Medicare Benefits Administrator
12 certifies are necessary to make—

13 ''(A) payments under section 1860G (relat-
14 ing to low-income subsidy payments);

15 ''(B) payments under section 1860H (re-
16 lating to reinsurance subsidy payments); and

17 ''(C) payments with respect to administra-
18 tive expenses under this part in accordance with
19 section 201(g).

20 ''(2) TRANSFERS TO MEDICAID ACCOUNT FOR
21 INCREASED ADMINISTRATIVE COSTS.—The Man-
22 aging Trustee shall transfer from time to time from
23 the Account to the Grants to States for Medicaid ac-
24 count amounts the Secretary certifies are attrib-
25 utable to increases in payment resulting from the

1 application of a higher Federal matching percentage
2 under section 1935(b).
3 ''(3) TREATMENT IN RELATION TO PART B PRE-
4 MIUM.—Amounts payable from the Account shall not
5 be taken into account in computing actuarial rates
6 or premium amounts under section 1839.
7 ''(c) DEPOSITS INTO ACCOUNT.—
8 ''(1) MEDICAID TRANSFER.—There is hereby
9 transferred to the Account, from amounts appro-
10 priated for Grants to States for Medicaid, amounts
11 equivalent to the aggregate amount of the reductions
12 in payments under section 1903(a)(1) attributable to
13 the application of section 1935(c).
14 ''(2) APPROPRIATIONS TO COVER GOVERNMENT
15 CONTRIBUTIONS.—There are authorized to be appro-
16 priated from time to time, out of any moneys in the
17 Treasury not otherwise appropriated, to the Ac-
18 count, an amount equivalent to the amount of pay-
19 ments made from the Account under subsection (b),
20 reduced by the amount transferred to the Account
21 under paragraph (1).
22 **''SEC. 1860J. DEFINITIONS; TREATMENT OF REFERENCES**
23 **TO PROVISIONS IN PART C.**
24 ''(a) DEFINITIONS.—For purposes of this part:

1 "(1) COVERED OUTPATIENT DRUGS.—The term
2 'covered outpatient drugs' is defined in section
3 1860B(f).
4 "(2) INITIAL COVERAGE LIMIT.—The term 'ini-
5 tial coverage limit' means the such limit as estab-
6 lished under section 1860B(b)(3), or, in the case of
7 coverage that is not standard coverage, the com-
8 parable limit (if any) established under the coverage.
9 "(3) MEDICARE PRESCRIPTION DRUG AC-
10 COUNT.—The term 'Medicare Prescription Drug Ac-
11 count' means the Account in the Federal Supple-
12 mentary Medical Insurance Trust Fund created
13 under section 1860I(a).
14 "(4) PDP SPONSOR.—The term 'PDP sponsor'
15 means an entity that is certified under this part as
16 meeting the requirements and standards of this part
17 for such a sponsor.
18 "(5) PRESCRIPTION DRUG PLAN.—The term
19 'prescription drug plan' means health benefits cov-
20 erage that—
21 "(A) is offered under a policy, contract, or
22 plan by a PDP sponsor pursuant to, and in ac-
23 cordance with, a contract between the Medicare
24 Benefits Administrator and the sponsor under
25 section 1860D(b);

1 ‘‘(B) provides qualified prescription drug
2 coverage; and
3 ‘‘(C) meets the applicable requirements of
4 the section 1860C for a prescription drug plan.
5 ‘‘(6) QUALIFIED PRESCRIPTION DRUG COV-
6 ERAGE.—The term ‘qualified prescription drug cov-
7 erage’ is defined in section 1860B(a).
8 ‘‘(7) STANDARD COVERAGE.—The term ‘stand-
9 ard coverage’ is defined in section 1860B(b).
10 ‘‘(b) APPLICATION OF MEDICARE+CHOICE PROVI-
11 SIONS UNDER THIS PART.—For purposes of applying pro-
12 visions of part C under this part with respect to a pre-
13 scription drug plan and a PDP sponsor, unless otherwise
14 provided in this part such provisions shall be applied as
15 if—
16 ‘‘(1) any reference to a Medicare+Choice plan
17 included a reference to a prescription drug plan;
18 ‘‘(2) any reference to a provider-sponsored or-
19 ganization included a reference to a PDP sponsor;
20 ‘‘(3) any reference to a contract under section
21 1857 included a reference to a contract under sec-
22 tion 1860D(b); and
23 ‘‘(4) any reference to part C included a ref-
24 erence to this part.’’.

1 (b) CONFORMING AMENDMENTS TO FEDERAL SUP-
2 PLEMENTARY MEDICAL INSURANCE TRUST FUND.—Sec-
3 tion 1841 of the Social Security Act (42 U.S.C. 1395t)
4 is amended—
5 (1) in the last sentence of subsection (a)—
6 (A) by striking ''and'' before ''such
7 amounts''; and
8 (B) by inserting before the period the fol-
9 lowing: ''and such amounts as may be deposited
10 in, or appropriated to, the Medicare Prescrip-
11 tion Drug Account established by section
12 1860I''; and
13 (2) in subsection (g), by inserting after ''by this
14 part,'' the following: ''the payments provided for
15 under part D (in which case the payments shall
16 come from the Medicare Prescription Drug Account
17 in the Trust Fund),''.
18 (c) ADDITIONAL CONFORMING CHANGES.—
19 (1) CONFORMING REFERENCES TO PREVIOUS
20 PART D.—Any reference in law (in effect before the
21 date of the enactment of this Act) to part D of title
22 XVIII of the Social Security Act is deemed a ref-
23 erence to part E of such title (as in effect after such
24 date).

1 (2) SECRETARIAL SUBMISSION OF LEGISLATIVE
2 PROPOSAL.—Not later than 6 months after the date
3 of the enactment of this Act, the Secretary of
4 Health and Human Services shall submit to the ap-
5 propriate committees of Congress a legislative pro-
6 posal providing for such technical and conforming
7 amendments in the law as are required by the provi-
8 sions of this subtitle.

9 **SEC. 102. OFFERING OF QUALIFIED PRESCRIPTION DRUG**
10 **COVERAGE UNDER THE MEDICARE+CHOICE**
11 **PROGRAM.**

12 (a) IN GENERAL.—Section 1851 of the Social Secu-
13 rity Act (42 U.S.C. 1395w–21) is amended by adding at
14 the end the following new subsection:

15 ''(j) AVAILABILITY OF PRESCRIPTION DRUG BENE-
16 FITS.—

17 ''(1) IN GENERAL.—A Medicare+Choice orga-
18 nization may not offer prescription drug coverage
19 (other than that required under parts A and B) to
20 an enrollee under a Medicare+Choice plan unless
21 such drug coverage is at least qualified prescription
22 drug coverage and unless the requirements of this
23 subsection with respect to such coverage are met.

24 ''(2) COMPLIANCE WITH ADDITIONAL BENE-
25 FICIARY PROTECTIONS.—With respect to the offer-

1 ing of qualified prescription drug coverage by a
2 Medicare+Choice organization under a
3 Medicare+Choice plan, the organization and plan
4 shall meet the requirements of section 1860C, in-
5 cluding requirements relating to information dis-
6 semination and grievance and appeals, in the same
7 manner as they apply to a PDP sponsor and a pre-
8 scription drug plan under part D. The Medicare
9 Benefits Administrator shall waive such require-
10 ments to the extent the Administrator determines
11 that such requirements duplicate requirements oth-
12 erwise applicable to the organization or plan under
13 this part.

14 ''(3) TREATMENT OF COVERAGE.—Except as
15 provided in this subsection, qualified prescription
16 drug coverage offered under this subsection shall be
17 treated under this part in the same manner as sup-
18 plemental health care benefits described in section
19 1852(a)(3)(A).

20 ''(4) AVAILABILITY OF PREMIUM AND COST-
21 SHARING SUBSIDIES FOR LOW-INCOME ENROLLEES
22 AND REINSURANCE SUBSIDY PAYMENTS FOR ORGA-
23 NIZATIONS.—For provisions—

24 ''(A) providing premium and cost-sharing
25 subsidies to low-income individuals receiving

1 qualified prescription drug coverage through a
2 Medicare+Choice plan, see section 1860G; and
3 ‘‘(B) providing a Medicare+Choice organi-
4 zation with reinsurance subsidy payments for
5 providing qualified prescription drug coverage
6 under this part, see section 1860H.
7 ‘‘(5) SPECIFICATION OF SEPARATE AND STAND-
8 ARD PREMIUM.—
9 ‘‘(A) IN GENERAL.—For purposes of ap-
10 plying section 1854 and section 1860G(b)(2)(B)
11 with respect to qualified prescription drug cov-
12 erage offered under this subsection under a
13 plan, the Medicare+Choice organization shall
14 compute and publish the following:
15 ‘‘(i) SEPARATE PRESCRIPTION DRUG
16 PREMIUM.—A premium for prescription
17 drug benefits that constitute qualified pre-
18 scription drug coverage that is separate
19 from other coverage under the plan.
20 ‘‘(ii) PORTION OF COVERAGE ATTRIB-
21 UTABLE TO STANDARD BENEFITS.—The
22 ratio of the actuarial value of standard
23 coverage to the actuarial value of the
24 qualified prescription drug coverage offered
25 under the plan.

1 "(iii) PORTION OF PREMIUM ATTRIB-
2 UTABLE TO STANDARD BENEFITS.—A
3 standard premium equal to the product of
4 the premium described in clause (i) and
5 the ratio under clause (ii).
6 The premium under clause (i) shall be compute
7 without regard to any reduction in the premium
8 permitted under subparagraph (B).
9 "(B) REDUCTION OF PREMIUMS AL-
10 LOWED.—Nothing in this subsection shall be
11 construed as preventing a Medicare+Choice or-
12 ganization from reducing the amount of a pre-
13 mium charged for prescription drug coverage
14 because of the application of section
15 1854(f)(1)(A) to other coverage.
16 "(C) ACCEPTANCE OF REFERENCE PRE-
17 MIUM AS FULL PREMIUM IF NO STANDARD (OR
18 EQUIVALENT) COVERAGE IN AN AREA.—For re-
19 quirement to accept reference premium as full
20 premium if there is no standard (or equivalent)
21 coverage in the area of a Medicare+Choice
22 plan, see section 1860F(d).
23 "(6) TRANSITION IN INITIAL ENROLLMENT PE-
24 RIOD.—Notwithstanding any other provision of this
25 part, the annual, coordinated election period under

1 subsection (e)(3)(B) for 2003 shall be the 6-month
2 period beginning with November 2002.
3 ''(7) QUALIFIED PRESCRIPTION DRUG COV-
4 ERAGE; STANDARD COVERAGE.—For purposes of
5 this part, the terms 'qualified prescription drug cov-
6 erage' and 'standard coverage' have the meanings
7 given such terms in section 1860B.''.
8 (b) CONFORMING AMENDMENTS.—Section 1851 of
9 such Act (42 U.S.C. 1395w–21) is amended—
10 (1) in subsection (a)(1)—
11 (A) by inserting ''(other than qualified pre-
12 scription drug benefits)'' after ''benefits'';
13 (B) by striking the period at the end of
14 subparagraph (B) and inserting a comma; and
15 (C) by adding after and below subpara-
16 graph (B) the following:
17 ''and may elect qualified prescription drug coverage
18 in accordance with section 1860A.''; and
19 (2) in subsection (g)(1), by inserting ''and sec-
20 tion 1860A(c)(2)(B)'' after ''in this subsection''.
21 (c) EFFECTIVE DATE.—The amendments made by
22 this section apply to coverage provided on or after January
23 1, 2003.

1 **SEC. 103. MEDICAID AMENDMENTS.**

2 (a) DETERMINATIONS OF ELIGIBILITY FOR LOW-IN-
3 COME SUBSIDIES.—

4 (1) REQUIREMENT.—Section 1902 of the Social
5 Security Act (42 U.S.C. 1396a) is amended—

6 (A) in subsection (a)—

7 (i) by striking ''and'' at the end of
8 paragraph (64);

9 (ii) by striking the period at the end
10 of paragraph (65) and inserting ''; and'';
11 and

12 (iii) by inserting after paragraph (65)
13 the following new paragraph:

14 ''(66) provide for making eligibility determina-
15 tions under section 1935(a).''.

