I

106TH CONGRESS
2D SESSION

H. R. 4680

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.

IN THE HOUSE OF REPRESENTATIVES

JUNE 15, 2000

Mr. THOMAS (for himself, Mr. BURR of North Carolina, Mr. PETERSON of Minnesota, Mr. BLILEY, and Mr. HALL of Texas) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committee on Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

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.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

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

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

SEC. 101. ESTABLISHMENT OF A MEDICARE PRESCRIPTION DRUG BENEFIT.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended—

(1) by redesignating part D as part E; and

(2) by inserting after part C the following new part:

''PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

''SEC. 1860A. BENEFITS; ELIGIBILITY; ENROLLMENT; AND COVERAGE PERIOD.

''(a) PROVISION OF QUALIFIED PRESCRIPTION DRUG COVERAGE THROUGH ENROLLMENT IN PLANS.—Subject to the succeeding provisions of this part, each individual who is enrolled under part B is entitled to obtain qualified

prescription drug coverage (described in section 1860B(a)) as follows:

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

''(2) PRESCRIPTION DRUG PLAN.—If the individual is not enrolled in a Medicare+Choice plan that provides qualified prescription drug coverage, the individual may enroll under this part in a prescription drug plan (as defined in section 1860C(a)).

Such individuals shall have a choice of such plans under section 1860E(d).

''(b) GENERAL ELECTION PROCEDURES.—

''(1) IN GENERAL.—An individual may elect to enroll in a prescription drug plan under this part, or elect the option of qualified prescription drug coverage under a Medicare+Choice plan under part C, and change such election only in such manner and form as may be prescribed by regulations of the Administrator of the Medicare Benefits Administration (appointed under section 1807(b)) (in this part referred to as the 'Medicare Benefits Administrator')

and only during an election period prescribed in or under this subsection.

''(2) ELECTION PERIODS.—

''(A) IN GENERAL.—Except as provided in this paragraph, the election periods under this subsection shall be the same as the coverage election periods under the Medicare+Choice program under section 1851(e), including—

''(i) annual coordinated election periods; and

''(ii) special election periods.

In applying the last sentence of section 1851(e)(4) (relating to discontinuance of a Medicare+Choice election during the first year of eligibility) under this subparagraph, in the case of an election described in such section in which the individual had elected or is provided qualified prescription drug coverage at the time of such first enrollment, the individual shall be permitted to enroll in a prescription drug plan under this part at the time of the election of coverage under the original fee-for-service plan.

''(B) INITIAL ELECTION PERIODS.—

''(i) INDIVIDUALS CURRENTLY COVERED.—In the case of an individual who is

enrolled under part B as of November 1, 2002, there shall be an initial election period of 6 months beginning on that date.

"(ii) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who is first enrolled under part B after November 1, 2002, there shall be an initial election period which is the same as the initial election period under section 1851(e)(1).

"(C) ADDITIONAL SPECIAL ELECTION PERIODS.—The Medicare Benefits Administrator shall establish special election periods—

"(i) in cases of individuals who have and involuntarily lose prescription drug coverage described in subsection (c)(2)(C); and

"(ii) in cases described in section 1837(h) (relating to errors in enrollment), in the same manner as such section applies to part B.

"(D) ONE-TIME ENROLLMENT PERMITTED FOR CURRENT PART A ONLY BENEFICIARIES.—In the case of an individual who as of November 1, 2002—

''(i) is entitled to benefits under part A; and

''(ii) is not (and has not previously been) enrolled under part B;

the individual shall be eligible to enroll in a prescription drug plan under this part but only during the period described in subparagraph (B)(i). If the individual enrolls in such a plan, the individual may change such enrollment under this part, but the individual may not enroll in a Medicare+Choice plan under part C unless the individual enrolls under part B. Nothing in this subparagraph shall be construed as providing for coverage under a prescription drug plan of benefits that are excluded because of the application of section 1860B(f)(2)(B).

''(c) GUARANTEED ISSUE; COMMUNITY RATING; AND NONDISCRIMINATION.—

''(1) GUARANTEED ISSUE.—

''(A) IN GENERAL.—An eligible individual who is eligible to elect qualified prescription drug coverage under a prescription drug plan or Medicare+Choice plan at a time during which elections are accepted under this part with re-

spect to the plan shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

''(B) MEDICARE+CHOICE LIMITATIONS PERMITTED.—The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i), relating to default enrollment) of section 1851(g) (relating to priority and limitation on termination of election) shall apply to PDP sponsors under this subsection.

''(2) COMMUNITY-RATED PREMIUM.—

''(A) IN GENERAL.—In the case of an individual who maintains (as determined under subparagraph (C)) continuous prescription drug coverage since first qualifying to elect prescription drug coverage under this part, a PDP sponsor or Medicare+Choice organization offering a prescription drug plan or Medicare+Choice plan that provides qualified prescription drug coverage and in which the individual is enrolled may not deny, limit, or condition the coverage or provision of covered prescription drug benefits or increase the premium under the plan based on any health status-re-

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

''(B) LATE ENROLLMENT PENALTY.—In the case of an individual who does not maintain such continuous prescription drug coverage, a PDP sponsor or Medicare+Choice organization may (notwithstanding any provision in this title) increase the premium otherwise applicable or impose a pre-existing condition exclusion with respect to qualified prescription drug coverage in a manner that reflects additional actuarial risk involved. Such a risk shall be established through an appropriate actuarial opinion of the type described in subparagraphs (A) through (C) of section 2103(c)(4).

''(C) CONTINUOUS PRESCRIPTION DRUG COVERAGE.—An individual is considered for purposes of this part to be maintaining continuous prescription drug coverage on and after a date if the individual establishes that there is no period of 63 days or longer on and after such date (beginning not earlier than January 1, 2003) during all of which the individual did

not have any of the following prescription drug coverage:

"(i) COVERAGE UNDER PRESCRIPTION DRUG PLAN OR MEDICARE+CHOICE PLAN.—Qualified prescription drug coverage under a prescription drug plan or under a Medicare+Choice plan.

"(ii) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care for the Elderly (PACE) under section 1934, through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997), or through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

"(iii) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any out-

patient prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan as defined in section 1860H(f)(1).

''(iv) PRESCRIPTION DRUG COVERAGE UNDER CERTAIN MEDIGAP POLICIES.—Coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)), but only if the policy was in effect on January 1, 2003, and only until the date such coverage is terminated.

''(v) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program.

''(vi) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans under chapter 17 of title 38, United States Code.

"(D) CERTIFICATION.—For purposes of carrying out this paragraph, the certifications of the type described in sections 2701(e) of the Public Health Service Act and in section 9801(e) of the Internal Revenue Code shall also include a statement for the period of coverage of whether the individual involved had prescription drug coverage described in subparagraph (C).

"(E) CONSTRUCTION.—Nothing in this section shall be construed as preventing the disenrollment of an individual from a prescription drug plan or a Medicare+Choice plan based on the termination of an election described in section 1851(g)(3), including for nonpayment of premiums or for other reasons specified in subsection (d)(3), which takes into account a grace period described in section 1851(g)(3)(B)(i).

"(3) NONDISCRIMINATION.—A PDP sponsor offering a prescription drug plan shall not establish a service area in a manner that would discriminate based on health or economic status of potential enrollees.

"(d) EFFECTIVE DATE OF ELECTIONS.—

''(1) IN GENERAL.—Except as provided in this section, the Medicare Benefits Administrator shall provide that elections under subsection (b) take effect at the same time as the Secretary provides that similar elections under section 1851(e) take effect under section 1851(f).

''(2) NO ELECTION EFFECTIVE BEFORE 2003.—In no case shall any election take effect before January 1, 2003.

''(3) TERMINATION.—The Medicare Benefits Administrator shall provide for the termination of elections in the case of—

''(A) termination of coverage under part B (other than the case of an individual described in subsection (b)(2)(D) (relating to part A only individuals); and

''(B) termination of elections described in section 1851(g)(3) (including failure to pay required premiums).

''SEC. 1860B. REQUIREMENTS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

''(a) REQUIREMENTS.—

''(1) IN GENERAL.—For purposes of this part and part C, the term 'qualified prescription drug coverage' means either of the following:

''(A) STANDARD COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Standard coverage (as defined in subsection (b)) and access to negotiated prices under subsection (d).

''(B) ACTUARIALLY EQUIVALENT COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Coverage of covered outpatient drugs which meets the alternative coverage requirements of subsection (c) and access to negotiated prices under subsection (d).

''(2) PERMITTING ADDITIONAL OUTPATIENT PRESCRIPTION DRUG COVERAGE.—

''(A) IN GENERAL.—Subject to subparagraph (B), nothing in this part shall be construed as preventing qualified prescription drug coverage from including coverage of covered outpatient drugs that exceeds the coverage required under paragraph (1), but any such additional coverage shall be limited to coverage of covered outpatient drugs.

''(B) DISAPPROVAL AUTHORITY.—The Medicare Benefits Administrator shall review the offering of qualified prescription drug coverage under this part or part C. If the Administrator finds that, in the case of a qualified pre-

scription drug coverage under a prescription drug plan or a Medicare+Choice plan, that the organization or sponsor offering the coverage is purposefully engaged in activities intended to result in favorable selection of those eligible medicare beneficiaries obtaining coverage through the plan, the Administrator may terminate the contract with the sponsor or organization under this part or part C.

''(3) APPLICATION OF SECONDARY PAYOR PROVISIONS.—The provisions of section 1852(a)(4) shall apply under this part in the same manner as they apply under part C.

''(b) STANDARD COVERAGE.—For purposes of this part, the 'standard coverage' is coverage of covered outpatient drugs (as defined in subsection (f)) that meets the following requirements:

''(1) DEDUCTIBLE.—The coverage has an annual deductible—

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

''(B) for a subsequent year, that is equal to the amount specified under this paragraph for the previous year increased by the percentage specified in paragraph (5) for the year involved.

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

''(2) LIMITS ON COST-SHARING.—The coverage has cost-sharing (for costs above the annual deductible specified in paragraph (1) and up to the initial coverage limit under paragraph (3)) that is equal to 50 percent or that is actuarially consistent (using processes established under subsection (e)) with an average expected payment of 50 percent of such costs.

''(3) INITIAL COVERAGE LIMIT.—Subject to paragraph (4), the coverage has an initial coverage limit on the maximum costs that may be recognized for payment purposes (above the annual deductible)—

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

''(B) for a subsequent year, that is equal to the amount specified in this paragraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

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

''(4) LIMITATION ON OUT-OF-POCKET EXPENDITURES BY BENEFICIARY.—

''(A) IN GENERAL.—Notwithstanding paragraph (3), the coverage provides benefits without any cost-sharing after the individual has incurred costs (as described in subparagraph (C)) for covered outpatient drugs in a year equal to the annual out-of-pocket limit specified in subparagraph (B).

''(B) ANNUAL OUT-OF-POCKET LIMIT.—For purposes of this part, the 'annual out-of-pocket limit' specified in this subparagraph—

''(i) for 2003, is equal to $6,000; or

''(ii) for a subsequent year, is equal to the amount specified in the subparagraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

Any amount determined under clause (ii) that is not a multiple of $100 shall be rounded to the nearest multiple of $100.

''(C) APPLICATION.—In applying subparagraph (A)—

''(i) incurred costs shall only include costs incurred for the annual deductible

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

''(ii) costs shall be treated as incurred without regard to whether the individual or another person, including a State program, has paid for such costs, but shall not be counted insofar as such costs are covered as benefits under a prescription drug plan, a Medicare+Choice plan, or other third-party coverage.

''(5) ANNUAL PERCENTAGE INCREASE.—For purposes of this part, the annual percentage increase specified in this paragraph for a year is equal to the annual percentage increase in average per capita aggregate expenditures for covered outpatient drugs in the United States for medicare beneficiaries, as determined by the Medicare Benefits Administrator for the 12-month period ending in July of the previous year.

''(c) ALTERNATIVE COVERAGE REQUIREMENTS.—A prescription drug plan or Medicare+Choice plan may provide a different prescription drug benefit design from the

standard coverage described in subsection (b)(1) so long as the following requirements are met:

"(1) ASSURING AT LEAST ACTUARIALLY EQUIVALENT COVERAGE.—

"(A) ASSURING EQUIVALENT VALUE OF TOTAL COVERAGE.—The actuarial value of the total coverage (as determined under subsection (e)) is at least equal to the actuarial value (as so determined) of standard coverage.

"(B) ASSURING EQUIVALENT UNSUBSIDIZED VALUE OF COVERAGE.—The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard coverage. For purposes of this subparagraph, the unsubsidized value of coverage is the amount by which the actuarial value of the coverage (as determined under subsection (e)) exceeds the actuarial value of the reinsurance subsidy payments under section 1860H with respect to such coverage.

"(C) ASSURING STANDARD PAYMENT FOR COSTS AT INITIAL COVERAGE LIMIT.—The coverage is designed, based upon an actuarially representative pattern of utilization (as determined under subsection (e)), to provide for the

payment, with respect to costs incurred that are equal to the sum of the deductible under subsection (b)(1) and the initial coverage limit under subsection (b)(3), of an amount equal to at least such initial coverage limit multiplied by the percentage specified in subsection (b)(2).

''(2) LIMITATION ON OUT-OF-POCKET EXPENDITURES BY BENEFICIARIES.—The coverage provides the limitation on out-of-pocket expenditures by beneficiaries described in subsection (b)(4).

