

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

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.

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

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

4 (a) SHORT TITLE.—This Act may be cited as the
5 “Medicare Rx 2000 Act”.

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

Sec. 1. Short title; table of contents.

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

Sec. 101. Establishment of a medicare prescription drug benefit.

“PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

“Sec. 1860A. Benefits; eligibility; enrollment; and coverage period.

“Sec. 1860B. Requirements for qualified prescription drug coverage.

“Sec. 1860C. Beneficiary protections for qualified prescription drug coverage.

“Sec. 1860D. Requirements for prescription drug plan (PDP) sponsors.

“Sec. 1860E. Process for beneficiaries to select qualified prescription drug coverage.

“Sec. 1860F. Premiums.

“Sec. 1860G. Premium and cost-sharing subsidies for low-income individuals.

“Sec. 1860H. Subsidies for all medicare beneficiaries through reinsurance for qualified prescription drug coverage.

“Sec. 1860I. Medicare Prescription Drug Account in Federal Supplementary Medical Insurance Trust Fund.

“Sec. 1860J. Definitions; treatment of references to provisions in part C.

Sec. 102. Offering of qualified prescription drug coverage under the Medicare+Choice program.

Sec. 103. Medicaid amendments.

Sec. 104. Medigap transition provisions.

TITLE II—MODERNIZATION OF ADMINISTRATION OF MEDICARE

Subtitle A—Medicare Benefits Administration

Sec. 201. Establishment of administration.

“Sec. 1807. Medicare Benefits Administration.

Sec. 202. Miscellaneous administrative provisions.

Subtitle B—Oversight of Financial Sustainability of the Medicare Program

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

Subtitle C—Changes in Medicare Coverage and Appeals Process

Sec. 221. Revisions to medicare appeals process.

Sec. 222. Provisions with respect to limitations on liability of beneficiaries.

Sec. 223. Waivers of liability for cost sharing amounts.

Sec. 224. Elimination of motions by the Secretary on decisions of the Provider Reimbursement Review Board.

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

Subtitle A—Medicare+Choice Reforms

1 prescription drug coverage (described in section
2 1860B(a)) as follows:

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

8 “(2) PRESCRIPTION DRUG PLAN.—If the indi-
9 vidual is not enrolled in a Medicare+Choice plan
10 that provides qualified prescription drug coverage,
11 the individual may enroll under this part in a pre-
12 scription drug plan (as defined in section 1860C(a)).

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

15 “(b) GENERAL ELECTION PROCEDURES.—

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

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

3 “(2) ELECTION PERIODS.—

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

9 “(i) annual coordinated election peri-
10 ods; and

11 “(ii) special election periods.

12 In applying the last sentence of section
13 1851(e)(4) (relating to discontinuance of a
14 Medicare+Choice election during the first year
15 of eligibility) under this subparagraph, in the
16 case of an election described in such section in
17 which the individual had elected or is provided
18 qualified prescription drug coverage at the time
19 of such first enrollment, the individual shall be
20 permitted to enroll in a prescription drug plan
21 under this part at the time of the election of
22 coverage under the original fee-for-service plan.

23 “(B) INITIAL ELECTION PERIODS.—

24 “(i) INDIVIDUALS CURRENTLY COV-
25 ERED.—In the case of an individual who is

1 enrolled under part B as of November 1,
2 2002, there shall be an initial election pe-
3 riod of 6 months beginning on that date.

4 “(ii) INDIVIDUAL COVERED IN FU-
5 TURE.—In the case of an individual who is
6 first enrolled under part B after November
7 1, 2002, there shall be an initial election
8 period which is the same as the initial elec-
9 tion period under section 1851(e)(1).

10 “(C) ADDITIONAL SPECIAL ELECTION PE-
11 RIODS.—The Medicare Benefits Administrator
12 shall establish special election periods—

13 “(i) in cases of individuals who have
14 and involuntarily lose prescription drug
15 coverage described in subsection (c)(2)(C);
16 and

17 “(ii) in cases described in section
18 1837(h) (relating to errors in enrollment),
19 in the same manner as such section applies
20 to part B.

21 “(D) ONE-TIME ENROLLMENT PERMITTED
22 FOR CURRENT PART A ONLY BENEFICIARIES.—
23 In the case of an individual who as of Novem-
24 ber 1, 2002—

1 “(i) is entitled to benefits under part
2 A; and

3 “(ii) is not (and has not previously
4 been) enrolled under part B;

5 the individual shall be eligible to enroll in a pre-
6 scription drug plan under this part but only
7 during the period described in subparagraph
8 (B)(i). If the individual enrolls in such a plan,
9 the individual may change such enrollment
10 under this part, but the individual may not en-
11 roll in a Medicare+Choice plan under part C
12 unless the individual enrolls under part B.
13 Nothing in this subparagraph shall be con-
14 strued as providing for coverage under a pre-
15 scription drug plan of benefits that are excluded
16 because of the application of section
17 1860B(f)(2)(B).

18 “(c) GUARANTEED ISSUE; COMMUNITY RATING; AND
19 NONDISCRIMINATION.—

20 “(1) GUARANTEED ISSUE.—

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

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

5 “(B) MEDICARE+CHOICE LIMITATIONS
6 PERMITTED.—The provisions of paragraphs (2)
7 and (3) (other than subparagraph (C)(i), relat-
8 ing to default enrollment) of section 1851(g)
9 (relating to priority and limitation on termi-
10 nation of election) shall apply to PDP sponsors
11 under this subsection.

12 “(2) COMMUNITY-RATED PREMIUM.—

13 “(A) IN GENERAL.—In the case of an indi-
14 vidual who maintains (as determined under sub-
15 paragraph (C)) continuous prescription drug
16 coverage since first qualifying to elect prescrip-
17 tion drug coverage under this part, a PDP
18 sponsor or Medicare+Choice organization offer-
19 ing a prescription drug plan or
20 Medicare+Choice plan that provides qualified
21 prescription drug coverage and in which the in-
22 dividual is enrolled may not deny, limit, or con-
23 dition the coverage or provision of covered pre-
24 scription drug benefits or increase the premium
25 under the plan based on any health status-re-

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

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

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

1 not have any of the following prescription drug
2 coverage:

3 “(i) COVERAGE UNDER PRESCRIPTION
4 DRUG PLAN OR MEDICARE+CHOICE
5 PLAN.—Qualified prescription drug cov-
6 erage under a prescription drug plan or
7 under a Medicare+Choice plan.

8 “(ii) MEDICAID PRESCRIPTION DRUG
9 COVERAGE.—Prescription drug coverage
10 under a medicaid plan under title XIX, in-
11 cluding through the Program of All-inclu-
12 sive Care for the Elderly (PACE) under
13 section 1934, through a social health main-
14 tenance organization (referred to in section
15 4104(c) of the Balanced Budget Act of
16 1997), or through a Medicare+Choice
17 project that demonstrates the application
18 of capitation payment rates for frail elderly
19 medicare beneficiaries through the use of a
20 interdisciplinary team and through the
21 provision of primary care services to such
22 beneficiaries by means of such a team at
23 the nursing facility involved.

24 “(iii) PRESCRIPTION DRUG COVERAGE
25 UNDER GROUP HEALTH PLAN.—Any out-

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

8 “(iv) PRESCRIPTION DRUG COVERAGE
9 UNDER CERTAIN MEDIGAP POLICIES.—
10 Coverage under a medicare supplemental
11 policy under section 1882 that provides
12 benefits for prescription drugs (whether or
13 not such coverage conforms to the stand-
14 ards for packages of benefits under section
15 1882(p)(1)), but only if the policy was in
16 effect on January 1, 2003, and only until
17 the date such coverage is terminated.

18 “(v) STATE PHARMACEUTICAL ASSIST-
19 ANCE PROGRAM.—Coverage of prescription
20 drugs under a State pharmaceutical assist-
21 ance program.

22 “(vi) VETERANS’ COVERAGE OF PRE-
23 SCRIPTON DRUGS.—Coverage of prescrip-
24 tion drugs for veterans under chapter 17
25 of title 38, United States Code.

1 “(D) CERTIFICATION.—For purposes of
2 carrying out this paragraph, the certifications
3 of the type described in sections 2701(e) of the
4 Public Health Service Act and in section
5 9801(e) of the Internal Revenue Code shall also
6 include a statement for the period of coverage
7 of whether the individual involved had prescrip-
8 tion drug coverage described in subparagraph
9 (C).

10 “(E) CONSTRUCTION.—Nothing in this
11 section shall be construed as preventing the
12 disenrollment of an individual from a prescrip-
13 tion drug plan or a Medicare+Choice plan
14 based on the termination of an election de-
15 scribed in section 1851(g)(3), including for non-
16 payment of premiums or for other reasons spec-
17 ified in subsection (d)(3), which takes into ac-
18 count a grace period described in section
19 1851(g)(3)(B)(i).

20 “(3) NONDISCRIMINATION.—A PDP sponsor of-
21 fering a prescription drug plan shall not establish a
22 service area in a manner that would discriminate
23 based on health or economic status of potential en-
24 rollees.

25 “(d) EFFECTIVE DATE OF ELECTIONS.—

1 “(1) IN GENERAL.—Except as provided in this
2 section, the Medicare Benefits Administrator shall
3 provide that elections under subsection (b) take ef-
4 fect at the same time as the Secretary provides that
5 similar elections under section 1851(e) take effect
6 under section 1851(f).

7 “(2) NO ELECTION EFFECTIVE BEFORE 2003.—
8 In no case shall any election take effect before Janu-
9 ary 1, 2003.

10 “(3) TERMINATION.—The Medicare Benefits
11 Administrator shall provide for the termination of
12 elections in the case of—

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

17 “(B) termination of elections described in
18 section 1851(g)(3) (including failure to pay re-
19 quired premiums).

20 **“SEC. 1860B. REQUIREMENTS FOR QUALIFIED PRESCRIP-**
21 **TION DRUG COVERAGE.**

22 “(a) REQUIREMENTS.—

23 “(1) IN GENERAL.—For purposes of this part
24 and part C, the term ‘qualified prescription drug
25 coverage’ means either of the following:

1 “(A) STANDARD COVERAGE WITH ACCESS
2 TO NEGOTIATED PRICES.—Standard coverage
3 (as defined in subsection (b)) and access to ne-
4 gotiated prices under subsection (d).

5 “(B) ACTUARIALY EQUIVALENT COV-
6 ERAGE WITH ACCESS TO NEGOTIATED
7 PRICES.—Coverage of covered outpatient drugs
8 which meets the alternative coverage require-
9 ments of subsection (c) and access to negotiated
10 prices under subsection (d).

11 “(2) PERMITTING ADDITIONAL OUTPATIENT
12 PRESCRIPTION DRUG COVERAGE.—

13 “(A) IN GENERAL.—Subject to subpara-
14 graph (B), nothing in this part shall be con-
15 strued as preventing qualified prescription drug
16 coverage from including coverage of covered
17 outpatient drugs that exceeds the coverage re-
18 quired under paragraph (1), but any such addi-
19 tional coverage shall be limited to coverage of
20 covered outpatient drugs.

21 “(B) DISAPPROVAL AUTHORITY.—The
22 Medicare Benefits Administrator shall review
23 the offering of qualified prescription drug cov-
24 erage under this part or part C. If the Adminis-
25 trator finds that, in the case of a qualified pre-

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

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

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

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

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

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

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

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

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

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

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

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

1 “(4) LIMITATION ON OUT-OF-POCKET EXPENDI-
2 TURES BY BENEFICIARY.—

3 “(A) IN GENERAL.—Notwithstanding para-
4 graph (3), the coverage provides benefits with-
5 out any cost-sharing after the individual has in-
6 curred costs (as described in subparagraph (C))
7 for covered outpatient drugs in a year equal to
8 the annual out-of-pocket limit specified in sub-
9 paragraph (B).

10 “(B) ANNUAL OUT-OF-POCKET LIMIT.—
11 For purposes of this part, the ‘annual out-of-
12 pocket limit’ specified in this subparagraph—

13 “(i) for 2003, is equal to \$6,000; or

14 “(ii) for a subsequent year, is equal to
15 the amount specified in the subparagraph
16 for the previous year, increased by the an-
17 nual percentage increase described in para-
18 graph (5) for the year involved.

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

22 “(C) APPLICATION.—In applying subpara-
23 graph (A)—

24 “(i) incurred costs shall only include
25 costs incurred for the annual deductible

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

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

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

23 “(c) ALTERNATIVE COVERAGE REQUIREMENTS.—A
24 prescription drug plan or Medicare+Choice plan may pro-
25 vide a different prescription drug benefit design from the

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

3 “(1) ASSURING AT LEAST ACTUARIALLY EQUIV-
4 ALENT COVERAGE.—

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

10 “(B) ASSURING EQUIVALENT UNSUB-
11 SIDIZED VALUE OF COVERAGE.—The unsub-
12 sidized value of the coverage is at least equal to
13 the unsubsidized value of standard coverage.
14 For purposes of this subparagraph, the unsub-
15 sidized value of coverage is the amount by
16 which the actuarial value of the coverage (as
17 determined under subsection (e)) exceeds the
18 actuarial value of the reinsurance subsidy pay-
19 ments under section 1860H with respect to
20 such coverage.

21 “(C) ASSURING STANDARD PAYMENT FOR
22 COSTS AT INITIAL COVERAGE LIMIT.—The cov-
23 erage is designed, based upon an actuarially
24 representative pattern of utilization (as deter-
25 mined under subsection (e)), to provide for the

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

7 “(2) LIMITATION ON OUT-OF-POCKET EXPENDI-
8 TURES BY BENEFICIARIES.—The coverage provides
9 the limitation on out-of-pocket expenditures by bene-
10 ficiaries described in subsection (b)(4).

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

21 “(e) ACTUARIAL VALUATION; DETERMINATION OF
22 ANNUAL PERCENTAGE INCREASES.—

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

1 “(A) for determining the actuarial valu-
2 ation of prescription drug coverage, including—

3 “(i) an actuarial valuation of standard
4 coverage and of the reinsurance subsidy
5 payments under section 1860H;

6 “(ii) the use of generally accepted ac-
7 tuarial principles and methodologies; and

8 “(iii) applying the same methodology
9 for determinations of alternative coverage
10 under subsection (c) as is used with re-
11 spect to determinations of standard cov-
12 erage under subsection (b); and

13 “(B) for determining annual percentage in-
14 creases described in subsection (b)(5).

15 “(2) USE OF OUTSIDE ACTUARIES.—Under the
16 processes under paragraph (1)(A), PDP sponsors
17 and Medicare+Choice organizations may use actu-
18 arial opinions certified by independent, qualified ac-
19 tuaries to establish actuarial values.