16 (2) NEW SECTION.—Title XIX of such Act is
17 further amended—

18 (A) by redesignating section 1935 as sec-
19 tion 1936; and

20 (B) by inserting after section 1934 the fol-
21 lowing new section:

22 ''SPECIAL PROVISIONS RELATING TO MEDICARE
23 PRESCRIPTION DRUG BENEFIT

24 ''SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGI-
25 BILITY DETERMINATIONS FOR LOW-INCOME SUB-
26 SIDIES.—As a condition of its State plan under this title

1 under section 1902(a)(66) and receipt of any Federal fi-
2 nancial assistance under section 1903(a), a State shall—
3 "(1) make determinations of eligibility for pre-
4 mium and cost-sharing subsidies under (and in ac-
5 cordance with) section 1860G;
6 "(2) inform the Administrator of the Medicare
7 Benefits Administration of such determinations in
8 cases in which such eligibility is established; and
9 "(3) otherwise provide such Administrator with
10 such information as may be required to carry out
11 part D of title XVIII (including section 1860G).
12 "(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE
13 COSTS.—
14 "(1) IN GENERAL.—The amounts expended by
15 a State in carrying out subsection (a) are, subject to
16 paragraph (2), expenditures reimbursable under the
17 appropriate paragraph of section 1903(a); except
18 that, notwithstanding any other provision of such
19 section, the applicable Federal matching rates with
20 respect to such expenditures under such section shall
21 be increased as follows:
22 "(A) For expenditures attributable to costs
23 incurred during 2003, the otherwise applicable
24 Federal matching rate shall be increased by 20

1 percent of the percentage otherwise payable
2 (but for this subsection) by the State.
3 "(B) For expenditures attributable to costs
4 incurred during 2004, the otherwise applicable
5 Federal matching rate shall be increased by 40
6 percent of the percentage otherwise payable
7 (but for this subsection) by the State.
8 "(C) For expenditures attributable to costs
9 incurred during 2005, the otherwise applicable
10 Federal matching rate shall be increased by 60
11 percent of the percentage otherwise payable
12 (but for this subsection) by the State.
13 "(D) For expenditures attributable to costs
14 incurred during 2006, the otherwise applicable
15 Federal matching rate shall be increased by 80
16 percent of the percentage otherwise payable
17 (but for this subsection) by the State.
18 "(E) For expenditures attributable to costs
19 incurred after 2006, the otherwise applicable
20 Federal matching rate shall be increased to 100
21 percent.
22 "(2) COORDINATION.—The State shall provide
23 the Secretary with such information as may be nec-
24 essary to properly allocate administrative expendi-

1 tures described in paragraph (1) that may otherwise
2 be made for similar eligibility determinations.''.
3 (b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID
4 RESPONSIBILITY FOR PREMIUM AND COST-SHARING SUB-
5 SIDIES FOR DUALLY ELIGIBLE INDIVIDUALS.—
6 (1) IN GENERAL.—Section 1903(a)(1) of the
7 Social Security Act (42 U.S.C. 1396b(a)(1)) is
8 amended by inserting before the semicolon the fol-
9 lowing: '', reduced by the amount computed under
10 section 1935(c)(1) for the State and the quarter''.
11 (2) AMOUNT DESCRIBED.—Section 1935 of
12 such Act, as inserted by subsection (a)(2), is amend-
13 ed by adding at the end the following new sub-
14 section:
15 ''(c) FEDERAL ASSUMPTION OF MEDICAID PRE-
16 SCRIPTION DRUG COSTS FOR DUALLY-ELIGIBLE BENE-
17 FICIARIES.—
18 ''(1) IN GENERAL.—For purposes of section
19 1903(a)(1), for a State that is one of the 50 States
20 or the District of Columbia for a calendar quarter
21 in a year (beginning with 2003) the amount com-
22 puted under this subsection is equal to the product
23 of the following:
24 ''(A) MEDICARE SUBSIDIES.—The total
25 amount of payments made in the quarter under

1 section 1860G (relating to premium and cost-
2 sharing prescription drug subsidies for low-in-
3 come medicare beneficiaries) that are attrib-
4 utable to individuals who are residents of the
5 State and are entitled to benefits with respect
6 to prescribed drugs under the State plan under
7 this title (including such a plan operating under
8 a waiver under section 1115).
9 ''(B) STATE MATCHING RATE.—A propor-
10 tion computed by subtracting from 100 percent
11 the Federal medical assistance percentage (as
12 defined in section 1905(b)) applicable to the
13 State and the quarter.
14 ''(C) PHASE-OUT PROPORTION.—The
15 phase-out proportion (as defined in paragraph
16 (2)) for the quarter.
17 ''(2) PHASE-OUT PROPORTION.—For purposes
18 of paragraph (1)(C), the 'phase-out proportion' for
19 a calendar quarter in—
20 ''(A) 2003 is 80 percent;
21 ''(B) 2004 is 60 percent;
22 ''(C) 2005 is 40 percent;
23 ''(D) 2006 is 20 percent; or
24 ''(E) a year after 2006 is 0 percent.''.

1 (c) MEDICAID PROVIDING WRAP-AROUND BENE-
2 FITS.—Section 1935 of such Act, as so inserted and
3 amended, is further amended by adding at the end the
4 following new subsection:

5 "(d) ADDITIONAL PROVISIONS.—

6 "(1) MEDICAID AS SECONDARY PAYOR.—In the
7 case of an individual dually entitled to qualified pre-
8 scription drug coverage under a prescription drug
9 plan under part D of title XVIII (or under a
10 Medicare+Choice plan under part C of such title)
11 and medical assistance for prescribed drugs under
12 this title, medical assistance shall continue to be pro-
13 vided under this title for prescribed drugs to the ex-
14 tent payment is not made under the prescription
15 drug plan or the Medicare+Choice plan selected by
16 the individual.

17 "(2) CONDITION.—A State may require, as a
18 condition for the receipt of medical assistance under
19 this title with respect to prescription drug benefits
20 for an individual eligible to obtain qualified prescrip-
21 tion drug coverage described in paragraph (1), that
22 the individual elect qualified prescription drug cov-
23 erage under section 1860A.".

24 (d) TREATMENT OF TERRITORIES.—

1 (1) IN GENERAL.—Section 1935 of such Act, as
2 so inserted and amended, is further amended—
3 (A) in subsection (a) in the matter pre-
4 ceding paragraph (1), by inserting ''subject to
5 subsection (e)'' after ''section 1903(a)'';
6 (B) in subsection (c)(1), by inserting ''sub-
7 ject to subsection (e)'' after ''1903(a)(1)''; and
8 (C) by adding at the end the following new
9 subsection:
10 ''(e) TREATMENT OF TERRITORIES.—
11 ''(1) IN GENERAL.—In the case of a State,
12 other than the 50 States and the District of
13 Columbia—
14 ''(A) the previous provisions of this section
15 shall not apply to residents of such State; and
16 ''(B) if the State establishes a plan de-
17 scribed in paragraph (2) (for providing medical
18 assistance with respect to the provision of pre-
19 scription drugs to medicare beneficiaries), the
20 amount otherwise determined under section
21 1108(f) (as increased under section 1108(g))
22 for the State shall be increased by the amount
23 specified in paragraph (3).
24 ''(2) PLAN.—The plan described in this para-
25 graph is a plan that—

1 “(A) provides medical assistance with re-
2 spect to the provision of covered outpatient
3 drugs (as defined in section 1860B(f)) to low-
4 income medicare beneficiaries; and
5 “(B) assures that additional amounts re-
6 ceived by the State that are attributable to the
7 operation of this subsection are used only for
8 such assistance.
9 “(3) INCREASED AMOUNT.—
10 “(A) IN GENERAL.—The amount specified
11 in this paragraph for a State for a year is equal
12 to the product of—
13 “(i) the aggregate amount specified in
14 subparagraph (B); and
15 “(ii) the amount specified in section
16 1108(g)(1) for that State, divided by the
17 sum of the amounts specified in such sec-
18 tion for all such States.
19 “(B) AGGREGATE AMOUNT.—The aggre-
20 gate amount specified in this subparagraph
21 for—
22 “(i) 2003, is equal to $20,000,000; or
23 “(ii) a subsequent year, is equal to the
24 aggregate amount specified in this sub-
25 paragraph for the previous year increased

1 by annual percentage increase specified in
2 section 1860B(b)(5) for the year involved.
3 "(4) REPORT.—The Secretary shall submit to
4 Congress a report on the application of this sub-
5 section and may include in the report such rec-
6 ommendations as the Secretary deems appropriate.".
7 (2) CONFORMING AMENDMENT.—Section
8 1108(f) of such Act is amended by inserting "and
9 section 1935(e)(1)(B)" after "Subject to subsection
10 (g)".

11 **SEC. 104. MEDIGAP TRANSITION PROVISIONS.**

12 (a) IN GENERAL.—Notwithstanding any other provi-
13 sion of law, no new medicare supplemental policy that pro-
14 vides coverage of expenses for prescription drugs may be
15 issued under section 1882 of the Social Security Act on
16 or after January 1, 2003, to an individual unless it re-
17 places a medicare supplemental policy that was issued to
18 that individual and that provided some coverage of ex-
19 penses for prescription drugs.
20 (b) ISSUANCE OF SUBSTITUTE POLICIES IF OBTAIN
21 PRESCRIPTION DRUG COVERAGE THROUGH MEDICARE.—
22 (1) IN GENERAL.—The issuer of a medicare
23 supplemental policy—
24 (A) may not deny or condition the issuance
25 or effectiveness of a medicare supplemental pol-

1 icy that has a benefit package classified as "A",
2 "B", "C", "D", "E", "F", or "G" (under the
3 standards established under subsection (p)(2) of
4 section 1882 of the Social Security Act, 42
5 U.S.C. 1395ss) and that is offered and is avail-
6 able for issuance to new enrollees by such
7 issuer;

8 (B) may not discriminate in the pricing of
9 such policy, because of health status, claims ex-
10 perience, receipt of health care, or medical con-
11 dition; and

12 (C) may not impose an exclusion of bene-
13 fits based on a pre-existing condition under
14 such policy,

15 in the case of an individual described in paragraph
16 (2) who seeks to enroll under the policy not later
17 than 63 days after the date of the termination of en-
18 rollment described in such paragraph and who sub-
19 mits evidence of the date of termination or
20 disenrollment along with the application for such
21 medicare supplemental policy.

22 (2) INDIVIDUAL COVERED.—An individual de-
23 scribed in this paragraph is an individual who—

1 (A) enrolls in a prescription drug plan
2 under part D of title XVIII of the Social Secu-
3 rity Act; and
4 (B) at the time of such enrollment was en-
5 rolled and terminates enrollment in a medicare
6 supplemental policy which has a benefit pack-
7 age classified as ''H'', ''I'', or ''J'' under the
8 standards referred to in paragraph (1)(A) or
9 terminates enrollment in a policy to which such
10 standards do not apply but which provides ben-
11 efits for prescription drugs.
12 (3) ENFORCEMENT.—The provisions of para-
13 graph (1) shall be enforced as though they were in-
14 cluded in section 1882(s) of the Social Security Act
15 (42 U.S.C. 1395ss(s)).
16 (4) DEFINITIONS.—For purposes of this sub-
17 section, the term ''medicare supplemental policy''
18 has the meaning given such term in section 1882(g)
19 of the Social Security Act (42 U.S.C. 1395ss(g)).

20 **SEC. 105. STATE PHARMACEUTICAL ASSISTANCE TRANSI-**
21 **TION COMMISSION.**

22 (a) ESTABLISHMENT.—
23 (1) IN GENERAL.—There is established as of
24 October 1, 2000, a State Pharmaceutical Assistance
25 Transition Commission (in this section referred to as

1 the "Commission") to develop a proposal for ad-
2 dressing the unique transitional issues facing State
3 pharmaceutical assistance programs, and program
4 participants, due to the implementation of the medi-
5 care prescription drug program under part D of title
6 XVIII of the Social Security Act.

7 (2) DEFINITIONS.—For purposes of this sec-
8 tion:

9 (A) STATE PHARMACEUTICAL ASSISTANCE
10 PROGRAM DEFINED.—The term "State pharma-
11 ceutical assistance program" means a program
12 (other than the medicaid program) operated by
13 a State (or under contract with a State) that
14 provides as of the date of the enactment of this
15 Act assistance to low-income medicare bene-
16 ficiaries for the purchase of prescription drugs.

17 (B) PROGRAM PARTICIPANT.—The term "pro-
18 gram participant" means a low-income medicare
19 beneficiary who is a participant in a State pharma-
20 ceutical assistance program.

21 (b) COMPOSITION.—The Commission shall consist of
22 the following:

23 (1) A representative of each governor of each
24 State that the Secretary identifies as operating on a
25 statewide basis a State pharmaceutical assistance

1 program that provides for eligibility and benefits
2 that are comparable or more generous than the low-
3 income assistance eligibility and benefits offered
4 under part D of title XVIII of the Social Security
5 Act.

6 (2) Representatives from other States that the
7 Secretary identifies have in operation other State
8 pharmaceutical assistance programs, as appointed by
9 the Secretary.

10 (3) Representatives of organizations that rep-
11 resent the interests of program participants, as ap-
12 pointed by the Secretary but not to exceed the num-
13 ber of representatives under under paragraphs (1)
14 and (2).

15 (4) The Secretary (or the Secretary's designee).
16 The Secretary shall designate a member to serve as chair
17 of the Commission and the Commission shall meet at the
18 call of the chair.

19 (c) DEVELOPMENT OF PROPOSAL.—The Commission
20 shall develop the proposal described in subsection (a) in
21 a manner consistent with the following principles:

22 (1) Protection of the interests of program par-
23 ticipants in a manner that is the least disruptive to
24 such participants.

1 (2) Protection of the financial interests of
2 States so that States are not financially worse off as
3 a result of the enactment of this title.
4 (d) REPORT.—By not later than July 1, 2001, the
5 Commission shall submit to the President and the Con-
6 gress a report that contains a detailed proposal (including
7 specific legislative or administrative recommendations, if
8 any) and such other recommendations as the Commission
9 deems appropriate.
10 (e) SUPPORT.—The Secretary shall provide the Com-
11 mission with the administrative support services necessary
12 for the Commission to carry out its responsibilities under
13 this section.
14 (f) TERMINATION.—The Commission shall terminate
15 30 days after the date of submission of the report under
16 subsection (d).
17 **SEC. 106. DEMONSTRATION PROJECT FOR DISEASE MAN-**
18 **AGEMENT FOR SEVERELY CHRONICALLY ILL**
19 **MEDICARE BENEFICIARIES.**
20 (a) IN GENERAL.—The Administrator of the Medi-
21 care Benefits Administration (in this section referred to
22 as the ''Administrator'') shall conduct a demonstration
23 project under this section (in this section referred to as
24 the ''project'') to demonstrate the impact on costs and
25 health outcomes of applying disease management to medi-

1 care beneficiaries with diagnosed, advanced-stage conges-
2 tive heart failure, diabetes, or coronary heart disease. In
3 no case may the number of participants in the project ex-
4 ceed 30,000 at any time.