''(d) ACCESS TO NEGOTIATED PRICES.—Under qualified prescription drug coverage offered by a PDP sponsor or a Medicare+Choice organization, the sponsor or organization shall provide beneficiaries with access to negotiated prices (including applicable discounts) used for payment for covered outpatient drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of cost-sharing or an initial coverage limit (described in subsection (b)(3)).

''(e) ACTUARIAL VALUATION; DETERMINATION OF ANNUAL PERCENTAGE INCREASES.—

''(1) PROCESSES.—For purposes of this section, the Medicare Benefits Administrator shall establish processes and methods—

''(A) for determining the actuarial valuation of prescription drug coverage, including—

''(i) an actuarial valuation of standard coverage and of the reinsurance subsidy payments under section 1860H;

''(ii) the use of generally accepted actuarial principles and methodologies; and

''(iii) applying the same methodology for determinations of alternative coverage under subsection (c) as is used with respect to determinations of standard coverage under subsection (b); and

''(B) for determining annual percentage increases described in subsection (b)(5).

''(2) USE OF OUTSIDE ACTUARIES.—Under the processes under paragraph (1)(A), PDP sponsors and Medicare+Choice organizations may use actuarial opinions certified by independent, qualified actuaries to establish actuarial values.

''(f) COVERED OUTPATIENT DRUGS DEFINED.—

''(1) IN GENERAL.—Except as provided in this subsection, for purposes of this part, the term 'covered outpatient drug' means—

''(A) a drug that may be dispensed only upon a prescription and that is described in

subparagraph (A)(i) or (A)(ii) of section 1927(k)(2); or

"(B) a biological product or insulin described in subparagraph (B) or (C) of such section.

"(2) EXCLUSIONS.—

"(A) IN GENERAL.—Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents).

"(B) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this part shall not be so considered if payment for such drug is available under part A or B (but shall be so considered if such payment is not available because benefits under part A or B have been exhausted), without regard to whether the individual is entitled to benefits under part A or enrolled under part B.

"(3) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under

this part shall not be so considered under a plan if the plan excludes the drug under a formulary that meets the requirements of section 1860C(f)(2) (including providing an appeal process).

''(4) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A prescription drug plan or Medicare+Choice plan may exclude from qualified prescription drug coverage any covered outpatient drug—

''(A) for which payment would not be made if section 1862(a) applied to part D; or

''(B) which are not prescribed in accordance with the plan or this part.

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860C(f).

''SEC. 1860C. BENEFICIARY PROTECTIONS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

''(a) GUARANTEED ISSUE AND NONDISCRIMINATION.—For provisions requiring guaranteed issue, community-rated premiums, and nondiscrimination, see sections 1860A(c) and 1860F(b).

''(b) DISSEMINATION OF INFORMATION.—

''(1) GENERAL INFORMATION.—A PDP sponsor shall disclose, in a clear, accurate, and standardized form to each enrollee with a prescription drug plan

offered by the sponsor under this part at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such plan. Such information includes the following:

"(A) Access to covered outpatient drugs, including access through pharmacy networks.

"(B) How any formulary used by the sponsor functions.

"(C) Co-payments and deductible requirements.

"(D) Grievance and appeals procedures.

"(2) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an individual eligible to enroll under a prescription drug plan, the PDP sponsor shall provide the information described in section 1852(c)(2) (other than subparagraph (D)) to such individual.

"(3) RESPONSE TO BENEFICIARY QUESTIONS.—Each PDP sponsor offering a prescription drug plan shall have a mechanism for providing specific information to enrollees upon request. The sponsor shall make available, through an Internet website and in

writing upon request, information on specific changes in its formulary.

''(4) CLAIMS INFORMATION.—Each PDP sponsor offering a prescription drug plan must furnish to enrolled individuals in a form easily understandable to such individuals an explanation of benefits (in accordance with section 1806(a) or in a comparable manner) and a notice of the benefits in relation to initial coverage limit and annual out-of-pocket limit for the current year, whenever prescription drug benefits are provided under this part (except that such notice need not be provided more often than monthly).

''(c) ACCESS TO COVERED BENEFITS.—

''(1) ASSURING PHARMACY ACCESS.—The PDP sponsor of the prescription drug plan shall secure the participation of sufficient numbers of pharmacies (which may include mail order pharmacies) to ensure convenient access (including adequate emergency access) for enrolled beneficiaries. Nothing in this paragraph shall be construed as requiring the participation of all pharmacies in any area under a plan.

''(2) ACCESS TO NEGOTIATED PRICES FOR PRESCRIPTION DRUGS.—The PDP sponsor of a prescrip-

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

''(3) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—Insofar as a PDP sponsor of a prescription drug plan uses a formulary, the following requirements must be met:

''(A) FORMULARY COMMITTEE.—The sponsor must establish a pharmaceutical and therapeutic committee that develops the formulary. Such committee shall include at least one physician and at least one pharmacist.

''(B) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES.—The formulary must include drugs within all therapeutic categories and classes of covered outpatient drugs (although not necessarily for all drugs within such categories and classes).

''(C) APPEALS AND EXCEPTIONS TO APPLICATION.—The PDP sponsor must have, as part of the appeals process under subsection (i)(2),

a process for appeals for denials of coverage based on such application of the formulary.

''(d) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE; MEDICATION THERAPY MANAGEMENT PROGRAM.—

''(1) IN GENERAL.—The PDP sponsor shall have in place—

''(A) an effective cost and drug utilization management program, including appropriate incentives to use generic drugs, when appropriate;

''(B) quality assurance measures and systems to reduce medical errors and adverse drug interactions, including a medication therapy management program described in paragraph (2); and

''(C) a program to control fraud, abuse, and waste.

''(2) MEDICATION THERAPY MANAGEMENT PROGRAM.—

''(A) IN GENERAL.—A medication therapy management program described in this paragraph is a program of drug therapy management and medication administration that is designed to assure that covered outpatient drugs under the prescription drug plan are appro-

priately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

"(B) ELEMENTS.—Such program may include—

"(i) enhanced beneficiary understanding of such appropriate use through beneficiary education, counseling, and other appropriate means; and

"(ii) increased beneficiary adherence with prescription medication regimens through medication refill reminders, special packaging, and other appropriate means.

"(C) DEVELOPMENT OF PROGRAM IN COOPERATION WITH LICENSED PHARMACISTS.—The program shall be developed in cooperation with licensed pharmacists and physicians.

"(D) CONSIDERATIONS IN PHARMACY FEES.—The PDP sponsor of a prescription drug program shall take into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program.

''(3) TREATMENT OF ACCREDITATION.—Section 1852(e)(4) (relating to treatment of accreditation) shall apply to prescription drug plans under this part with respect to the following requirements, in the same manner as they apply to Medicare+Choice plans under part C with respect to the requirements described in a clause of section 1852(e)(4)(B):

''(A) Paragraph (1) (including quality assurance), including medication therapy management program under paragraph (2).

''(B) Subsection (c)(1) (relating to access to covered benefits).

''(C) Subsection (g) (relating to confidentiality and accuracy of enrollee records).

''(e) GRIEVANCE MECHANISM.—Each PDP sponsor shall provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the sponsor provides covered benefits) and enrollees with prescription drug plans of the sponsor under this part in accordance with section 1852(f).

''(f) COVERAGE DETERMINATIONS, RECONSIDERATIONS, AND APPEALS.—

''(1) IN GENERAL.—A PDP sponsor shall meet the requirements of section 1852(g) with respect to

covered benefits under the prescription drug plan it offers under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

''(2) APPEALS OF FORMULARY DETERMINATIONS.—Under the appeals process under paragraph (1) an individual who is enrolled in a prescription drug plan offered by a PDP sponsor may appeal to obtain coverage for a medically necessary covered outpatient drug that is not on the formulary of the sponsor (established under subsection (c)) if the prescribing physician determines that the therapeutically similar drug that is on the formulary is not effective for the enrollee or has significant adverse effects for the enrollee.

''(g) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—A PDP sponsor shall meet the requirements of section 1852(h) with respect to enrollees under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to enrollees under part C.

"SEC. 1860D. REQUIREMENTS FOR PRESCRIPTION DRUG PLAN (PDP) SPONSORS.

"(a) GENERAL REQUIREMENTS.—Each PDP sponsor of a prescription drug plan shall meet the following requirements:

"(1) LICENSURE.—Subject to subsection (c), the sponsor is organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a prescription drug plan.

"(2) ASSUMPTION OF FULL FINANCIAL RISK.—

"(A) IN GENERAL.—Subject to subparagraph (B) and section 1860E(d)(2), the entity assumes full financial risk on a prospective basis for qualified prescription drug coverage that it offers under a prescription drug plan and that is not covered under reinsurance under section 1860H.

"(B) REINSURANCE PERMITTED.—The entity may obtain insurance or make other arrangements for the cost of coverage provided to any enrolled member under this part.

"(3) SOLVENCY FOR UNLICENSED SPONSORS.—In the case of a sponsor that is not described in paragraph (1), the sponsor shall meet solvency

standards established by the Medicare Benefits Administrator under subsection (d).

''(b) CONTRACT REQUIREMENTS.—

''(1) IN GENERAL.—The Medicare Benefits Administrator shall not permit the election under section 1860A of a prescription drug plan offered by a PDP sponsor under this part, and the sponsor shall not be eligible for payments under section 1860G or 1860H, unless the Administrator has entered into a contract under this subsection with the sponsor with respect to the offering of such plan. Such a contract with a sponsor may cover more than 1 prescription drug plan. Such contract shall provide that the sponsor agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

''(2) INCORPORATION OF CERTAIN MEDICARE+CHOICE CONTRACT REQUIREMENTS.—The following provisions of section 1857 shall apply, subject to subsection (c)(5), to contracts under this section in the same manner as they apply to contracts under section 1857(a):

''(A) MINIMUM ENROLLMENT.—Paragraphs (1) and (3) of section 1857(b).

"(B) CONTRACT PERIOD AND EFFECTIVENESS.—Paragraphs (1) through (3) and (5) of section 1857(e).

"(C) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—Section 1857(d).

"(D) ADDITIONAL CONTRACT TERMS.—Section 1857(e); except that in applying section 1857(e)(2) under this part—

"(i) such section shall be applied separately to costs relating to this part (from costs under part C);

"(ii) in no case shall the amount of the fee established under this subparagraph for a plan exceed 20 percent of the maximum amount of the fee that may be established under subparagraph (B) of such section; and

"(iii) no fees shall be applied under this subparagraph with respect to Medicare+Choice plans.

"(E) INTERMEDIATE SANCTIONS.—Section 1857(g).

"(F) PROCEDURES FOR TERMINATION.—Section 1857(h).

''(3) RULES OF APPLICATION FOR INTERMEDIATE SANCTIONS.—In applying paragraph (2)(E)—

''(A) the reference in section 1857(g)(1)(B) to section 1854 is deemed a reference to this part; and

''(B) the reference in section 1857(g)(1)(F) to section 1852(k)(2)(A)(ii) shall not be applied.

''(c) WAIVER OF CERTAIN REQUIREMENTS TO EXPAND CHOICE.—

''(1) IN GENERAL.—In the case of an entity that seeks to offer a prescription drug plan in a State, the Medicare Benefits Administrator shall waive the requirement of subsection (a)(1) that the entity be licensed in that State if the Administrator determines, based on the application and other evidence presented to the Administrator, that any of the grounds for approval of the application described in paragraph (2) has been met.

''(2) GROUNDS FOR APPROVAL.—The grounds for approval under this paragraph are the grounds for approval described in subparagraph (B), (C), and (D) of section 1855(a)(2), and also include the

application by a State of any grounds other than those required under Federal law.

''(3) APPLICATION OF MEDICARE+CHOICE PSO WAIVER PROCEDURES.—With respect to an application for a waiver (or a waiver granted) under this subsection, the provisions of subparagraphs (E), (F), and (G) of section 1855(a)(2) shall apply.

''(4) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that an entity is licensed in accordance with subsection (a)(1) does not deem the entity to meet other requirements imposed under this part for a PDP sponsor.

''(5) REFERENCES TO CERTAIN PROVISIONS.—For purposes of this subsection, in applying provisions of section 1855(a)(2) under this subsection to prescription drug plans and PDP sponsors—

''(A) any reference to a waiver application under section 1855 shall be treated as a reference to a waiver application under paragraph (1); and

''(B) any reference to solvency standards were treated as a reference to solvency standards established under subsection (c).

''(d) SOLVENCY STANDARDS FOR NON-LICENSED SPONSORS.—

''(1) ESTABLISHMENT.—The Medicare Benefits Administrator shall establish, by not later than October 1, 2001, financial solvency and capital adequacy standards that an entity that does not meet the requirements of subsection (a)(1) must meet to qualify as a PDP sponsor under this part.

''(2) COMPLIANCE WITH STANDARDS.—Each PDP sponsor that is not licensed by a State under subsection (a)(1) and for which a waiver application has been approved under subsection (c) shall meet solvency and capital adequacy standards established under paragraph (1). The Medicare Benefits Administrator shall establish certification procedures for such PDP sponsors with respect to such solvency standards in the manner described in section 1855(c)(2).

''(e) OTHER STANDARDS.—The Medicare Benefits Administrator shall establish by regulation other standards (not described in subsection (d)) for PDP sponsors and plans consistent with, and to carry out, this part. The Administrator shall publish such regulations by October 1, 2001. In order to carry out this requirement in a timely manner, the Administrator may promulgate regulations

that take effect on an interim basis, after notice and pending opportunity for public comment.