20 “(f) COVERED OUTPATIENT DRUGS DEFINED.—

21 “(1) IN GENERAL.—Except as provided in this
22 subsection, for purposes of this part, the term ‘cov-
23 ered outpatient drug’ means—

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

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

3 “(B) a biological product or insulin de-
4 scribed in subparagraph (B) or (C) of such sec-
5 tion.

6 “(2) EXCLUSIONS.—

7 “(A) IN GENERAL.—Such term does not
8 include drugs or classes of drugs, or their med-
9 ical uses, which may be excluded from coverage
10 or otherwise restricted under section
11 1927(d)(2), other than subparagraph (E) there-
12 of (relating to smoking cessation agents).

13 “(B) AVOIDANCE OF DUPLICATE COV-
14 ERAGE.—A drug prescribed for an individual
15 that would otherwise be a covered outpatient
16 drug under this part shall not be so considered
17 if payment for such drug is available under part
18 A or B (but shall be so considered if such pay-
19 ment is not available because benefits under
20 part A or B have been exhausted), without re-
21 gard to whether the individual is entitled to
22 benefits under part A or enrolled under part B.

23 “(3) APPLICATION OF FORMULARY RESTRIC-
24 TIONS.—A drug prescribed for an individual that
25 would otherwise be a covered outpatient drug under

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

5 “(4) APPLICATION OF GENERAL EXCLUSION
 6 PROVISIONS.—A prescription drug plan or
 7 Medicare+Choice plan may exclude from qualified
 8 prescription drug coverage any covered outpatient
 9 drug—

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

12 “(B) which are not prescribed in accord-
 13 ance with the plan or this part.

14 Such exclusions are determinations subject to recon-
 15 sideration and appeal pursuant to section 1860C(f).

16 **“SEC. 1860C. BENEFICIARY PROTECTIONS FOR QUALIFIED**
 17 **PRESCRIPTION DRUG COVERAGE.**

18 “(a) GUARANTEED ISSUE AND NONDISCRIMINA-
 19 TION.—For provisions requiring guaranteed issue, com-
 20 munity-rated premiums, and nondiscrimination, see sec-
 21 tions 1860A(c) and 1860F(b).

22 “(b) DISSEMINATION OF INFORMATION.—

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

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

6 “(A) Access to covered outpatient drugs,
7 including access through pharmacy networks.

8 “(B) How any formulary used by the spon-
9 sor functions.

10 “(C) Co-payments and deductible require-
11 ments.

12 “(D) Grievance and appeals procedures.

13 “(2) DISCLOSURE UPON REQUEST OF GENERAL
14 COVERAGE, UTILIZATION, AND GRIEVANCE INFORMA-
15 TION.—Upon request of an individual eligible to en-
16 roll under a prescription drug plan, the PDP spon-
17 sor shall provide the information described in section
18 1852(c)(2) (other than subparagraph (D)) to such
19 individual.

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

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

3 “(4) CLAIMS INFORMATION.—Each PDP spon-
4 sor offering a prescription drug plan must furnish to
5 enrolled individuals in a form easily understandable
6 to such individuals an explanation of benefits (in ac-
7 cordance with section 1806(a) or in a comparable
8 manner) and a notice of the benefits in relation to
9 initial coverage limit and annual out-of-pocket limit
10 for the current year, whenever prescription drug
11 benefits are provided under this part (except that
12 such notice need not be provided more often than
13 monthly).

14 “(c) ACCESS TO COVERED BENEFITS.—

15 “(1) ASSURING PHARMACY ACCESS.—The PDP
16 sponsor of the prescription drug plan shall secure
17 the participation of sufficient numbers of pharmacies
18 (which may include mail order pharmacies) to en-
19 sure convenient access (including adequate emer-
20 gency access) for enrolled beneficiaries. Nothing in
21 this paragraph shall be construed as requiring the
22 participation of all pharmacies in any area under a
23 plan.

24 “(2) ACCESS TO NEGOTIATED PRICES FOR PRE-
25 SCRIPTIION DRUGS.—The PDP sponsor of a prescrip-

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

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

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

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

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

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

3 “(d) COST AND UTILIZATION MANAGEMENT; QUAL-
4 ITY ASSURANCE; MEDICATION THERAPY MANAGEMENT
5 PROGRAM.—

6 “(1) IN GENERAL.—The PDP sponsor shall
7 have in place—

8 “(A) an effective cost and drug utilization
9 management program, including appropriate in-
10 centives to use generic drugs, when appropriate;

11 “(B) quality assurance measures and sys-
12 tems to reduce medical errors and adverse drug
13 interactions, including a medication therapy
14 management program described in paragraph
15 (2); and

16 “(C) a program to control fraud, abuse,
17 and waste.

18 “(2) MEDICATION THERAPY MANAGEMENT PRO-
19 GRAM.—

20 “(A) IN GENERAL.—A medication therapy
21 management program described in this para-
22 graph is a program of drug therapy manage-
23 ment and medication administration that is de-
24 signed to assure that covered outpatient drugs
25 under the prescription drug plan are appro-

1 priately used to achieve therapeutic goals and
2 reduce the risk of adverse events, including ad-
3 verse drug interactions.

4 “(B) ELEMENTS.—Such program may
5 include—

6 “(i) enhanced beneficiary under-
7 standing of such appropriate use through
8 beneficiary education, counseling, and
9 other appropriate means; and

10 “(ii) increased beneficiary adherence
11 with prescription medication regimens
12 through medication refill reminders, special
13 packaging, and other appropriate means.

14 “(C) DEVELOPMENT OF PROGRAM IN CO-
15 OPERATION WITH LICENSED PHARMACISTS.—
16 The program shall be developed in cooperation
17 with licensed pharmacists and physicians.

18 “(D) CONSIDERATIONS IN PHARMACY
19 FEES.—The PDP sponsor of a prescription
20 drug program shall take into account, in estab-
21 lishing fees for pharmacists and others pro-
22 viding services under the medication therapy
23 management program, the resources and time
24 used in implementing the program.

1 “(3) TREATMENT OF ACCREDITATION.—Section
2 1852(e)(4) (relating to treatment of accreditation)
3 shall apply to prescription drug plans under this
4 part with respect to the following requirements, in
5 the same manner as they apply to Medicare+Choice
6 plans under part C with respect to the requirements
7 described in a clause of section 1852(e)(4)(B):

8 “(A) Paragraph (1) (including quality as-
9 surance), including medication therapy manage-
10 ment program under paragraph (2).

11 “(B) Subsection (c)(1) (relating to access
12 to covered benefits).

13 “(C) Subsection (g) (relating to confiden-
14 tiality and accuracy of enrollee records).

15 “(e) GRIEVANCE MECHANISM.—Each PDP sponsor
16 shall provide meaningful procedures for hearing and re-
17 solving grievances between the organization (including any
18 entity or individual through which the sponsor provides
19 covered benefits) and enrollees with prescription drug
20 plans of the sponsor under this part in accordance with
21 section 1852(f).

22 “(f) COVERAGE DETERMINATIONS, RECONSIDER-
23 ATIONS, AND APPEALS.—

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

1 covered benefits under the prescription drug plan it
2 offers under this part in the same manner as such
3 requirements apply to a Medicare+Choice organiza-
4 tion with respect to benefits it offers under a
5 Medicare+Choice plan under part C.

6 “(2) APPEALS OF FORMULARY DETERMINA-
7 TIONS.—Under the appeals process under paragraph
8 (1) an individual who is enrolled in a prescription
9 drug plan offered by a PDP sponsor may appeal to
10 obtain coverage for a medically necessary covered
11 outpatient drug that is not on the formulary of the
12 sponsor (established under subsection (c)) if the pre-
13 scribing physician determines that the therapeuti-
14 cally similar drug that is on the formulary is not ef-
15 fective for the enrollee or has significant adverse ef-
16 fects for the enrollee.

17 “(g) CONFIDENTIALITY AND ACCURACY OF EN-
18 ROLLEE RECORDS.—A PDP sponsor shall meet the re-
19 quirements of section 1852(h) with respect to enrollees
20 under this part in the same manner as such requirements
21 apply to a Medicare+Choice organization with respect to
22 enrollees under part C.

1 **“SEC. 1860D. REQUIREMENTS FOR PRESCRIPTION DRUG**
2 **PLAN (PDP) SPONSORS.**

3 “(a) GENERAL REQUIREMENTS.—Each PDP sponsor
4 of a prescription drug plan shall meet the following re-
5 quirements:

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

11 “(2) ASSUMPTION OF FULL FINANCIAL RISK.—

12 “(A) IN GENERAL.—Subject to subpara-
13 graph (B) and section 1860E(d)(2), the entity
14 assumes full financial risk on a prospective
15 basis for qualified prescription drug coverage
16 that it offers under a prescription drug plan
17 and that is not covered under reinsurance
18 under section 1860H.

19 “(B) REINSURANCE PERMITTED.—The en-
20 tity may obtain insurance or make other ar-
21 rangements for the cost of coverage provided to
22 any enrolled member under this part.

23 “(3) SOLVENCY FOR UNLICENSED SPONSORS.—

24 In the case of a sponsor that is not described in
25 paragraph (1), the sponsor shall meet solvency

1 standards established by the Medicare Benefits Ad-
2 ministrator under subsection (d).

3 “(b) CONTRACT REQUIREMENTS.—

4 “(1) IN GENERAL.—The Medicare Benefits Ad-
5 ministrator shall not permit the election under sec-
6 tion 1860A of a prescription drug plan offered by a
7 PDP sponsor under this part, and the sponsor shall
8 not be eligible for payments under section 1860G or
9 1860H, unless the Administrator has entered into a
10 contract under this subsection with the sponsor with
11 respect to the offering of such plan. Such a contract
12 with a sponsor may cover more than 1 prescription
13 drug plan. Such contract shall provide that the spon-
14 sor agrees to comply with the applicable require-
15 ments and standards of this part and the terms and
16 conditions of payment as provided for in this part.

17 “(2) INCORPORATION OF CERTAIN
18 MEDICARE+CHOICE CONTRACT REQUIREMENTS.—

19 The following provisions of section 1857 shall apply,
20 subject to subsection (c)(5), to contracts under this
21 section in the same manner as they apply to con-
22 tracts under section 1857(a):

23 “(A) MINIMUM ENROLLMENT.—Para-
24 graphs (1) and (3) of section 1857(b).

1 “(B) CONTRACT PERIOD AND EFFECTIVE-
2 NESS.—Paragraphs (1) through (3) and (5) of
3 section 1857(e).

4 “(C) PROTECTIONS AGAINST FRAUD AND
5 BENEFICIARY PROTECTIONS.—Section 1857(d).

6 “(D) ADDITIONAL CONTRACT TERMS.—
7 Section 1857(e); except that in applying section
8 1857(e)(2) under this part—

9 “(i) such section shall be applied sepa-
10 rately to costs relating to this part (from
11 costs under part C);

12 “(ii) in no case shall the amount of
13 the fee established under this subpara-
14 graph for a plan exceed 20 percent of the
15 maximum amount of the fee that may be
16 established under subparagraph (B) of
17 such section; and

18 “(iii) no fees shall be applied under
19 this subparagraph with respect to
20 Medicare+Choice plans.

21 “(E) INTERMEDIATE SANCTIONS.—Section
22 1857(g).

23 “(F) PROCEDURES FOR TERMINATION.—
24 Section 1857(h).

1 “(3) RULES OF APPLICATION FOR INTER-
2 MEDIATE SANCTIONS.—In applying paragraph
3 (2)(E)—

4 “(A) the reference in section
5 1857(g)(1)(B) to section 1854 is deemed a ref-
6 erence to this part; and

7 “(B) the reference in section
8 1857(g)(1)(F) to section 1852(k)(2)(A)(ii) shall
9 not be applied.

10 “(c) WAIVER OF CERTAIN REQUIREMENTS TO EX-
11 PAND CHOICE.—

12 “(1) IN GENERAL.—In the case of an entity
13 that seeks to offer a prescription drug plan in a
14 State, the Medicare Benefits Administrator shall
15 waive the requirement of subsection (a)(1) that the
16 entity be licensed in that State if the Administrator
17 determines, based on the application and other evi-
18 dence presented to the Administrator, that any of
19 the grounds for approval of the application described
20 in paragraph (2) has been met.

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

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

3 “(3) APPLICATION OF MEDICARE+CHOICE PSO
4 WAIVER PROCEDURES.—With respect to an applica-
5 tion for a waiver (or a waiver granted) under this
6 subsection, the provisions of subparagraphs (E), (F),
7 and (G) of section 1855(a)(2) shall apply.

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

14 “(5) REFERENCES TO CERTAIN PROVISIONS.—
15 For purposes of this subsection, in applying provi-
16 sions of section 1855(a)(2) under this subsection to
17 prescription drug plans and PDP sponsors—

18 “(A) any reference to a waiver application
19 under section 1855 shall be treated as a ref-
20 erence to a waiver application under paragraph
21 (1); and

22 “(B) any reference to solvency standards
23 were treated as a reference to solvency stand-
24 ards established under subsection (c).

1 “(d) SOLVENCY STANDARDS FOR NON-LICENSED
2 SPONSORS.—

3 “(1) ESTABLISHMENT.—The Medicare Benefits
4 Administrator shall establish, by not later than Oc-
5 tober 1, 2001, financial solvency and capital ade-
6 quacy standards that an entity that does not meet
7 the requirements of subsection (a)(1) must meet to
8 qualify as a PDP sponsor under this part.

9 “(2) COMPLIANCE WITH STANDARDS.—Each
10 PDP sponsor that is not licensed by a State under
11 subsection (a)(1) and for which a waiver application
12 has been approved under subsection (c) shall meet
13 solvency and capital adequacy standards established
14 under paragraph (1). The Medicare Benefits Admin-
15 istrator shall establish certification procedures for
16 such PDP sponsors with respect to such solvency
17 standards in the manner described in section
18 1855(c)(2).

19 “(e) OTHER STANDARDS.—The Medicare Benefits
20 Administrator shall establish by regulation other stand-
21 ards (not described in subsection (d)) for PDP sponsors
22 and plans consistent with, and to carry out, this part. The
23 Administrator shall publish such regulations by October
24 1, 2001. In order to carry out this requirement in a timely
25 manner, the Administrator may promulgate regulations

1 that take effect on an interim basis, after notice and pend-
2 ing opportunity for public comment.

3 “(f) RELATION TO STATE LAWS.—

4 “(1) IN GENERAL.—The standards established
5 under this subsection shall supersede any State law
6 or regulation (including standards described in para-
7 graph (2)) with respect to prescription drug plans
8 which are offered by PDP sponsors under this part
9 to the extent such law or regulation is inconsistent
10 with such standards, in the same manner as such
11 laws and regulations are superseded under section
12 1856(b)(3).