5 (b) VOLUNTARY PARTICIPATION.—

6 (1) ELIGIBILITY.—Medicare beneficiaries are
7 eligible to participate in the project only if—

8 (A) they meet specific medical criteria
9 demonstrating the appropriate diagnosis and
10 the advanced nature of their disease;

11 (B) their physicians approve of participa-
12 tion in the project; and

13 (C) they are not enrolled in a
14 Medicare+Choice plan.

15 (2) BENEFITS.—A beneficiary who is enrolled
16 in the project shall be eligible—

17 (A) for disease management services re-
18 lated to their chronic health condition; and

19 (B) if the beneficiary—

20 (i) is enrolled in a prescription drug
21 plan under part D of title XVIII of the So-
22 cial Security Act, for payment of any pre-
23 miums for such plan, any deductible or
24 cost-sharing, and any amounts not covered

1 under the plan because of the application
2 of an initial coverage limit; or
3 (ii) is not enrolled in such a plan, for
4 payment for all costs for prescription drugs
5 without regard to whether or not they re-
6 late to the chronic health condition,
7 except that the project may provide for modest
8 cost-sharing with respect to prescription drug
9 coverage.
10 (3) TREATMENT AS QUALIFYING COVERAGE
11 FOR PURPOSES OF CONTINUOUS COVERAGE.—For
12 purposes of applying section 1860A(c)(2)(C) of the
13 Social Security Act, coverage under the project shall
14 be treated as coverage under a prescription drug
15 plan under part D of title XVIII of such Act.
16 (c) CONTRACTS WITH DISEASE MANAGEMENT ORGA-
17 NIZATIONS.—
18 (1) IN GENERAL.—The Administrator shall
19 carry out the project through contracts with up to
20 three disease management organizations. The Ad-
21 ministrator shall not enter into such a contract with
22 an organization unless the organization dem-
23 onstrates that it can produce improved health out-
24 comes and reduce aggregate medicare expenditures
25 consistent with paragraph (2).

1 (2) CONTRACT PROVISIONS.—Under such
2 contracts—
3 (A) such an organization shall be required
4 to provide for prescription drug coverage de-
5 scribed in subsection (b)(2)(B);
6 (B) such an organization shall be paid a
7 fee negotiated and established by the Adminis-
8 trator in a manner so that (taking into account
9 savings in expenditures under parts A and B of
10 the medicare program) there will be a net re-
11 duction in expenditures under the medicare pro-
12 gram as a result of the project; and
13 (C) such an organization shall guarantee,
14 through an appropriate arrangement with a re-
15 insurance company or otherwise, the net reduc-
16 tion in expenditures described in subparagraph
17 (B).
18 (3) PAYMENTS.—Payments to such organiza-
19 tions shall be made in appropriate proportion from
20 the Trust Funds established under title XVIII of the
21 Social Security Act.
22 (d) DURATION.—The project shall last for not longer
23 than 3 years.
24 (e) REPORT.—The Administrator shall submit to
25 Congress an interim report on the project not later than

2 years after the date it is first implemented and a final report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of the project on costs and health outcomes and recommendations on the cost-effectiveness of extending or expanding the project.

TITLE II—MODERNIZATION OF ADMINISTRATION OF MEDICARE

Subtitle A—Medicare Benefits Administration

SEC. 201. ESTABLISHMENT OF ADMINISTRATION.

(a) IN GENERAL.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended by inserting after section 1806 the following new section:

"MEDICARE BENEFITS ADMINISTRATION

"SEC. 1807. (a) ESTABLISHMENT.—There is established within the Department of Health and Human Services an agency to be known as the Medicare Benefits Administration.

"(b) ADMINISTRATOR AND DEPUTY ADMINISTRATOR.—

"(1) ADMINISTRATOR.—

"(A) IN GENERAL.—The Medicare Benefits Administration shall be headed by an Administrator (in this section referred to as the 'Administrator') who shall be appointed by the

1 President, by and with the advice and consent
2 of the Senate. The Administrator shall be in di-
3 rect line of authority to the Secretary.
4 "(B) COMPENSATION.—The Administrator
5 shall be paid at the rate of basic pay payable
6 for level III of the Executive Schedule under
7 section 5314 of title 5, United States Code.
8 "(C) TERM OF OFFICE.—The Adminis-
9 trator shall be appointed for a term of 5 years.
10 In any case in which a successor does not take
11 office at the end of an Administrator's term of
12 office, that Administrator may continue in of-
13 fice until the entry upon office of such a suc-
14 cessor. An Administrator appointed to a term of
15 office after the commencement of such term
16 may serve under such appointment only for the
17 remainder of such term.
18 "(D) GENERAL AUTHORITY.—The Admin-
19 istrator shall be responsible for the exercise of
20 all powers and the discharge of all duties of the
21 Administration, and shall have authority and
22 control over all personnel and activities thereof.
23 "(E) RULEMAKING AUTHORITY.—The Ad-
24 ministrator may prescribe such rules and regu-
25 lations as the Administrator determines nec-

1 essary or appropriate to carry out the functions
2 of the Administration. The regulations pre-
3 scribed by the Administrator shall be subject to
4 the rulemaking procedures established under
5 section 553 of title 5, United States Code.

6 "(F) AUTHORITY TO ESTABLISH ORGANI-
7 ZATIONAL UNITS.—The Administrator may es-
8 tablish, alter, consolidate, or discontinue such
9 organizational units or components within the
10 Administration as the Administrator considers
11 necessary or appropriate, except that this sub-
12 paragraph shall not apply with respect to any
13 unit, component, or provision provided for by
14 this section.

15 "(G) AUTHORITY TO DELEGATE.—The Ad-
16 ministrator may assign duties, and delegate, or
17 authorize successive redelegations of, authority
18 to act and to render decisions, to such officers
19 and employees of the Administration as the Ad-
20 ministrator may find necessary. Within the lim-
21 itations of such delegations, redelegations, or
22 assignments, all official acts and decisions of
23 such officers and employees shall have the same
24 force and effect as though performed or ren-
25 dered by the Administrator.

1 "(2) DEPUTY ADMINISTRATOR.—
2 "(A) IN GENERAL.—There shall be a Dep-
3 uty Administrator of the Medicare Benefits Ad-
4 ministration who shall be appointed by the
5 President, by and with the advice and consent
6 of the Senate.
7 "(B) COMPENSATION.—The Deputy Ad-
8 ministrator shall be paid at the rate of basic
9 pay payable for level IV of the Executive Sched-
10 ule under section 5315 of title 5, United States
11 Code.
12 "(C) TERM OF OFFICE.—The Deputy Ad-
13 ministrator shall be appointed for a term of 5
14 years. In any case in which a successor does not
15 take office at the end of a Deputy Administra-
16 tor's term of office, such Deputy Administrator
17 may continue in office until the entry upon of-
18 fice of such a successor. A Deputy Adminis-
19 trator appointed to a term of office after the
20 commencement of such term may serve under
21 such appointment only for the remainder of
22 such term.
23 "(D) DUTIES.—The Deputy Administrator
24 shall perform such duties and exercise such
25 powers as the Administrator shall from time to

1 time assign or delegate. The Deputy Adminis-
2 trator shall be Acting Administrator of the Ad-
3 ministration during the absence or disability of
4 the Administrator and, unless the President
5 designates another officer of the Government as
6 Acting Administrator, in the event of a vacancy
7 in the office of the Administrator.

8 "(3) SECRETARIAL COORDINATION OF PROGRAM
9 ADMINISTRATION.—The Secretary shall ensure ap-
10 propriate coordination between the Administrator
11 and the Administrator of the Health Care Financing
12 Administration in carrying out the programs under
13 this title.

14 "(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

15 "(1) DUTIES.—

16 "(A) GENERAL DUTIES.—The Adminis-
17 trator shall carry out parts C and D,
18 including—

19 "(i) negotiating, entering into, and en-
20 forcing, contracts with plans for the offer-
21 ing of Medicare+Choice plans under part
22 C, including the offering of qualified pre-
23 scription drug coverage under such plans;
24 and

1 "(ii) negotiating, entering into, and
2 enforcing, contracts with PDP sponsors for
3 the offering of prescription drug plans
4 under part D.

5 "(B) OTHER DUTIES.—The Administrator
6 shall carry out any duty provided for under
7 part C or part D, including demonstration
8 projects carried out in part or in whole under
9 such parts, the programs of all-inclusive care
10 for the elderly (PACE program) under section
11 1894, the social health maintenance organiza-
12 tion (SHMO) demonstration projects (referred
13 to in section 4104(c) of the Balanced Budget
14 Act of 1997), and through a Medicare+Choice
15 project that demonstrates the application of
16 capitation payment rates for frail elderly medi-
17 care beneficiaries through the use of a inter-
18 disciplinary team and through the provision of
19 primary care services to such beneficiaries by
20 means of such a team at the nursing facility in-
21 volved).

22 "(C) NONINTERFERENCE.—In carrying
23 out its duties with respect to the provision of
24 qualified prescription drug coverage to bene-

1 ficiaries under this title, the Administrator may
2 not—
3 “(i) require a particular formulary or
4 institute a price structure for the reim-
5 bursement of covered outpatient drugs;
6 “(ii) interfere in any way with nego-
7 tiations between PDP sponsors and
8 Medicare+Choice organizations and drug
9 manufacturers, wholesalers, or other sup-
10 pliers of covered outpatient drugs; and
11 “(iii) otherwise interfere with the
12 competitive nature of providing such cov-
13 erage through such sponsors and organiza-
14 tions.
15 “(D) ANNUAL REPORTS.—Not later March
16 31 of each year, the Administrator shall submit
17 to Congress and the President a report on the
18 administration of parts C and D during the
19 previous fiscal year.
20 “(2) STAFF.—
21 “(A) IN GENERAL.—The Administrator,
22 with the approval of the Secretary, may employ,
23 without regard to chapter 31 of title 5, United
24 States Code, such officers and employees as are
25 necessary to administer the activities to be car-

1 ried out through the Medicare Benefits Admin-
2 istration.
3 "(B) FLEXIBILITY WITH RESPECT TO COM-
4 PENSATION.—
5 "(i) IN GENERAL.—The staff of the
6 Medicare Benefits Administration shall,
7 subject to clause (ii), be paid without re-
8 gard to the provisions of chapter 51 and
9 chapter 53 of such title (relating to classi-
10 fication and schedule pay rates).
11 "(ii) MAXIMUM RATE.—In no case
12 may the rate of compensation determined
13 under clause (i) exceed the rate of basic
14 pay payable for level IV of the Executive
15 Schedule under section 5315 of title 5,
16 United States Code.
17 "(C) LIMITATION ON FULL-TIME EQUIVA-
18 LENT STAFFING FOR CURRENT HCFA FUNC-
19 TIONS BEING TRANSFERRED.—The Adminis-
20 trator may not employ under this paragraph a
21 number of full-time equivalent employees, to
22 carry out functions that were previously con-
23 ducted by the Health Care Financing Adminis-
24 tration and that are conducted by the Adminis-
25 trator by reason of this section, that exceeds

1 the number of such full-time equivalent employ-
2 ees authorized to be employed by the Health
3 Care Financing Administration to conduct such
4 functions as of the date of the enactment of
5 this Act.

6 ‘‘(3) REDELEGATION OF CERTAIN FUNCTIONS
7 OF THE HEALTH CARE FINANCING ADMINISTRA-
8 TION.—

9 ‘‘(A) IN GENERAL.—The Secretary, the
10 Administrator, and the Administrator of the
11 Health Care Financing Administration shall es-
12 tablish an appropriate transition of responsi-
13 bility in order to redelegate the administration
14 of part C from the Secretary and the Adminis-
15 trator of the Health Care Financing Adminis-
16 tration to the Administrator as is appropriate
17 to carry out the purposes of this section.