''(f) RELATION TO STATE LAWS.—

''(1) IN GENERAL.—The standards established under this subsection shall supersede any State law or regulation (including standards described in paragraph (2)) with respect to prescription drug plans which are offered by PDP sponsors under this part to the extent such law or regulation is inconsistent with such standards, in the same manner as such laws and regulations are superseded under section 1856(b)(3).

''(2) STANDARDS SPECIFICALLY SUPERSEDED.—State standards relating to the following are superseded under this subsection:

''(A) Benefit requirements.

''(B) Requirements relating to inclusion or treatment of providers.

''(C) Coverage determinations (including related appeals and grievance processes).

''(3) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to premiums paid to PDP sponsors for prescription drug plans under this part, or with respect to any payments made to such

a sponsor by the Medicare Benefits Administrator under this part.

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

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

"(b) ELEMENTS.—Such process shall include the following:

"(1) Annual, coordinated election periods, in which such individuals can change the qualifying plans through which they obtain coverage, in accordance with section 1860A(b)(2).

"(2) Active dissemination of information to promote an informed selection among qualifying plans based upon price, quality, and other features, in the manner described in (and in coordination with) section 1851(d), including the provision of annual comparative information, maintenance of a toll-free hotline, and the use of non-federal entities.

''(3) Coordination of elections through filing with a Medicare+Choice organization or a PDP sponsor, in the manner described in (and in coordination with) section 1851(c)(2).

''(c) MEDICARE+CHOICE ENROLLEE IN PLAN OFFERING PRESCRIPTION DRUG COVERAGE MAY ONLY OBTAIN BENEFITS THROUGH THE PLAN.—An individual who is enrolled under a Medicare+Choice plan that offers qualified prescription drug coverage may only elect to receive qualified prescription drug coverage under this part through such plan.

''(d) ASSURING ACCESS TO A CHOICE OF QUALIFIED PRESCRIPTION DRUG COVERAGE.—

''(1) IN GENERAL.—The Medicare Benefits Administrator shall assure that each individual who is enrolled under part B and who is residing in an area has available a choice of enrollment in at least 2 qualifying plans (as defined in paragraph (5)) in the area in which the individual resides, at least 1 of which is a prescription drug plan.

''(2) GUARANTEEING ACCESS TO COVERAGE.—In order to assure access under paragraph (1) and consistent with paragraph (3), the Medicare Benefits Administrator may provide financial incentives (including partial underwriting of risk) for a PDP

sponsor to expand the service area under an existing prescription drug plan to adjoining or additional areas or to establish such a plan (including offering such a plan on a regional or nationwide basis), but only so long as (and to the extent) necessary to assure the access guaranteed under paragraph (1).

''(3) LIMITATION ON AUTHORITY.—In exercising authority under this subsection, the Medicare Benefits Administrator—

''(A) shall not provide for the full underwriting of financial risk for any PDP sponsor;

''(B) shall not provide for any underwriting of financial risk for a public PDP sponsor with respect to the offering of a nationwide prescription drug plan; and

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

''(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.

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

"SEC. 1860F. PREMIUMS.

''(a) SUBMISSION OF PREMIUMS AND RELATED INFORMATION.—

''(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).

''(2) TYPE OF INFORMATION.—The information described in this paragraph is the following:

''(A) Information on the qualified prescription drug coverage to be provided.

''(B) Information on the actuarial value of the coverage.

''(C) Information on the monthly premium to be charged for the coverage, including an actuarial certification of—

"(i) the actuarial basis for such premium;

"(ii) the portion of such premium attributable to benefits in excess of standard coverage; and

"(iii) the reduction in such premium resulting from the reinsurance subsidy payments provided under section 1860H.

"(D) Such other information as the Medicare Benefits Administrator may require to carry out this part.

"(3) REVIEW.—The Medicare Benefits Administrator shall review the information filed under paragraph (2) and shall approve or disapprove such rates, amounts, and values so submitted. In exercising such authority, the Administrator shall take into account the reinsurance subsidy payments under section 1860H and the adjusted community rate (as defined in section 1854(f)(3)) for the benefits covered and shall have the same authority to negotiate the terms and conditions of such premiums and other terms and conditions of plans as the Director of the Office of Personnel Management has with respect to health benefits plans under chapter 89 of title 5, United States Code.

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

''(c) TERMS AND CONDITIONS FOR IMPOSING PREMIUMS.—The provisions of section 1854(d) shall apply under this part in the same manner as they apply under part C, and, for this purpose, the reference in such section to section 1851(g)(3)(B)(i) is deemed a reference to section 1860A(d)(3)(B) (relating to failure to pay premiums required under this part).

''(d) ACCEPTANCE OF REFERENCE PREMIUM AS FULL PREMIUM IF NO STANDARD (OR EQUIVALENT) COVERAGE IN AN AREA.—

''(1) IN GENERAL.—If there is no standard prescription drug coverage (as defined in paragraph (2)) offered in an area, in the case of an individual who is eligible for a premium subsidy under section 1860G and resides in the area, the PDP sponsor of any prescription drug plan offered in the area (and any Medicare+Choice organization that offers qualified prescription drug coverage in the area) shall accept 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-

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

''(2) SLIDING SCALE PREMIUM SUBSIDY FOR INDIVIDUALS WITH INCOME ABOVE 135, BUT BELOW 150 PERCENT, OF FEDERAL POVERTY LEVEL.—In the case of a subsidy eligible individual who is determined to have income that exceeds 135 percent, but does not exceed 150 percent, of the Federal poverty level, the individual is entitled under this section to a premium subsidy determined on a linear sliding scale ranging from 100 percent of the amount described in subsection (b)(1) for individuals with incomes at 135 percent of such level to 0 percent of such amount for individuals with incomes at 150 percent of such level.

''(3) DETERMINATION OF ELIGIBILITY.—

''(A) SUBSIDY ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, subject to subparagraph (D), the term 'subsidy eligible individual' means an individual who—

''(i) is eligible to elect, and has elected, to obtain qualified prescription drug coverage under this part;

"(ii) has income below 150 percent of the Federal poverty line; and

"(iii) meets the resources requirement described in section 1905(p)(1)(C).

"(B) DETERMINATIONS.—The determination of whether an individual residing in a State is a subsidy eligible individual and the amount of such individual's income shall be determined under the State medicaid plan for the State under section 1935(a). In the case of a State that does not operate such a medicaid plan (either under title XIX or under a statewide waiver granted under section 1115), such determination shall be made under arrangements made by the Medicare Benefits Administrator.

"(C) INCOME DETERMINATIONS.—For purposes of applying this section—

"(i) income shall be determined in the manner described in section 1905(p)(1)(B); and

"(ii) the term 'Federal poverty line' means the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget

Reconciliation Act of 1981) applicable to a family of the size involved.

''(D) TREATMENT OF TERRITORIAL RESIDENTS.—In the case of an individual who is not a resident of the 50 States or the District of Columbia, the individual is not eligible to be a subsidy eligible individual but may be eligible for financial assistance with prescription drug expenses under section 1935(e).

''(b) PREMIUM SUBSIDY AMOUNT.—

''(1) IN GENERAL.—The premium subsidy amount described in this subsection for an individual residing in an area is the reference premium (as defined in paragraph (2)) for qualified prescription drug coverage offered by the prescription drug plan or the Medicare+Choice plan in which the individual is enrolled.

''(2) REFERENCE PREMIUM DEFINED.—For purposes of this subsection, the term 'reference premium' means, with respect to qualified prescription drug coverage offered under—

''(A) a prescription drug plan that—

''(i) provides standard coverage (or alternative prescription drug coverage the actuarial value is equivalent to that of

standard coverage), the premium imposed for enrollment under the plan under this part (determined without regard to any subsidy under this section or any late enrollment penalty under section 1860A(c)(2)(B)); or

''(ii) provides alternative prescription drug coverage the actuarial value of which is greater than that of standard coverage, the premium described in clause (i) multiplied by the ratio of (I) the actuarial value of standard coverage, to (II) the actuarial value of the alternative coverage; or

''(B) a Medicare+Choice plan, the standard premium computed under section 1851(j)(4)(A)(iii), determined without regard to any reduction effected under section 1851(j)(4)(B).

''(c) RULES IN APPLYING COST-SHARING SUBSIDIES.—

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

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

imum cost-sharing described in such subsection that may be incurred for standard coverage;

''(B) the Medicare Benefits Administrator shall determine what is 'nominal' taking into account the rules applied under section 1916(a)(3); and

''(C) nothing in this part shall be construed as preventing a plan or provider from waiving or reducing the amount of cost-sharing otherwise applicable.

''(2) LIMITATION ON CHARGES.—In the case of an individual receiving cost-sharing subsidies under subsection (a)(1)(B), the PDP sponsor may not charge more than a nominal amount in cases in which the cost-sharing subsidy is provided under such subsection.

''(d) ADMINISTRATION OF SUBSIDY PROGRAM.—The Medicare Benefits Administrator shall provide a process whereby, in the case of an individual who is determined to be a subsidy eligible individual and who is enrolled in prescription drug plan or is enrolled in a Medicare+Choice plan under which qualified prescription drug coverage is provided—

''(1) the Administrator provides for a notification of the PDP sponsor or Medicare+Choice orga-

nization involved that the individual is eligible for a subsidy and the amount of the subsidy under subsection (a);

''(2) the sponsor or organization involved reduces the premiums or cost-sharing otherwise imposed by the amount of the applicable subsidy and submits to the Administrator information on the amount of such reduction; and

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

The reimbursement under paragraph (3) with respect to cost-sharing subsidies may be computed on a capitated basis, taking into account the actuarial value of the subsidies and with appropriate adjustments to reflect differences in the risks actually involved.

''(e) RELATION TO MEDICAID PROGRAM.—

''(1) IN GENERAL.—For provisions providing for eligibility determinations, and additional financing, under the medicaid program, see section 1935.

''(2) MEDICAID PROVIDING WRAP AROUND BENEFITS.—The coverage provided under this part is primary payor to benefits for prescribed drugs provided under the medicaid program under title XIX.

"SEC. 1860H. SUBSIDIES FOR ALL MEDICARE BENEFICIARIES THROUGH REINSURANCE FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

''(a) REINSURANCE SUBSIDY PAYMENT.—In order to reduce premium levels applicable to qualified prescription drug coverage for all medicare beneficiaries, to reduce adverse selection among prescription drug plans and Medicare+Choice plans that provide qualified prescription drug coverage, and to promote the participation of PDP sponsors under this part, the Medicare Benefits Administrator shall provide in accordance with this section for payment to a qualifying entity (as defined in subsection (b)) of the reinsurance payment amount (as defined in subsection (c)) for excess costs incurred in providing qualified prescription drug coverage—

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

''(2) for individuals enrolled with a Medicare+Choice plan that provides qualified prescription drug coverage under part C; and

''(3) for medicare primary individuals (described in subsection (f)(3)(D)) who are enrolled in a qualified retiree prescription drug plan.

This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Ad-

ministrator to provide for the payment of amounts provided under this section.

''(b) QUALIFYING ENTITY DEFINED.—For purposes of this section, the term 'qualifying entity' means any of the following that has entered into an agreement with the Administrator to provide the Administrator with such information as may be required to carry out this section:

''(1) A PDP sponsor offering a prescription drug plan under this part.

''(2) A Medicare+Choice organization that provides qualified prescription drug coverage under a Medicare+Choice plan under part C.

''(3) The sponsor of a qualified retiree prescription drug plan (as defined in subsection (f)).

''(c) REINSURANCE PAYMENT AMOUNT.—

''(1) IN GENERAL.—Subject to subsection (d)(2) and paragraph (4), the reinsurance payment amount under this subsection for a qualifying covered individual (as defined in subsection (g)(1)) for a coverage year (as defined in subsection (g)(2)) is equal to the sum of the following:

''(A) For the portion of the individual's gross covered prescription drug costs (as defined in paragraph (3)) for the year that exceeds $1,250, but does not exceed $1,350, an

amount equal to 30 percent of the allowable costs (as defined in paragraph (2)) attributable to such gross covered prescription drug costs.

"(B) For the portion of the individual's gross covered prescription drug costs for the year that exceeds $1,350, but does not exceed $1,450, an amount equal to 50 percent of the allowable costs attributable to such gross covered prescription drug costs.

"(C) For the portion of the individual's gross covered prescription drug costs for the year that exceeds $1,450, but does not exceed $1,550, an amount equal to 70 percent of the allowable costs attributable to such gross covered prescription drug costs.

"(D) For the portion of the individual's gross covered prescription drug costs for the year that exceeds $1,550, but does not exceed $2,350, an amount equal to 90 percent of the allowable costs attributable to such gross covered prescription drug costs.

"(E) For the portion of the individual's gross covered prescription drug costs for the year that exceeds $7,050, an amount equal to

90 percent of the allowable costs attributable to such gross covered prescription drug costs.

''(2) ALLOWABLE COSTS.—For purposes of this section, the term 'allowable costs' means, with respect to gross covered prescription drug costs under a plan described in subsection (b) offered by a qualifying entity, the part of such costs that are actually paid under the plan, but in no case more than the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were standard coverage.

''(3) GROSS COVERED PRESCRIPTION DRUG COSTS.—For purposes of this section, the term 'gross covered prescription drug costs' means, with respect to an enrollee with a qualifying entity under a plan described in subsection (b) during a coverage year, the costs incurred under the plan for covered prescription drugs dispensed during the year, including costs relating to the deductible, whether paid by the enrollee or under the plan, regardless of whether the coverage under the plan exceeds standard coverage and regardless of when the payment for such drugs is made.