13 “(2) STANDARDS SPECIFICALLY SUPER-
14 SEDED.—State standards relating to the following
15 are superseded under this subsection:

16 “(A) Benefit requirements.

17 “(B) Requirements relating to inclusion or
18 treatment of providers.

19 “(C) Coverage determinations (including
20 related appeals and grievance processes).

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

1 a sponsor by the Medicare Benefits Administrator
2 under this part.

3 **“SEC. 1860E. PROCESS FOR BENEFICIARIES TO SELECT**
4 **QUALIFIED PRESCRIPTION DRUG COVERAGE.**

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

13 “(b) ELEMENTS.—Such process shall include the fol-
14 lowing:

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

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

1 “(3) Coordination of elections through filing
2 with a Medicare+Choice organization or a PDP
3 sponsor, in the manner described in (and in coordi-
4 nation with) section 1851(c)(2).

5 “(c) MEDICARE+CHOICE ENROLLEE IN PLAN OF-
6 FERING PRESCRIPTION DRUG COVERAGE MAY ONLY OB-
7 TAIN BENEFITS THROUGH THE PLAN.—An individual
8 who is enrolled under a Medicare+Choice plan that offers
9 qualified prescription drug coverage may only elect to re-
10 ceive qualified prescription drug coverage under this part
11 through such plan.

12 “(d) ASSURING ACCESS TO A CHOICE OF QUALIFIED
13 PRESCRIPTION DRUG COVERAGE.—

14 “(1) IN GENERAL.—The Medicare Benefits Ad-
15 ministrators shall assure that each individual who is
16 enrolled under part B and who is residing in an area
17 has available a choice of enrollment in at least 2
18 qualifying plans (as defined in paragraph (5)) in the
19 area in which the individual resides, at least 1 of
20 which is a prescription drug plan.

21 “(2) GUARANTEEING ACCESS TO COVERAGE.—
22 In order to assure access under paragraph (1) and
23 consistent with paragraph (3), the Medicare Benefits
24 Administrators may provide financial incentives (in-
25 cluding partial underwriting of risk) for a PDP

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

7 “(3) LIMITATION ON AUTHORITY.—In exer-
8 cising authority under this subsection, the Medicare
9 Benefits Administrator—

10 “(A) shall not provide for the full under-
11 writing of financial risk for any PDP sponsor;

12 “(B) shall not provide for any under-
13 writing of financial risk for a public PDP spon-
14 sor with respect to the offering of a nationwide
15 prescription drug plan; and

16 “(C) shall seek to maximize the assump-
17 tion of financial risk by PDP sponsors or
18 Medicare+Choice organizations.

19 “(4) REPORTS.—The Medicare Benefits Admin-
20 istrator shall, in each annual report to Congress
21 under section 1807(f), include information on the
22 exercise of authority under this subsection. The Ad-
23 ministrator also shall include such recommendations
24 as may be appropriate to minimize the exercise of

1 such authority, including minimizing the assumption
2 of financial risk.

3 “(5) QUALIFYING PLAN DEFINED.—For pur-
4 poses of this subsection, the term ‘qualifying plan’
5 means a prescription drug plan or a a
6 Medicare+Choice plan that includes qualified pre-
7 scription drug coverage.

8 **“SEC. 1860F. PREMIUMS.**

9 “(a) SUBMISSION OF PREMIUMS AND RELATED IN-
10 FORMATION.—

11 “(1) IN GENERAL.—Each PDP sponsor shall
12 submit to the Medicare Benefits Administrator in-
13 formation of the type described in paragraph (2) in
14 the same manner as information is submitted by a
15 Medicare+Choice organization under section
16 1854(a)(1).

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

19 “(A) Information on the qualified prescrip-
20 tion drug coverage to be provided.

21 “(B) Information on the actuarial value of
22 the coverage.

23 “(C) Information on the monthly premium
24 to be charged for the coverage, including an ac-
25 tuarial certification of—

1 “(i) the actuarial basis for such pre-
2 mium;

3 “(ii) the portion of such premium at-
4 tributable to benefits in excess of standard
5 coverage; and

6 “(iii) the reduction in such premium
7 resulting from the reinsurance subsidy
8 payments provided under section 1860H.

9 “(D) Such other information as the Medi-
10 care Benefits Administrator may require to
11 carry out this part.

12 “(3) REVIEW.—The Medicare Benefits Admin-
13 istrator shall review the information filed under
14 paragraph (2) and shall approve or disapprove such
15 rates, amounts, and values so submitted. In exer-
16 cising such authority, the Administrator shall take
17 into account the reinsurance subsidy payments
18 under section 1860H and the adjusted community
19 rate (as defined in section 1854(f)(3)) for the bene-
20 fits covered and shall have the same authority to ne-
21 gotiate the terms and conditions of such premiums
22 and other terms and conditions of plans as the Di-
23 rector of the Office of Personnel Management has
24 with respect to health benefits plans under chapter
25 89 of title 5, United States Code.

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

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

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

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

1 1860G(b)(2) as payment in full for the premium
2 charge for qualified prescription drug coverage.

3 “(2) STANDARD PRESCRIPTION DRUG COV-
4 ERAGE DEFINED.—For purposes of this subsection,
5 the term ‘standard prescription drug coverage’
6 means qualified prescription drug coverage that is
7 standard coverage or that has an actuarial value
8 equivalent to the actuarial value for standard cov-
9 erage.

10 **“SEC. 1860G. PREMIUM AND COST-SHARING SUBSIDIES FOR**
11 **LOW-INCOME INDIVIDUALS.**

12 “(a) IN GENERAL.—

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

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

24 “(B) subject to subsection (c), to the sub-
25 stitution for the beneficiary cost-sharing de-

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

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

18 “(3) DETERMINATION OF ELIGIBILITY.—

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

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

1 “(ii) has income below 150 percent of
2 the Federal poverty line; and

3 “(iii) meets the resources requirement
4 described in section 1905(p)(1)(C).

5 “(B) DETERMINATIONS.—The determina-
6 tion of whether an individual residing in a State
7 is a subsidy eligible individual and the amount
8 of such individual’s income shall be determined
9 under the State medicaid plan for the State
10 under section 1935(a). In the case of a State
11 that does not operate such a medicaid plan (ei-
12 ther under title XIX or under a statewide waiv-
13 er granted under section 1115), such deter-
14 mination shall be made under arrangements
15 made by the Medicare Benefits Administrator.

16 “(C) INCOME DETERMINATIONS.—For pur-
17 poses of applying this section—

18 “(i) income shall be determined in the
19 manner described in section
20 1905(p)(1)(B); and

21 “(ii) the term ‘Federal poverty line’
22 means the official poverty line (as defined
23 by the Office of Management and Budget,
24 and revised annually in accordance with
25 section 673(2) of the Omnibus Budget

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

3 “(D) TREATMENT OF TERRITORIAL RESI-
4 DENTS.—In the case of an individual who is not
5 a resident of the 50 States or the District of
6 Columbia, the individual is not eligible to be a
7 subsidy eligible individual but may be eligible
8 for financial assistance with prescription drug
9 expenses under section 1935(e).

10 “(b) PREMIUM SUBSIDY AMOUNT.—

11 “(1) IN GENERAL.—The premium subsidy
12 amount described in this subsection for an individual
13 residing in an area is the reference premium (as de-
14 fined in paragraph (2)) for qualified prescription
15 drug coverage offered by the prescription drug plan
16 or the Medicare+Choice plan in which the individual
17 is enrolled.

18 “(2) REFERENCE PREMIUM DEFINED.—For
19 purposes of this subsection, the term ‘reference pre-
20 mium’ means, with respect to qualified prescription
21 drug coverage offered under—

22 “(A) a prescription drug plan that—

23 “(i) provides standard coverage (or al-
24 ternative prescription drug coverage the
25 actuarial value is equivalent to that of

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

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

14 “(B) a Medicare+Choice plan, the stand-
 15 ard premium computed under section
 16 1851(j)(4)(A)(iii), determined without regard to
 17 any reduction effected under section
 18 1851(j)(4)(B).

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

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

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

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

3 “(B) the Medicare Benefits Administrator
4 shall determine what is ‘nominal’ taking into
5 account the rules applied under section
6 1916(a)(3); and

7 “(C) nothing in this part shall be con-
8 strued as preventing a plan or provider from
9 waiving or reducing the amount of cost-sharing
10 otherwise applicable.

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

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

24 “(1) the Administrator provides for a notifica-
25 tion of the PDP sponsor or Medicare+Choice orga-

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

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

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

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

17 “(e) RELATION TO MEDICAID PROGRAM.—

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

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

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

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

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

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

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

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

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

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

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

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

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

15 “(c) REINSURANCE PAYMENT AMOUNT.—

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

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

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

4 “(B) For the portion of the individual’s
5 gross covered prescription drug costs for the
6 year that exceeds \$1,350, but does not exceed
7 \$1,450, an amount equal to 50 percent of the
8 allowable costs attributable to such gross cov-
9 ered prescription drug costs.

10 “(C) For the portion of the individual’s
11 gross covered prescription drug costs for the
12 year that exceeds \$1,450, but does not exceed
13 \$1,550, an amount equal to 70 percent of the
14 allowable costs attributable to such gross cov-
15 ered prescription drug costs.

16 “(D) For the portion of the individual’s
17 gross covered prescription drug costs for the
18 year that exceeds \$1,550, but does not exceed
19 \$2,350, an amount equal to 90 percent of the
20 allowable costs attributable to such gross cov-
21 ered prescription drug costs.

22 “(E) For the portion of the individual’s
23 gross covered prescription drug costs for the
24 year that exceeds \$7,050, an amount equal to

1 90 percent of the allowable costs attributable to
2 such gross covered prescription drug costs.

3 “(2) ALLOWABLE COSTS.—For purposes of this
4 section, the term ‘allowable costs’ means, with re-
5 spect to gross covered prescription drug costs under
6 a plan described in subsection (b) offered by a quali-
7 fying entity, the part of such costs that are actually
8 paid under the plan, but in no case more than the
9 part of such costs that would have been paid under
10 the plan if the prescription drug coverage under the
11 plan were standard coverage.

12 “(3) GROSS COVERED PRESCRIPTION DRUG
13 COSTS.—For purposes of this section, the term
14 ‘gross covered prescription drug costs’ means, with
15 respect to an enrollee with a qualifying entity under
16 a plan described in subsection (b) during a coverage
17 year, the costs incurred under the plan for covered
18 prescription drugs dispensed during the year, includ-
19 ing costs relating to the deductible, whether paid by
20 the enrollee or under the plan, regardless of whether
21 the coverage under the plan exceeds standard cov-
22 erage and regardless of when the payment for such
23 drugs is made.

24 “(4) INDEXING DOLLAR AMOUNTS.—

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

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

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

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

22 “(d) ADJUSTMENT OF PAYMENTS.—

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

1 “(A) the total payments to be made (with-
2 out regard to this subsection) during a year
3 under this section; and

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

8 “(2) ADJUSTMENT OF PAYMENTS.—The Ad-
9 ministrator shall proportionally adjust the payments
10 made under this section for a coverage year in such
11 manner so that the total of the payments made for
12 the year under this section is equal to 35 percent of
13 the total payments described in paragraph (1)(B)
14 during the year.

15 “(e) PAYMENT METHODS.—

16 “(1) IN GENERAL.—Payments under this sec-
17 tion shall be based on such a method as the Medi-
18 care Benefits Administrator determines. The Admin-
19 istrator may establish a payment method by which
20 interim payments of amounts under this section are
21 made during a year based on the Administrator’s
22 best estimate of amounts that will be payable after
23 obtaining all of the information.

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

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

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

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

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

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

3 “(C) PROVISION OF CERTIFICATION OF
4 PRESCRIPTION DRUG COVERAGE.—The sponsor
5 of the plan shall provide for issuance of certifi-
6 cations of the type described in section
7 1860A(c)(2)(D).

8 “(D) OTHER REQUIREMENTS.—The spon-
9 sor of the plan shall comply with such other re-
10 quirements as the Medicare Benefits Adminis-
11 trator finds necessary to administer the pro-
12 gram under this section.

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

18 “(A) is covered under the plan; and

19 “(B) is eligible to obtain qualified prescrip-
20 tion drug coverage under section 1860A but did
21 not elect such coverage under this part (either
22 through a prescription drug plan or through a
23 Medicare+Choice plan).

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

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

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

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

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

1 “(g) GENERAL DEFINITIONS.—For purposes of this
2 section:

3 “(1) QUALIFYING COVERED INDIVIDUAL.—The
4 term ‘qualifying covered individual’ means an indi-
5 vidual who—

6 “(A) is enrolled with a prescription drug
7 plan under this part;

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

11 “(C) is covered as a medicare primary in-
12 dividual under a qualified retiree prescription
13 drug plan.

14 “(2) COVERAGE YEAR.—The term ‘coverage
15 year’ means a calendar year in which covered out-
16 patient drugs are dispensed if a claim for payment
17 is made under the plan for such drugs, regardless of
18 when the claim is paid.

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

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

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

8 “(b) PAYMENTS FROM ACCOUNT.—

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

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

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

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

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

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

3 “(c) DEPOSITS INTO ACCOUNT.—

4 “(1) MEDICAID TRANSFER.—There is hereby
5 transferred to the Account, from amounts appro-
6 priated for Grants to States for Medicaid, amounts
7 equivalent to the aggregate amount of the reductions
8 in payments under section 1903(a)(1) attributable to
9 the application of section 1935(c).

10 “(2) APPROPRIATIONS TO COVER GOVERNMENT
11 CONTRIBUTIONS.—There are authorized to be appro-
12 priated from time to time, out of any moneys in the
13 Treasury not otherwise appropriated, to the Ac-
14 count, an amount equivalent to the amount of pay-
15 ments made from the Account under subsection (b),
16 reduced by the amount transferred to the Account
17 under paragraph (1).

18 **“SEC. 1860J. DEFINITIONS; TREATMENT OF REFERENCES**
19 **TO PROVISIONS IN PART C.**

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

21 “(1) COVERED OUTPATIENT DRUGS.—The term
22 ‘covered outpatient drugs’ is defined in section
23 1860B(f).

24 “(2) INITIAL COVERAGE LIMIT.—The term ‘ini-
25 tial coverage limit’ means the such limit as estab-

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

4 “(3) MEDICARE PRESCRIPTION DRUG AC-
5 COUNT.—The term ‘Medicare Prescription Drug Ac-
6 count’ means the Account in the Federal Supple-
7 mentary Medical Insurance Trust Fund created
8 under section 1860I(a).

9 “(4) PDP SPONSOR.—The term ‘PDP sponsor’
10 means an entity that is certified under this part as
11 meeting the requirements and standards of this part
12 for such a sponsor.