18 ‘‘(B) TRANSFER OF DATA AND INFORMA-
19 TION.—The Secretary shall ensure that the Ad-
20 ministrator of the Health Care Financing Ad-
21 ministration transfers to the Administrator of
22 the Medicare Benefits Administration such in-
23 formation and data in the possession of the Ad-
24 ministrator of the Health Care Financing Ad-
25 ministration as the Administrator of the Medi-

1 care Benefits Administration requires to carry
2 out the duties described in paragraph (1).
3 ''(C) CONSTRUCTION.—Insofar as a re-
4 sponsibility of the Secretary or the Adminis-
5 trator of the Health Care Financing Adminis-
6 tration is redelegated to the Administrator
7 under this section, any reference to the Sec-
8 retary or the Administrator of the Health Care
9 Financing Administration in this title or title
10 XI with respect to such responsibility is deemed
11 to be a reference to the Administrator.
12 ''(d) OFFICE OF BENEFICIARY ASSISTANCE.—
13 ''(1) ESTABLISHMENT.—The Secretary shall es-
14 tablish within the Medicare Benefits Administration
15 an Office of Beneficiary Assistance to carry out
16 functions relating to medicare beneficiaries under
17 this title, including making determinations of eligi-
18 bility of individuals for benefits under this title, pro-
19 viding for enrollment of medicare beneficiaries under
20 this title, and the functions described in paragraph
21 (2). The Office shall be separate operating division
22 within the Administration.
23 ''(2) DISSEMINATION OF INFORMATION ON
24 BENEFITS AND APPEALS RIGHTS.—

1 "(A) DISSEMINATION OF BENEFITS INFOR-
2 MATION.—The Office of Beneficiary Assistance
3 shall disseminate to medicare beneficiaries, by
4 mail, by posting on the Internet site of the
5 Medicare Benefits Administration and through
6 the toll-free telephone number provided for
7 under section 1804(b), information with respect
8 to the following:
9 "(i) Benefits, and limitations on pay-
10 ment (including cost-sharing, stop-loss pro-
11 visions, and formulary restrictions) under
12 parts C and D.
13 "(ii) Benefits, and limitations on pay-
14 ment under parts A and B, including in-
15 formation on medicare supplemental poli-
16 cies under section 1882.
17 Such information shall be presented in a man-
18 ner so that medicare beneficiaries may compare
19 benefits under parts A, B, D, and medicare
20 supplemental policies with benefits under
21 Medicare+Choice plans under part C.
22 "(B) DISSEMINATION OF APPEALS RIGHTS
23 INFORMATION.—The Office of Beneficiary As-
24 sistance shall disseminate to medicare bene-
25 ficiaries in the manner provided under subpara-

1 graph (A) a description of procedural rights (in-
2 cluding grievance and appeals procedures) of
3 beneficiaries under the original medicare fee-
4 for-service program under parts A and B, the
5 Medicare+Choice program under part C, and
6 the Voluntary Prescription Drug Benefit Pro-
7 gram under part D.

8 ''(3) MEDICARE OMBUDSMAN.—

9 ''(A) IN GENERAL.—Within the Office of
10 Beneficiary Assistance, there shall be a Medi-
11 care Ombudsman, appointed by the Secretary
12 from among individuals with expertise and ex-
13 perience in the fields of health care and advo-
14 cacy, to carry out the duties described in sub-
15 paragraph (B).

16 ''(B) DUTIES.—The Medicare Ombudsman
17 shall—

18 ''(i) receive complaints, grievances,
19 and requests for information submitted by
20 a medicare beneficiary, with respect to any
21 aspect of the medicare program;

22 ''(ii) provide assistance with respect to
23 complaints, grievances, and requests re-
24 ferred to in clause (i), including—

1 "(I) assistance in collecting rel-
2 evant information for such bene-
3 ficiaries, to seek an appeal of a deci-
4 sion or determination made by a fiscal
5 intermediary, carrier,
6 Medicare+Choice organization, a
7 PDP sponsor under part D, or the
8 Secretary; and

9 "(II) assistance to such bene-
10 ficiaries with any problems arising
11 from disenrollment from a
12 Medicare+Choice plan under part C
13 or a prescription drug plan under part
14 D; and

15 "(iii) submit annual reports to Con-
16 gress, the Secretary, and the Medicare Pol-
17 icy Advisory Board describing the activities
18 of the Office, and including such rec-
19 ommendations for improvement in the ad-
20 ministration of this title as the Ombuds-
21 man determines appropriate.

22 "(C) COORDINATION WITH STATE OM-
23 BUDSMAN PROGRAMS AND CONSUMER ORGANI-
24 ZATIONS.—The Medicare Ombudsman shall, to
25 the extent appropriate, coordinate with State

1 medical Ombudsman programs, and with State-
2 and community-based consumer organizations,
3 to—
4 ''(i) provide information about the
5 medicare program; and
6 ''(ii) conduct outreach to educate
7 medicare beneficiaries with respect to man-
8 ners in which problems under the medicare
9 program may be resolved or avoided.
10 ''(e) MEDICARE POLICY ADVISORY BOARD.—
11 ''(1) ESTABLISHMENT.—There is established
12 within the Medicare Benefits Administration the
13 Medicare Policy Advisory Board (in this section re-
14 ferred to the 'Board'). The Board shall advise, con-
15 sult with, and make recommendations to the Admin-
16 istrator of the Medicare Benefits Administration
17 with respect to the administration of parts C and D,
18 including the review of payment policies under such
19 parts.
20 ''(2) REPORTS.—
21 ''(A) IN GENERAL.—With respect to mat-
22 ters of the administration of parts C and D, the
23 Board shall submit to Congress and to the Ad-
24 ministrator of the Medicare Benefits Adminis-
25 tration such reports as the Board determines

1 appropriate. Each such report may contain such
2 recommendations as the Board determines ap-
3 propriate for legislative or administrative
4 changes to improve the administration of such
5 parts, including the topics described in subpara-
6 graph (B). Each such report shall be published
7 in the Federal Register.

8 "(B) TOPICS DESCRIBED.—Reports re-
9 quired under subparagraph (A) may include the
10 following topics:

11 "(i) FOSTERING COMPETITION.—Rec-
12 ommendations or proposals to increase
13 competition under parts C and D for serv-
14 ices furnished to medicare beneficiaries.

15 "(ii) EDUCATION AND ENROLL-
16 MENT.—Recommendations for the im-
17 provement to efforts to provide medicare
18 beneficiaries information and education on
19 the program under this title, and specifi-
20 cally parts C and D, and the program for
21 enrollment under the title.

22 "(iii) IMPLEMENTATION OF RISK-AD-
23 JUSTMENT.—Evaluation of the implemen-
24 tation under section 1853(a)(3)(C) of the
25 risk adjustment methodology to payment

1 rates under that section to
2 Medicare+Choice organizations offering
3 Medicare+Choice plans that accounts for
4 variations in per capita costs based on
5 health status and other demographic fac-
6 tors.
7 "(iv) DISEASE MANAGEMENT PRO-
8 GRAMS.—Recommendations on the incor-
9 poration of disease management programs
10 under parts C and D.
11 "(v) RURAL ACCESS.—Recommenda-
12 tions to improve competition and access to
13 plans under parts C and D in rural areas.
14 "(C) MAINTAINING INDEPENDENCE OF
15 BOARD.—The Board shall directly submit to
16 Congress reports required under subparagraph
17 (A). No officer or agency of the United States
18 may require the Board to submit to any officer
19 or agency of the United States for approval,
20 comments, or review, prior to the submission to
21 Congress of such reports.
22 "(3) DUTY OF ADMINISTRATOR OF MEDICARE
23 BENEFITS ADMINISTRATION.—With respect to any
24 report submitted by the Board under paragraph
25 (2)(A), not later than 90 days after the report is

1 submitted, the Administrator of the Medicare Bene-
2 fits Administration shall submit to Congress and the
3 President an analysis of recommendations made by
4 the Board in such report. Each such analysis shall
5 be published in the Federal Register.
6 ''(4) MEMBERSHIP.—
7 ''(A) APPOINTMENT.—Subject to the suc-
8 ceeding provisions of this paragraph, the Board
9 shall consist of seven members to be appointed
10 as follows:
11 ''(i) Three members shall be ap-
12 pointed by the President.
13 ''(ii) Two members shall be appointed
14 by the Speaker of the House of Represent-
15 atives, with the advice of the chairman and
16 the ranking minority member of the Com-
17 mittees on Ways and Means and on Com-
18 merce of the House of Representatives.
19 ''(iii) Two members shall be appointed
20 by the President pro tempore of the Senate
21 with the advice of the chairman and the
22 ranking minority member of the Senate
23 Committee on Finance.
24 ''(B) QUALIFICATIONS.—The members
25 shall be chosen on the basis of their integrity,

1 impartiality, and good judgment, and shall be
2 individuals who are, by reason of their edu-
3 cation and experience in health care benefits
4 management, exceptionally qualified to perform
5 the duties of members of the Board.
6 ‘‘(C) PROHIBITION ON INCLUSION OF FED-
7 ERAL EMPLOYEES.—No officer or employee of
8 the United States may serve as a member of
9 the Board.
10 ‘‘(5) COMPENSATION.—Members of the Board
11 shall receive, for each day (including travel time)
12 they are engaged in the performance of the functions
13 of the board, compensation at rates not to exceed
14 the daily equivalent to the annual rate in effect for
15 level IV of the Executive Schedule under section
16 5315 of title 5, United States Code.
17 ‘‘(6) TERMS OF OFFICE.—
18 ‘‘(A) IN GENERAL.—The term of office of
19 members of the Board shall be 3 years.
20 ‘‘(B) TERMS OF INITIAL APPOINTEES.—As
21 designated by the President at the time of ap-
22 pointment, of the members first appointed—
23 ‘‘(i) one shall be appointed for a term
24 of 1 year;

1 "(ii) three shall be appointed for
2 terms of 2 years; and
3 "(iii) three shall be appointed for
4 terms of 3 years.
5 "(C) REAPPOINTMENTS.—Any person ap-
6 pointed as a member of the Board may not
7 serve for more than 8 years.
8 "(D) VACANCY.—Any member appointed
9 to fill a vacancy occurring before the expiration
10 of the term for which the member's predecessor
11 was appointed shall be appointed only for the
12 remainder of that term. A member may serve
13 after the expiration of that member's term until
14 a successor has taken office. A vacancy in the
15 Board shall be filled in the manner in which the
16 original appointment was made.
17 "(7) CHAIR.—The Chair of the Board shall be
18 elected by the members. The term of office of the
19 Chair shall be 3 years.
20 "(8) MEETINGS.—The Board shall meet at the
21 call of the Chair, but in no event less than three
22 times during each fiscal year.
23 "(9) DIRECTOR AND STAFF.—

1 "(A) APPOINTMENT OF DIRECTOR.—The
2 Board shall have a Director who shall be ap-
3 pointed by the Chair.
4 "(B) IN GENERAL.—With the approval of
5 the Board, the Director may appoint, without
6 regard to chapter 31 of title 5, United States
7 Code, such additional personnel as the Director
8 considers appropriate.
9 "(C) FLEXIBILITY WITH RESPECT TO COM-
10 PENSATION.—
11 "(i) IN GENERAL.—The Director and
12 staff of the Board shall, subject to clause
13 (ii), be paid without regard to the provi-
14 sions of chapter 51 and chapter 53 of such
15 title (relating to classification and schedule
16 pay rates).
17 "(ii) MAXIMUM RATE.—In no case
18 may the rate of compensation determined
19 under clause (i) exceed the rate of basic
20 pay payable for level IV of the Executive
21 Schedule under section 5315 of title 5,
22 United States Code.
23 "(D) ASSISTANCE FROM THE ADMINIS-
24 TRATOR OF THE MEDICARE BENEFITS ADMINIS-
25 TRATION.—The Administrator of the Medicare

1 Benefits Administration shall make available to
2 the Board such information and other assist-
3 ance as it may require to carry out its func-
4 tions.

5 ''(10) CONTRACT AUTHORITY.—The Board may
6 contract with and compensate government and pri-
7 vate agencies or persons to carry out its duties
8 under this subsection, without regard to section
9 3709 of the Revised Statutes (41 U.S.C. 5).

10 ''(f) FUNDING.—There is authorized to be appro-
11 priated, in appropriate part from the Federal Hospital In-
12 surance Trust Fund and from the Federal Supplementary
13 Medical Insurance Trust Fund (including the Medicare
14 Prescription Drug Account), such sums as are necessary
15 to carry out this section.''.

16 (b) EFFECTIVE DATE.—

17 (1) IN GENERAL.—The amendment made by
18 subsection (a) shall take effect on the date of the en-
19 actment of this Act.

20 (2) TIMING OF INITIAL APPOINTMENTS.—The
21 Administrator and Deputy Administrator of the
22 Medicare Benefits Administration may not be ap-
23 pointed before March 1, 2001.

24 (3) DUTIES WITH RESPECT TO ELIGIBILITY DE-
25 TERMINATIONS AND ENROLLMENT.—The Adminis-

1 trator of the Medicare Benefits Administration shall
2 carry out enrollment under title XVIII of the Social
3 Security Act, make eligibility determinations under
4 such title, and carry out part C of such title for
5 years beginning or after January 1, 2003.

6 **SEC. 202. MISCELLANEOUS ADMINISTRATIVE PROVISIONS.**

7 (a) ADMINISTRATOR AS MEMBER OF THE BOARD OF
8 TRUSTEES OF THE MEDICARE TRUST FUNDS.—Section
9 1817(b) and section 1841(b) of the Social Security Act
10 (42 U.S.C. 1395i(b), 1395t(b)) are each amended by
11 striking "and the Secretary of Health and Human Serv-
12 ices, all ex officio," and inserting "the Secretary of Health
13 and Human Services, and the Administrator of the Medi-
14 care Benefits Administration, all ex officio,".

15 (b) INCREASE IN GRADE TO EXECUTIVE LEVEL III
16 FOR THE ADMINISTRATOR OF THE HEALTH CARE FI-
17 NANCING ADMINISTRATION.—

18 (1) IN GENERAL.—Section 5314 of title 5,
19 United States Code, by adding at the end the fol-
20 lowing:

21 "Administrator of the Health Care Financing
22 Administration.".

23 (2) CONFORMING AMENDMENT.—Section 5315
24 of such title is amended by striking "Administrator
25 of the Health Care Financing Administration.".