''(4) INDEXING DOLLAR AMOUNTS.—

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

"(B) FOR 2004.—The dollar amounts applied under paragraph (1) for 2004 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase described in section 1860B(b)(5) for 2004.

"(C) FOR SUBSEQUENT YEARS.—The dollar amounts applied under paragraph (1) for a year after 2004 shall be the amounts (under this paragraph) applied under paragraph (1) for the preceding year increased by the annual percentage increase described in section 1860B(b)(5) for the year involved.

"(D) ROUNDING.—Any amount, determined under the preceding provisions of this paragraph for a year, which is not a multiple of $5 shall be rounded to the nearest multiple of $5.

"(d) ADJUSTMENT OF PAYMENTS.—

"(1) IN GENERAL.—The Medicare Benefits Administrator shall estimate—

"(A) the total payments to be made (without regard to this subsection) during a year under this section; and

"(B) the total payments to be made by qualifying entities for standard coverage under plans described in subsection (b) during the year.

"(2) ADJUSTMENT OF PAYMENTS.—The Administrator shall proportionally adjust the payments made under this section for a coverage year in such manner so that the total of the payments made for the year under this section is equal to 35 percent of the total payments described in paragraph (1)(B) during the year.

"(e) PAYMENT METHODS.—

"(1) IN GENERAL.—Payments under this section shall be based on such a method as the Medicare Benefits Administrator determines. The Administrator may establish a payment method by which interim payments of amounts under this section are made during a year based on the Administrator's best estimate of amounts that will be payable after obtaining all of the information.

''(2) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Medicare Prescription Drug Account.

''(f) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN DEFINED.—

''(1) IN GENERAL.—For purposes of this section, the term 'qualified retiree prescription drug plan' means employment-based retiree health coverage (as defined in paragraph (3)(A)) if, with respect to an individual enrolled (or eligible to be enrolled) under this part who is covered under the plan, the following requirements are met:

''(A) ASSURANCE.—The sponsor of the plan shall annually attest, and provide such assurances as the Medicare Benefits Administrator may require, that the coverage meets the requirements for qualified prescription drug coverage.

''(B) AUDITS.—The sponsor (and the plan) shall maintain, and afford the Medicare Benefits Administrator access to, such records as the Administrator may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug cov-

erage, the accuracy of payments made, and such other matters as may be appropriate.

''(C) PROVISION OF CERTIFICATION OF PRESCRIPTION DRUG COVERAGE.—The sponsor of the plan shall provide for issuance of certifications of the type described in section 1860A(c)(2)(D).

''(D) OTHER REQUIREMENTS.—The sponsor of the plan shall comply with such other requirements as the Medicare Benefits Administrator finds necessary to administer the program under this section.

''(2) LIMITATION ON BENEFIT ELIGIBILITY.—No payment shall be provided under this section with respect to an individual who is enrolled under a qualified retiree prescription drug plan unless the individual is a medicare primary individual who—

''(A) is covered under the plan; and

''(B) is eligible to obtain qualified prescription drug coverage under section 1860A but did not elect such coverage under this part (either through a prescription drug plan or through a Medicare+Choice plan).

''(3) DEFINITIONS.—As used in this section:

"(A) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage of health care costs for medicare primary individuals (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

"(B) EMPLOYER.—The term 'employer' has the meaning given such term by section 3(5) of the Employee Retirement Income Security Act of 1974 (except that such term shall include only employers of two or more employees).

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

"(D) MEDICARE PRIMARY INDIVIDUAL.—The term 'medicare primary individual' means, with respect to a plan, an individual who is covered under the plan and with respect to whom the plan is not a primary plan (as defined in section 1862(b)(2)(A)).

''(g) GENERAL DEFINITIONS.—For purposes of this section:

''(1) QUALIFYING COVERED INDIVIDUAL.—The term 'qualifying covered individual' means an individual who—

''(A) is enrolled with a prescription drug plan under this part;

''(B) is enrolled with a Medicare+Choice plan that provides qualified prescription drug coverage under part C; or

''(C) is covered as a medicare primary individual under a qualified retiree prescription drug plan.

''(2) COVERAGE YEAR.—The term 'coverage year' means a calendar year in which covered outpatient drugs are dispensed if a claim for payment is made under the plan for such drugs, regardless of when the claim is paid.

"SEC. 1860I. MEDICARE PRESCRIPTION DRUG ACCOUNT IN FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.

''(a) IN GENERAL.—There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1841 an account to be known as the 'Medicare Prescription Drug Account' (in this section re-

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

''(b) PAYMENTS FROM ACCOUNT.—

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

''(A) payments under section 1860G (relating to low-income subsidy payments);

''(B) payments under section 1860H (relating to reinsurance subsidy payments); and

''(C) payments with respect to administrative expenses under this part in accordance with section 201(g).

''(2) TRANSFERS TO MEDICAID ACCOUNT FOR INCREASED ADMINISTRATIVE COSTS.—The Managing Trustee shall transfer from time to time from the Account to the Grants to States for Medicaid account amounts the Secretary certifies are attributable to increases in payment resulting from the

application of a higher Federal matching percentage under section 1935(b).

''(c) DEPOSITS INTO ACCOUNT.—

''(1) MEDICAID TRANSFER.—There is hereby transferred to the Account, from amounts appropriated for Grants to States for Medicaid, amounts equivalent to the aggregate amount of the reductions in payments under section 1903(a)(1) attributable to the application of section 1935(c).

''(2) APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Account, an amount equivalent to the amount of payments made from the Account under subsection (b), reduced by the amount transferred to the Account under paragraph (1).

''SEC. 1860J. DEFINITIONS; TREATMENT OF REFERENCES TO PROVISIONS IN PART C.

''(a) DEFINITIONS.—For purposes of this part:

''(1) COVERED OUTPATIENT DRUGS.—The term 'covered outpatient drugs' is defined in section 1860B(f).

''(2) INITIAL COVERAGE LIMIT.—The term 'initial coverage limit' means the such limit as estab-

lished under section 1860B(b)(3), or, in the case of coverage that is not standard coverage, the comparable limit (if any) established under the coverage.

''(3) MEDICARE PRESCRIPTION DRUG ACCOUNT.—The term 'Medicare Prescription Drug Account' means the Account in the Federal Supplementary Medical Insurance Trust Fund created under section 1860I(a).

''(4) PDP SPONSOR.—The term 'PDP sponsor' means an entity that is certified under this part as meeting the requirements and standards of this part for such a sponsor.

''(5) PRESCRIPTION DRUG PLAN.—The term 'prescription drug plan' means health benefits coverage that—

''(A) is offered under a policy, contract, or plan by a PDP sponsor pursuant to, and in accordance with, a contract between the Medicare Benefits Administrator and the sponsor under section 1860D(b);

''(B) provides qualified prescription drug coverage; and

''(C) meets the applicable requirements of the section 1860C for a prescription drug plan.

''(6) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term 'qualified prescription drug coverage' is defined in section 1860B(a).

''(7) STANDARD COVERAGE.—The term 'standard coverage' is defined in section 1860B(b).

''(b) APPLICATION OF MEDICARE+CHOICE PROVISIONS UNDER THIS PART.—For purposes of applying provisions of part C under this part with respect to a prescription drug plan and a PDP sponsor, unless otherwise provided in this part such provisions shall be applied as if—

''(1) any reference to a Medicare+Choice plan included a reference to a prescription drug plan;

''(2) any reference to a provider-sponsored organization included a reference to a PDP sponsor;

''(3) any reference to a contract under section 1857 included a reference to a contract under section 1860D(b); and

''(4) any reference to part C included a reference to this part.''.

(c) CONFORMING AMENDMENTS TO FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—Section 1841 of the Social Security Act (42 U.S.C. 1395t) is amended—

(1) in the last sentence of subsection (a)—

(A) by striking ''and'' before ''such amounts'', and

(B) by inserting before the period the following: ''and such amounts as may be deposited in, or appropriated to, the Medicare Prescription Drug Account established by section 1860I''; and

(2) in subsection (g), by inserting after ''by this part,'' the following: ''the payments provided for under part D (in which case the payments shall come from the Medicare Prescription Drug Account in the Trust Fund),''.

(d) ADDITIONAL CONFORMING CHANGES.—

(1) CONFORMING REFERENCES TO PREVIOUS PART D.—Any reference in law (in effect before the date of the enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part E of such title (as in effect after such date).

(2) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming

amendments in the law as are required by the provisions of this subtitle.

SEC. 102. OFFERING OF QUALIFIED PRESCRIPTION DRUG COVERAGE UNDER THE MEDICARE+CHOICE PROGRAM.

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

''(j) AVAILABILITY OF PRESCRIPTION DRUG BENEFITS.—

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

''(2) COMPLIANCE WITH ADDITIONAL BENEFICIARY PROTECTIONS.—With respect to the offering of qualified prescription drug coverage by a Medicare+Choice organization under a Medicare+Choice plan, the organization and plan shall meet the requirements of section 1860C, including requirements relating to information dissemination and grievance and appeals, in the same

manner as they apply to a PDP sponsor and a prescription drug plan under part D. The Medicare Benefits Administrator shall waive such requirements to the extent the Administrator determines that such requirements duplicate requirements otherwise applicable to the organization or plan under this part.

''(3) TREATMENT OF COVERAGE.—Except as provided in this subsection, qualified prescription drug coverage offered under this subsection shall be treated under this part in the same manner as supplemental health care benefits described in section 1852(a)(3)(A).

''(4) AVAILABILITY OF PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME ENROLLEES AND REINSURANCE SUBSIDY PAYMENTS FOR ORGANIZATIONS.—For provisions—

''(A) providing premium and cost-sharing subsidies to low-income individuals receiving qualified prescription drug coverage through a Medicare+Choice plan, see section 1860G; and

''(B) providing a Medicare+Choice organization with reinsurance subsidy payments for providing qualified prescription drug coverage under this part, see section 1860H.

''(5) SPECIFICATION OF SEPARATE AND STANDARD PREMIUM.—

''(A) IN GENERAL.—For purposes of applying section 1854 and section 1860G(b)(2)(B) with respect to qualified prescription drug coverage offered under this subsection under a plan, the Medicare+Choice organization shall compute and publish the following:

''(i) SEPARATE PRESCRIPTION DRUG PREMIUM.—A premium for prescription drug benefits that constitute qualified prescription drug coverage that is separate from other coverage under the plan.

''(ii) PORTION OF COVERAGE ATTRIBUTABLE TO STANDARD BENEFITS.—The ratio of the actuarial value of standard coverage to the actuarial value of the qualified prescription drug coverage offered under the plan.

''(iii) PORTION OF PREMIUM ATTRIBUTABLE TO STANDARD BENEFITS.—A standard premium equal to the product of the premium described in clause (i) and the ratio under clause (ii).

The premium under clause (i) shall be compute without regard to any reduction in the premium permitted under subparagraph (B).

''(B) REDUCTION OF PREMIUMS ALLOWED.—Nothing in this subsection shall be construed as preventing a Medicare+Choice organization from reducing the amount of a premium charged for prescription drug coverage because of the application of section 1854(f)(1)(A) to other coverage.

''(C) ACCEPTANCE OF REFERENCE PREMIUM AS FULL PREMIUM IF NO STANDARD (OR EQUIVALENT) COVERAGE IN AN AREA.—For requirement to accept reference premium as full premium if there is no standard (or equivalent) coverage in the area of a Medicare+Choice plan, see section 1860F(d).

''(6) TRANSITION IN INITIAL ENROLLMENT PERIOD.—Notwithstanding any other provision of this part, the annual, coordinated election period under subsection (e)(3)(B) for 2003 shall be the 6-month period beginning with November 2002.

''(7) QUALIFIED PRESCRIPTION DRUG COVERAGE; STANDARD COVERAGE.—For purposes of this part, the terms 'qualified prescription drug cov-

erage' and 'standard coverage' have the meanings given such terms in section 1860B.''.

(b) CONFORMING AMENDMENTS.—Section 1851 of such Act (42 U.S.C. 1395w–21) is amended—

(1) in subsection (a)(1)—

(A) by inserting ''(other than qualified prescription drug benefits)'' after ''benefits'';

(B) by striking the period at the end of subparagraph (B) and inserting a comma; and

(C) by adding after and below subparagraph (B) the following:

''and may elect qualified prescription drug coverage in accordance with section 1860A.''; and

(2) in subsection (g)(1), by inserting ''and section 1860A(c)(2)(B)'' after ''in this subsection''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to coverage provided on or after January 1, 2003.

SEC. 103. MEDICAID AMENDMENTS.

(a) DETERMINATIONS OF ELIGIBILITY FOR LOW-INCOME SUBSIDIES.—

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

(A) in subsection (a)—

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

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

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

''(66) provide for making eligibility determinations under section 1935(a).''.

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

(A) by redesignating section 1935 as section 1936; and

(B) by inserting after section 1934 the following new section:

''SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

''SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGIBILITY DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—As a condition of its State plan under this title under section 1902(a)(66) and receipt of any Federal financial assistance under section 1903(a), a State shall—

''(1) make determinations of eligibility for premium and cost-sharing subsidies under (and in accordance with) section 1860G;

''(2) inform the Administrator of the Medicare Benefits Administration of such determinations in cases in which such eligibility is established; and

''(3) otherwise provide such Administrator with such information as may be required to carry out part D of title XVIII (including section 1860G).