13 “(5) PRESCRIPTION DRUG PLAN.—The term
14 ‘prescription drug plan’ means health benefits cov-
15 erage that—

16 “(A) is offered under a policy, contract, or
17 plan by a PDP sponsor pursuant to, and in ac-
18 cordance with, a contract between the Medicare
19 Benefits Administrator and the sponsor under
20 section 1860D(b);

21 “(B) provides qualified prescription drug
22 coverage; and

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

1 “(6) QUALIFIED PRESCRIPTION DRUG COV-
2 ERAGE.—The term ‘qualified prescription drug cov-
3 erage’ is defined in section 1860B(a).

4 “(7) STANDARD COVERAGE.—The term ‘stand-
5 ard coverage’ is defined in section 1860B(b).

6 “(b) APPLICATION OF MEDICARE+CHOICE PROVI-
7 SIONS UNDER THIS PART.—For purposes of applying pro-
8 visions of part C under this part with respect to a pre-
9 scription drug plan and a PDP sponsor, unless otherwise
10 provided in this part such provisions shall be applied as
11 if—

12 “(1) any reference to a Medicare+Choice plan
13 included a reference to a prescription drug plan;

14 “(2) any reference to a provider-sponsored or-
15 ganization included a reference to a PDP sponsor;

16 “(3) any reference to a contract under section
17 1857 included a reference to a contract under sec-
18 tion 1860D(b); and

19 “(4) any reference to part C included a ref-
20 erence to this part.”.

21 “(c) CONFORMING AMENDMENTS TO FEDERAL SUP-
22 PLEMENTARY MEDICAL INSURANCE TRUST FUND.—Sec-
23 tion 1841 of the Social Security Act (42 U.S.C. 1395t)
24 is amended—

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

1 (A) by striking “and” before “such
2 amounts”, and

3 (B) by inserting before the period the fol-
4 lowing: “and such amounts as may be deposited
5 in, or appropriated to, the Medicare Prescrip-
6 tion Drug Account established by section
7 1860I”; and

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

13 (d) ADDITIONAL CONFORMING CHANGES.—

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

20 (2) SECRETARIAL SUBMISSION OF LEGISLATIVE
21 PROPOSAL.—Not later than 6 months after the date
22 of the enactment of this Act, the Secretary of
23 Health and Human Services shall submit to the ap-
24 propriate committees of Congress a legislative pro-
25 posal providing for such technical and conforming

1 amendments in the law as are required by the provi-
2 sions of this subtitle.

3 **SEC. 102. OFFERING OF QUALIFIED PRESCRIPTION DRUG**
4 **COVERAGE UNDER THE MEDICARE+CHOICE**
5 **PROGRAM.**

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

9 “(j) AVAILABILITY OF PRESCRIPTION DRUG BENE-
10 FITS.—

11 “(1) IN GENERAL.—A Medicare+Choice orga-
12 nization may not offer prescription drug coverage
13 (other than that required under parts A and B) to
14 an enrollee under a Medicare+Choice plan unless
15 such drug coverage is at least qualified prescription
16 drug coverage and unless the requirements of this
17 subsection with respect to such coverage are met.

18 “(2) COMPLIANCE WITH ADDITIONAL BENE-
19 FICIARY PROTECTIONS.—With respect to the offer-
20 ing of qualified prescription drug coverage by a
21 Medicare+Choice organization under a
22 Medicare+Choice plan, the organization and plan
23 shall meet the requirements of section 1860C, in-
24 cluding requirements relating to information dis-
25 semination and grievance and appeals, in the same

1 manner as they apply to a PDP sponsor and a pre-
2 scription drug plan under part D. The Medicare
3 Benefits Administrator shall waive such require-
4 ments to the extent the Administrator determines
5 that such requirements duplicate requirements oth-
6 erwise applicable to the organization or plan under
7 this part.

8 “(3) TREATMENT OF COVERAGE.—Except as
9 provided in this subsection, qualified prescription
10 drug coverage offered under this subsection shall be
11 treated under this part in the same manner as sup-
12 plemental health care benefits described in section
13 1852(a)(3)(A).

14 “(4) AVAILABILITY OF PREMIUM AND COST-
15 SHARING SUBSIDIES FOR LOW-INCOME ENROLLEES
16 AND REINSURANCE SUBSIDY PAYMENTS FOR ORGA-
17 NIZATIONS.—For provisions—

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

22 “(B) providing a Medicare+Choice organi-
23 zation with reinsurance subsidy payments for
24 providing qualified prescription drug coverage
25 under this part, see section 1860H.

1 “(5) SPECIFICATION OF SEPARATE AND STAND-
2 ARD PREMIUM.—

3 “(A) IN GENERAL.—For purposes of ap-
4 plying section 1854 and section 1860G(b)(2)(B)
5 with respect to qualified prescription drug cov-
6 erage offered under this subsection under a
7 plan, the Medicare+Choice organization shall
8 compute and publish the following:

9 “(i) SEPARATE PRESCRIPTION DRUG
10 PREMIUM.—A premium for prescription
11 drug benefits that constitute qualified pre-
12 scription drug coverage that is separate
13 from other coverage under the plan.

14 “(ii) PORTION OF COVERAGE ATTRIB-
15 UTABLE TO STANDARD BENEFITS.—The
16 ratio of the actuarial value of standard
17 coverage to the actuarial value of the
18 qualified prescription drug coverage offered
19 under the plan.

20 “(iii) PORTION OF PREMIUM ATTRIB-
21 UTABLE TO STANDARD BENEFITS.—A
22 standard premium equal to the product of
23 the premium described in clause (i) and
24 the ratio under clause (ii).

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

4 “(B) REDUCTION OF PREMIUMS AL-
5 LOWED.—Nothing in this subsection shall be
6 construed as preventing a Medicare+Choice or-
7 ganization from reducing the amount of a pre-
8 mium charged for prescription drug coverage
9 because of the application of section
10 1854(f)(1)(A) to other coverage.

11 “(C) ACCEPTANCE OF REFERENCE PRE-
12 MIUM AS FULL PREMIUM IF NO STANDARD (OR
13 EQUIVALENT) COVERAGE IN AN AREA.—For re-
14 quirement to accept reference premium as full
15 premium if there is no standard (or equivalent)
16 coverage in the area of a Medicare+Choice
17 plan, see section 1860F(d).

18 “(6) TRANSITION IN INITIAL ENROLLMENT PE-
19 RIOD.—Notwithstanding any other provision of this
20 part, the annual, coordinated election period under
21 subsection (e)(3)(B) for 2003 shall be the 6-month
22 period beginning with November 2002.

23 “(7) QUALIFIED PRESCRIPTION DRUG COV-
24 ERAGE; STANDARD COVERAGE.—For purposes of
25 this part, the terms ‘qualified prescription drug cov-

1 erage’ and ‘standard coverage’ have the meanings
 2 given such terms in section 1860B.”.

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

5 (1) in subsection (a)(1)—

6 (A) by inserting “(other than qualified pre-
 7 scription drug benefits)” after “benefits”;

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

10 (C) by adding after and below subpara-
 11 graph (B) the following:

12 “and may elect qualified prescription drug coverage
 13 in accordance with section 1860A.”; and

14 (2) in subsection (g)(1), by inserting “and sec-
 15 tion 1860A(c)(2)(B)” after “in this subsection”.

16 (c) EFFECTIVE DATE.—The amendments made by
 17 this section apply to coverage provided on or after January
 18 1, 2003.

19 **SEC. 103. MEDICAID AMENDMENTS.**

20 (a) DETERMINATIONS OF ELIGIBILITY FOR LOW-IN-
 21 COME SUBSIDIES.—

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

24 (A) in subsection (a)—

1 (i) by striking “and” at the end of
2 paragraph (64);

3 (ii) by striking the period at the end
4 of paragraph (65) and inserting “; and”;
5 and

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

8 “(66) provide for making eligibility determina-
9 tions under section 1935(a).”.

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

12 (A) by redesignating section 1935 as sec-
13 tion 1936; and

14 (B) by inserting after section 1934 the fol-
15 lowing new section:

16 “SPECIAL PROVISIONS RELATING TO MEDICARE
17 PRESCRIPTION DRUG BENEFIT

18 “SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGI-
19 BILITY DETERMINATIONS FOR LOW-INCOME SUB-
20 SIDIES.—As a condition of its State plan under this title
21 under section 1902(a)(66) and receipt of any Federal fi-
22 nancial assistance under section 1903(a), a State shall—

23 “(1) make determinations of eligibility for pre-
24 mium and cost-sharing subsidies under (and in ac-
25 cordance with) section 1860G;

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

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

7 “(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE
8 COSTS.—

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

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

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

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

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

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

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

17 “(2) COORDINATION.—The State shall provide
18 the Secretary with such information as may be nec-
19 essary to properly allocate administrative expendi-
20 tures described in paragraph (1) that may otherwise
21 be made for similar eligibility determinations.”.

22 (b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID
23 RESPONSIBILITY FOR PREMIUM AND COST-SHARING SUB-
24 SIDIES FOR DUALY ELIGIBLE INDIVIDUALS.—

1 (1) IN GENERAL.—Section 1903(a)(1) of the
2 Social Security Act (42 U.S.C. 1396b(a)(1)) is
3 amended by inserting before the semicolon the fol-
4 lowing: “, reduced by the amount computed under
5 section 1935(c)(1) for the State and the quarter”.

6 (2) AMOUNT DESCRIBED.—Section 1935 of
7 such Act, as inserted by subsection (a)(2), is amend-
8 ed by adding at the end the following new sub-
9 section:

10 “(c) FEDERAL ASSUMPTION OF MEDICAID PRE-
11 SCRIPTION DRUG COSTS FOR DUALY-ELIGIBLE BENE-
12 FIICIARIES.—

13 “(1) IN GENERAL.—For purposes of section
14 1903(a)(1), for a State that is one of the 50 States
15 or the District of Columbia for a calendar quarter
16 in a year (beginning with 2003) the amount com-
17 puted under this subsection is equal to the product
18 of the following:

19 “(A) MEDICARE SUBSIDIES.—The total
20 amount of payments made in the quarter under
21 section 1860G (relating to premium and cost-
22 sharing prescription drug subsidies for low-in-
23 come medicare beneficiaries) that are attrib-
24 utable to individuals who are residents of the
25 State and are entitled to benefits with respect

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

4 “(B) STATE MATCHING RATE.—A propor-
 5 tion computed by subtracting from 100 percent
 6 the Federal medical assistance percentage (as
 7 defined in section 1905(b)) applicable to the
 8 State and the quarter.

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

12 “(2) PHASE-OUT PROPORTION.—For purposes
 13 of paragraph (1)(C), the ‘phase-out proportion’ for
 14 a calendar quarter in—

15 “(A) 2003 is 80 percent;

16 “(B) 2004 is 60 percent;

17 “(C) 2005 is 40 percent;

18 “(D) 2006 is 20 percent; or

19 “(E) a year after 2006 is 0 percent.”.

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

24 “(d) ADDITIONAL PROVISIONS.—

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

12 “(2) CONDITION.—A State may require, as a
13 condition for the receipt of medical assistance under
14 this title with respect to prescription drug benefits
15 for an individual eligible to obtain qualified prescrip-
16 tion drug coverage described in paragraph (1), that
17 the individual elect qualified prescription drug cov-
18 erage under section 1860A.”.

19 (d) TREATMENT OF TERRITORIES.—

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

22 (A) in subsection (a)(1), by inserting “sub-
23 ject to subsection (e),” after “section 1903 ”;

24 (B) in subsection (c)(1), by inserting “sub-
25 ject to subsection (e),” after “1903(a)”; and

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

3 “(e) TREATMENT OF TERRITORIES.—

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

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

9 “(B) if the State establishes a plan de-
10 scribed in paragraph (2) (for providing medical
11 assistance with respect to the provision of pre-
12 scription drugs to medicare beneficiaries), the
13 amount otherwise determined under section
14 1108(f) (as increased under section 1108(g))
15 for the State shall be increased by the amount
16 specified in paragraph (3).

17 “(2) PLAN.—The plan described in this para-
18 graph is a plan that—

19 “(A) provides medical assistance with re-
20 spect to the provision of covered outpatient
21 drugs (as defined in section 1860B(f)) to low-
22 income medicare beneficiaries; and

23 “(B) assures that additional amounts re-
24 ceived by the State that are attributable to the

1 operation of this subsection are used only for
2 such assistance.

3 “(3) INCREASED AMOUNT.—

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

7 “(i) the aggregate amount specified in
8 subparagraph (B); and

9 “(ii) the amount specified in section
10 1108(g)(1) for that State, divided by the
11 sum of the amounts specified in such sec-
12 tion for all such States.

13 “(B) AGGREGATE AMOUNT.—The aggre-
14 gate amount specified in this subparagraph
15 for—

16 “(i) 2003, is equal to \$20,000,000; or

17 “(ii) a subsequent year, is equal to the
18 aggregate amount specified in this sub-
19 paragraph for the previous year increased
20 by annual percentage increase specified in
21 section 1860(b)(5) for the year involved.

22 “(4) REPORT.—The Secretary shall submit to
23 Congress a report on the application of this sub-
24 section and may include in the report such rec-
25 ommendations as the Secretary deems appropriate.”.

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

5 **SEC. 104. MEDIGAP TRANSITION PROVISIONS.**

6 (a) IN GENERAL.—Notwithstanding any other provi-
7 sion of law, no new medicare supplemental policy that pro-
8 vides coverage of expenses for prescription drugs may be
9 issued under section 1882 of the Social Security Act on
10 or after January 1, 2003, to an individual unless it re-
11 places a medicare supplemental policy that was issued to
12 that individual and that provided some coverage of ex-
13 penses for prescription drugs.

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

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

18 (A) may not deny or condition the issuance
19 or effectiveness of a medicare supplemental poli-
20 cy that has a benefit package classified as “A”,
21 “B”, “C”, “D”, “E”, “F”, or “G” (under the
22 standards established under subsection (p)(2) of
23 section 1882 of the Social Security Act, 42
24 U.S.C. 1395ss) and that is offered and is avail-

1 able for issuance to new enrollees by such
2 issuer;

3 (B) may not discriminate in the pricing of
4 such policy, because of health status, claims ex-
5 perience, receipt of health care, or medical con-
6 dition; and

7 (C) may not impose an exclusion of bene-
8 fits based on a pre-existing condition under
9 such policy,

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

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

19 (A) enrolls in a prescription drug plan
20 under part D of title XVIII of the Social Secu-
21 rity Act; and

22 (B) at the time of such enrollment was en-
23 rolled and terminates enrollment in a medicare
24 supplemental policy which has a benefit pack-
25 age classified as “H”, “I”, or “J” under the

1 standards referred to in paragraph (1)(A) or
2 terminates enrollment in a policy to which such
3 standards do not apply but which provides ben-
4 efits for prescription drugs.