1 (3) EFFECTIVE DATE.—The amendments made
2 by this subsection take effect on March 1, 2001.

3 Subtitle B—Oversight of Financial 4 Sustainability of the Medicare 5 Program

6 SEC. 211. ADDITIONAL REQUIREMENTS FOR ANNUAL FI- 7 NANCIAL REPORT AND OVERSIGHT ON MEDI- 8 CARE PROGRAM.

9 (a) IN GENERAL.—Section 1817 of the Social Secu-
10 rity Act (42 U.S.C. 1395i) is amended by adding at the
11 end the following new subsection:

12 "(l) COMBINED REPORT ON OPERATION AND STATUS
13 OF THE TRUST FUND AND THE FEDERAL SUPPLE-
14 MENTARY MEDICAL INSURANCE TRUST FUND.—

15 "(1) IN GENERAL.—In addition to the duty of
16 the Board of Trustees to report to Congress under
17 subsection (b), on the date the Board submits the
18 report required under subsection (b)(2), the Board
19 shall submit to Congress a report on the operation
20 and status of the Trust Fund and the Federal Sup-
21 plementary Medical Insurance Trust Fund estab-
22 lished under section 1841 (in this subsection re-
23 ferred to as the 'Trust Funds'). Such report shall
24 included the following information:

1 "(A) OVERALL SPENDING FROM THE GEN-
2 ERAL FUND OF THE TREASURY.—A statement
3 of total amounts obligated during the preceding
4 fiscal year from the General Revenues of the
5 Treasury to the Trust Funds for payment for
6 benefits covered under this title, stated in terms
7 of the total amount and in terms of the per-
8 centage such amount bears to all other amounts
9 obligated from such General Revenues during
10 such fiscal year.

11 "(B) HISTORICAL OVERVIEW OF SPEND-
12 ING.—From the date of the inception of the
13 program of insurance under this title through
14 the fiscal year involved, a statement of the total
15 amounts referred to in subparagraph (A).

16 "(C) 10-YEAR AND 50-YEAR PROJEC-
17 TIONS.—An estimate of total amounts referred
18 to in subparagraph (A) required to be obligated
19 for payment for benefits covered under this title
20 for each of the 10 fiscal years succeeding the
21 fiscal year involved and for the 50-year period
22 beginning with the succeeding fiscal year.

23 "(D) RELATION TO GDP GROWTH.—A
24 comparison of the rate of growth of the total
25 amounts referred to in subparagraph (A) to the

1 rate of growth in the gross domestic product for
2 the same period.
3 "(2) PUBLICATION.—Each report submitted
4 under paragraph (1) shall be published by the Com-
5 mittee on Ways and Means as a public document
6 and shall be made available by such Committee on
7 the Internet.".
8 (b) EFFECTIVE DATE.—The amendment made by
9 subsection (a) shall apply with respect to fiscal years be-
10 ginning on or after the date of the enactment of this Act.
11 (c) CONGRESSIONAL HEARINGS.—It is the sense of
12 the Congress that the committees of jurisdiction shall hold
13 hearings on the reports submitted under section 1817(l)
14 of the Social Security Act.

15 Subtitle C—Changes in Medicare 16 Coverage and Appeals Process

17 SEC. 221. REVISIONS TO MEDICARE APPEALS PROCESS.

18 (a) CONDUCT OF RECONSIDERATIONS OF DETER-
19 MINATIONS BY INDEPENDENT CONTRACTORS.—Section
20 1869 of the Social Security Act (42 U.S.C. 1395ff) is
21 amended to read as follows:
22 "DETERMINATIONS; APPEALS
23 "SEC. 1869. (a) INITIAL DETERMINATIONS.—The
24 Secretary shall promulgate regulations and make initial
25 determinations with respect to benefits under part A or

1 part B in accordance with those regulations for the fol-
2 lowing:
3 "(1) The initial determination of whether an in-
4 dividual is entitled to benefits under such parts.
5 "(2) The initial determination of the amount of
6 benefits available to the individual under such parts.
7 "(3) Any other initial determination with re-
8 spect to a claim for benefits under such parts, in-
9 cluding an initial determination by the Secretary
10 that payment may not be made, or may no longer
11 be made, for an item or service under such parts, an
12 initial determination made by a utilization and qual-
13 ity control peer review organization under section
14 1154(a)(2), and an initial determination made by an
15 entity pursuant to a contract with the Secretary to
16 administer provisions of this title or title XI.
17 "(b) APPEAL RIGHTS.—
18 "(1) IN GENERAL.—
19 "(A) RECONSIDERATION OF INITIAL DE-
20 TERMINATION.—Subject to subparagraph (D),
21 any individual dissatisfied with any initial de-
22 termination under subsection (a) shall be enti-
23 tled to reconsideration of the determination,
24 and, subject to subparagraphs (D) and (E), a
25 hearing thereon by the Secretary to the same

1 extent as is provided in section 205(b) and to
2 judicial review of the Secretary's final decision
3 after such hearing as is provided in section
4 205(g).

5 "(B) REPRESENTATION BY PROVIDER OR
6 SUPPLIER.—

7 "(i) IN GENERAL.—Sections 206(a),
8 1102, and 1871 shall not be construed as
9 authorizing the Secretary to prohibit an in-
10 dividual from being represented under this
11 section by a person that furnishes or sup-
12 plies the individual, directly or indirectly,
13 with services or items, solely on the basis
14 that the person furnishes or supplies the
15 individual with such a service or item.

16 "(ii) MANDATORY WAIVER OF RIGHT
17 TO PAYMENT FROM BENEFICIARY.—Any
18 person that furnishes services or items to
19 an individual may not represent an indi-
20 vidual under this section with respect to
21 the issue described in section 1879(a)(2)
22 unless the person has waived any rights for
23 payment from the beneficiary with respect
24 to the services or items involved in the ap-
25 peal.

1 "(iii) PROHIBITION ON PAYMENT FOR
2 REPRESENTATION.—If a person furnishes
3 services or items to an individual and rep-
4 resents the individual under this section,
5 the person may not impose any financial li-
6 ability on such individual in connection
7 with such representation.
8 "(iv) REQUIREMENTS FOR REP-
9 RESENTATIVES OF A BENEFICIARY.—The
10 provisions of section 205(j) and section
11 206 (regarding representation of claim-
12 ants) shall apply to representation of an
13 individual with respect to appeals under
14 this section in the same manner as they
15 apply to representation of an individual
16 under those sections.
17 "(C) SUCCESSION OF RIGHTS IN CASES OF
18 ASSIGNMENT.—The right of an individual to an
19 appeal under this section with respect to an
20 item or service may be assigned to the provider
21 of services or supplier of the item or service
22 upon the written consent of such individual
23 using a standard form established by the Sec-
24 retary for such an assignment.
25 "(D) TIME LIMITS FOR APPEALS.—

1 "(i) RECONSIDERATIONS.—Reconsid-
2 eration under subparagraph (A) shall be
3 available only if the individual described
4 subparagraph (A) files notice with the Sec-
5 retary to request reconsideration by not
6 later than 180 days after the individual re-
7 ceives notice of the initial determination
8 under subsection (a) or within such addi-
9 tional time as the Secretary may allow.
10 "(ii) HEARINGS CONDUCTED BY THE
11 SECRETARY.—The Secretary shall establish
12 in regulations time limits for the filing of
13 a request for a hearing by the Secretary in
14 accordance with provisions in sections 205
15 and 206.
16 "(E) AMOUNTS IN CONTROVERSY.—
17 "(i) IN GENERAL.—A hearing (by the
18 Secretary) shall not be available to an indi-
19 vidual under this section if the amount in
20 controversy is less than $100, and judicial
21 review shall not be available to the indi-
22 vidual if the amount in controversy is less
23 than $1,000.
24 "(ii) AGGREGATION OF CLAIMS.—In
25 determining the amount in controversy, the

1 Secretary, under regulations, shall allow
2 two or more appeals to be aggregated if
3 the appeals involve—

4 "(I) the delivery of similar or re-
5 lated services to the same individual
6 by one or more providers of services
7 or suppliers, or

8 "(II) common issues of law and
9 fact arising from services furnished to
10 two or more individuals by one or
11 more providers of services or sup-
12 pliers.

13 "(F) EXPEDITED PROCEEDINGS.—

14 "(i) EXPEDITED DETERMINATION.—
15 In the case of an individual who—

16 "(I) has received notice by a pro-
17 vider of services that the provider of
18 services plans to terminate services
19 provided to an individual and a physi-
20 cian certifies that failure to continue
21 the provision of such services is likely
22 to place the individual's health at sig-
23 nificant risk, or

24 "(II) has received notice by a
25 provider of services that the provider

1 of services plans to discharge the indi-
2 vidual from the provider of services,
3 the individual may request, in writing or
4 orally, an expedited determination or an
5 expedited reconsideration of an initial de-
6 termination made under subsection (a), as
7 the case may be, and the Secretary shall
8 provide such expedited determination or
9 expedited reconsideration.
10 "(ii) EXPEDITED HEARING.—In a
11 hearing by the Secretary under this sec-
12 tion, in which the moving party alleges
13 that no material issues of fact are in dis-
14 pute, the Secretary shall make an expe-
15 dited determination as to whether any such
16 facts are in dispute and, if not, shall
17 render a decision expeditiously.
18 "(G) REOPENING AND REVISION OF DE-
19 TERMINATIONS.—The Secretary may reopen or
20 revise any initial determination or reconsidered
21 determination described in this subsection
22 under guidelines established by the Secretary in
23 regulations.
24 "(2) REVIEW OF COVERAGE DETERMINA-
25 TIONS.—

1 "(A) NATIONAL COVERAGE DETERMINA-
2 TIONS.—
3 "(i) IN GENERAL.—Review of any na-
4 tional coverage determination shall be sub-
5 ject to the following limitations:
6 "(I) Such a determination shall
7 not be reviewed by any administrative
8 law judge.
9 "(II) Such a determination shall
10 not be held unlawful or set aside on
11 the ground that a requirement of sec-
12 tion 553 of title 5, United States
13 Code, or section 1871(b) of this title,
14 relating to publication in the Federal
15 Register or opportunity for public
16 comment, was not satisfied.
17 "(III) Upon the filing of a com-
18 plaint by an aggrieved party, such a
19 determination shall be reviewed by the
20 Departmental Appeals Board of the
21 Department of Health and Human
22 Services. In conducting such a review,
23 the Departmental Appeals Board shall
24 review the record and shall permit dis-
25 covery and the taking of evidence to

1 evaluate the reasonableness of the de-
2 termination. In reviewing such a de-
3 termination, the Departmental Ap-
4 peals Board shall defer only to the
5 reasonable findings of fact, reasonable
6 interpretations of law, and reasonable
7 applications of fact to law by the Sec-
8 retary.

9 "(IV) A decision of the Depart-
10 mental Appeals Board constitutes a
11 final agency action and is subject to
12 judicial review.

13 "(ii) DEFINITION OF NATIONAL COV-
14 ERAGE DETERMINATION.—For purposes of
15 this section, the term 'national coverage
16 determination' means a determination by
17 the Secretary respecting whether or not a
18 particular item or service is covered na-
19 tionally under this title, including such a
20 determination under 1862(a)(1).

21 "(B) LOCAL COVERAGE DETERMINATION.—In
22 the case of a local coverage determination made by
23 a fiscal intermediary or a carrier under part A or
24 part B respecting whether a particular type or class

1 of items or services is covered under such parts, the
2 following limitations apply:
3 ''(i) Upon the filing of a complaint by an
4 aggrieved party, such a determination shall be
5 reviewed by an administrative law judge of the
6 Social Security Administration. The administra-
7 tive law judge shall review the record and shall
8 permit discovery and the taking of evidence to
9 evaluate the reasonableness of the determina-
10 tion. In reviewing such a determination, the ad-
11 ministrative law judge shall defer only to the
12 reasonable findings of fact, reasonable interpre-
13 tations of law, and reasonable applications of
14 fact to law by the Secretary.
15 ''(ii) Such a determination may be re-
16 viewed by the Departmental Appeals Board of
17 the Department of Health and Human Services.
18 ''(iii) A decision of the Departmental Ap-
19 peals Board constitutes a final agency action
20 and is subject to judicial review.
21 ''(C) NO MATERIAL ISSUES OF FACT IN DIS-
22 PUTE.—In the case of review of a determination
23 under subparagraph (A)(i)(III) or (B)(i) where the
24 moving party alleges that there are no material
25 issues of fact in dispute, and alleges that the only

1 issue is the constitutionality of a provision of this
2 title, or that a regulation, determination, or ruling
3 by the Secretary is invalid, the moving party may
4 seek review by a court of competent jurisdiction.

5 ''(D) PENDING NATIONAL COVERAGE DETER-
6 MINATIONS.—

7 ''(i) IN GENERAL.—In the event the Sec-
8 retary has not issued a national coverage or
9 noncoverage determination with respect to a
10 particular type or class of items or services, an
11 affected party may submit to the Secretary a
12 request to make such a determination with re-
13 spect to such items or services. By not later
14 than the end of the 90-day period beginning on
15 the date the Secretary receives such a request,
16 the Secretary shall take one of the following ac-
17 tions:

18 ''(I) Issue a national coverage deter-
19 mination, with or without limitations.

20 ''(II) Issue a national noncoverage de-
21 termination.