''(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE COSTS.—

''(1) IN GENERAL.—The amounts expended by a State in carrying out subsection (a) are, subject to paragraph (2), expenditures reimbursable under the appropriate paragraph of section 1903(a); except that, notwithstanding any other provision of such section, the applicable Federal matching rates with respect to such expenditures under such section shall be increased as follows:

''(A) For expenditures attributable to costs incurred during 2003, the otherwise applicable Federal matching rate shall be increased by 20 percent of the percentage otherwise payable (but for this subsection) by the State.

''(B) For expenditures attributable to costs incurred during 2004, the otherwise applicable Federal matching rate shall be increased by 40

percent of the percentage otherwise payable (but for this subsection) by the State.

''(C) For expenditures attributable to costs incurred during 2005, the otherwise applicable Federal matching rate shall be increased by 60 percent of the percentage otherwise payable (but for this subsection) by the State.

''(D) For expenditures attributable to costs incurred during 2006, the otherwise applicable Federal matching rate shall be increased by 80 percent of the percentage otherwise payable (but for this subsection) by the State.

''(E) For expenditures attributable to costs incurred after 2006, the otherwise applicable Federal matching rate shall be increased to 100 percent.

''(2) COORDINATION.—The State shall provide the Secretary with such information as may be necessary to properly allocate administrative expenditures described in paragraph (1) that may otherwise be made for similar eligibility determinations.''.

(b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID RESPONSIBILITY FOR PREMIUM AND COST-SHARING SUBSIDIES FOR DUALLY ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—Section 1903(a)(1) of the Social Security Act (42 U.S.C. 1396b(a)(1)) is amended by inserting before the semicolon the following: ", reduced by the amount computed under section 1935(c)(1) for the State and the quarter".

(2) AMOUNT DESCRIBED.—Section 1935 of such Act, as inserted by subsection (a)(2), is amended by adding at the end the following new subsection:

"(c) FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION DRUG COSTS FOR DUALLY-ELIGIBLE BENEFICIARIES.—

"(1) IN GENERAL.—For purposes of section 1903(a)(1), for a State that is one of the 50 States or the District of Columbia for a calendar quarter in a year (beginning with 2003) the amount computed under this subsection is equal to the product of the following:

"(A) MEDICARE SUBSIDIES.—The total amount of payments made in the quarter under section 1860G (relating to premium and cost-sharing prescription drug subsidies for low-income medicare beneficiaries) that are attributable to individuals who are residents of the State and are entitled to benefits with respect

to prescribed drugs under the State plan under this title (including such a plan operating under a waiver under section 1115).

''(B) STATE MATCHING RATE.—A proportion computed by subtracting from 100 percent the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State and the quarter.

''(C) PHASE-OUT PROPORTION.—The phase-out proportion (as defined in paragraph (2)) for the quarter.

''(2) PHASE-OUT PROPORTION.—For purposes of paragraph (1)(C), the 'phase-out proportion' for a calendar quarter in—

''(A) 2003 is 80 percent;

''(B) 2004 is 60 percent;

''(C) 2005 is 40 percent;

''(D) 2006 is 20 percent; or

''(E) a year after 2006 is 0 percent.''.

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

''(d) ADDITIONAL PROVISIONS.—

''(1) MEDICAID AS SECONDARY PAYOR.—In the case of an individual dually entitled to qualified prescription drug coverage under a prescription drug plan under part D of title XVIII (or under a Medicare+Choice plan under part C of such title) and medical assistance for prescribed drugs under this title, medical assistance shall continue to be provided under this title for prescribed drugs to the extent payment is not made under the prescription drug plan or the Medicare+Choice plan selected by the individual.

''(2) CONDITION.—A State may require, as a condition for the receipt of medical assistance under this title with respect to prescription drug benefits for an individual eligible to obtain qualified prescription drug coverage described in paragraph (1), that the individual elect qualified prescription drug coverage under section 1860A.''.

(d) TREATMENT OF TERRITORIES.—

(1) IN GENERAL.—Section 1935 of such Act, as so inserted and amended, is further amended—

(A) in subsection (a)(1), by inserting ''subject to subsection (e),'' after ''section 1903 '';

(B) in subsection (c)(1), by inserting ''subject to subsection (e),'' after ''1903(a)''; and

(C) by adding at the end the following new subsection:

''(e) TREATMENT OF TERRITORIES.—

''(1) IN GENERAL.—In the case of a State, other than the 50 States and the District of Columbia—

''(A) the previous provisions of this section shall not apply to residents of such State; and

''(B) if the State establishes a plan described in paragraph (2) (for providing medical assistance with respect to the provision of prescription drugs to medicare beneficiaries), the amount otherwise determined under section 1108(f) (as increased under section 1108(g)) for the State shall be increased by the amount specified in paragraph (3).

''(2) PLAN.—The plan described in this paragraph is a plan that—

''(A) provides medical assistance with respect to the provision of covered outpatient drugs (as defined in section 1860B(f)) to low-income medicare beneficiaries; and

''(B) assures that additional amounts received by the State that are attributable to the

operation of this subsection are used only for such assistance.

''(3) INCREASED AMOUNT.—

''(A) IN GENERAL.—The amount specified in this paragraph for a State for a year is equal to the product of—

''(i) the aggregate amount specified in subparagraph (B); and

''(ii) the amount specified in section 1108(g)(1) for that State, divided by the sum of the amounts specified in such section for all such States.

''(B) AGGREGATE AMOUNT.—The aggregate amount specified in this subparagraph for—

''(i) 2003, is equal to $20,000,000; or

''(ii) a subsequent year, is equal to the aggregate amount specified in this subparagraph for the previous year increased by annual percentage increase specified in section 1860(b)(5) for the year involved.

''(4) REPORT.—The Secretary shall submit to Congress a report on the application of this subsection and may include in the report such recommendations as the Secretary deems appropriate.''.

(2) CONFORMING AMENDMENT.—Section 1108(f) of such Act is amended by inserting ''and section 1935(e)(1)(B)'' after ''Subject to subsection (g)''.

SEC. 104. MEDIGAP TRANSITION PROVISIONS.

(a) IN GENERAL.—Notwithstanding any other provision of law, no new medicare supplemental policy that provides coverage of expenses for prescription drugs may be issued under section 1882 of the Social Security Act on or after January 1, 2003, to an individual unless it replaces a medicare supplemental policy that was issued to that individual and that provided some coverage of expenses for prescription drugs.

(b) ISSUANCE OF SUBSTITUTE POLICIES IF OBTAIN PRESCRIPTION DRUG COVERAGE THROUGH MEDICARE.—

(1) IN GENERAL.—The issuer of a medicare supplemental policy—

(A) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as ''A'', ''B'', ''C'', ''D'', ''E'', ''F'', or ''G'' (under the standards established under subsection (p)(2) of section 1882 of the Social Security Act, 42 U.S.C. 1395ss) and that is offered and is avail-

able for issuance to new enrollees by such issuer;

(B) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

(C) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in paragraph (2) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such paragraph and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

(2) INDIVIDUAL COVERED.—An individual described in this paragraph is an individual who—

(A) enrolls in a prescription drug plan under part D of title XVIII of the Social Security Act; and

(B) at the time of such enrollment was enrolled and terminates enrollment in a medicare supplemental policy which has a benefit package classified as ''H'', ''I'', or ''J'' under the

standards referred to in paragraph (1)(A) or terminates enrollment in a policy to which such standards do not apply but which provides benefits for prescription drugs.

(3) ENFORCEMENT.—The provisions of paragraph (1) shall be enforced as though they were included in section 1882(s) of the Social Security Act (42 U.S.C. 1395ss(s)).

(4) DEFINITIONS.—For purposes of this subsection, the term ''medicare supplemental policy'' has the meaning given such term in section 1882(g) of the Social Security Act (42 U.S.C. 1395ss(g)).

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 President, by and with the advice and consent of the Senate. The Administrator shall be in direct line of authority to the Secretary.

''(B) COMPENSATION.—The Administrator shall be paid at the rate of basic pay payable for level III of the Executive Schedule under section 5314 of title 5, United States Code.

''(C) TERM OF OFFICE.—The Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of an Administrator's term of office, that Administrator may continue in office until the entry upon office of such a successor. An Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(D) GENERAL AUTHORITY.—The Administrator shall be responsible for the exercise of all powers and the discharge of all duties of the Administration, and shall have authority and control over all personnel and activities thereof.

''(E) RULEMAKING AUTHORITY.—The Administrator may prescribe such rules and regulations as the Administrator determines necessary or appropriate to carry out the functions of the Administration. The regulations prescribed by the Administrator shall be subject to the rulemaking procedures established under section 553 of title 5, United States Code.

''(F) AUTHORITY TO ESTABLISH ORGANIZATIONAL UNITS.—The Administrator may establish, alter, consolidate, or discontinue such organizational units or components within the Administration as the Administrator considers necessary or appropriate, except that this subparagraph shall not apply with respect to any unit, component, or provision provided for by this section.

''(G) AUTHORITY TO DELEGATE.—The Administrator may assign duties, and delegate, or authorize successive redelegations of, authority

to act and to render decisions, to such officers and employees of the Administration as the Administrator may find necessary. Within the limitations of such delegations, redelegations, or assignments, all official acts and decisions of such officers and employees shall have the same force and effect as though performed or rendered by the Administrator.

''(2) DEPUTY ADMINISTRATOR.—

''(A) IN GENERAL.—There shall be a Deputy Administrator of the Medicare Benefits Administration who shall be appointed by the President, by and with the advice and consent of the Senate.

''(B) COMPENSATION.—The Deputy Administrator shall be paid at the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(C) TERM OF OFFICE.—The Deputy Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of a Deputy Administrator's term of office, such Deputy Administrator may continue in office until the entry upon of-

fice of such a successor. A Deputy Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(D) DUTIES.—The Deputy Administrator shall perform such duties and exercise such powers as the Administrator shall from time to time assign or delegate. The Deputy Administrator shall be Acting Administrator of the Administration during the absence or disability of the Administrator and, unless the President designates another officer of the Government as Acting Administrator, in the event of a vacancy in the office of the Administrator.

''(3) SECRETARIAL COORDINATION OF PROGRAM ADMINISTRATION.—The Secretary shall ensure appropriate coordination between the Administrator and the Administrator of the Health Care Financing Administration in carrying out the programs under this title.

''(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

''(1) DUTIES.—

''(A) GENERAL DUTIES.—The Administrator shall carry out parts C and D, including—

''(i) negotiating, entering into, and enforcing, contracts with plans for the offering of Medicare+Choice plans under part C, including the offering of qualified prescription drug coverage under such plans; and

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

''(B) OTHER DUTIES.—The Administrator shall carry out any duty provided for under part C or part D, including demonstration projects carried out in part or in whole under such parts, the programs of all-inclusive care for the elderly (PACE program) under section 1894, the social health maintenance organization (SHMO) demonstration projects (referred to in section 4104(c) of the Balanced Budget Act of 1997), and through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medi-

care beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved).

''(C) ANNUAL REPORTS.—Not later March 31 of each year, the Administrator shall submit to Congress and the President a report on the administration of parts C and D during the previous fiscal year.

''(2) STAFF.—

''(A) IN GENERAL.—The Administrator, with the approval of the Secretary, may employ, without regard to chapter 31 of title 5, United States Code, such officers and employees as are necessary to administer the activities to be carried out through the Medicare Benefits Administration.

''(B) FLEXIBILITY WITH RESPECT TO CIVIL SERVICE LAWS.—

''(i) IN GENERAL.—The staff of the Medicare Benefits Administration shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service,

and, subject to clause (ii), shall be paid without regard to the provisions of chapter 51 and chapter 53 of such title (relating to classification and schedule pay rates).

''(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(3) REDELEGATION OF CERTAIN FUNCTIONS OF THE HEALTH CARE FINANCING ADMINISTRATION.—

''(A) IN GENERAL.—The Secretary, the Administrator, and the Administrator of the Health Care Financing Administration shall establish an appropriate transition of responsibility in order to redelegate the administration of part C from the Secretary and the Administrator of the Health Care Financing Administration to the Administrator as is appropriate to carry out the purposes of this section.

''(B) TRANSFER OF DATA AND INFORMATION.—The Secretary shall ensure that the Administrator of the Health Care Financing Ad-

ministration transfers to the Administrator of the Medicare Benefits Administration such information and data in the possession of the Administrator of the Health Care Financing Administration as the Administrator of the Medicare Benefits Administration requires to carry out the duties described in paragraph (1).

''(C) CONSTRUCTION.—Insofar as a responsibility of the Secretary or the Administrator of the Health Care Financing Administration is redelegated to the Administrator under this section, any reference to the Secretary or the Administrator of the Health Care Financing Administration in this title or title XI with respect to such responsibility is deemed to be a reference to the Administrator.

''(d) OFFICE OF BENEFICIARY ASSISTANCE.—

''(1) ESTABLISHMENT.—The Secretary shall establish within the Medicare Benefits Administration an Office of Beneficiary Assistance to carry out functions relating to medicare beneficiaries under this title, including making determinations of eligibility of individuals for benefits under this title, providing for enrollment of medicare beneficiaries under this title, and the functions described in paragraph

(2). The Office shall be separate operating division within the Administration.

''(2) DISSEMINATION OF INFORMATION ON BENEFITS AND APPEALS RIGHTS.—

''(A) DISSEMINATION OF BENEFITS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries, by mail, by posting on the Internet site of the Medicare Benefits Administration and through the toll-free telephone number provided for under section 1804(b), information with respect to the following:

''(i) Benefits, and limitations on payment (including cost-sharing, stop-loss provisions, and formulary restrictions) under parts C and D.