5 (3) ENFORCEMENT.—The provisions of para-
6 graph (1) shall be enforced as though they were in-
7 cluded in section 1882(s) of the Social Security Act
8 (42 U.S.C. 1395ss(s)).

9 (4) DEFINITIONS.—For purposes of this sub-
10 section, the term “medicare supplemental policy”
11 has the meaning given such term in section 1882(g)
12 of the Social Security Act (42 U.S.C. 1395ss(g)).

13 **TITLE II—MODERNIZATION OF**
14 **ADMINISTRATION OF MEDICARE**
15 **Subtitle A—Medicare Benefits**
16 **Administration**

17 **SEC. 201. ESTABLISHMENT OF ADMINISTRATION.**

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

21 “MEDICARE BENEFITS ADMINISTRATION

22 “SEC. 1807. (a) ESTABLISHMENT.—There is estab-
23 lished within the Department of Health and Human Serv-
24 ices an agency to be known as the Medicare Benefits Ad-
25 ministration.

1 “(b) ADMINISTRATOR AND DEPUTY ADMINIS-
2 TRATOR.—

3 “(1) ADMINISTRATOR.—

4 “(A) IN GENERAL.—The Medicare Bene-
5 fits Administration shall be headed by an Ad-
6 ministrator (in this section referred to as the
7 ‘Administrator’) who shall be appointed by the
8 President, by and with the advice and consent
9 of the Senate. The Administrator shall be in di-
10 rect line of authority to the Secretary.

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

15 “(C) TERM OF OFFICE.—The Adminis-
16 trator shall be appointed for a term of 5 years.
17 In any case in which a successor does not take
18 office at the end of an Administrator’s term of
19 office, that Administrator may continue in of-
20 fice until the entry upon office of such a suc-
21 cesssor. An Administrator appointed to a term of
22 office after the commencement of such term
23 may serve under such appointment only for the
24 remainder of such term.

1 “(D) GENERAL AUTHORITY.—The Admin-
2 istrator shall be responsible for the exercise of
3 all powers and the discharge of all duties of the
4 Administration, and shall have authority and
5 control over all personnel and activities thereof.

6 “(E) RULEMAKING AUTHORITY.—The Ad-
7 ministrator may prescribe such rules and regu-
8 lations as the Administrator determines nec-
9 essary or appropriate to carry out the functions
10 of the Administration. The regulations pre-
11 scribed by the Administrator shall be subject to
12 the rulemaking procedures established under
13 section 553 of title 5, United States Code.

14 “(F) AUTHORITY TO ESTABLISH ORGANI-
15 ZATIONAL UNITS.—The Administrator may es-
16 tablish, alter, consolidate, or discontinue such
17 organizational units or components within the
18 Administration as the Administrator considers
19 necessary or appropriate, except that this sub-
20 paragraph shall not apply with respect to any
21 unit, component, or provision provided for by
22 this section.

23 “(G) AUTHORITY TO DELEGATE.—The Ad-
24 ministrator may assign duties, and delegate, or
25 authorize successive redelegations of, authority

1 to act and to render decisions, to such officers
2 and employees of the Administration as the Ad-
3 ministrator may find necessary. Within the lim-
4 itations of such delegations, redelegations, or
5 assignments, all official acts and decisions of
6 such officers and employees shall have the same
7 force and effect as though performed or ren-
8 dered by the Administrator.

9 “(2) DEPUTY ADMINISTRATOR.—

10 “(A) IN GENERAL.—There shall be a Dep-
11 uty Administrator of the Medicare Benefits Ad-
12 ministration who shall be appointed by the
13 President, by and with the advice and consent
14 of the Senate.

15 “(B) COMPENSATION.—The Deputy Ad-
16 ministrator shall be paid at the rate of basic
17 pay payable for level IV of the Executive Sched-
18 ule under section 5315 of title 5, United States
19 Code.

20 “(C) TERM OF OFFICE.—The Deputy Ad-
21 ministrator shall be appointed for a term of 5
22 years. In any case in which a successor does not
23 take office at the end of a Deputy Administra-
24 tor’s term of office, such Deputy Administrator
25 may continue in office until the entry upon of-

1 fice of such a successor. A Deputy Adminis-
2 trator appointed to a term of office after the
3 commencement of such term may serve under
4 such appointment only for the remainder of
5 such term.

6 “(D) DUTIES.—The Deputy Administrator
7 shall perform such duties and exercise such
8 powers as the Administrator shall from time to
9 time assign or delegate. The Deputy Adminis-
10 trator shall be Acting Administrator of the Ad-
11 ministration during the absence or disability of
12 the Administrator and, unless the President
13 designates another officer of the Government as
14 Acting Administrator, in the event of a vacancy
15 in the office of the Administrator.

16 “(3) SECRETARIAL COORDINATION OF PROGRAM
17 ADMINISTRATION.—The Secretary shall ensure ap-
18 propriate coordination between the Administrator
19 and the Administrator of the Health Care Financing
20 Administration in carrying out the programs under
21 this title.

22 “(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

23 “(1) DUTIES.—

1 “(A) GENERAL DUTIES.—The Adminis-
2 trator shall carry out parts C and D,
3 including—

4 “(i) negotiating, entering into, and en-
5 forcing, contracts with plans for the offer-
6 ing of Medicare+Choice plans under part
7 C, including the offering of qualified pre-
8 scription drug coverage under such plans;
9 and

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

14 “(B) OTHER DUTIES.—The Administrator
15 shall carry out any duty provided for under
16 part C or part D, including demonstration
17 projects carried out in part or in whole under
18 such parts, the programs of all-inclusive care
19 for the elderly (PACE program) under section
20 1894, the social health maintenance organiza-
21 tion (SHMO) demonstration projects (referred
22 to in section 4104(c) of the Balanced Budget
23 Act of 1997), and through a Medicare+Choice
24 project that demonstrates the application of
25 capitation payment rates for frail elderly medi-

1 care beneficiaries through the use of a inter-
2 disciplinary team and through the provision of
3 primary care services to such beneficiaries by
4 means of such a team at the nursing facility in-
5 volved).

6 “(C) ANNUAL REPORTS.—Not later March
7 31 of each year, the Administrator shall submit
8 to Congress and the President a report on the
9 administration of parts C and D during the
10 previous fiscal year.

11 “(2) STAFF.—

12 “(A) IN GENERAL.—The Administrator,
13 with the approval of the Secretary, may employ,
14 without regard to chapter 31 of title 5, United
15 States Code, such officers and employees as are
16 necessary to administer the activities to be car-
17 ried out through the Medicare Benefits Admin-
18 istration.

19 “(B) FLEXIBILITY WITH RESPECT TO
20 CIVIL SERVICE LAWS.—

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

1 and, subject to clause (ii), shall be paid
2 without regard to the provisions of chapter
3 51 and chapter 53 of such title (relating to
4 classification and schedule pay rates).

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

11 “(3) REDELEGATION OF CERTAIN FUNCTIONS
12 OF THE HEALTH CARE FINANCING ADMINISTRA-
13 TION.—

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

23 “(B) TRANSFER OF DATA AND INFORMA-
24 TION.—The Secretary shall ensure that the Ad-
25 ministrator of the Health Care Financing Ad-

1 ministration transfers to the Administrator of
2 the Medicare Benefits Administration such in-
3 formation and data in the possession of the Ad-
4 ministrator of the Health Care Financing Ad-
5 ministration as the Administrator of the Medi-
6 care Benefits Administration requires to carry
7 out the duties described in paragraph (1).

8 “(C) CONSTRUCTION.—Insofar as a re-
9 sponsibility of the Secretary or the Adminis-
10 trator of the Health Care Financing Adminis-
11 tration is redelegated to the Administrator
12 under this section, any reference to the Sec-
13 retary or the Administrator of the Health Care
14 Financing Administration in this title or title
15 XI with respect to such responsibility is deemed
16 to be a reference to the Administrator.

17 “(d) OFFICE OF BENEFICIARY ASSISTANCE.—

18 “(1) ESTABLISHMENT.—The Secretary shall es-
19 tablish within the Medicare Benefits Administration
20 an Office of Beneficiary Assistance to carry out
21 functions relating to medicare beneficiaries under
22 this title, including making determinations of eligi-
23 bility of individuals for benefits under this title, pro-
24 viding for enrollment of medicare beneficiaries under
25 this title, and the functions described in paragraph

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

3 “(2) DISSEMINATION OF INFORMATION ON
4 BENEFITS AND APPEALS RIGHTS.—

5 “(A) DISSEMINATION OF BENEFITS INFOR-
6 MATION.—The Office of Beneficiary Assistance
7 shall disseminate to medicare beneficiaries, by
8 mail, by posting on the Internet site of the
9 Medicare Benefits Administration and through
10 the toll-free telephone number provided for
11 under section 1804(b), information with respect
12 to the following:

13 “(i) Benefits, and limitations on pay-
14 ment (including cost-sharing, stop-loss pro-
15 visions, and formulary restrictions) under
16 parts C and D.

17 “(ii) Benefits, and limitations on pay-
18 ment under parts A and B, including in-
19 formation on medicare supplemental poli-
20 cies under section 1882.

21 Such information shall be presented in a man-
22 ner so that medicare beneficiaries may compare
23 benefits under parts A, B, D, and medicare
24 supplemental policies with benefits under
25 Medicare+Choice plans under part C.

1 “(B) DISSEMINATION OF APPEALS RIGHTS
2 INFORMATION.—The Office of Beneficiary As-
3 sistance shall disseminate to medicare bene-
4 ficiaries in the manner provided under subpara-
5 graph (A) a description of procedural rights (in-
6 cluding grievance and appeals procedures) of
7 beneficiaries under the original medicare fee-
8 for-service program under parts A and B, the
9 Medicare+Choice program under part C, and
10 the Voluntary Prescription Drug Benefit Pro-
11 gram under part D.

12 “(3) MEDICARE OMBUDSMAN.—

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

20 “(B) DUTIES.—The Medicare Ombudsman
21 shall—

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

1 “(ii) provide assistance with respect to
2 complaints, grievances, and requests re-
3 ferred to in clause (i), including—

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

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

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

1 “(C) COORDINATION WITH STATE OM-
2 BUDSMAN PROGRAMS AND CONSUMER ORGANI-
3 ZATIONS.—The Medicare Ombudsman shall, to
4 the extent appropriate, coordinate with State
5 medical Ombudsman programs, and with State-
6 and community-based consumer organizations,
7 to—

8 “(i) provide information about the
9 medicare program; and

10 “(ii) conduct outreach to educate
11 medicare beneficiaries with respect to man-
12 ners in which problems under the medicare
13 program may be resolved or avoided.

14 “(e) MEDICARE POLICY ADVISORY BOARD.—

15 “(1) ESTABLISHMENT.—There is established
16 within the Medicare Benefits Administration the
17 Medicare Policy Advisory Board (in this section re-
18 ferred to the ‘Board’). The Board shall advise, con-
19 sult with, and make recommendations to the Admin-
20 istrator of the Medicare Benefits Administration
21 with respect to the administration of parts C and D,
22 including the review of payment policies under such
23 parts.

24 “(2) REPORTS.—

1 “(A) IN GENERAL.—With respect to mat-
2 ters of the administration of parts C and D, the
3 Board shall submit to Congress and to the Ad-
4 ministrator of the Medicare Benefits Adminis-
5 tration such reports as the Board determines
6 appropriate. Each such report may contain such
7 recommendations as the Board determines ap-
8 propriate for legislative or administrative
9 changes to improve the administration of such
10 parts, including the topics described in subpara-
11 graph (B). Each such report shall be published
12 in the Federal Register.

13 “(B) TOPICS DESCRIBED.—Reports re-
14 quired under subparagraph (A) may include the
15 following topics:

16 “(i) FOSTERING COMPETITION.—Rec-
17 ommendations or proposals to increase
18 competition under parts C and D for serv-
19 ices furnished to medicare beneficiaries.

20 “(ii) EDUCATION AND ENROLL-
21 MENT.—Recommendations for the im-
22 provement to efforts to provide medicare
23 beneficiaries information and education on
24 the program under this title, and specifi-

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

3 “(iii) IMPLEMENTATION OF RISK-AD-
4 JUSTMENT.—Evaluation of the implemen-
5 tation under section 1853(a)(3)(C) of the
6 risk adjustment methodology to payment
7 rates under that section to
8 Medicare+Choice organizations offering
9 Medicare+Choice plans that accounts for
10 variations in per capita costs based on
11 health status and other demographic fac-
12 tors.

13 “(iv) DISEASE MANAGEMENT PRO-
14 GRAMS.—Recommendations on the incor-
15 poration of disease management programs
16 under parts C and D.

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

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

10 “(4) MEMBERSHIP.—

11 “(A) APPOINTMENT.—Subject to the suc-
12 ceeding provisions of this paragraph, the Board
13 shall consist of 7 members to be appointed as
14 follows:

15 “(i) 3 members shall be appointed by
16 the President.

17 “(ii) 2 members shall be appointed by
18 the Speaker of the House of Representa-
19 tives, with the advice of the chairman and
20 the ranking minority member of the Com-
21 mittees on Ways and Means and on Com-
22 merce of the House of Representatives.

23 “(iii) 2 members shall be appointed by
24 the President pro tempore of the Senate
25 with the advice of the chairman and the

1 ranking minority member of the Senate
2 Committee on Finance.

3 “(B) QUALIFICATIONS.—The members
4 shall be chosen on the basis of their integrity,
5 impartiality, and good judgment, and shall be
6 individuals who are, by reason of their edu-
7 cation and experience in health care benefits
8 management, exceptionally qualified to perform
9 the duties of members of the Board.

10 “(C) PROHIBITION ON INCLUSION OF FED-
11 ERAL EMPLOYEES.—No officer or employee of
12 the United States may serve as a member of
13 the Board.

14 “(5) COMPENSATION.—Members of the Board
15 shall receive, for each day (including travel time)
16 they are engaged in the performance of the functions
17 of the board, compensation at rates not to exceed
18 the daily equivalent to the annual rate in effect for
19 level IV of the Executive Schedule under section
20 5315 of title 5, United States Code.

21 “(6) TERMS OF OFFICE.—

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

1 “(B) TERMS OF INITIAL APPOINTEES.—As
2 designated by the President at the time of ap-
3 pointment, of the members first appointed—

4 “(i) 1 shall be appointed for a term of
5 1 year;

6 “(ii) 3 shall be appointed for terms of
7 2 years; and

8 “(iii) 3 shall be appointed for terms of
9 3 years.