22 ''(III) Issue a determination that no
23 national coverage or noncoverage deter-
24 mination is appropriate as of the end of

1 such 90-day period with respect to national
2 coverage of such items or services.
3 "(IV) Issue a notice that states that
4 the Secretary has not completed a review
5 of the request for a national coverage de-
6 termination and that includes an identi-
7 fication of the remaining steps in the Sec-
8 retary's review process and a deadline by
9 which the Secretary will complete the re-
10 view and take an action described in sub-
11 clause (I), (II), or (III).
12 "(ii) In the case of an action described in
13 clause (i)(IV), if the Secretary fails to take an
14 action referred to in such clause by the deadline
15 specified by the Secretary under such clause,
16 then the Secretary is deemed to have taken an
17 action described in clause (i)(III) as of the
18 deadline.
19 "(iii) When issuing a determination under
20 clause (i), the Secretary shall include an expla-
21 nation of the basis for the determination. An
22 action taken under clause (i) (other than sub-
23 clause (IV)) is deemed to be a national coverage
24 determination for purposes of review under sub-
25 paragraph (A).

1 "(E) ANNUAL REPORT ON NATIONAL COVERAGE
2 DETERMINATIONS.—
3 "(i) IN GENERAL.—Not later than Decem-
4 ber 1 of each year, beginning in 2001, the Sec-
5 retary shall submit to Congress a report that
6 sets forth a detailed compilation of the actual
7 time periods that were necessary to complete
8 and fully implement national coverage deter-
9 minations that were made in the previous fiscal
10 year for items, services, or medical devices not
11 previously covered as a benefit under this title,
12 including, with respect to each new item, serv-
13 ice, or medical device, a statement of the time
14 taken by the Secretary to make the necessary
15 coverage, coding, and payment determinations,
16 including the time taken to complete each sig-
17 nificant step in the process of making such de-
18 terminations.
19 "(ii) PUBLICATION OF REPORTS ON THE
20 INTERNET.—The Secretary shall publish each
21 report submitted under clause (i) on the medi-
22 care Internet site of the Department of Health
23 and Human Services.
24 "(3) PUBLICATION ON THE INTERNET OF DECI-
25 SIONS OF HEARINGS OF THE SECRETARY.—Each de-

1 cision of a hearing by the Secretary shall be made
2 public, and the Secretary shall publish each decision
3 on the Medicare Internet site of the Department of
4 Health and Human Services. The Secretary shall re-
5 move from such decision any information that would
6 identify any individual, provider of services, or sup-
7 plier.

8 ''(4) LIMITATION ON REVIEW OF CERTAIN REG-
9 ULATIONS.—A regulation or instruction which re-
10 lates to a method for determining the amount of
11 payment under part B and which was initially issued
12 before January 1, 1981, shall not be subject to judi-
13 cial review.

14 ''(5) STANDING.—An action under this section
15 seeking review of a coverage determination (with re-
16 spect to items and services under this title) may be
17 initiated only by one (or more) of the following ag-
18 grieved persons, or classes of persons:

19 ''(A) Individuals entitled to benefits under
20 part A, or enrolled under part B, or both, who
21 are in need of the items or services that are the
22 subject of the coverage determination.

23 ''(B) Persons, or classes of persons, who
24 make, manufacture, offer, supply, make avail-
25 able, or provide such items and services.

1 “(c) CONDUCT OF RECONSIDERATIONS BY INDE-
2 PENDENT CONTRACTORS.—
3 “(1) IN GENERAL.—The Secretary shall enter
4 into contracts with qualified independent contractors
5 to conduct reconsiderations of initial determinations
6 made under paragraphs (2) and (3) of subsection
7 (a). Contracts shall be for an initial term of three
8 years and shall be renewable on a triennial basis
9 thereafter.
10 “(2) QUALIFIED INDEPENDENT CON-
11 TRACTOR.—For purposes of this subsection, the
12 term ‘qualified independent contractor’ means an en-
13 tity or organization that is independent of any orga-
14 nization under contract with the Secretary that
15 makes initial determinations under subsection (a),
16 and that meets the requirements established by the
17 Secretary consistent with paragraph (3).
18 “(3) REQUIREMENTS.—Any qualified inde-
19 pendent contractor entering into a contract with the
20 Secretary under this subsection shall meet the fol-
21 lowing requirements:
22 “(A) IN GENERAL.—The qualified inde-
23 pendent contractor shall perform such duties
24 and functions and assume such responsibilities
25 as may be required under regulations of the

Secretary promulgated to carry out the provisions of this subsection, and such additional duties, functions, and responsibilities as provided under the contract.

"(B) DETERMINATIONS.—The qualified independent contractor shall determine, on the basis of such criteria, guidelines, and policies established by the Secretary and published under subsection (d)(2)(D), whether payment shall be made for items or services under part A or part B and the amount of such payment. Such determination shall constitute the conclusive determination on those issues for purposes of payment under such parts for fiscal intermediaries, carriers, and other entities whose determinations are subject to review by the contractor; except that payment may be made if—

"(i) such payment is allowed by reason of section 1879;

"(ii) in the case of inpatient hospital services or extended care services, the qualified independent contractor determines that additional time is required in order to arrange for postdischarge care, but payment may be continued under this

1 clause for not more than 2 days, and only
2 in the case in which the provider of such
3 services did not know and could not rea-
4 sonably have been expected to know (as de-
5 termined under section 1879) that pay-
6 ment would not otherwise be made for
7 such services under part A or part B prior
8 to notification by the qualified independent
9 contractor under this subsection;

10 "(iii) such determination is changed
11 as the result of any hearing by the Sec-
12 retary or judicial review of the decision
13 under this section; or

14 "(iv) such payment is authorized
15 under section 1861(v)(1)(G).

16 "(C) DEADLINES FOR DECISIONS.—

17 "(i) DETERMINATIONS.—The quali-
18 fied independent contractor shall conduct
19 and conclude a determination under sub-
20 paragraph (B) or an appeal of an initial
21 determination, and mail the notice of the
22 decision by not later than the end of the
23 45-day period beginning on the date a re-
24 quest for reconsideration has been timely
25 filed.

1 "(ii) CONSEQUENCES OF FAILURE TO
2 MEET DEADLINE.—In the case of a failure
3 by the qualified independent contractor to
4 mail the notice of the decision by the end
5 of the period described in clause (i), the
6 party requesting the reconsideration or ap-
7 peal may request a hearing before an ad-
8 ministrative law judge, notwithstanding
9 any requirements for a reconsidered deter-
10 mination for purposes of the party's right
11 to such hearing.
12 "(iii) EXPEDITED RECONSIDER-
13 ATIONS.—The qualified independent con-
14 tractor shall perform an expedited recon-
15 sideration under subsection (b)(1)(F) of a
16 notice from a provider of services or sup-
17 plier that payment may not be made for an
18 item or service furnished by the provider of
19 services or supplier, of a decision by a pro-
20 vider of services to terminate services fur-
21 nished to an individual, or in accordance
22 with the following:
23 "(I) DEADLINE FOR DECISION.—
24 Notwithstanding section 216(j), not
25 later than 1 day after the date the

1 qualified independent contractor has
2 received a request for such reconsider-
3 ation and has received such medical
4 or other records needed for such re-
5 consideration, the qualified inde-
6 pendent contractor shall provide no-
7 tice (by telephone and in writing) to
8 the individual and the provider of
9 services and attending physician of
10 the individual of the results of the re-
11 consideration. Such reconsideration
12 shall be conducted regardless of
13 whether the provider of services or
14 supplier will charge the individual for
15 continued services or whether the indi-
16 vidual will be liable for payment for
17 such continued services.

18 ''(II) CONSULTATION WITH BEN-
19 EFICIARY.—In such reconsideration,
20 the qualified independent contractor
21 shall solicit the views of the individual
22 involved.

23 ''(D) LIMITATION ON INDIVIDUAL REVIEW-
24 ING DETERMINATIONS.—

1 "(i) PHYSICIANS.—No physician
2 under the employ of a qualified inde-
3 pendent contractor may review—
4 "(I) determinations regarding
5 health care services furnished to a pa-
6 tient if the physician was directly re-
7 sponsible for furnishing such services;
8 or
9 "(II) determinations regarding
10 health care services provided in or by
11 an institution, organization, or agen-
12 cy, if the physician or any member of
13 the physician's family has, directly or
14 indirectly, a significant financial inter-
15 est in such institution, organization,
16 or agency.
17 "(ii) PHYSICIAN'S FAMILY DE-
18 SCRIBED.—For purposes of this para-
19 graph, a physician's family includes the
20 physician's spouse (other than a spouse
21 who is legally separated from the physician
22 under a decree of divorce or separate
23 maintenance), children (including step-
24 children and legally adopted children),
25 grandchildren, parents, and grandparents.

1 "(E) EXPLANATION OF DETERMINA-
2 TIONS.—Any determination of a qualified inde-
3 pendent contractor shall be in writing, and shall
4 include a detailed explanation of the determina-
5 tion as well as a discussion of the pertinent
6 facts and applicable regulations applied in mak-
7 ing such determination.
8 "(F) NOTICE REQUIREMENTS.—Whenever
9 a qualified independent contractor makes a de-
10 termination under this subsection, the qualified
11 independent contractor shall promptly notify
12 such individual and the entity responsible for
13 the payment of claims under part A or part B
14 of such determination.
15 "(G) DISSEMINATION OF INFORMATION.—
16 Each qualified independent contractor shall,
17 using the methodology established by the Sec-
18 retary under subsection (d)(4), make available
19 all determinations of such qualified independent
20 contractors to fiscal intermediaries (under sec-
21 tion 1816), carriers (under section 1842), peer
22 review organizations (under part B of title XI),
23 Medicare+Choice organizations offering
24 Medicare+Choice plans under part C, and
25 other entities under contract with the Secretary

1 to make initial determinations under part A or
2 part B or title XI.
3 "(H) ENSURING CONSISTENCY IN DETER-
4 MINATIONS.—Each qualified independent con-
5 tractor shall monitor its determinations to en-
6 sure the consistency of its determinations with
7 respect to requests for reconsideration of simi-
8 lar or related matters.
9 "(I) DATA COLLECTION.—
10 "(i) IN GENERAL.—Consistent with
11 the requirements of clause (ii), a qualified
12 independent contractor shall collect such
13 information relevant to its functions, and
14 keep and maintain such records in such
15 form and manner as the Secretary may re-
16 quire to carry out the purposes of this sec-
17 tion and shall permit access to and use of
18 any such information and records as the
19 Secretary may require for such purposes.
20 "(ii) TYPE OF DATA COLLECTED.—
21 Each qualified independent contractor
22 shall keep accurate records of each deci-
23 sion made, consistent with standards es-
24 tablished by the Secretary for such pur-
25 pose. Such records shall be maintained in

1 an electronic database in a manner that
2 provides for identification of the following:
3 ‘‘(I) Specific claims that give rise
4 to appeals.
5 ‘‘(II) Situations suggesting the
6 need for increased education for pro-
7 viders of services, physicians, or sup-
8 pliers.
9 ‘‘(III) Situations suggesting the
10 need for changes in national or local
11 coverage policy.
12 ‘‘(IV) Situations suggesting the
13 need for changes in local medical re-
14 view policies.
15 ‘‘(iii) ANNUAL REPORTING.—Each
16 qualified independent contractor shall sub-
17 mit annually to the Secretary (or otherwise
18 as the Secretary may request) records
19 maintained under this paragraph for the
20 previous year.
21 ‘‘(J) HEARINGS BY THE SECRETARY.—The
22 qualified independent contractor shall (i) pre-
23 pare such information as is required for an ap-
24 peal of its reconsidered determination to the
25 Secretary for a hearing, including as necessary,

explanations of issues involved in the determination and relevant policies, and (ii) participate in such hearings as required by the Secretary.

"(4) NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—The Secretary shall enter into contracts with not fewer than 12 qualified independent contractors under this subsection.

"(5) LIMITATION ON QUALIFIED INDEPENDENT CONTRACTOR LIABILITY.—No qualified independent contractor having a contract with the Secretary under this subsection and no person who is employed by, or who has a fiduciary relationship with, any such qualified independent contractor or who furnishes professional services to such qualified independent contractor, shall be held by reason of the performance of any duty, function, or activity required or authorized pursuant to this subsection or to a valid contract entered into under this subsection, to have violated any criminal law, or to be civilly liable under any law of the United States or of any State (or political subdivision thereof) provided due care was exercised in the performance of such duty, function, or activity.

"(d) ADMINISTRATIVE PROVISIONS.—

1 "(1) OUTREACH.—The Secretary shall perform
2 such outreach activities as are necessary to inform
3 individuals entitled to benefits under this title and
4 providers of services and suppliers with respect to
5 their rights of, and the process for, appeals made
6 under this section. The Secretary shall use the toll-
7 free telephone number maintained by the Secretary
8 (1–800–MEDICAR(E)) (1–800–633–4227) to pro-
9 vide information regarding appeal rights and re-
10 spond to inquiries regarding the status of appeals.

11 "(2) GUIDANCE FOR RECONSIDERATIONS AND
12 HEARINGS.—

13 "(A) REGULATIONS.—Not later than 1
14 year after the date of the enactment of this sec-
15 tion, the Secretary shall promulgate regulations
16 governing the processes of reconsiderations of
17 determinations by the Secretary and qualified
18 independent contractors and of hearings by the
19 Secretary. Such regulations shall include such
20 specific criteria and provide such guidance as
21 required to ensure the adequate functioning of
22 the reconsiderations and hearings processes and
23 to ensure consistency in such processes.