''(ii) Benefits, and limitations on payment under parts A and B, including information on medicare supplemental policies under section 1882.

Such information shall be presented in a manner so that medicare beneficiaries may compare benefits under parts A, B, D, and medicare supplemental policies with benefits under Medicare+Choice plans under part C.

''(B) DISSEMINATION OF APPEALS RIGHTS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries in the manner provided under subparagraph (A) a description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program under parts A and B, the Medicare+Choice program under part C, and the Voluntary Prescription Drug Benefit Program under part D.

''(3) MEDICARE OMBUDSMAN.—

''(A) IN GENERAL.—Within the Office of Beneficiary Assistance, there shall be a Medicare Ombudsman, appointed by the Secretary from among individuals with expertise and experience in the fields of health care and advocacy, to carry out the duties described in subparagraph (B).

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

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

"(ii) provide assistance with respect to complaints, grievances, and requests referred to in clause (i), including—

"(I) assistance in collecting relevant information for such beneficiaries, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, Medicare+Choice organization, a PDP sponsor under part D, or the Secretary; and

"(II) assistance to such beneficiaries with any problems arising from disenrollment from a Medicare+Choice plan under part C or a prescription drug plan under part D; and

"(iii) submit annual reports to Congress, the Secretary, and the Medicare Policy Advisory Board describing the activities of the Office, and including such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.

''(C) COORDINATION WITH STATE OMBUDSMAN PROGRAMS AND CONSUMER ORGANIZATIONS.—The Medicare Ombudsman shall, to the extent appropriate, coordinate with State medical Ombudsman programs, and with State- and community-based consumer organizations, to—

''(i) provide information about the medicare program; and

''(ii) conduct outreach to educate medicare beneficiaries with respect to manners in which problems under the medicare program may be resolved or avoided.

''(e) MEDICARE POLICY ADVISORY BOARD.—

''(1) ESTABLISHMENT.—There is established within the Medicare Benefits Administration the Medicare Policy Advisory Board (in this section referred to the 'Board'). The Board shall advise, consult with, and make recommendations to the Administrator of the Medicare Benefits Administration with respect to the administration of parts C and D, including the review of payment policies under such parts.

''(2) REPORTS.—

"(A) IN GENERAL.—With respect to matters of the administration of parts C and D, the Board shall submit to Congress and to the Administrator of the Medicare Benefits Administration such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of such parts, including the topics described in subparagraph (B). Each such report shall be published in the Federal Register.

"(B) TOPICS DESCRIBED.—Reports required under subparagraph (A) may include the following topics:

"(i) FOSTERING COMPETITION.—Recommendations or proposals to increase competition under parts C and D for services furnished to medicare beneficiaries.

"(ii) EDUCATION AND ENROLLMENT.—Recommendations for the improvement to efforts to provide medicare beneficiaries information and education on the program under this title, and specifi-

cally parts C and D, and the program for enrollment under the title.

''(iii) IMPLEMENTATION OF RISK-ADJUSTMENT.—Evaluation of the implementation under section 1853(a)(3)(C) of the risk adjustment methodology to payment rates under that section to Medicare+Choice organizations offering Medicare+Choice plans that accounts for variations in per capita costs based on health status and other demographic factors.

''(iv) DISEASE MANAGEMENT PROGRAMS.—Recommendations on the incorporation of disease management programs under parts C and D.

''(C) MAINTAINING INDEPENDENCE OF BOARD.—The Board shall directly submit to Congress reports required under subparagraph (A). No officer or agency of the United States may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to the submission to Congress of such reports.

''(3) DUTY OF ADMINISTRATOR OF MEDICARE BENEFITS ADMINISTRATION.—With respect to any report submitted by the Board under paragraph (2)(A), not later than 90 days after the report is submitted, the Administrator of the Medicare Benefits Administration shall submit to Congress and the President an analysis of recommendations made by the Board in such report. Each such analysis shall be published in the Federal Register.

''(4) MEMBERSHIP.—

''(A) APPOINTMENT.—Subject to the succeeding provisions of this paragraph, the Board shall consist of 7 members to be appointed as follows:

''(i) 3 members shall be appointed by the President.

''(ii) 2 members shall be appointed by the Speaker of the House of Representatives, with the advice of the chairman and the ranking minority member of the Committees on Ways and Means and on Commerce of the House of Representatives.

''(iii) 2 members shall be appointed by the President pro tempore of the Senate with the advice of the chairman and the

ranking minority member of the Senate Committee on Finance.

''(B) QUALIFICATIONS.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education and experience in health care benefits management, exceptionally qualified to perform the duties of members of the Board.

''(C) PROHIBITION ON INCLUSION OF FEDERAL EMPLOYEES.—No officer or employee of the United States may serve as a member of the Board.

''(5) COMPENSATION.—Members of the Board shall receive, for each day (including travel time) they are engaged in the performance of the functions of the board, compensation at rates not to exceed the daily equivalent to the annual rate in effect for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(6) TERMS OF OFFICE.—

''(A) IN GENERAL.—The term of office of members of the Board shall be 3 years.

''(B) TERMS OF INITIAL APPOINTEES.—As designated by the President at the time of appointment, of the members first appointed—

''(i) 1 shall be appointed for a term of 1 year;

''(ii) 3 shall be appointed for terms of 2 years; and

''(iii) 3 shall be appointed for terms of 3 years.

''(C) REAPPOINTMENTS.—Any person appointed as a member of the Board may not serve for more than 8 years.

''(D) VACANCY.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Board shall be filled in the manner in which the original appointment was made.

''(7) CHAIR.—The Chair of the Board shall be elected by the members. The term of office of the Chair shall be 3 years.

''(8) MEETINGS.—The Board shall meet at the call of the Chair, but in no event less than 3 times during each fiscal year.

''(9) DIRECTOR AND STAFF.—

''(A) APPOINTMENT OF DIRECTOR.—The Board shall have a Director who shall be appointed by the Chair.

''(B) STAFF.—With the approval of the Board, the Director may appoint and fix the pay of such additional personnel as the Director considers appropriate.

''(C) FLEXIBILITY IN APPLICATION OF CIVIL SERVICE LAWS.—

''(i) IN GENERAL.—The Director and staff of the Board shall be appointed without regard to the provisions of chapter 31 of title 5, United States Code, governing appointments in the competitive service, and, subject to clause (ii), shall be paid without regard to the provisions of chapters 51 and 53 of such title (relating to classification and General Schedule pay rates).

''(ii) MAXIMUM RATE.—In no case may the rate of compensation determined

under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(D) ASSISTANCE FROM THE ADMINISTRATOR OF THE MEDICARE BENEFITS ADMINISTRATION.—The Administrator of the Medicare Benefits Administration shall make available to the Board such information and other assistance as it may require to carry out its functions.

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

''(f) FUNDING.—There is authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (including the Medicare Prescription Drug Account), such sums as are necessary to carry out this section.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

(2) TIMING OF INITIAL APPOINTMENTS.—The Administrator and Deputy Administrator of the Medicare Benefits Administration may not be appointed before March 1, 2001.

(3) DUTIES WITH RESPECT TO ELIGIBILITY DETERMINATIONS AND ENROLLMENT.—The Administrator of the Medicare Benefits Administration shall carry out enrollment under title XVIII of the Social Security Act, make eligibility determinations under such title, and carry out part C of such title for years beginning or after January 1, 2003.

SEC. 202. MISCELLANEOUS ADMINISTRATIVE PROVISIONS.

(a) ADMINISTRATOR AS MEMBER OF THE BOARD OF TRUSTEES OF THE MEDICARE TRUST FUNDS.—Section 1817(b) and section 1841(b) of the Social Security Act (42 U.S.C. 1395i(b), 1395t(b)) are each amended by striking ''and the Secretary of Health and Human Services, all ex officio,'' and inserting '', the Secretary of Health and Human Services, and the Administrator of the Medicare Benefits Administration, all ex officio,''.

(b) INCREASE IN GRADE TO EXECUTIVE LEVEL III FOR THE ADMINISTRATOR OF THE HEALTH CARE FINANCING ADMINISTRATION.—

(1) IN GENERAL.—Section 5314 of title 5, United States Code, by adding at the end the following:

''Administrator of the Health Care Financing Administration.''.

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

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

Subtitle B—Oversight of Financial Sustainability of the Medicare Program

SEC. 211. ADDITIONAL REQUIREMENTS FOR ANNUAL FINANCIAL REPORT AND OVERSIGHT ON MEDICARE PROGRAM.

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

''(l) COMBINED REPORT ON OPERATION AND STATUS OF THE TRUST FUND AND THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—

"(1) IN GENERAL.—In addition to the duty of the Board of Trustees to report to Congress under subsection (b), on the date the Board submits the report required under subsection (b)(2), the Board shall submit to Congress a report on the operation and status of the Trust Fund and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 (in this subsection referred to as the 'Trust Funds'). Such report shall included the following information:

"(A) OVERALL SPENDING FROM THE GENERAL FUND OF THE TREASURY.—A statement of total amounts obligated during the preceding fiscal year from the General Revenues of the Treasury to the Trust Funds for payment for benefits covered under this title, stated in terms of the total amount and in terms of the percentage such amount bears to all other amounts obligated from such General Revenues during such fiscal year.

"(B) HISTORICAL OVERVIEW OF SPENDING.—From the date of the inception of the program of insurance under this title through the fiscal year involved, a statement of the total amounts referred to in subparagraph (A).

''(C) 10-YEAR AND 50-YEAR PROJECTIONS.—An estimate of total amounts referred to in subparagraph (A) required to be obligated for payment for benefits covered under this title for each of the 10 fiscal years succeeding the fiscal year involved and for the 50-year period beginning with the succeeding fiscal year.

''(D) RELATION TO GDP GROWTH.—A comparison of the rate of growth of the total amounts referred to in subparagraph (A) to the rate of growth in the gross domestic product for the same period.

''(2) PUBLICATION.—Each report submitted under paragraph (1) shall be published by the Committee on Ways and Means as a public document and shall be made available by such Committee on the Internet.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to fiscal years beginning on or after the date of the enactment of this Act.

(c) CONGRESSIONAL HEARINGS.—It is the sense of Congress that the committees of jurisdiction shall hold hearings on the reports submitted under section 1817(l) of the Social Security Act.

Subtitle C—Changes in Medicare Coverage and Appeals Process

SEC. 221. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) CONDUCT OF RECONSIDERATIONS OF DETERMINATIONS BY INDEPENDENT CONTRACTORS.—Section 1869 of the Social Security Act (42 U.S.C. 1395ff) is amended to read as follows:

''DETERMINATIONS; APPEALS

''SEC. 1869. (a) INITIAL DETERMINATIONS.—The Secretary shall promulgate regulations and make initial determinations with respect to benefits under part A or part B in accordance with those regulations for the following:

''(1) The initial determination of whether an individual is entitled to benefits under such parts.

''(2) The initial determination of the amount of benefits available to the individual under such parts.

''(3) Any other initial determination with respect to a claim for benefits under such parts, including an initial determination by the Secretary that payment may not be made, or may no longer be made, for an item or service under such parts, an initial determination made by a utilization and quality control peer review organization under section 1154(a)(2), and an initial determination made by an

entity pursuant to a contract with the Secretary to administer provisions of this title or title XI.

''(b) APPEAL RIGHTS.—

''(1) IN GENERAL.—

''(A) RECONSIDERATION OF INITIAL DETERMINATION.—Subject to subparagraph (D), any individual dissatisfied with any initial determination under subsection (a) shall be entitled to reconsideration of the determination, and, subject to subparagraphs (D) and (E), a hearing thereon by the Secretary to the same extent as is provided in section 205(b) and to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

''(B) REPRESENTATION BY PROVIDER OR SUPPLIER.—

''(i) IN GENERAL.—Sections 206(a), 1102, and 1871 shall not be construed as authorizing the Secretary to prohibit an individual from being represented under this section by a person that furnishes or supplies the individual, directly or indirectly, with services or items, solely on the basis

that the person furnishes or supplies the individual with such a service or item.

''(ii) MANDATORY WAIVER OF RIGHT TO PAYMENT FROM BENEFICIARY.—Any person that furnishes services or items to an individual may not represent an individual under this section with respect to the issue described in section 1879(a)(2) unless the person has waived any rights for payment from the beneficiary with respect to the services or items involved in the appeal.

''(iii) PROHIBITION ON PAYMENT FOR REPRESENTATION.—If a person furnishes services or items to an individual and represents the individual under this section, the person may not impose any financial liability on such individual in connection with such representation.

''(iv) REQUIREMENTS FOR REPRESENTATIVES OF A BENEFICIARY.—The provisions of section 205(j) and section 206 (regarding representation of claimants) shall apply to representation of an individual with respect to appeals under

this section in the same manner as they apply to representation of an individual under those sections.

''(C) SUCCESSION OF RIGHTS IN CASES OF ASSIGNMENT.—The right of an individual to an appeal under this section with respect to an item or service may be assigned to the provider of services or supplier of the item or service upon the written consent of such individual using a standard form established by the Secretary for such an assignment.

''(D) TIME LIMITS FOR APPEALS.—

''(i) RECONSIDERATIONS.—Reconsideration under subparagraph (A) shall be available only if the individual described subparagraph (A) files notice with the Secretary to request reconsideration by not later than 180 days after the individual receives notice of the initial determination under subsection (a) or within such additional time as the Secretary may allow.