10 “(C) REAPPOINTMENTS.—Any person ap-
11 pointed as a member of the Board may not
12 serve for more than 8 years.

13 “(D) VACANCY.—Any member appointed
14 to fill a vacancy occurring before the expiration
15 of the term for which the member’s predecessor
16 was appointed shall be appointed only for the
17 remainder of that term. A member may serve
18 after the expiration of that member’s term until
19 a successor has taken office. A vacancy in the
20 Board shall be filled in the manner in which the
21 original appointment was made.

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

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

4 “(9) DIRECTOR AND STAFF.—

5 “(A) APPOINTMENT OF DIRECTOR.—The
6 Board shall have a Director who shall be ap-
7 pointed by the Chair.

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

12 “(C) FLEXIBILITY IN APPLICATION OF
13 CIVIL SERVICE LAWS.—

14 “(i) IN GENERAL.—The Director and
15 staff of the Board shall be appointed with-
16 out regard to the provisions of chapter 31
17 of title 5, United States Code, governing
18 appointments in the competitive service,
19 and, subject to clause (ii), shall be paid
20 without regard to the provisions of chap-
21 ters 51 and 53 of such title (relating to
22 classification and General Schedule pay
23 rates).

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

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

5 “(D) ASSISTANCE FROM THE ADMINIS-
6 TRATOR OF THE MEDICARE BENEFITS ADMINIS-
7 TRATION.—The Administrator of the Medicare
8 Benefits Administration shall make available to
9 the Board such information and other assist-
10 ance as it may require to carry out its func-
11 tions.

12 “(10) CONTRACT AUTHORITY.—The Board may
13 contract with and compensate government and pri-
14 vate agencies or persons to carry out its duties
15 under this subsection, without regard to section
16 3709 of the Revised Statutes (41 U.S.C. 5).

17 “(f) FUNDING.—There is authorized to be appro-
18 priated, in appropriate part from the Federal Hospital In-
19 surance Trust Fund and from the Federal Supplementary
20 Medical Insurance Trust Fund (including the Medicare
21 Prescription Drug Account), such sums as are necessary
22 to carry out this section.”.

23 (b) EFFECTIVE DATE.—

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

4 (2) TIMING OF INITIAL APPOINTMENTS.—The
5 Administrator and Deputy Administrator of the
6 Medicare Benefits Administration may not be ap-
7 pointed before March 1, 2001.

8 (3) DUTIES WITH RESPECT TO ELIGIBILITY DE-
9 TERMINATIONS AND ENROLLMENT.—The Adminis-
10 trator of the Medicare Benefits Administration shall
11 carry out enrollment under title XVIII of the Social
12 Security Act, make eligibility determinations under
13 such title, and carry out part C of such title for
14 years beginning or after January 1, 2003.

15 **SEC. 202. MISCELLANEOUS ADMINISTRATIVE PROVISIONS.**

16 (a) ADMINISTRATOR AS MEMBER OF THE BOARD OF
17 TRUSTEES OF THE MEDICARE TRUST FUNDS.—Section
18 1817(b) and section 1841(b) of the Social Security Act
19 (42 U.S.C. 1395i(b), 1395t(b)) are each amended by
20 striking “and the Secretary of Health and Human Serv-
21 ices, all ex officio,” and inserting “, the Secretary of
22 Health and Human Services, and the Administrator of the
23 Medicare Benefits Administration, all ex officio,”.

1 (b) INCREASE IN GRADE TO EXECUTIVE LEVEL III
 2 FOR THE ADMINISTRATOR OF THE HEALTH CARE FI-
 3 NANCING ADMINISTRATION.—

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

7 “Administrator of the Health Care Financing
 8 Administration.”.

9 (2) CONFORMING AMENDMENT.—Section 5315
 10 of such title is amended by striking “Administrator
 11 of the Health Care Financing Administration.”.

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

14 **Subtitle B—Oversight of Financial**
 15 **Sustainability of the Medicare**
 16 **Program**

17 **SEC. 211. ADDITIONAL REQUIREMENTS FOR ANNUAL FI-**
 18 **NANCIAL REPORT AND OVERSIGHT ON MEDI-**
 19 **CARE PROGRAM.**

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

23 “(1) COMBINED REPORT ON OPERATION AND STATUS
 24 OF THE TRUST FUND AND THE FEDERAL SUPPLE-
 25 MENTARY MEDICAL INSURANCE TRUST FUND.—

1 “(1) IN GENERAL.—In addition to the duty of
2 the Board of Trustees to report to Congress under
3 subsection (b), on the date the Board submits the
4 report required under subsection (b)(2), the Board
5 shall submit to Congress a report on the operation
6 and status of the Trust Fund and the Federal Sup-
7 plementary Medical Insurance Trust Fund estab-
8 lished under section 1841 (in this subsection re-
9 ferred to as the ‘Trust Funds’). Such report shall
10 included the following information:

11 “(A) OVERALL SPENDING FROM THE GEN-
12 ERAL FUND OF THE TREASURY.—A statement
13 of total amounts obligated during the preceding
14 fiscal year from the General Revenues of the
15 Treasury to the Trust Funds for payment for
16 benefits covered under this title, stated in terms
17 of the total amount and in terms of the per-
18 centage such amount bears to all other amounts
19 obligated from such General Revenues during
20 such fiscal year.

21 “(B) HISTORICAL OVERVIEW OF SPEND-
22 ING.—From the date of the inception of the
23 program of insurance under this title through
24 the fiscal year involved, a statement of the total
25 amounts referred to in subparagraph (A).

1 “(C) 10-YEAR AND 50-YEAR PROJEC-
2 TIONS.—An estimate of total amounts referred
3 to in subparagraph (A) required to be obligated
4 for payment for benefits covered under this title
5 for each of the 10 fiscal years succeeding the
6 fiscal year involved and for the 50-year period
7 beginning with the succeeding fiscal year.

8 “(D) RELATION TO GDP GROWTH.—A
9 comparison of the rate of growth of the total
10 amounts referred to in subparagraph (A) to the
11 rate of growth in the gross domestic product for
12 the same period.

13 “(2) PUBLICATION.—Each report submitted
14 under paragraph (1) shall be published by the Com-
15 mittee on Ways and Means as a public document
16 and shall be made available by such Committee on
17 the Internet.”.

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

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

1 **Subtitle C—Changes in Medicare**
2 **Coverage and Appeals Process**

3 **SEC. 221. REVISIONS TO MEDICARE APPEALS PROCESS.**

4 (a) CONDUCT OF RECONSIDERATIONS OF DETER-
5 MINATIONS BY INDEPENDENT CONTRACTORS.—Section
6 1869 of the Social Security Act (42 U.S.C. 1395ff) is
7 amended to read as follows:

8 “DETERMINATIONS; APPEALS

9 “SEC. 1869. (a) INITIAL DETERMINATIONS.—The
10 Secretary shall promulgate regulations and make initial
11 determinations with respect to benefits under part A or
12 part B in accordance with those regulations for the fol-
13 lowing:

14 “(1) The initial determination of whether an in-
15 dividual is entitled to benefits under such parts.

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

18 “(3) Any other initial determination with re-
19 spect to a claim for benefits under such parts, in-
20 cluding an initial determination by the Secretary
21 that payment may not be made, or may no longer
22 be made, for an item or service under such parts, an
23 initial determination made by a utilization and qual-
24 ity control peer review organization under section
25 1154(a)(2), and an initial determination made by an

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

3 “(b) APPEAL RIGHTS.—

4 “(1) IN GENERAL.—

5 “(A) RECONSIDERATION OF INITIAL DE-
6 TERMINATION.—Subject to subparagraph (D),
7 any individual dissatisfied with any initial de-
8 termination under subsection (a) shall be enti-
9 tled to reconsideration of the determination,
10 and, subject to subparagraphs (D) and (E), a
11 hearing thereon by the Secretary to the same
12 extent as is provided in section 205(b) and to
13 judicial review of the Secretary’s final decision
14 after such hearing as is provided in section
15 205(g).

16 “(B) REPRESENTATION BY PROVIDER OR
17 SUPPLIER.—

18 “(i) IN GENERAL.—Sections 206(a),
19 1102, and 1871 shall not be construed as
20 authorizing the Secretary to prohibit an in-
21 dividual from being represented under this
22 section by a person that furnishes or sup-
23 plies the individual, directly or indirectly,
24 with services or items, solely on the basis

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

3 “(ii) MANDATORY WAIVER OF RIGHT
4 TO PAYMENT FROM BENEFICIARY.—Any
5 person that furnishes services or items to
6 an individual may not represent an indi-
7 vidual under this section with respect to
8 the issue described in section 1879(a)(2)
9 unless the person has waived any rights for
10 payment from the beneficiary with respect
11 to the services or items involved in the ap-
12 peal.

13 “(iii) PROHIBITION ON PAYMENT FOR
14 REPRESENTATION.—If a person furnishes
15 services or items to an individual and rep-
16 resents the individual under this section,
17 the person may not impose any financial li-
18 ability on such individual in connection
19 with such representation.

20 “(iv) REQUIREMENTS FOR REP-
21 REPRESENTATIVES OF A BENEFICIARY.—The
22 provisions of section 205(j) and section
23 206 (regarding representation of claim-
24 ants) shall apply to representation of an
25 individual with respect to appeals under

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

4 “(C) SUCCESSION OF RIGHTS IN CASES OF
5 ASSIGNMENT.—The right of an individual to an
6 appeal under this section with respect to an
7 item or service may be assigned to the provider
8 of services or supplier of the item or service
9 upon the written consent of such individual
10 using a standard form established by the Sec-
11 retary for such an assignment.

12 “(D) TIME LIMITS FOR APPEALS.—

13 “(i) RECONSIDERATIONS.—Reconsid-
14 eration under subparagraph (A) shall be
15 available only if the individual described
16 subparagraph (A) files notice with the Sec-
17 retary to request reconsideration by not
18 later than 180 days after the individual re-
19 ceives notice of the initial determination
20 under subsection (a) or within such addi-
21 tional time as the Secretary may allow.

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

1 accordance with provisions in sections 205
2 and 206.

3 “(E) AMOUNTS IN CONTROVERSY.—

4 “(i) IN GENERAL.—A hearing (by the
5 Secretary) shall not be available to an indi-
6 vidual under this section if the amount in
7 controversy is less than \$100, and judicial
8 review shall not be available to the indi-
9 vidual if the amount in controversy is less
10 than \$1,000.

11 “(ii) AGGREGATION OF CLAIMS.—In
12 determining the amount in controversy, the
13 Secretary, under regulations, shall allow 2
14 or more appeals to be aggregated if the ap-
15 peals involve—

16 “(I) the delivery of similar or re-
17 lated services to the same individual
18 by one or more providers of services
19 or suppliers, or

20 “(II) common issues of law and
21 fact arising from services furnished to
22 2 or more individuals by one or more
23 providers of services or suppliers.

24 “(F) EXPEDITED PROCEEDINGS.—

1 “(i) EXPEDITED DETERMINATION.—

2 In the case of an individual who—

3 “(I) has received notice by a pro-
4 vider of services that the provider of
5 services plans to terminate services
6 provided to an individual and a physi-
7 cian certifies that failure to continue
8 the provision of such services is likely
9 to place the individual’s health at sig-
10 nificant risk, or

11 “(II) has received notice by a
12 provider of services that the provider
13 of services plans to discharge the indi-
14 vidual from the provider of services,
15 the individual may request, in writing or
16 orally, an expedited determination or an
17 expedited reconsideration of an initial de-
18 termination made under subsection (a), as
19 the case may be, and the Secretary shall
20 provide such expedited determination or
21 expedited reconsideration.

22 “(ii) EXPEDITED HEARING.—In a
23 hearing by the Secretary under this sec-
24 tion, in which the moving party alleges
25 that no material issues of fact are in dis-

1 pute, the Secretary shall make an expedited determination as to whether any such
2 facts are in dispute and, if not, shall
3 render a decision expeditiously.
4

5 “(G) REOPENING AND REVISION OF DETERMINATIONS.—The Secretary may reopen or
6 revise any initial determination or reconsidered
7 determination described in this subsection
8 under guidelines established by the Secretary in
9 regulations.
10

11 “(2) REVIEW OF COVERAGE DETERMINATIONS.—
12

13 “(A) NATIONAL COVERAGE DETERMINATIONS.—
14

15 “(i) IN GENERAL.—Review of any national coverage determination shall be subject to the following limitations:
16
17

18 “(I) Such a determination shall
19 not be reviewed by any administrative
20 law judge.

21 “(II) Such a determination shall
22 not be held unlawful or set aside on
23 the ground that a requirement of section 553 of title 5, United States
24 Code, or section 1871(b) of this title,
25

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

4 “(III) Upon the filing of a com-
5 plaint by an aggrieved party, such a
6 determination shall be reviewed by the
7 Departmental Appeals Board of the
8 Department of Health and Human
9 Services. In conducting such a review,
10 the Departmental Appeals Board shall
11 review the record and shall permit dis-
12 covery and the taking of evidence to
13 evaluate the reasonableness of the de-
14 termination. In reviewing such a de-
15 termination, the Departmental Ap-
16 peals Board shall defer only to the
17 reasonable findings of fact, reasonable
18 interpretations of law, and reasonable
19 applications of fact to law by the Sec-
20 retary.

21 “(IV) A decision of the Depart-
22 mental Appeals Board constitutes a
23 final agency action and is subject to
24 judicial review.

1 “(ii) DEFINITION OF NATIONAL COV-
2 ERAGE DETERMINATION.—For purposes of
3 this section, the term ‘national coverage
4 determination’ means a determination by
5 the Secretary respecting whether or not a
6 particular item or service is covered under
7 this title, including such a determination
8 under 1862(a)(1).

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

15 “(i) Upon the filing of a complaint by an
16 aggrieved party, such a determination shall be
17 reviewed by an administrative law judge of the
18 Social Security Administration. The administra-
19 tive law judge shall review the record and shall
20 permit discovery and the taking of evidence to
21 evaluate the reasonableness of the determina-
22 tion. In reviewing such a determination, the ad-
23 ministrative law judge shall defer only to the
24 reasonable findings of fact, reasonable interpre-

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

3 “(ii) Such a determination may be re-
4 viewed by the Departmental Appeals Board of
5 the Department of Health and Human Services.

6 “(iii) A decision of the Departmental Ap-
7 peals Board constitutes a final agency action
8 and is subject to judicial review.

9 “(C) NO MATERIAL ISSUES OF FACT IN DIS-
10 PUTE.—In the case of review of a determination
11 under subparagraph (A)(i)(III) or (B)(i) where the
12 moving party alleges that there are no material
13 issues of fact in dispute, and alleges that the only
14 issue is the constitutionality of a provision of this
15 title, or that a regulation, determination, or ruling
16 by the Secretary is invalid, the moving party may
17 seek review by a court of competent jurisdiction.