24 "(B) DEADLINES FOR ADMINISTRATIVE
25 ACTION.—

1 "(i) HEARING BY ADMINISTRATIVE
2 LAW JUDGE.—
3 "(I) IN GENERAL.—Except as
4 provided in subclause (II), an admin-
5 istrative law judge shall conduct and
6 conclude a hearing on a decision of a
7 qualified independent contractor
8 under subsection (c) and render a de-
9 cision on such hearing by not later
10 than the end of the 90-day period be-
11 ginning on the date a request for
12 hearing has been timely filed.
13 "(II) WAIVER OF DEADLINE BY
14 PARTY SEEKING HEARING.—The 90-
15 day period under subclause (i) shall
16 not apply in the case of a motion or
17 stipulation by the party requesting the
18 hearing to waive such period.
19 "(ii) DEPARTMENTAL APPEALS BOARD
20 REVIEW.—The Departmental Appeals
21 Board of the Department of Health and
22 Human Services shall conduct and con-
23 clude a review of the decision on a hearing
24 described in subparagraph (B) and make a
25 decision or remand the case to the admin-

1 istrative law judge for reconsideration by
2 not later than the end of the 90-day period
3 beginning on the date a request for review
4 has been timely filed.

5 "(iii) CONSEQUENCES OF FAILURE TO
6 MEET DEADLINES.—In the case of a fail-
7 ure by an administrative law judge to
8 render a decision by the end of the period
9 described in clause (ii), the party request-
10 ing the hearing may request a review by
11 the Departmental Appeals Board of the
12 Department of Health and Human Serv-
13 ices, notwithstanding any requirements for
14 a hearing for purposes of the party's right
15 to such a review.

16 "(iv) DAB HEARING PROCEDURE.—In
17 the case of a request described in clause
18 (iii), the Departmental Appeals Board
19 shall review the case de novo.

20 "(C) POLICIES.—The Secretary shall pro-
21 vide such specific criteria and guidance, includ-
22 ing all applicable national and local coverage
23 policies and rationale for such policies, as is
24 necessary to assist the qualified independent
25 contractors to make informed decisions in con-

1 sidering appeals under this section. The Sec-
2 retary shall furnish to the qualified independent
3 contractors the criteria and guidance described
4 in this paragraph in a published format, which
5 may be an electronic format.

6 "(D) PUBLICATION OF MEDICARE COV-
7 ERAGE POLICIES ON THE INTERNET.—The Sec-
8 retary shall publish national and local coverage
9 policies under this title on an Internet site
10 maintained by the Secretary.

11 "(E) EFFECT OF FAILURE TO PUBLISH
12 POLICIES.—

13 "(i) NATIONAL AND LOCAL COVERAGE
14 POLICIES.—Qualified independent contrac-
15 tors shall not be bound by any national or
16 local medicare coverage policy established
17 by the Secretary that is not published on
18 the Internet site under subparagraph (D).

19 "(ii) OTHER POLICIES.—With respect
20 to policies established by the Secretary
21 other than the policies described in clause
22 (i), qualified independent contractors shall
23 not be bound by such policies if the Sec-
24 retary does not furnish to the qualified
25 independent contractor the policies in a

1 published format consistent with subpara-
2 graph (C).
3 "(3) CONTINUING EDUCATION REQUIREMENT
4 FOR QUALIFIED INDEPENDENT CONTRACTORS AND
5 ADMINISTRATIVE LAW JUDGES.—
6 "(A) IN GENERAL.—The Secretary shall
7 provide to each qualified independent con-
8 tractor, and, in consultation with the Commis-
9 sioner of Social Security, to administrative law
10 judges that decide appeals of reconsiderations
11 of initial determinations or other decisions or
12 determinations under this section, such con-
13 tinuing education with respect to policies of the
14 Secretary under this title or part B of title XI
15 as is necessary for such qualified independent
16 contractors and administrative law judges to
17 make informed decisions with respect to ap-
18 peals.
19 "(B) MONITORING OF DECISIONS BY
20 QUALIFIED INDEPENDENT CONTRACTORS AND
21 ADMINISTRATIVE LAW JUDGES.—The Secretary
22 shall monitor determinations made by all quali-
23 fied independent contractors and administrative
24 law judges under this section and shall provide
25 continuing education and training to such quali-

1 fied independent contractors and administrative
2 law judges to ensure consistency of determina-
3 tions with respect to appeals on similar or re-
4 lated matters. To ensure such consistency, the
5 Secretary shall provide for administration and
6 oversight of qualified independent contractors
7 and, in consultation with the Commissioner of
8 Social Security, administrative law judges
9 through a central office of the Department of
10 Health and Human Services. Such administra-
11 tion and oversight may not be delegated to re-
12 gional offices of the Department.

13 ''(4) DISSEMINATION OF DETERMINATIONS.—
14 The Secretary shall establish a methodology under
15 which qualified independent contractors shall carry
16 out subsection (c)(3)(G).

17 ''(5) SURVEY.—Not less frequently than every 5
18 years, the Secretary shall conduct a survey of a valid
19 sample of individuals entitled to benefits under this
20 title, providers of services, and suppliers to deter-
21 mine the satisfaction of such individuals or entities
22 with the process for appeals of determinations pro-
23 vided for under this section and education and train-
24 ing provided by the Secretary with respect to that
25 process. The Secretary shall submit to Congress a

1 report describing the results of the survey, and shall
2 include any recommendations for administrative or
3 legislative actions that the Secretary determines ap-
4 propriate.

5 ''(6) REPORT TO CONGRESS.—The Secretary
6 shall submit to Congress an annual report describing
7 the number of appeals for the previous year, identi-
8 fying issues that require administrative or legislative
9 actions, and including any recommendations of the
10 Secretary with respect to such actions. The Sec-
11 retary shall include in such report an analysis of de-
12 terminations by qualified independent contractors
13 with respect to inconsistent decisions and an anal-
14 ysis of the causes of any such inconsistencies.''.

15 (b) APPLICABILITY OF REQUIREMENTS AND LIMITA-
16 TIONS ON LIABILITY OF QUALIFIED INDEPENDENT CON-
17 TRACTORS TO MEDICARE+CHOICE INDEPENDENT AP-
18 PEALS CONTRACTORS.—Section 1852(g)(4) of the Social
19 Security Act (42 U.S.C. 1395w–22(e)(3)) is amended by
20 adding at the end the following: ''The provisions of section
21 1869(c)(5) shall apply to independent outside entities
22 under contract with the Secretary under this paragraph.''.

23 (c) CONFORMING AMENDMENT TO REVIEW BY THE
24 PROVIDER REIMBURSEMENT REVIEW BOARD.—Section
25 1878(g) of the Social Security Act (42 U.S.C. 1395oo(g))

1 is amended by adding at the end the following new para-
2 graph:
3 "(3) Findings described in paragraph (1) and deter-
4 minations and other decisions described in paragraph (2)
5 may be reviewed or appealed under section 1869.".

6 **SEC. 222. PROVISIONS WITH RESPECT TO LIMITATIONS ON**
7 **LIABILITY OF BENEFICIARIES.**

8 (a) EXPANSION OF LIMITATION OF LIABILITY PRO-
9 TECTION FOR BENEFICIARIES WITH RESPECT TO MEDI-
10 CARE CLAIMS NOT PAID OR PAID INCORRECTLY.—
11 (1) IN GENERAL.—Section 1879 of the Social
12 Security Act (42 U.S.C. 1395pp) is amended by
13 adding at the end the following new subsections:
14 "(i) Notwithstanding any other provision of this Act,
15 an individual who is entitled to benefits under this title
16 and is furnished a service or item is not liable for repay-
17 ment to the Secretary of amounts with respect to such
18 benefits—
19 "(1) subject to paragraph (2), in the case of a
20 claim for such item or service that is incorrectly paid
21 by the Secretary; and
22 "(2) in the case of payments made to the indi-
23 vidual by the Secretary with respect to any claim
24 under paragraph (1), the individual shall be liable
25 for repayment of such amount only up to the

1 amount of payment received by the individual from
2 the Secretary.
3 ''(j)(1) An individual who is entitled to benefits under
4 this title and is furnished a service or item is not liable
5 for payment of amounts with respect to such benefits in
6 the following cases:
7 ''(A) In the case of a benefit for which an ini-
8 tial determination has not been made by the Sec-
9 retary under subsection (a) whether payment may be
10 made under this title for such benefit.
11 ''(B) In the case of a claim for such item or
12 service that is—
13 ''(i) improperly submitted by the provider
14 of services or supplier; or
15 ''(ii) rejected by an entity under contract
16 with the Secretary to review or pay claims for
17 services and items furnished under this title, in-
18 cluding an entity under contract with the Sec-
19 retary under section 1857.
20 ''(2) The limitation on liability under paragraph (1)
21 shall not apply if the individual signs a waiver provided
22 by the Secretary under subsection (l) of protections under
23 this paragraph, except that any such waiver shall not
24 apply in the case of a denial of a claim for noncompliance

1 with applicable regulations or procedures under this title
2 or title XI.

3 ‘‘(k) An individual who is entitled to benefits under
4 this title and is furnished services by a provider of services
5 is not liable for payment of amounts with respect to such
6 services prior to noon of the first working day after the
7 date the individual receives the notice of determination to
8 discharge and notice of appeal rights under paragraph (1),
9 unless the following conditions are met:

10 ‘‘(1) The provider of services shall furnish a no-
11 tice of discharge and appeal rights established by the
12 Secretary under subsection (l) to each individual en-
13 titled to benefits under this title to whom such pro-
14 vider of services furnishes services, upon admission
15 of the individual to the provider of services and upon
16 notice of determination to discharge the individual
17 from the provider of services, of the individual’s limi-
18 tations of liability under this section and rights of
19 appeal under section 1869.

20 ‘‘(2) If the individual, prior to discharge from
21 the provider of services, appeals the determination to
22 discharge under section 1869 not later than noon of
23 the first working day after the date the individual
24 receives the notice of determination to discharge and
25 notice of appeal rights under paragraph (1), the pro-

1 vider of services shall, by the close of business of
2 such first working day, provide to the Secretary (or
3 qualified independent contractor under section 1869,
4 as determined by the Secretary) the records required
5 to review the determination.

6 "(l) The Secretary shall develop appropriate standard
7 forms for individuals entitled to benefits under this title
8 to waive limitation of liability protections under subsection
9 (j) and to receive notice of discharge and appeal rights
10 under subsection (k). The forms developed by the Sec-
11 retary under this subsection shall clearly and in plain lan-
12 guage inform such individuals of their limitations on liabil-
13 ity, their rights under section 1869(a) to obtain an initial
14 determination by the Secretary of whether payment may
15 be made under part A or part B for such benefit, and
16 their rights of appeal under section 1869(b), and shall in-
17 form such individuals that they may obtain further infor-
18 mation or file an appeal of the determination by use of
19 the toll-free telephone number (1–800–MEDICAR(E))
20 (1–800–633–4227) maintained by the Secretary. The
21 forms developed by the Secretary under this subsection
22 shall be the only manner in which such individuals may
23 waive such protections under this title or title XI.

24 "(m) An individual who is entitled to benefits under
25 this title and is furnished an item or service is not liable

1 for payment of cost sharing amounts of more than $50
2 with respect to such benefits unless the individual has
3 been informed in advance of being furnished the item or
4 service of the estimated amount of the cost sharing for
5 the item or service using a standard form established by
6 the Secretary.''.

7 (2) CONFORMING AMENDMENT.—Section
8 1870(a) of the Social Security Act (42 U.S.C.
9 1395gg(a)) is amended by striking ''Any payment
10 under this title'' and inserting ''Except as provided
11 in section 1879(i), any payment under this title''.

12 (b) INCLUSION OF BENEFICIARY LIABILITY INFOR-
13 MATION IN EXPLANATION OF MEDICARE BENEFITS.—
14 Section 1806(a) of the Social Security Act (42 U.S.C.
15 1395b–7(a)) is amended—

16 (1) in paragraph (1), by striking ''and'' at the
17 end;

18 (2) by redesignating paragraph (2) as para-
19 graph (3); and

20 (3) by inserting after paragraph (1) the fol-
21 lowing new paragraph:

22 ''(2) lists with respect to each item or service
23 furnished the amount of the individual's liability for
24 payment;'';

1 (4) in paragraph (3), as so redesignated, by
2 striking the period at the end and inserting ''; and'';
3 and

4 (5) by adding at the end the following new
5 paragraph:

6 ''(4) includes the toll-free telephone number (1–
7 800–MEDICAR(E)) (1–800–633–4227) for infor-
8 mation and questions concerning the statement, li-
9 ability of the individual for payment, and appeal
10 rights.''.