''(ii) HEARINGS CONDUCTED BY THE SECRETARY.—The Secretary shall establish in regulations time limits for the filing of a request for a hearing by the Secretary in

accordance with provisions in sections 205 and 206.

''(E) AMOUNTS IN CONTROVERSY.—

''(i) IN GENERAL.—A hearing (by the Secretary) shall not be available to an individual under this section if the amount in controversy is less than $100, and judicial review shall not be available to the individual if the amount in controversy is less than $1,000.

''(ii) AGGREGATION OF CLAIMS.—In determining the amount in controversy, the Secretary, under regulations, shall allow 2 or more appeals to be aggregated if the appeals involve—

''(I) the delivery of similar or related services to the same individual by one or more providers of services or suppliers, or

''(II) common issues of law and fact arising from services furnished to 2 or more individuals by one or more providers of services or suppliers.

''(F) EXPEDITED PROCEEDINGS.—

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

"(I) has received notice by a provider of services that the provider of services plans to terminate services provided to an individual and a physician certifies that failure to continue the provision of such services is likely to place the individual's health at significant risk, or

"(II) has received notice by a provider of services that the provider of services plans to discharge the individual from the provider of services,

the individual may request, in writing or orally, an expedited determination or an expedited reconsideration of an initial determination made under subsection (a), as the case may be, and the Secretary shall provide such expedited determination or expedited reconsideration.

"(ii) EXPEDITED HEARING.—In a hearing by the Secretary under this section, in which the moving party alleges that no material issues of fact are in dis-

pute, the Secretary shall make an expedited determination as to whether any such facts are in dispute and, if not, shall render a decision expeditiously.

''(G) REOPENING AND REVISION OF DETERMINATIONS.—The Secretary may reopen or revise any initial determination or reconsidered determination described in this subsection under guidelines established by the Secretary in regulations.

''(2) REVIEW OF COVERAGE DETERMINATIONS.—

''(A) NATIONAL COVERAGE DETERMINATIONS.—

''(i) IN GENERAL.—Review of any national coverage determination shall be subject to the following limitations:

''(I) Such a determination shall not be reviewed by any administrative law judge.

''(II) Such a determination shall not be held unlawful or set aside on the ground that a requirement of section 553 of title 5, United States Code, or section 1871(b) of this title,

relating to publication in the Federal Register or opportunity for public comment, was not satisfied.

''(III) Upon the filing of a complaint by an aggrieved party, such a determination shall be reviewed by the Departmental Appeals Board of the Department of Health and Human Services. In conducting such a review, the Departmental Appeals Board shall review the record and shall permit discovery and the taking of evidence to evaluate the reasonableness of the determination. In reviewing such a determination, the Departmental Appeals Board shall defer only to the reasonable findings of fact, reasonable interpretations of law, and reasonable applications of fact to law by the Secretary.

''(IV) A decision of the Departmental Appeals Board constitutes a final agency action and is subject to judicial review.

"(ii) DEFINITION OF NATIONAL COVERAGE DETERMINATION.—For purposes of this section, the term 'national coverage determination' means a determination by the Secretary respecting whether or not a particular item or service is covered under this title, including such a determination under 1862(a)(1).

"(B) LOCAL COVERAGE DETERMINATION.—In the case of a local coverage determination made by a fiscal intermediary or a carrier under part A or part B respecting whether a particular type or class of items or services is covered under such parts, the following limitations apply:

"(i) Upon the filing of a complaint by an aggrieved party, such a determination shall be reviewed by an administrative law judge of the Social Security Administration. The administrative law judge shall review the record and shall permit discovery and the taking of evidence to evaluate the reasonableness of the determination. In reviewing such a determination, the administrative law judge shall defer only to the reasonable findings of fact, reasonable interpre-

tations of law, and reasonable applications of fact to law by the Secretary.

''(ii) Such a determination may be reviewed by the Departmental Appeals Board of the Department of Health and Human Services.

''(iii) A decision of the Departmental Appeals Board constitutes a final agency action and is subject to judicial review.

''(C) NO MATERIAL ISSUES OF FACT IN DISPUTE.—In the case of review of a determination under subparagraph (A)(i)(III) or (B)(i) where the moving party alleges that there are no material issues of fact in dispute, and alleges that the only issue is the constitutionality of a provision of this title, or that a regulation, determination, or ruling by the Secretary is invalid, the moving party may seek review by a court of competent jurisdiction.

''(D) PENDING NATIONAL COVERAGE DETERMINATIONS.—

''(i) IN GENERAL.—In the event the Secretary has not issued a national coverage or noncoverage determination with respect to a particular type or class of items or services, an affected party may submit to the Secretary a request to make such a determination with re-

spect to such items or services. By not later than the end of the 90-day period beginning on the date the Secretary receives such a request, the Secretary shall take one of the following actions:

"(I) Issue a national coverage determination, with or without limitations.

"(II) Issue a national noncoverage determination.

"(III) Issue a determination that no national coverage or noncoverage determination is appropriate as of the end of such 90-day period with respect to national coverage of such items or services.

"(IV) Issue a notice that states that the Secretary has not completed a review of the national coverage determination and that includes an identification of the remaining steps in the Secretary's review process and a deadline by which the Secretary will complete the review and take an action described in subclause (I), (II), or (III).

"(ii) In the case of an action described in clause (i)(IV), if the Secretary fails to take an

action referred to in such clause by the deadline specified by the Secretary under such clause, then the Secretary is deemed to have taken an action described in clause (i)(III) as of the deadline.

''(iii) When issuing a determination under clause (i), the Secretary shall include an explanation of the basis for the determination. An action taken under clause (i) (other than subclause (IV)) is deemed to be a national coverage determination for purposes of review under subparagraph (A).

''(3) PUBLICATION ON THE INTERNET OF DECISIONS OF HEARINGS OF THE SECRETARY.—Each decision of a hearing by the Secretary shall be made public, and the Secretary shall publish each decision on the Medicare Internet site of the Department of Health and Human Services. The Secretary shall remove from such decision any information that would identify any individual, provider of services, or supplier.

''(4) LIMITATION ON REVIEW OF CERTAIN REGULATIONS.—A regulation or instruction which relates to a method for determining the amount of payment under part B and which was initially issued

before January 1, 1981, shall not be subject to judicial review.

''(5) STANDING.—An action under this section seeking review of a coverage determination (with respect to items and services under this title) may be initiated only by one (or more) of the following aggrieved persons, or classes of persons:

''(A) Individuals entitled to benefits under part A, or enrolled under part B, or both, who are in need of the items or services involved in the coverage determination.

''(B) Persons, or classes of persons, who make, manufacture, offer, supply, make available, or provide such items and services.

''(c) CONDUCT OF RECONSIDERATIONS BY INDEPENDENT CONTRACTORS.—

''(1) IN GENERAL.—The Secretary shall enter into contracts with qualified independent contractors to conduct reconsiderations of initial determinations made under paragraphs (2) and (3) of subsection (a). Contracts shall be for an initial term of three years and shall be renewable on a triennial basis thereafter.

''(2) QUALIFIED INDEPENDENT CONTRACTOR.—For purposes of this subsection, the

term 'qualified independent contractor' means an entity or organization that is independent of any organization under contract with the Secretary that makes initial determinations under subsection (a), and that meets the requirements established by the Secretary consistent with paragraph (3).

''(3) REQUIREMENTS.—Any qualified independent contractor entering into a contract with the Secretary under this subsection shall meet the following requirements:

''(A) IN GENERAL.—The qualified independent contractor shall perform such duties and functions and assume such responsibilities 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 clause for not more than 2 days, and only in the case in which the provider of such services did not know and could not reasonably have been expected to know (as determined under section 1879) that payment would not otherwise be made for such services under part A or part B prior to notification by the qualified independent contractor under this subsection;

''(iii) such determination is changed as the result of any hearing by the Sec-

retary or judicial review of the decision under this section; or

''(iv) such payment is authorized under section 1861(v)(1)(G).

''(C) DEADLINES FOR DECISIONS.—

''(i) DETERMINATIONS.—The qualified independent contractor shall conduct and conclude a determination under subparagraph (B) or an appeal of an initial determination, and mail the notice of the decision by not later than the end of the 45-day period beginning on the date a request for reconsideration has been timely filed.

''(ii) CONSEQUENCES OF FAILURE TO MEET DEADLINE.—In the case of a failure by the qualified independent contractor to mail the notice of the decision by the end of the period described in clause (i), the party requesting the reconsideration or appeal may request a hearing before an administrative law judge, notwithstanding any requirements for a reconsidered determination for purposes of the party's right to such hearing.

"(iii) EXPEDITED RECONSIDERATIONS.—The qualified independent contractor shall perform an expedited reconsideration under subsection (b)(1)(F) of a notice from a provider of services or supplier that payment may not be made for an item or service furnished by the provider of services or supplier, of a decision by a provider of services to terminate services furnished to an individual, or of a decision of the provider of services to discharge the individual from the provider of services, in accordance with the following:

"(I) DEADLINE FOR DECISION.—Notwithstanding section 216(j), not later than 1 day after the date the qualified independent contractor has received a request for such reconsideration and has received such medical or other records needed for such reconsideration, the qualified independent contractor shall provide notice (by telephone and in writing) to the individual and the provider of services and attending physician of

the individual of the results of the reconsideration. Such reconsideration shall be conducted regardless of whether the provider of services or supplier will charge the individual for continued services or whether the individual will be liable for payment for such continued services.

''(II) CONSULTATION WITH BENEFICIARY.—In such reconsideration, the qualified independent contractor shall solicit the views of the individual involved.

''(D) LIMITATION ON INDIVIDUAL REVIEWING DETERMINATIONS.—

''(i) PHYSICIANS.—No physician under the employ of a qualified independent contractor may review—

''(I) determinations regarding health care services furnished to a patient if the physician was directly responsible for furnishing such services; or

''(II) determinations regarding health care services provided in or by

an institution, organization, or agency, if the physician or any member of the physician's family has, directly or indirectly, a significant financial interest in such institution, organization, or agency.

"(ii) PHYSICIAN'S FAMILY DESCRIBED.—For purposes of this paragraph, a physician's family includes the physician's spouse (other than a spouse who is legally separated from the physician under a decree of divorce or separate maintenance), children (including stepchildren and legally adopted children), grandchildren, parents, and grandparents.

"(E) EXPLANATION OF DETERMINATIONS.—Any determination of a qualified independent contractor shall be in writing, and shall include a detailed explanation of the determination as well as a discussion of the pertinent facts and applicable regulations applied in making such determination.

"(F) NOTICE REQUIREMENTS.—Whenever a qualified independent contractor makes a determination under this subsection, the qualified

independent contractor shall promptly notify such individual and the entity responsible for the payment of claims under part A or part B of such determination.

"(G) DISSEMINATION OF INFORMATION.—Each qualified independent contractor shall, using the methodology established by the Secretary under subsection (d)(4), make available all determinations of such qualified independent contractors to fiscal intermediaries (under section 1816), carriers (under section 1842), peer review organizations (under part B of title XI), Medicare+Choice organizations offering Medicare+Choice plans under part C, and other entities under contract with the Secretary to make initial determinations under part A or part B or title XI.

"(H) ENSURING CONSISTENCY IN DETERMINATIONS.—Each qualified independent contractor shall monitor its determinations to ensure consistency of determinations with respect to requests for reconsideration of similar or related matters.

"(I) DATA COLLECTION.—

''(i) IN GENERAL.—Consistent with the requirements of clause (ii), a qualified independent contractor shall collect such information relevant to its functions, and keep and maintain such records in such form and manner as the Secretary may require to carry out the purposes of this section and shall permit access to and use of any such information and records as the Secretary may require for such purposes.

''(ii) TYPE OF DATA COLLECTED.—Each qualified independent contractor shall keep accurate records of each decision made, consistent with standards established by the Secretary for such purpose. Such records shall be maintained in an electronic database in a manner that provides for identification of the following:

''(I) Specific claims that give rise to appeals.

''(II) Situations suggesting the need for increased education for providers of services, physicians, or suppliers.

"(III) Situations suggesting the need for changes in national or local coverage policy.

"(IV) Situations suggesting the need for changes in local medical review policies.

"(iii) ANNUAL REPORTING.—Each qualified independent contractor shall submit annually to the Secretary (or otherwise as the Secretary may request) records maintained under this paragraph for the previous year.

"(J) HEARINGS BY THE SECRETARY.—The qualified independent contractor shall (i) prepare such information as is required for an appeal of its reconsidered determination to the 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 more 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) OUTREACH.—The Secretary shall perform such outreach activities as are necessary to inform individuals entitled to benefits under this title and providers of services and suppliers with respect to their rights of, and the process for, appeals made under this section. The Secretary shall use the toll-free telephone number maintained by the Secretary (1–800–MEDICAR(E)) (1–800–633–4227) to pro-

vide information regarding appeal rights and respond to inquiries regarding the status of appeals.

''(2) GUIDANCE FOR RECONSIDERATIONS AND HEARINGS.—

''(A) REGULATIONS.—Not later than 1 year after the date of the enactment of this section, the Secretary shall promulgate regulations governing the processes of reconsiderations of determinations by the Secretary and qualified independent contractors and of hearings by the Secretary. Such regulations shall include such specific criteria and provide such guidance as required to ensure the adequate functioning of the reconsiderations and hearings processes and to ensure consistency in such processes.