18 “(D) PENDING NATIONAL COVERAGE DETER-
19 MINATIONS.—

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

1 spect to such items or services. By not later
2 than the end of the 90-day period beginning on
3 the date the Secretary receives such a request,
4 the Secretary shall take one of the following ac-
5 tions:

6 “(I) Issue a national coverage deter-
7 mination, with or without limitations.

8 “(II) Issue a national noncoverage de-
9 termination.

10 “(III) Issue a determination that no
11 national coverage or noncoverage deter-
12 mination is appropriate as of the end of
13 such 90-day period with respect to national
14 coverage of such items or services.

15 “(IV) Issue a notice that states that
16 the Secretary has not completed a review
17 of the national coverage determination and
18 that includes an identification of the re-
19 maining steps in the Secretary’s review
20 process and a deadline by which the Sec-
21 retary will complete the review and take an
22 action described in subclause (I), (II), or
23 (III).

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

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

6 “(iii) When issuing a determination under
7 clause (i), the Secretary shall include an expla-
8 nation of the basis for the determination. An
9 action taken under clause (i) (other than sub-
10 clause (IV)) is deemed to be a national coverage
11 determination for purposes of review under sub-
12 paragraph (A).

13 “(3) PUBLICATION ON THE INTERNET OF DECI-
14 SIONS OF HEARINGS OF THE SECRETARY.—Each de-
15 cision of a hearing by the Secretary shall be made
16 public, and the Secretary shall publish each decision
17 on the Medicare Internet site of the Department of
18 Health and Human Services. The Secretary shall re-
19 move from such decision any information that would
20 identify any individual, provider of services, or sup-
21 plier.

22 “(4) LIMITATION ON REVIEW OF CERTAIN REG-
23 ULATIONS.—A regulation or instruction which re-
24 lates to a method for determining the amount of
25 payment under part B and which was initially issued

1 before January 1, 1981, shall not be subject to judi-
2 cial review.

3 “(5) STANDING.—An action under this section
4 seeking review of a coverage determination (with re-
5 spect to items and services under this title) may be
6 initiated only by one (or more) of the following ag-
7 grieved persons, or classes of persons:

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

12 “(B) Persons, or classes of persons, who
13 make, manufacture, offer, supply, make avail-
14 able, or provide such items and services.

15 “(c) CONDUCT OF RECONSIDERATIONS BY INDE-
16 PENDENT CONTRACTORS.—

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

24 “(2) QUALIFIED INDEPENDENT CON-
25 TRACTOR.—For purposes of this subsection, the

1 term ‘qualified independent contractor’ means an en-
2 tity or organization that is independent of any orga-
3 nization under contract with the Secretary that
4 makes initial determinations under subsection (a),
5 and that meets the requirements established by the
6 Secretary consistent with paragraph (3).

7 “(3) REQUIREMENTS.—Any qualified inde-
8 pendent contractor entering into a contract with the
9 Secretary under this subsection shall meet the fol-
10 lowing requirements:

11 “(A) IN GENERAL.—The qualified inde-
12 pendent contractor shall perform such duties
13 and functions and assume such responsibilities
14 as may be required under regulations of the
15 Secretary promulgated to carry out the provi-
16 sions of this subsection, and such additional du-
17 ties, functions, and responsibilities as provided
18 under the contract.

19 “(B) DETERMINATIONS.—The qualified
20 independent contractor shall determine, on the
21 basis of such criteria, guidelines, and policies
22 established by the Secretary and published
23 under subsection (d)(2)(D), whether payment
24 shall be made for items or services under part
25 A or part B and the amount of such payment.

1 Such determination shall constitute the conclu-
2 sive determination on those issues for purposes
3 of payment under such parts for fiscal inter-
4 mediaries, carriers, and other entities whose de-
5 terminations are subject to review by the con-
6 tractor; except that payment may be made if—

7 “(i) such payment is allowed by rea-
8 son of section 1879;

9 “(ii) in the case of inpatient hospital
10 services or extended care services, the
11 qualified independent contractor deter-
12 mines that additional time is required in
13 order to arrange for postdischarge care,
14 but payment may be continued under this
15 clause for not more than 2 days, and only
16 in the case in which the provider of such
17 services did not know and could not rea-
18 sonably have been expected to know (as de-
19 termined under section 1879) that pay-
20 ment would not otherwise be made for
21 such services under part A or part B prior
22 to notification by the qualified independent
23 contractor under this subsection;

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

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

3 “(iv) such payment is authorized
4 under section 1861(v)(1)(G).

5 “(C) DEADLINES FOR DECISIONS.—

6 “(i) DETERMINATIONS.—The quali-
7 fied independent contractor shall conduct
8 and conclude a determination under sub-
9 paragraph (B) or an appeal of an initial
10 determination, and mail the notice of the
11 decision by not later than the end of the
12 45-day period beginning on the date a re-
13 quest for reconsideration has been timely
14 filed.

15 “(ii) CONSEQUENCES OF FAILURE TO
16 MEET DEADLINE.—In the case of a failure
17 by the qualified independent contractor to
18 mail the notice of the decision by the end
19 of the period described in clause (i), the
20 party requesting the reconsideration or ap-
21 peal may request a hearing before an ad-
22 ministrative law judge, notwithstanding
23 any requirements for a reconsidered deter-
24 mination for purposes of the party’s right
25 to such hearing.

1 “(iii) EXPEDITED RECONSIDER-
2 ATIONS.—The qualified independent con-
3 tractor shall perform an expedited recon-
4 sideration under subsection (b)(1)(F) of a
5 notice from a provider of services or sup-
6 plier that payment may not be made for an
7 item or service furnished by the provider of
8 services or supplier, of a decision by a pro-
9 vider of services to terminate services fur-
10 nished to an individual, or of a decision of
11 the provider of services to discharge the in-
12 dividual from the provider of services, in
13 accordance with the following:

14 “(I) DEADLINE FOR DECISION.—

15 Notwithstanding section 216(j), not
16 later than 1 day after the date the
17 qualified independent contractor has
18 received a request for such reconsider-
19 ation and has received such medical
20 or other records needed for such re-
21 consideration, the qualified inde-
22 pendent contractor shall provide no-
23 tice (by telephone and in writing) to
24 the individual and the provider of
25 services and attending physician of

1 the individual of the results of the re-
2 consideration. Such reconsideration
3 shall be conducted regardless of
4 whether the provider of services or
5 supplier will charge the individual for
6 continued services or whether the indi-
7 vidual will be liable for payment for
8 such continued services.

9 “(II) CONSULTATION WITH BEN-
10 EFICIARY.—In such reconsideration,
11 the qualified independent contractor
12 shall solicit the views of the individual
13 involved.

14 “(D) LIMITATION ON INDIVIDUAL REVIEW-
15 ING DETERMINATIONS.—

16 “(i) PHYSICIANS.—No physician
17 under the employ of a qualified inde-
18 pendent contractor may review—

19 “(I) determinations regarding
20 health care services furnished to a pa-
21 tient if the physician was directly re-
22 sponsible for furnishing such services;
23 or

24 “(II) determinations regarding
25 health care services provided in or by

1 an institution, organization, or agen-
2 cy, if the physician or any member of
3 the physician’s family has, directly or
4 indirectly, a significant financial inter-
5 est in such institution, organization,
6 or agency.

7 “(ii) PHYSICIAN’S FAMILY DE-
8 SCRIBED.—For purposes of this para-
9 graph, a physician’s family includes the
10 physician’s spouse (other than a spouse
11 who is legally separated from the physician
12 under a decree of divorce or separate
13 maintenance), children (including step-
14 children and legally adopted children),
15 grandchildren, parents, and grandparents.

16 “(E) EXPLANATION OF DETERMINA-
17 TIONS.—Any determination of a qualified inde-
18 pendent contractor shall be in writing, and shall
19 include a detailed explanation of the determina-
20 tion as well as a discussion of the pertinent
21 facts and applicable regulations applied in mak-
22 ing such determination.

23 “(F) NOTICE REQUIREMENTS.—Whenever
24 a qualified independent contractor makes a de-
25 termination under this subsection, the qualified

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

5 “(G) DISSEMINATION OF INFORMATION.—
6 Each qualified independent contractor shall,
7 using the methodology established by the Sec-
8 retary under subsection (d)(4), make available
9 all determinations of such qualified independent
10 contractors to fiscal intermediaries (under sec-
11 tion 1816), carriers (under section 1842), peer
12 review organizations (under part B of title XI),
13 Medicare+Choice organizations offering
14 Medicare+Choice plans under part C, and
15 other entities under contract with the Secretary
16 to make initial determinations under part A or
17 part B or title XI.

18 “(H) ENSURING CONSISTENCY IN DETER-
19 MINATIONS.—Each qualified independent con-
20 tractor shall monitor its determinations to en-
21 sure consistency of determinations with respect
22 to requests for reconsideration of similar or re-
23 lated matters.

24 “(I) DATA COLLECTION.—

1 “(i) IN GENERAL.—Consistent with
2 the requirements of clause (ii), a qualified
3 independent contractor shall collect such
4 information relevant to its functions, and
5 keep and maintain such records in such
6 form and manner as the Secretary may re-
7 quire to carry out the purposes of this sec-
8 tion and shall permit access to and use of
9 any such information and records as the
10 Secretary may require for such purposes.

11 “(ii) TYPE OF DATA COLLECTED.—
12 Each qualified independent contractor
13 shall keep accurate records of each deci-
14 sion made, consistent with standards es-
15 tablished by the Secretary for such pur-
16 pose. Such records shall be maintained in
17 an electronic database in a manner that
18 provides for identification of the following:

19 “(I) Specific claims that give rise
20 to appeals.

21 “(II) Situations suggesting the
22 need for increased education for pro-
23 viders of services, physicians, or sup-
24 pliers.

1 “(III) Situations suggesting the
2 need for changes in national or local
3 coverage policy.

4 “(IV) Situations suggesting the
5 need for changes in local medical re-
6 view policies.

7 “(iii) ANNUAL REPORTING.—Each
8 qualified independent contractor shall sub-
9 mit annually to the Secretary (or otherwise
10 as the Secretary may request) records
11 maintained under this paragraph for the
12 previous year.

13 “(J) HEARINGS BY THE SECRETARY.—The
14 qualified independent contractor shall (i) pre-
15 pare such information as is required for an ap-
16 peal of its reconsidered determination to the
17 Secretary for a hearing, including as necessary,
18 explanations of issues involved in the deter-
19 mination and relevant policies, and (ii) partici-
20 pate in such hearings as required by the Sec-
21 retary.

22 “(4) NUMBER OF QUALIFIED INDEPENDENT
23 CONTRACTORS.—The Secretary shall enter into con-
24 tracts with not more than 12 qualified independent
25 contractors under this subsection.

1 “(5) LIMITATION ON QUALIFIED INDEPENDENT
2 CONTRACTOR LIABILITY.—No qualified independent
3 contractor having a contract with the Secretary
4 under this subsection and no person who is em-
5 ployed by, or who has a fiduciary relationship with,
6 any such qualified independent contractor or who
7 furnishes professional services to such qualified inde-
8 pendent contractor, shall be held by reason of the
9 performance of any duty, function, or activity re-
10 quired or authorized pursuant to this subsection or
11 to a valid contract entered into under this sub-
12 section, to have violated any criminal law, or to be
13 civilly liable under any law of the United States or
14 of any State (or political subdivision thereof) pro-
15 vided due care was exercised in the performance of
16 such duty, function, or activity.

17 “(d) ADMINISTRATIVE PROVISIONS.—

18 “(1) OUTREACH.—The Secretary shall perform
19 such outreach activities as are necessary to inform
20 individuals entitled to benefits under this title and
21 providers of services and suppliers with respect to
22 their rights of, and the process for, appeals made
23 under this section. The Secretary shall use the toll-
24 free telephone number maintained by the Secretary
25 (1-800-MEDICAR(E)) (1-800-633-4227) to pro-

1 vide information regarding appeal rights and re-
2 spond to inquiries regarding the status of appeals.

3 “(2) GUIDANCE FOR RECONSIDERATIONS AND
4 HEARINGS.—

5 “(A) REGULATIONS.—Not later than 1
6 year after the date of the enactment of this sec-
7 tion, the Secretary shall promulgate regulations
8 governing the processes of reconsiderations of
9 determinations by the Secretary and qualified
10 independent contractors and of hearings by the
11 Secretary. Such regulations shall include such
12 specific criteria and provide such guidance as
13 required to ensure the adequate functioning of
14 the reconsiderations and hearings processes and
15 to ensure consistency in such processes.

16 “(B) DEADLINES FOR ADMINISTRATIVE
17 ACTION.—

18 “(i) HEARING BY ADMINISTRATIVE
19 LAW JUDGE.—

20 “(II) IN GENERAL.—Except as
21 provided in subclause (II), an admin-
22 istrative law judge shall conduct and
23 conclude a hearing on a decision of a
24 qualified independent contractor
25 under subsection (c) and render a de-

1 cision on such hearing by not later
2 than the end of the 90-day period be-
3 ginning on the date a request for
4 hearing has been timely filed.

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

11 “(ii) DEPARTMENTAL APPEALS BOARD
12 REVIEW.—The Departmental Appeals
13 Board of the Department of Health and
14 Human Services shall conduct and con-
15 clude a review of the decision on a hearing
16 described in subparagraph (B) and make a
17 decision or remand the case to the admin-
18 istrative law judge for reconsideration by
19 not later than the end of the 90-day period
20 beginning on the date a request for review
21 has been timely filed.

22 “(iii) CONSEQUENCES OF FAILURE TO
23 MEET DEADLINES.—In the case of a fail-
24 ure by an administrative law judge to
25 render a decision by the end of the period

1 described in clause (ii), the party request-
2 ing the hearing may request a review by
3 the Departmental Appeals Board of the
4 Department of Health and Human Serv-
5 ices, notwithstanding any requirements for
6 a hearing for purposes of the party's right
7 to such a review.

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

12 “(C) POLICIES.—The Secretary shall pro-
13 vide such specific criteria and guidance, includ-
14 ing all applicable national and local coverage
15 policies and rationale for such policies, as is
16 necessary to assist the qualified independent
17 contractors to make informed decisions in con-
18 sidering appeals under this section. The Sec-
19 retary shall furnish to the qualified independent
20 contractors the criteria and guidance described
21 in this paragraph in a published format, which
22 may be an electronic format.