11 **SEC. 223. WAIVERS OF LIABILITY FOR COST SHARING**
12 **AMOUNTS.**

13 (a) IN GENERAL.—Section 1128A(i)(6)(A) of the So-
14 cial Security Act (42 U.S.C. 1320a–7a(i)(6)(A)) is amend-
15 ed by striking clauses (i) through (iii) and inserting the
16 following:

17 ''(i) the waiver is offered as a part of
18 a supplemental insurance policy or retiree
19 health plan;

20 ''(ii) the waiver is not offered as part
21 of any advertisement or solicitation, other
22 than in conjunction with a policy or plan
23 described in clause (i);

24 ''(iii) the person waives the coinsur-
25 ance and deductible amount after the bene-

1 ficiary informs the person that payment of
2 the coinsurance or deductible amount
3 would pose a financial hardship for the in-
4 dividual; or
5 "(iv) the person determines that the
6 coinsurance and deductible amount would
7 not justify the costs of collection.".
8 (b) CONFORMING AMENDMENT.—Section 1128B(b)
9 of the Social Security Act (42 U.S.C. 1320a–7b(b)) is
10 amended by adding at the end the following new para-
11 graph:
12 "(4) In this section, the term 'remuneration' in-
13 cludes the meaning given such term in section
14 1128A(i)(6).".

15 **SEC. 224. ELIMINATION OF MOTIONS BY THE SECRETARY**
16 **ON DECISIONS OF THE PROVIDER REIM-**
17 **BURSEMENT REVIEW BOARD.**

18 Section 1878(f)(1) of such Act (42 U.S.C.
19 1395oo(f)(1)) is amended—
20 (1) in the first sentence, by striking "unless the
21 Secretary, on his own motion, and within 60 days
22 after the provider of services is notified of the
23 Board's decision, reverses, affirms, or modifies the
24 Board's decision";

1 (2) in the second sentence, by striking '', or of
2 any reversal, affirmance, or modification by the Sec-
3 retary,'' and ''or of any reversal, affirmance, or
4 modification by the Secretary''; and
5 (3) in the fifth sentence, by striking ''and not
6 subject to review by the Secretary''.

7 **SEC. 225. EFFECTIVE DATE OF SUBTITLE.**

8 In no case shall the amendments made by this sub-
9 title apply before October 1, 2000.

10 TITLE III—MEDICARE+CHOICE 11 REFORMS; PRESERVATION OF 12 MEDICARE PART B DRUG 13 BENEFIT

14 Subtitle A—Medicare+Choice 15 Reforms

16 **SEC. 301. INCREASE IN NATIONAL PER CAPITA**
17 **MEDICARE+CHOICE GROWTH PERCENTAGE**
18 **IN 2001 AND 2002.**

19 Section 1853(c)(6)(B) of the Social Security Act (42
20 U.S.C. 1395w–23(c)(6)(B)) is amended—
21 (1) in clause (iv), by striking ''for 2001, 0.5
22 percentage points'' and inserting ''for 2001, 0 per-
23 centage points''; and

1 (2) in clause (v), by striking ''for 2002, 0.3 per-
2 centage points'' and inserting ''for 2002, 0 percent-
3 age points''.

4 **SEC. 302. PERMANENTLY REMOVING APPLICATION OF**
5 **BUDGET NEUTRALITY BEGINNING IN 2002.**

6 Section 1853(c) of the Social Security Act (42 U.S.C.
7 1395w–23(c)) is amended—

8 (1) in paragraph (1)(A), in the matter following
9 clause (ii), by inserting ''(for years before 2002)''
10 after ''multiplied''; and

11 (2) in paragraph (5), by inserting ''(before
12 2002)'' after ''for each year''.

13 **SEC. 303. INCREASING MINIMUM PAYMENT AMOUNT.**

14 (a) IN GENERAL.—Section 1853(c)(1)(B)(ii) of the
15 Social Security Act (42 U.S.C. 1395w–23(c)(1)(B)(ii)) is
16 amended—

17 (1) by striking ''(ii) For a succeeding year'' and
18 inserting ''(ii)(I) Subject to subclause (II), for a suc-
19 ceeding year''; and

20 (2) by adding at the end the following new sub-
21 clause:

22 ''(II) For 2002 for any of the 50
23 States and the District of Columbia,
24 $450.''.

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) apply to years beginning with 2002.

3 **SEC. 304. ALLOWING MOVEMENT TO 50:50 PERCENT BLEND**
4 **IN 2002.**

5 Section 1853(c)(2) of the Social Security Act (42
6 U.S.C. 1395w–23(c)(2)) is amended—
7 (1) by striking the period at the end of sub-
8 paragraph (F) and inserting a semicolon; and
9 (2) by adding after and below subparagraph
10 (F) the following:
11 ''except that a Medicare+Choice organization may
12 elect to apply subparagraph (F) (rather than sub-
13 paragraph (E)) for 2002.''.

14 **SEC. 305. INCREASED UPDATE FOR PAYMENT AREAS WITH**
15 **ONLY ONE OR NO MEDICARE+CHOICE CON-**
16 **TRACTS.**

17 (a) IN GENERAL.—Section 1853(c)(1)(C)(ii) of the
18 Social Security Act (42 U.S.C. 1395w–23(c)(1)(C)(ii)) is
19 amended—
20 (1) by striking ''(ii) For a subsequent year''
21 and inserting ''(ii)(I) Subject to subclause (II), for
22 a subsequent year''; and
23 (2) by adding at the end the following new sub-
24 clause:

1 "(II) During 2002, 2003, 2004, and
2 2005, in the case of a Medicare+Choice
3 payment area in which there is no more
4 than one contract entered into under this
5 part as of July 1 before the beginning of
6 the year, 102.5 percent of the annual
7 Medicare+Choice capitation rate under
8 this paragraph for the area for the pre-
9 vious year.".

10 (b) CONSTRUCTION.—The amendments made by sub-
11 section (a) do not affect the payment of a first time bonus
12 under section 1853(i) of the Social Security Act (42
13 U.S.C. 1395w–23(i)).

14 **SEC. 306. PERMITTING HIGHER NEGOTIATED RATES IN**
15 **CERTAIN MEDICARE+CHOICE PAYMENT**
16 **AREAS BELOW NATIONAL AVERAGE.**

17 Section 1853(c)(1) of the Social Security Act (42
18 U.S.C. 1395w–23(c)(1)) is amended—

19 (1) in the matter before subparagraph (A), by
20 striking "or (C)" and inserting "(C), or (D)"; and

21 (2) by adding at the end the following new sub-
22 paragraph:

23 "(D) PERMITTING HIGHER RATES
24 THROUGH NEGOTIATION.—

1 "(i) IN GENERAL.—For each year be-
2 ginning with 2004, in the case of a
3 Medicare+Choice payment area for which
4 the Medicare+Choice capitation rate under
5 this paragraph would otherwise be less
6 than the United States per capita cost
7 (USPCC), as calculated by the Secretary,
8 a Medicare+Choice organization may ne-
9 gotiate with the Medicare Benefits Admin-
10 istrator an annual per capita rate that—
11 "(I) reflects an annual rate of in-
12 crease up to the rate of increase speci-
13 fied in clause (ii);
14 "(II) takes into account audited
15 current data supplied by the organiza-
16 tion on its adjusted community rate
17 (as defined in section 1854(f)(3)); and
18 "(III) does not exceed the United
19 States per capita cost, as projected by
20 the Secretary for the year involved.
21 "(ii) MAXIMUM RATE DESCRIBED.—
22 The rate of increase specified in this clause
23 for a year is the rate of inflation in private
24 health insurance for the year involved, as
25 projected by the Medicare Benefits Admin-

1 istrator, and includes such adjustments as
2 may be necessary—
3 "(I) to reflect the demographic
4 characteristics in the population under
5 this title; and
6 "(II) to eliminate the costs of
7 prescription drugs.
8 "(iii) ADJUSTMENTS FOR OVER OR
9 UNDER PROJECTIONS.—If subparagraph is
10 applied to an organization and payment
11 area for a year, in applying this subpara-
12 graph for a subsequent year the provisions
13 of paragraph (6)(C) shall apply in the
14 same manner as such provisions apply
15 under this paragraph.".

16 **SEC. 307. 10-YEAR PHASE IN OF RISK ADJUSTMENT BASED**
17 **ON DATA FROM ALL SETTINGS.**

18 Section 1853(a)(3)(C)(ii) of the Social Security Act
19 (42 U.S.C. 1395w–23(c)(1)(C)(ii)) is amended—
20 (1) by striking the period at the end of sub-
21 clause (II) and inserting a semicolon; and
22 (2) by adding after and below subclause (II) the
23 following:
24 "and, beginning in 2004, insofar as such
25 risk adjustment is based on data from all

1 settings, the methodology shall be phased
2 in equal increments over a 10 year period,
3 beginning with 2004 or (if later) the first
4 year in which such data is used.''.

5 **SEC. 308. DELAY FROM JULY TO OCTOBER, 2000 IN DEAD-**
6 **LINE FOR OFFERING AND WITHDRAWING**
7 **MEDICARE+CHOICE PLANS FOR 2001.**

8 Notwithstanding any other provision of law, the dead-
9 line for a Medicare+Choice organization to withdraw the
10 offering of a Medicare+Choice plan under part C of title
11 XVIII of the Social Security Act (or otherwise to submit
12 information required for the offering of such a plan) for
13 2001 is delayed from July 1, 2000, to October 1, 2000,
14 and any such organization that provided notice of with-
15 drawal of such a plan during 2000 before the date of the
16 enactment of this Act may rescind such withdrawal at any
17 time before October 1, 2000.

18 Subtitle B—Preservation of Medi-
19 care Coverage of Drugs and
20 Biologicals

21 **SEC. 311. PRESERVATION OF COVERAGE OF DRUGS AND**
22 **BIOLOGICALS UNDER PART B OF THE MEDI-**
23 **CARE PROGRAM.**

24 (a) IN GENERAL.—Section 1861(s)(2) of the Social
25 Security Act (42 U.S.C. 1395x(s)(2)) is amended, in each

1 of subparagraphs (A) and (B), by striking ''(including
2 drugs and biologicals which cannot, as determined in ac-
3 cordance with regulations, be self-administered)'' and in-
4 serting ''(including injectable and infusable drugs and
5 biologicals which are not usually self-administered by the
6 patient)''.

7 (b) EFFECTIVE DATE.—The amendment made by
8 subsection (a) applies to drugs and biologicals adminis-
9 tered on or after October 1, 2000.

10 **SEC. 312. GAO REPORT ON PART B PAYMENT FOR DRUGS**
11 **AND BIOLOGICALS AND RELATED SERVICES.**

12 (a) IN GENERAL.—The Comptroller General of the
13 United States shall conduct a study to quantify the extent
14 to which reimbursement for drugs and biologicals under
15 the current medicare payment methodology (provided
16 under section 1842(o) of the Social Security Act (42
17 U.S.C. 1395u(o)) overpays for the cost of such drugs and
18 biologicals compared to the average acquisition cost paid
19 by physicians or other suppliers of such drugs.

20 (B) ELEMENTS.—The study shall also assess the con-
21 sequences of changing the current medicare payment
22 methodology to a payment methodology that is based on
23 the average acquisition cost of the drugs. The study shall,
24 at a minimum, assess the effects of such a reduction on—

1 (1) the delivery of health care services to Medi-
2 care beneficiaries with cancer;
3 (2) total Medicare expenditures, including an
4 estimate of the number of patients who would, as a
5 result of the payment reduction, receive chemo-
6 therapy in a hospital rather than in a physician's of-
7 fice;
8 (3) the delivery of dialysis services;
9 (4) the delivery of vaccines;
10 (5) the administration in physician offices of
11 drugs other than cancer therapy drugs; and
12 (6) the effect on the delivery of drug therapies
13 by hospital outpatient departments of changing the
14 average wholesale price as the basis for Medicare
15 pass-through payments to such departments, as in-
16 cluded in the Medicare, Medicaid, and SCHIP Bal-
17 anced Budget Refinement Act of 1999.
18 (c) PAYMENT FOR RELATED PROFESSIONAL SERV-
19 ICES.—The study shall also include a review of the extent
20 to which other payment methodologies under part B of
21 the medicare program, if any, intended to reimburse phy-
22 sician and other suppliers of drugs and biologicals de-
23 scribed in subsection (a) for costs incurred in handling,
24 storing and administering such drugs and biologicals are
25 inadequate to cover such costs and whether an additional

payment would be required to cover these costs under the average acquisition cost methodology.

(d) CONSIDERATION OF ISSUES IN IMPLEMENTING AN AVERAGE ACQUISITION COST METHODOLOGY.—The study shall assess possible means by which a payment method based on average acquisition cost could be implemented, including at least the following:

(1) Identification of possible bases for determining the average acquisition cost of drugs, such as surveys of wholesaler catalog prices, and determination of the advantages, disadvantages, and costs (to the government and public) of each possible approach.

(2) The impact on individual providers and practitioners if average or median prices are used as the payment basis.

(3) Methods for updating and keeping current the prices used as the payment basis.

(e) COORDINATION WITH BBRA STUDY.—The Comptroller General shall conduct the study under this section in coordination with the study provided for under section 213(a) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A–350), as enacted into law by section 1000(a)(6) of Public Law 106–113.

1 (f) REPORT.—Not later than 6 months after the date
2 of the enactment of this Act, the Comptroller General shall
3 submit a report on the study conducted under this section,
4 as well as the study referred to in subsection (e). Such
5 report shall include recommendations regarding such
6 changes in the medicare reimbursement policies described
7 in subsections (a) and (c) as the Comptroller General
8 deems appropriate, as well as the recommendations de-
9 scribed in section 213(b) of the Medicare, Medicaid, and
10 SCHIP Balanced Budget Refinement Act of 1999.

Passed the House of Representatives June 28, 2000.

Attest:

Clerk.