''(B) DEADLINES FOR ADMINISTRATIVE ACTION.—

''(i) HEARING BY ADMINISTRATIVE LAW JUDGE.—

''(II) IN GENERAL.—Except as provided in subclause (II), an administrative law judge shall conduct and conclude a hearing on a decision of a qualified independent contractor under subsection (c) and render a de-

cision on such hearing by not later than the end of the 90-day period beginning on the date a request for hearing has been timely filed.

"(II) WAIVER OF DEADLINE BY PARTY SEEKING HEARING.—The 90-day period under subclause (i) shall not apply in the case of a motion or stipulation by the party requesting the hearing to waive such period.

"(ii) DEPARTMENTAL APPEALS BOARD REVIEW.—The Departmental Appeals Board of the Department of Health and Human Services shall conduct and conclude a review of the decision on a hearing described in subparagraph (B) and make a decision or remand the case to the administrative law judge for reconsideration by not later than the end of the 90-day period beginning on the date a request for review has been timely filed.

"(iii) CONSEQUENCES OF FAILURE TO MEET DEADLINES.—In the case of a failure by an administrative law judge to render a decision by the end of the period

described in clause (ii), the party requesting the hearing may request a review by the Departmental Appeals Board of the Department of Health and Human Services, notwithstanding any requirements for a hearing for purposes of the party's right to such a review.

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

''(C) POLICIES.—The Secretary shall provide such specific criteria and guidance, including all applicable national and local coverage policies and rationale for such policies, as is necessary to assist the qualified independent contractors to make informed decisions in considering appeals under this section. The Secretary shall furnish to the qualified independent contractors the criteria and guidance described in this paragraph in a published format, which may be an electronic format.

''(D) PUBLICATION OF MEDICARE COVERAGE POLICIES ON THE INTERNET.—The Secretary shall publish national and local coverage

policies under this title on an Internet site maintained by the Secretary.

''(E) EFFECT OF FAILURE TO PUBLISH POLICIES.—

''(i) NATIONAL AND LOCAL COVERAGE POLICIES.—Qualified independent contractors shall not be bound by any national or local medicare coverage policy established by the Secretary that is not published on the Internet site under subparagraph (D).

''(ii) OTHER POLICIES.—With respect to policies established by the Secretary other than the policies described in clause (i), qualified independent contractors shall not be bound by such policies if the Secretary does not furnish to the qualified independent contractor the policies in a published format consistent with subparagraph (C).

''(3) CONTINUING EDUCATION REQUIREMENT FOR QUALIFIED INDEPENDENT CONTRACTORS AND ADMINISTRATIVE LAW JUDGES.—

''(A) IN GENERAL.—The Secretary shall provide to each qualified independent contractor, and to administrative law judges that

decide appeals of reconsiderations of initial determinations or other decisions or determinations under this section, such continuing education with respect to policies of the Secretary under this title or part B of title XI as is necessary for such qualified independent contractors and administrative law judges to make informed decisions with respect to appeals.

"(B) MONITORING OF DECISIONS BY QUALIFIED INDEPENDENT CONTRACTORS AND ADMINISTRATIVE LAW JUDGES.—The Secretary shall monitor determinations made by all qualified independent contractors and administrative law judges under this section and shall provide continuing education and training to such qualified independent contractors and administrative law judges to ensure consistency of determinations with respect to appeals on similar or related matters. To ensure such consistency, the Secretary shall provide for administration and oversight of qualified independent contractors and administrative law judges through a central office of the Department of Health and Human Services. Such administration and oversight

may not be delegated to regional offices of the Department.

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

''(5) SURVEY.—Not less frequently than every 5 years, the Secretary shall conduct a survey of a valid sample of individuals entitled to benefits under this title, providers of services, and suppliers to determine the satisfaction of such individuals or entities with the process for appeals of determinations provided for under this section and education and training provided by the Secretary with respect to that process. The Secretary shall submit to Congress a report describing the results of the survey, and shall include any recommendations for administrative or legislative actions that the Secretary determines appropriate.

''(6) REPORT TO CONGRESS.—The Secretary shall submit to Congress an annual report describing the number of appeals for the previous year, identifying issues that require administrative or legislative actions, and including any recommendations of the Secretary with respect to such actions. The Sec-

retary shall include in such report an analysis of determinations by qualified independent contractors with respect to inconsistent decisions and an analysis of the causes of any such inconsistencies.''.

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

(c) CONFORMING AMENDMENT TO REVIEW BY THE PROVIDER REIMBURSEMENT REVIEW BOARD.—Section 1878(g) of the Social Security Act (42 U.S.C. 1395oo(g)) is amended by adding at the end the following new paragraph:

''(3) Findings described in paragraph (1) and determinations and other decisions described in paragraph (2) may be reviewed or appealed under section 1869.''.

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

(a) EXPANSION OF LIMITATION OF LIABILITY PROTECTION FOR BENEFICIARIES WITH RESPECT TO MEDICARE CLAIMS NOT PAID OR PAID INCORRECTLY.—

(1) IN GENERAL.—Section 1879 of the Social Security Act (42 U.S.C. 1395pp) is amended by adding at the end the following new subsections:

''(i) Notwithstanding any other provision of this Act, an individual who is entitled to benefits under this title and is furnished a service or item is not liable for repayment to the Secretary of amounts with respect to such benefits—

''(1) subject to paragraph (2), in the case of a claim for such item or service that is incorrectly paid by the Secretary; and

''(2) in the case of payments made to the individual by the Secretary with respect to any claim under paragraph (1), the individual shall be liable for repayment of such amount only up to the amount of payment received by the individual from the Secretary.

''(j)(1) An individual who is entitled to benefits under this title and is furnished a service or item is not liable for payment of amounts with respect to such benefits in the following cases:

''(A) In the case of a benefit for which an initial determination has not been made by the Secretary under subsection (a) whether payment may be made under this title for such benefit.

''(B) In the case of a claim for such item or service that is—

''(i) improperly submitted by the provider of services or supplier; or

''(ii) rejected by an entity under contract with the Secretary to review or pay claims for services and items furnished under this title, including an entity under contract with the Secretary under section 1857.

''(2) The limitation on liability under paragraph (1) shall not apply if the individual signs a waiver provided by the Secretary under subsection (l) of protections under this paragraph, except that any such waiver shall not apply in the case of a denial of a claim for noncompliance with applicable regulations or procedures under this title or title XI.

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

''(1) The provider of services shall furnish a notice of discharge and appeal rights established by the

Secretary under subsection (l) to each individual entitled to benefits under this title to whom such provider of services furnishes services, upon admission of the individual to the provider of services and upon notice of determination to discharge the individual from the provider of services, of the individual's limitations of liability under this section and rights of appeal under section 1869.

''(2) If the individual, prior to discharge from the provider of services, appeals the determination to discharge under section 1869 not later than noon of the first working day after the date the individual receives the notice of determination to discharge and notice of appeal rights under paragraph (1), the provider of services shall, by the close of business of such first working day, provide to the Secretary (or qualified independent contractor under section 1869, as determined by the Secretary) the records required to review the determination.

''(l) The Secretary shall develop appropriate standard forms for individuals entitled to benefits under this title to waive limitation of liability protections under subsection (j) and to receive notice of discharge and appeal rights under subsection (k). The forms developed by the Secretary under this subsection shall clearly and in plain lan-

guage inform such individuals of their limitations on liability, their rights under section 1869(a) to obtain an initial determination by the Secretary of whether payment may be made under part A or part B for such benefit, and their rights of appeal under section 1869(b), and shall inform such individuals that they may obtain further information or file an appeal of the determination by use of the toll-free telephone number (1–800–MEDICAR(E)) (1–800–633–4227) maintained by the Secretary. The forms developed by the Secretary under this subsection shall be the only manner in which such individuals may waive such protections under this title or title XI.

''(m) An individual who is entitled to benefits under this title and is furnished an item or service is not liable for payment of cost sharing amounts of more than $50 with respect to such benefits unless the individual has been informed in advance of being furnished the item or service of the estimated amount of the cost sharing for the item or service using a standard form established by the Secretary.''.

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

(b) INCLUSION OF BENEFICIARY LIABILITY INFORMATION IN EXPLANATION OF MEDICARE BENEFITS.—Section 1806(a) of the Social Security Act (42 U.S.C. 1395b–7(a)) is amended—

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

(2) by redesignating paragraph (2) as paragraph (3); and

(3) by inserting after paragraph (1) the following new paragraph:

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

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

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

''(4) includes the toll-free telephone number (1–800–MEDICAR(E)) (1–800–633–4227) for information and questions concerning the statement, liability of the individual for payment, and appeal rights.''.

SEC. 223. WAIVERS OF LIABILITY FOR COST SHARING AMOUNTS.

(a) IN GENERAL.—Section 1128A(i)(6)(A) of the Social Security Act (42 U.S.C. 1320a–7a(i)(6)(A)) is amended by striking clauses (i) through (iii) and inserting the following:

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

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

''(iii) the person waives the coinsurance and deductible amount after the beneficiary informs the person that payment of the coinsurance or deductible amount would pose a financial hardship for the individual; or

''(iv) the person determines that the coinsurance and deductible amount would not justify the costs of collection.''.

(b) CONFORMING AMENDMENT.—Section 1128B(b) of the Social Security Act (42 U.S.C. 1320a–7b(b)) is amended by adding at the end the following new paragraph:

''(4) In this section, the term 'remuneration' includes the meaning given such term in section 1128A(i)(6).''.

SEC. 224. ELIMINATION OF MOTIONS BY THE SECRETARY ON DECISIONS OF THE PROVIDER REIMBURSEMENT REVIEW BOARD.

Section 1878(f)(1) of such Act (42 U.S.C. 1395oo(f)(1)) is amended—

(1) in the first sentence, by striking ''unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision'';

(2) in the second sentence, by striking '', or of any reversal, affirmance, or modification by the Secretary,'' and ''or of any reversal, affirmance, or modification by the Secretary''; and

(3) in the fifth sentence, by striking '' and not subject to review by the Secretary''.

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.

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

(1) in clause (iv), by striking ''for 2001, 0.5 percentage points'' and inserting ''for 2001, 0.4 percentage points''; and

(2) in clause (v), by striking ''for 2002, 0.3 percentage points'' and inserting ''for 2002, 0.2 percentage points''.

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

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

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

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

SEC. 303. INCREASING MINIMUM PAYMENT AMOUNT.

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

(1) by striking ''(ii) For a succeeding year'' and inserting ''(ii)(I) Subject to subclause (II), for a succeeding year''; and

(2) by adding at the end the following new subclause:

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

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

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

Section 1853(c)(2) of the Social Security Act (42 U.S.C. 1395w–23(c)(2)) is amended—

(1) by striking the period at the end of subparagraph (F) and inserting a semicolon; and

(2) by adding after and below subparagraph (F) the following:

''except that a Medicare+Choice organization may elect to apply subparagraph (F) (rather than subparagraph (E)) for 2002.''.

SEC. 305. INCREASED UPDATE FOR PAYMENT AREAS WITH ONLY ONE OR NO MEDICARE+CHOICE CONTRACTS.

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

(1) in clause (i), by striking ''(ii) For a subsequent year'' and inserting ''(ii)(I) Subject to subclause (II), for a subsequent year''; and

(2) by adding at the end the following new subclause:

''(II) During 2002, 2003, 2004, and 2005, in the case of a Medicare+Choice payment area in which there is no more than 1 contract entered into under this part as of July 1 before the beginning of the year, 102.5 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.''.

(b) CONSTRUCTION.—The amendments made by subsection (a) do not affect the payment of a first time bonus

under section 1853(i) of the Social Security Act (42 U.S.C. 1395w–23(i)).

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

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

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

(2) by adding at the end the following new subparagraph:

''(D) PERMITTING HIGHER RATES THROUGH NEGOTIATION.—

''(i) IN GENERAL.—For each year beginning with 2004, in the case of a Medicare+Choice payment area for which the Medicare+Choice capitation rate under this paragraph would otherwise be less than the United States per capita cost (USPCC), as calculated by the Secretary, a Medicare+Choice organization may negotiate with the Medicare Benefits Administrator an annual per capita rate that—

"(I) reflects an annual rate of increase up to the rate of increase specified in clause (ii);

"(II) takes into account audited current data supplied by the organization on its adjusted community rate (as defined in section 1854(f)(3)); and

"(III) does not exceed the United States per capita cost, as projected by the Secretary for the year involved.

"(ii) MAXIMUM RATE DESCRIBED.—The rate of increase specified in this clause for a year is the rate of inflation in private health insurance for the year involved, as projected by the Medicare Benefits Administrator, and includes such adjustments as may be necessary—

"(I) to reflect the demographic characteristics in the population under this title; and

"(II) to eliminate the costs of prescription drugs.

"(iii) ADJUSTMENTS FOR OVER OR UNDER PROJECTIONS.—If subparagraph is applied to an organization and payment

area for a year, in applying this subparagraph for a subsequent year the provisions of paragraph (6)(C) shall apply in the same manner as such provisions apply under this paragraph.''.

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

Section 1853(a)(3)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–23(c)(1)(C)(ii)) is amended—

(1) by striking the period at the end of subclause (II) and inserting a semicolon; and

(2) by adding after and below subclause (II) the following:

''and, beginning in 2004, insofar as such risk adjustment is based on data from all settings, the methodology shall be phased in equal increments over a 10 year period, beginning with 2004 or (if later) the first year in which such data is used.''.

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.

(a) IN GENERAL.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended, in each of subparagraphs (A) and (B), by striking ''(including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered)'' and inserting ''(including drugs and biologicals which are not usually self-administered by the patient)''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) applies to drugs and biologicals administered on or after October 1, 2000.

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