23 “(D) PUBLICATION OF MEDICARE COV-
24 ERAGE POLICIES ON THE INTERNET.—The Sec-
25 retary shall publish national and local coverage

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

3 “(E) EFFECT OF FAILURE TO PUBLISH
4 POLICIES.—

5 “(i) NATIONAL AND LOCAL COVERAGE
6 POLICIES.—Qualified independent contrac-
7 tors shall not be bound by any national or
8 local medicare coverage policy established
9 by the Secretary that is not published on
10 the Internet site under subparagraph (D).

11 “(ii) OTHER POLICIES.—With respect
12 to policies established by the Secretary
13 other than the policies described in clause
14 (i), qualified independent contractors shall
15 not be bound by such policies if the Sec-
16 retary does not furnish to the qualified
17 independent contractor the policies in a
18 published format consistent with subpara-
19 graph (C).

20 “(3) CONTINUING EDUCATION REQUIREMENT
21 FOR QUALIFIED INDEPENDENT CONTRACTORS AND
22 ADMINISTRATIVE LAW JUDGES.—

23 “(A) IN GENERAL.—The Secretary shall
24 provide to each qualified independent con-
25 tractor, and to administrative law judges that

1 decide appeals of reconsiderations of initial de-
2 terminations or other decisions or determina-
3 tions under this section, such continuing edu-
4 cation with respect to policies of the Secretary
5 under this title or part B of title XI as is nec-
6 essary for such qualified independent contrac-
7 tors and administrative law judges to make in-
8 formed decisions with respect to appeals.

9 “(B) MONITORING OF DECISIONS BY
10 QUALIFIED INDEPENDENT CONTRACTORS AND
11 ADMINISTRATIVE LAW JUDGES.—The Secretary
12 shall monitor determinations made by all quali-
13 fied independent contractors and administrative
14 law judges under this section and shall provide
15 continuing education and training to such quali-
16 fied independent contractors and administrative
17 law judges to ensure consistency of determina-
18 tions with respect to appeals on similar or re-
19 lated matters. To ensure such consistency, the
20 Secretary shall provide for administration and
21 oversight of qualified independent contractors
22 and administrative law judges through a central
23 office of the Department of Health and Human
24 Services. Such administration and oversight

1 may not be delegated to regional offices of the
2 Department.

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

7 “(5) SURVEY.—Not less frequently than every 5
8 years, the Secretary shall conduct a survey of a valid
9 sample of individuals entitled to benefits under this
10 title, providers of services, and suppliers to deter-
11 mine the satisfaction of such individuals or entities
12 with the process for appeals of determinations pro-
13 vided for under this section and education and train-
14 ing provided by the Secretary with respect to that
15 process. The Secretary shall submit to Congress a
16 report describing the results of the survey, and shall
17 include any recommendations for administrative or
18 legislative actions that the Secretary determines ap-
19 propriate.

20 “(6) REPORT TO CONGRESS.—The Secretary
21 shall submit to Congress an annual report describing
22 the number of appeals for the previous year, identi-
23 fying issues that require administrative or legislative
24 actions, and including any recommendations of the
25 Secretary with respect to such actions. The Sec-

1 retary shall include in such report an analysis of de-
 2 terminations by qualified independent contractors
 3 with respect to inconsistent decisions and an anal-
 4 ysis of the causes of any such inconsistencies.”.

5 (b) **APPLICABILITY OF REQUIREMENTS AND LIMITA-**
 6 **TIONS ON LIABILITY OF QUALIFIED INDEPENDENT CON-**
 7 **TRACTORS TO MEDICARE+CHOICE INDEPENDENT AP-**
 8 **PEALS CONTRACTORS.**—Section 1852(g)(4) of the Social
 9 Security Act (42 U.S.C. 1395w–22(e)(3)) is amended by
 10 adding at the end the following: “The provisions of section
 11 1869(c)(5) shall apply to independent outside entities
 12 under contract with the Secretary under this paragraph.”.

13 (c) **CONFORMING AMENDMENT TO REVIEW BY THE**
 14 **PROVIDER REIMBURSEMENT REVIEW BOARD.**—Section
 15 1878(g) of the Social Security Act (42 U.S.C. 1395oo(g))
 16 is amended by adding at the end the following new para-
 17 graph:

18 “(3) Findings described in paragraph (1) and deter-
 19 minations and other decisions described in paragraph (2)
 20 may be reviewed or appealed under section 1869.”.

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

23 (a) **EXPANSION OF LIMITATION OF LIABILITY PRO-**
 24 **TECTION FOR BENEFICIARIES WITH RESPECT TO MEDI-**
 25 **CARE CLAIMS NOT PAID OR PAID INCORRECTLY.**—

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

4 “(i) Notwithstanding any other provision of this Act,
5 an individual who is entitled to benefits under this title
6 and is furnished a service or item is not liable for repay-
7 ment to the Secretary of amounts with respect to such
8 benefits—

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

12 “(2) in the case of payments made to the indi-
13 vidual by the Secretary with respect to any claim
14 under paragraph (1), the individual shall be liable
15 for repayment of such amount only up to the
16 amount of payment received by the individual from
17 the Secretary.

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

22 “(A) In the case of a benefit for which an ini-
23 tial determination has not been made by the Sec-
24 retary under subsection (a) whether payment may be
25 made under this title for such benefit.

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

3 “(i) improperly submitted by the provider
4 of services or supplier; or

5 “(ii) rejected by an entity under contract
6 with the Secretary to review or pay claims for
7 services and items furnished under this title, in-
8 cluding an entity under contract with the Sec-
9 retary under section 1857.

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

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

24 “(1) The provider of services shall furnish a no-
25 tice of discharge and appeal rights established by the

1 Secretary under subsection (l) to each individual en-
2 titled to benefits under this title to whom such pro-
3 vider of services furnishes services, upon admission
4 of the individual to the provider of services and upon
5 notice of determination to discharge the individual
6 from the provider of services, of the individual's limi-
7 tations of liability under this section and rights of
8 appeal under section 1869.

9 “(2) If the individual, prior to discharge from
10 the provider of services, appeals the determination to
11 discharge under section 1869 not later than noon of
12 the first working day after the date the individual
13 receives the notice of determination to discharge and
14 notice of appeal rights under paragraph (1), the pro-
15 vider of services shall, by the close of business of
16 such first working day, provide to the Secretary (or
17 qualified independent contractor under section 1869,
18 as determined by the Secretary) the records required
19 to review the determination.

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

1 guage inform such individuals of their limitations on liabil-
2 ity, their rights under section 1869(a) to obtain an initial
3 determination by the Secretary of whether payment may
4 be made under part A or part B for such benefit, and
5 their rights of appeal under section 1869(b), and shall in-
6 form such individuals that they may obtain further infor-
7 mation or file an appeal of the determination by use of
8 the toll-free telephone number (1-800-MEDICAR(E))
9 (1-800-633-4227) maintained by the Secretary. The
10 forms developed by the Secretary under this subsection
11 shall be the only manner in which such individuals may
12 waive such protections under this title or title XI.

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

21 (2) CONFORMING AMENDMENT.—Section
22 1870(a) of the Social Security Act (42 U.S.C.
23 1395gg(a)) is amended by striking “Any payment
24 under this title” and inserting “Except as provided
25 in section 1879(i), any payment under this title”.

1 (b) INCLUSION OF BENEFICIARY LIABILITY INFOR-
2 MATION IN EXPLANATION OF MEDICARE BENEFITS.—
3 Section 1806(a) of the Social Security Act (42 U.S.C.
4 1395b–7(a)) is amended—

5 (1) in paragraph (1), by striking “and” at the
6 end;

7 (2) by redesignating paragraph (2) as para-
8 graph (3); and

9 (3) by inserting after paragraph (1) the fol-
10 lowing new paragraph:

11 “(2) lists with respect to each item or service
12 furnished the amount of the individual’s liability for
13 payment;”;

14 (4) in paragraph (3), as so redesignated, by
15 striking the period at the end and inserting “; and”;
16 and

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

19 “(4) includes the toll-free telephone number (1–
20 800–MEDICAR(E)) (1–800–633–4227) for infor-
21 mation and questions concerning the statement, li-
22 ability of the individual for payment, and appeal
23 rights.”.

1 **SEC. 223. WAIVERS OF LIABILITY FOR COST SHARING**
2 **AMOUNTS.**

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

7 “(i) the waiver is offered as a part of
8 a supplemental insurance policy or retiree
9 health plan;

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

14 “(iii) the person waives the coinsur-
15 ance and deductible amount after the bene-
16 ficiary informs the person that payment of
17 the coinsurance or deductible amount
18 would pose a financial hardship for the in-
19 dividual; or

20 “(iv) the person determines that the
21 coinsurance and deductible amount would
22 not justify the costs of collection.”.

23 (b) **CONFORMING AMENDMENT.**—Section 1128B(b)
24 of the Social Security Act (42 U.S.C. 1320a–7b(b)) is
25 amended by adding at the end the following new para-
26 graph:

1 “(4) In this section, the term ‘remuneration’ in-
2 cludes the meaning given such term in section
3 1128A(i)(6).”.

4 **SEC. 224. ELIMINATION OF MOTIONS BY THE SECRETARY**
5 **ON DECISIONS OF THE PROVIDER REIM-**
6 **BURSEMENT REVIEW BOARD.**

7 Section 1878(f)(1) of such Act (42 U.S.C.
8 1395oo(f)(1)) is amended—

9 (1) in the first sentence, by striking “unless the
10 Secretary, on his own motion, and within 60 days
11 after the provider of services is notified of the
12 Board’s decision, reverses, affirms, or modifies the
13 Board’s decision”;

14 (2) in the second sentence, by striking “, or of
15 any reversal, affirmance, or modification by the Sec-
16 retary,” and “or of any reversal, affirmance, or
17 modification by the Secretary”; and

18 (3) in the fifth sentence, by striking “ and not
19 subject to review by the Secretary”.

1 **TITLE III—MEDICARE+CHOICE**
2 **REFORMS; PRESERVATION OF**
3 **MEDICARE PART B DRUG**
4 **BENEFIT**
5 **Subtitle A—Medicare+Choice**
6 **Reforms**

7 **SEC. 301. INCREASE IN NATIONAL PER CAPITA**
8 **MEDICARE+CHOICE GROWTH PERCENTAGE**
9 **IN 2001 AND 2002.**

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

12 (1) in clause (iv), by striking “for 2001, 0.5
13 percentage points” and inserting “for 2001, 0.4 per-
14 centage points”; and

15 (2) in clause (v), by striking “for 2002, 0.3 per-
16 centage points” and inserting “for 2002, 0.2 per-
17 centage points”.

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

20 Section 1853(c) of the Social Security Act (42 U.S.C.
21 1395w-23(c)) is amended—

22 (1) in paragraph (1)(A), in the matter following
23 clause (ii), by inserting “(for years before 2002)”
24 after “multiplied”; and

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

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

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

7 (1) by striking “(ii) For a succeeding year” and
8 inserting “(ii)(I) Subject to subclause (II), for a suc-
9 ceeding year”; and

10 (2) by adding at the end the following new sub-
11 clause:

12 “(II) For 2002 for any of the 50
13 States and the District of Columbia,
14 \$450.”.

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

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

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

21 (1) by striking the period at the end of sub-
22 paragraph (F) and inserting a semicolon; and

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

1 “except that a Medicare+Choice organization may
2 elect to apply subparagraph (F) (rather than sub-
3 paragraph (E)) for 2002.”.

4 **SEC. 305. INCREASED UPDATE FOR PAYMENT AREAS WITH**
5 **ONLY ONE OR NO MEDICARE+CHOICE CON-**
6 **TRACTS.**

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

10 (1) in clause (i), by striking “(ii) For a subse-
11 quent year” and inserting “(ii)(I) Subject to sub-
12 clause (II), for a subsequent year”; and

13 (2) by adding at the end the following new sub-
14 clause:

15 “(II) During 2002, 2003, 2004, and
16 2005, in the case of a Medicare+Choice
17 payment area in which there is no more
18 than 1 contract entered into under this
19 part as of July 1 before the beginning of
20 the year, 102.5 percent of the annual
21 Medicare+Choice capitation rate under
22 this paragraph for the area for the pre-
23 vious year.”.

24 (b) CONSTRUCTION.—The amendments made by sub-
25 section (a) do not affect the payment of a first time bonus

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

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

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

8 (1) in the matter before subparagraph (A), by
9 striking “or (C)” and inserting “(C), or (D)”; and

10 (2) by adding at the end the following new sub-
11 paragraph:

12 “(D) PERMITTING HIGHER RATES
13 THROUGH NEGOTIATION.—

14 “(i) IN GENERAL.—For each year be-
15 ginning with 2004, in the case of a
16 Medicare+Choice payment area for which
17 the Medicare+Choice capitation rate under
18 this paragraph would otherwise be less
19 than the United States per capita cost
20 (USPCC), as calculated by the Secretary,
21 a Medicare+Choice organization may ne-
22 gotiate with the Medicare Benefits Admin-
23 istrator an annual per capita rate that—

1 “(I) reflects an annual rate of in-
2 crease up to the rate of increase speci-
3 fied in clause (ii);

4 “(II) takes into account audited
5 current data supplied by the organiza-
6 tion on its adjusted community rate
7 (as defined in section 1854(f)(3)); and

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

11 “(ii) MAXIMUM RATE DESCRIBED.—
12 The rate of increase specified in this clause
13 for a year is the rate of inflation in private
14 health insurance for the year involved, as
15 projected by the Medicare Benefits Admin-
16 istrator, and includes such adjustments as
17 may be necessary—

18 “(I) to reflect the demographic
19 characteristics in the population under
20 this title; and

21 “(II) to eliminate the costs of
22 prescription drugs.

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

1 area for a year, in applying this subpara-
2 graph for a subsequent year the provisions
3 of paragraph (6)(C) shall apply in the
4 same manner as such provisions apply
5 under this paragraph.”.

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

8 Section 1853(a)(3)(C)(ii) of the Social Security Act
9 (42 U.S.C. 1395w-23(c)(1)(C)(ii)) is amended—

10 (1) by striking the period at the end of sub-
11 clause (II) and inserting a semicolon; and

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

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

1 **Subtitle B—Preservation of Medi-**
2 **care Coverage of Drugs and**
3 **Biologicals**

4 **SEC. 311. PRESERVATION OF COVERAGE OF DRUGS AND**
5 **BIOLOGICALS UNDER PART B OF THE MEDI-**
6 **CARE PROGRAM.**

7 (a) IN GENERAL.—Section 1861(s)(2) of the Social
8 Security Act (42 U.S.C. 1395x(s)(2)) is amended, in each
9 of subparagraphs (A) and (B), by striking “(including
10 drugs and biologicals which cannot, as determined in ac-
11 cordance with regulations, be self-administered)” and in-
12 serting “(including drugs and biologicals which are not
13 usually self-administered by the patient)”.

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

○